Save the Children

IMPLEMENTING THE CARE GROUP APPROACH: TANZANIA CASE STUDY

October, 2016. Lindi, Tanzania

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Acronyms

ANC	Ante Natal Care
CG	Care Groups
CGV	Care Group Volunteer
FGDS	Focus Group Discussions
HANO	Harnessing Agriculture for Nutrition Outcomes
HH	House Hold
IGA	Income Generating Activity
IYCF	Infant and Young Child Feeding
LISAWE	Lindi Support Agency for Welfare
MAM	Moderate Acute Malnutrition
MCH	Mother and Child Health
MIYCN	Maternal Infant and Young Child Nutrition
MMSG	Mother to Mother Support Group
NW	Neighbour Women
PD	Positive Deviance
ROPA	Ruangwa Organization for Poverty Alleviation
SAM	Severe Acute Malnutrition
VICOBA	Village Community Bank

Executive Summary

The Harnessing Agriculture for Nutrition Outcomes (HANO) project is an Irish Aid funded multi-year project (2012-2017) implemented by Save the Children in collaboration with Lindi Support Agency for Welfare (LISAWE) and Ruangwa Organization for Poverty Alleviation (ROPA) in Lindi and Ruangwa Districts respectively, Lindi Region, Tanzania. The integrated agriculture and nutrition project aims to reduce chronic malnutrition in children aged 0-23 months by 10%.

To achieve the aims of the project, strategies to promote behaviour change around key Infant and Young Child Feeding (IYCF) practices were developed using peer support approaches. During the first phase of implementation (2012-2015), the Mother to Mother Support Group (MMSG) approach was adopted and after a midterm review undertaken in 2015, it was recommended to use the Care Group (CG) approach to improve coverage and effectiveness of the behaviour change messaging and promotion.

This case study aimed to document the CG approach as well as to identify the differences between the CG and MMSG approaches. Qualitative methods using focus group discussions and key informant interviews as well as a review of project documents was undertaken in October 2016.

This case study documents that MMSG and CG approaches as implemented in the HANO project, identifies the differences, strengths and weaknesses of the approaches as well as compares the Care Groups against the recommended criteria.

Findings

Mother to Mother support Groups: The MMSG approach was an adaptation of the Mother to Mother Support Groups and the Positive Deviance approaches. The integration of the 12 days consecutive training using cooking demonstrations, growth monitoring and linkages with health facilities and schools were identified as the strengths of the approach while the weaknesses were mainly related to a lack of structure, guidance, tools and follow up; and that the mixture of different approaches may have created some confusion for the staffs leading to poor implementation. In addition, targeting only pregnant and lactating women was seen to be discriminative by others (community leaders, men) who wanted to be part of and learn from the groups.

The Care Group Approach: The Care Groups as implemented in the HANO project align well with the recommended Care Group Criteria (World Relief) and there has been good reception and acceptance at the community level.

The main differences between the two approaches were:

- The Care Groups target both women and male volunteers interested in being part of the groups as compared with the MMSGs that only targeted pregnant and lactating women.
- The Care Groups have a clear structure, have standardised tools (training and supervision toolkit) and guidelines that allow monitoring, follow up, supervision and reporting as opposed to the MMSGs which did not have the proper guidelines and tools for monitoring and follow up.

Following this study; it is recommended that:

- Promoters are provided with refresher training on facilitation skills, with a focus on those found to be weak during supervision visits.
- Explore with the community leaders and volunteers the best approach for provision of food items for cooking demonstrations as a majority of the volunteers do not wish to provide the food items.
- Consider ways in which community leaders and health workers can be integrated into the project, borrowing lessons from the first phase of implementation.
- Consider the feedback from the project participants on the kind of small livestock to promote for future projects. The participants' feedback was that poultry keeping is not ideal as the poultry is prone to diseases as compared to fish or goats which are considered more viable.

Introduction

The Harnessing Agriculture for Nutrition Outcomes (HANO) project is an Irish Aid funded multi-year project (2012-2017) implemented by Save the Children in collaboration with Lindi Support Agency for Welfare (LISAWE) and Ruangwa Organization for Poverty Alleviation (ROPA) in Lindi and Ruangwa Districts respectively, Lindi Region, Tanzania. The integrated agriculture and nutrition project aims to reduce chronic malnutrition in children aged 0-23 months by 10%.

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The CG approach was implemented from April 2016 with formation of new groups and existing MMSGs transitioning into the CG structure. The CG approach was implemented as an action research so that improvements to the approach can be made as the implementation progresses. This case study aimed to document the CG approach as well as to identify the differences between the CG and MMSG approaches. Specifically, the case study aimed to fulfil the following objectives:

1. Describe the CG model as implemented within the HANO project.
2. Identify the differences, strengths and weakness of the CG model as compared to the MMSGs.
3. Identify the impact of the CG model in the target communities.
4. Make recommendations on how the CG model can be implemented for greater project outcomes (including how to coordinate with other government service providers).

Figure 1: Mandarawe CGV attending a meeting

Methodology

- A desk review of project documents was undertaken to understand the design and implementation of the CG and MMSG approaches. In addition, guidance documents on CGs from the COREGROUP website were reviewed to compare the extent to which the HANO CGs conform to the guidelines.
- Focus Group Discussions (FGDs) were undertaken with CG volunteers, community leaders, previous members of the MMSGs and neighbour women. A total of 22 FGDs each comprising 7-15 members were undertaken in 16 villages (8 in Lindi Rural and 8 in Ruangwa districts) using a structured FGD guide. Interviews were conducted in Kiswahili and responses audio recorded using Samsung Tablets and later transcribed and translated into English for analysis.
- Key informant interviews were undertaken with health workers and project staffs from Save the Children and partners.

Description of the Behaviour Change and Communication approaches used in the HANO project

Mother to Mother Support Group Approach

During the first phase of implementation (2012-2015), the HANO project used an adapted model that combined the MMSGs[1] approach and the Positive Deviance (PD) approach[2]. In this model, MMSGs consisted of 30 pregnant and lactating mothers with one group per village. After training, each group member was expected to reach out to 10 women (either pregnant or with children under 24 months) and provide a minimum of four follow up visits to discuss issues around Maternal and Infant and Young Child Nutrition (MIYCN).

The group members received practical training over a period of 12 days (2 hours per day) on meal preparation and feeding of children aged 6-24 months, as well as other lessons on feeding during pregnancy and when breastfeeding; importance of using iodized salt, iron folate supplementation, sanitation and hygiene, care of the sick child among others. Women with underweight babies were particularly encouraged to attend as the training also involved weighing of children at the start and end of the 12 days to monitor weight gain. The women attending provided all of the foods and the utensils used for training. The aim of the 12 days training (adapted from the PD Hearth approach) was to demonstrate to mothers how local foods can be combined to provide balanced meals for young children and once the mothers see the benefits from the weight gain in their children, they would be motived to support other women to adopt these practices. In addition, the group members also benefitted from the agriculture component in which they received communal solar driers to encourage post-harvest preservation of fruits and vegetables, they received agriculture training and extension kitchen gardening and cultivation of fruit crops.

Figure 2: A cooking demonstration session by a MMSG

After graduation from the 12 days training, mothers were encouraged to join the Village Community Banks (VICOBA) to enable them have internal savings and lending as a way of sustaining the groups.

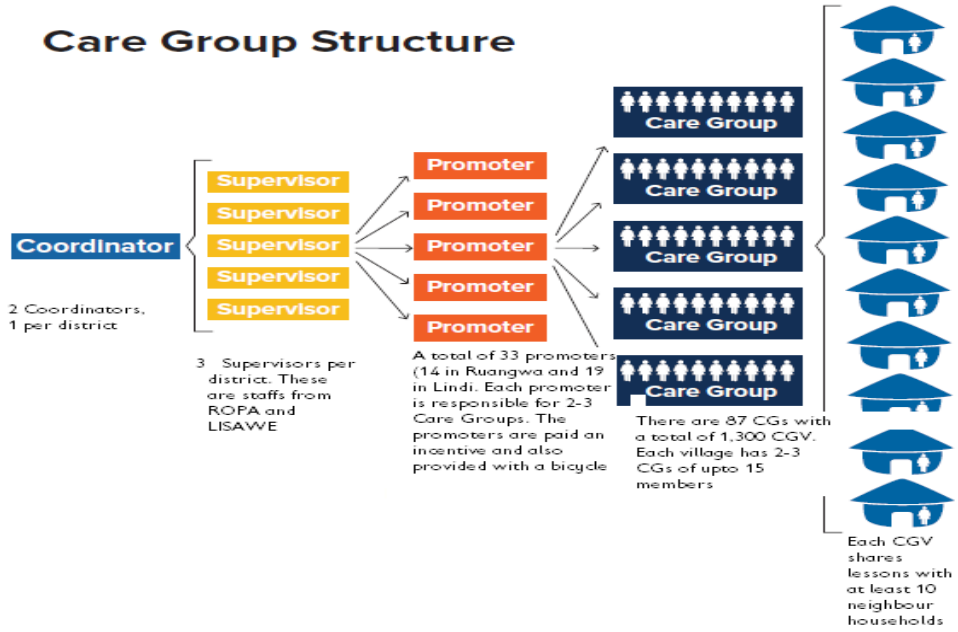
[1] Visit www.iycn.org for further resources

[2] Positive Deviance is based on the observation that in every community there are certain individuals or groups whose uncommon behaviors and strategies enable them to find better solutions to problems than their peers, while having access to the same resources and facing similar or worse challenges. For more information refer to http://www.positivedeviance.org/

The Care Group Approach

The CG approach was implemented during the second phase of the project (from April 2016). The creation of the groups and training followed the model created by WorldRelief and was based on the Care Group Training Manual for Programme Design and Implementation[3]. The core group structure is as shown below and is implemented in the 33 intervention villages.

Figure 3: The Care Group Structure



Source: Modified from Serino *et al.*, 2015

The Care Groups are composed of a group of up to 15 volunteers (Care Group Volunteers (CGV) who meet twice a month to receive training and to train their neighbours (Neighbour Women (NW). Membership into the CGs was primarily done by converting the existing MMSGs into CGs then allowing for additional members (up to 15 per group). The additional members were anyone from the community who volunteered to join the groups and this saw some groups having male members (up to 77 men have joined the CGs). The CGVs are trained by the promoters who in turn are trained by the supervisors and coordinators. The trainings are structured in such a way that they are interactive, motivating, new knowledge is shared and commitments are made on actions that will be practiced by each individual to adopt the new behaviours taught. The volunteers also share information on any births or deaths that have occurred in their neighbourhoods and this facilitates reporting on vital events that can then be shared with district and health authorities. After the training, the CGVs use the following 2 weeks to visit and train at least 10 neighbour women and their families on what they have learnt during training using teaching aids (bongo kitita).

Each district has one coordinator, 3 supervisors and 1 promoter per village, each responsible for 2-3 CGs (some promoters have more than 3 CGs as some villages created more groups due to demand). The promoters were members of the CGs selected by their group members to lead the groups. Supervision is done one a monthly basis with the promoters supervising the CGVs; promoters are supervised by the supervisors who are then supervised by the coordinators. The supervision checklists from all the levels are then used to prepare the monthly reports.

As with the MMSGs the CGs are also encouraged to join the VICOBA and through the agriculture component, are rearing small livestock and maintaining individual kitchen gardens and communal gardens which they use for Income Generating Activities (IGAs).

[3] http://caregroups.info/

Findings

The Care Group Criteria

The Care Groups as implemented in the HANO project closely align with the recommended criteria[4] as indicated in the table below:

Table 1: Comparison between the recommended CG criteria and the HANO Care Group Criteria

Care Group Criteria	Care Group Criteria in HANO project
Recommended	
The model is based on peer-to-peer health promotion (mother-to mother for Mother Child Health (MCH) and nutrition behaviours.) 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.	The model transitioned from MMSGs with women/men volunteering to be group members. The leaders (promoters) were selected by the group members.
The workload of CG volunteers is limited: No more than 15 HH per CG volunteer.	10 households per CG volunteer
The Care Group size is limited to 16 members and attendance is monitored.	Care group size is a maximum of 15 and attendance is monitored
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.	Contact is done once or twice monthly and frequency is monitored
Required	
Plan is to reach 100% 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.	Coverage to be monitored
Care Group volunteers collect vital events data on pregnancies, births, and death.	Yes
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).	Yes
The Care Group volunteers use some sort of visual teaching tool (e.g., flipcharts) to do health promotion at the household level.	Yes (bongo Kitita)
The Care Group instructional time (when a Promoter teaches CG volunteers) is no more than two hours per meeting.	Yes – all sessions are scheduled for 2 hours

[4] http://caregroups.info/

Supervision of Promoters and at least one of the Care Group Volunteers (e.g., data collection, observation of skills) occurs at least monthly	Yes- supervision is done monthly.
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.	Actual distance yet to be determined.
The implementing agency needs to successfully create a project/program culture that conveys respect for the population and volunteers, especially women.	Yes. During the interviews one of the volunteers said "*My husband is also happy with the way I train the neighbour women*".
Suggested	
Formative research should be conducted, especially on key behaviors promoted.	A study on Maternal, Infant and Young Child feeding practices was undertaken in 2013 and informed the key behaviors. No additional study was undertaken when the CG approach was established.
The Promoter: Care Group ratio should be no more than 1:9.	Yes. 1:2-5
Measurement of many of the results-level indicators should be conducted annually at a minimum.	Yes
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).	Yes: However one of the issues that has emerged is younger volunteers working with older neighbour women as the older women feel they have the experience.

Differences between the MMSGs and Care Groups

Findings from the document review and interviews indicated the following differences between the MMSGs and CGs

Table 2: Differences and similarities between the MMSG and CG approaches

	MMSGs	Care Groups
1.Structure	1 Save the Children staff, 2 partner staffs, 33 MMSGs of up to 30 members each	1 coordinator per district 3 supervisors per district (1 supervisor for 4-6 promoters) 1 promoter per village (responsible for 2-5 CGs) 15 CGV per CG. Each CGV responsible for 10 NW
2.Membership	Only open to pregnant and lactating mothers with Children 0-24 months	Open to all men and women as they are reached through the neighbour groups
3.Frequency of meetings	After training, it was expected that meetings take place monthly but there was poor follow up and no reports required of the meetings	Meetings are held bi-weekly. In the first meeting, the volunteers receive training on the issue they will practice and train other women on and during the second meeting, they train the neighbour women/men on the month's topic/issue. They also submit their activity reports during these meetings

4.Supervision	There was minimal supervision and follow up after training hence the dropout rate was high	A monthly supervision structure exists where the coordinator supervises the promoters and promoters supervise the CGVs and a supervision checklist is used during all the visits with a report prepared monthly
5.monitoring	Weak monitoring and follow up. Poor documentation of the processes and lack of monitoring tools	Guidelines and tools have been adopted from the Care Group toolkit and used for monitoring and reporting.
6.Coordination	Health facility staff and teachers were enjoined in the trainings for mothers	Coordination with health facilities and other community structures is done and from the feedback from interview, this should be strengthened.
7. Training	12 days consecutive training	Training follows a schedule developed so that each of the 5 modules are covered in 5 months. Training takes place once a month during which one topic is taught and the volunteers are expected to practice the required behaviours and also teach the neighbour women. The CGV receive training on how to deliver the trainings to the neighbour women.

Based on the feedback received, the MMSGs approach was seen to have been unsuccessful due to the following reasons:

- Group members were either pregnant or lactating women and this prevented other women and men who may have wanted to join the groups from doing so. *The Health facility staff did not like the idea that PD-Hearth sessions were done to a small group of people. The men who were interviewed felt that they should have been involved in the groups as they equally needed to understand nutrition information. Community leaders were of the opinion that the MMSG model was discriminative in nature and hence became unpopular as it targeted very few people (only pregnant and lactating women). According to community leaders, they should also have been invited to observe and learn from the nutrition sessions. .*
- There were no clear guidelines/strategy for the MMSGs as different aspects of a number of approaches were used and this may have been why supervision and monitoring was challenging to implement. In addition, the cascading model was built into the approach but due to poor follow up and supervision this was not implemented.
- Training was done as a one off activity (12 days) with no follow up or structure to guide how the cascading of the information should happen.
- Sensitization of group members and the community at large on the MMSGs role and structure was not done well hence group members were reluctant to contribute food items for the cooking demonstrations leading to high rates of drop outs.

On the other hand, a key feature of the MMSGs that was liked by a majority of those interviewed was the PD hearth sessions. *FGDs with mothers who were members of the MMSGs indicated that they liked the fact that their children had gained weight by the 12th day. They also liked that the trainings were practical in nature (cooking demonstrations and weighing of children) and the fact that there was a lot of emphasis on issues that they associated with such as pregnancy and lactation. As a result of attending the sessions, the respondents reported that they started attending Ante Natal Care (ANC) and also delivered babies at the health facilities. Health facility staff not only liked that children gained weight at the time and that women celebrated the achievement but also the fact that during the time the MMSG approach was implemented, there was a surge in ANC visits. Project staff indicated that of the MMSG approach, they liked the 12 days PD Hearths sessions because it led to children gaining weight which was highly motivating to the mothers and also because the practical nature of the sessions reinforced the messages given.*

Strengths and weaknesses of the Care Group approach

The study documented the following strengths and weaknesses of the Care Group approach as implemented in the HANO project:

Table 3: Strengths and weaknesses of the HANO Care Group Model

Strengths	Weakness/issues that need to be addressed
The approach has the potential of reaching the whole community as the trainings can be cascaded using the "tell a neighbour to tell a neighbour" approach, which also allows for inclusion of everyone (no restrictions by target group)	More community engagement to reduce the hostility some of the CGV are facing from NW
Regular meetings allow for follow up and addressing of issues as they arise	The CGV feel that they are spending a lot of time training the NW and reporting and hence should be paid/incentivised for their time
The approach has a standard toolkit that enables supervision, monitoring and reporting on a monthly basis.	Some of the CGV have little confidence in the quality of training provided by some promoters
The CGs have been linked with agriculture activities that promote kitchen/communal gardens and promotion of small livestock rearing.	CGV suggest that the project should provide food items used during cooking demonstrations
Some of the promoters have received bicycles to enable them visit the groups and do home visits. The promoters and volunteers get monetary incentives during meetings and have also received t-shirts to help with identification when they do home visits.	Weak engagement with community leaders and health workers in some of the villages

Knowledge of malnutrition and child nourishment

All interviews revealed that the problem of malnutrition in Lindi and Ruangwa districts has seen a huge reduction in the recent months although the problem still exists. Women and community leaders particularly explained that before community nutrition programs started in the region, malnutrition was a big problem which was associated with witch craft. *"One community leader cited that previously people believed that witchcraft caused malnutrition since they did not have education on nutrition, but now the rate has decreased".* Care group volunteers highlighted that the contributing factors to reduction in malnutrition were improved knowledge on nutritious foods, and improvement in breastfeeding practice at the community. A few women thought that malnutrition still exists because nutritious foods such as fruits are not widely available. Informants at the health facilities also revealed that the number of children with Severe Acute Malnutrition (SAM) has greatly reduced, though they were quick to acknowledge that Moderate Acute Malnutrition (MAM) is rampant. In Mandarawe dispensary, the In-charge explained that, an average of 5 children are diagnosed with acute malnutrition per month. .

Most of the interviewees believe that well-nourished children always gain weight, have healthy skin, are always active and happy, look "fat", do not fall sick often and are clever in school.

With regards, to sharing of information, it appeared that there were limited options available for sharing nutrition information within communities in Lindi region. All FGDs acknowledged that the main channel to receiving and sharing nutrition information for pregnant and lactating mothers is through the community groups championed by Save the Children. Other ways included; through health facilities and to a less extent broadcast media. *One FGD with Village leaders in Ruangwa district explained that during community gatherings, they invite promoters to give nutrition information to other participants. Interestingly to note is; some of the nutrition information shared in health facility has also been received through health facility staff attending meetings organized by Save the Children.*

Conclusions and recommendations

Findings of this study reveal that the Care Group model is an acceptable behaviour change approach in Lindi Region despite the fact that it has been operational for a short period of time. The study also identified the weaknesses of the mother to mother support group approach which were mainly related to a lack of structure, guidance, tools and follow up and that the mixture of different approaches may have created some confusion for the staffs leading to poor implementation.

Following this study; it is recommended that:

- Promoters are provided with refresher training on facilitation skills, with a focus on those found to be weak during supervision visits.
- Explore with the community leaders and volunteers the best approach for provision of food items for cooking demonstrations as a majority of the volunteers do not wish to provide the food items.
- Consider ways in which community leaders and health workers can be integrated into the project, borrowing lessons from the first phase of implementation.
- Consider the feedback from the project participants on the kind of small livestock to promote for future projects. The participants' feedback was that poultry keeping is not ideal as the poultry is prone to diseases as compared to fish or goats which are considered more viable.