1st 1000 Most Critical Days

The Best Start to Life

FANSER Good Practices: Volume I

The FANSER Care Group Model with structured training curriculum for cost-efficient & large-scale household-counselling to trigger nutrition specific & nutrition sensitive behaviour change in Zambia

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In cooperation with CRS

EAT HEALTHY
EAT DIVERSE
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FOOD GROUPS

Good Practices: The Care Group Model

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Sources
CRS;
The TOPS Program, Care Groups: A Reference Guide for Practitioners, 2016;
CORE Group/Food for the Hungry/World Relief (https://caregroupinfo.org)

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About this Book

This book is part of the Food and Nutrition Security, Enhanced Resilience Project (FANSER). FANSER has been initiated and commissioned by the German Federal Ministry of Economic Cooperation and Development (BMZ) as part of the Special Initiative ONE WORLD – No Hunger. The initiative aims to address the challenges of hunger and malnutrition.

In Zambia, FANSER aims to improve the nutritional situation for women of reproductive age and young children in the following five fields of intervention, corresponding to the 1000 Most Critical Days Programme (MCDP) minimum service package (except critical situations).

1. Increase knowledge about nutrition, change attitudes positively
2. Increase knowledge about hygiene, change attitudes positively
3. Increasing the year-round availability of nutrient-rich foods / nutrition-sensitive agriculture
4. Developing improved strategies for households to manage their household and productive resources
5. Strengthening nutrition governance at the district, provincial and national level

As part of the national Scaling Up Nutrition (MCDP) process and the 1000 Most Critical Days Programme, FANSER reaches out to 110,000 women and 70,000 children in Eastern and Luapula Provinces. To reach this target group, the project relies on the Care Group Model - first implemented in Zambia by our partner Catholic Relief Services.

This book aims to give an overview about the benefits of the model in wide-scale projects and encourage other organisations to consider it in their planning.

Moritz Heldmann

Coordinator for the Agriculture and Food Security Cluster GIZ Zambia

List of Abbreviations

BMZ	German Federal Ministry for Economic Cooperation and Development
CRS	Catholic Relief Services
FADDAUH	Frequency, Amount, Diversity, Density, and Active Feeding
FANSER	Food and Nutrition Security, Enhanced Resilience Project
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
MCDP	1000 Most Critical Days Programme
MoA	Ministry of Agriculture
NFNC `	National Food and Nutrition Commission
NV	Nutrition Volunteer
SEWOH	Special Initiative ONE WORLD - No Hunger
SILC	Savings and Internal Lending Communities
SUN	Scaling Up Nutrition
WR	World Relief

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Introduction

The Care Group model provides inclusive equitable access to health information, mobilizes the community into action to improve health, promotes behavioural change, educates women on basic health issues and creates a sustainable project using minimal financial resources. The model aims to reach high numbers of beneficiaries with relevant training in a short time with reasonable costs. FANSER has been using the Care Group model since 2016 to promote the adoption of positive health, WASH, and nutrition practices.

By cascading, this model has helped to reach a large scale. The monthly staggered delivery of lessons ensures that Nutritional Volunteers have sufficient time to reach out to their targeted households. Further, through accompaniment of Health Promoters and Sanitation Promoters strengthen the facilitation skills of the Nutritional Volunteers while at the same time promoting program quality. The monthly individual training of Health Promoters by the Nutrition Field Supervisors allows for calibrated capacity building aligned with the Health Promoter' and Sanitation Promoter' needs and level of progress. Finally, having nutrition passbooks (passports) allows the project team to track progress in implementation and promotes a more robust monitoring of program performance and quality.

Quick Facts: CRS Care Groups in Zambia (Eastern Province)

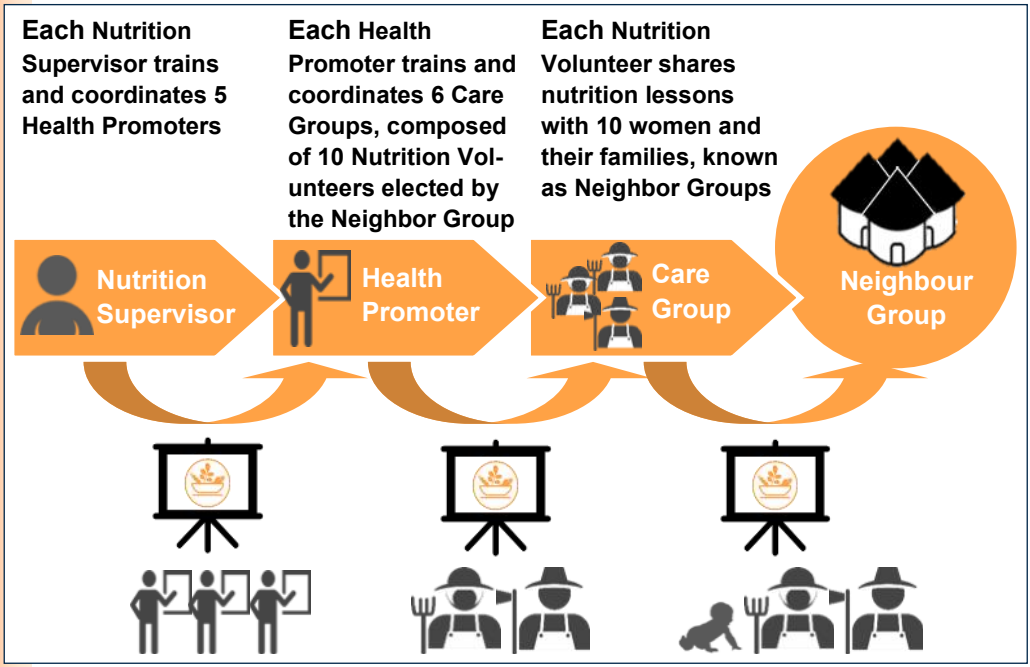
Implemented in:	**2015**
Outreach (Up to 2020):	**82,754 women of reproductive age**
	51,612 children under 2 years of age
Number of Volunteers (and related staff):	**77 Health Promoters**
	78 Sanitation Promoters
	4,400 Nutrition Volunteers
	152 Gender Champions

What is the Care Group Model?

The first application of the Care Group Model took place in 1995. Employees of the World Relief (WR) used it in Mozambique to support efforts around maternal and child health to reduce maternal, newborn and child mortality. Within a few years, and with evidence generated on its effectiveness, the concept became an accepted model to deliver social behaviour trainings and accompaniment to large numbers of beneficiaries. Food for the Hungry (FH) adopted the model also in Mozambique in 1997 after discussions with WR project staff, and both organisations have been pioneering the use of the model since then. To date, more than 25 organisations in nearly 30 countries have been implementing the Care Group methodology, and have continued to contribute to the body of evidence concerning the efficacy of the approach. The approach has been adapted for use to complement social behaviour change efforts in a number of different program interventions including child survival, maternal health, and integrated nutrition.

Set up

A Care Group consists of 10 to 15 people from different households/ villages known as Care Group volunteers. Depending on the intervention, these volunteers are often 'lead mothers' or community champions that have a passion to tackle a social issues or behavioural barriers within their communities. Volunteers are selected from within their community and are endorsed by their community leaders and neighbours for participation in a Care Group. The engagement of other community members and leaders in this selection process is critical in ensuring acceptance of the volunteer by the targeted households. Volunteers, once trained, serve as role models to support the adaption of new practices intended to influence positive behaviour change.



Picture 1: Organisation of Care Groups

There is evidence that "block leaders" (like Care Group Volunteers) can be more effective in promoting the adoption of behaviours among their neighbours than others who do not know them as well[1].

The number of households supported by a Care Group Volunteer is often kept to a minimum to reduce the workload required in the dissemination of messages. Care Group Volunteers do not receive monetary incentives but are often motivated by the social recognition within their communities when they are seen as repositories for critical and life changing messages.

Evidence indicates that the ideal size for one's "sympathy group" - the group of people to whom you devote the most time - is 10 to 15 people[2]. Other considerations related to the time needed by volunteers to fulfil their duties include the length of time it takes for a volunteer to walk to the furthest household. It is advisable that the volunteers should not have to walk more than 45 minutes. Care groups usually meet at least once a

[1] *Please see: 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] *Please see: Gladwell, M. 2002. The tipping point. Boston: Little, Brown and Company, pp. 175–181.*

Implementation in Zambia

Within the FANSER project in Zambia, the Care Group model has been the primary vehicle for promoting the adoption of positive health, WASH and nutrition practices. The project has been using the approach to promote the consumption of nutrient-dense and protein-rich foods, with a focus on preventing malnutrition among children under two years and pregnant and lactating women, particularly young mothers.

The National Food and Nutrition Commission in Zambia recognizes the Care Group Model as a best practice to implement the MCDP II: "The Community Care Group (CCG) model's multiplying effect coupled with robust social behavior change communication, advocacy for action at all operational levels and reinforced accountability from implementers, is expected to saturate geographic areas and priority population groups with the 6 high impact interventions to reach the 90% coverage[3]."

In the FANSER project, Care Groups comprise of lead mothers and community champions known as Nutrition Volunteers. These volunteers are overseen by Health Promoters who meet with the Care Groups monthly to build new skills, consolidate learning and propose solutions based on practice and observation to address obstacles that negatively impact health and nutrition status. The Health Promoter presents a key nutrition, health or WASH related message each month to ensure that the volunteers understand the importance of that message. S/he then accompanies the volunteers to a few households to ensure that the messages have been understood and are being conveyed accurately to the target households.

Having received the monthly messages, the Nutrition Volunteers then provide counselling and support to women and influential household members (including male partners and grandmothers) through monthly household visits and lessons around improving nutrition for pregnant and lactating women and children under 2 years.

[3] *Please see: MFMC. 2009. The first 1000 most critical day programme, pp. 19.*

The adapted Care Group manual currently being used by FANSER has approximately 16 modules described in more detail in figure 1. Knowledge, attitude and practices assessments are conducted within the project to determine whether targeted households are applying key lessons learned through the Care Group structure. If there is evidence of lack of clarity around a particular message, the project team facilitates a refresher exercise, or will work to revise the lessons and ensure they are accessible and easily understood by the health promoter, volunteer and household.

Ensuring quality in a large scale cascade model

Picture 2: Nutrition Passport

Real time activity tracking & operative monitoring are key to the success of the model. The project uses an adapted version of the nutrition passport (Picture 2) that has been implemented in other FANSER supported countries to track interventions (including lessons and complementary services received) at household level. This includes a list of key trainings/modules received, and the dates offered. The passport serves as an important source document that is verified during monitoring visits.

Data from the nutrition passports is uploaded to a database that houses all beneficiaries served including women of reproductive age, children under 2 years and men. The database includes output information for all key interventions offered and numbers of beneficiaries served.

On an annual basis, survey data is collected from participating households to determine relay progress made on project outcomes by intervention. The results of the annual survey are used as a reflection tool to support course correction in ensuring efficient and effective delivery to households.

“Knowledge Sharing is Easy”

A FANSER Publication

Lisa Mubuka: Health and Nutrition Field Supervisor (Katete)

What is your role within the care-group model?

As a nutrition field supervisor, it is my responsibility to get monthly lessons from the nutrition project officer which I have to deliver to the intermediaries that we have. This includes the Health Promoters and the Sanitation Promoters.

Each care-group has a specific date when the lesson is shared. On those dates, I have to attend at least 3 care-group meetings from each Health Promoter for Supervision. Both nutrition and WASH lessons carry key messages that are sensitive, if the lesson is distorted it could lead to wrong information being disseminated. It is my role to give guidance and clarity to the lessons while being delivered to the Nutrition Volunteers.

What are the benefits of the care-group model for development cooperation?

It has a wider coverage, which involves 80% of the community, making it easier to reach the targeted beneficiaries. It has a multiplying factor in such a manner that one field supervisor is in charge of maximum 5 Health Promoters and Sanitation Promoters who supervise 50 Nutrition Volunteers (NV). Each NV has ten households to deliver lessons too. This means that as a supervisor I am able to reach about 5000 beneficiaries.

Knowledge sharing is easy, information can be easily conveyed to the targeted beneficiaries. The NVs can easily reach the beneficiaries since they stay in the same neighbourhood. It allows the community to be fully involved which allows them to own the project.

How do you monitor the impact and progress during the implementation?

Monitoring of results and progress of the project is done through household visitations. This is done by the HNFS going personally to the households and check the progress of the activities that they committed to do during lesson delivery.

During household visits, the Health and Nutrition Field Supervisor checks the nutrition passports to see the progress in terms of lessons received and other IEC materials.

Nutrition Volunteers write reports every month and through them, we are able to track the number of households that have received the lessons.

month to ensure regular contact and the achievement of goals.

Structured curriculum with 16 modules

The materials for the current Care Group manual includes key messages from: the infant and young child feeding manuals from the National Food and Nutrition Commission; WASH messages from the Ministry of Water Development, Sanitation and Environmental Protection and essential WASH actions adapted from USAID's SPRING project; and keyhole gardens materials initially developed by CRS with recent revision from GIZ and the Ministry of Agriculture. The materials are published in different languages including the main dialects in the target areas.

Health Promoters deliver each key message monthly using the ASPIRE learning techniques (Ask, Show, Probe, Inform, Request and Exam), designed to reinforce key lessons being disseminated. Refresher trainings

Working as a Nutrition Volunteer: Changing behaviour gives me confidence

The Care Group model clearly states my position in the project and what and how I should carry out my roles. Every month, the Health Promoters teach us how to deliver the messages and how to address the households under my care.

Febby Mwanza: Nutrition Volunteer
Mondola Camp (Petauke)

I meet my households at least twice each month to deliver the lesson of the month and to make follow ups to their commitments. My Health Promoter meets me at least three times in a month to teach me on the lesson of the month, to collect reports on the monthly lesson and to make follow ups.

are conducted and/or materials revised if there are new messages that need to be offered or if volunteers are struggling to convey a critical message to their households. The curriculum is regularly updated - its current content can be found below:

The 16 modules of the CRS Care Group model in Zambia

Module 1: Smart, Healthy and Strong

Module 2: Best Start to Life: Why Good Nutrition Matters

Module 3: Healthy Diet for Pregnant and Breastfeeding Women

Module 4: Better Breastfeeding

Module 5: Hand Washing

Module 6: Sanitation

Module 7: Water Handling and Treatment

Module 8: Food Hygiene

Module 9: Feeding a Child 6-23 Months- FADDAUH

Module 10: Food Groups and Diversity

Module 11: Feeding Your Child 0 to 6 month old, During and After Illness

Module 12: Feeding Your Child 6 to 23 months old During and After Illness

Module 13: Best start to life: child growth and development

Module 14: Catching Child Health Problems Early

Module 15: Food Processing and Preservation

Module 16: Planning for the Growing Season - Considering Nutrition and Crop Diversification

Figure 1: 16 Modules for nutrition and WASH in Zambia

“High impact due to peer learning”: Interview with the Provincial Nutrition Support Coordinator Eastern Province

Felisters Nyimba Simpasa: Provincial Nutrition Support Coordinator Eastern Province, NFNC

What are the benefits of the Care Group Model for large-scale projects?

The model enables you to reach out to a large number of targeted beneficiaries within a short period without overburdening the volunteers. Each volunteer reaches 10 beneficiaries at their own time but within a specified period e.g. a month.

It is cost effective in terms of human resources, as you are not using paid up staff but volunteers who do not need to be paid a lot of finances if they need to be paid.

The capacity building for the volunteers comes with reasonable costs as it is conducted within the communities and the volunteers are incentivized with some inputs and the increase of their position within the communities.

It has higher impact due to peer learning which enables the messages to reach the beneficiaries at their own level.

How does the model work in your project region?

1. The District Nutritionist provides overall oversight of nutrition efforts.
2. The Environmental Health Technicians (full-time paid positions) are the field supervisors and they support 4-5 Health promoters.
3. The Health Promoters (community health workers) manage not more then 5 Care Groups. These Health Promoters should be provided with a monthly stipend as they are responsible for training nutrition volunteers in Care Groups, data collection and reporting on household level interaction of volunteers.

4. Care Groups comprise 10 nutrition volunteers. No financial incentives or stipends are provided. They however receive a bicycle, t-shirt, branded bag and training materials to reach their targeted households.

5. Each Nutrition Volunteer covers 8-12 households.

What are the main topics implemented through the Care Group Model in your region?

The trainings focus on five main areas:

- Environment and personal hygiene
- Collection, treatment and storage of drinking water
- Child care and feeding practices, maternal nutrition
- Food preparation, food groups/dietary diversity
- How to conduct community-based growth monitoring and promotion, referral recommendations

What were the main challenges implementing organisations can face when implementing the Care Group Model?

The implementing organisation are likely to face difficulties in communities where there are other partners working, using the same volunteers and are providing better or more incentives.

Formation of parallel structures in the communities is another challenge as sustainability is not there when the implementing organisation closes out, especially if the volunteers were specifically meant to implement interventions for the organisation.

What is your advice for organisations implementing the Care Group Model?

Avoid formation of parallel structures in the implementation of the Care Group model.

The implementing organisation should instead strengthen the already existing volunteers under the line ministries. This way, you are assured of continuity of the Care Group interventions even after the organisation closes out.

Implementing at reasonable cost:
Voluntary work & incentives used in Zambia

To support the cascade of nutrition messages to targeted households, from years of implementation in Zambia, CRS has found the following mix for field supervision and training support to households works most effectively:

1. Each Field Supervisor (or Environmental Health Technicians) is responsible for 4-5 Health Promoters.
2. Health Promoters (or Community Health Workers) should manage not more than 5 Care Groups.
3. Care Groups comprise of 10 Nutrition Volunteers.
4. Each Nutrition Volunteer covers 8-12 households.

This allocation is used to guide the number of volunteers, health promoters and staff needed to effectively reach the targeted number of project beneficiaries per camp, ward and district.

"Being cooperative"

Zelipa Mwale: HP Chimtanda 1 Camp

What is your role within the Care Group Model?
My role as a Health Promoter starts with being trained every month by my supervisor in lessons delivery. Afterwards, I conduct meetings for my five Care Groups.

- I train the Nutrition Volunteers in lesson delivery and collect reports. I compile the reports and submit them to my supervisor.
- I also support the NVs as they deliver lessons to the households and organize and coordinate community mobilization meetings and trainings
- If possible, I use the phone to train Care Groups in lessons delivery, for reporting and to receive information about NVs and their households.

Can you describe the cooperation with your Nutrition Volunteers?
In my four years working with FANSER, I worked well with my Nutrition Volunteers. The response from the NVs is good and the participation has been encouraging. Whenever called upon to attend trainings or to mobilize the households , the Nutrition Volunteers have been cooperative.

Incentives used in Zambia (under CRS)

Position	Incentives
 **Coordinator/ Nutrition Officer**	Salaried worker under CRS
 **Nutrition Field Supervisors/ SILC Field Supervisors/Gender Animators**	Salaried worker under Caritas. A motorbike, full motorbike gear, and lunch allowance working out of station more than 8 hours are provided.
 **Health Promoters, Sanitation Promoters, SILC Field Agents**	Given a monthly stipend of K400. Bicycles, t-shirts, bags, transport refund and dinner allowance are provided when attending residential trainings. Health Promoters have phones for data collection and communication, food for community trainings taking more than 3 hours is provided.
 **Nutrition Volunteers Gender Champions**	Bicycles, t-shirts, bags, lunch/food during community meetings that take more than three hours are provided. Lunch provided to nutrition volunteers when they direct enumerators

“I appreciate the Care Group model as part of my outreach activities”

Joseph Mwewa: Environmental Health Technician for Kagolo Health Center (Katete)

What are the benefits of the Care Group model for large scale projects?

The benefits of the Care Group are that from the time project activities started in the communities surrounding the health Centre we only see few malnourished cases unlike the way it was before the FANSER set its operations here. The Care group model is a very good approach because it comes to the household as behaviour change process. Through the involvement of local community volunteers it is easily acceptable for all community members. The health/ nutritional advise given through the CG are very helpful in the sense that it is based on locally acceptable and doable ideas to solve problems affecting households. As a health worker, I appreciate the model as part of my outreach activities.

How does a Care Group model work in your region?

Through the Care Group model, mothers now have more time to interact and care for their children. Most mothers have now adapted good nutrition and caring practices such as complementary feeding for their children and hygiene practice to keep their children strong and healthy.

What are the main topics implemented through the Care Group model in your region?

The main topics are sanitation and hygiene, good nutrition, food preservation and child caring practices.

What are the main challenges implementing organisations can face when implementing a Care Group model?

The main challenges that affected the implementation of the Care Groups were low literacy levels in the communities and volunteers who may be used to better incentive from other NGOs than the FANSER project offers.

What is your advice for organisations implementing the Care Group model?

The model requires lots of monitoring and evaluation to ensure effective implementation. If the intermediaries are left on their own, messages might be altered or lost completely. In a case like this, good results may be difficult to realize.

Nutrition Volunteers in Eastern Province

Zeipa Miti, 35 years, Mandowa Village: By helping others, we change the lives in our community through training in sanitation and hygiene practices as well as the promotion of better diets.

Violet Sakala, 52 years, Nyanoka Village: I want to see how the results of FANSER will benefit the people at the end of the project.

Esther Tembo, 50 years, Matonje Village: I want to spread the messages on health to benefit the people of Zambia.

John Phiri, 54 years, Kambwili Village: I help women and children on health issues such as proper feeding practices as well as health and hygiene.

Christine Zimba, 28 years, Dani Village: I love my work as a nutrition volunteer because I help my neighbors to change their child feeding habits.

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