Nurturing Care Groups
A Training Manual for Program Design and Implementation
Nurturing Care Group: A Training Manual for Program Design and Implementation was developed by World Vision International and Hesperian Health Guides.

It draws from an earlier manual, Care Groups: A Training Manual for Program Design and Implementation that was developed by Food for the Hungry (FH) and adapted by members of the Food Security and Nutrition (FSN) Network Care Groups Forward Interest Group, the CORE Group Social &Behavioural Change Working Group (SBCWG), and by World Relief (WR).

It also draws from Education Cascade Groups: Being Your Child’s First Teacher, A Training Manual for Program Design and Implementation, developed for Project Concern International by Tom Davis MPH (now World Vision International’s Global Sector Lead for Sustainable Health), Cindy Pfitzenmaier MPH, and Alex Soko.

Recommended Citation

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Abbreviations and Acronyms

AIDS    acquired immune deficiency syndrome
BA      Barrier Analysis
BCC     behaviour change communication
CDC     community development committee
CHW     community health worker
CG      Care Group
CGV     Care Group Volunteer
CP      Child Protection
CS      child survival
CSHGP   USAID Child Survival and Health Grants Program
DHS     Demographic and Health Survey
EFB     exclusive breastfeeding
ECD     early childhood development
EHA     Essential Hygiene Actions
ENA     Essential Nutrition Actions
FANTA   Food and Nutrition Technical Assistance Project
FH      Food for the Hungry
FSN     Food Security and Nutrition (Network)
HIV     human immunodeficiency virus
HWWS    hand washing with soap
IMC     International Medical Corps
ITN     insecticide-treated bed net
KPC     Knowledge, Practice and Coverage (survey)
LNRA    Learning Needs and Resources Assessment
LQAS    Lot Quality Assurance Sampling
LSM     learning station materials
M&E     monitoring and evaluation
MCHIP   Maternal and Child Health Integrated Program
MCHN    maternal and child health and nutrition
MOH     Ministry of Health
MUAC    Mid-Upper Arm Circumference
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>NC</td>
<td>Neighbour Caregiver</td>
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<tr>
<td>NG</td>
<td>Neighbour Group</td>
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<tr>
<td>NCG</td>
<td>Nurturing Care Group</td>
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<tr>
<td>NCGSA</td>
<td>Nurturing Care Group Service Area</td>
</tr>
<tr>
<td>NCGV</td>
<td>Nurturing Care Group Volunteer</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>OR</td>
<td>operations research</td>
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<tr>
<td>ORS</td>
<td>oral rehydration solution</td>
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<tr>
<td>PLW</td>
<td>pregnant and lactating women</td>
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<td>PVO</td>
<td>private voluntary organization</td>
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<td>QIVC</td>
<td>quality improvement and verification checklist</td>
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<td>SBCTF</td>
<td>Food Security and Nutrition Networks Social and Behavioural Change Task Force</td>
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<tr>
<td>SBCWG</td>
<td>CORE Group Social &amp; Behavioural Change Working Group</td>
</tr>
<tr>
<td>TOPS</td>
<td>Technical and Operational Performance Support (Program)</td>
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<tr>
<td>US</td>
<td>United States</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>USAID</td>
<td>U.S. Agency for International Development</td>
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<tr>
<td>WASH</td>
<td>water, sanitation and hygiene</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WR</td>
<td>World Relief</td>
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<tr>
<td>WRA</td>
<td>women of reproductive age</td>
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<td>WV</td>
<td>World Vision</td>
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<td>WVI</td>
<td>World Vision International</td>
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Preface

Objectives of the Nurturing Care Group Training Manual
This manual was developed as a training resource for designing, training, implementing and monitoring Nurturing Care Group (NCG) programs. It seeks to help NCG project model implementers to clearly understand the structure of the NCG approach, how to establish NCGs, how to monitor the work of NCGs and assess their impact, and how to maintain the quality of the approach through supportive supervision and quality control.

This is a draft manual. It was created for the first use of WV’s Nurturing Care Group approach in Ghana which largely focuses on WASH behaviours and some Child Protection behaviours. There may be errors that will be corrected in future versions of the manual.

Planning for a Care Group Training
This training would be most useful if implemented after funds for a program are secured and key sectoral management and technical personnel have been hired, but before community staff are hired. Certain lessons also could be used or adapted to train new staff or for staff refresher training to address weaknesses in the program discovered at any time. When feasible, it might work best to do this training in shorter sessions to allow for better absorption and retention of the material. Certain lessons may not be needed for all groups.
Getting Started

Fitting This Training into a Broader Scheme
This training is most useful as part of an organization’s broader plan to support behaviour change. Organizations should start by making sure that headquarters and field staff, managers and implementers are all familiar with the Care Group (CG) approach and with WV’s NCG project model. Following training, staff at all levels can look for ways to integrate the concepts and tools into their work.

For some basic guidance on how the Nurturing Care Group approach could be integrated with other WV Core Project Models, please see Appendix 11: Integrating NCGs with WV Core Project Models.

For organizations that are unfamiliar with the Care Group approach and are still deciding if this training course is the appropriate next step, The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Educators¹, written by World Relief and published by the CORE Group in 2004, provides a very useful overview. To learn more about WV’s Nurturing Care Group project model, a narrated presentation on can be accessed at http://bit.ly/NCGPM, and the slides for local presentation can be downloaded here². A short handout on this project model can be downloaded here³.

Identifying a Planning Team
This training requires a lot of planning, and you will find it helpful to have a team to handle many of the details. The planning team should include people who are:

- Familiar with the training materials and the Care Group approach or NCG project model (including staff from WV’s Technical Service Organization)
- Familiar with the participants (or organizations) that will be invited
- Knowledgeable about the training site

Selecting Facilitators
Workshop facilitators should have experience with the NCG project model (or at least the CG approach), supportive supervision and the quality improvement and verification checklist (QIVC), as well as adult education methodologies and participatory learning. (In WV, several Technical Service Organization members have experience with the Care Group approach and NCG project model.) Ideally, the ratio of facilitators to participants should be at least 1 to 10 to maximize facilitator-participant interaction, especially during group work. So, for a group of 20–25 participants, two co-facilitators are recommended.

Selecting Participants
This manual is intended for use by organizations that have already decided that NCGs are the right approach for their program and context and by organizations that are considering the approach and want to learn more about the implementation process. The people who will benefit the most from this training include Nurturing Care Group program staff and any government staff or volunteers who will be involved in implementation of the model (e.g., MOH CHWs). This includes implementers, designers, technical staff and program managers. At least one technical staff person should be drawn from the

² https://drive.google.com/open?id=1gCbbm4yQg5jyNCVcYhrD176cwwu04ly7
³ https://drive.google.com/open?id=1JGA5UzzESIsOb9FPlJ3ryF9mSWmhgF7hm
different sectors for which this project model will be used (e.g., health & nutrition, WASH, Child Protection, Education, Livelihoods).

**Selecting a Location**
The workshop should be conducted in a comfortable setting, such as a conference room, that is large enough for plenary sessions and for small groups to work without disturbing each other, since participants will work in small groups for most of the tasks. Therefore, setting up small groups at the beginning of each day of training will ensure that participants are seated in a way that promotes maximum sharing, minimizes time spent reorganizing seating for small group work and enhances learning. To facilitate sharing and learning among participants, the trainer should devise different seating arrangements each day, or else participants will tend to sit in the same place each day.

**Recommended Seating Arrangement**

**Front of Room with Flip Chart Stand**

Table for Trainer

5 people

5 people

5 people

5 people

5 people

**Conducting a Learning Needs and Resource Assessment (LNRA)**
Workshop planners will benefit from learning about participants’ experiences and interests before the workshop. Several weeks prior, send a set of questions to registered participants. Members of the workshop planning team may need to follow up with participants to encourage them to submit their responses. Share participant responses with all facilitators prior to the workshop. An example LNRA is provided in Appendix 2: Learning Needs and Resource Assessment.

**Preparing Materials, Supplies and Equipment**
Nearly all the materials you need to conduct the NCG workshop are included in this manual, except for some flip charts and index cards that facilitators must prepare ahead of time. The checklists and materials lists found later in this section will help you prepare the necessary materials for the training. The following is a list of supplies and equipment that should be available for the training.
1. **Handouts to Copy**
   - 1 copy of this NCG training manual per participant (ideally, but if that is not feasible, provide all the handouts for each of the lessons you will be including in the training)
   - 2 copies of the Pre-/Post-Test (found in Appendix 1) per participant (can be copied double-sided)
   - 1 copy of the workshop evaluation (found in Appendix 3) per participant (can be copied double-sided)
   - 5 end-of-day evaluation forms for each participant (found in Appendix 3)

2. **Supplies**
   - 1 reusable name tag per participant
   - 2–3 pads of flip chart paper
   - 1 flip chart stand
   - 2 rolls of masking tape
   - 1 stapler with staples
   - 1 marker per participant
   - 4 markers for each trainer (multiple colours, preferably wide-tipped)
   - 1 small notepad per participant
   - 1 pen per participant
   - 1 pair of scissors
   - 1 ream of copy paper
   - 100 index cards or 3×5 cards (a couple of different colours, if available)
   - Post-its (4–5 packs)
   - One copy of “The Care Group Difference”, published by WR in 2004 so participants can review

3. **Equipment**
   - LCD projector and screen
   - Printer that can be connected to a laptop (printer driver)
   - 1–2 large garbage cans

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4 If printing is cost prohibitive, you can write out the evaluation questions on a flip chart and have participants write their answers on a blank sheet of paper.

• Cell phone for training facilitator

4. Services

• Internet access
• Water, tea and coffee for the trainer and participants, especially during the two breaks
• Lunch, preferably in an area close to but not in the training room

5. Copies of Learning Station Materials (if these will be used in the project and demonstrated in the training)

How to Use This Manual

• Topics are grouped together into lessons. Each lesson begins with an overview of the objectives, estimated time it takes to teach the lesson and lists any materials, handouts and/or flip charts needed.
• It is important to read through every lesson well in advance of teaching because there are some lessons that require pre-work and many of the flip charts should be prepared ahead of time.
• Blue text boxes provide additional information including examples from different organizations.
• For use at World Vision, or other Christian Faith Based Organizations we have included Biblical references to connect the model to the values of the organization. These blue text boxes can be easily removed if not relevant to the intended audience.
## Nurturing Care Group Training Sample Agenda

### Day One
- **Lesson 1:** Opening Session
- **Morning Break**
- **Lesson 2:** Introduction to the Care Group Approach and Nurturing Care
- **Lunch**
- **Lesson 3:** Nurturing Care Group Structure, Targeting and Behaviours
- **Afternoon Break**
- **Lesson 4:** Care Group Approach: Definitions and Criteria
- **End of Day Evaluation**

### Day Two
- **Lesson 5:** Using Formative Research to Strengthen Nurturing Care Groups
- **Morning Break**
- **Lesson 6:** Organizing Communities into Nurturing Care Groups and the Numbering System
- **Lunch**
- **Lesson 7:** Nurturing Care Group Roles, Responsibilities and Job Descriptions
- **Afternoon Break**
- **Lesson 8:** Volunteer Motivation and Incentives
- **End of Day Evaluation**

### Day Three
- **Lesson 9:** Behaviour Change and Nurturing Care Groups: What Happens in a Nurturing Care Group Meeting, Neighbour Group Meeting and Home Visit (Part 1)
- **Morning Break**
- **Lesson 9:** Behaviour Change and Nurturing Care Groups: What Happens in a Nurturing Care Group Meeting, Neighbour Group Meeting and Home Visit (Part 2)
- **Lunch**
- **Lesson 10:** Home Visits: The Audience, Timing and Content (Part 1)
- **Afternoon Break**
- **Lesson 10:** Home Visits: The Audience, Timing and Content (Part 2)
- **End of Day Evaluation**

### Day Four
- **Lesson 11:** The Meeting Schedule
- **Morning Break**
- **Lesson 12:** The Learning Station Materials
- **Lunch**
- **Lesson 13:** Supportive Supervision: Checklists and Supervisory Work plans (Part 1)
- **Afternoon Break**
- **Lesson 13:** Supportive Supervision: Checklists and Supervisory Work plans (Part 2)
- **End of Day Evaluation**

### Day Five
- **Lesson 14:** Quality Improvement and Verification Checklists (QIVCs) and Giving Feedback
- **Morning Break**
- **Lesson 15:** Calculating Scores and Using Data from the Quality Improvement and Verification Checklist (QIVC)
- **Lunch**
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## Initial WV/Ghana Nurturing Care Group Training Agenda

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**Note:** If skipping the QIVC sections (lessons 14 and 15), this training could fit easily into five days.
Lesson 1: Opening Session

Achievement-Based Objectives
By the end of this lesson participants will have:

- Discussed training expectations
- Begun to learn about the background and experience of others in the training
- Completed the pre-test

Duration
2 hours

Materials Needed

- Attendance sheet
- Name tags for each participant
- Pre-/Post-Test (available in Appendix 1)
- Lesson 1 Flip Chart 1: Getting to Know You
- Lesson 1 Flip Chart 2: Our Expectations (with LNRA results)
- Lesson 1 Handout 1: Nurturing Care Group Project Model Training Objectives
- Lesson 1 Flip Chart 3: Nurturing Care Group Project Model Training Schedule
- Lesson 1 Flip Chart 4: Nurturing Care Group Approach Project Model Norms and Procedures
- Flip chart paper and markers

Steps

1. Welcome and Introduction to the Workshop

- Explain that since the success of the project depends on people changing their behaviours, we need to use effective behaviour change activities. One of the most effective behaviour change activities is the Care Group (CG) approach. Many organizations have decided to use the CG approach to promote healthy behaviours, particularly those behaviours associated with reducing morbidity and mortality due to childhood malnutrition.

- This project model is unique because it integrates the CG approach with the WHO’s Nurturing Care Framework to create “Nurturing Care Groups.” The basic purpose of the workshop is to learn about the NCG project model and how to implement it.

2. Collecting Baseline Information from the Participants

- Explain that before we begin the workshop, we would like to collect some data using a pre-test so we can assess the effectiveness of the workshop when it is finished.

- Pass out the pre-test, located in Appendix 1, or use one that you have developed. Give participants sufficient time to complete the pre-test, then collect it.
• Remind participants to put their names at the top of the paper.
  o Ask them to circle “Pre-“.
  o Let participants know that the pre-test is a set of multiple-choice questions, and they should circle the letter of the one answer that they think best answers the question.

3. Introducing Participants

• Write some getting-to-know-you questions on Lesson 1 Flip Chart 1: Getting to Know You, such as the participant’s name, organization, country (if at a regional workshop), workplace, prior experience working with CGs or NCGs (design or implementation) and one thing they want to learn about NCGs.
  o Note: This is an opportunity to collect additional information from the participants that you may need for the training. You can also ask “silly” information (such as favourite colour, birth month, or height) that you can use each day as a way to organize seating arrangements so that the trainees are seated with different people each day. Add these types of questions to the flip chart.

• Use a creative way to pair up each participant with someone he/she does not know and ask each pair to interview each other about the getting-to-know-you questions on the flip chart. Tell participants to write down the responses on a sheet of paper.

• Then ask each participant to introduce the person he/she met to the rest of the workshop participants and facilitators.

4. Expectations

• Show Lesson 1 Flip Chart 2: Our Expectations.
  o Note: Facilitators should review the expectations from the Learning Needs and Resources Assessments (LNRA) prior to the start of the training so that any expectations listed by participants in the LNRA can be included in this flip chart.

• Ask a volunteer to read the flip chart.

• Ask participants if they want to add any other expectations to the list.

5. Training Objectives

• Review Lesson 1 Handout 1: Nurturing Care Group Project Model Training Objectives.

• Point out any of the expectations listed on Lesson 1 Flip Chart 2 that probably will NOT be met during this training.

6. Training Schedule

• Before the training begins, adjust the sample agenda found earlier in this manual to fit the scheduled days, dates and times of your training, as necessary, and write it on Lesson 1 Flip Chart 3: Nurturing Care Group Project Model Training Schedule.
• Show the flip chart to participants and review it with them. Discuss any logistical issues, such as per diem, breaks and meals.

7. Learning Norms and Procedures

• Brainstorm with the group the norms and procedures the group wants to follow to create the best learning environment. Record these on **Lesson 1 Flip Chart 4: Nurturing Care Group Project Model Training Norms and Procedures**.

8. Roles of the Facilitators

• Mention that many people may want to replicate the training for their colleagues. Ask that participants who intend to replicate this workshop raise their hands.

• Explain that the facilitators will be modelling the Learning-Centred Adult Education (Vella) methodology during this workshop, and from time to time they will be making comments specifically about facilitation techniques that participants may find helpful to use when they replicate the training.

9. Asking Questions during the Training

• Set up a flip chart entitled “Parking Lot” for any questions that might arise at any point during the training, and let participants know its purpose is to put aside (or “park”) these questions to address later.

• Ask participants to set aside a page near the back of their notepads and label it “Ideas to Remember”. Suggest that they use this sheet to write down any ideas that come up throughout the training.
Lesson 1 Handout 1: Nurturing Care Group Project Model Training Objectives

Achievement-Based Objectives

By the end of this training, participants will have:

- Analysed the structure of the Nurturing Care Group (NCG) project model
- Examined the criteria for NCGs (what is or is not part of the NCG approach)
- Learned the steps in the different NCG meetings
- Learned how to conduct home visits as part of the NCG PM
- Examined learning station materials and identified possible local options
- Identified ways to use formative research in the NCG approach
- Practiced using data from quality improvement and verification checklists (QIVCs)
- Examined tools used to monitor the work and impact of the NCG approach
Lesson 2: Introduction to the Care Group Approach and Nurturing Care

Achievement-Based Objectives
By the end of this lesson participants will have:
- Familiarized to the Care Group approach
- Learned the importance of Nurturing Care
- Identified childhood milestones in Early Childhood Development
- Analysed why the Care Group (CG) approach and Nurturing Care are so effective

Duration
1 hour and 30 minutes

Materials Needed
- Flip chart paper, index cards and markers
- Lesson 2 Flipchart 1: WHO definition of Nurturing Care
- Lesson 2 Handout 1: Nurturing Care Components and Interventions
- Lesson 2 Handout 2: Undernutrition Happens Early
- Lesson 2 Handout 3: Importance of Early Childhood Development
- Lesson 2 Handout 4: Causes of Death in Children under 5 Years of Age
- Lesson 2 Handout 5: Child Milestones and Skills Exercise
- Lesson 2 Handout 6: Key to Child Milestones and Skills Exercise
- Lesson 2 Handout 7: Care Group Approach Effectiveness
- Lesson 2 Handout 8: Care Group Approach Sustainability Studies

Steps

1. Introduction
   - Tell participants that the main objective of this training is to help them understand NCGs and how to implement the NCG project model.
   - Ask participants: How many people have read or heard of the WHO’s Nurturing Care Framework?

2. What is Nurturing Care?
   - Children’s bodies and brains are growing rapidly from conception to three years of age. Keeping children healthy and safe during this time period promotes growth and development for the rest of their lives.
     - “For example, early interventions have been shown to substantially improve adult cardiovascular health. And interpersonal skills – fostered through secure affectionate relationships with caregivers – engender empathy and self-control that inhibit crime and violence. So, abilities created in early
childhood not only last an individual’s life, they also have an effect on the next generation’s human development”.

- To provide a healthy and safe environment for all children is complex and covers multiple sectors. It is not just a health, WASH or child protection project but an approach that integrates physical, social, emotional (and sometimes spiritual) health with protection and positive parenting.

- The WHO Nurturing Care Framework attempts to provide a way to examine the evidence-based areas that most impact children and provide guidance on how to integrate them together.

- Display Lesson 2 Flipchart 1: WHO definition of Nurturing Care. Walk through the definition with participants making sure all understand.
  - “Nurturing care refers to conditions created by public policies, programmes and services. These conditions enable communities and caregivers to ensure children’s good health, nutrition and protect them from threats. Nurturing care also means giving young children opportunities for early learning, through interactions that are responsive and emotionally supportive.”

- **Ask participants:** What kinds of things stop children from thriving in their communities? **Ask:** What can we do to prevent these things? Add the responses on a flip chart.

- Refer participants to Lesson 2 Handout 1: Nurturing Care Components and Interventions. Let’s look at how the WHO has categorized the different areas of interventions.
  - Point out each component of Nurturing Care
  - The handout includes a 2-page table with policy and intervention recommendations. Point out that this project model will focus on the household level and so will not address the policy interventions. However, this project model can be used with other project models such as Community Health Committees (COMM), Channels of Hope (CoH) and Citizen Voice & Action (CVA) to have a more holistic approach that focuses on community-level and environmental/policy level changes.

- **Ask participants:** How does the WHO list of interventions compare with our list?


- Tell participants: Many of the services and interventions listed include specific content and messages that need to be shared with the community and behaviours that need to be changed. Let’s now examine an evidence-based platform to share these messages and create lasting behaviour change.

3. **What are Care Groups (CG)?**

- **Ask participants:** How many of you have already had experience working on a project that used the Care Group approach? How many of you have read or heard about the approach before?

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Ask participants: What have you heard about Care Groups? As they respond, write their ideas on flip chart paper. Add the following points if participants do not mention them:

- The CG approach is a community-based strategy for promoting behaviour change.
- Dr. Pieter Ernst and WR/Mozambique developed the Care Group approach in 1995. Since then, staff from WR and Food for the Hungry (FH) have pioneered and championed the approach.
- The CG approach is now used by at least 28 organizations in 28 countries.
- A CG is a group of 10–15 community-based volunteers that regularly meet together with project staff for training and supportive supervision.
- CGs are different from typical mothers’ groups in that each volunteer is responsible for regularly meeting with 10–15 of her neighbours, sharing what she has learned and facilitating behaviour change at the household level.
- CGs create a multiplying effect and equitably reach every beneficiary household through neighbour to neighbour peer support using interpersonal behaviour change activities. Behaviour change is enhanced through peer support, resulting in the creation of new community norms.
- Care Group Volunteers (CGVs) provide greater peer support to one another, develop stronger commitments to activities and find more creative solutions to challenges by working as a group compared to individual volunteers expected to work independently.
- CGs provide the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits.
When Dr. Peter Ernst was designing the original Care Group project, he was inspired by the 18th chapter of Exodus where Moses is leading God’s people through the wilderness.

13 The next day Moses sat as judge for the people, while the people stood around him from morning until evening. 14 When Moses’ father-in-law saw all that he was doing for the people, he said, “What is this that you are doing for the people? Why do you sit alone, while all the people stand around you from morning until evening?” Moses said to his father-in-law, “Because the people come to me to inquire of God. 16 When they have a dispute, they come to me and I decide between one person and another, and I make known to them the statutes and instructions of God.” 17 Moses’ father-in-law said to him, “What you are doing is not good. 18 You will surely wear yourself out, both you and these people with you. For the task is too heavy for you; you cannot do it alone. 19 Now listen to me. I will give you counsel, and God be with you! You should represent the people before God, and you should bring their cases before God; teach them the statutes and instructions and make known to them the way they are to go and the things they are to do. 21 You should also look for able men among all the people, men who fear God, are trustworthy, and hate dishonest gain; set such men over them as officers over thousands, hundreds, fifties, and tens. 22 Let them sit as judges for the people at all times; let them bring every important case to you but decide every minor case themselves. So, it will be easier for you, and they will bear the burden with you. 23 If you do this, and God so commands you, then you will be able to endure, and all these people will go to their home in peace. 24 So Moses listened to his father-in-law and did all that he had said. 25 Moses chose able men from all Israel and appointed them as heads over the people, as officers over thousands, hundreds, fifties, and tens. 26 And they judged the people at all times; hard cases they brought to Moses, but any minor case they decided themselves.” Exodus 18:13-26.

Similar to Moses, NGO, government and community workers can become over-burdened thinking that they need to create all the changes in a community. Has this ever happened to you?

The wise counsel provided by Moses’ father-in-law was to empower others and set them in charge of groups of ten. This is the basis of the Care Group model that seeks to empower caregivers to reach out to ten of her neighbours. Promoters (staff) are available for teaching and guidance. Does anyone have an experience that they would like to share about how empowering others created greater change than they could have done on their own?

- For more information encourage participants to seek out the following references:
  - A video explaining the FH Care Group Model used in Mozambique is available at https://www.youtube.com/watch?v=WJkJC0HyMwQ
  - The Care Group Difference, published by WR in 2004. Have one printed copy available for them to see during breaks.
  - Care Group website at www.caregroupinfo.org (Note: this website is currently being renovated and some links may be temporarily unavailable)
  - FSN Network’s Resource page at https://www.fsnnetwork.org/resources

4. Nurturing Care Groups
• **Explain to participants:** The Care Group approach is also a behaviour change platform. While it was first used to promote health and nutrition messages, the structure can be used for a variety of messages. In fact, organizations have used CGs to create behaviour change in multiple areas including WASH, livelihoods, agriculture, and even community violence prevention.

• In the Nurturing Care Group project model, the topics and principles from the WHO’s Nurturing Care Framework are addressed through the CG approach.

• The CG behaviour change platform can also be used to create changes from other WVI project models, such as “Go Baby Go!”.

• In this manual, we will discuss how to identify and select the most appropriate messages and topics for your project area. However, because multi-sectoral integration is one of the key principles of the Nurturing Framework, it is essential that some of the key behaviours from each of the sectors be included in all NCG projects.

5. **Early Childhood Development and the First 1,000 Days**

• **Ask participants:** Why do you think it would be important to focus on health, nutrition, WASH, and early child development messages for children in their first 1,000 days of life? Have participants discuss this question in small groups and then report back. Write correct answers on a flip chart and add the following points if participants do not mention them.7

  o The 1,000 days between the beginning of a woman’s pregnancy and her child’s 2nd birthday offer a unique window of opportunity. Children who are well-nourished, cared for and protected from disease, violence and toxic stress during this 1,000-day window can have a profound impact on a child’s ability to grow, learn and rise out of poverty. It can also shape a society’s long-term health, stability and prosperity.

  o At every stage during the 1,000-day window, a child’s rapidly developing brain is vulnerable to poor nutrition, neglect and the “toxic stress” that comes along with hunger and food insecurity. The damage done to a child’s development can be profound and irreversible.

  o During pregnancy, undernutrition can have a devastating impact on the healthy growth and development of a child. Babies who are malnourished in the womb have a higher risk of dying in infancy and are more likely to face lifelong cognitive and physical deficits and chronic health problems.

  o For children under 2, undernutrition can be life threatening. It can weaken a child’s immune system and make him or her more susceptible to dying from common illnesses such as pneumonia, diarrhoea and malaria.

  o Early stimulation of babies helps with their brain development and to reach milestones. Good infant attachment to caregivers is a prerequisite for attaining other child wellbeing outcomes.

  o There are many skills and milestones that children should attain before attending school that cannot be learned when a child is under two years of age. For that reason, we will also be focusing on caregivers of children 0-5 years of age.

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7 This information comes from The First 1000 Days Initiative ([https://thousanddays.org](https://thousanddays.org)).
• Show and explain to participants the graph on undernutrition found in Lesson 2 Handout 2: Undernutrition Happens Early. Note to participants that this graph dramatically illustrates the importance of early childhood nutrition.

• Ask the larger group, why do you think it is important for us to focus on early childhood development and early stimulation? Distribute Lesson 2 Handout 3: Importance of Early Childhood Development. Explain the graphs and highlight the following information:
  
  o Advances in brain research tell us that by the age of 5, more than 90% of the architecture of the brain is already in place.
  
  o Proven programs such as voluntary home visiting maximizes early childhood health and development during the critical first three years of life.
  
  o Children in a longitudinal study who had attended preschool were less likely to drop out of high school, be placed in special education and held back a grade, and they scored better on reading and math achievement tests.
  
  o Early childhood education saves governments from spending as much on K-12 education, public assistance and the criminal justice system, and increases tax revenues as a result of higher earnings.
  
  o Babies are constantly learning. Very young children are learning through play, the active exploration of their environment, and, most importantly, through interactions with the significant adults in their lives. According to recent brain research, even in the womb, the infant is turning towards the melody of its mother's voice. The brain is setting up the circuitry needed to decipher and reproduce language.
  
  o Learning begins at birth. By the time children turn three, they have already begun laying the foundation for lifelong learning and success. Early language and literacy skills are learned best through everyday moments with one’s child — reading them books, talking with them, and laughing and playing together. Children learn language when caregivers talk to them, and also when children communicate back to caregivers. They also learn by hearing stories read and songs sung aloud. Scientific studies have found that children learn much better in school when their parents talk to them a lot when they are very young – before three years of age. Giving young children encouragement is also important.
  
  o An important part of the NCG Program is that caregivers play, interact and participate with their children. This includes helping them to use objects to learn (like cans, blocks and letter cards), describing things to the children, asking questions, and praising children for their efforts.

6. Why do Nurturing Care Groups focus on household behaviours?

• Give participants copies of Lesson 2 Handout 4: Causes of Death in Children under 5 Years of Age.

  While at their tables or in small groups, ask participants to spend 10 minutes looking at the diagram and discussing what it means.

  After 10 minutes, request a volunteer to share one group’s interpretation. Mention the following points if the volunteer does not:
The diagram shows the proportion of all the deaths of children under 5 years old that could be prevented with a specific intervention.

- 57% of the deaths of children under 5 could have been prevented with interventions that rely on household behaviour change, including behaviours related to breastfeeding; using insecticide-treated material; complementary feeding; clean delivery; water, sanitation and hygiene (WASH); newborn temperature management; and consuming zinc, vitamin A and oral rehydration solution (ORS) and of course changing these and other household behaviours would yield many additional benefits for child protection and education!

- Refer participants back to the WHO Table of Interventions in Lesson 2 Handout 1. How many of the interventions listed could be significantly impacted by household behaviour change?

- Distribute Lesson 2 Handout 5: Milestones and Skills for Young Children to participants while they are in small groups. Assign each group 5 rows in the Table of Interventions. (It may be helpful to highlight the selected rows ahead of time.)

- Explain to participants: A developmental milestone is an ability that most children achieve by a certain age. These milestones can involve physical, social and emotional, cognitive, and communication skills such as walking, sharing with others, expressing emotions, recognizing familiar sounds, and talking. Each child is unique and not all children develop milestone skills at the same time or the same rate.

- Tell participants: Please spend 10 minutes looking at the Table of Interventions and work quickly. Fill in the two columns of the table for your selected rows:
  - Column 2: At what age should a child attain each of these skills and milestones?
  - Column 3: Where would a child usually demonstrate these different milestones and skills?—Would you expect to observe them at home, at a preschool, in primary school, or somewhere else?

- Pass out Lesson 2 Handout 6: Key to Child Milestones and Skills Exercise and give the small groups 10 minutes to review it and discuss any observations or surprises. After the 10 minutes, request a volunteer to share ONE group’s interpretation. Mention the following points if the volunteer does not:
  - All of these milestones and skills can and should happen before a child reaches primary school age. Many of them should happen before a child is three years of age, and therefore need to happen at home or in neighbourhood groups like Nurturing Care Groups.
  - Parents and other caregivers – older siblings, grandparents, etc. – can help children to attain these skills and milestones earlier in life. Unless caregivers work with children to attain these skills and milestones, many children will not attain them or will attain them much later in their development.
  - Attaining skills and milestones earlier helps children to be more “school ready” by the time they reach age 5, and to do better in school in the long run.

7. Optional: How effective is the Care Group approach?

- Give participants copies of Lesson 2 Handout 7: Care Group Approach Effectiveness. Say: Here’s the best proof I’ve seen of the effectiveness of the Care Group approach.
Note: Nurturing Care Groups are a new project model, based on the Care Group approach, so the details listed here are specific to traditional Care Groups.

However, there is plenty of evidence on the effectiveness of promoting health, nutrition, WASH, and some education behaviours through project models based on the Care Group approach. More evidence will need to be gathered on the effectiveness of NCGs in promoting child protection, livelihoods, and some education behaviours.

Go through some of these points, depending on the comfort level of the participants with graphs and charts.

Direct participants to Figure One and share with them the following.

- On this figure, we have compared how child survival projects perform on 14 different Rapid CATCH indicators.\(^8\) One of these is an impact indicator (underweight), but most are results-level behavioural indicators or coverage indicators.

- The bars show the amount of gap closure for each indicator. For example, if you started at 20% exclusive breastfeeding (EBF), and increased that to 40%, you would have closed 20 of 80 possible percentage points, or 25% gap closure \((20 \div 80 = 25\%)\). Looking at gap closure is one of the best ways to compare performance across projects.

- The blue bars show the average indicator gap closure for each of these indicators for 58 child survival projects ending between 2003 and 2009 that did not use Care Groups.

- The tan bars show the average indicator gap closure for each of these indicators for nine Care Group projects. What can you see about the difference? (Wait for answers.)

- Care Group projects out-performed the average child survival project in terms of indicator gap closure on all indicators except hand washing with soap, or HWWS where there was a slight non-significant difference. The average gap closure was in the 35 to 70% range for the nine Care Group projects as compared with 25 to 45% with all the other Child Survival and Health Grants Program, or CSHGP, projects.

- There were only nine Care Group projects to compare to, but the difference between those nine projects and the 58 other projects is statistically-significant for EBF.

- So, what this shows is that Care Groups are outperforming the other methods we generally use for behaviour change.

- Direct participants to Figure Two and share with them the following.

- In case you might think that these results are atypical, here’s a graph showing the estimated mortality reduction in 13 CSHGP-funded Care Group projects in eight different countries.

- The average estimated reduction in under-5 mortality was 30% in Care Group projects. This is almost double what non-Care Group projects often achieve.

- Most of these are 5-year projects. We see this as compelling evidence that these Care Group Volunteers, coached and trained by paid community health workers or Promoters, make a dramatic difference.

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\(^8\) Rapid CATCH indicators are a set of priority health indicators, as defined by the U.S. Agency for International Development (USAID), for their Child Survival and Health Grants Program (CSHGP) portfolio.
A more scientific study\(^9\) was published in 2015 and found that projects using the Care Group approach had double the behaviour change and 53% better estimated reduction in child deaths than projects with similar budgets and in the same countries that used more traditional CHW behaviour promotion methods.

- Direct participants to Figure Three and share with them the following.
  - Figure Three shows performance of World Relief’s Care Group project in Cambodia, represented by the gold bars, compared to the other Care Group projects represented by blue bars and non-Care Group projects represented by tan bars.
  - The Care Group model in Cambodia showed even better performance than in other countries across regions, even in hand washing. In Asia, for example, Care Groups have been used in Cambodia, Indonesia and the Philippines. The success in Cambodia was despite an initial strong concern by World Relief national staff that the model would not be effective in their context. Staff in Cambodia were concerned that women would not agree to work as volunteers, but this was not a problem in the project, and they saw some of their best results to date.

- **Ask the group:** Why do you think the Care Group approach is so effective?
  - Write this information on a flip chart, and keep it posted for the remainder of the training.
  - If participants do not mention any of the following, add them to the flip chart: multiplying effect, complete population/beneficiary coverage, mother-to-mother support, peer motivation, changed communities, cost effectiveness, sustainability, and behaviour change in a large part of community, reduced child death and malnutrition.

8. **Optional: Care Group Sustainability**

- Give participants **Lesson 2 Handout 8: Care Group Sustainability Studies.** Explain, while data on sustainability is usually limited, there have been a few studies of Care Group projects. Let’s explore some of their findings.
  - The first was a review of a Care Group project in Gaza Province, Mozambique conducted by World Relief in 2002 and 2003\(^10\).
    - 93% of the 1,457 volunteers active at the end of WR’s Care Group project were active 20 months after end of project.
    - Changes brought about in the original program were maintained: A full four years after the end of the project (when all interventions and funding ceased), final program goals on eight key indicators continued to be exceeded.
  - FANTA conducted a review of Title II projects for multiple organizations in Bolivia. Included in the research was FH’s Care Group Project that ran from 2002-2006. The sustainability data was collected

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\(^10\) “Promising Initiatives on the Motivation of Volunteer Health Workers: FH/Mozambique Care Group Project” Presentation by Cecelia Lopes, Emma Hernandez Avilan, Carolyn Wetzel, Tom Davis and Henry Perry for APHA in October 2011.
by FANTA in 2011 and found that the following indicators continued to improve past the end of project results\textsuperscript{11}:

- Stunting continued to decline significantly
- Percentage of mothers reporting any prenatal care during last pregnancy increased
- Percentage of mothers reporting prenatal care in first five months during last pregnancy increased
- Percentage of mothers reporting exclusive breastfeeding for child less than six months of age increased
- Percentage of children 12–23 months of age receiving the third dose of DPT or pentavalent vaccine increased

Most recently, the University of Iowa conducted a sustainability study in Sofala Province, Mozambique following a FH Child Survival Project that ran from 2006-2010\textsuperscript{12}.

Regarding sustainability of the behaviours, they found:

- The percentage of children underweight continued to decline from 29.5\% at baseline, to 17.8\% at final evaluation to 15.8\% five years after the end of the project.
- Two of the four indicators regarding health seeking behaviours increased after the project ended. The other two decreased slightly after the project ended but remained significantly above baseline.
- Four of the seven indicators regarding feeding practices increased after the project ended. The other three decreased slightly after the project ended but remained significantly above baseline.
- All five maternal health indicators continued to improve from the final evaluation levels.
- The two WASH indicators measured both showed decreases when compared to the final project evaluation, but still showed large increases from the baseline.

Regarding the sustainability of the volunteer activities, they found:

- 52\% of CGVs were still active five years after the project ended.
- 59\% said they had received visits from CGVs during labour, delivery and afterward.
- 57\% said caregivers, other than the mother, received health information from CGVs.
- 61\% said they received a visit from CGVs in the last two weeks.


\textsuperscript{12} Halkeno Terfasa Tura and University of Northern Iowa “Mothers-to-Mothers Health Promotion Model: Evaluating Longer-Term Impact of a Cascading Approach to Health Promotion in Mozambique” May 2016. A Summary presentation of this thesis from July 2017 is available at https://coregroup.org/webinar/summary-of-findings-on-care-groups-sustainability-study-in-mozambique/
65% said they have come in contact with CGVs at least one time and at most 4 times in the last one month.

67% said they get advice from CGVs on health or nutrition.

64% said they see the CGV as their general source for health information.

9. Wrap Up

- Thank the group for their comments.
- Tell participants: Now that we have a better idea of the structure of Nurturing Care Groups and what makes the Care Group approach effective, we are going to discuss how you should plan for implementing the Nurturing Care Group project model.
Lesson 2 Handout 1: Nurturing Care Components and Interventions

### Component 1: Good Health

**Universal health coverage**

This is when everyone gets the good-quality health services they need without suffering financial hardship. It is especially important that caregivers and families are able to access the full range of these services from health facilities and in their communities. These should include promotive and preventive services, as well as treatment, rehabilitation and palliative care.

- Family planning
- Immunization for mothers and children
- Prevention and cessation of smoking, alcohol and substance use
- Prevention of mother-to-child transmission of HIV
- Support for caregivers’ mental health
- Antenatal and childbirth care
- Prevention of preterm births
- Essential care for newborn babies, with extra care for small and sick babies
- Kangaroo care for low-birthweight babies
- Support for timely and appropriate care seeking for sick children
- Integrated management of childhood illness
- Early detection of disabling conditions (such as problems with sight and hearing)
- Care for children with developmental difficulties and disabilities

### Component 2: Adequate Nutrition

1. **The International Code of Marketing of Breastmilk Substitutes, and the accompanying guidance**

   The inappropriate marketing of food products is an important factor that negatively affects mothers’ choice to breastfeed in the best way. There is a Code and guidance on ending this inappropriate promotion of foods for infants and young children. These are important tools for creating an environment that enables mothers to make the best possible feeding choice, based on impartial information and free of commercial influences. And it helps mothers to be fully supported when they make that choice.

   **Baby-friendly Hospital Initiative (BFHI)**

   Maternity services play an important role, supporting mothers in bonding with their children through body contact and optimal breastfeeding practices. The services do this supporting mother to put their baby to the breast immediately after birth, not providing water and not allowing formula samples to be distributed. The BFHI’s ten steps describe the essential conditions for protecting, promoting and supporting breastfeeding. And the Baby-friendly Community Initiative extends this support for breastfeeding beyond health facilities.

   - Maternal nutrition
   - Support for early initiation, exclusive breastfeeding and continued breastfeeding after 6 months
   - Support for appropriate complementary feeding and for transition to a healthy family diet
   - Micronutrient supplementation for mother and child, as needed
   - Fortification of staple foods
   - Growth monitoring and promotion, including intervention and referral when indicated
   - Deworming
   - Support for appropriate child feeding during illness
   - Management of moderate and severe malnutrition as well as being overweight or obese

### Component 3: Responsive Caregiving

**Paid parental leave**

Paid parental leave is associated with several health benefits for children. They include supporting the bonding between mother and child, increasing the

- Skin-to-skin contact immediately after birth
- Kangaroo care for low-birthweight
initiation and duration of breastfeeding, and improving the likelihood of infants being vaccinated and receiving preventive care. New fathers are more involved with their young children and take on more child-care responsibilities when they take leave from work.

**Affordable child-care services**
There has been an increase in the number of women in the workforce and therefore, caregivers need affordable, good quality day care for their children. This is also important for the high numbers of single mothers, and for caregivers of children living with disabilities.

**Urban design**
This should include green and child-friendly spaces that promote play between caregivers and children, as well as learning.

<table>
<thead>
<tr>
<th>Component 4: Opportunities for early learning</th>
<th>Universal access to good-quality day care for children, as well as pre-primary and primary education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmentally appropriate early education is crucial to children’s cognitive and social development, and to their preparation for formal schooling. It is important for children across all demographic groups to have access to tuition-free pre-primary and primary education. This is especially important for children from vulnerable populations, as stress adversely affects children’s learning.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Component 5: Security and safety</th>
<th>Social protection and social services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social protection encompasses both insurance and income assistance (such as social grants and pensions) and provides direct, regular and predictable income for poor and vulnerable households. An important and growing part of social welfare in many countries, social assistance provides income security that reduces household poverty, mitigates against shocks, improves access to health and other services, and can increase immunization coverage, improve children’s and mothers’ health and nutrition, and boost school attendance and achievement.</td>
<td></td>
</tr>
<tr>
<td>Minimum wage</td>
<td>When caregivers are not able to earn adequate income, children’s basic needs – including health care and education – cannot be met and early childhood development suffers. A minimum wage has the potential to improve the lives of millions of children, whether their caregivers work in the formal or informal economy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>babies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rooming-in for mothers and young infants, and feeding on demand</td>
<td></td>
</tr>
<tr>
<td>Responsive feeding</td>
<td></td>
</tr>
<tr>
<td>Interventions that encourage play and communication activities of caregiver with the child</td>
<td></td>
</tr>
<tr>
<td>Interventions to promote caregiver sensitivity and responsiveness to children cues</td>
<td></td>
</tr>
<tr>
<td>Support for caregivers’ mental health</td>
<td></td>
</tr>
<tr>
<td>Involving fathers, extended family and other partners</td>
<td></td>
</tr>
<tr>
<td>Social support from families, community groups and faith communities</td>
<td></td>
</tr>
</tbody>
</table>

| Information, support and counselling about opportunities for early learning, including the use of common household objects and home-made toys |  |
| Play, reading and story-telling groups for caregivers and children |  |
| Book sharing |  |
| Mobile toy and book libraries |  |
| Good-quality day care for children, and pre-primary education |  |
| Storytelling of elders with children |  |
| Using local language in children’s daily care |  |

| Birth registration |  |
| Provision of safe water and sanitation |  |
| Good hygiene practices – at home, at work and in the community |  |
| Prevention and reduction of indoor and outdoor air pollution |  |
| Clean environments free of hazardous chemicals |  |
| Safe family and play spaces in urban and rural areas |  |
| Prevention of violence by intimate partners and in families, as well as services for addressing it |  |
| Social care services |  |
| Cash or in-kind transfers and social insurance |  |
| Supporting family care and foster care over institutional care |  |
Notes:

- This graph shows how infant growth drops off dramatically (and very similarly in different world regions) after about 3 months of age.

- This underscores the importance of working with pregnant and lactating women (PLW) to reduce infant malnutrition and promote exclusive breastfeeding (EBF) in the first 6 months, appropriate complementary feeding, good hand washing and prevention of illnesses from exposure to contaminated food and water.

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Lesson 2 Handout 3: Importance of Early Childhood Development

Return on Investment is Strong

Schools should invest in young children, where the return on investment is stronger than in K-12

Disparities in Early Vocabulary

Source: Heckman (2005)
Why Early Child Education?

- Advances in brain research tell us that by the age of 5, more than 90% of the architecture of the brain is already in place.
- Proven programs such as voluntary home visiting maximizes early childhood health and development during the critical first three years of life.
- Children in a longitudinal study who had attended preschool were less likely to drop out of high school, be placed in special education and held back a grade, and they scored better on reading and math achievement tests.
- Early childhood education saves governments from spending as much on K-12 education, public assistance and the criminal justice system, and increases tax revenues as a result of higher earnings.
- Babies are constantly learning. Very young children are learning through play, the active exploration of their environment, and, most importantly, through interactions with the significant adults in their lives. According to recent brain research, even in the womb, the infant is turning towards the melody of its mother's voice. The brain is setting up the circuitry needed to decipher and reproduce language.
- Learning begins at birth. By the time children turn three, they have already begun laying the foundation for lifelong learning and success. Early language and literacy skills are learned best through everyday moments with one’s child — reading them books, talking with them, and laughing and playing together. Children learn language when caregivers talk to them, and also when children communicate back to caregivers. They also learn by hearing stories read and songs sung aloud. Scientific studies have found that children learn much better in school when their parents talk to them a lot when they are very young – before three years of age. Giving young children encouragement is also important.
- An important part of the ECG Program is that caregivers play, interact and participate with their children. This includes helping them to use objects to learn (like cans, blocks and letter cards), describing things to the children, asking questions, and praising children for their efforts.
Lesson 2 Handout 4: Causes of Death in Children under 5 Years of Age

Notes:

- The diagram shows the proportion of all deaths of children under 5 years of age that could be prevented with a specific intervention.

- 57% of under-5 deaths could have been prevented with interventions that rely on household behaviour change, including breastfeeding; insecticide-treated material; complementary feeding; zinc supplementation; clean delivery; water, sanitation and hygiene (WASH); newborn temperature management; vitamin A; and oral rehydration solution (ORS).

- The Care Group Approach and the Nurturing Care Group Project Model both work to change the household practices that can dramatically reduce these preventable deaths.

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## Lesson 2 Handout 5: Child Milestones and Skills Exercise

<table>
<thead>
<tr>
<th>Skills / Milestones</th>
<th>By what age should a child do this?</th>
<th>Where should this skill/milestone first be demonstrated? (Home, School, Other)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child reaches for toy with one hand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child can hold a toy and shake it and swing at dangling toys</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child moves to rhythms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child looks for things s/he sees you hide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child nests 2 then 3 cans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child recognizes and points to 4 animal pictures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child matches sounds to pictures of animals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child builds a tower using 4-6 blocks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child makes shapes using clay or other mouldable solid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child uses 3-word sentences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child builds a tower using 8 blocks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child sorts shapes (e.g., circle, triangle, square), sorting objects of the same types</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child sorts things by colour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child points to several colours when named</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child participates in story telling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child vocalizes for all needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child plays make believe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child copies circles with chalk on the chalkboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child understands what 2 means</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child builds a tower using 9 blocks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child draws a square imitating an adult</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child holds a pencil/chalk using thumb and fingers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child runs and changes direction without stopping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child draws a person with 2-4 body parts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child uses 4- to 8-word sentences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child can recognize or read numbers 0-9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child associates numbers 1-10 with numerals 1-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child counts orally to 10 with one-on-one correspondence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child understands the idea of counting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child begins to do simple addition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child hops on one foot, and may be able to skip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child counts 10 or more things</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child draws a person with 6 or more body parts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child reads simple 3-letter words when paired with pictures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Lesson 2 Handout 6: Key to Child Milestones and Skills Exercise

<table>
<thead>
<tr>
<th>Skills / Milestones</th>
<th>By what age should a child do this?</th>
<th>Where should this skill/milestone first be demonstrated? (Home, School, Other)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child reaches for toy with one hand</td>
<td>6 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child can hold a toy and shake it and swing at dangling toys</td>
<td>6 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child moves to rhythms</td>
<td>12 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child looks for things s/he sees you hide</td>
<td>12 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child nests 2 then 3 cans</td>
<td>18 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child recognizes and points to 4 animal pictures</td>
<td>18 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child matches sounds to pictures of animals</td>
<td>24 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child builds a tower using 4-6 blocks</td>
<td>24 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child makes shapes using clay or other mouldable solid</td>
<td>30 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child uses 3-word sentences</td>
<td>30 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child builds a tower using 8 blocks</td>
<td>30 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child sorts shapes (e.g., circle, triangle, square), sorting objects of the same types</td>
<td>36 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child sorts things by colour</td>
<td>36 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child points to several colours when named</td>
<td>36 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child participates in story telling</td>
<td>36 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child vocalizes for all needs</td>
<td>36 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child plays make believe</td>
<td>36 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child copies circles with chalk on the chalkboard</td>
<td>42 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child understands what 2 means</td>
<td>42 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child builds a tower using 9 blocks</td>
<td>42 months</td>
<td>Home</td>
</tr>
<tr>
<td>Child draws a square imitating an adult</td>
<td>48 months</td>
<td>Home or preschool</td>
</tr>
<tr>
<td>Child holds a pencil/chalk using thumb and fingers</td>
<td>48 months</td>
<td>Home or preschool</td>
</tr>
<tr>
<td>Child runs and changes direction without stopping</td>
<td>48 months</td>
<td>Home or preschool</td>
</tr>
<tr>
<td>Child draws a person with 2-4 body parts</td>
<td>54 months</td>
<td>Home or preschool</td>
</tr>
<tr>
<td>Child uses 4- to 8-word sentences</td>
<td>54 months</td>
<td>Home or preschool</td>
</tr>
<tr>
<td>Child can recognize or read numbers 0-9</td>
<td>54 months</td>
<td>Home or preschool</td>
</tr>
<tr>
<td>Child associates numbers 1-10 with numerals 1-10</td>
<td>54 months</td>
<td>Home or preschool</td>
</tr>
<tr>
<td>Child counts orally to 10 with one-on-one correspondence</td>
<td>54 months</td>
<td>Home or preschool</td>
</tr>
<tr>
<td>Child understands the idea of counting.</td>
<td>54 months</td>
<td>Home or preschool</td>
</tr>
<tr>
<td>Child begins to do simple addition</td>
<td>54 months</td>
<td>Home or preschool</td>
</tr>
<tr>
<td>Child hops on one foot, and may be able to skip</td>
<td>60 months</td>
<td>Home or preschool</td>
</tr>
<tr>
<td>Child counts 10 or more things</td>
<td>60 months</td>
<td>Home or preschool</td>
</tr>
<tr>
<td>Child draws a person with 6 or more body parts</td>
<td>60 months</td>
<td>Home or preschool</td>
</tr>
<tr>
<td>Child reads simple 3-letter words when paired with pictures</td>
<td>60 months</td>
<td>Home or preschool</td>
</tr>
</tbody>
</table>

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Lesson 2 Handout 7: Care Group Approach Effectiveness

Figure One

Notes:

- The U.S. Agency for International Development (USAID)'s Child Survival and Health Grants Program (CSHGP) has supported community-oriented health projects implemented since 1985. The purpose of this program is to contribute to sustained improvements in child survival and health outcomes by supporting the innovations of private voluntary organizations (PVOs) and nongovernmental organizations (NGOs) and their in-country partners in reaching vulnerable populations.

- Rapid CATCH Indicators are priority health indicators as defined by USAID for the CSHGP portfolio. For a full list of Rapid CATCH indicators and their definitions, please see: http://mchipngo.net/controllers/link.cfc?method=tools_kpc.

- Acronyms used above include:
  - SBA: skilled birth attendant
  - TT2: two tetanus toxoid vaccines
  - EBF: exclusive breastfeeding
  - All Vacs: youngest child received all childhood vaccines
  - ITN: child slept under insecticide-treated bed net last night
  - Danger Signs: maternal knowledge of child danger signs
- AIDS Know: maternal knowledge of HIV risk reduction
- HWWS: Hand washing with soap

- For the complete definition of indicators, please see: http://mchipngo.net/controllers/link.cfc?method=tools_mande.

- Data are drawn from final evaluations from all CSHGPs that ended between 2003 and 2010 (reported and collated by Maternal and Child Health Integrated Program [MCHIP]).

- Gap closure refers to “closing the gap” between indicators at the beginning of a program and how much that indicator improved. For example, if you started at 20% exclusive breastfeeding (EBF) and increased to 40%, you would have closed 20 (40 - 20 = 20) of the 80 possible percentage points, or 25% gap closure (20 ÷ 80 = 25%). Looking at gap closure is a useful way to compare performance across projects.

Figure Two

![Care Group Performance: Estimated Percent Reduction in Child Death Rate (0-59 Months) in 13 CSHGP Care Group Projects in Eight Countries](image-url)
Notes:
- Data were drawn from final evaluations from all CSHGPs that ended between 2003 and 2010. Mortality was estimated using LiST: the Lives Saved Tool, an evidence-based tool for estimating intervention impact created by the Johns Hopkins Bloomberg School of Public Health (available at http://www.jhsph.edu/dept/ih/IIP/list/index.html).
- All LiST calculators used for this study are publicly posted at http://www.caregroupinfo.org/docs/PVO_Lives_Saved_Calculators_Bellagio.zip.

Figure Three

Indicator Gap Closure on Rapid CATCH Indicators: Care Group CSHGP vs. Non-Care Group CSHGP Projects, Selected Indicators

Notes:
- Figure Three shows performance of World Relief (WR)’s NCG project in Cambodia (gold bars) as compared with other NCG (blue bars) and non-NCG (tan bars) projects.
- The NCG model in Cambodia showed even better performance than in other Latin American and the Caribbean, Asian and African countries, even in hand washing, despite an initial strong concern by WR national staff that the model would not be effective in their context. In Asia, NCGs have been used in Cambodia, Indonesia and the Philippines.
Lesson 2 Handout 8: Care Group Approach Sustainability Studies

Study 1: World Relief study on their CSP in Gaza Province, Mozambique
The first was a review of a Care Group project in Gaza Province, Mozambique conducted by World Relief in 2002 and 200316.

- The sustainability plan included interventions that were phased in. Then responsibilities slowly shifted from project-paid Promoters to Care Group leaders.
- 93% of the 1,457 volunteers active at the end of WR’s Care Group project (in Gaza Province) were active 20 months after end of project.
- 92 volunteers left their post or moved out; 44 died.
- Out of these 132 vacant roles, communities selected 40 replacements and trained them on their own.
- Changes brought about in the original program were maintained: A full four years after the end of the project (all interventions and funding ceased), final program goals on eight key indicators continued to be exceeded.
- The percentage of children with diarrhoea treated with ORS continued to increase after the project ended.

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16 “Promising Initiatives on the Motivation of Volunteer Health Workers: FH/Mozambique Care Group Project” Presentation by Cecelia Lopes, Emma Hernandez Avilan, Carolyn Wetzel, Tom Davis and Henry Perry for APHA in October 2011.
The percentage of children 12-23 months of age completely vaccinated decreased a small amount after the project but remained significantly above the baseline and the project goal.

**Study 2: FANTA Study of Projects in Bolivia including an FH Care Group Project**

FANTA conducted a review of Title II projects for multiple organizations in Bolivia. Included in the research was FH’s Care Group Project that ran from 2002-2006. The sustainability data was collected by FANTA in 2011 and found that the following indicators continued to improve past the end of project results:

- Stunting continued to decline significantly after exit.
- Percentage of mothers reporting any prenatal care during last pregnancy increased.
- Percentage of mothers reporting prenatal care in first 5 months during last pregnancy increased.
- Percentage of mothers reporting exclusive breastfeeding for child less than six months of age increased.
- Percentage of children 12–23 months of age receiving the third dose of DPT or pentavalent vaccine increased.

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Study 3: University of Iowa Study of FH Project in Sofala, Mozambique

In 2015, researchers from the University of Iowa conducted a sustainability study in Sofala Province, Mozambique following a FH Child Survival Project that ran from 2006-2010.\(^\text{18}\)

Regarding sustainability of the behaviours, they found:

- The percentage of children underweight continued to decline from 29.5% at baseline, to 17.8% at final evaluation to 15.8% five years later.

![Result: Undernutrition](image)

**Fig 3.** Percent underweight/undernutrition compared to the previous studies

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- Two of the four indicators regarding health seeking behaviours increased after the project ended. The other two decreased slightly after the project but remained significantly above baseline.

![Result: Health-Seeking Behavior](image)

- Four of the seven indicators regarding feeding practices increased after the project ended. The other three decreased slightly after the project but remained significantly above baseline.

![Result: Feeding Practices](image)
• All five maternal health indicators continued to improve from the final evaluation levels.

Result: Maternal Health

• The two WASH indicators measured both showed decreases compared to the final evaluation, but still showed large increases from the baseline.

Result: Hygiene and Sanitation
Regarding the sustainability of the volunteer activities, they found:

- 52% of CGVs were still active five years after the project ended.
- 59% said they received visits from CGVs during labour, delivery and afterward.
- 57% said caregivers, other than the mother, received health information from CGVs.
- 61% said they received a visit from CGVs in the last two weeks.
- 65% said they have come in contact with CGVs at least one time and at most 4 times in the last one month.
- 67% said they get advice from CGVs on health or nutrition.
- 64% said they see CGVs as their general source for health information.
Lesson 3: Nurturing Care Group Structure, Targeting and Behaviours

Achievement-Based Objectives
By the end of this lesson participants will have:

- Analysed possible target groups for a NCG project
- Identified a framework for selection of behaviours to promote
- Diagrammed the structure of a NCG

Duration
2 hours

Materials Needed

- Flip chart paper, index cards and markers
- Lesson 3 Handout 1: Targeting Exercise
- Lesson 3 Flip Chart 1: T-Chart with Easier and Harder Behaviours to Adopt
- Lesson 3 Handout 2 and Flip Chart 2: Nurturing Care Group Key Terms
- Lesson 3 Handout 3: Nurturing Care Group Structure Diagrams
- Lesson 3 Flip Chart 3: Nurturing Care Group Calculations Game
- Answer Key to Lesson 3 Flip Chart 3: Nurturing Care Group Calculations Game

1. Who should the Nurturing Care Group Approach Target?

- **Ask participants:** Now that we have examined the Nurturing Care Framework and understand the different components of change, who do you think the NCGs should target for maximum effectiveness and efficiency?

- In WR’s original use of CGs in Gaza, Mozambique, all women of reproductive age (15-49) were included in the project. In practice this meant including every household in the community.

Reaching every household has the following benefits:

- With this project, we hope to achieve lasting community-wide behaviour change. Many of the behaviours that the NCGs will promote are complex and not always under the sole discretion of a young mother. So, by targeting every household with the same message, we help to create change at the community level, create new community norms and provide a supportive environment for parents who wish to practice the new behaviours. Influencers like mothers-in-law, sisters, pastors, imams, other religious leaders and community leaders are all reached.

- Reaching every household makes it easier to identify new households and new pregnancies. It also creates an environment where young girls who are about to be married are more easily integrated into the NCG structure.
o Also, it provides an opportunity to strengthen the support to young women who are not yet mothers. Messages targeting proper nutrition, WASH, family planning, and HIV can have lasting impacts on the wellbeing of the women themselves and their future children.

o Reaching every household also cuts down on the administrative burden of the project in tracking more limited groups who may move in and out of the project (such as pregnant and lactating women).

o Adoption of WASH behaviours is needed in most communities in a community, not only those with the youngest children.

o Reaching every household (rather than selected ones), means that the people NCG Promoters need to reach are in a smaller geographic area, which may make it possible for them to use bicycles rather than motorcycles, reducing project costs.

• Including every household does increase the number of NCGVs and project staff needed, and overall costs. However, the effects on sustainability should be taken into account. If the project cannot afford to work with every household in an entire area (e.g., a WV Area Programme), consider working in a few communities for a set period of time and then moving on to a new set of communities. A minimal number of staff (e.g., Promoters) could stay at the original location to provide some supervision and support.

• We also recognize that specific grants may have limitations on which beneficiaries they will fund within a project area. In this case, it is important to match the target group to the stage of life when the messages will have the greatest impact on health outcomes, such as pregnant and lactating women, children less than two years of age and/or children less than five years of age.

Adapting the NCG model for these specific subsets is possible but can be complicated. Please reach out to your national, regional, or partnership-level (e.g., WV Technical Service Organization, Global Center) staff for assistance. Important questions to consider are:

o How will every member of the target group be identified and tracked through time?

o Will the number of people in the project vary over time?
  • If so, consider making the groups smaller than the maximum size initially so new members can be added without groups then exceeding a proper small group size.
  • If participants will not remain for the entire project, how will this be tracked?
  • If a caregiver enjoys meeting in a group will the project, but his or her child has “aged out” of your target group, will the NCGV ask him/her not to attend?

o Are there enough participants in the project area to allow each NCGV to reach all her Neighbour Caregivers (NC) quickly and does each one live within one hour travel time of her Promoter?

o What other influencers and leaders can the project target to help facilitate a broader community-wide change?

2. **Activity: Targeting Exercise**

• Divide the participants into small groups and distribute *Lesson 3 Handout 1: Targeting Exercise.*
Tell the participants that they are on the planning team for a new NCG project in Marromona District. The handout includes some important data collected during a baseline survey. Their task is to review the data and answer the following questions: (Give the teams 15 minutes to do this.)

1. Given the data above, what behaviours or topics do you feel are most important to focus on?
2. If you design activities on these behaviours, what ages should you focus on to have the greatest impact?
3. Who do you need to target in order to see the impact on the selected ages?

- Have the small groups write their responses on flip chart paper and post them up in the room. Give the small groups 5 minutes to walk around and read the other team’s responses.

- Lead a discussion about the differences between the groups’ responses. Highlight the following:
  - In an integrated, holistic project, we may need a broader target than when using the project model for fewer sectors.
  - When targeting a broader range of people/households there is a greater chance of creating a community-wide change in norms.
  - When more people are included, the information is not wasted, even if a household does not include a small child. This is because everyone has a role in supporting children in a community, as a grandparent, auntie, uncle, sister, brother, godparent, Sunday-school teacher, pastor, imam, etc.

3. Prioritizing and Selecting Behaviours to Promote

- Tell participants: Looking back at the “WHO Table: Laws, policies and interventions for creating enabling environments” in Lesson 2 Handout 1: Nurturing Care Components and Interventions, there are multiple interventions or behaviours that are included. Since we do not have unlimited time or resources, we need to carefully select which behaviours our project will address to make the greatest impact in the lives of those we serve. One method of prioritization is to look at behaviours that are easier to change compared to those that are harder to change.

- Ask participants: What is a behaviour from the Nurturing Care Framework that would be easier to change? Then, ask them what is a behaviour that would be harder to change? Write these on a flip chart.

- Ask participants: Why is one harder and the other easier? When the participants explain, transform their response into the comparative phrases we are looking for and write those on Lesson 3 Flip Chart 1: T-Chart with Easier and Harder Behaviours to Adopt, which should have two columns: one for easier Behaviours and one for harder Behaviours. Introduce the idea that some Behaviours have characteristics that make them more difficult to adopt and promote than others, and as change agents we need to keep this in mind when we are choosing the Behaviours to promote.

- Ask participants: Why is this important? They should respond: The harder the Behaviour, the more challenging it is to promote and the more time that may be needed to achieve a change.

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• Working with the large group and continuing to use Lesson 3 Flip Chart 1, generate a list of characteristics that would make a Behaviour either easier or more difficult to adopt/promote. Write these characteristics on the T-chart.
  
  o For each characteristic, ask participants to also share one example of a Behaviour with that characteristic.
  
  o Prompt participants until all of the following Behaviour characteristics are listed (use this list for the T-chart):

<table>
<thead>
<tr>
<th>Easier to Adopt</th>
<th>More Difficult to Adopt</th>
</tr>
</thead>
<tbody>
<tr>
<td>One time</td>
<td>Ongoing or frequent</td>
</tr>
<tr>
<td>Requires little skill</td>
<td>Requires complex skills</td>
</tr>
<tr>
<td>Immediate positive result</td>
<td>Delayed positive result (or mixed result)</td>
</tr>
<tr>
<td>No or low cost</td>
<td>High cost</td>
</tr>
<tr>
<td>Requires little time</td>
<td>Requires a lot of time</td>
</tr>
<tr>
<td>Fits with current social norms</td>
<td>Against social norms (i.e., requires more norm change)</td>
</tr>
<tr>
<td>Resources always available to do the behaviour</td>
<td>Resources often unavailable</td>
</tr>
<tr>
<td>Requires one person to do</td>
<td>Requires many people to do</td>
</tr>
<tr>
<td>Single-step behaviour</td>
<td>Multiple-step behaviour</td>
</tr>
<tr>
<td>Low tech</td>
<td>High tech</td>
</tr>
</tbody>
</table>

• Explain to participants: These are important criteria, but they must also be balanced against the degree to which the adoption of the behaviour will lead to a high level of child wellbeing improvement. We should give preference to those behaviours, even if they are a bit difficult to adopt, that are most likely to save children’s lives, prevent disease, protect children from abuse and harm, and assure that they have the intellectual capacity to do well in school later on. Project managers should also take into account the objectives of a given project which will be partly dependent on the donor’s requirements. Remember, multi-sectoral integration is one of the key principles of the Nurturing Framework; therefore, it is essential that some of the key behaviours from each of the sectors be included in all NCG projects. We recommend that at least four behaviours per sector be promoted in any NCG project (but more is better).

• Explain to participants: Another important factor to consider is the current level of adoption, or how many people in the community are already practicing the behaviour.
  
  o If there is a behaviour with low adoption rates, there is a more of an opportunity to create a big change and ultimately impact more people.
  
  o However, if most of the people are already doing a behaviour, focusing on the small percentage of those who are not practicing it may only impact only a few people. Also, the change may be more difficult to bring about, and the small change may be difficult to detect at a project level.

• Tell participants: We recommend that behaviours with the lowest adoption rates be prioritized over those with medium adoption rates. Behaviours with high adoption rates (for example over 90%) can be mentioned in a lesson, but should not be prioritized or have their own lesson.
4. The Nurturing Care Group Approach and Structure

- This project will combine WHO’s Nurturing Care Framework with the Care Group approach to create a holistic Nurturing Care Group project model.

- Refer participants to Lesson 3 Handout 2 and Flip Chart 3: Nurturing Care Group Key Terms and display the flip chart. Explain that though many organizations have given different names to the different groups/people, Lesson 3 Handout 2 shows the terms that we will be using throughout the training. Review each term with participants.

- Using index cards of different colours, sizes and shapes, create a diagram of a typical NCG structure on the wall in the front of the room that follows Lesson 3 Handout 3: Nurturing Care Group Structure Diagrams.

- As you place the cards, say the name of each staff member/volunteer and his/her main role (for example, the Coordinator supervises 3–6 Supervisors), as shown in Lesson 2 Handout 1. Engage participants who have prior experience/knowledge of the CG approach or the NCG project model. Emphasize that NCGs are a behaviour change platform. Be sure to point out which people are typically paid staff, and which are unpaid volunteers.

- After explaining the staffing structure of the NCG approach, briefly explain the main responsibilities of each person, including training, supervision, behaviour change meetings with Promoters and behaviour change visits with Neighbour Caregivers (NC).

- Once the full diagram is on the wall, ask the participants what questions they have about the NCG approach and respond. If a particular topic will be covered in depth in a later lesson, defer discussion of those points until later.

5. Activity: The Nurturing Care Group Calculations Game

- Divide participants into pairs.

- Ask each pair to calculate how many caregivers they would reach given the different scenarios listed in Lesson 3 Flip Chart 3: Nurturing Care Group Calculations Game. Answers can be found in Answer Key to Lesson 3 Flip Chart 3: Nurturing Care Group Calculations Game.

6. Activity: Alternative Care Group Diagram

- Give out markers and a sheet of flip chart paper to each small group.

- Ask the groups to draw their own representations of the NCG project model in one village, using the following breakdown (or another breakdown devised by the facilitator).
  - 5 Nurturing Care Group (NCG) Promoters
  - 6 Nurturing Care Groups (NCGs) per Promoter
  - 10–15 Nurturing Care Group Volunteers (NCGVs) per NCG
  - 10–15 Neighbour Caregivers (NC) per NCGV

- Ask participants to diagram this in a different way than what is shown in Lesson 2 Handout 3.
Pastoral Care Groups

Studies show that people are more likely to change their behaviour if positive messages are shared and practiced by a wide group of people. To help create this community-wide behaviour change, WR often sets up “Pastoral Care Groups” in their project areas. They bring together all the religious leaders in the community regardless of religion, sect or denomination. The NCG Promoter meets with them at the beginning of the project to explain the goals of the project and how the leaders could help. Then, together, they set up monthly (or every other month) meetings during which the NCG Promoter shares the upcoming lessons. They discuss barriers and share how the leaders are encouraging their members to adopt new behaviours.

The leaders often stay after the Promoter left to discuss other issues important to the community, including those pertaining to faith. In many communities in their project areas, there was deep animosity between Christian and Zionist leaders. However, by meeting together regularly they were able to heal their divisions and focus on common goals for the community.

Note: the WR area in which this was implemented is in predominantly Christian and Zionist areas, where the term “pastor” is culturally appropriate. You may want to consider changing the name to “Religious Leaders Nurturing Care Groups” depending on what is appropriate in your project area.)
Lesson 3 Handout 1: Targeting Exercise

Congratulations! You are on the planning committee for the new Nurturing Care Groups project in Marromona District. Below is some data that was collected from a baseline survey to help you as you design the project.

- The population of the Municipality stands at 135,450 with 69,721 males and 65,729 females
- Children less than five years of age make up 14% of the population
- Under 5 mortality is 77/100; Maternal mortality is 319/100,000
- 11% of live births are born with low birthweight
- 17% of girls have had a child by the age of 18
- 19% of children are moderately to severely stunted
- 40% of children face inadequate supervision at home
- 56% of pregnant women living with HIV are receiving treatment
- 56% of children with pneumonia receive care in a timely manner
- 52% of children 0-6 months of age are exclusively breastfed
- 13% of children under 5 receive a minimally acceptable diet
- 78% of people have access to basic drinking water
- 14% of households have access to basic sanitation
- 39.2% of children age 6-59 months tested positive for malaria
- 58% of women 15-49 have received no education, 29% are literate
- 29.4% of people practice open-defecation
- 38% of women are part of a polygamous household
- The fertility rate is 5.8; The median number of months between pregnancies is 38
- 59% of births were at a health facility; 66% of infants had a post-natal check-up within two days
- 41% of homes have children’s books; 21% of children have support for learning
- 6% of children have playthings at home; 68% of children receive early childhood education
- 94% of children aged 1 to 14 years experienced at least one form of violent discipline (psychological aggression and/or physical punishment) in the past month
- 83.5% of women feel that there are times when wife beating is justified
- 40% of children receive early stimulation and responsive care (by any adult household member)
- The leading causes of death among children under five in 2017 were hypothermia (at birth), acute respiratory infections, malnutrition, and diarrhoea.
- 24 percent of households that have a designated place for washing hands, only half of that percentage had soap and water available at those points at the time of the survey.
- 42% of children slept under a bed net the previous night

1. **Given the data above, what behaviours and topics do you feel are most important to focus on?**
2. **If you design activities on these behaviours and topics, what age groups and other cohorts (e.g., pregnant women) should you focus on to have the greatest impact?**
3. **Who do you need to target in order to see the most impact on the selected age groups?**
Lesson 3 Handout 2 and Flip Chart 2: Nurturing Care Group Key Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurturing Care Group (NCG)</td>
<td>A group of 10–15 Nurturing Care Group Volunteers (NCGVs) led by a NCG Promoter</td>
</tr>
<tr>
<td>Neighbour Group (NG)</td>
<td>A group of 10–15 caregivers that meets with the selected NCGV The NCGV shares new health lessons with them every 2 weeks as a group or individually (through home visits). This can also be referred to as a Neighbour Circle.</td>
</tr>
<tr>
<td>Neighbour Caregiver (NC)</td>
<td>Caregivers in the NG who meet with the NCGV once every 2 weeks to hear a new health lesson</td>
</tr>
<tr>
<td>Nurturing Care Group Volunteer (NCGV)</td>
<td>Volunteers who meet with the NCG Promoter Usually nominated or elected for that position by the neighbour caregivers in their NG</td>
</tr>
<tr>
<td>NCG Promoter</td>
<td>A community member hired to train and supervise the NCGVs in their community</td>
</tr>
<tr>
<td>Supervisor</td>
<td>Hired to directly supervise and train Promoters in each community and to monitor the NCG program. (This role may be played by different staff members in WV.)</td>
</tr>
<tr>
<td>Coordinator</td>
<td>Hired to directly supervise Supervisors and monitor the NCG program. Reports to the project manager. (This role may vary based on your organization and responsibility structures.)</td>
</tr>
<tr>
<td>Supportive supervision</td>
<td>A process of observation and feedback from each successive level in the NCG approach that contributes to strong and mutually respectful working relationships, builds skills and productivity, and creates a sense of unity in working together toward common goals.</td>
</tr>
<tr>
<td>Quality improvement and verification checklist (QIVC)</td>
<td>A monitoring tool focused on improving the quality of a worker’s performance. Assesses how a worker carries out various aspects of his/her job, such as a NCG Promoter leading a NCG meeting, or a NCGV conducting a home visit. Seeks to encourage workers, improve his/her performance and monitor progress. Results of multiple QIVCs used to identify “system problems”.</td>
</tr>
<tr>
<td>Learning Station Materials (LSMs)</td>
<td>Materials such as cans, blocks, toys, slates/chalk, and letter/number cards that are maintained by the NCG Promoter and/or NCGVs and used to help children attain new skills and milestones in their development. Caregivers replicate some of these materials for use in their homes.</td>
</tr>
</tbody>
</table>
Lesson 3 Handout 3: Nurturing Care Group Diagrams

NURTURING CARE GROUP STRUCTURE

Each **Coordinator** (paid staff) is responsible for 3–6 Supervisors. A project may hire multiple Coordinators (overseen by a **Manager**) if needed to meet the desired coverage.

Each **Supervisor** (paid staff) is responsible for 4–6 Nurturing Care Group Volunteers.

Each **NCG Promoter** (paid staff) supports 4-9 Nurturing Care Groups.

Each **Nurturing Care Group** has 10–15 Nurturing Care Group Volunteers that are elected by Neighbour Group members.

Each **Nurturing Care Group Volunteer** shares lessons with 10–15 Neighbour Caregivers and their families, known as a Neighbour Group (or Neighbour Circle). (There is a maximum of 15 Neighbour Caregivers in each Neighbour Group.)

Each NCG Promoter reaches about 800 to 4,000 caregivers (and 2,000 to 10,000 population).
Lesson 3 Flip Chart 3: Nurturing Care Group Calculations Game

How many caregiver households would be reached in each scenario?

1. 30 Promoters, 6 NCGs per Promoter, 10 NCGVs per NCG, 12 NC per NCGV
2. 15 Promoters, 5 NCGs per Promoter, 10 NCGVs per NCG, 10 NC per NCGV
3. 3 Promoters, 7 NCGs per Promoter, 12 NCGVs per NCG, 12 NC per NCGV
4. 20 Promoters, 5 NCGs per Promoters, 8 NCGVs per NCG, 9 NC per NCGV
5. 18 Promoters, 8 NCGs per Promoters, 15 NCGVs per NCG, 12 NC per NCGV
Answer Key to Lesson 3 Flip Chart 2: Care Group Calculations Game

1.  $30 \times 6 \times 10 = 1,800$ NCGVs
   $1,800 \times 12 = 21,600$ NC
   $1,800$ NCGVs + $21,600$ NC = $23,400$ caregiver households total (remember that NCGVs are included in caregiver households, too. Multiple caregivers can be found in a given “caregiver household”.)

2.  $750$ NCGVs + $7,500$ NC = $8,250$ caregiver households

3.  $252$ NCGVs + $3,024$ NC = $3,276$ caregiver households

4.  $800$ NCGVs + $7,200$ NC = $8,000$ caregiver households

5.  $1,188$ NCGVs + $11,880$ NC = $13,068$ caregiver households
Lesson 4: Care Group Approach Criteria

Achievement-Based Objectives
By the end of this lesson participants will have:

- Identified the criteria of the traditional Care Group (CG) approach
- Listed reasons why each of the three CG criteria are important

Duration
2 hours

Materials Needed
- Lesson 4 Handout 1: Care Group Approach Program Criteria Worksheet
- Lesson 4 Handout 2: Establishing Care Group Criteria

Steps

1. Introduction

- Tell participants: Now that you have learned the structure of the Nurturing Care Group model and become familiar with the terms associated with the Nurturing Care Group model, we need to look more carefully at what distinguishes this approach from other behaviour change project models that might, at first glance, seem to be the same.

- Ask participants: What other project models have you seen or heard of that seem to have some similarities in terms of structure or criteria to the Nurturing Care Group project model? (Answers could include mother-to-mother support groups, Grandmother Approach project model, youth peer groups and others.)

2. Care Group Criteria

- Explain to participants: While it is true that Nurturing Care Groups may seem similar to other approaches, the Care Group approach that it is based on has been studied and modified since its creation in 1995 to make it as effective as possible. During that time certain criteria of the approach have been shown to be critical to its effectiveness. This means that for everyone who uses a project model based on the Care Group approach to have the same results, each organization needs to be aware of the critical features of the approach. In this lesson, we are going to identify those critical Criteria and explain why they are so important.

3. Activity: Exploring the Criteria

- Refer participants to Lesson 4 Handout 1: Care Group Approach Program Criteria Worksheet. Explain that in the first column are some of the criteria that Food for the Hungry (FH) and World Relief (WR) consider to be critical to the effectiveness of the CG approach. Give the participants 3 minutes to review these.
Note: Since these criteria were developed for the traditional Care Group approach, some terms will be slightly different, such as a Care Group Volunteer (CGV) instead of a Nurturing Care Group Volunteer (NCGV), women of reproductive age (WRA) instead of caregiver and Neighbour Woman instead of Neighbour Caregiver.

- Assign each small group three to five criteria to review. Instruct participants to fill in the second column: “Why is this important?” for their assigned criteria. They should note their response in the space within the column.

- Go through the criteria one at a time, asking the small group that focused on each one to report out on why they thought it was important. As needed, highlight the ideas below if not addressed by the group.

1. The intended group ideally should be all women of reproductive age (WRA), or at least pregnant women and mothers of young children.
   - The model is based on mother-to-mother behaviour promotion [with some involvement of other caregivers (e.g., husbands, grandmothers)].
   - Pregnant women and young children are most vulnerable to death and disease, so health and nutrition interventions can have the greatest impact with these groups.
   - Ideally a program would reach all WRA but grant requirements or other constraints may prevent this.

2. The plan is to reach 100% of households in the intended group (and attain at least 80% monthly attendance).
   - In order to create a “new social norm” (not one person changing behaviour, but many encouraging each other) a program needs to reach most or all of the households with women who could get pregnant, are currently pregnant or have young children (under 5).
   - People are more likely to change when others around them are hearing the same message and talking about making their own changes.
   - The World Relief (WR) CG manual says, “Changed communities: 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. Behaviour change becomes more than an individual decision—it becomes a social movement involving the entire community.”
   - While creating a new social norm, everyone in the community hears the message together. This way the community as a whole can make changes together.
   - Community learning helps to increase change.

3. Each CG (or NCG) should have no more than 15 CG or NCG volunteers.
   - The larger the group, the less time there is for participants to ask questions and for CGVs to discuss and interact with participants.
   - If there are 15 or fewer people, you can more easily interact with each of them.

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• When groups become larger than 15 people, a few people begin dominating conversation and others stop talking. A group larger than 15 is harder to facilitate and makes encouraging, discussing and addressing the issues of others much more difficult.

<table>
<thead>
<tr>
<th>Group Size and Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source: Jenny Rogers (1989)</td>
</tr>
<tr>
<td>3–6 people: Everyone speaks</td>
</tr>
<tr>
<td>7–10 people: Almost everyone speaks</td>
</tr>
<tr>
<td>Quieter people say less</td>
</tr>
<tr>
<td>One or two may not speak at all</td>
</tr>
<tr>
<td>11–18 people: 5 or 6 people speak a lot</td>
</tr>
<tr>
<td>3 or 4 others join in occasionally</td>
</tr>
<tr>
<td>19–30 people: 3 or 4 people dominate</td>
</tr>
<tr>
<td>30+ people: Little participation is possible</td>
</tr>
</tbody>
</table>

4. Care Group Volunteers (and NCGVs) should have responsibility for no more than 15 households (with Neighbour Women [NW] or Neighbour Caregivers [NC]).

• NGVs are volunteers and must be able to sustain the activities required by the program. If you ask too much of them, they will not stay in the program. [In general, we aim for most volunteers to spend no more than 8 hours/week on NCG activities.]

• Many practitioners find it works better with an even lower maximum number of households; 10–12 households seems to be the right size for many CGVs.

• We want CGVs to form strong bonds with the households (of NW) they meet with. For example:
  ➢ Being someone’s close friend requires a certain amount of time and emotional energy. We begin to emotionally overload if we care for more than about 10–15 people because we cannot take the emotional strain and energies needed to do so.
  ➢ In the same manner, we want our CGVs to invest in the people that they meet and have time and energy to get involved in the lives of those they visit.

• Based on previous research, 16 households are too many for CGVs to handle. We suggest 10–15 households per CGV (and NCGV). If you exceed this number, the quality of CGV interactions is greatly reduced. And, the more households you add, the greater the dropout rate and less change is achieved.

• You may ask, how can we reach almost all (80–100%) households if CGVs only can reach 10–15 houses?

Example from Ethiopia

In one of Food for the Hungry (FH)’s programs in Ethiopia, the local partner already had a group of 20 people meeting every week. So, it added more participants and began teaching some of the health practices to a larger group, up to 50 people at a time. As a result, there was very little behaviour change among the members of this group because it was so big that people were not able to interact, ask questions or relate to the facilitator. And, because the participants were not among the facilitator’s 10–15 closest neighbours, they were not able to directly “see the behaviours”, so he did not serve as a role model for them.
• We need to make sure that we have a sufficient number of CGVs so we can have saturation coverage, effectively reaching almost all the households in our intended group.

• Do not overburden CGVs with too many households. Make sure your budget includes the right number of CGVs to cover your entire community. [For the first WV/Ghana NCG project, we budgeted to have each of the 12 NCG Promoters cover 8 NCGs, with each NCG having 12 NCGVs, and each NCGV reaching 12 Neighbour Caregiver households. This is called an “8x12x12 structure”, that allows each NCG to reach more than 1,100 households and 12 Promoters (each covering 8 NGCs) to cover almost 14,000 households altogether. For the current project, we will add 4 trained CHWs who will each cover 2 NCGs, and in this way, we will reach a total of almost 15,000 households.]

5. **When possible, CGVs (or NCGVs) should be chosen by the mothers in their groups.**

• People will choose someone they respect and are willing to listen to. A volunteer chosen by an outsider is less likely to be accepted by the community. [They will also be more likely to choose someone whom they feel comfortable having in their homes and that they like.]

• The community will be somewhat reluctant to listen to an outsider’s ideas. If a volunteer is “one of their own” they are already comfortable and ready to listen to messages.

• Research has found that using a neighbour to discuss sensitive topics is more effective than using an outsider.

• Chosen CGVs probably do not already practice the behaviours we want them to. It is the Promoter’s responsibility to help CGVs change their own behaviour.

• It is very important for the Promoters to really invest in sharing and encouraging CGVs to change and for Promoters and Supervisors to model that change.

• The CG approach relies on peer-to-peer behaviour promotion. The chosen CGVs will be role models (early adopters) of the behaviour.

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**Sympathy Groups**

In his book, *The Tipping Point*, Malcolm Gladwell explains what sympathy groups are and why they are so important:

"Make a list of all the people you know whose death would leave you truly devastated. Chances are you will come up with around 12 names. That, at least, is the average answer most people give to that question. Those names make up what psychologists call our sympathy group. Why aren't groups any larger? Partly it's a question of time. ...To be someone's friend requires a minimum investment of time. More than that, though, it takes emotional energy. Caring about someone deeply is exhausting. At a certain point, at somewhere between 10 to 15 people, we begin to overload."
• If the CGVs have made changes in their own lives that their neighbours witness, they will be much more effective at supporting behaviour change than those who do not “practice what they preach”.

• It is very important that project staff and volunteers try out the behaviours first and believe in their value so they can be good role models for NCs. [But it is not necessary to select volunteers who have already adopted a lot of the behaviours.]

• Once CGVs are convinced that the changed behaviour works, their influence and credibility in the community and their ability to be role models will greatly increase.

• Encourage but do not force project staff and CGVs to try the key practices. Excessive pressure can provoke resistance. Change takes time; it will not happen overnight.

• The more CGVs teach others about changing behaviour the more likely they will change their own behaviour.

Note: Sometimes it is not possible for mothers to select their CGVs. There are successful examples, such as WR’s Vurhonga projects in Mozambique, where mothers did not select their CGVs. If it is not possible to have the groups select their CGVs, perhaps because you are expected to use the MOH’s community volunteers, do not give up—you can still have great results. Project staff should be aware that in this case the community workers or volunteers may have to work harder to gain the trust and respect of the households they serve and should address this concern in CG meetings.

6. All of a CGV’s (or NCGVs) beneficiaries should live within a distance that facilitates frequent home visitation, and all CGVs or (NCGVs) should live less than a 1 hour walk from the Promoter’s meeting place.

• Some restructuring of groups may be needed if volunteers and groups do not fit this requirement.

• This makes sure we respect the time and workload of the volunteer.

7. Each Promoter should be responsible for no more than nine CGs (or NCGs).

• For Promoters to know and have the trust of those they work with, it is best to limit the number of CGVs they work with to about 150, or nine CGs (assuming a CG size of 10–15 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

• Remember that nine CGs per Promoter should be the maximum. The actual number will be context specific, depending on factors that include geography and population density (how much time the promoter needs to travel between CGs), whether the Promoters work full time or part time and other duties the Promoters may have.

• For example, consider a Promoter working full time who has 8 CGs that meet every 2 weeks. That is 8 group meetings × 2 contacts every 2 weeks = 32 sessions per month. Suppose that each CG session takes about a ½ day, including travel time. This equals 16 total work days and leaves only 4 more days per month for report writing, biweekly meetings with Supervisors, supportive
supervision visits with CGVs, and any meetings with local leaders, health centre staff and village health committees—a very full schedule!

- In more densely populated or peri-urban areas, where travel time between groups is minimal, it might be possible for a Promoter to meet with more CGs per day, which also would free up time for additional supportive supervision visits. [Note that the CG approach has been used successfully in rural, urban, and peri-urban areas, and in both fragile and more stable contexts.]

8. **Promoters will supervise at least one CGV (or NCGV) from each CG (or NCG) per month [preferably one CGV (or NCGV) from each CG (or NCG) every 2 weeks].**
   - Volunteers sharing inaccurate information or failing to perform their responsibilities can do more harm than good.
   - Projects are responsible to their donors to make sure we meet our program goals.
   - Promoters will supervise using a quality improvement and verification checklist (QIVC). This encourages the volunteers and makes them feel that their work is valued.

9. **The amount of CGV (or NCGV) contact with their assigned beneficiary mothers and NCG meeting frequency should be at least once per month, preferably twice monthly.**
   - [Note: that while this was the original recommendation, we know of no CG projects that have done less than biweekly contacts, and some projects have used weekly visits.]
   - Regular visits with NW and their families build trust and sympathy (as in the sympathy groups discussed at the end of point 4).
   - Regular meetings build strong relationships between CGVs and their neighbours. The better the relationship between CGVs and NW, the greater the behaviour change, as the CGVs walk them through stages of change.
   - Regular meetings enable good relationships over an extended period of time. The more often CGVs and NW meet, the more they will develop deep relationships and the more the program becomes sustainable, as meeting and discussing health habits become part of the fabric of the community.
   - Frequent contact allows CGVs to follow up on previous lessons and facilitates greater encouragement and monitoring of activities. For example, the CGV could say: “Two weeks ago you committed to washing your hands after using the latrine. How is that going? Have you been able to do this every time you go to the latrine?”
   - Regular meetings help to build community ownership of the groups after the program funding has ended.

10. **CGVs (or NCGVs) use visual teaching tools such as flip charts to promote health and nutrition in each household.**
   - Flip charts guide discussions to make sure all CGVs share the same messages.
   - The pictures serve as reminders, while the words help people who can read to remember the key practices for each picture.
   - The pictures are attractive and make people curious. They not only aid CGVs in teaching, but also encourage beneficiaries to listen, watch and learn.
   - [While use of digital technologies, such as tablets, were not contemplated in early CG projects, this may be an option for future projects if prices continue to drop.]
11. CGVs (or NCGVs) use participatory learning methods in a non-formal educational setting to conduct health promotion at each household.

- The educational setting is non-formal. CGVs are not in a school or university setting, which facilitate formal education.
- What is participatory learning?
  - It is not just giving information and it is more than a two-way dialogue between the facilitator and the participants.
  - It includes seeing, hearing, doing, discussing and critical thinking. It is a more active method of learning.
  - It involves caregiver-to-caregiver support and sharing experiences, learning from one another, mutual encouragement and helping each other find ways to overcome barriers to practicing the new behaviours.
  - NCGVs help household members interact with the learning through discussion, drawing, writing, acting and verbally responding, which are more effective than just telling people what to do.
  - Active, participatory methods help participants connect with the material emotionally and mentally so that they remember much more and are motivated to use what they have learned.

12. CGVs (or NCGVs) will collect information on pregnancies, births and deaths at each household and report it to the Promoters.

- [NOTE: This will be optional for our NCG project model, as there may be different outcomes we wish to track.]
- Collecting this information will help CGVs become more aware of epidemics and health behaviours in their community, as well as how their work affects others.
- This information can be used to help alert local health clinics and communities of areas that need more assistance or interventions.
- Working together, CGs, with Promoter support, identify what the CGVs can do to respond to a situation.
- CGs need to be designed in a way that allows for CGVs to be trained by the Promoter’s example in problem solving and understanding the health statistics they gather in the community. This way, when the program is over, CGVs know exactly how to interpret the information they gather.

Verbal Autopsies to Discover Causes of Death

In some projects that focus on health outcomes, Promoters or other project staff may conduct a verbal autopsy, also called a social autopsy. Verbal autopsies discuss circumstances of a health event, signs of illness, care seeking behaviours and barriers to care seeking that were experienced to learn more about probable causes and circumstances when a child or woman dies. This helps identify steps that can be taken to prevent additional deaths from the same or similar causes.

For example, one project found that maternal deaths increased on the weekend because clinics were closed when MOH health care providers were not working. The project worked with the community to establish a system whereby project health providers were on call during weekends to assist with emergencies. Another project in Haiti found that one-day – rather than 3-day – follow-up was needed.
when children had both diarrhoea and vomiting.

Verbal autopsies should be used with great care and conducted by very well-trained staff so that neither the family members, volunteers, nor staff members feel they have been blamed for the death. When done too soon after a loss or done insensitively, the verbal autopsy experience can be a traumatizing event for the bereaved family. When done sensitively by well-trained and empathetic staff, it can help the bereaved family members feel that their loss has been acknowledged with respect and that sharing their experience may help others in the future. [Some WV Technical Service Organization staff know how to use this methodology and can train project staff.]

- How does this level of data collection contribute to larger health [and development] initiatives?
  - If the community has community development committees (CDCs) or similar organizations, such as village health committees, often one or more NCGV can become a member. NCGVs are often able to provide updates on vital statistics and health and other sector information gathered by their NCGs to these community organizations. This data equips CDCs to make well-informed decisions regarding issues affecting community members’ health and child wellbeing.

  - The Ministry of Health (MOH) can rely on NCGs to help with their community mobilization efforts. For example, MOH staff can call on NCGVs to rally households for immunization campaigns or weighing sessions. After the MOH communicates to health centre staff, they can meet with Promoters and CGVs can spread the news to their assigned households, generating a greater turnout for the event.

- How do NCGVs collect data?
  - During home visits and group meetings, they ask about family members’ health and behaviours.
  - They take note of births, deaths, pregnancies, or other events or “installations” that the project decides to measure (e.g., handwashing stations installed).
  - They ask about circumstances surrounding events, such as symptoms and the family’s response to health events.
  - At one of the two NCG meetings each month, the NCGV verbally reports important events to the entire NCG.
  - NCGVs who cannot read should easily be able to recall vital statistics because these events are generally infrequent among their 10–15 assigned Neighbour Caregivers. This information is verbally reported to the Promoter during the “Attendance, troubleshooting and important events” section of the Nurturing Care Group meeting.

- How do NCG Promoters make use of collected data? NCG Promoters should:
  - Immediately discuss the household vital statistics with NCGVs as they report the information
  - Ask reporting NCGVs to give a possible reason for the event
• Invite the other NCGVs to share their understanding of the event
• Discuss the event with NCGVs, learn from their insight and correct any false information, if necessary
• Help NCGVs link behaviours or environmental factors to effects on child wellbeing
• Identify actions NCGVs can take in the future, based on lessons learned from the discussion

○ This reporting process is discussed in depth in Lesson 16: Nurturing Care Group Monitoring Information System: Introduction to Registers and Lesson 17: Nurturing Care Group Monitoring Information System: Promoter, Supervisor and Coordinator Reports.

Examples of Promoter Problem Solving

Remind the NCGV: “You remember that your neighbour had a lot of bleeding in her last pregnancy. We will need to watch her (for danger signs / to get help) in case that happens with the next baby.”

Ask the NCGVs: “We had two children die and another 22 are sick. Do you know what’s happening here?”

13. Formative research should be used to help intended behaviour change communication activities.

Conducting formative research, specifically a Local Determinants of Malnutrition study or a Barrier Analysis, may help your program to focus on the specific barriers (or enablers) that families face in changing the behaviours of interest. More systematic use of formative research on behaviours will lead to the best adoption rates. Formative research also helps assure that the behaviours promoted by project staff are feasible for community members.

14. The workload of a NCGV is limited to no more than 15 households per volunteer.

• The criteria documents require a maximum of 15 households per NCGV, though 10–12 households works better, in the experience of many practitioners.
• Care should be taken not to overload a NCGV. She has other work to do, and if her NCG responsibilities are overwhelming she may have to resign.

4. Alternative Activity: Handout Review

Have participants review Appendix 4: Care Group Approach: Definition and Criteria. Lead a discussion of the elements of the Care Group Approach Minimum Criteria Reviewer Checklist, and go through each item and ask, “Why is this important?”

5. Wrap Up

• Tell participants that it is important to review all of these criteria developed by FH and WR staff in 2009 (and updated in 2010) to give practitioners a clear definition of what a program based on the CG approach is and what it is not.
• Tell participants that programs that do not meet the definition of a CG program are encouraged to either adjust their plan so that they can meet the criteria or to refer to their program by another name, such as a Cascade Group.
The project model that combines the Nurturing Care Framework with the Care Group model meets the definition of Care Groups. Therefore, this new WVI project model is a type of Care Group – specifically, a “Nurturing Care Group”.
### Lesson 4 Handout 1: Care Group Approach Program Criteria Worksheet

<table>
<thead>
<tr>
<th>Criteria for Care Groups</th>
<th>Rationale</th>
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</thead>
<tbody>
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<td>3. The CG size is limited to 16 members and attendance is monitored.</td>
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<td>4. CGV contact with her assigned beneficiary mothers—and CG meeting frequency—is monitored and should be at a minimum once a month, preferably twice monthly.</td>
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<td>5. The plan is to reach 100% of 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.</td>
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<td>6. CGVs collect important events data on pregnancies, births and death.</td>
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<td>7. The majority of what is promoted through the CGs creates behaviour change directed towards reduction of mortality and malnutrition (e.g., Essential Nutrition Actions [ENA], Essential Hygiene Actions [EHA]) [but can also include elements of Education, Child Protection, and Livelihoods].</td>
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<td>13. The implementing agency needs to successfully create a project/program culture that conveys respect for the population and volunteers, especially women.</td>
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Lesson 4 Handout 2: Establishing Care Group Criteria

Rationale for this Document

World Relief (WR) staff developed the Care Group (CG) 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 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 neighbours, sharing what she has learned and facilitating behaviour change at the household level. CGs create a multiplying effect to equitably reach every beneficiary household with interpersonal behaviour 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 24 other private voluntary organizations (PVOs) in more than 21 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 CG 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 CGs 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 (CSHGP) 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 WR and FH staff members on April 23, 2009, the CG 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 CGs 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 CG model. The CORE Group Social & Behavioural Change Working Group (SBCWG) has helped with the

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21 The Care Group criteria and this handout were created by Alyssa Davis, MPH, and Muriel Elmer, PhD, formerly of WR; Pieter Ernst, MD, Rachel Hower, MPH, and Melanie Morrow, MPH, of WR; and Tom Davis, MPH, Carolyn Wetzel, MPH, and Sarah Borger, MPH, of FH. This document was last revised on November 12, 2010.
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.

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<td>CGs 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 neighbours. There is evidence that “block leaders” (like CGVs) can be more effective in promoting adoption of behaviours among their neighbours than others who do not know them as well. CGVs should be mothers of young children or other respected women from the community. CGVs who are chosen by their neighbours (or by a consensus of the full complement of [formal and informal] community leaders) will be the most dedicated to their jobs, 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.</td>
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<tr>
<td>2. The workload of CGVs is limited: No more than 15 households per CGV.</td>
<td>Having one volunteer trained to serve 30+ households is more in line with the traditional community health worker (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 CGV 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.</td>
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<td>3. The CG size is limited to 16 members and attendance is monitored.</td>
<td>To allow for participatory learning, the number of CGVs in the CG should be between six 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 (less than 70%) at CG 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.</td>
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23 Operations Research on NCGs in Sofala, Mozambique, showed that NCGVs chosen by the mothers that they serve were 2.7 times more likely to serve for the life of the project (p=0.009).

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<th>4. CGV contact with her assigned beneficiary mothers—and CG meeting frequency—is monitored and should be at a minimum once a month, preferably twice monthly.</th>
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<td>In order to establish trust and regular rapport with the mothers with which the CGV works, we feel it is necessary to have at least monthly contact with them. CGs should meet at least once monthly, as well. We also believe that overall contact time between the CGV and the mother (and other family members) correlates with behaviour change. We recommend twice a month contact between CGVs 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).</td>
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<th>5. The plan is to reach 100% of 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.</th>
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<td>In order to create a supportive social environment for behaviour change, it is important that many mothers adopt the new practices being promoted. Behaviour change is much more likely to happen when there is regular, direct contact with all 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 household visit. Household 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.</td>
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<th>6. CGVs collect vital events data on pregnancies, births and death.</th>
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<td>Regular collection of vital events data helps CGVs 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 CG 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.</td>
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<th>7. The majority of what is promoted through the CGs creates behaviour change directed towards reduction of mortality and malnutrition (e.g., Essential Nutrition Actions [ENA], Essential Hygiene Actions [EHA]).</th>
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<td>This requirement was included mainly for advocacy purposes. We want to establish that the CG 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 Millennium Development Goals. While the cascading or multiplier approach used in CGs 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”).</td>
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</table>
8. The CGVs use some sort of visual teaching tool (e.g., flip charts) to do health promotion at the household level.

We believe the provision of visual teaching tools to CGVs 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 behaviour change communication (BCC) are used in the CG with the CGVs and by the volunteers when doing health promotion at the household or small-group level.

Principles of adult education should be applied in CGs and by CGVs since they have been proven to be more effective than lecture and more formal methods when teaching adults.

10. The CG instructional time (when a Promoter teaches CGVs) is no more than 2 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.)

11. Supervision of Promoters and at least one of the CGVs (e.g., data collection, observation of skills) occurs at least monthly.

For Promoters (who teach CGVs) and CGVs to be effective we believe that regular, supportive supervision and feedback is necessary on a regular basis (monthly or more). For supervision of CGVs, the usual pattern is for the Promoter to supervise through direct observation at least one volunteer following the CG meeting.

12. All of a CGV's beneficiaries should live within a distance that facilitates frequent home visitation and all CGVs should live less than a 1-hour walk from the Promoter meeting place.

It is preferable that the CGV 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 CGV:Mother Beneficiaries 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 CG 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, CGVs (“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 CGVs are sensing this respect.

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<tr>
<td><strong>1. Formative research should be conducted, especially on key behaviours promoted.</strong> A review of the most effective projects in terms of behaviour change for both exclusive breastfeeding and hand washing with soap (by the SBCWG) found that they included formative research (e.g., Barrier Analysis, Doer/Non-Doer Analysis) on the behaviours. We believe that more systematic use of formative research on behaviours will lead to the best adoption rates. Formative research also helps assure that the behaviours promoted by project staff are more feasible by community members.</td>
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<td><strong>2. The Promoter:CG ratio should be no more than 1:9.</strong> 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 six 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).</td>
</tr>
<tr>
<td><strong>3. Measurement of many of the results-level indicators should be conducted annually at a minimum.</strong> 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.</td>
</tr>
<tr>
<td><strong>4. Social/educational differences between the Promoter and CGV should not be too extreme (e.g., it is not a good match to have bachelor-degree level staff working with CGVs).</strong> We believe that the less educational difference there is between the Promoter and CGVs, the more likely that the Promoters will use language/concepts that the CGVs can understand. It also helps keep the costs of the model low.</td>
</tr>
</tbody>
</table>
Lesson 5: Using Formative Research to Strengthen Nurturing Care Groups

[NOTE: This lesson is not recommended for use in the initial WV/Ghana NCG training. Key staff have already received this training.]

Achievement-Based Objectives
By the end of this lesson participants will have:

- Defined “formative research”
- Heard/read a description of Barrier Analysis (BA), including a list of the 12 determinants of behaviour change
- Identified ways that formative research could be used in a Nurturing Care Group (NCG) approach to improve behaviour change

Duration
1 hour 30 minutes

Materials Needed
- Lesson 5 Handout 1: Barrier Analysis Description
- Lesson 5 Handout 2: The Twelve Determinants of Behaviour Change
- 12 index cards with behaviour statements and determinants
- Lesson 5 Handout 3: Example Behaviour Statements and Determinants

Steps

1. Introduction

- Tell participants that the main objective of this lesson is to help them understand how to use the results of formative research to improve the chances that neighbours will adopt new behaviours.
- **Ask participants**: How many of you have already had experience using formative research either on a project using the Care Group approach or one that doesn’t use the Care Group approach?
- **Ask some participants** what type of formative research they used.

2. What is formative research?

- **Ask participants** what they know about formative research. Add the following points if participants do not mention them.
  - Formative research focuses more on quality than quantity.
  - Formative research is more likely to answer the questions of why, who and how.
  - Formative research can use many different research methods.
  - Formative research is often not expressed in percentages.

3. Formative Research using a Barrier Analysis
• Explain that this lesson and the NCG approach primarily will use a research method called Barrier Analysis, or BA. Ask how many participants are familiar with this method.

• Tell participants: To “even the playing field” for people who are not familiar with Barrier Analysis, we will provide a short description of the approach.

• Distribute Lesson 5 Handout 1: Barrier Analysis Description. Ask participants that are already familiar with BA to underline anything that is new to them. Answer any questions.

• Distribute Lesson 5 Handout 2: The Twelve Determinants of Behaviour Change. Explain that the BA survey identifies which of the 12 determinants is more critical to changing the behaviour. Since many of the determinants are barriers, they are considered obstacles to behaviour change.

• Allow time for the participants to read the description of determinants, then ask volunteers to give one example for each determinant. For example, an example for Cue for Action could be: Mothers can’t remember all the times that they should wash their hands.

• Remind participants that when they do a BA, some of the 12 determinants will be revealed as significant. This means that programmers should address those determinants (obstacles) in some way in their projects so that the priority group is more likely to adopt the new behaviour.

4. Using Barrier Analysis Results in the Nurturing Care Group Model

• Ask one or two participants that have experience using BA (or any other formative research results) to describe what the research results revealed and how those results were used in their NCG model (or other program) to help remover a barrier to behaviour change.

• Share with the group the following example: In the research conducted by Concern in Uganda, mothers said they thought that community leaders did not approve of hand washing. To address this, they incorporated a picture of community leaders washing their hands into the Care Group flip chart.

• Remind the group that the results of formative research do not just inform which pictures are used, but also can inform the story that is told during the NCG meeting. Results also can inform other aspects of the project’s strategy (such as placing hand washing reminder pictures on the inside of the door of a latrine or in the kitchen).

5. Activity: Practice Using Formative Research

• Divide participants into pairs. Give each pair an index card with a behaviour statement on it along with a determinant (or explanation of a formative research result). Examples of behaviour statements and related determinants can be found in Lesson 5 Handout 3: Example Behaviour Statements and Determinants.

• Each pair of participants should discuss the meaning of the research and propose how they would address the findings listed on the card.

• Pairs will then share their ideas with other pairs at their table. Ask a few pairs to share their suggestions with the entire group.
6. Wrap Up

- Remind the participants that to be useful the results of the formative research have to be acted upon. Sometimes results may influence the flip chart pictures used, sometimes the text used in the NCG meeting, and sometimes other aspects of the project.
Lesson 5 Handout 1: Barrier Analysis Description

Purpose
Barrier Analysis (BA) is a rapid assessment tool that can help organizations identify why a promoted behaviour has low coverage or has not been adopted at all. It is usually used at the beginning of a program to determine key messages, strategies and activities for boosting behaviour change in food security, child survival and other community development programs. It can also be used in an ongoing program to determine how to improve the promotion of specific behaviours that continue to show low adoption rates.

Details of Use
Overview. BA explores 12 behavioural determinants: perceived self-efficacy/skills, perceived social norms, perceived positive consequences, perceived negative consequences, access, perceived barriers/enablers, cues for action/reminders, perceived susceptibility, perceived severity, perceived divine will, culture and policy. Ninety respondents are selected (45 “Doers” and 45 “Non-Doers” of the behaviour) and asked a series of questions to identify which determinants are impeding or enabling them to do the behaviour. This comparison of people who do and do not do a behaviour is very helpful in identifying which of the determinants are the most important ones to focus on during the behaviour change plan. The tabulation table allows the user to make statements such as “Doers of the behaviour are 5.2 times more likely to say that their husband approves of the practice than Non-Doers.” Project staff members then use these results to develop key activities and messages to make changes related to each determinant found to be important (e.g., to convince wives that husbands approve of the practice).

There are seven steps in developing a BA:

1. Define the goal, behaviour and intended group
2. Develop the behaviour question
3. Develop questions about determinants and pre-test questionnaire
4. Organize the data collection
5. Collect field data for BA
6. Organize and analyse the results
7. Use the BA results

Usual Audiences. The audience can include mothers of young children, farmers, youth, school children and others. The BA also can be used among service providers, such as nurses, midwives and extension agents.

Level of skill needed. The tool is meant for use by project management staff and community-level implementers. Past experience with social and behaviour change programs is helpful, as well as skill in conducting interviews, developing questionnaires and using MS Excel. Analysis is done manually with

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25 This handout is based on the TOPS handout “Barrier Analysis: A Food Security and Nutrition Network SBC Task Force Endorsed Method/Tool.”

markers, paper and a computer loaded with an MS Excel BA Tabulation Table (which can be downloaded\(^27\)).

**Time/staff required.** BA can be done quite rapidly by trained personnel. Training in BA is usually done as part of the 6.5 day *Designing for Behaviour Change* training. If you have a team of 10 people available to carry out BA, the data collection for each behaviour you study can usually be done in about 9–10 communities in 1–2 days (total). Tabulation of the data usually can be done in a single day. A larger team of people can generally analyse more behaviours in the same amount of time.

**Common constraints/difficulties.** The BA cannot be used on behaviours that are brand new, where no “doers” can be found. The facilitator in the process should be skilled in helping people to think of activities that focus on each determinant identified to be important. (Otherwise project staff often may default to repeating the same message as before.)

**Evidence for Efficacy of the Method/Tool**

- Barrier Analysis was designed by Food for the Hungry (FH) staff in 1990 using the scientific literature on behaviour change. The main theories that support the method are the Health Belief Model and the Theory of Reasoned Action. Knowledge is not enough to change behaviour. There are many different determinants of behaviours that should be explored when putting together a behaviour change plan.

- “Powerful to Change Analysis”\(^28\) was conducted by the CORE Group Social & Behaviour Change Working Group (SBCWG) in order to compare those projects that successfully boosted behaviour change for different practices (e.g., exclusive breastfeeding [EBF], hand washing with soap) in comparison with those that did not. Those projects that showed the highest levels of behaviour change used formative research tools like BA and Doer/Non-Doer Analysis.

- BA has generally been used to improve health, nutrition and hygiene practices at the household and community levels, working with health personnel, community health workers, mothers and caregivers. However, the methodology has recently been updated based on determinants of agricultural and natural resource management practices, and the latest *Designing for Behaviour Change* manual (available on the Food Security and Nutrition Network website) includes these modifications. BA should be useful to better understand all types of behaviour at the community level, including behaviours related to value chains. It has been applied in both developing and industrialized countries.

- BA is practical because it can be applied in a short time frame, does not require a lot of time or money and produces enough information to design behaviour change communication (BCC) messages, strategies and activities for food security, child survival and other types of programs. BA is most useful at the beginning of a project to focus on key practices most linked with impact and later in a project to focus on other practices where widespread adoption has not occurred.

\(^{27}\) The MS Excel file can be downloaded [www.caregroupinfo.org/docs/BA_Tab_Table_Eng_9_30_10.xls](http://www.caregroupinfo.org/docs/BA_Tab_Table_Eng_9_30_10.xls). An instruction sheet for use of the BA Tabulation Table is available at [www.caregroupinfo.org/docs/BA_Analysis_Excel_Sheet_Tab_Sheet_Explanation_Sept_2010.doc](http://www.caregroupinfo.org/docs/BA_Analysis_Excel_Sheet_Tab_Sheet_Explanation_Sept_2010.doc).

Resources


- Barrier Analysis Narrated Presentation: http://caregroupinfo.org/vids/bavid/player.html
Lesson 5 Handout 2: The Twelve Determinants of Behaviour Change

The first four determinants listed below should always be explored in formative research on determinants. These four are more commonly found to be significant, especially for health and nutrition behaviours.

1. **Perceived positive consequences**: what positive things a person thinks will happen, as a result of doing a behaviour. Responses to questions related to positive consequences may reveal advantages (benefits) of the behaviour, attitudes about the behaviour and perceived positive attributes of the behaviour.

2. **Perceived negative consequences**: what negative things a person thinks will happen as a result of doing the behaviour. Responses to questions related to negative consequences may reveal disadvantages of the behaviour, attitudes about the behaviour and perceived negative attributes of the behaviour.

3. **Perceived social norms**: the individual’s perceptions that people important to him/her think that he/she should do the behaviour. Social norms have two parts: who matters most to the person on a particular issue and what he/she perceives those people think he/she should do.

4. **Perceived self-efficacy/skills**: an individual's belief that he/she can do a particular behaviour, given his/her current knowledge and skills, or the set of knowledge, skills or abilities necessary to perform a particular behaviour.

5. **Access**: the degree of availability (to a particular audience) of the needed products (e.g., fertilizer, insecticide-treated bed nets [ITNs], condoms) or services (e.g., veterinary services, immunization posts) required to adopt a given behaviour. This also includes an audience's comfort in accessing desired types of products or using a service.

6. **Cues for action/reminders**: an individual’s perception that he/she is able to remember when to do the behaviour and an individual’s perception that he/she can remember how to do the behaviour. This also includes key powerful events that triggered a behaviour change in a person (e.g., “my brother-in-law got AIDS”, “the drought happened”). An example of reminders is posters on the doors of latrines reminding users to wash their hands afterward.

7. **Perceived susceptibility/risk**: a person's perception of how vulnerable he/she feels to the problem. For example, does he/she feel that it is possible that his/her crops could have cassava wilt, or how likely is it that he/she will get HIV.

8. **Perceived severity**: the belief that the problem (which the behaviour can prevent) is serious. For example, a farmer may be more likely to apply fertilizer to his fields if he perceives that “weak soil” will result in a poor harvest, and a mother may be more likely to take her child for immunizations if she believes that measles is a serious disease.

9. **Perceived action efficacy**: the belief that by practicing the behaviour one will avoid the problem or that the behaviour is effective in avoiding the problem. For example: If I sleep under a mosquito net, I won’t get malaria.
10. **Perceived divine will**: a person’s belief that it is God’s will (or the gods’ will) for him/her to have the problem and/or to overcome it. Numerous unpublished BA studies have found this determinant to be important for many behaviours (particularly for health and nutrition behaviours).

11. **Policy**: laws and regulations that affect behaviours and access to products and services. For example, the presence of good land title laws (and clear title) may make it more likely for a person to take steps to improve their farm land, or a policy of automatic HIV testing during antenatal visits may make it more likely for women to have HIV testing.

12. **Culture**: the set of history, customs, lifestyles, values and practices within a self-defined group. Culture may also be associated with ethnicity or lifestyle, such as “gay” or “youth” culture.
## Lesson 5 Handout 3: Example Behaviour Statements and Determinants

<table>
<thead>
<tr>
<th>Behaviour Statement</th>
<th>Determinant</th>
<th>Respondents said:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nutrition</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mothers of children 6–12 months of age feed them meals each day that are the consistency of thick porridge.</td>
<td>Perceived self-efficacy/skills</td>
<td>The mother cannot make the porridge thick enough.</td>
</tr>
<tr>
<td>Mothers of children 9–23 months of age feed them meals containing foods from at least 4 of the 7 food groups each day.</td>
<td>Perceived self-efficacy/skills</td>
<td>The mother cannot remember the different food groups.</td>
</tr>
<tr>
<td></td>
<td>Cues for action/reminders</td>
<td></td>
</tr>
<tr>
<td>Mothers of children 9–23 months of age feed them at least three cooked meals that contain a staple food per day.</td>
<td>Access</td>
<td>There is not enough time.</td>
</tr>
<tr>
<td>Mothers of children under 24 months of age continue to breastfeed their children.</td>
<td>Culture</td>
<td>We do not do that here.</td>
</tr>
<tr>
<td>Mothers of children under 6 months of age feed them only breast milk.</td>
<td>Perceived negative consequences</td>
<td>People will think I’m a bad mother.</td>
</tr>
<tr>
<td>Mothers breastfeed their newborns within 1 hour of birth.</td>
<td>Perceived divine will</td>
<td>Religious practice calls for Koranic verse plus honey to be the first thing a newborn consumes which can take long time.</td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mothers with children under 5 years of age who do not want to become pregnant use a modern contraceptive method.</td>
<td>Perceived social norm</td>
<td>The husband wants many children.</td>
</tr>
<tr>
<td>Pregnant women give birth at a health facility.</td>
<td>Perceived action efficacy</td>
<td>The mother and infant would be better off at home.</td>
</tr>
<tr>
<td>Mothers of sick children under 24 months of age seek medical attention at a health facility within 24 hours of noticing symptoms of fever, diarrhoea or difficulties breathing.</td>
<td>Access</td>
<td>There is no money for transport.</td>
</tr>
<tr>
<td>Mothers of children under 5 years of age ensure that their children sleep under an insecticide-treated bed net (ITN) each night.</td>
<td>Perceived negative consequences</td>
<td>Children might suffocate or feel too hot sleeping under an ITN.</td>
</tr>
<tr>
<td>Mothers of children under 5 years of age that have diarrhoea give them oral rehydration solution (ORS).</td>
<td>Perceived severity</td>
<td>Diarrhoea is not a serious disease.</td>
</tr>
<tr>
<td><strong>Water, Sanitation and Hygiene (WASH)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mothers of children under 5 years of age wash their hands with soap at the five critical times each day.</td>
<td>Cues of action</td>
<td>The mother can't remember to wash before cooking.</td>
</tr>
<tr>
<td>Behaviour Statement</td>
<td>Determinant</td>
<td>Respondents said:</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Heads of households ensure that household-generated garbage is disposed of in a designated place at least once per week.</td>
<td>Perceived susceptibility/risk</td>
<td>The father does not think he is at risk of vector-borne diseases.</td>
</tr>
<tr>
<td>Mothers/caregivers of children under 5 years of age treat/chlorinate the drinking water consumed by the family in the home all the times.</td>
<td>Perceived negative consequences</td>
<td>It costs too much to treat/chlorinate water at all times.</td>
</tr>
<tr>
<td>Mothers of children under 5 years of age store household drinking water in a closed/tightly covered container.</td>
<td>Perceived action efficacy</td>
<td>Mothers think that a cloth over the container is enough.</td>
</tr>
<tr>
<td>Mothers of children under 5 years of age defecate in a latrine at all times.</td>
<td>Perceived negative consequences</td>
<td>Mothers fear that the smell of feces is what transmits diarrhoea.</td>
</tr>
<tr>
<td>Intended wives/partners who are members of savings and loan groups decide together with their spouses/partners how to spend the money they borrowed from the savings and loan group.</td>
<td>Culture</td>
<td>I wouldn’t know how to initiate this discussion. We don’t do that here.</td>
</tr>
<tr>
<td>Intended wives/partners who are members of savings and loan groups decide together with their spouses/partners how to spend the money they borrowed from the savings and loan group.</td>
<td>Perceived self-efficacy/skills</td>
<td>I wouldn’t know how to initiate this discussion. We don’t do that here.</td>
</tr>
<tr>
<td>Parents of daughters 5–14 years of age ensure that their daughters attend elementary school.</td>
<td>Perceived negative consequences</td>
<td>I need my daughters at home to help me.</td>
</tr>
<tr>
<td>Intended youth (male and female) 18–30 years of age use a condom every time they have sex with a non-regular partner.</td>
<td>Cues for action</td>
<td>I get too caught up in the moment to remember.</td>
</tr>
<tr>
<td>Intended youth (male and female) 18–30 years of age use a condom every time they have sex with a non-regular partner.</td>
<td>Perceived negative consequences</td>
<td>My boyfriend won’t like it or me.</td>
</tr>
</tbody>
</table>
Lesson 6: Organizing Households in a Community into Nurturing Care Groups and the Numbering System

Achievement-Based Objectives

By the end of this lesson participants will have:

- Identified three different ways to identify the intended participants for Nurturing Care Groups (NCGs) and Neighbour Groups (NGs)
- Practiced organizing the beneficiary population into NGs and NCGs through a census, community list or community gathering
- Identified which people and groups are linked to which number
- Practiced identifying NCG actors and groups by the number system

Duration

2 hours

Materials Needed

- Lesson 6 Handout 1: Forming Nurturing Care Groups
- Lesson 6 Handout 2: Community Map
- Lesson 6 Flip Chart 1: Nurturing Care Group Numbering System
- Lesson 6 Flip Chart 2: Numbering System Practice Codes
- Answer Key to Lesson 6 Flip Chart 2: Numbering System Practice Codes
- Lesson 6 Handout 3: Numbers for the Numbering Game (write each number on an index card and colour code the index cards to help visually depict the groups)
- Lesson 6 Handout 4: Making Sense of the Numbering System

Steps

1. Introduction

- Explain to participants: After we have explained the Nurturing Care Group approach to our collaborating partners and to the leaders of the community, we need to work with the community to identify the members of the Neighbour Groups and to establish the Nurturing Care Groups.

2. Priorities When Organizing Nurturing Care Groups and Neighbour Groups

- Tell participants that they will now learn how to form NCGs. One of the most important things to keep in mind when forming NCGs is to make sure that the Care Group Volunteers (NCGVs) and Neighbour Caregivers (NC) live close together.

- Ask participants: Why is this important? Why do we need Nurturing Care Group Volunteers and

Adapting CGs in Emergency Situations

The project run in Samburu, Kenya, by International Medical Corps faced a lot of difficulties during the 2011 famine because the coverage of the program was not optimal. A lot of mothers moved with their livestock to areas where groups were not present, so there were higher numbers of defaulters from the group. This could have been prevented by ensuring that there was CG program coverage in areas where the mothers had moved to.
Neighbour Caregivers to live close to each other? Tell participants that it is preferable that the NCGVs do not have to walk too far, usually not more than 45 minutes to get to the farthest house that she visits so that regular home visitation is not hindered. In many NCG projects, the average travel time is much less than this. This also makes it more likely that NCGVs will have prior relationships with the people they serve, which will help to foster behaviour change. It is also important that caregivers not have to walk over 1 hour to get to the NCG meeting. Whatever way that projects decide to form NCGs, they should place a high priority on ensuring that they assemble caregivers by geographic proximity.

- **Ask participants:** If after attempting to form Nurturing Care Groups you find that caregivers are walking more than 1 hour to attend Nurturing Care Group meetings, what should you do? Tell participants that if caregivers are walking more than 1 hour to attend NCG meetings, the problem should be raised with project management. Management should then review the coverage strategy and adjust it to allow for smaller NCGs, composed of NCGVs who live closer together.

- Tell participants that another important factor in forming NCGs is to make sure that all (or nearly all) of the intended beneficiaries, such as caregivers, WRA, or PLW are in NCGs.

- **Ask participants:** Why is this important? Why do we need to ensure that nearly all of our intended beneficiaries are a part of a Nurturing Care Group? Tell participants that in order to create a supportive social environment for behaviour change, it is important that many mothers adopt the new practices being promoted. Behaviour change is much more likely to happen when there is regular, direct contact with all 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, though this approach will probably be more expensive.

3. **Forming Nurturing Care Groups**

- Tell participants: When attempting to reach all caregiver households in a project area, the most efficient method of forming NCGs is to use a community map and census. This method ensures that all households are included and makes grouping households by proximity easier.

- Explain the following steps, having participants follow along in Lesson 6 Handout 1: Forming Nurturing Care Groups.

  1. The first step is to select your census takers and provide them with the materials they need to take a census and create maps.

   - Make a map of the entire community, with the neighbourhoods subdivided into sections of approximately 50 to 100 houses. There are two methods for creating a community map:
     - Walking through the community and visiting houses.
     - Meeting with a group of people who know the neighbourhoods well and can create a map of their neighbourhoods.
2. After the map is created, we then need to add details and identify houses, neighbourhood boundaries, community boundaries, roads, landmarks of interest (such as rivers) and buildings of interest (such as schools, churches and clinics).

3. *If you are targeting a subset of caregivers instead of every household, you will then need to identify the households that include members of your target group. In general, it is recommended to target every household since almost all households will have a caregiver of at least one child 18 years or younger or a woman of reproductive age.*

4. Give each house (or each identified house) a number.

5. Write the primary caregiver’s name and household information on a community census list, making sure that the number of the house on the map is the same as the number on the census list. For example, in the table below, Leena Samuel’s house is marked 1 on the map and 1 on the community census list.

<table>
<thead>
<tr>
<th>Number</th>
<th>Caregiver’s Name</th>
<th>Community Area</th>
<th>Temporary Group #</th>
<th>Elected NCGV</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Leena Samuel</td>
<td>Kivo</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Niragira Regine</td>
<td>Kivo</td>
<td>1</td>
<td>✓A</td>
</tr>
<tr>
<td>3</td>
<td>Sarah Borger</td>
<td>Kivo</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Nzoyisenga Claudine</td>
<td>Kivo</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Judy Davis</td>
<td>Kivo</td>
<td>2</td>
<td>✓B</td>
</tr>
</tbody>
</table>

6. When the caregivers you want to form into a Neighbour Group (NG) have been identified based on their geographic proximity, gather them together. Review the profile and job description of a Nurturing Care Group Volunteer (NCGV) with the caregiver and ask them to elect a NCGV from among them.

7. Mark the caregiver elected as the NCGV by placing a check mark in the column titled “Elected NCGV” and assign him/her a letter. You will learn how to assign codes and therefore track all volunteers and health workers later in the lesson.

4. **Alternative Methods of Forming Nurturing Care Groups**

- Tell participants: There are two other methods for forming Nurturing Care Groups, more information on these can be found in Lesson 6 Handout 1: Forming Nurturing Care Groups
  - Community list: If there are active programs in your geographic areas that work with all households already, they might have a recent census or list you could use. In some communities, community leaders are well organized and already maintain a list of residents or they can recall by memory where all the households are.
  - Community gathering: If community participation and communication is high, community leaders could call everyone in the community together to a central meeting place on a particular day for a community gathering.
5. **Important Things to Consider When Forming NCGs**

- **Remind participants:** When forming neighbour groups, remember that one person from each will be elected to be the NCGV. For example, if you want to have 10 NC assigned to each NCGV, then at the beginning you need to form NGs of 11 caregivers.

- **Explain to participants:** Also, when deciding the number of Neighbour Caregivers assigned to each NCGV, consider the length of the project and how quickly the population in the project area is growing. If the project aims to have no more than 12 caregivers assigned to each NCGV, consider forming initial Neighbour Groups (NGs) of 10–11 Neighbour Caregivers. This will make it easier to include new households without over-burdening the NCGV.

- **Ask participants:** What if a locality doesn’t have enough (neighbour) caregivers that are eligible to participate in the NCG program to form a group with 6–16 caregivers? Tell participants: If there are not enough caregivers to form a Neighbour Group and elect a NCGV, the NCG Promoter should report this problem to his or her supervisor. Potentially another NCG Promoter covering a nearby set of NCGs has too many eligible caregivers in his or her area, requiring that s/he form groups larger than the intended number. In this case some Neighbour Caregivers could be shifted around to make groups closer to the ideal group size.

- **Ask participants:** What if after organizing all NCGVs into NCGs (for example, in groups of 12) there are 5 NCGVs left? Should these volunteers make their own smaller, five-person NCG? Or should they be added to another NCG, making that group much larger than the rest? Tell participants: Five caregivers are too few to make up one NCG, but 17 are too many. If there are nearby NCGs, it would be best to assign the NCGV to two different NCGs to gain a closer-to-ideal group size.

- **Tell participants:** No matter which method is used, it is very important to double check the information and make sure no household is left out. This is especially true for households with lower economic status, those with disabled members, those with a minority religion, those on the outskirts of town, and/or those of a perceived lower caste, class or tribe.

6. **Activity: Practicing Forming Neighbour Groups and Care Groups**
Randomization using NCGSAs
In mental health studies in Uganda, FH and WV selected their intervention and control participants based on NCGSAs. This allowed them to alter the lessons given to the intervention participants, while limiting the “spill-over” since an entire NCG was either in the intervention group or the control group.

7. Monitoring Care Group Volunteers, Neighbour Caregivers, Care Groups and Promoters

- Refer the participants to Lesson 6 Handout 3: Community Map. Explain to participants that this is a village, with households, a church, health centre and roads (represented by lines).

- Working in pairs, have participants form the households into NGs of 9-14 caregivers. This number is purposefully low to leave space in each group for more caregivers to join, if necessary. Participants should then put a star next to one caregiver to represent that she has been selected to be the NCGV.

- When all the pairs are finished, go around the room and ask how many NGs were formed and how many NCGs.

- Explain to participants: when referring to all the households reached by NCGVs in a particular Nurturing Care Group, it is called a Nurturing Care Group Service Area (NCGSA).

- Tell participants: Now that we have formed all households into Neighbour Groups and NCGs we need to create a way to monitor the program activities.

- Tell participants that a special numbering system is used to track the monitoring register and reports that different people submit to the project. This way, Supervisors and Coordinators can accurately track who is doing what and how well each group and each person is performing.

- Show participants Lesson 6 Flipchart 1: Nurturing Care Group Numbering System. Explain how the numbers and letters relate and how they allow programs to identify each member of the NCG team. Present the following points and remind participants about which numbers and letters refer to what/whom.

- The numbering system has 1 to 4 digits. Each digit stands for an individual or group. These digits allow you to track each Promoter, NCGV and Neighbour Caregiver reached by your program.

  **Note to the presenter:** It is helpful to refer back to the NCG diagram and point to the specific group you are talking about. If you have a good diagram on flip chart paper, use a different coloured marker to write the number or letter next to the appropriate group.

  - The first digit is a number and stands for the Promoter.
    - Each Promoter is assigned his/her own specific number.
    - For example, if a project employed 37 Promoters, the first digit would range from 1 to 37.
  - The second digit is a number and stands for the Nurturing Care Group.
    - Each Promoter will number the NCGs he/she is responsible for.
    - In most programs, Promoters are responsible for five to nine NCGs, but no more than nine. Therefore, the second digit should range from 1 to 9, depending on the project design.
    - For example, if Promoter 2 has eight NCGs, his/her NCGs would be numbered 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7 and 2.8.
- The **third digit is a letter** and stands for the Nurturing Care Group Volunteer.
  - Each NCGV will receive a separate letter.
  - In most programs, NCGs are composed of 10–15 NCGVs. Therefore, the third digit should range from A through O, depending on the project design.
  - For example, in NCG 4, supported by Promoter 3, there are 12 NCGVs. They would be numbered 3.4.A, 3.4.B, 3.4.C, 3.4.D, 3.4.E, 3.4.F, 3.4.G, 3.4.H, 3.4.I and 3.4.J.

- The final, **fourth digit is a number** and stands for the Neighbour Household.
  - Each NC who meets with a NCGV is assigned a number by the NCGV.
  - In most programs, the NG is comprised of 10 to 15 NC. Therefore, the fourth digit will range from 1 through 15, depending on the program design.
  - For example, NCGV F in NCG 6, supported by Promoter 1, meets with eight NC. They would be numbered 1.6.F.1, 1.6.F.2, 1.6.F.3, 1.6.F.4, 1.6.F.5, 1.6.F.6, 1.6.F.7 and 1.6.F.8.

### Modifying the Numbering System
Ladd from ACDI/VOCA suggests adding a letter at the beginning of the CG numbering system to represent the region, province, chiefdom or other name for the project area. This would allow the project to look at project areas and groups within them and compare those groups against other areas to see if there are differences. Doing so would enable the project to work to improve those areas that are not doing as well.

8. **Activity: Fun with Numbers**

- Using **Lesson 6 Handout 4: Numbers for the Numbering Game**, make index cards by writing one number per index card and colour-coding each position. Distribute two or three cards to each participant. When distributing the index cards, take care to give each participant a card for a separate group.

- Start by asking Promoter 3 (i.e., whoever received the Promoter paper) to come to the front of the room.

- The Promoter will then call a meeting with all of his/her NCGVs (i.e., everyone who has a NCGV number associated with Promoter 3 should come to the front of the room).

- NCGV 3.3.C will then call a meeting of NC (i.e., everyone who has a NC number associated with that NCGV should come to the front of the room).

- Then, NCGV 3.3.F will call her meeting of NC in the same way.  
  **Note:** This activity will allow participants to visually see how the coding logically follows and tracks the NCGs.

9. **Activity: Numbering- Check for Understanding**

- Display **Lesson 6 Flip Chart 2: Number System Practice Codes** and ask participants to work in pairs to state what each code indicates.

- Once finished, ask pairs to share their answers with the larger group. Check answers against the **Answer Key to Lesson 6 Flip Chart 2: Number System Practice Codes**
• Depending on the level of understanding of the participants, continue this exercise by writing other feasible codes on a flip chart and request that participants (either individually or in tables/pairs) try to interpret the codes.

10. Wrap Up

• Wrap up this lesson by reviewing information with participants in a question and answer format.
  o **Ask participants**: What are two things that need to be considered when forming your Nurturing Care Groups and Neighbour Groups? They should answer proximity of NCGVs to NC and making sure that at least 80% of the intended population is reached.
  o **Ask participants**: For which groups/people do we create a numbering code? They should answer Promoters, NCGs, NCGVs and NC.
  o **Ask participants**: Why do we need to create number codes for these people/groups? They should answer to more easily track the activities of each group.
Lesson 6 Handout 1: Forming Nurturing Care Groups

Community Mapping and Census

1. The first step is to select your census takers and provide them with the materials they need to take a census and create maps.

   • Make a map of the entire community, with the neighbourhoods subdivided into sections of approximately 50 to 100 houses. There are two methods for creating a community map:

     o Walking through the community and visiting houses.

     o Meeting with a group of people who know the neighbourhoods well and can create a map of their neighbourhoods.

2. After the map is created, we then need to add details and identify houses, neighbourhood boundaries, community boundaries, roads, landmarks of interest (such as rivers) and buildings of interest (such as schools, churches and clinics).

3. If you are targeting a subset of caregivers instead of every household, you will then need to identify the households that include members of your target group.

4. Give each house (or each identified house) a number.

5. Write the primary caregiver’s name and household information on a community census list, making sure that the number of her house on the map is the same as her number on the census list. For example, in the table below, Leena Samuel’s house is marked 1 on the map and 1 on the community census list.

<table>
<thead>
<tr>
<th>Number</th>
<th>Caregiver’s Name</th>
<th>Community Area</th>
<th>Temporary Group #</th>
<th>Elected NCGV</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Leena Samuel</td>
<td>Kivo</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Niragira Regine</td>
<td>Kivo</td>
<td>1</td>
<td>✔️ A</td>
</tr>
<tr>
<td>3</td>
<td>Joshua Nduwayo</td>
<td>Kivo</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Nzoyisenga Claudine</td>
<td>Kivo</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Alice Nzomukunda</td>
<td>Kivo</td>
<td>2</td>
<td>✔️ A</td>
</tr>
</tbody>
</table>

6. When the caregivers you want to form into a Neighbour Group (NG) have been identified based on their geographic proximity, gather them together. Review the profile and job description of a Nurturing Care Group Volunteer (NCGV) with the caregiver and ask them to elect a NCGV from among them.

7. Mark the caregiver elected as the NCGV by placing a check mark in the column titled “Elected NCGV” and assign her a letter. You will learn how to assign codes and therefore track all volunteers and health workers later in the lesson.
8. If you wish to form a Neighbour Group (or Neighbour Circle) with 10 caregivers (for example), you should organize the caregivers into groups of 11. One will be elected as the NCGV and 10 will remain as Neighbour Caregivers.

Alternative Method 1: Forming Nurturing Care Groups Based on Lists

1. If community leaders do not feel it is necessary to use a map to group caregivers into NCGs because they know or have accurate lists of all households, they can simply use those lists.

2. Even if the community leaders think they know everyone, it is important to verify the existence of all households listed by community leaders.

3. It is also important to ensure that all households are included. Sometimes, marginalized or vulnerable households are not included in community records.

4. It is more difficult to tell how close the NCGVs and NC are to each other using this method.

Alternative Method 2: Community Gatherings to Create Nurturing Care Groups

1. If community participation and communication is high, community leaders can call all caregivers to a central meeting place on a particular day.

2. If the main caregiver of the household is ill or cannot attend, s/he could appoint someone to represent him/her.

3. Using this method, it is very likely that multiple caregivers from each household will attend the community gathering. Make sure that you are counting caregiver households, not individual caregivers.

4. Caregivers could be asked to group themselves first into neighbourhoods, then into smaller groups.

No matter what method is used, it is very important to double check the information and make sure no household is left out. This is especially true for households with lower economic status, those with disabled members, those of a perceived lower caste/class/tribe or those with a minority religion.
Lesson 6 Handout 2: Community Map
Lesson 6 Flip Chart 1: Nurturing Care Group Numbering System

7. 6. A. 1
7 = Promoter number
6 = Nurturing Care Group number
A = Nurturing Care Group Volunteer number
1 = Neighbour Household number
Lesson 6 Flip Chart 2: Numbering System Practice Codes

37. 2. C. 3
5. 9. D. 6
17.4. A. 10
20. 7. J. 4
9. 1.H.7
Answer Key to Lesson 6 Flip Chart 2: Numbering System Practice Codes

37. 2. C. 3 = 37th Promoter, 2nd NCG, NCGV “C”, 3rd NC
5. 9. D. 6 = 5th Promoter, 9th NCG, NCGV “D”, 6th NC
17. 4. A. = 17th Promoter, 4th NCG, NCGV “A”, 10th NC
20. 7. J. 4 = 20th Promoter, 7th NCG, NCGV “J”, 4th NC
9. 1. H. 7 = 9th Promoter, 1st NCG, NCGV “H”, 7th NC
Lesson 6 Handout 3: Numbers for the Numbering Game

Write the following names and numbers on separate index cards and distribute them to the participants for the numbering game. Make up other combinations if you want to give the participants more practice understanding the numbering system.

Promoter 3

<table>
<thead>
<tr>
<th>NCGV 3.3.A</th>
<th>NCGV 3.3.E</th>
<th>NCGV 3.3.I</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCGV 3.3.B</td>
<td>NCGV 3.3.F</td>
<td>NCGV 3.3.J</td>
</tr>
<tr>
<td>NCGV 3.3.C</td>
<td>NCGV 3.3.G</td>
<td></td>
</tr>
<tr>
<td>NCGV 3.3.D</td>
<td>NCGV 3.3.H</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NC 3.3.C.1</th>
<th>NC 3.3.C.4</th>
<th>NC 3.3.C.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>NC 3.3.C.2</td>
<td>NC 3.3.C.5</td>
<td>NC 3.3.C.8</td>
</tr>
<tr>
<td>NC 3.3.C.3</td>
<td>NC 3.3.C.6</td>
<td>NC 3.3.C.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NC 3.3.F.1</th>
<th>NC 3.3.F.4</th>
<th>NC 3.3.F.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>NC 3.3.F.2</td>
<td>NC 3.3.F.5</td>
<td>NC 3.3.F.8</td>
</tr>
<tr>
<td>NC 3.3.F.3</td>
<td>NC 3.3.F.6</td>
<td>NC 3.3.F.9</td>
</tr>
</tbody>
</table>
Lesson 6 Handout 4: Making Sense of the Numbering System

This example is for a NCG program with the following ratios/group sizes. You should adapt this tool to match your program specifications.
- 9 Supervisors
- Supervisor to Promoter ratio = 1:4
- Promoter to NCG ratio = 1:6
- Each NCG has 12 NCG Volunteers
- Each NCG has 13 Neighbour Caregivers

<table>
<thead>
<tr>
<th>Supervisor #</th>
<th>Promoter (Name &amp; Number)</th>
<th>NCG #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promoter</td>
<td>Leonie</td>
<td>1-6</td>
</tr>
<tr>
<td>Promoter</td>
<td>Sylvestre</td>
<td>2-6</td>
</tr>
<tr>
<td>Promoter</td>
<td>Yves</td>
<td>3-6</td>
</tr>
<tr>
<td>Promoter</td>
<td>Janie</td>
<td>4-6</td>
</tr>
<tr>
<td>Supervisor 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promoter</td>
<td>Dieudonne</td>
<td>5-6</td>
</tr>
<tr>
<td>Promoter</td>
<td>Jean-Claude</td>
<td>6-6</td>
</tr>
<tr>
<td>Promoter</td>
<td>Janine</td>
<td>7-6</td>
</tr>
<tr>
<td>Promoter</td>
<td>Leonie</td>
<td>8-6</td>
</tr>
<tr>
<td>Supervisor 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promoter</td>
<td>Mamadou</td>
<td>9-6</td>
</tr>
<tr>
<td>Promoter</td>
<td>Raphael</td>
<td>10-6</td>
</tr>
<tr>
<td>Promoter</td>
<td>Sylvestre</td>
<td>11-6</td>
</tr>
<tr>
<td>Promoter</td>
<td>Yves</td>
<td>12-6</td>
</tr>
<tr>
<td>Supervisor 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promoter</td>
<td>Anne-Marie</td>
<td>34-6</td>
</tr>
<tr>
<td>Promoter</td>
<td>Sylvestre</td>
<td>35-6</td>
</tr>
<tr>
<td>Promoter</td>
<td>Yves</td>
<td>36-6</td>
</tr>
<tr>
<td>Promoter</td>
<td>Mitzi</td>
<td>37-6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Promoter #7</th>
<th>Nurturing Care Group</th>
<th>Neighbor Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCG #7.6</td>
<td>7.6.A NCG Volunteer</td>
<td>7.6.F.1 Neighbor Caregiver</td>
</tr>
<tr>
<td>7.6.B NCG Volunteer</td>
<td>7.6.F.2 Neighbor Caregiver</td>
<td></td>
</tr>
<tr>
<td>7.6.C NCG Volunteer</td>
<td>7.6.F.3 Neighbor Caregiver</td>
<td></td>
</tr>
<tr>
<td>7.6.D NCG Volunteer</td>
<td>7.6.F.4 Neighbor Caregiver</td>
<td></td>
</tr>
<tr>
<td>7.6.E NCG Volunteer</td>
<td>7.6.F.5 Neighbor Caregiver</td>
<td></td>
</tr>
<tr>
<td>7.6.F NCG Volunteer</td>
<td>7.6.F.6 Neighbor Caregiver</td>
<td></td>
</tr>
<tr>
<td>7.6.G NCG Volunteer</td>
<td>7.6.F.7 Neighbor Caregiver</td>
<td></td>
</tr>
<tr>
<td>7.6.H NCG Volunteer</td>
<td>7.6.F.8 Neighbor Caregiver</td>
<td></td>
</tr>
<tr>
<td>7.6.I NCG Volunteer</td>
<td>7.6.F.9 Neighbor Caregiver</td>
<td></td>
</tr>
<tr>
<td>7.6.J NCG Volunteer</td>
<td>7.6.F.10 Neighbor Caregiver</td>
<td></td>
</tr>
<tr>
<td>7.6.K NCG Volunteer</td>
<td>7.6.F.11 Neighbor Caregiver</td>
<td></td>
</tr>
<tr>
<td>7.6.L NCG Volunteer</td>
<td>7.6.F.12 Neighbor Caregiver</td>
<td></td>
</tr>
<tr>
<td>7.6.F.13 Neighbor Caregiver</td>
<td>7.6.F.13 Neighbor Caregiver</td>
<td></td>
</tr>
</tbody>
</table>

Supervisors are not included in the coding system. Promoters are identified by their individual number. NCGs are identified by the Promoter number and the NCG number. NCG Volunteers are identified by the Promoter number, the NCG number and NCGV letter. Neighbor Caregivers are identified by the Promoter number, the NCG number, the NCG Volunteer letter and the Neighbor Women number.
Lesson 7: Nurturing Care Group Roles, Responsibilities and Job Descriptions

Achievement-Based Objectives
By the end of this lesson participants will have:

- Distinguished the essential responsibilities for Care Group Volunteers (NCGVs), Promoters, Supervisors and Maternal and Child Health and Nutrition (MCHN) Coordinators
- Listed essential qualities of NCGVs

Duration
1 hour 45 minutes

Materials Needed
- Flip chart paper and markers
- Lesson 7 Handout 1: The “Who’s responsible?” Game
- Answer Key to Lesson 6 Handout 1: The “Who’s responsible?” Game
- Lesson 7 Handout 2: Nurturing Care Group Team Essential Responsibilities
- Lesson 7 Flip Chart 1: Importance of Nurturing Care Group Volunteer Qualities/Selection Guidelines
- Lesson 7 Handout 3: Possible Nurturing Care Group Volunteer Qualities/Selection Guidelines

Facilitator’s Notes

Review and adapt as necessary the essential responsibilities for each position so they match those of organizations’ Nurturing Care Group (NCG) programs. For example, the NCGV essential responsibilities, below, indicate that NCGVs should visit each home and lead one group session per month. If a program has decided that all NCGV behaviour change promotion will occur via home visits, then you would change the essential responsibilities to reflect this.

When facilitating this training for a particular project, be sure to modify the titles of the individuals serving in these particular roles prior to introducing this lesson and playing the game if they are different from those used in this manual. (Some CG approach projects have used different, more localized names for the CGV such as “Madres Líderes [Leader Mothers],” or “Mother Chiefs [Mae Chefe].”)

When working with participants who have not yet started a NCG program, emphasize that the roles and responsibilities mentioned here are guidelines and not meant to be completely prescriptive.

As you go through the list, put increased emphasis on staff modelling the new positive behaviours. Behaviour change begins with us. If the Supervisors and Coordinators do not practice a behaviour while in the field, how can they expect others to follow? This also includes modelling good facilitation skills and supportive supervision.

Steps

1. Introduction
• **Tell participants:** Now that we have learned how to organize communities into Nurturing Care Groups and how to number them so we can monitor their work, we need to identify their specific duties, tasks and responsibilities.

• **Ask participants:** Why is it important to know each Nurturing Care Group team member’s responsibilities? Answers should include: so we can be sure their work will result in positive behaviour change, so we can supervise them well and so we can monitor the quality of their work.

• **Ask participants:** Who are the different members of the Nurturing Care Group team? What are their titles? Answer should include: NCGV, NCG Promoter, Supervisor and Coordinator. List these on a flip chart as they are mentioned.

2. **The Responsibilities of the Nurturing Care Group Team**

• **Ask participants:** Knowing what you know about the purpose of this project model and the organization of the groups, what major activities do you think that the NCG Volunteer will carry out?

  *Lead a discussion focusing on the NCG Volunteer essential responsibilities listed below. Ask questions to help participants think through what the responsibilities might be. If they do not come up with the responsibilities listed below, mention those they have not.*

**NCG Volunteer Essential Responsibilities**

1. Conduct a home visit to about 12 Neighbour Caregivers and their families once or twice a month to promote behaviour change using an education flip chart.
2. Meet once or twice a month with a group of about 12 Neighbour Caregivers to share behaviour change messages using an education flip chart.
3. In some projects, NCGVs monitor the growth of children in her Neighbour Group (or Neighbour Circle) using a MUAC tape to measure the size of the arm and referring children as appropriate to the nearest health facility.
4. Report to the NCG Promoter every two weeks the number of Neighbour Caregivers they have visited or who attended the behaviour change meeting.
5. Monitor and report significant events such as births, deaths, and severe illness that have occurred within the households that they visit.
6. Mobilize Neighbour Caregivers to participate in community development activities that will benefit their families such as immunization campaigns, food distribution, registration for preschool, and latrine construction.
7. Attend NCG meetings (the trainings every two weeks) provided by the NCG Promoter.
8. Report problems that cannot be solved at the household level to the local leadership and request support and collaboration from the NCG Promoter.
9. *Model the new positive behaviours they are teaching Neighbour Caregivers.*

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**Love thy neighbour: Connecting this work to the mission of Faith Based Organizations**

The Care Group model is based on neighbours caring for neighbours. In John 13, Jesus has finished washing the disciples’ feet at the last supper. He tries to prepare them for his departure and gives them this instruction:

34 “A new command I give you: Love one another. As I have loved you, so you must love one another. 35 By this everyone will know that you are my disciples, if you love one another.”

What are some tangible ways that Promoters and NCGVs can show the love of Christ to their neighbours through this work?
We believe that it is important that the NCGV be a woman, and ideally a mother or grandmother.

Some organizations have tried to use men as the Care Group Volunteers; however, they have faced a number of challenges such as:

- Men face greater responsibilities to bring in income for the family. Therefore, male volunteers are less willing to volunteer (without pay) for an extended period of time.
- Men also have more opportunities to work outside the home and tend to have higher dropout rates than female volunteers.
- Household visits are a key part of implementing the model and it can be a protection/safety issue for men to be visiting female caregivers in their homes, often when women are alone.
- When men have been involved as volunteers, they seemed to enjoy learning new skills at the Care Group meetings but were less likely to conduct household visits.
- Also, the volunteer is supposed to be an “early adopter” of new behaviors so they can share with their neighbours the benefits of the new behavior and how to overcome some of the challenges. This is more difficult for men as many of the new behaviors are most typically conducted by women (or in the case of breastfeeding and pregnancy, only by women).
- Some of the behaviors discussed are personal and private and female caregivers may not be comfortable discussing them with her neighbour’s husband.

You could consider having a married couple serve as a NCG couple, visiting households together. However, the size of the NCG would need to stay the same since it is based on the optimal size for a small group. So, if you had two volunteers going to every house, the NCG would only be able to reach half the number of houses. This would dramatically increase the number of NCGs, Promoters and supervisory staff needed for the NCG project- almost doubling the budget. We do not recommend this option. Men can be engaged as volunteers using other project models.

- **Ask participants**: What major activities do you think the NCG Promoter will carry out?

  *Lead a discussion focusing on the NCG Promoter essential responsibilities listed below.*

**NCG Promoter Essential Responsibilities**

1. Coordinate activities at the local level and maintain cooperation with other institutions at community level such as the village council, churches and schools.
2. Meet with the local leadership committee in each community (e.g., Community Health Committees) every other week for coordination, monitoring and evaluation (if these committees exist).
3. Facilitate organized, participatory learning sessions with each of their NCGs (made up of 10-12 NCG Volunteers) every two weeks, following the lesson plans in the educational materials provided.
4. Attend Bi-Weekly Training and Reporting Meetings provided by the NC Supervisor and the Module Training Sessions to accurately replicate trainings received with NCGVs, sharing correct information and demonstrating skills learned.

5. **Model the new positive behaviours they are teaching to NCGVs in their own homes, located in the community.**

6. Visit, monitor, and evaluate each NCG Volunteer at least quarterly. Supervise the work of NCGVs by accompanying them on home visits to Neighbour Caregivers and observing them providing group instruction (1-2 NCGVs supervised per NCG meeting).

7. Assist with other program activities such as: National Vaccination Days, distribution of Vitamin A and deworming medicine, water committee meetings, Baby-friendly Hospital work, etc.

8. Attend training and coordination meetings at the district/Area Program/cluster office, providing verbal and written reports of activities completed.

**Ask participants:** What major activities do you think the NCG Supervisor will carry out?

*Lead a discussion focusing on the NCG Supervisor essential responsibilities listed below.*

**NCG Supervisor Essential Responsibilities**

1. Coordinates with project partners, project staff, government ministry staff (e.g., MOH and MOE), and other stakeholders regarding upcoming activities and needs at the community and provincial levels.

2. Responsible for the performance and professional development of the NCG Promoters who report to him/her.

3. Review Flipchart Lesson Plans with NCG Promoters every two weeks and assure they understand the information well and can teach back the information in a participatory manner.

4. **Model good facilitation and supportive supervision techniques.**

5. **Model the new positive behaviours they are teaching to NCG Promoters in their own homes and while in the community.**

6. Collect NCG Promoter reports on a monthly basis, review the reports and assure the information presented is reasonable and complete.

7. Prepare a monthly report using the information provided by NCG Promoters.

8. Maintain a filing system in the project office (or on a computer) so copies of NCG Promoter Reports, MCHN Supervisor Reports and QIVCs are easily accessible.

9. Responsible to supervise each NCG Promoter who reports to him or her in the field at least twice a month, using QIVCs and completing all sections of the NCG Promoter Supervision Checklist every quarter.

10. Responsible to liaison with the appropriate people in a timely and professional manner to ensure the financial, logistical and procurement issues required to implement project activities.

**Ask participants:** What major activities do you think the NCG Coordinator will carry out?

*Lead a discussion focusing on the NCG Coordinator essential responsibilities listed below.*

**NCG Coordinator Essential Responsibilities**

1. Lead program planning and provide strategic direction to program managers.
2. Ensure internal and external reporting and documentation requirements are on-time and accurate.
3. Assess staff capacities and coordinate initial or ongoing trainings based on need and program goals.
4. Play a lead role in the recruitment, orientation and training of new technical program staff.
5. Model leadership to all staff and intentionally develop the leadership potential of the NC Supervisors.
6. Model the new positive behaviours they are teaching to NCG Supervisors in their own homes and while in the community.
7. Prepare a monthly report using the information provided by NCG Supervisors.
8. Responsible to supervise each NCG Supervisor who reports to him or her in the field at least once a month, using QIVCs and completing all sections of the NCG Supervisor Supervision Checklist every quarter.
9. Ensure that the project is well represented in regular provincial/state/national level meetings and forums.

- Assure that participants have a general idea of the roles of the four positions in the Nurturing Care Group team.

3. Activity: Who’s responsible?

- Tell participants that they will now participate in a game that requires them to decide who among the NCG team members is responsible for specific tasks.
- Distribute Lesson 7 Handout 1: The “Who’s responsible?” Game and have the participants work either in pairs or individually (if they already have some NCG experience/exposure). Give participants about 20 minutes to complete the game.
- Refer participants to Answer Key to Lesson 7 Handout 1: The “Who’s responsible?” Game and have them correct their own work.
- Refer participants to Lesson 7 Handout 2: NCG Team Essential Responsibilities. Give them a few minutes to review the handout and compare it with their game results.
- Ask participants: Which NCG team members do you seem to be most clear about regarding their responsibilities? Which ones are not so clear? Are there any responsibilities that you are confused about or have issues with? Discuss any issues that arise.

4. Activity: Care Group Volunteer Selection Guidelines

- Explain to participants: Now that we have a better idea of the responsibilities of each Nurturing Care Group team member, let’s focus a bit more on NCGVs. Selecting the right NCGV is critical to the effectiveness of the NCG approach as a behaviour change strategy.
- Ask participants: Given the responsibilities of the NCGV, what should be the requirements for being a NCGV? Write this question on a flip chart and ask each small group to take 3 minutes to discuss potential answers.
- Ask participants: Are there specific characteristics or requirements based on the NCG Criteria discussed in Lesson 4? Refer to Lesson 4 Handout 2: Establishing Nurturing Care Group Criteria.
"REQUIRED: The model is based on peer-to-peer health promotion (mother-to-mother for MCH and nutrition behaviours.) NCG Volunteers should be chosen by the that are in the group the Volunteer will serve or by the leadership in the village.”

"REQUIRED: All of a NCG Volunteer’s beneficiaries (Neighbour Caregivers) should live within a distance that facilitates frequent home visitation and all CG Volunteers should live < 1 hour walk from the NCG Promoter meeting place.”

"SUGGESTED: Social/educational differences between the Promoter and NCG volunteer should not be too extreme (e.g., it is not a good match to have bachelor-degree level staff working with NCG Volunteers).

We believe that the less educational difference there is between the NCG Promoter and NCG Volunteers, the more likely that the Promoters will use language/concepts that the NCG Volunteers can understand. It also helps keep the costs of the model low.”

- Explain to participants: Over the years several non-governmental organizations, or NGOs, using the Care Group approach have developed some CGV selection guidelines. We’d like to now give you a chance to reflect on these recommendations and to decide for yourselves which ones are essential, desirable or unnecessary.

- Provide each table with a copy of Lesson 7 Flip Chart 1: Importance of Nurturing Care Group Volunteer Qualities/Selection Guidelines. Refer participants to Lesson 7 Handout 3: Possible Nurturing Care Group Volunteer Qualities/Selection Guidelines.

- Ask each table to discuss the guidelines in Lesson 6 Handout 3 and determine the relative importance of each criterion—essential, desirable or unnecessary—by writing its number in the appropriate column. Give participants 15 minutes to do this.

- Once finished, ask participants to walk around the room to see how the other groups categorized the guidelines.

- Discuss with the larger group which items most tables agreed on and which had significant differences of opinion.

- Explain to participants that each project will decide on the selection guidelines for themselves and that this should also be done in dialogue with the community.

Note: Some projects are experimenting with using males (e.g., fathers) as NCGVs in certain settings. This is complicated and potentially problematic, since the model relies heavily on peer (mother-to-mother) support. If projects vary in significant ways from NCG criteria listed in Lesson 4, the authors of this manual highly recommend that another name besides Care Group be used, such as cascade group.
Lesson 7 Handout 1: The “Who’s responsible?” Game

**Instructions:** Read the task in the left-hand column and put an X in the one column indicating who is most likely responsible for that task.

<table>
<thead>
<tr>
<th>Task/Responsibility</th>
<th>NCGV</th>
<th>Promoter</th>
<th>Supervisor</th>
<th>Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Meets once per month with a group of Neighbour Caregivers (NC) to share behaviour change practices using an education flip chart</td>
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<tr>
<td>2. Reports to the Promoter every two weeks the number of NC he/she has visited or who attended the behaviour change meeting</td>
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<tr>
<td>3. Meets monthly with the local leadership committee in each community for coordination, monitoring and evaluation (if these committees exist)</td>
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<tr>
<td>4. Monitors and reports important events that have occurred in her NG, such as births, deaths and severe illness</td>
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<tr>
<td>5. Prepares a monthly report using the information provided by the Supervisor</td>
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<td>6. Mobilizes caregivers to participate in community activities that will benefit their families, such as immunization campaigns, food distribution or preschool registration</td>
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<td>7. Models the behaviours she is teaching to the NC</td>
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<td>8. Coordinates local-level activities and maintains cooperation with other community-level institutions, such as the village council, churches, mosques, and schools</td>
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<td>9. Completes monthly reports based on volunteer and NC registers</td>
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<td>10. Monitors behaviour change among the NCGVs</td>
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<td>11. Attends meetings organized by the Supervisor</td>
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<td>12. Maintains a filing system in the project office (or on computer) so copies of Promoter reports and quality improvement and verification checklists (QIVCs) are easily accessible</td>
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<tr>
<td>13. Responsible for the performance and professional development of the Promoters who report to him/her</td>
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<td>14. Models leadership to all staff and intentionally develops the Supervisor’s leadership potential</td>
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<tr>
<td>15. Reviews flip chart lesson plans with Promoters every 2 weeks to ensure they understand the information well and can teach the information in a participatory manner</td>
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<tr>
<td>16. Assesses staff capacities and coordinates initial or ongoing trainings based on need and program goals</td>
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<td>Task/Responsibility</td>
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<tr>
<td>17. Visits, monitors and evaluates at least one NCGV from each NCG each month,</td>
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<td>and supervises NCGVs’ work by accompanying them on home visits and observing</td>
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<td>them leading group meetings</td>
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<td>18. Collects Promoter reports on a monthly basis, reviews the reports and</td>
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<td>ensures the information presented is reasonable and complete</td>
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<td>19. Ensures that the project is well represented in regular provincial/state/</td>
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<td>national-level meetings and forums</td>
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<td>20. Prepares a monthly report using the information provided by Promoters</td>
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<td>21. Plays a lead role in the recruitment, orientation and training of new</td>
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<td>technical program staff</td>
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<td>22. Supervises each Promoter who reports to him/her in the field at least twice</td>
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<td>per month, uses QIVCs and completes all sections of the Promoter supportive</td>
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<td>supervision checklist every quarter</td>
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<td>23. Ensures that supervisors and promoters have the supplies necessary</td>
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<td>24. Supervises each Supervisor who reports to him/her in the field, uses QIVCs</td>
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<td>and completes all sections of the Supervisor supportive supervision checklist</td>
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<td>25. Attends NCG meetings held by the Promoter</td>
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<td>completed on-time and accurately</td>
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<td>27. Facilitates/organizes participatory learning sessions with each of their</td>
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## Answer Key to Lesson 7 Handout 1: The “Who’s responsible?” Game

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</table>
Lesson 7 Handout 2: Nurturing Care Group Team Essential Responsibilities

These are guidelines. Each program will establish its own job descriptions for each staff member and volunteer.

**Nurturing Care Group Volunteer (NCGV)**

1. Conduct a home visit to about 12 Neighbour Caregivers and their families once or twice a month to promote behaviour change using an education flip chart.
2. Meet once or twice a month with a group of about 12 Neighbour Caregivers to share behaviour change messages using an education flip chart.
3. Report to the NCG Promoter every two weeks the number of Neighbour Caregivers they have visited or who attended the behaviour change meeting.
4. In some projects, NCGVs monitor the growth of children in her Neighbour Group (or Neighbour Circle) using a MUAC tape and referring children as appropriate to the nearest health facility.
5. Monitor and report significant events such as births, deaths, and severe illness that have occurred within the households that they visit.
6. Mobilize Neighbour Caregivers to participate in community development activities that will benefit their families such as immunization campaigns, food distribution, registration for preschool, and latrine construction.
7. Attend NCG meetings (the trainings every two weeks) provided by the NCG Promoter.
8. Report problems that cannot be solved at the household level to the local leadership and request support and collaboration from the NCG Promoter.
9. Model the new positive behaviours they are teaching Neighbour Caregivers.

**NCG Promoter**

1. Coordinate activities at the local level and maintain cooperation with other institutions at community level such as the village council, churches and schools.
2. Meet with the local leadership committee in each community (e.g., Community Health Committees) every other week for coordination, monitoring and evaluation (if these committees exist).
3. Facilitate organized, participatory learning sessions with each of their NCGs (made up of 10-12 NCG Volunteers) every two weeks, following the lesson plans in the educational materials provided.
4. Attend Bi-Weekly Training and Reporting Meetings provided by the NC Supervisor and the Module Training Sessions to accurately replicate trainings received with NCGVs, sharing correct information and demonstrating skills learned.
5. Model the new positive behaviours they are teaching to NCGVs in their own homes, located in the community.
6. Visit, monitor, and evaluate each NCG Volunteer at least quarterly. Supervise the work of NCGVs by accompanying them on home visits to Neighbour Caregivers and observing them when they are providing group instruction (1-2 NCGVs supervised per NCG meeting).
7. Assist with other program activities such as: National Vaccination Days, distribution of Vitamin A and deworming medicine, water committee meetings, Baby-friendly Hospital work, etc.
8. Attend training and coordination meetings at the district/Area Program/cluster office, providing verbal and written reports of activities completed.
### NCG Supervisor

1. Coordinates with project partners, project staff, government ministry staff (e.g., MOH and MOE), and other stakeholders regarding upcoming activities and needs at the community and provincial levels.
2. Responsible for the performance and professional development of the NCG Promoters who report to him/her.
3. Review Flipchart Lesson Plans with NCG Promoters every two weeks and assure they understand the information well and can teach back the information in a participatory manner.
4. **Model good facilitation and supportive supervision techniques.**
5. **Model the new positive behaviours they are teaching to NCG Promoters in their own homes and while in the community.**
6. Collect NCG Promoter reports on a monthly basis, review the reports and assure the information presented is reasonable and complete.
7. Prepare a monthly report using the information provided by NCG Promoters.
8. Maintain a filing system in the project office (or on a computer) so copies of NCG Promoter Reports, MCHN Supervisor Reports and QIVCs are easily accessible.
9. Responsible to supervise each NCG Promoter who reports to him or her in the field at least twice a month, using QIVCs and completing all sections of the NCG Promoter Supervision Checklist every quarter.
10. Responsible to liaison with the appropriate people in a timely and professional manner to ensure the financial, logistical and procurement issues required to implement project activities.

### NCG Coordinator

1. Lead program planning and provide strategic direction to program managers.
2. Ensure internal and external reporting and documentation requirements are on-time and accurate.
3. Assess staff capacities and coordinate initial or ongoing trainings based on need and program goals.
4. Play a lead role in the recruitment, orientation and training of new technical program staff.
5. **Model leadership to all staff and intentionally develop the leadership potential of the NCG Supervisors.**
6. **Model the new positive behaviours they are teaching to NCG Supervisors in their own homes and while in the community.**
7. Prepare a monthly report using the information provided by NCG Supervisors.
8. Responsible to supervise each NCG Supervisor who reports to him or her in the field at least once a month, using QIVCs and completing all sections of the NCG Supervisor Supervision Checklist every quarter.
9. Ensure that the project is well represented in regular provincial/state/national level meetings and forums.
Lesson 7 Flip Chart 1: Importance of Nurturing Care Group Volunteer Qualities/Selection Guidelines

<table>
<thead>
<tr>
<th>Essential</th>
<th>Desirable</th>
<th>Not Necessary</th>
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Lesson 7 Handout 3: Examples of Nurturing Care Group Volunteer Qualities/Selection Guidelines

Note: The following list of qualities offers suggestions and contains examples that other projects have used. Your project team may have different ideas of what may or may not be considered necessary. For example, in some project areas literacy levels are very low, so only a few volunteers will know how to read and write.

1. Willing to work as a volunteer
2. Desires to serve his/her neighbours
3. Female
4. Positive attitude (hopeful and optimistic)
5. Is a mother or grandmother
6. Models good hygiene, sanitation, nutrition and other early child development practices
7. Respected by the neighbourhood and the community
8. Capable of leading a discussion with 8–12 Caregivers and able to conduct home visits
9. Expresses an interest in health issues
10. Is not addicted to alcohol or drugs
11. Does not smoke
12. Knows how to read and write
13. Can get permission from her husband and other influential family members (e.g., mother-in-law) to be a volunteer
14. Married or widowed
15. Religious and devoted (any religion)
16. Has children
17. Has a bicycle or able to walk longer distances
18. Has children in good health
19. Has had at least 3 years of primary education
20. If married, has a good (moral) man for a husband
21. Has good social relationships with community leaders
22. Is between 18 and 40 years of age
23. Has good relationships with existing community health workers/volunteers
Lesson 8: Volunteer Motivation and Incentives

Achievement-Based Objectives
By the end of this lesson participants will have:

- Explained why it is important to keep Nurturing Care Group Volunteers (NCGVs) motivated
- Identified ways that the Care Group approach typically helps to keep volunteers motivated
- Listed practical, creative ideas to make NCGVs feel motivated

Duration
1 hour

Materials Needed

- Flip chart paper and markers
- Lesson 8 Handout 1: Programmatic Reasons to Keep Volunteers Motivated
- Lesson 8 Handout 2 and Flip Chart 1: Three Volunteer Motivators
- Lesson 8 Handout 3: Ideas to for Ways to Help NCG Volunteers Feel Connected, Valued and Effective

Steps

1. Introduction

- Tell participants: Now that we’ve talked about the responsibilities of each member of the Nurturing Care Group team, let’s talk about what makes the Coordinators and Supervisors and sometimes Promoters different from the Nurturing Care Group Volunteers.

- Ask participants: What is a significant difference between these two groups? Answers should include: The first group (Coordinators, Supervisors and most NGO Promoters) are paid staff, whereas NCGVs are not paid.
  
  - However, sometimes NCG Promoters are government CHWs and may be volunteers as well.

- Explain that in this lesson we are going to talk about how to keep volunteers happy and motivated to work.

2. Why NCGVs are Good for the Program

- Ask participants: Why are volunteers the strength of a Nurturing Care Group program? Answers may include:

  - They work without monetary payment, allowing the program to reach more intended beneficiaries at a lower cost.
  
  - They provide sustainable services that do not require new grants or other sources of income.
  
  - They already have close relationships with their neighbours. They will always be part of this community and have a long-term investment in the community and people they serve.
o Many of them have children of their own and know the local practices.
o They have a common language, history and experiences with their neighbours.
o They are learners along with their neighbours. What they learn can be easily shared with
and observed by their neighbours.

• Explain to participants: For the good of the program, sometimes an ineffective NCGV must be
removed. Project goals should include retaining high-quality volunteers, mentoring those that need
more support and removing those that are long-term low-quality performers. For example, if you
are teaching about exclusive breastfeeding and the volunteer is teaching incorrect information to
the Neighbour Caregivers, malnutrition might increase! NCGVs should be supervised and helped to
gain skills and adopt the new behaviours themselves, making sure they are meeting regularly for
training and are equipped with correct information.

3. Activity: Keeping Care Group Volunteers Motivated

• Ask participants: Why is it important to keep volunteers happy and motivated? List their answers on a flip chart.

• Pass out Lesson 8 Handout 1: Programmatic Reasons to Keep Volunteers Motivated and explain each reason.

• Ask participants to compare the reasons that they gave on the first flip chart to each topic on Lesson 7 Handout 1.

• Ask participants to raise their hands if they have ever done any volunteer work. Instruct participants to tell the person
next to them what volunteer work they did and why they did it. Ask them to share with each other what motivated them
to work without pay. After a few minutes, ask participants to return to the larger group and to share some reasons that
kept them motivated to work as volunteers.

• Show Lesson 8 Handout 2 and Flip Chart 1: Three Volunteer Motivators and explain that, based on research by McCurley and Lynch, three common motivators for volunteers are: feeling connected, feeling valued and feeling effective. Do not show the responses to each category until after the participants have given their own ideas.

• First explain why feeling connected is important to volunteer motivation.
  o Explain to participants: Volunteers need to feel like they are part of a group; they need to
feel connected to others and to the group as a whole.
  o Ask participants in their small groups to identify how the NCG approach helps NCGVs feel
connected. Ask two or three participants to share their answers with the larger group.
  o Now show from Lesson 7 Handout 2 and Flip Chart 1 the three relationships that affect
connectedness and compare them to participants’ responses.

• Next explain why feeling uniquely valued is important to volunteer motivation.

Experience with Incentives
Concern Worldwide has successfully used giveaways, like identifier t-shirts and tools
for work (registers and teaching materials) for CGVs. These are sometimes referred to
as non-monetary incentives or simply “work tools”. They can serve as extrinsic
motivators that support intrinsic
motivation (through having tools for work and feeling supported and valued by
project staff). These should be used
judiciously, as any gift or payment to a
volunteer can “crowd out” intrinsic
motivation. For more details, watch the
online presentation at:
https://caregroupinfo.org/vids/CHW_Moti
vation_iPad/story_html5.html
Explain to participants: Volunteers need to feel like they have something to offer the program, that their personal skills and life experiences are valued.

Ask the participants in their small groups to identify how the NCG approach helps NCGVs feel valued. Ask two or three participants to share their answers with the larger group.

Now show from on Lesson 7 Handout 2 and Flip Chart 1 the ways volunteers feel uniquely valued and compare them with participants’ responses.

Lastly explain why feeling effective is important to volunteer motivation.

Explain to participants: Volunteers need to feel like they are making a difference; they need to feel effective. Volunteers will become discouraged and quit if they believe that their time and effort is not being used well. This means that volunteers should be continually reminded that they are working on something that matters, as well as be provided with feedback on their success and the success of the program.

Ask the participants in their small groups to identify the tools the NCG approach uses to help NCGVs feel effective. Ask two or three participants to share their answers with the larger group.

Now show the tools listed in Lesson 7 Handout 2 and Flip Chart 1 and compare them with participants’ responses.

4. **Activity: From Theory to Practice**

   Explain to participants: It is one thing to talk about motivation in theory and another thing to implement it. So let’s begin to think practically within the context of our Nurturing Care Group programs.

   Divide participants into small groups and give each group a marker and some blank flip chart paper. Ask each group to brainstorm and write down actions to help NCGVs feel more connected, valued and effective. Remind the groups that their ideas should be sustainable and that the program budget is limited, so they should focus on ideas that are free or very low cost.

   After about 15 minutes, ask small groups to post their ideas on the walls. Have the groups walk around and note the most creative and feasible ideas. Ask each small group to “star” those ideas.

   Review the most creative and feasible ideas with the entire group.

   Refer participants to Lesson 8 Handout 3: Ideas for Ways to Help Volunteers Feel Connected, Valued and Effective for more ideas.
5. Wrap Up

- Explain to participants: Many nongovernmental organizations have fallen into the trap of thinking that they have to provide many tangible and costly incentives to ensure that NCGVs are happy and motivated. With limits on the amount of work time that we ask of them, and with more reflection and creative thinking, we can learn to use other more sustainable and effective means to keep our volunteers feeling connected, valued and effective.
Lesson 8 Handout 1: Programmatic Reasons to Keep Nurturing Care Group Volunteers Motivated

1. Intellectual Capital
You have spent time, money and effort training Care Group Volunteers (NCGVs). When a NCGV leaves or stops working for the program, the organization loses all of the NCGV’s experience, training and skills. The NCG loses its continuity. Just as a family feels loss when someone dies or goes away on a long trip, a NCG can feel a similar loss when a NCGV stops participating for whatever reason.

2. Financial Investment
When NCGVs leave the program, Promoters and NCG colleagues must reinvest time, money and energy to retrain a new person. New materials, specifically flip charts, might be needed. The new time and energy spent puts a strain on the organization or NCG, which can lower satisfaction.

3. Neighbour Caregiver Satisfaction
If Neighbour Caregivers know their NCGV has been working in their community for many years they are more likely to believe her, especially if they have seen her bring change to the community and make a difference. New NCGVs lack the same trust, time and relationship with the Neighbour Caregivers, making it harder to reach program goals.

4. Reaching Program Goals
With each staff turnover, we have to refocus time or retrain. This moves us away from our intention of focusing on behaviour change that can decrease child deaths, keep children protected, and help them to thrive in their intellectual and physical growth.

29 The headings in bold can be written on a flip chart.
Lesson 8 Handout 2 and Flip Chart 1: Three Volunteer Motivators

1. **The Need to Feel Connected**
   
   The three relationships that affect connectedness are:
   
   • The relationship between a NCGV and her Promoter
   • The relationship between a NCGV and the caregivers in her community
   • The relationship NCGVs share with each other

2. **The Need to Feel Uniquely Valued/Valuable**

   • NCG team members know each volunteer by name, as well as her family situation.
   • NCG team members regularly give sincere and specific praise to the volunteer, both in private and in front of others.
   • Some studies found that CGVs reported feeling more respected after serving as a volunteer by other women (100%), community leaders (64%), husbands (61%), parents (48%), and health facility staff (48%).
   • Promoters encourage each volunteer’s strengths and show tolerance and understanding of her weaknesses.

3. **The Need to Feel Effective**

   Tools the Care Group program uses to help volunteers know that they are effective and are part of an effective program include:

   • Supportive supervision forms
   • Quality improvement and verification checklists (QIVCs)
   • Training pre- and post-tests
   • Important events reporting (e.g., of child deaths) as part of the NG and CG Registers
   • Behaviour change tracking tools
   • Baseline and follow-up surveys

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30 Only the headings in bold should be listed on the flip chart. A prepared list of the other points can be written out to be revealed only after the group participants have given their own ideas.
Lesson 8 Handout 3: Ideas for Ways to Help Volunteers Feel Connected, Valued and Effective

Ways to Feel Connected

- Celebrate group achievements, such as recognizing when all NCGVs are present at three meetings in a row.
- Invite special guests to NCG meetings that can speak on how the program has impacted them personally, such as testimonies from community members that have seen malnutrition decrease in their homes.
- Provide NCGVs with goods (such as hats and shirts) that identify them as a CGV and as part of a larger group. Using a project name and the MOH’s logo is fine (with their permission), but if an organizational logo is included, make it small – we want to reinforce that volunteers are working for their community or their country, not a development organization.
- Hold regular staff meetings so NCGVs have the opportunity to ask questions, clarify their roles and participate in decision making.
- Bring up with project management concerns any NCGVs raise during meetings so NCGVs see that their voices are important.
- Develop a program identity, for example, by using slogans, team phrases and a formal program name.
- Share life events, such as weddings or funerals, together. Foster an environment where NCGVs can support each other through these life events.
- Arrange site visits to other programs so NCGVs have a better understanding of the big picture of what they are working toward.

Ways to Feel Uniquely Valued/Valuable

- Learn each volunteer’s name, address her by name, and thank her regularly.
- Identify a “Nurturing Care Group of the Month” to be recognized at a monthly meeting. Specify the reasons that the volunteers received the award.
- Rotate special roles (e.g., committee secretary) so that more people have the opportunity to hold unique positions.
- Express concern for the individual needs of volunteers.
- Spend time each year discussing the positive things Promoters have seen in the lives of the volunteers.
- Provide a special celebration annually. (This can be encouraged by the organization, and some resources can be offered to each group if funding permits but try to allow the group to organize the celebration themselves to increase ownership by their group.)
• Give annual certificates or awards that highlight volunteers’ special qualities (e.g. most inspirational).

• Provide time at NCG meetings so that volunteers have the opportunity to voice their individual experiences, challenges and concerns.

• Share life events, such as weddings or funerals, together. Foster an environment where NCGVs can support each other through these life events.

**Ways to Feel Effective**

• Ask volunteers or community members to share their testimonies on how the program has changed their lives.

• Provide consistent and objective feedback on each volunteer’s performance.

• Hold annual community celebrations to share program results and to recognize what has been accomplished over the previous year.

• Invite local leaders (e.g., community and religious leaders, government officials) to provide words of encouragement.

• Ask volunteers for their opinions when deciding how to address any special needs of a beneficiary.

• Create posters that show volunteers’ progress toward targets.

• Hang a banner to celebrate major accomplishments.

• Let volunteers know when a person from outside of the community notices their work.

• At each volunteer training, provide quarterly updates of recent evaluations, field visits or surveys.

• Hold discussions where volunteers can share their success stories with each other. We often focus on the troubles we are having, but we need a balance. Many times we need to know about successes to keep us motivated.
Lesson 9: Behaviour Change and Nurturing Care Groups: What Happens in a Nurturing Care Group Meeting, Neighbour Group Meeting and Home Visit

NOTE: Since no education lessons will be used in the WV/Ghana test of the NCG Project Model the following steps (also marked * below) can be skipped in the WV/Ghana August 2019 training:

- Step 9: Adaptation for some early childhood development (ECD) lessons and
- Lesson 9 Handout 3: Early Child Education Group Meeting Steps and Facilitation Cues

Achievement-Based Objectives

By the end of this lesson participants will have:

- Named the two most critical behaviour change responsibilities of NCG Promoters and Nurturing Care Group Volunteers (NCGVs)
- Identified the different elements of a typical NCG lesson
- Matched facilitation cues to the steps of a NCG meeting
- Identified ways to adapt the meetings for ECD lessons*
- Reviewed the agenda of the meetings held every two weeks between Supervisors and Promoters
- Contrasted the various types of meetings

Duration

2 hours

Materials Needed

- Flip chart paper and markers
- Lesson 9 Flipchart 1: Benefits of Household Visits
  Lesson 9 Handout 1: Nurturing Care Group and Neighbour Group Lesson Steps
- Lesson 9 Handout 2: Lesson Facilitation Cues (make 5–6 copies and cut the pictures into squares without the titles of the steps)
- Lesson 9 Handout 2: Early Child Education Group Meeting Steps and Facilitation Cues*
- Larger-scale versions of each facilitation cue, as found in Lesson 9 Handout 2
- Lesson 9 Handout 4: Structure for Training Meetings held every two weeks Lesson 9 Handout 5: Example Agenda for Training Meetings held every two weeks

Steps

1. Introduction

- Tell participants: Now that we’ve discussed the NCG structure, NCG team members and their responsibilities, how to organize communities into NCGs and how to keep NCGVs motivated, we need to look at the main behaviour change activities of the Promoters and NCGVs.
• **Ask participants**: What are the most critical responsibilities that NCG Promoters and NCGVs have that result in changed behaviours? Answer should include holding group meetings and home visits, conducting NCG and NG meetings, and modelling behaviours.

*Reminder: “In order to change others, it is helpful to first change ourselves.”* I would encourage you to display this phrase on the wall of your office and practice doing these things with those you supervise.

• Explain to participants that healthy behaviours are introduced first by the Supervisors to the Promoters, then by the Promoters to the NCGVs. This usually happens at the meetings that happen monthly or every two weeks, with only one lesson being taught at each meeting. NCGVs then introduce the new behaviours to their Neighbour Caregivers (NC) during Neighbour Group (NG) meetings and home visits. Since these are critical behaviour change activities, projects need to make sure that those meetings are as effective as possible.

2. **Nurturing Care Group Module and Lesson Process**

• Explain to participants: Typically, there are four to six modules used to train NCGVs to promote new positive behaviours among NC, each of which is related to a specific theme, such as healthy pregnancy and delivery, newborn care and nutrition, WASH, positive parenting, or early childhood development. Each module is then divided into different lessons. One lesson is taught each meeting. A “module” is simply a group of NCG lesson plans that have a common theme.

• Tell participants: The NCG lessons are specifically developed to provide a small amount of information at a time. It gives the NC a chance to think about the message in different ways, address any challenges they may have implementing the new behaviour and, if possible, to practice the new skill together. As NGOs, we are often tempted to provide all the information that a NC would want on a specific topic. However, to create behaviour change, it is often best to go slowly and focus on the essentials.

• Tell participants: Let’s see how this would work in reality. (Write the following information on a flip chart.) If you have five modules with a total of 22 lessons and a new lesson is introduced every 2 weeks, how long would it take to cover all of the lessons?

They should answer 44 weeks, or approximately 11 months.

• **Ask participants**: Is there anything you can think of that might prevent a program from being implemented this smoothly? At the community level, for example, there are holidays, weeks when roads are impassable, and local events that will disrupt the program, which could lead to implementation taking longer than originally planned. Sometimes Promoters will be fully engaged in other activities, like a midterm evaluation, that may prevent them from training NCGVs in a particular week. So, you always need to plan for a little more time to cover all the modules and lessons.

3. **Nurturing Care Group Lesson Structure**

• Review: The Nurturing Care Group is the group of volunteers, the NCGVs. They meet together in a NCG every two weeks and are led by a paid Promoter.
• Explain to participants: Over the years, staff from several organizations have refined the behaviour change process that takes place during the lessons. Specific steps are followed in each lesson. To help Promoters and NCGVs remember these steps, a picture called a “facilitation cue” has been assigned to each step. Facilitation cues are reminders to facilitators as they help others learn new skills and practices. In the past, we assigned words and letters to these steps, but now we just use the pictures as reminders. But, before we look at the facilitation cues, let’s break down the steps in a typical lesson and the approximate amount of time spent on each step.

• Refer participants to Lesson 9 Handout 1: Nurturing Care Group Lesson Steps so they can follow along and see how much time should be allocated to each step.

• Review and explain the steps in the lesson.
  o Step 1. Lesson objectives
    ▪ Each lesson begins with the behaviour, knowledge and belief objectives that will be covered. Most objectives are behavioural objectives, written as action statements. These are the behaviours that we expect the NCGVs and NC to practice based on the key messages in the flip chart.
    ▪ All of the materials needed for the lesson are listed under the objectives section in the agenda. Materials with an asterisk (*) should be brought by the Promoter.
  o Step 2. Game or song
    ▪ Each new lesson starts with a game or a song.
    ▪ **Ask participants:** Why do you think this approach was chosen to start each lesson? Answers should include that games help mothers to feel relaxed and forget the worries of their day. Also, games build a sense of safety, and when caregivers feel safe, they are more likely to share their experiences, talk openly about their struggles and consider trying new practices at home.
  o Step 3. Attendance and troubleshooting and Important Events Reporting
    ▪ Note who is present at the meeting. Find out if there are any important events to report (births, deaths, new pregnancies, or other events your project is tracking).
    ▪ Discuss any problems NCGVs had teaching the last lesson to Neighbour Caregivers (NCs).
    ▪ At this point, the Promoter also discusses any materials needed for the next meeting and asks NCGVs to bring the items needed for the activity.
    ▪ **Ask participants:** Why is this step important? Answers should include, to monitor who is attending the lesson regularly and who is not, to help track important events, to know which caregivers may need extra care (or prayer), and to help volunteers overcome challenges they may have.
    ▪ This step should also be used to ask about the experience of volunteers and NCs when they were trying out the behaviours or taking the actions they committed to

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last time. This provides an opportunity to troubleshoot any barriers that come up in practicing the new behaviour.

- **Step 4. Behaviour change promotion through pictures**
  - The Promoter reads the story printed on the flip chart, using the images to share the story. The story in each lesson is followed by discussion questions. Discussion questions are used to discuss the problems faced by the two main characters in the lesson. Use the story and discussion questions to find out the current practices of the caregivers in the group.
  - It is important that these pictures be pretested and informed by the formative research that should have been conducted to better understand the barriers to behaviour change. For example, if mothers say that their own mothers and mothers-in-law do not approve of point of use water treatment, then the flip chart picture should show a grandmother helping her daughter (the child’s mother) to treat their home’s water or refusing to let her daughter give untreated water to an older child.

- **Step 5. Activity (demonstrate the behaviour)**
  - **Ask participants:** Do people usually change their behaviours if you just tell them to? They should answer, no, not usually.
  - Tell participants: Behaviour change will be much more likely if you arrange for Care Group Volunteers and Neighbour Caregivers to try out the new behaviour in a safe environment. That is the purpose of this part of the lesson. Telling people what to do will not be as effective as demonstrating and practicing. Therefore, each lesson includes an activity. The Promoter is responsible for organizing materials for each lesson’s activity.
  - The activity uses materials provided by CVG from their own homes to create, as much as possible, a “real life” situation.
  - Keep in mind that some behaviours cannot be demonstrated during the meeting. Some, however, like ORS preparation or treating water with chlorine tablets are very easy to demonstrate and make it much easier for caregivers to feel comfortable doing it in the future.

- **Step 6. Discuss potential barriers and solutions**
  - **Ask participants:** Why do you think discussing potential barriers to practicing the new behaviour is so important? Answers should include that it gives the NCGVs an opportunity to seriously consider what it will take to try the new behaviour, and to think through how to overcome barriers.
  - When NCGVs discuss barriers during each lesson, they have to really imagine doing the behaviour within their household context. This takes the caregivers beyond just hearing about the behaviour. It also leads to the next step, which is also critical.
  - In this step everyone is engaged in helping to figure out how to overcome the barriers they mention. It is not the only the responsibility of the Promoter to offer
up solutions. Brainstorming solutions is a group responsibility and will help to empower the caregivers to become effective problem solvers. Other caregivers will often have the most practical solutions, as well.

- **Step 7. Practice and coach**
  - This is the opportunity for each NCGV to practice teaching a lesson to someone else and for the Promoter to give advice about the NCGV’s facilitation skills. This helps the NCGVs become familiar and comfortable with the flip charts and the messages. It is a very necessary step since the Promoter will not be able to observe, supervise, and encourage all 12 NCGVs doing their work regularly outside of the NCG meeting.

- **Step 8. Request a commitment to try out the new behaviour**
  - **Ask participants:** Why do you think we ask NCGVs and Neighbour Caregivers to commit to trying out the new behaviour, or to at least take a step towards trying out the behaviour? Why is this important?
  - **Tell participants:** Studies have shown that when someone verbally promises to do something in front of a group, they are much more likely to do it. The facilitation cue for commitment should reflect how people make a promise in the local culture.

### Additional Nurturing Care Group Roles

In previous CG projects, some CGs decided that they would like to have the NCG meetings function like other community committees. This included nominating key positions, keeping notes, etc. In this structure, the following positions were typically seen:

- **President:** this NCGV was the main point of contact with the Promoter when setting up the next meeting. S/He ensured all the NCGVs show up to the meeting and nominated NCGVs to bring materials and supplies as required for the activity. The President served as a liaison with the community leadership and accompanied the NC Promoter when visiting local government entities such as the health centres, local water and sanitation offices, schools, etc.
- **Vice-President:** Assisted the President as needed
- **Secretary:** this NCGV took notes regarding important issues in the community, special recognition, or tasks that need to be followed up on.

It is important to note that the committee structure does NOT change the format of the NCG meeting itself, all elements are still included.

### 4. Activity: Facilitation Cues

- **Tell participants:** Now that we’ve discussed the steps of lessons given in meetings between Promoters and NCGVs, let’s look at the pictures that help Promoters remember the steps.

- **Ask participants:** What are these pictures called? They should answer “facilitation cues”.

- **Before the training, make 5–6 sets of the pictures found in Lesson 9 Handout 2: Facilitation Cues by cutting them into squares but without the numbered step names. Give a set of pictures to each table of participants. Ask the participants to examine the pictures and decide which step in the**
meeting the picture seems to best prompt. Put the pictures in the order just described and shown in Lesson 9 Handout 1. Ask the participants to check their work by referring to Lesson 9 Handout 2.

- Share with participants that if they have good Internet access, they might enjoy viewing at home this interactive presentation on facilitation cues found at http://www.caregroupinfo.org/vids/NCGFacilitation/story.html.

5. **Neighbour Groups as Peer Support Groups**

- Share with participants the following information on the importance of peer support as part of the NCG approach.
  
  o Peer support is an important element in the success of the NCG approach, and we need to be mindful of it and not to take it for granted. NCGVs receive and give one another much needed support at their regular NCG meetings, facilitated by the Promoter.
  
  o This peer support that NCGVs give and receive can be highly rewarding and contributes powerfully to motivation and the desire to stay actively involved. It is key in building new social norms and support for the new behaviours being promoted. This support helps mothers and fathers through major transitions (such as, becoming a parent or a death), joys and sorrows, and all the large and small challenges life and parenthood brings. Peer support also has been shown to prevent depression, and home visits have been found to reduce violence against children. Though the effects of peer support are not easy to separate out from other project interventions and may be difficult to quantify, the power of mother-to-mother and parent-to-parent support should never be underestimated. It is an important ingredient that makes the NCG approach so successful.

6. **Cascading the messages to Neighbour Families at the household level**

- In the original Care Group model, after CGVs received a new lesson from their Promoter they would go out during the next two weeks to every household assigned to them (between 10-15) to share the lesson.
  
  o As an estimate, a home visit takes about a half hour to conduct. If the NCGV has 12 households this would take her approximately six hours every two weeks, or three hours a week. Combined with the time she spends in NCG meetings with her Promoter, she would average four hours per week (eight hours over two weeks).

- **Ask participants:** Why do you think household visits are important? Write their responses on Lesson 9 Flipchart 1. Ask additional questions and fill in items to ensure that the following are covered:
  
  o Welcoming someone into your home promotes a close relationship.
  
  o Being in someone’s home allows the NCGV to observe the effects of the messages she is sharing.

  - In the WV/Uganda project, we will use “Model Family Posters” where the NCGV can mark off specific behaviours that she sees have been adopted within the home (e.g., point of use water treatment, proper storage of water, installation and use of a hand washing station with soap, presence of a clean latrine and a potty for young children’s use, a mat for children to play on to separate them from animal faeces).
- It also gives her an opportunity to check in on the children and see: do they look healthy, happy, and protected?
- It provides a private space for more personal conversations. This includes questions that the mother may have about the lesson but is too timid to share in a group setting but also personal conversations about the mother’s mental health or possible abuse of her or her children.
- Speaking to someone one-on-one is often less intimidating than leading and speaking in front of a group.
- After a NCGV has been fully trained, conducting household visits allows the NCGV to tailor messages and lessons that are most needed for a specific household.
- Also, NCGVs have the opportunity to share behaviour change messages and key practices with others in the home, such as fathers, grandparents and other relatives. This provides a powerful opportunity to support the whole family and to increase family support for the changes we want to promote. For some behaviours, such as installing a latrine, involvement of men will be critical to success.
- However, there could be times that it would be better for the NCGV to call all her households together and share the message at one time. **Ask participants:** When do you think it would be good for a NCGV to conduct a lesson in a group rather than through individual home visits? Answers should include the following:
  - Some lessons require greater engagement of family members, such as WASH lessons requiring the family to invest and build a latrine. In these situations, it may be better to gather all the households together and make a special invitation to the men.
  - As we discussed earlier, when caregivers meet in regular groups it can provide peer support. This is true for groups of neighbour households (Neighbour Groups) as well as for the groups of NCGVs or NCGs.
  - Many of the Education-focused lessons (e.g., from WV’s Go Baby Go project model) are structured for a group of mothers and their children. They practice songs and games which would not be as easy in a household or one-on-one environment.
  - They can be less time intensive for the NCGV.
    - However, we have found that the time to organize a meeting – including finding a time when most people are available and preparing for a full meeting – is often underestimated unless a regular set time for group meetings is established.
- There is flexibility with this model to choose which types of contacts – group meetings or home visits – are the most appropriate for your context and for the outcomes that you wish to achieve in your project. **However, we highly recommend that you prioritize household visits as the standard approach with occasional neighbour group meetings where appropriate based on the content of a lesson.**
  - The lesson plans will provide guidance on which type of visit is most appropriate given the lesson. The lesson plan will indicate whether a group meeting is best, a home visit is best, or if it does not matter which approach is used.
7. **Activity: Delivering a Lesson during a Home Visit**

- *(If the facilitator's project has an established procedure for delivering a lesson during the home visit, you can share that information with participants rather than having them do the activity below.)*

- *Tell participants:* Discuss in your small groups whether or not you would adapt the steps for a home visit and, if so, what you would change. On a piece of paper, list the steps you would use to deliver a lesson during a home visit and post the paper on the wall. Then circulate around the room to see what the other groups decided.

- Discuss how to modify each step with the entire group, as follows.
  - Step 1. Lesson objectives: It probably is important to tell the neighbour household the objectives or topic of the current lesson.
  - Step 2. Game or song: Including either a game or song may depend on the activity. For example, some caregivers will want to learn the hand washing song or the whole household will enjoy the game. Other times, creating a safe and comfortable atmosphere with a little relaxed conversation and greeting everyone in the family might be more beneficial.
  - Step 3. Attendance and troubleshooting: Of course, it would seem a little silly to take attendance with only one household represented. But you would want to know if the caregiver has important news, such as a new pregnancy or birth, and this would be a great time to find out if the caregiver needs a little support and troubleshooting with her attempts to try out new behaviours from previous lessons. Also, you will need to check off on the NG Register that this caregiver’s family has been visited.
  - Step 4. Behaviour change promotion through pictures: Yes, this step should definitely be carried out. In many cases, most of the household, including adults and older children in addition to the NC, will be interested in hearing the story and seeing the pictures from the flip chart.
  - Step 5. Activity (demonstrate and practice the behaviour): Whether this step is carried out will depend on the activity. But, where possible, you should demonstrate the behaviour.
  - Step 6. Discuss potential barriers and solutions: Yes, this step should be carried out, as it can be a very important discussion to have with influential household members for certain behaviours where influencers have a big role in determining whether the behaviour is practiced or not. In addition to discussing barriers, the NCGV can use their eyes and ears to see if there are barriers to adopting behaviours in the home (e.g., having 8 children, not having a latrine).
  - Step 7. Request a commitment to try out the new behaviour: Yes, this step should be carried out. Remember, the commitment can be to take a small action, or first step, towards adopting the new behaviour, such as “I will tell my husband what I have learned and talk with him about building a latrine.” The neighbour caregiver does not have to promise to build the latrine this week, but to take a step towards the goal.

- *If your project is using model family posters, or a similar checklist tool, visually inspecting or asking the NC about the selected behaviours is an important step. Ask participants:* Given your context, when do you think would be the best time to do review the model family poster with the NC?
8. Neighbour Group Meetings

- When it is appropriate, a NCGV may share lessons by calling all her Neighbour Caregivers and their families for a group meeting.

- Refer participants back to Lesson 9 Handout 1: Nurturing Care Group Lesson Steps. Ask: Which of these steps should be included in a Neighbour Group meeting? Do any need to be changed or altered? Ensure that the following points are addressed:
  
  o Step 1. Lesson objectives
    
    ▪ This step would stay the same
  
  o Step 2. Game or song
    
    ▪ This step would stay the same
  
  o Step 3. Attendance and troubleshooting and Important Events
    
    ▪ It is important for the NCGV to note who attends the meeting and keep track of the important events (being tracked by the project) in their household. However, NCGVs are not required to read or write. Therefore, this information is sometimes collected by memory and reported to the Promoter verbally during their next meeting. This is another reason to keep the number of households assigned to a NCGV low so they can more easily remember information about each household.
  
  o Step 4. Behaviour change promotion through pictures
    
    ▪ This step would stay the same
  
  o Step 5. Activity (demonstrate the behaviour)
    
    ▪ This step would stay the same
  
  o Step 6. Discuss potential barriers and solutions
    
    ▪ This step would stay the same
  
  o Step 7. Practice and coach
    
    ▪ We have found this to be an important step. We want to encourage the Neighbour Caregivers to each reach out to her family and friends. Also, when we repeat information, or even better, teach someone else, we are more likely to remember it.
  
  o Step 8. Request a commitment to try out the new behaviour
    
    ▪ This step would stay the same.

9. Adaptation for some early childhood development (ECD) lessons

(Note to Facilitator: This section can be skipped in WV/Ghana since all lessons will focus on WASH and CP where this lesson plan and meeting format will not be used.)

- For some ECD lessons, especially those that promote early child stimulation through learning activities for the child, the approach will need to be altered to better teach caregivers how to engage positively with their child.
• Note: While small children are always welcome at group meetings (especially those who need to be exclusively breastfed!) it is important that, if they are present in the home, they should come to these ECD sessions. These special lessons (drawn from WV’s Go Baby Go Project Model) are specially designed to engage both the caregiver and child.

• Refer participants to Lesson 9 Handout 3: Early Childhood Development Group Meeting Steps and Facilitation Cues so they can follow along and see how much time should be allocated to each step for this type of lesson.

• Let’s look at how these lessons are organized and note how they are different from regular group meetings.
  
  o Step 1. Attendance, troubleshooting and Important Events
    
    ▪ Note who is present at the meeting. Find out if there are any important events to report (births, deaths, new pregnancies or other events tracked by the project).
    
    ▪ During NCG meetings only, discuss any problems NCGVs had teaching the last lesson to caregivers.
    
    ▪ The Promoter also discusses any materials needed for the next meeting and asks NCGVs and caregivers to bring the items needed for the activity. This is particularly important since many of the lessons that promote early child stimulation require caregivers to provide materials to their children (e.g., bottle caps to sort and stack) for that stimulation.
    
    ▪ Ask: Why is this step important? (Answers should include, to monitor who is attending the lesson regularly and who is not, and to help volunteers overcome challenges they may have.)
    
    ▪ During both the NCG meetings and NG meetings, this step should also be used to ask how it went for volunteers and caregivers, trying out the behaviours or taking the actions they committed to last time. This provides an opportunity to troubleshoot any barriers that come up in practicing the new behaviour. In the NG meeting, the NCGV can also ask caregivers to bring any materials needed for the next meeting.
    
  o Note: Steps 2 – 7 below are all considered part of the “First Circle” time.
    
    ▪ During First Circle time in ECD-focused NCG meetings, the NCGVs should sit in a circle with the Promoter. Two of the NCGVs should bring a preschool child with them to the NCG meeting so that certain things that can be demonstrated with the child.
    
    ▪ During First Circle time in NG meetings, caregivers and their children should be seated in a circle with the NCGV as part of the circle. The caregivers and their preschool children should sit on mats (rather than on the ground).
    
  o Step 2: Sing songs (e.g., a national song, a welcome song, a commitment song)
    
    ▪ At the beginning of the First Circle time, the NCGV leads the caregivers in different songs that children or caregivers should learn, such as a national song, welcome
song, and/or commitment song. Usually, the same songs are sung at every meeting for every lesson.

- This is a time to help children get settled and that provides some routine before the other steps in the First Circle take place.

- **Step 5: Give the Caregiver Talk / Story**
  - This caregiver talk or story is used to introduce a particular value that we want caregivers to adopt and to promote in their children (e.g., cooperation, honesty), to introduce a caregiving skill we want caregivers to adopt (e.g., using positive discipline), or to introduce a skill or milestone that children need to develop (e.g., crossing the midline with their hands). The NCG Promoter uses the story with the NCGVs and then the NCGVs – in the NG meeting – teaches the caregivers the same talk or story.
  - Following this talk or story, the NCGV asks caregivers about their current practices, and encourage discussion around the story.

- **Step 6: Explain the skills and milestones covered in the lesson**
  - During this step, the Promoter teaches NCGVs in the NCG meeting (and then NCGVs teach neighbour caregivers (NCs) over the next two weeks) about the skills and milestones that the lesson helps children to develop, and the importance of each. For example, “Playing with blocks or cans stimulates young children to imagine, plan, discover, invent, problem solve, and build through active play.”
  - NCGVs then caregivers also learn during this step about a new Learning Station Activity, such as nesting two then three cans, and the types of skills that the particular activity can help children achieve (e.g., logical thinking, scientific thinking, social skills).

- **Step 7: Introduce the new Learning Station Materials**
  - During this step the Promoter teaches the NCGVs and then the NCGVs teach the caregivers new Learning Station Activities – such as how to teach children how to teach children to nest and stack cans – using the new Learning Station Materials (e.g., cans) needed for the activity. There are specific steps in the curricula that help caregivers to teach children the new skill more easily.

- **Step 8: Learning Station Time (children use stations)**
  - During this 30 to 60-minute period, caregivers can visit several “Learning Stations” that have different toys and materials that caregivers can use with children to help them develop new skills. The Learning Stations are set up on different mats (e.g., used commodity bags). Children should be encouraged to play with toys and materials at several different stations during this time period, but all caregivers should try to visit the new featured station with the learning materials that were just introduced. Caregivers and the ECGVs can “point” children to specific stations to try to help them to develop new skills and milestones appropriate for their age and development, but children should not (and really cannot) be forced to play with certain ones. The stations are added gradually over the course of the project, one
per ECD-focused lesson until all have been added. If possible, budget to give one set of these Learning Station Materials (LSMs) to each NCGV and to each NCG Promoter. If not, have the NCGVs and Promoters find or make the materials they need. Some of the materials and toys that will be available at these learning stations include:

- Chalk and Chalkboard (for drawing and writing). Smooth sitting stools often make great boards for writing, as well.
- Aluminium Cans in different sizes (for stacking, nesting, and measuring)
- Number Rods and Number Cards/Tiles (1-10, for learning to count, add, subtract, and to learn numerals)
- A set of Alphabet and Number Cards with pictures (to build vocabulary, to learn letter sounds, to learn how letters are made). These are often more expensive but can be made locally.
- Objects for Sorting (e.g., bottle caps, coloured yarn) and containers to sort objects into (e.g., cups, bowls, or cans).
- Rattle, Rhythm Bucket and Streamer (for dance, learning rhythm, dramatic play, etc.)
- Jump Rope (to encourage physical development)
- An obstacle course (made from large baskets, empty maize sacks, sticks, etc., to encourage physical development).
- Several large picture reading books (these are the most expensive but may be available in some areas for borrowing).
o Step 9: Clean up time
  - Children and caregivers are encouraged to help pick up the Learning Station Materials after the Learning Station time. Caregivers should help clean them off with soap and water or a chlorine spray.

o Step 10: Give homework (instructions, barriers, solutions, and commitments)
  - If children only practice with Learning Station Materials, sing, and do other activities during the First Teachers Group meetings, they will not have enough time to gain many skills. Remember, we are teaching caregivers how to be the best early teachers of their children. For that reason, caregivers are assigned activities to do with their children following each meeting. In addition to the instructions, caregivers discuss barriers they may have to doing the homework, solutions to those problems, and then make commitments on what they can do at home to continue the learning.
    - For example, the homework for nesting cans is, “Caregivers should use bowls, cups, or pots at home to help the child practice the nesting/stacking/measuring activity with children—anything that is smaller than another object can be used, as long as it is not easily swallowed.”

o Step 11: Goodbye and tell children goodbye.
All children should be encouraged to tell the NCGV goodbye using an appropriate method for the local context (e.g., shaking hands, hugging) and also to say goodbye to one another at the end of the meeting. This is the last step in the meeting.

- Review the facilitation cues for the ECD-focused lessons and note the differences from the traditional meeting facilitation cues.

10. Bi-Monthly Meeting between Supervisors and Promoters

- Tell participants: Now that we have reviewed in detail what takes place during the meetings between Promoters and NCGVs and between NCGVs and Neighbour Caregivers, let’s take a bit of time to look into what happens during the training meeting between the Supervisors and their Promoters.
- Ask participants to review Lesson 9 Handout 4: Structure for Training Meetings held every two weeks and Lesson 9 Handout 5: Example Agenda for Training Meetings held every two weeks. Ask participants to identify the similarities and differences between this type of meeting and the meetings between Promoters and NCGVs.

11. Wrap Up

- Wrap up this lesson by reminding the participants that they should choose learning opportunities that require participants to actively engage in the learning process by talking to each other, practicing activities, playing games, laughing, singing, discussing and reflecting on the information. Whatever their role as a teacher or facilitator, they must always remember to be intentional about how they teach others. A successful training is one where the participants learn by discovering things on their own and by learning from their colleagues as well as from the facilitator. If the only person they hear from is the facilitator, a great learning opportunity will be lost.
- When preparing a training meeting or the next NCG training, always plan for and encourage interaction and discussion among participants and be mindful of the importance of modelling good participatory training skills.
## Lesson 9 Handout 1: Nurturing Care Group Lesson Steps

<table>
<thead>
<tr>
<th>Step #</th>
<th>Step name</th>
<th>Time Allocated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Lesson objectives</td>
<td>5 minutes</td>
</tr>
<tr>
<td>2</td>
<td>Game or song</td>
<td>5 minutes</td>
</tr>
<tr>
<td>3</td>
<td>Attendance, troubleshooting and important events</td>
<td>5 minutes</td>
</tr>
<tr>
<td>4</td>
<td>Behaviour change promotion through pictures</td>
<td>30 minutes</td>
</tr>
<tr>
<td>5</td>
<td>Activity (demonstrate the behaviour)</td>
<td>15–30 minutes</td>
</tr>
<tr>
<td>6</td>
<td>Discuss potential barriers and solutions</td>
<td>15 minutes</td>
</tr>
<tr>
<td>7</td>
<td>Practice and coach</td>
<td>20 minutes</td>
</tr>
<tr>
<td>8</td>
<td>Request a commitment to try out the new behaviour</td>
<td>10 minutes</td>
</tr>
</tbody>
</table>

**Total time:** 2 hours or less
Lesson 9 Handout 2: Facilitation Cues

1. Objectives

2. Game or song

3. Attendance and troubleshooting

4. Behaviour change promotion through pictures

5. Activity

6. Discuss barriers and solutions

7. Practice and Coach

8. Ask for a commitment
Lesson 9 Handout 3: Early Child Education Group Meeting Steps and Facilitation Cues

<table>
<thead>
<tr>
<th>Step #</th>
<th>Step name</th>
<th>Time Allocated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Attendance, troubleshooting and important events</td>
<td>10 minutes</td>
</tr>
<tr>
<td>2</td>
<td>First Circle time</td>
<td>(~20-30 mins for steps below)</td>
</tr>
<tr>
<td></td>
<td>Singing: national song, welcome song, or commitment songs</td>
<td>5 mins</td>
</tr>
<tr>
<td></td>
<td>Caregiver Talk / Story</td>
<td>~10 mins</td>
</tr>
<tr>
<td></td>
<td>Explaining the skills and milestones covered in lesson</td>
<td>~5 mins</td>
</tr>
<tr>
<td>3</td>
<td>Introducing new Learning Station Materials</td>
<td>~10 mins</td>
</tr>
<tr>
<td>4</td>
<td>Learning Station Time (children use stations)</td>
<td>30-60 mins</td>
</tr>
<tr>
<td>4</td>
<td>Clean up Time</td>
<td>3 mins</td>
</tr>
<tr>
<td></td>
<td>Homework (instructions, barriers, solutions, commitments)</td>
<td>~10 minutes</td>
</tr>
<tr>
<td>6</td>
<td>Goodbyes</td>
<td>~15 minutes</td>
</tr>
</tbody>
</table>

**Total time:** 2 hours or less
Facilitation Cues for Early Child Education-focused Lessons

Attendance and Trouble Shooting

1. Singing

1. Ask

1. Explain

1. Introduce

Learning Station Time

1. Clean Up Time
Discuss Barriers

Request Commitments

Brainstorm Solutions

Goodbyes
Lesson 9 Handout 4: Structure for Training Meetings held every two weeks

What are the objectives?
- To encourage and improve Promoters’ work
- To review this month’s health lesson
- To discuss troubles or problems Promoters have encountered
- To coach and mentor the Promoters, giving them the ability to overcome these problems
- To alert the Promoters to upcoming program events
- To gather NCG meeting attendance and vital information from the Promoters’ last meetings with the NCGVs.

Who attends?
- The Supervisor and his/her Promoters

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

How often does this meeting happen?
- Twice per month ideally (this will vary from program to program)

How long are these meetings?
- The meeting lasts about 4-6 hours (length will vary)
- The Supervisor should be mindful to be well organized and prepared so that the meeting will make good use of the Promoters’ time (some must travel great distances)
- Some Promoters may have to arrive the day before and return home the day after

What is the cost?
- Refer to your staff budget
- A day-long meeting might include lunch (if budgeted)

What should the Supervisor bring?
- Flip chart for this month’s health lesson and lesson plans
- Any teaching materials that could help improve the Promoters’ supportive supervision and facilitation skills
• A schedule of upcoming program information
• His/her work plan for the next month
• Regional monthly report form (to be filled out during the meeting by getting information from the Promoters)

**What should the Promoter bring?**
• Flip chart for this month’s health lesson and lesson plans
• Attendance registers from their last meetings
• Quality improvement and verification checklists (QIVCs) used in the last month
• Completed monthly report from their last meetings
• Their work plans for the next month
**Lesson 9 Handout 5: Example Agenda for Training Meeting held every two weeks**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Objective</th>
<th>Ideas/Materials/Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Devotional or Reflection (30 minutes)</strong></td>
<td>To strengthen and encourage Promoters To orient Promoters to a worldview that facilitates development.</td>
<td>Devotional Materials Invite leaders religious leaders to facilitate this part of the meeting (be sure to give them a strict time limit).</td>
</tr>
<tr>
<td><strong>2. Review of the flip chart lesson (20 minutes)</strong></td>
<td>To reinforce key health practices To reinforce activities that accompany the teaching of the lesson</td>
<td>Use the lesson plan template to help you remember each part of the lesson, including the game, discussion of barriers and activity. Demonstrate/model the teaching of the entire lesson.</td>
</tr>
<tr>
<td><strong>3. Practice and coaching (1 hour – 1 hour 30 minutes)</strong></td>
<td>To ensure Promoters are able to teach the lessons effectively</td>
<td>Break up the Promoters into pairs so they can teach the lessons to each other while the Supervisor observes and coaches them.</td>
</tr>
<tr>
<td><strong>4. Optional: Skill building (30 minutes)</strong></td>
<td>Continuous improvement and learning on supportive supervision, QIVC feedback, facilitation and adult learning</td>
<td>Supervisors can pull individual lessons from this manual, the TOPS “Make me a Change Agent” toolkit, or others to improve the Promoters’ skills in delivering messages.</td>
</tr>
<tr>
<td><strong>5. Collect and review Promoter reports (20 minutes)</strong></td>
<td>To gather information on important events and attendance for quarterly reports To meet monthly and quarterly targets</td>
<td>Promoters fill out the report using their completed registers. Registers track attendance, important events and other key program elements. (Registers that are made with carbon copies can allow the Promoter to turn in one copy of their report to the Supervisor and retain a copy for their own records.) The Supervisor and the Promoters create a community- or district-level report.</td>
</tr>
<tr>
<td><strong>6. Discuss solutions to problems that have arisen (30 minutes)</strong></td>
<td>To help staff overcome problems, such as poor attendance or important events that need intervention (e.g., Cholera outbreak)</td>
<td>Discuss good things that are happening, as well as the challenges. Work together to solve challenges and find a way forward.</td>
</tr>
<tr>
<td><strong>7. Discuss plans for upcoming community or organization events (20 minutes)</strong></td>
<td>To prepare staff and the community for upcoming events To ensure that no other events are planned that conflict with activities</td>
<td>Consider possible problems that could arise during these events. Work with the Promoters to create plans to overcome these problems. If a time conflict is found, work together to reschedule events, if possible.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>Objective</th>
<th>Ideas/Materials/Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Review of Promoters’ four-week work plan (5 minutes)</td>
<td>To ensure that Promoters are preparing all of their given activities and are scheduling them in advance</td>
<td>Promoter share the four-week work plan, prepared in advance. The Supervisor makes a copy of the work plan to have on file for him/herself.</td>
</tr>
<tr>
<td>9. Supportive supervision scheduling (5 minutes)</td>
<td>To let each Promoter know when the Supervisor will come for a planned visit</td>
<td>The Supervisor informs the Promoters of when they will receive their scheduled visit over the next month. Ensure both the Promoters and the Supervisor note the visit time and place.</td>
</tr>
</tbody>
</table>
Lesson 10: Home Visits: The Audience, Timing and Content

Achievement-Based Objectives
By the end of this lesson participants will have:

- Reviewed the Nurturing Care Group Volunteer (NCGV) role and responsibilities and pointed out the expectations related to home visits
- Defined the purpose of the home visit
- Identified the audiences and timeframes for a home visit
- Listed the qualities of an effective home visit
- Listed the components of the home visit
- Practiced conducting a home visit using previously learned communication skills and the steps in negotiated behaviour change
- Identified households that require special attention and ways to help

Duration
3 hours and 30 minutes

Materials Needed
- Lesson 7 Handout 2: Nurturing Care Group Team Essential Responsibilities
- Lesson 10 Flip Chart 1: Purpose of a Home Visit
- Lesson 10 Handout 1: Purpose of a Home Visit
- Lesson 10 Flip Chart 2: Qualities of an Effective Home Visit
- Lesson 10 Handout 2: Role Play: Steps in a Home Visit using the Negotiated Behaviour Change Process
- Lesson 10 Handout 3: Steps in a Home Visit
- Lesson 10 Flip Chart 3: Difficulties in Conducting Home Visits
- Lesson 10 Handout 4: Home Visit Role Play Scenarios
- Lesson 10 Handout 5: Model Family Poster Example
- Lesson 10 Handout 6: Household Vulnerability Assessment
- Lesson 10 Handout 7: Barriers faced by those living with disabilities
- Lesson 10 Handout 8: Newborn Survival
- Lesson 10: Handout 9: Newborn Survival Checklist
- Flip chart paper and markers

Facilitator’s Notes
Step 4 is a role play using the script in Lesson 10 Handout 2: Role Play Dialogue: Showing Steps in a Home Visit using the Negotiated Behaviour Change Process. The role play requires three participants. If there are only one or two facilitators, enlist the help of as many participants as necessary to carry out
the role play. Choose the participants and provide them with the role play handout ahead of time to give them an opportunity to practice.

**Steps**

1. **Introduction**

   - **Ask participants**: If we only hold monthly Neighbour Group meetings with mothers, how many mothers do you think will adopt the new behaviour? They should answer, not very many.

   - **Ask participants**: Why do you think not many mothers will change their behaviours after participating in a Neighbour Group meeting that is once a month? They should give answers like, because they will encounter difficulties when they try the behaviour at home, maybe they will forget or maybe they are not really convinced.

   - Explain to participants that in most programs as part of their responsibilities, NCGVs conduct home visits to their Neighbour Caregivers (NC). Home visits allow NCGVs to see if the NC are practicing the behaviour(s) and to provide support if NC are encountering problems.

   - Refer participants back to the section on NCGVs in **Lesson 7 Handout 2: Care Group Team Essential Responsibilities** and ask them to recall the frequency of home visits. “Visit 10 Neighbour Caregivers and their families at least twice a month to promote behaviour change using an education flip chart.”

2. **Purpose of a Home Visit**

   - **Ask participants**: What do you think is the purpose of a home visit?

   - Brainstorm potential answers with the participants for about 5 minutes and write their ideas on **Lesson 10 Flip Chart 1: Purpose of a Home Visit**.

   - Refer participants to **Lesson 10 Handout 1: Purpose of a Home Visit**. Compare and contrast the information on the handout with what participants listed on **Lesson 10 Flip Chart 1**.

   - Tell participants that it is the job of the Promoter to help NCGVs conduct effective home visits, during which caregivers are strongly encouraged and assisted to adopt the new behaviours. This is what makes the CG approach more effective than other approaches (and will hopefully make the NCG project model more effective, as well). The Promoter will join NCGVs from time to time on a home visit and use a quality assurance tool called a quality improvement and verification checklist (QIVC) to help make the home visit be as effective as possible.

3. **Qualities of an Effective Home Visit**

   - **Ask participants**: Have any of you ever been visited at home by a community health volunteer, visiting nurse, social worker, church member or other such community leader? Thinking about one such home visit, how did you feel about it? Was it a positive experience? What made it positive? How did the person doing the visit act? (Skip these questions if no participant has experienced a home visit.)
• **Ask participants** to brainstorm the qualities of a good home visit. List them on **Lesson 10 Flip Chart 2: Qualities of an Effective Home Visit**. The list should include the signs of respect discussed earlier, such as:
  - Show respect by calling the caregiver/parent by name.
  - Ask if the time of the visit is convenient.
  - Ask about the welfare of family members.
  - Be culturally sensitive.
  - Provide context-specific information.
  - Show interest in understanding the caregiver’s particular situation.
  - Do not be intrusive.
  - Be patient.

• Explain to participants that NCGVs should show all these signs of respect to make the home visit as successful as possible and to increase the chances that the mother will try the new behaviours.

4. **Who should the NCGV speak with during a Home Visit?**

• The NCGV must meet with the primary caregiver. However, we know that families are complex and the decisions that they make about health and how to raise children are also complex. Depending on an individual family, many people may have influence over the decision to practice a behaviour. This includes fathers, but also parents, in-laws, sisters, etc.

• There may also be young men and women in the home who will be starting their own families soon. This is a powerful opportunity to form them as future parents. In some CG projects, daughters attended over half of all home visits by the volunteer. We hope to have more fathers and boys attending, as well.

• One advantage of using neighbours as NCGVs is that they are aware of some of the family dynamics around them.

• NCGVs should schedule her home visit during a time when the most influencers are available. This means they may need to visit in the early morning, late afternoon or on the weekends.
  - Note: If, in the context of your project, fathers (or other influencers) do not arrive back to the household until after dark, it could create a safety issue for the volunteer. The safety and security of the NCGV must always come first! In this case, the volunteer may want to consider other safer times to visit when the father or other influencer is present, such as a weekend.

• Certain lessons may have topics that a woman feels less comfortable discussing with her husband present. Or, the caregiver may be hesitant to talk about some of the barriers in front of someone in their family, such as a mother-in-law. The NCGV should be sensitive to this. Consider sharing messages with a wider household group and then having a more personal conversation with the primary caregiver one-on-one.
5. Role Play: Steps in an Effective Home Visit

- Explain to participants that you now will look at how a home visit should be conducted. The facilitators will demonstrate a simple home visit through a role play using a script provided in this lesson. The role play will include the steps in negotiated behaviour change participants learned about in Lesson 9: Behaviour Change and Nurturing Care Groups: What Happens in a Nurturing Care Group Meeting, Neighbour Group Meeting and Home Visit. The participants will observe and try to identify the different elements.

- Use Lesson 10 Handout 2: Role Play: Steps in a Home Visit using the Negotiated Behaviour Change Process to conduct the role play. Ask participants to be mindful of the negotiated behaviour change steps they observe.

- After the role play, ask participants to name the negotiated behaviour change steps they observed. List these on a flip chart.

- Ask participants: What did you observe in this home visit that is different from the typical home visit? Point out that this role play focused on promoting behaviour change through negotiated behaviour change.

- The facilitator will then refer participants to Lesson 10 Handout 3: Steps in a Home Visit and ask them to identify which of the steps in the process correspond to the steps in negotiated behaviour change they learned about in Lesson 8. They should identify steps 5–10.

- Ask participants: Can you foresee any difficulties the NCVs might have in conducting a home visit like this? What might these difficulties be?

6. Model Family Posters

- Distribute Lesson 10 Handout 5: Model Family Poster Example and highlight the following.
  - This is an example of a Model Family Poster developed for a Care Group project that was carried out in the Sofala Province of Mozambique.
  - Each Model Family Poster needs to be adapted to include specific and observable nurturing care behaviours that will contribute to a reduction in child malnutrition and deaths, to better child protection, to improved attainment of developmental milestones, or to another improvement in child wellbeing.
  - Behaviours should also be economically feasible for most families in the communities where the poster is being used.
  - Select behaviours that can be measured by visual observation during a household visit only. For example, you may want to include exclusive breastfeeding as a "key model family behaviour" but exclusive breastfeeding cannot be observed in a household visit. A latrine with a lid and roof can be observed in a household visit. Although the lid and roof may not always be there, we can say at the time of the visit if there was a latrine with a lid and roof.
  - The objective of the Model Family Poster is to measure behaviours rather than knowledge or attitudes. In many projects people learn many things but do not put into practice what they have learned.
Jesus loved and cared for the most vulnerable
Christians, and people of other faiths, have a responsibility to care for the poor and vulnerable. Jesus spoke often about caring for the poor, orphan, and the widows. More importantly, his actions exhibited mercy and love—often on those who society loved and valued the least. If a Christian’s goal is to look as much like Christ as possible, then we need to love those whom he loved.

How many examples can you recall about when Jesus cared for the most vulnerable?

The Model Family Poster is designed to motivate people to take action, and to help track adoption of behaviours.

After a particular module is taught urging families to adopt a particular element in the Model Family Poster, the poster can be used to remind parents which things they should be doing.

Once it is done, the volunteer circles Yes on the poster. The project staff can set criteria for when a family will be called a Model Family (e.g., completion of 6 of the 8 components or 8 of the 8) and a small ceremony can be done in the Neighbour Circle or at the community level to celebrate the accomplishment of the families that have achieved that status.

This poster was designed for a health and nutrition project. Ask participants: what behaviours could we add to align it with Nurturing Care, or a particular sector, such as WASH?

[NOTE: For the WV/Ghana training, work with the participants to decide what can go on a WASH/CP Model Family Poster. They will need to see if they have budget for this.]

7. Households that need extra attention: the most vulnerable

Within any community, there will be those who are the most vulnerable. Ask the participants: What are some of the things that would make a household more vulnerable than others? Write their responses on a flip chart.

The Go Baby Go! project created a vulnerability assessment to help identify those family most in need of support. Distribute Lesson 10 Handout 6: Household Vulnerability Assessment and give participants 5-10 minutes to read through it silently.

Ask participants: How does our list compare with the vulnerability assessment tool?

People and families may move in and out of “vulnerability”. There are often times in our lives when we need more help than other times. Therefore, the assessment should not be something that is only done one time. Consider having Promoters do this assessment at the beginning of the project and then every six months. (This can be done on a rotating basis.) The results should be shared with the NCGV and appropriate referrals made.

For the most vulnerable households, it is important that the NCGV conduct a household visit at least once every two weeks, regardless of the lesson, and to try to visit these households more often than other less vulnerable households. For example, if the scheduled lesson is about household latrines and the recommendation is for a neighbour group meeting, the NCGV should conduct the group meeting and ALSO do home visits for those households who are most vulnerable.

8. Households that need extra attention: those living with disabilities
Every child is valued and loved by God
God loves every child because God created every child. Every child has unique gifts. God sees potential in every person, regardless of how society views someone.

Consider Psalm 139: 13-16
For you created my inmost being; you knit me together in my mother’s womb. I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well. My frame was not hidden from you when I was made in the secret place, when I was woven together in the depths of the earth. Your eyes saw my unformed body; all the days ordained for me were written in your book before one of them came to be.

What does this teach us about God’s love for every person God created? What then should be our response?

- Explain to participants: Many NCGVs will encounter children with disabilities in the families they visit. It’s important that they are alert to special issues these children may face in accessing services. It’s also important they recognize stigma the children encounter, sometimes even in their own families, and are able to address this.

- In this activity, participants are going to examine disability by looking at the types of barriers they face in the community.
  - Divide participants in pairs and ask them to think about a child (preferably) or adult they know who has a disability. Then they will interview each other using the following two questions:
    - What challenges does the person experience in their daily life?
    - What gifts and assets does the person bring to the community?
  - After 10 minutes bring everyone back to the larger group, ask two to three participants to share what they learned from their partner.

- Distribute Lesson 10 Handout 7: Barriers faced by those living with disabilities. Have a participant read each of the three types of barriers that exist in the community for persons with disabilities. After each one, ask participants to think about the person they discussed in the interview (#1). Did they learn something new about what the person might be experiencing?

- Discuss this statement: Children with disabilities require all of the same things as other children (health, nutrition, nurturing, sensitive and responsive caregiving, etc.) plus a little extra support.
  - As with any baby, we need to see the baby first as a unique, valuable person for who they are.

- Now, let’s look at ways to help access support for children and household members with disabilities. As a group, start a list of services where children with disabilities can be referred for further support (e.g. Primary Health Clinic). Write the responses on a flip chart.

If the NCGV, Promoter or other project staff are concerned about the child’s development, and thinks a childhood disability may be present, the Promoter may choose to reference the information called: Including a Baby with a Childhood Disability (developed by Noah’s Ark) found in the GBG Appendix (Appendix O). This information is not to be used to diagnose, but rather to assist Facilitators in understanding when a child might have a disability, and therefore needs to be referred to a health care provider.
9. **Households that need extra attention: pregnant women**

- For NCGVs with pregnant women in their Neighbour Group, they should spend extra time with the pregnant woman during the household visit. Regardless of the behaviours promoted in a particular NCG project, in addition to the planned lesson, the NCGV should review:
  - Danger signs during pregnancy;
  - Ask if the new mother has gone for all of the recommended pre-natal check-ups; and
  - How much the new mother is eating and the importance of eating a variety of foods.

10. **Households that need extra attention: newborns and their mothers**

- Directly after birth and the first few days of a child’s life is a critical time in the life of a mother and child. Direct participants to **Lesson 10 Handout 8: Newborn Survival**.
  
  Refer to the first graph, “Causes of Neonatal Deaths” and highlight the following:
  - Nearly 40% of all deaths of children under five years old occur in the first 28 days of life (the neonatal or newborn period).
  - Just three causes – infections, asphyxia, and preterm birth – together account for nearly 80% of these deaths.
  - Additionally, a baby born with low birth weight, particularly if preterm, is at much greater risk of dying or getting sick than other newborns.

  Refer to the second graph, “Daily risk of death during the first month of life”
  - Three-quarters of all neonatal deaths occur during the first week of life, 25–45% in the first 24 hours (9) (Figure 3). This is also the period when most maternal deaths occur. This is just as important for WASH-focused NCG project as those that focus more on Health and Nutrition! Handwashing with soap, for example, can help prevent many neonatal and maternal deaths.

- **Ask participants:** Given this information, how should our project respond? Answer: we can have NCGVs check in on new mothers and their newborn children.

- NCGVs can have a dramatic impact in the life of a new mother and her newborn child. Once a woman in her Neighbour Group has given birth, we recommend that the NCGV visit:
  - Every day in the 1st week of life;
  - Visit three times in the 2nd week;
  - Visit twice a week in the 3rd week;
  - Visit once in the 4th week.

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If, in your project area, there is a system for regular post-partum and neonatal visits, the NCGV should accompany the health worker. If there is a system, but the health workers do not show up at the home, the NCGV should conduct the visit alone and advocate for the woman at the health centre or post.

- Refer participants to Lesson 10: Handout 9: Newborn Survival Checklist. Explain that this checklist is designed to help NCGV remember the danger signs for newborns and to keep track of when she has visited a newborn.

11. Wrap Up

- Wrap up with a discussion about the home visits lesson. Is there anything that surprised you? Do you have any concerns?
Lesson 10 Handout 1: Purpose of a Home Visit

1. Get to know the neighbour caregiver better. Allow time for individual dialogue.
2. Get to know the other members of the family. Engage any influencing groups.
3. Demonstrate to the neighbour caregiver that you (as the Nurturing Care Group Volunteer) care about her as an individual.
4. Learn about the context in which the behaviours will be practiced so you will be better able to suggest ways to overcome obstacles.
5. Check if the neighbour caregiver and/or her family practice the behaviour.
6. Negotiate with the neighbour caregiver about trying the new behaviour. Help her to identify practical ways to overcome any barriers.
Lesson 10 Handout 2: Role Play: Steps in a Home Visit using the Negotiated Behaviour Change Process

Conduct the role play in the order the steps are listed. Read the role play by line, from left to write. If a space in the table is blank, skip to the line under the next role.

<table>
<thead>
<tr>
<th>Step</th>
<th>Care Group Volunteer Name: Rosemary</th>
<th>Neighbour Caregiver Name: Mary</th>
<th>Mother-in-Law Name: Fancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Greet the neighbour caregiver in a friendly manner and introduce yourself to/greet the head of household if the person is present.</td>
<td>Good morning, Mary. How are you doing? Did you remember that I was going to visit you today?</td>
<td>Hi, Rosemary. Yes, I remembered. Welcome. Come in.</td>
</tr>
<tr>
<td></td>
<td>How is your husband? Is he here now?</td>
<td>Oh, he’s fine. But he’s at work now.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Please tell him I said hello.</td>
<td>OK, I will. Thanks.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Ask if other members of the family are present who might need to participate in the discussion (influencing groups).</td>
<td>Is your mother-in-law at home now? I would like her to join us if she can.</td>
<td>Yes, she’s here. Let me get her.</td>
</tr>
<tr>
<td></td>
<td>(When mother-in-law arrives) Hello, my name is Rosemary and I'm here to talk with Mary about what she can do to keep the family healthy. We have been meeting with other mothers in the neighbourhood these past few months to talk about this. I think your input will be important in this discussion.</td>
<td>Hi, my name is Fancy. Yes, Mary has told me a bit about the meetings. I also think it’s important to talk about ways to keep the family healthy.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Talk with the neighbour caregiver about changes in the health of the children, such as any cases of diarrhoea. If a child is sick, observe the mother and refer the child to the health centre for care, if necessary.</td>
<td>How are Paul and Timothy doing?</td>
<td>Both the kids are doing well now, thanks. But last week Paul had a bout of diarrhoea.</td>
</tr>
<tr>
<td></td>
<td>Hmm, I’m sorry to hear that. Tell me about what happened.</td>
<td>Well, it started on Monday. He had several loose stools for 2 days.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hmm. That sounds serious. What did you do?</td>
<td>Well the first day I didn’t do anything since all children get diarrhoea from time to time. But then he got very weak and I got scared.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What did you do then?</td>
<td>I talked with my husband and we decided to wait another day to see what would happen.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I see. During this time, what were you giving Paul to eat and drink?</td>
<td>Well, I remembered the lesson, so I prepared the oral rehydration solution and gave that to him. I also encouraged him to eat. But he refused.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I am so pleased you prepared the oral rehydration solution.</td>
<td>As I said, even though I gave him the oral rehydration solution.</td>
<td></td>
</tr>
<tr>
<td>Step</td>
<td>Care Group Volunteer Name: Rosemary</td>
<td>Neighbour Caregiver Name: Mary</td>
<td>Mother-in-Law Name: Fancy</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td></td>
<td>It’s also important that children with diarrhoea continue to eat. Then what happened?</td>
<td>solution because he wasn’t eating and the diarrhoea continued, he got very weak. On the third day we finally decided to take him to the clinic where they gave him some medicine and he got better quickly.</td>
<td>Well, I wish we had taken Paul to the clinic sooner, like after the first day. The clinic is fairly close. But my son didn’t approve.</td>
</tr>
<tr>
<td>I am glad you decided to take him to the clinic. How do you feel about that decision, Fancy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Review the key points of the last (prior) home visit or Neighbour Group meeting.</td>
<td>Mary, can you tell me what you remember about the lesson about seeking help at the clinic when a child has diarrhoea?</td>
<td>Hmm. We talked about how dangerous diarrhoea in children can be and that it’s important to go to the clinic. And that’s what we did.</td>
<td></td>
</tr>
<tr>
<td>That’s true. Do you remember what we said about when you should take a sick child to the clinic, as in how quickly?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>That’s right, Fancy. Good memory! If a child passes three loose stools in a day or has blood in the stool, it’s very important to go to the clinic immediately. Waiting at home, even if you are giving oral rehydration solution, can be dangerous. A young child can easily die if the diarrhoea is bad enough.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Ask the mother about her experience trying to practice the new behaviour.</td>
<td>What prevented you from going to the clinic more quickly?</td>
<td>Well my husband thought we should wait. He didn’t think it was that serious.</td>
<td></td>
</tr>
<tr>
<td>6. Listens to/reflect on what the mother says.</td>
<td>Reflecting on Mary’s response: Hmm, I see.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Identify difficulties/obstacles to behaviour adoption, if any, along with the causes of the difficulty.</td>
<td>Well if he doesn’t agree then we can’t go.</td>
<td>Yes, he needs to give Mary the money to buy the medicines.</td>
<td></td>
</tr>
<tr>
<td>8. Neighbour caregiver suggests different feasible ways to</td>
<td>I see. So, in the future it would be important to make sure your husband understands how serious diarrhoea in children</td>
<td>I could arrange for you to talk to him.</td>
<td></td>
</tr>
<tr>
<td>Step</td>
<td>Care Group Volunteer Name: Rosemary</td>
<td>Neighbour Caregiver Name: Mary</td>
<td>Mother-in-Law Name: Fancy</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>8.</td>
<td>overcome the obstacles.</td>
<td>can be. How do you think we could help him understand this? What can you do?</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Solicit doable actions: Present options and negotiate with the mother to help her select one that she can try.</td>
<td>Fancy, is there anything you can do?</td>
<td>Well, I could also talk to him about the importance of seeking health care quickly, and if this happens again, I can remind him that we shouldn’t wait. If he doesn’t agree then I will try to convince him.</td>
</tr>
<tr>
<td>10.</td>
<td>The neighbour caregiver agrees to try one or more of the solutions and repeats the agreed-upon action.</td>
<td>Those are all great ideas! Which of these solutions do you want to try?</td>
<td>I will talk to him about the importance of going to the clinic quickly when one of the kids has diarrhoea and what can happen if we wait too long. Fancy, can you help me? Yes, I can help you, for sure.</td>
</tr>
<tr>
<td>11.</td>
<td>Set a date for the follow-up visit.</td>
<td>That sounds like a fine plan. I can also lend you the flip charts from the lesson. When do you think you’ll have time to talk with him?</td>
<td>The picture will help to convince him. I’ll try to do it this week. OK? Yes, that’s fine. Then would it be OK if I passed by the week after next, say 2 weeks from today, to see how things went? Yes, that would be fine. Yes, no problem.</td>
</tr>
<tr>
<td>12.</td>
<td>Congratulate the neighbour caregiver on her good work and thank the neighbour caregiver for making time to talk with her and remind her when you will be coming back for a follow up visit.</td>
<td>Well, Mary, I want you to know that it was great that you remembered to give oral rehydration solution to Paul when he had diarrhoea. That really helped him a lot. Keep up the good work. And I’ll see you 2 weeks from today.</td>
<td>Thanks for the visit, Rosemary. Yes, thanks for including me in the discussion. We look forward to seeing you again.</td>
</tr>
</tbody>
</table>
Lesson 10 Handout 3: Steps in Conducting a Home Visit

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

2. Ask if other members of the family are present who might need to participate in the discussion (influencing groups).

3. Talk with the neighbour caregiver about changes in the health of the children, such as any cases of diarrhoea. If a child is sick, observe the mother and refer the child to the health centre for care, if necessary.

4. Review the key points of the last (prior) home visit or neighbour group meeting.

5. Ask the mother about her experience trying to practice the new behaviour.

6. Listens to/reflect on what the mother says.

7. Identify difficulties/obstacles to behaviour adoption, if any, along with the causes of the difficulty.

8. Discusses with the neighbour caregiver different feasible ways to overcome the obstacles.

9. Recommend/solicit doable actions: Present options and negotiate with the mother to help her select one that she can try.

10. The neighbour caregiver agrees to try one or more of the solutions and repeats the agreed-upon action.

11. Set a date for the follow-up visit.

12. Congratulate the neighbour caregiver on her good work and thank the neighbour caregiver for making time to talk with her and remind her when you will be coming back for a follow up visit.
Lesson 10 Handout 4: Home Visit Role Play Scenarios

1. The mother can’t remember to wash her hands before she prepares food.
2. The caregiver thinks it’s too expensive to buy soap for hand washing.
3. The caregiver doesn’t have easy access to water for hand washing.
4. The caregiver thinks seeking care at a health facility can be expensive.
5. The caregiver thinks the (poor) service at the clinic isn’t worth going there for a child with diarrhoea.
6. The caregiver feels that there is no alternative to spanking a child to get them to behave.
7. The caregiver doesn’t think that ORS will help the child regain health.
8. The caregiver can’t remember how to make ORS.
9. The caregiver says it’s difficult to treat water when chlorine isn’t available in the market.
10. The caregiver can’t remember how to use positive parenting techniques.
11. The caregiver thinks her current water storage container (wide opening) is adequate.
12. The mother says her husband thinks it’s too expensive to buy a jerry can to carry water home in.
### Lesson 10 Handout 5: Model Family Poster Example

<table>
<thead>
<tr>
<th>Model Family Poster</th>
<th>YES</th>
<th>NO</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dries Dishes on a Dish Drying Rack</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Has a Hand Washing Station</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Has a Clean and Protected Water Source</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Maintains yard clean and free of animal faeces</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Has a Rubbish or Composting Pit</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Child Growth Card up-to-date</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Has a Latrine with Roof and Cover for Hole</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Has a Garden with at least 3 Different Vegetables</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>
This is an example of a Model Family Poster developed for the Sofala Province of Mozambique. Each Model Family Poster needs to be adapted to include specific and observable nutrition, sanitation, or caring for sick children behaviours that will contribute to a reduction in child malnutrition and deaths. Behaviours should also be economically feasible in the communities where the poster is being used. Select behaviours that can be measured by visual observation during a household visit only. For example, you may want to include exclusive breastfeeding as a "key model family behaviour", but exclusive breastfeeding cannot be observed in a household visit. A latrine with a lid and roof can be observed in a household visit. Although the lid and roof may not always be there, we can say at the time of the visit if there was a latrine with a lid and roof. The objective of the Model Family Poster is to measure behaviours and not knowledge. In many projects people learn many things but do not put into practice what they have learned. The Model Family Poster is designed to motivate people to take action.

After a particular module is taught urging families to adopt a particular element in the Model Family Poster, the poster can be used to remind parents which things they should be doing. Once it is done, the volunteer circles Yes on the poster. The project staff can set a criterion for when a family will be called a Model Family (e.g., completion of 6 of the 8 components or 8 of the 8) and a small ceremony can be done in the Neighbour Circle or at the community level to celebrate the accomplishment.
Lesson 10 Handout 6: Household Vulnerability Assessment

**GO BABY GO HOUSEHOLD VULNERABILITY ASSESSMENT (SHORT VERSION):**

<table>
<thead>
<tr>
<th>Section 1: Assessment Questions (households with 1 or more children under 3 years of age)</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please note if there is a yes response to any or all of the below this case must be immediately referred to the GBG Supervisor for immediate referral and follow up.</td>
<td></td>
</tr>
<tr>
<td>It is important to note that vulnerability can be fluid, and therefore a household who was not identified as vulnerable during the GBG assessment phase could become vulnerable at any time during program implementation.</td>
<td></td>
</tr>
<tr>
<td>Therefore, this short version of the GBG Household Vulnerability Assessment should be conducted following each home visits. A household with one or more responses on any of the below questions is considered vulnerable, and hence a priority household, and should begin to receive a home visit at least once per month if they are not already.</td>
<td></td>
</tr>
<tr>
<td>Discrimination &amp; psychosocial well-being</td>
<td></td>
</tr>
<tr>
<td>Child is failing to achieve at least 2 developmental milestones expected for their age range (Observe using GBG Developmental Milestone Cards)</td>
<td></td>
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<tr>
<td>Caregiver/ caregivers are showing signs of psychosocial distress/ mental illness (Observe)</td>
<td></td>
</tr>
<tr>
<td>Abusive or Exploitative Relationships</td>
<td></td>
</tr>
<tr>
<td>It is suspected that child is experiencing abuse in any form (physical, emotional, sexual) exploitation, neglect and other forms of violence (Observe)</td>
<td></td>
</tr>
<tr>
<td>Child is deprived of parental care, because of their parents’ destructive behaviour (alcoholism, drug addictions, in prison, sex workers, violence, extreme stress etc.) (via secondary sources)</td>
<td></td>
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<tr>
<td>Extreme Deprivation:</td>
<td></td>
</tr>
<tr>
<td>Child is living with parents/caregivers unable to provide for any of the 5 basic needs of their children (e.g. purchase of clothes and shoes if needed, basic meals, clean water (Observe)</td>
<td></td>
</tr>
<tr>
<td>Child appears to be malnourished, or extremely unwell (Observe)</td>
<td></td>
</tr>
<tr>
<td>Total number of Yes responses in section 1:</td>
<td></td>
</tr>
</tbody>
</table>

**Assessment Questions (households with 1 or more children under 3 years of age)**

A household with more than three Yes responses on any of the below questions is considered a vulnerable, and hence priority household, and should be visited at least once per month if they are not already.

<table>
<thead>
<tr>
<th>Caregivers do not demonstrate any of the following activities during your visit (Yes= does not demonstrate any) (Observe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Hugging or showing affection with child;</td>
</tr>
<tr>
<td>b) Talking, naming, counting/drawing things</td>
</tr>
<tr>
<td>c) Telling stories and speaking in a positive tone with eye contact;</td>
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<tr>
<td>d) Singing songs to the child including lullabies;</td>
</tr>
<tr>
<td>e) Making toys or playing with safe objects</td>
</tr>
<tr>
<td>f) Read books to or looked at picture books with child.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Household is observed to be unsafe (Yes= not meeting the below criteria) (not meeting the below criteria via observation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>n the indoor play space:</td>
</tr>
<tr>
<td>a) Are all poisons, toxic chemicals, alcohol and medicines safely stored where the child cannot reach them</td>
</tr>
<tr>
<td>b) Are harmful objects such as sharp objects, knives, farming equipment stored out of the child’s reach</td>
</tr>
<tr>
<td>c) Are electric wires and electric plug sockets covered (or taped up)</td>
</tr>
<tr>
<td>d) Are sharp edges of furniture covered</td>
</tr>
<tr>
<td>e) Is the play area clean and hygienic and free of animal waste</td>
</tr>
<tr>
<td>f) Is the floor swept and free of small items that could be choked on</td>
</tr>
<tr>
<td>n the outdoor play space:</td>
</tr>
<tr>
<td>b) Is the outdoor play space safe and clean, hygienic</td>
</tr>
<tr>
<td>c) Does the outdoor space have adequate supervision, have shade from sun and access to drinking water</td>
</tr>
<tr>
<td>d) Are any farming implements or sharp objects out of children access</td>
</tr>
<tr>
<td>e) Are all chemicals and toxic materials out of children access</td>
</tr>
</tbody>
</table>

| Parents use physical or emotional punishments (Observe) |

<table>
<thead>
<tr>
<th>Vulnerability to negative impact from a catastrophe or disaster:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children living and/or spending time in an unsafe environment (conflict, vulnerable to natural disaster) (Observe)</td>
</tr>
</tbody>
</table>

Include any contextually appreciate vulnerability or risk criteria here:

| Total number of Yes responses in section 2: |
Lesson 10 Handout 7: Barriers faced by those living with disabilities

- **Attitudinal** barriers are perhaps the most difficult to address. Within traditional belief systems, disabled people are often seen as cursed, having bad luck, not ‘normal’ or worthy. Examples of such barriers may be seen when disabled children are not allowed to participate in a mainstream school simply because they are ‘disabled’, or because their parents do not see value in education for disabled children. Disabled people may be excluded from employment opportunities if an employer considers that having a disabled employee is bad for business. There may be certain expectations of disabled people and how they should behave; e.g. unintelligent, violent, strange, tragic, in need of care, weak, incapable, patient, non-sexual, obedient or submissive.

- **Institutional** barriers are systematic barriers or discrimination for disabled people; e.g. family, religion, education, health and other social services, legal system, employment, political system, or even humanitarian and development agencies. Education and training discrimination can be particularly harmful. Segregated education makes fewer academic demands on pupils, much smaller schools and classes expose them to a more limited range of cultural stimulation and experiences.

- **Environmental** barriers include public transport, housing, building, roads, water points, leisure and recreation facilities, offices, factories, places of worship, communications systems, or access to information. Once alert, it is relatively easy to see the environmental barriers that disabled people face: inaccessible offices, schools, markets, shops, cinemas, toilets; inaccessible public transport; and poor signposting throughout. It is probably less easy to see how barriers in communications systems are disabling for a range of people, particularly those who have hearing or visual impairments.
Lesson 10 Handout 8: Newborn Survival

Causes of Neonatal Deaths\(^{35}\)

Daily risk of death during the first month of life\(^{36}\)

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### Newborn Survival Checklist

#### Home Visit of Newborns during First 30 Days of Life

In the 1st week of life, visit every day; in 2nd week, visit 3 times; in 3rd week, visit twice; in 4th week, visit once.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Child #</th>
<th>1st Week</th>
<th>2nd Week</th>
<th>3rd Week</th>
<th>4th Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Umbilicus red or smells bad</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Yellow skin or eyes, yellow palms of the</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>hands or soles of the feet</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not breastfeed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Low birth weight / premature</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Stiff neck</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Fever or really cold</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Difficulty breathing / Bad cough / Rapid</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>breathing</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Baby</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>I sent urgently to hospital (referral)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>
Lesson 11: The Meeting Schedule

Achievement-Based Objectives

- By the end of this lesson participants will have answered the five key questions related to the different types of training (meetings) that takes place in a Nurturing Care Group (NCG) program.

Duration

1 hour 40 minutes

Materials Needed

- Lesson 11 Flip Chart 1: Behaviour Change Meeting (Learning Event) Table (also serves as the key for the game)
- Lesson 11 Handout 1: Behaviour Change Meeting (Learning Event) Facilitation Responsibilities
- Lesson 11 Flip Chart 2: Behaviour Change Meeting (Learning Event) Table for the Training Puzzle Game (one copy for each team printed on a flip chart)
- Sets of answers to Lesson 11 Flip Chart 2 written on Post-its or index cards (one set of answers for each team)
- Masking tape

Facilitator’s Notes

You will need a large area to play the puzzle game. If necessary, move outside or move chairs away from the centre of the room to give more room. Display Lesson 11 Flip Chart 1: Behaviour Change Meeting (Training Event) Table. Leave this flip chart on the wall for the duration of this lesson.

Steps

1. Introduction

   - Tell participants: We have discussed what the Promoters and NCGVs do to promote new and healthier behaviours among Neighbour Caregivers and reviewed the contents of meetings between Promoters, NCGVs and Neighbour Caregivers. In this lesson we are going to look at the bigger picture and learn about all the different levels of training that need to take place in the Nurturing Care Group program. Specifically, we are going to answer the following questions (while pointing to the Lesson 11 Flip Chart 1):
     - Who is the facilitator?
     - Who is attending the learning event/meeting?
     - How long is the learning event/meeting?
     - How often does the meeting occur?

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37 Many programs refer to these meetings as “trainings”. However, since many people associate remuneration with training, some programs have opted to call them meetings or behaviour change meetings. In these meetings the participants learn about the behaviours to be promoted.
2. **Overview of Nurturing Care Group Meeting Structure**

- Using Lesson 10 Flip Chart 1 as a reference and [Lesson 11 Handout 1: Behaviour Change Meeting (Learning Event) Facilitation Responsibilities](#), answer the questions above for each NCG team member. Explain that all members of the NCG team from the Manager to the NCGV have responsibilities as facilitator and learner.

- Explain that the table is meant only as a guide and that each program will create their own schedule of learning events/meetings.

- Answer any questions from participants.

3. **Activity: Training Puzzle**

- Divide the participants into three or four teams of equal numbers. Post/tape copies of [Lesson 11 Flip Chart 2: Behaviour Change Meeting (Learning Event) Table for the Training Puzzle Game](#) in different places around the room. Give each team a set of the correct responses as found in Lesson 10 Flip Chart 1 written on Post-its or index cards with masking tape, mixed up and faced down. Ask the teams not to turn over the papers until you tell them to begin.

- Have the teams line up, one team member behind the other (so, three or four rows of participants, one row for each team), standing 10–15 feet away from the flip charts that are taped to the wall.

- Tell participants that the object of the game is for each team to complete the flip chart training table correctly by affixing all of the pieces of paper with responses to the table on the flip chart. Only one team member can be up at the team’s training table flip chart at a time affixing a response. Other members of the team can make changes to the flip chart, but only during their turn.

- Once all the teams have finished, note the order they finished and assign points accordingly. Compare each team’s responses to [Lesson 11 Flip Chart 1](#) and determine which team got the most correct responses. Assign 3 (or 4) points to the team with the most correct answers, 2 (or 3) points to the team with the second-highest number of correct answers, and so on. The team with the most points (points for order of completion + points for number of correct responses) wins the game.

4. **Wrap Up**

- Wrap up this lesson by asking participants: What were the most important things you learned during this lesson?
Lesson 11 Flip Chart 1: Behaviour Change Meeting (Learning Event) Table

*This table is meant as a guide. Each program will develop its own schedule.*

<table>
<thead>
<tr>
<th>Facilitator</th>
<th>People in Attendance</th>
<th>Length of the Event</th>
<th>Frequency</th>
<th>Materials</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>Coordinators, Supervisors and Promoters</td>
<td>5–7 days</td>
<td>Before each module distribution</td>
<td>New flip chart and lesson plan</td>
<td>Central location Large enough for the entire Care Group team</td>
</tr>
<tr>
<td>Supervisor</td>
<td>Promoters</td>
<td>½ day</td>
<td>Every 2 weeks or monthly</td>
<td>Review of this week's lesson in the flip chart and lesson plan</td>
<td>Central to the Promoters or in the project office</td>
</tr>
<tr>
<td>Promoters</td>
<td>Nurturing Care Group Volunteers</td>
<td>2 hours</td>
<td>Every 2 weeks or monthly</td>
<td>Flip chart and lesson plan</td>
<td>Typically in the village of the NCGVs</td>
</tr>
<tr>
<td>Nurturing Care Group Volunteers</td>
<td>Neighbour Caregivers</td>
<td>2 hours or less</td>
<td>Every 2 weeks or monthly</td>
<td>Flip chart</td>
<td>In the village near to where the Neighbour Caregivers live</td>
</tr>
</tbody>
</table>
Lesson 11 Handout 1: Behaviour Change Meeting (Learning Event) Facilitation Responsibilities

When the Manager Facilitates

- The Manager conducts a 5- to 7-day meeting for the Coordinators, Supervisors and Promoters to learn each new module before it is introduced to the Nurturing Care Group Volunteers (NCGVs) and Neighbour Caregivers (NC).

- Depending on the level of expertise the Manager has about the topics covered in the module, it may be helpful to invite an experienced community health care provider to co-facilitate the meeting and/or be available to answer questions that arise.

- This meeting includes the technical basis for the module, training on the use of the lesson plan and several days of coaching of and practicing by each Coordinator, Supervisor and Promoter.

- Normally this meeting happens about every 3 months, assuming each module is about six lessons, or before the distribution of each module.

- Inviting personnel who work in the schools, health facilities or other institutions where the Nurturing Care Group (NCG) program is operating to attend the 5- to 7-day module training is an excellent way to promote collaboration between the government/community system and the NCG project. It also equips government and community staff with knowledge and tools to share the same behaviour change practices when community members seek facility services.

- In larger NCG programs, the distances required for staff to travel to bring all the Coordinators, Supervisors and Promoters together may be prohibitive, or there may be too many staff members to run an effective meeting. (It is not recommended to train more than 25 people at one time.) In these cases, the Manager should only train the Coordinators and Supervisors in the module content and then have the Coordinators and Supervisors train the Promoters in their region.

When the Supervisor Facilitates

- The Supervisors review this current lesson with the Promoters every two weeks and spend time coaching them, so they are ready to replicate the lesson with the NCGVs.

- Remember this is the second time the Promoters will receive training on the module. The first training they received was the training by the Manager.

- The trainings held every two weeks are a good place to build the Promoters teaching and facilitation skills. Special emphasis should be given to review positive feedback, supportive supervision and adult learning techniques.
When the Promoter Facilitates

- The Promoters\textsuperscript{38} will teach a new lesson to the NCGVs every two weeks and spend time coaching them, so they are ready to teach others.

- This meeting includes discussion, games, activities and a time for discussing barriers and making commitments. Promoters will repeat with the NCGVs everything that learned from their Supervisor and Manager.

- The materials needed are a flip chart and a lesson plan. The lesson plan is like a teacher’s manual that guides the literate facilitator.

- Examples of detailed lesson plans that give literate staff extensive details about games to play with each lesson, activities to include and the procedure for the facilitator to go through each time she teaches are available at [www.caregroupinfo.org](http://www.caregroupinfo.org).

When the Nurturing Care Group Volunteer Facilitates

- NCGVs teach a new lesson to their Neighbour Caregivers (NC) every 2 weeks.

- Most NCGVs are not literate, so their only tool is the flip chart. However, they will model everything they saw and heard the Promoter say, so it is important that the Promoters model the correct facilitation behaviour during each meeting.

\textsuperscript{38} Note: The term Promoter includes both Promoters who each work with about 5-9 NCGs and are paid by an organization, and also CHWs who have been chosen to play the Promoter role, who work with 2 NCGs each and are not paid.
Lesson 11 Flip Chart 2: Behaviour Change Meeting (Learning Event) Table for the Training Puzzle Game[^39]

<table>
<thead>
<tr>
<th>Facilitator</th>
<th>People Attending</th>
<th>Length of the Event</th>
<th>Frequency</th>
<th>Materials</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promoters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurturing Care Group Volunteers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[^39]: See Lesson 10 Flip Chart 1 for the answers to the puzzle game.
Lesson 12: The Learning Station Materials

[NOTE: There is no need to cover this lesson in the WV/Ghana test of the NCG Project Model. No education lessons will be taught. Remind the participants that there is a lesson on this if they choose to use ECD-focused lessons through NCGs in the future.]

<table>
<thead>
<tr>
<th>Achievement-Based Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>By the end of this lesson participants will have:</td>
</tr>
<tr>
<td>• Identified characteristics of good learning station materials</td>
</tr>
<tr>
<td>• Listed possible learning station materials available in the project area</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 hour 15 minutes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Learning Station Materials that will be used in your NCG project, such as aluminium cans for stacking/nesting, stacking blocks, alphabet/number cards, chalk/chalkboard, items to sort and sorting containers, jump rope, number rods and number tiles, and a rattle, rhythm bucket and streamer.</td>
</tr>
<tr>
<td>• Lesson 12 Handout 1: Desirable Characteristics of Learning Station Materials for NCG Projects</td>
</tr>
<tr>
<td>• Lesson 12 Handout 2: Sample List of Learning Station Materials (LSMs) and their Usage</td>
</tr>
<tr>
<td>• Flip chart paper, markers and masking tape</td>
</tr>
</tbody>
</table>

Facilitator’s Notes

For this lesson, it is important to have at least one set of the Learning Station Materials (LSMs) that will be used in your NCG project. To the greatest extent, these should be able to be made using locally available materials or produced in the country where the project will be implemented (but not necessarily in the project area). Since this lesson is meant to show the types of LSMs that can be used, it is acceptable to import some items that serve as examples of LSMs that will later be produced locally when those items are not available locally at present or are more costly when purchased locally.

Steps

1. Introduction

• Explain to participants: This session further explains how to conduct the Learning Station step in the ECD lessons. For children to develop the skills and milestones needed at each age, they need to be given experiences that help them to develop. Providing children with objects and toys that are designed for learning – or that can be used for learning – is a great way to help children develop skills more quickly.
• In the NCG approach when teaching on ECD, we will call these objects and toys, “Learning Station Materials” or “LSMs” for short. They will be available during “Learning Station Time” which is a 30 to 60-minute session in the middle of the ECD meetings, after the Circle time.

• During this lesson, we will discuss and examine a few of these LSMs. Instructions for how to use each LSM in different ways should be integrated into the lesson plans that the Promoter and NCGV uses. Hesperian Health Guides produced these lesson plans originally for PCI in Tanzania, but they are “open source” lessons available to the public now. Other organizations may wish to contract with Hesperian Health Guides or another organization to produce different lessons that use different LSMs than the ones that we will discuss today.

• Explain to participants: Children need to play with the LSMs. Young children learn literacy, numeracy and other things through play. Play is important for two types of physical development: gross motor development and fine motor development.

  o **Gross** motor development deals with children’s ability to use their large muscles to move in ways that show control, balance, and coordination. Gross motor skills include things like sitting, crawling, walking and running.

  o **Fine** motor development deals with children’s ability to use their small muscles – especially their hands – to perform tasks such as writing, drawing, eating with a spoon and brushing teeth.

• Through play, children practice and perfect the control and coordination of both large and small muscles. Play is also important for healthy brain development. It is through play that very young children learn to engage in – and interact with – the world around them.

• **Ask participants:** During the Learning Station Time, do you think we should assign each child to a particular learning station – like having the first child play with blocks and the second child playing with cards with letters on them – and have them play with that same LSM for 30-60 minutes? Why or why not?

• Explain to participants: Instead of doing this, we recommend that children choose the Learning Stations that they go to, and how long to play at each one. This is called letting the child be “self-directed”. Research has found that children who are allowed more self-directed play time develop longer attention spans.

  o An attention span is the amount of time that a person can concentrate mentally on a particular activity without losing interest. Children who have longer attention spans do better in school.\(^4^0\) For a long time, people thought that a child’s attention span was something that they were born with, like their skin colour. But now we know that how caregivers interact with the child is a key factor in how the child will develop their attention span. A child begins developing an attention span very early on, at around 11 months.

• We want to let children choose the LSMs that they interact with because a child will be able to focus on something for longer if you let him or her play with toys, they are already interested in. We will ask caregivers to try to have their children spend some time with the LSM that was introduced in a

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given lesson, but since all of the LSMs will be available at every meeting after a certain point, there
will be other opportunities for children to use the LSM.

• Explain to participants: Caregivers do not need to play with their children all the time — that would
be impossible! But in the NCG and NGs, we want caregivers to do their best to be truly engaged with
their children, and to let them lead them through the different stations. Also, when they are at
home, caregivers should try to set aside some time to play with their children but giving them
different options for play so that they can continue to develop their attention span.

2. Characteristics of good Learning Station Materials

• Explain to participants: Keep in mind that our NCG project aims to reach as many households as
possible to create community-wide behaviour change. Ideally, the LSMs can be made by community
members using locally available materials. If this is not possible and based on your project budget,
you may consider providing every NCGV and every Promoter a set of these LSMs, so that they are
used by caregivers of preschool children and the children themselves to help them develop skills and
milestones.

• Ask participants: Knowing that, what are some of the characteristics of these LSMs that we should
keep in mind when selecting good ones to use in an ECG project?

  o For example, they probably will need to be low cost since thousands of sets of them will be
    needed. What other characteristics should they have? (Write “low cost” on the flip chart,
    and then add their other responses, probing for the reasons that each characteristic is
    mentioned.)

• Review the other suggested criteria for selecting good LSMs on Lesson 12 Handout 1: Desirable
  Characteristics of Learning Station Materials for ECG Projects. Compare the participants’ list to this
  list.

3. Demonstration of Learning Station Materials

• Now that we have discussed some of the desirable features of Learning Station Materials, let’s look
  at some of these and discuss some ways in which they can be used in an NCG project.

• Show the participants each of the LSMs that you have. Use Lesson 12 Handout 2: Sample List of
  Learning Station Materials (LSMs) and their Usage as you do this. Demonstrate briefly how each
  could be used in an ECG project using the handout.

• Put all of the LSMs on a table and give the participants at least 10 minutes to handle and examine
each of the LSMs and to ask questions about them.

4. Activity: Brainstorming a list of other possible LSMs

• Ask participants: Now that we have discussed some of the desirable features of Learning Station
  Materials, and seen them up close, what are some other types of materials that we could use for
  learning that meet the criteria we mentioned earlier?

• Refer them to Lesson 12 Handout 1, and have participants divide into at least two smaller groups to
  brainstorm some possible LSMs.
• When groups are finished, have each group present their ideas to the plenary.

• Refer to Lesson 12 Handout 1 and check off the characteristics that each new one mentioned fulfils. Talk about ways to have some of the LSM ideas presented meet more of the criteria.

• Explain: We may or may not use some of these in the lesson plans in our NCG project. However, we do plan to include instructions in at least one lesson for the Promoters and NCGVs to create their own learning station materials to use as a regular part of the NCG meeting.

5. Wrap Up

• Ask participants: What do you think the biggest challenge will be for coming up with useful LSMs to use in your program?
Lesson 12 Handout 1: Desirable Characteristics of Learning Station Materials for NCG Projects

1. **Low cost.** The shorter period of time the item can last without replacement, the less expensive it should be.

2. **Durable and long lasting** – is not damaged or destroyed easily after multiple uses by preschool children (who can be tough on things!).

3. **Cleanable, waterproof or water resistant.** Objects that are more likely to be used by younger children and put in their mouths should be able to be cleaned with bleach solution or with soap and water.

4. **Useful for multiple types of exercises**

5. **Useful for exercises appropriate for different ages of children** (0-59m). The full set of LSMs should be useful for helping children to attain skills and milestones for all the different age groups (not all for one age of child).

6. **Lightweight and relatively small** – easy to be picked up and manipulated by younger children (and at least some should be useful for infants who have smaller hands). Should not be a choking hazard if it cannot be used with constant parental supervision. Large enough or designed so that it cannot easily be swallowed. *(Note: The size of a young child's trachea [windpipe or breathing tube] is approximately the size of a drinking straw in diameter. Some smaller things can be adapted to help avoid choking, such as threading beans on a string.) All of the LSMs should fit in a medium-sized (e.g., commodity) bag.*

7. **Stimulating appearance** (e.g., colourful, noisy)

8. **Locally available, or able to be constructed locally (at low cost).**

9. **Used in the past by someone for learning purposes.** Some of the best LSMs may be completely novel – things that no one had thought previously to use for stimulating children’s learning and skill development. However, many of the best ones may also have been used for decades (or centuries) for child learning (e.g., chalk and chalkboard, flashcards, stacking blocks). For example, using alphabet nursery blocks for teaching children were referred to by the English philosopher John Locke more than 300 years ago (in 1693).41

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41 Locke said, “‘There may be dice and play-things, with the letters on them to teach children the alphabet by playing; and twenty other ways may be found, suitable to their particular tempers, to make this kind of learning a sport to them.” (From: https://en.wikipedia.org/wiki/Educational_toy#cite_note-Locke-12)
Lesson 12 Handout 2: Sample List of Learning Station Materials (LSMs) and their Usage

1. **Chalk and Chalkboard**: These can be used for drawing, tracing and writing letters, numbers, bodies, shapes (e.g., circles, triangles), and other purposes.

2. **Aluminium Cans**: These can be used to help children develop gross and fine motor development by nesting the cans (putting one inside of the other), stacking them (to make a tower), measuring liquids and solids (e.g., water, sand) to learn scientific principles, etc. Children can also use these to learn the concepts of bigger and smaller, taller and shorter, wider and narrower, and heavier and lighter.

3. **Number Rods and Number Cards/Tiles**: Children can use these to learn to associate spoken numbers with written numerals, one-to-one correspondence, simple addition and subtracting, etc.

4. **Set of Alphabet and Number Cards with pictures**: Children can use these to build their vocabulary (learn new words), to learn letter sounds, to learn how letters are made, to learn alphabetical order of letters and the order of numbers when counting, and other things. Sometimes people use cards that have sandpaper over the numbers or letters so that children can more easily trace with their finger the outline of letters and numbers.

5. **Objects for Sorting and containers to sort objects into**: Children can use these to learn how to group similar things, and to learn how different objects are similar for a given characteristic (e.g., colour, shape, size).

6. **Rattle, Rhythm Bucket and Streamer**: These can be used to teach children to dance, move with rhythms, to make simple music, to learn how movement affects motion, and for stimulation of infants.

7. **Jump Rope**: A jump rope can be used to encourage physical development. It can be used for jump rope games, as part of an obstacle course (e.g., where children have to step over it), and for dance (e.g., learning to do the “limbo”).

8. **Large picture reading books**: Reading books are used in every First Teachers Group meeting as reading is a priority activity. By seeing books used and hearing adults explain how they are used, children learn orientation to print (e.g., that one begins reading at the top of a page and proceeds down the page, and reads from left to right), how to turn pages, parts of a book (e.g., pages, front and back cover, spine), etc.

9. **Other assorted, expendable items**: Paper, pencils, crayons, string, cardstock, and other materials are not very durable and long-lasting, but if they can be found at low cost, are useful for teaching children how to make crafts, and how to write and draw.

10. **Other “found” materials provided by the caregivers**: These items are not required for any one lesson but may be helpful in creating learning stations. They include clay (for modelling), rocks, dried beans/maize, sticks, bottle caps for sorting/patterns, cooking pots/bowls for nesting, ladies and small wooden spoons, plastic cups, small mortar and pestle, medium-sized plastic basins, buckets, jerry cans, soap/ash/sand, pitchers, and tables/chairs/mats.

11. In addition to these materials, each Promoter and NCGV should have a set of about eight floor mats for children and caregivers to sit on during meetings and during Learning Station Time. These mats can be made of used commodity bags.
Lesson 13: Supportive Supervision: Checklists and Supervisory Work plans

Achievement-Based Objectives

By the end of this lesson participants will have:

- Defined supervision
- Distinguished supportive supervision from supervision
- Reviewed supportive supervision checklists
- Listed the different supportive supervision responsibilities of their position and those they supervise
- Prepared an example 4-week work plan for their position

Duration

2 hours

Materials Needed

- Flip chart paper, masking tape and markers
- Lesson 13 Flip Chart 1: Definition of Supportive Supervision
- Lesson 13 Handouts 1: Supervisor’s Checklist for Supervising a Promoter
- Lesson 13 Handout 2: Coordinator’s Checklist for Supervising a Supervisor
- Lesson 13 Handout 3: Program Manager’s Checklist for Supervising a Coordinator
- Lesson 13 Handout 4: Categories in the Supervisor’s Checklist for Supervising Promoters
- Lesson 13 Handout 5: Supportive Supervision Table
- Lesson 13 Flip Chart 2: Blank Supportive Supervision Table (three or four copies)
- Three or four sets of 12 Post-its/index cards/pieces of paper with supportive supervision table answers written on them
- Lesson 13 Flip Chart 3: Blank Work Plan
- Lesson 13 Handout 6: Activities to Plan
- Lesson 13 Handout 7: Sample Work Plan Schedules

Steps

1. Introduction

- Tell participants: Now that we have discussed the Nurturing Care Group structure, the content of the behaviour change meetings and the schedule, there is another very critical topic that we need to cover. It is the one thing that is always the weak link in a program, especially in government services. What do you think it is? Yes, supervision. We always have the best of intentions when it comes to supervision, but quite often we fail to deliver. In this lesson we are going to be talking about a specific kind of supervision, called supportive supervision.

2. Defining Supervision and Supportive Supervision
• Have participants break into pairs and brainstorm a short definition of supervision. After a few minutes, ask participants to share their definitions. Write on a flip chart key words from each definition shared, then summarize the definitions given.

• **Ask participants**: In what ways is supportive supervision different from regular supervision? Tell participants to discuss again in pairs. After a few minutes, ask several participants to share their ideas.

• Display **Lesson 13 Flip Chart 1: Definition of Supportive Supervision**. Review the definition with participants, highlighting key phrases as noted below.
  
  o It is a continuous process, not a onetime event.
  o It is a planned and designed process.
  o The purpose is to mentor and coach a worker so he/she can effectively accomplish the job.
  o Three things the worker will gain from supportive supervision are: independence, self-confidence and skills.

• **Ask participants** to think about a Supervisor they had and consider the following questions.
  
  o What was it like? Did you receive supportive supervision visits or meet regularly with your Supervisor?
  o Which of these aspects was missing?
  o Do you think you could be a Supervisor who did these things?

• Tell participants: Remember that in order to change others we first have to change ourselves. I would encourage you to put the definition of supportive supervision on the wall of your office and practice doing these things with those you supervise.

3. **Review of Supportive Supervision Checklists**

• Explain that in a Nurturing Care Group (NCG) program using two different types of supervision tools is recommended. One is the supportive supervision checklist and the other is quality improvement and verification checklist (QIVC). Write these on a flip chart. Explain the difference between the two to participants.
  
  o The supportive supervision checklist monitors and supports all aspects of a staff member’s work.
  o The QIVC tracks the quality of a specific task, such as a behaviour change meeting.

• Tell participants: In this lesson we will present the supportive supervision checklist.

• **Ask participants**: For those of you who have supervised field workers before, what are the different things that you need to watch, observe and review on a supportive supervision visit?

• Refer participants to **Lesson 13 Handout 1: Supervisor’s Checklist for Supervising a Promoter**, **Lesson 12 Handout 2: Coordinator’s Checklist for Supervising a Supervisor** and **Lesson 13 Handout 3: Program Manager’s Checklist for Supervising a Coordinator**.
• **Ask participants:** How do these actions compare to the Promoter’s essential responsibilities? Answers should include that these categories should be reflective of the duties presented in Lesson 7: Nurturing Care Group Roles, Responsibilities and Job Descriptions. Refer back to this lesson and discuss if the staff are confused or if they feel that there is any disconnect between the two.

• Each of these checklists is divided into categories. As an example, refer participants to Lesson 13 Handout 4: Categories in The Supervisor’s Checklist for Supervising Promoters. Read the introduction at the top and go over the categories with participants.

• **Ask participants:** Why is it important to have a checklist for supportive supervision visits?
  o A supportive supervision checklist makes it clear what a Supervisor is expected to do when they visit program staff.
  o There are too many tasks for a Supervisor to do in just one supportive supervision visit. The checklist helps the Supervisor remember what he/she did last time and what still needs to be done.
  o Recording behaviours over time helps us to see how we are improving and can provide encouragement to staff. It also helps us to see where there is more room to grow.
  o Supportive supervision checklists help us identify and troubleshoot smaller problems before they become larger issues.

• In summary, during supportive supervision visits the Supervisor should:
  o Watch what staff are doing
  o Look at the reports and registers
  o Talk to the people the staff work with, including Neighbour Caregivers (NC), local community leaders and health centre staff
  o Observe the staff at home

• **Ask participants:** Why is observing the Promoter’s household important? Tell them: If we don’t practice what we are teaching, no one will listen to us. Someone may say that that’s a lot to ask the Promoter. If it’s a lot to ask of the Promoter, then it’s a lot to ask the mother in the community. To be effective facilitators and leaders in the Nurturing Care Group program, staff must practice what they preach by putting into practice what they are learning. Therefore, also ask Promoters if they do the following practices.
  o Do you have mosquito nets in your home and regularly sleep under them?
  o Do you have a hand-washing station with soap near a clean, covered latrine at your home?
  o Do you use positive parenting techniques with your children?
  o Do you use filtered water for drinking?

_Note to facilitators:_ Adjust the example as appropriate or use other examples from your own experience.

“When I visit our project offices in the field, I am always surprised when I go to the latrine and see there is no soap or when I look for a place to wash hands and see that they have no hand washing station in the office compound. I can tell the minute I walk into the compound how the program is doing by the cleanliness and the health actions taken by the leaders of the program.”
• Tell participants: We listen to people we trust who are open about their own lives. We listen to people that have tried the new practices and can tell us personally about them. One of the strengths of the NCG model is that the NCGVs try the new practices first, then share with others their own experience and encourage them to try the new practice, too. If someone comes to you trying to sell something that they do not believe in or have not tried, their arguments will not be effective. In fact, you’ll feel the practice is a waste of time.

4. Supportive Supervision Responsibilities and Work Plans

• Tell participants: Now that we have reviewed all of the checklists, we will look at an overview of the supportive supervision responsibilities of each staff member. To help us remember the key decisions related to supportive supervision, we developed a table.

• Refer participants to Lesson 13 Handout 5: Supportive Supervision Table. Review the sections of the table and answer questions.

• Point out to participants that many of the positions listed in Lesson 13 Handout 5 make surprise supervision visits from time to time.

• Ask participants: What’s the purpose of surprise visits? Listen to their responses, then add the following if not already covered.
  
  o Surprise visits ensure that work is being done appropriately every day and help Supervisors get a sense of the day to day working conditions. Workers can make special preparations for a meeting when they know someone is coming to visit. However, we want our workers to carefully prepare for each and every meeting.
  
  o The working environment of a community worker is unstructured and depends a lot on personal discipline and motivation. Even the best employee may have a rough week and feel tempted to do personal tasks when he/she should be meeting with NCGs or visiting a Promoter. Knowing that surprise visits could occur at any time can provide that additional motivation a community worker needs to accomplish his/her assigned task.
  
  o Surprise visits should be part of routine, standard supportive supervision procedures. Let staff members know this and that no one is being singled out for surprise visits. Many staff members appreciate that their Supervisor takes an interest in their work.

Surprise Visits
Some people have expressed concern about surprise visits, wondering whether it will weaken the relationship between workers and supervisors, giving the impression that workers are not trusted or respected. Food for the Hungry (FH) and other organizations have not had this experience. Surprise visits can help workers remain disciplined about their work and help them avoid rumors that they are not doing their jobs properly. Surprise visits should be random in terms of the choice of the worker the supervisors visit in a given period, thus more equitable in the long run and not based on the level of trust a supervisor has for a given person. If the supervisor is truly practicing supportive supervision, the worker will come to appreciate the visits. Some Promoters have reported that it increases their visibility and status in a community when project leadership come to visit—surprise or scheduled.
• First, explain the Manager’s supportive supervision responsibilities.
  o The Manager supervises the maternal and child health and nutrition Coordinator once or twice each quarter (about once every 6 weeks). The Manager visits the Coordinator in the office while he/she is carrying out all of his/her regular activities.
  o Once per year, the Manager visits one Coordinator without scheduling the visit. This is called a surprise visit.
  o The Manager also observes the bi-monthly meetings led by the Supervisor.
  o The Manager visits the Promoters’ homes and talks with them about the program.
  o The Manager observes the home visits (or Neighbour Group [NG] meetings) and the NCG meetings.
  o Every time the Manager visits the Coordinator, he/she will use the appropriate supportive supervision checklist.
  o The Manager should know how to use the QIVC for behaviour change meeting session feedback and should observe others using it but is not required to use this on his/her visits.

• Next, explain the Coordinator’s responsibilities.
  o The Coordinator supervises each Supervisor once per month. Every third visit is a surprise. Every time he/she supervises the Supervisor, he/she will use the appropriate supportive supervision checklist and the QIVC.
  o The Coordinator supervises the Supervisor in the office to review his/her reporting and filing systems, office supplies, etc., as listed on the supportive supervision checklist.
  o The Coordinator should also observe the meetings held every two weeks by the Supervisor to train Promoters and uses the QIVC for meeting facilitation.
  o The Coordinator visits the Promoters’ homes and talks with them about the program.
  o The Coordinator also observes the home visits (or NG meetings) and NCG meetings.

• Next, explain the Supervisor’s supportive supervision responsibilities.
  o Almost all of the Promoter’s work is done in the community, so 90% of the supervisory observations are done in the community. Every time the Supervisor visits the Promoter, he/she will use the appropriate supportive supervision checklist and the QIVC.
  o The Supervisor supervises each of his/her Promoters two times per month: one scheduled supervisory visit and one surprise visit.
  o The Supervisor supervises his/her Promoters in their homes for that section of the supportive supervision checklist.
  o The Supervisor supervises Promoters as they teach NCGVs, using a QIVC for meeting facilitation to help them improve.
  o The Supervisor sometimes observes home visits (or NG meetings) and NCG meetings. There are other sections on the supportive supervision checklist. The Supervisor also, for instance,
visits the health facility and the community leaders. They should use the checklist to guide them in planning work responsibilities.

- Lastly, explain the Promoter’s supportive supervision responsibilities.
  
  o The Promoter visits NCGVs in their homes. This is the “model” mother in the community, so the Promoter should be able to see by her home and her practices that she is following the things she is teaching. If not, the Promoters need to help her overcome the barriers that she is facing that prevent her from practicing the new behaviours. It is not a requirement to be a Promoter, but Promoters need to really help their NCGVs to try the new behaviours and practice what they teach.

  o The Promoter supervises NCGVs while they conduct home visits and if they are teaching a group then by using the QIVC for meeting facilitation, as they teach NGs. After the observation, the Promoter and NCGV return to the NCGV’s home to give feedback using the QIVC. It is during this home visit that the Promoter also can ask about her nutrition, health and hygiene practices and observe her home.

  o Ideally the Promoter would visit each NCGV once per quarter. If he/she has nine NCGs (the maximum) and if each NCG has 15 NCGVs (the maximum), this would be 135 total supervisory visits per quarter, or 45 supervisory visits per month. In this case she probably will not be able to follow this guidance. If she does two (or sometime three) supervisory visits per day, this would take more than 20 days. But, remember, most Promoters do not have this many volunteers and not all volunteers will need to be supervised this frequently. As we will learn, the better performing NCGVs can be supervised less frequently.

  o Every time the Promoter observes a NCGV teaching in a group setting, he/she should use a QIVC to improve, encourage and monitor the volunteer’s work.

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A Story Illustrating the Value of Inspections

Years ago, a highly trusted worker dipped into the botiquín (community medicine chest) cash to pay for her sick mother’s insulin. She had hoped to pay it back before a routine inspection of the botiquín at the end of the month, but she was not able to return the money in time. As a result, she lost her privileges to handle money for quite a while.

Despite this, there were no hard feelings between her and her employers as she knew the inspection was coming—it was part of the system for all workers who managed the sale of medicines, and she understood the value of the inspection. The inspections (and consequences) were applied equitably, not just to those workers that were trusted the least. Her employer did not treat her with excessive harshness, realizing that she was in a difficult spot with her mother and because she was remorseful. The system worked as designed.
5. **Activity: Work Plans**

- Tell participants: Next we are going to be putting NCG project tasks into a work plan. What is a work plan?
  
  - Very simply, it is a plan that gives details on the tasks that you will be doing over a period of time in the future.
  - All the tasks that are given to you as a worker in the Nurturing Care Group program can seem overwhelming, so planning your time out for a 4-week period helps you to do the work effectively and efficiently.

- Explain what NCG work plans should include:
  
  - Time for gathering and reporting data for monthly or quarterly reports
  - Trainings (those the employee is receiving and conducting)
  - Supportive supervision visits (those the employee is receiving and conducting)
  - Dates of special community events (e.g., vaccination days)
  - Visits to health facilities, government and community leadership and other work-related tasks

- Explain to participants that they will now do an activity to help them learn to use the work plans. Assign each small group one of NCG Team roles (Supervisors in one group and all Coordinators in another.) Managers may visit both groups and help them as they develop a sample work plan.

- Provide each group with a copy of Lesson 13 Flip Chart 23 Blank Work Plan and refer them to Lesson 13 Handout 6: Activities to Plan For. Ask participants to create a work plan schedule on the flip chart using the list of activities in Lesson 13 Handout 6. They should fill up the entire schedule with the activities they know they will participate in. There might be additional activities that each group participates in that are not listed in Lesson 13 Handout 6.

- Remind participants that they are working full time at 8 hours per day and 5 days per week. If an activity takes only 2 hours, they will need to add two or three other activities on that day to reach a full day’s work. Remind them to be realistic about which activities can be done in a given period of time.

- Instruct participants to work on a piece of notebook paper first, then copy their final work plan onto the flip chart. When they are finished, have each group paste its work plan on the wall for everyone to see.

- Visit each group and help them with the work plan. It may take some time for them to organize their responsibilities this way. If one group is faster than other groups, ask them to develop a work plan schedule for the NCGVs. If the participants are having trouble, work through the NCGV schedule together at the front of the room. Once all work plans are posted, have the different groups walk around and appreciate the work of the other groups.

- Use the sample schedules found in Lesson 13 Handout 7: Sample Work Plan Schedules as guides to review and discuss the participants’ work plans.
• Review with participants:
  o When should the Promoter fill out the work plan?
  o How will the Promoter know when the Supervisor is going to come visit him/her for supportive supervision?

6. Wrap Up

• Wrap up by telling participants: Supervision is usually the weak link in most programs and the reason why staff do not feel valued or perform up to standard. Supportive supervision is one of the keys to the success of the Nurturing Care Group approach, so it’s critical that it be done well and on schedule.
Lesson 13 Flip Chart 1: Definition of Supportive Supervision

Note: The following definition should be written in a large font and with noticeable colours on the flip chart, so its importance is clear to participants.

Supportive supervision is an on-going process designed to mentor and coach a worker so he/she gains the independence, self-confidence and skills needed to effectively accomplish the work.
Lesson 13 Handout 1: Supervisor’s Checklist for Supervising a Promoter\textsuperscript{42,43}

Note: Every project will be slightly different. The items listed below are common but not all of them may apply to your project. Also, there may be important tasks that are not included in this form. Please review this carefully and adjust based on your project needs.

Name of Promoter being supervised: _____________________________________________
Name of Supervisor completing the form: ___________________________________________
Quarter: ____________________ Year: ___________________

Every Visit: Take time to find out how the Promoter is doing, how you can support him/her, and what challenges or success he/she has encountered since your last visit.

Instructions: Place a “Y” for Yes (the task was done) or an “N” for No (the task was not done). Write “n/a” (not assessed) if the item could not be (or was not) assessed for some reason. The grey cells are further instructions and do not require a written check mark.

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1. Observe the Promoter Teaching Care Group Volunteers

1a. Observe a behaviour change meeting and fill out the quality improvement and verification checklist (QIVC) for meeting facilitation.  
1b. Review the QIVC for meeting facilitation with the Promoter in private afterward.  
1c. Talk to some of the Neighbour Caregivers (NC) to assess their participation level, their interest in the program, and the quality and consistency of the Promoters’ work.  
1d. Visit some of the NC that the Care Group Volunteer (NCGV) reported meeting to verify that they received the lessons as the NCGV reported.  
1e. Did the majority of the NC you visited say that they participated in the lesson that should have been during the period?

2. Review the Promoter’s Registers of Care Group Volunteers and Neighbour Caregivers (once per quarter)

2a. Is the Promoter keeping the NCGV and NC registers in a safe, dry place?  
2b. Has the Promoter always marked attendance

\textsuperscript{42} Each Promoter is supervised twice per month. This checklist is used throughout the quarter and turned in at the end of the quarter. Use a new form each quarter.  
\textsuperscript{43} Some of the elements in this checklist may be better assessed by people on your team other than the Supervisor (e.g., monitoring and evaluation [M&E] statistician, logistician).
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<td>for the NCGVs over the last 3 months?</td>
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2c. Did the Promoter (or NCGV or someone else) always mark attendance for the NC over the last 3 months?

### 3. Review the Promoter’s Monthly Reports

3a. Has the Promoter completed the monthly reports correctly (e.g., there are few errors)?

### 4. Observation of the Promoter’s Equipment (transport, scale, storage area, other materials)

4a. Is the Education Promoter maintaining his/her mode of transport (e.g., motorbike/bicycle) in a fully functioning condition?

4b. Is the weighing scale working properly?

4c. Were all other materials (e.g., flip charts, LSMs, MUAC strip, lesson plans, blank reporting forms) stored in a safe and dry place?

4d. Does the Promoter have sufficient amounts of all materials needed?

### 5. Review of Visits and Interviews with Nurturing Care Group Volunteers

5a. Randomly select 3–5 NCGVs to visit and interview them. Were those selected all found, and did they confirm that they were attending teaching lessons and generally understood what they were learning?

### 6. Review of Visits and Interviews with Neighbour Caregivers

6a. Randomly select 3–5 NC to visit and interview them. Did the selected NC confirm that they attend meetings and generally understand what they are learning?

6b. Review the key messages the Promoter taught, ask the NC about an essential key message to test their understanding and practice. Was the NC practicing the behaviour?

6c. Ask selected caregivers about skills and milestones that children should develop. Were all caregivers able to mention at least several skills and milestones?

### 7. Review of Visit to Community Leaders or Participate in a Community Leadership Meeting and Interview the Leaders

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<td>7a. Ask community leaders about the Promoters’ activities and their coordination. Were they aware of the Promoter’s activities in the community?</td>
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<td>7b. Did the community leaders say that they have been coordinating with the Promoters?</td>
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<td>7c. Ask community leaders if they are actively resolving problems that arise related to the program?</td>
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<td><strong>8. Review of Visits to Health Facilities and Schools</strong></td>
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<td>8a. Visit local health workers at the nearest facility. Are the health workers aware of the work of the Promoter?</td>
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<td>8b. Has the Promoter been referring patients to the health centre for care?</td>
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<td>8c. Visit local schools. Are the education staff (e.g., school master, teachers) aware of the work of the Education Promoter?</td>
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<td>8d. Has the Promoter been referring children who need special assistance to services?</td>
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<td><strong>9. Review of Visit to the Promoter’s Home</strong></td>
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<td>9a. Observe: Does the Promoter have a latrine with a lid and a roof?</td>
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<td>9b. Observe: Does the Promoter have a hand washing station?</td>
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<td>9c. Observe: If there is a hand washing station, is there water?</td>
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<td>9d. Observe: If there is a hand washing station, is there soap/ash available</td>
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<td>9e. Observe: Does the Promoter have a system for purifying drinking water?</td>
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<td>9f. Observe: Does the Promoter have a system for keeping animals (including chickens) away from the child’s play area?</td>
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<td>9g. Observe: Does the Promoter have a mosquito net for every bed or sleeping mat?</td>
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<td>9h. Observe vaccination card: Are the Promoter’s youngest child’s vaccinations up to date?</td>
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9i. Observe: Does the Promoter’s preschool children (if any) know how to use the LSMs?

**TOTAL YES:**

**PERCENT YES:**

**Important: Providing Feedback at All Levels**

- Ask the Promoter/Supervisor/Coordinator how he/she feels he/she is doing in the role in general.
- Thank and encourage the Promoter for each of the things that he/she is doing correctly, according to the performance you have observed using this checklist.
- For mistakes, always ask before telling: Ask the Promoter/Supervisor/Coordinator what he/she feels he/she is not doing well. For each correct observation on a mistake, give advice on how to improve (e.g., “Yes, that’s right, your scale was not functioning properly. Next time you can notify me by text when you have a problem with it so we can get it fixed more quickly.”).
- Summarize areas for improvement based on observations.
- Ask the Promoter/Supervisor/Coordinator to make a verbal agreement to improve these things prior to the next meeting (e.g., “Do you agree to work on these things before our next meeting so you can improve?”).
- Signs of respect:
  - Be careful to correct the Promoter/Supervisor/Coordinator in private and to not embarrass or humiliate him/her in front of the people he/she works with.
  - Respect the Promoter/Supervisor/Coordinator and what he/she already knows and does.
Lesson 13 Handout 2: Coordinator’s Checklist for Supervising a Supervisor

Note: Please review this carefully and adjust based on your project needs.

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1. Observe the Supervisor Reviewing a Lesson with Promoters (once per quarter)

1a. Did the Supervisor review the Promoter lesson plan and clearly explain stories, games and activities that accompany the information?

1b. Did the Supervisor facilitate one or more practice sessions with the Promoters?

1c. Did the Supervisor ask the Promoters review questions to check if they understood the lessons?

1d. Privately ask the Supervisor review questions. Did the Supervisor understand the lessons?

2. Check the Supervisor’s Reporting and File System

2a. Review the latest Supervisor report, Promoter reports, NCG registers and Neighbour Group (NG) registers. Did the reported numbers in the reports match up and were they consistent?

2b. Review the Supervisor’s filing system. Was it well organized, and did it have copies of all reports sent and received (including the Supervisor reports, Promoter reports, quality improvement and verification checklists [QIVCs], and checklists for supervising the Promoters)?

2c. Review the Supervisor report and ask questions of the Supervisor. Did he/she understand each section clearly?

2d. Review the Supervisor’s work plans made every two weeks for all Promoters. Were they completed properly and up-to-date?

2e. If a surprise visit. Was the Supervisor following his/her own work plan and Promoter visit plan?

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44 All activities listed here should be completed on a quarterly basis for each Supervisor. Each Supervisor should be visited three times each quarter, with every third visit a surprise. Check off what you do in each visit. Start with a new form every quarter.
Visits during quarter: | 1 | 2 | 3
---|---|---|---
Visit date: | | | |

<table>
<thead>
<tr>
<th>3. Check the Supervisor’s Equipment and Office Supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>3a. Was the Supervisor’s computer and flash drive up-to-date for virus protection?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>3b. Was the date of the last computer back-up file recent (e.g., last month)?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>3c. Was the printer working well (i.e., ink available, test page prints, printer disk stored)?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>3d. Would the Supervisor’s computer power-up, and was it connected to a surge protector with all cables clear of moisture and exposed connections?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>3e. Was the Supervisor’s transportation in proper working condition?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>3f. Ask the Supervisor about Promoters’ transport and repair processes. Are all transportation modes (motorcycles/bicycles) in good condition or being rapidly repaired?</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Follow a Supervisor While He/she Supervises a Promoter</th>
</tr>
</thead>
<tbody>
<tr>
<td>4a. Review copies of the Supervisor’s checklist for supervising a Promoter. Is the Supervisor correctly using that checklist to supervise Promoters?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>4b. Review QIVCs. Is the Supervisor properly using the QIVC for educational session facilitation?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>4c. Randomly select one of the Promoter’s NCGs to visit, then randomly select 1–3 NCGVs listed as members of the NCG. Interview them. Is the frequency of teaching correct, and do they understand their role well?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>4d. Can the NCGVs selected accurately name all of the NC in their groups?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>4e. Ask the NCGVs to explain the flip chart pictures. Do they associate the correct practices with the images?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>4f. Does the Supervisor appear to be very familiar with the roads and paths in the area?</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Assist the Supervisor with Staff Development (once per quarter)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5a. Assist the Supervisor to develop and follow-up on staff development plans in a private area.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>5b. Is the Promoter making progress toward identified program and personal objectives? (Refer to the supportive supervision checklists for Promoters, Promoter reports, QIVCs, training post-test scores and attendance records.)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>5c. Counsel Promoters with the Supervisor, document unacceptable behaviour and specify improvements expected, if necessary. (Be sure to keep notes/documentation in the same folder with this form, or at the bottom of this form to make it easier to follow up).</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<p>| 6. Visit the appropriate Health, Education, Water and/or Gender Ministries (once per quarter) |</p>
<table>
<thead>
<tr>
<th>Visits during quarter:</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Visit date:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6a. Visit key ministry personnel in the area. Are they aware of project objectives and activities?  
6b. Are either monthly or quarterly reports being provided to the ministry district offices by the Supervisor?  
6c. Update key personnel of project achievements, impact, challenges and solutions.  

7. Visit Local Businesses that the Supervisor has Provided Receipts for and Check Reported versus Actual Costs (once per quarter)  
7a. Visit local businesses and review receipts provided for commune level activities incurred at those businesses. Did prices match current local prices at the business?  
7b. Talk to Promoters, NCGV, other staff and NC. Does it appear that goods and services reported have been provided through the program (e.g., LSMs have reached intended beneficiaries)?  

8. Receive Suggestions from the Supervisor on Program Activities, Communication and Support Services  
8a. Request feedback, ideas and suggestions from the Supervisor on how to improve programming and support services. Keep these notes in the same folder with this form (or in a few lines at the bottom of the form).  

9. Provide Feedback to the Supervisor Regarding His/her Performance  
9a. Review the Supervisor’s professional development plan. Use the supportive supervision checklists for Supervisors, monthly reports and training post-test scores to evaluate the Supervisor’s progress toward identified program and personal objectives.  
9b. Counsel the Supervisor, identify outstanding performance, document unacceptable behaviour and specify improvements expected. Keep these notes in the same folder with this form (or in a few lines at the bottom of the form).  

TOTAL YES:  
PERCENT YES:
Lesson 13 Handout 3: Manager’s Checklist for Supervising a Coordinator

*Note: Please review this carefully and adjust based on your project needs.*

Name of Coordinator being supervised: _____________________________________________
Name of Manager completing the form: _____________________________________________
Month: _______________ Year: _______________

Every visit: Take time to find out how the Coordinator is doing, how you can support him/her, and what challenges or success he/she has encountered since your last visit.

**Instructions:** Place a “Y” for Yes (the task was done) or an “N” for No (the task was not done). Write “n/a” (not assessed) if the item could not be (or was not) assessed for some reason. The greyed cells include further instructions and do not require a written check mark.

<table>
<thead>
<tr>
<th>Visits during quarter:</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Ensure the Coordinator Manages His/her Team of Supervisors Well

1a. Ask if there are any personnel problems the Coordinator is managing and provide support and/or suggestions to resolve difficulties.

1b. Talk to one or two Supervisors privately about instructions they have received about project implementation. Does it appear that the Coordinator is communicating instructions related to project implementation clearly and in a timely manner?

1c. Review the Coordinator’s work schedule. Does it appear that the Coordinator is meeting quarterly with his/her team and visiting them at least once a month in the field?

1d. Ask the Coordinator about what he/she is doing to build team unity and develop the Supervisors’ capacity. Does it appear to be adequate?

1e. In private, assist the Coordinator to develop and follow-up on Supervisors’ development plans.

1f. Use the checklists for supervising a Supervisor, monthly reports, quality improvement and verification checklists (QIVCs), training post-test scores and attendance records to evaluate the Supervisors’ progress toward identified program and personal objectives. Keep these notes in the same folder with this form.

1g. If needed, counsel a Supervisor with the Coordinator present, document unacceptable behaviour and specify improvements expected. Keep these notes in the same folder with this form.

---

45 All activities listed here should be completed on a quarterly basis for each Coordinator. Each Coordinator should be visited one or two times per quarter, plus one surprise visit. Check off what you do in each visit. Start with a new form each quarter.
<table>
<thead>
<tr>
<th>Visits during quarter:</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Check the Coordinator’s Reporting and File System**

2a. Use the latest report you received from the Coordinator and have him/her show you the Supervisors’ reports he/she used to create the report. Were the reported numbers supported by the local documents?

2b. Review the Coordinator’s filing system. Is it well organized and does it have copies of all reports sent and received? (Folders should exist for Supervisor’s reports, QIVCs, checklists for supervising the Supervisor and other forms.)

2c. Review the Coordinator’s last monthly report and discuss issues of poor NCG performance and/or errors in filling out the format. Document plans/ideas to improve NCG performance. Keep these notes in the same folder with this form (or in a few lines at the bottom of the form).

2d. Does the Coordinator have biweekly, up-to-date work plans on file for his/her Supervisors?

2e. (If during a surprise visit) Was the Coordinator following his/her own work plan and Supervisor’s visit plan?

2f. Was the Coordinator properly using the checklist for supervising a Promoter to follow up on any necessary actions?

3. **Visit Appropriate Regional Ministries of Health, Education, Water and/or Gender**

3a. Interview 2-3 key ministry of personnel at the regional level. Were they aware of project objectives and activities?

3b. Were program activities that were planned to be done in coordination with different Ministries being properly carried out?

3c. Were either monthly or quarterly reports being provided to the Regional Ministry Offices by the Coordinator?

3d. Were key Ministry personnel generally aware of project achievements, impact, challenges and solutions? (Discuss these with them.)

4. **Attend a Meeting between a Coordinator and His/her Supervisors (once per year)**

4a. Did the Coordinator communicate respectfully with his/her Supervisors?

4b. Prior to the meeting, ask the Coordinator for a copy of the agenda. Was the agenda for the meeting followed?

4c. Was technical and program information communicated correctly to the Supervisors?

5. **Visit Care Groups (at least once per year)**

5a. Randomly select one NCG to visit, then randomly select 1–3 NCGVs listed as a member of the group. Talk to the NCGVs. Is the frequency of teaching correct, and do they understand their role?

5b. Ask the NCGVs to explain the flip chart pictures. Can they associate the correct practices with the images?
<table>
<thead>
<tr>
<th>Visits during quarter:</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5c. Was the Coordinator generally familiar with the roads and paths in the area?  

6. Receive Suggestions from the Coordinator on Program Activities, Communication and Support Services  

6a. Request feedback, ideas and suggestions from the Coordinator on how to improve programming and support services. Keep these notes in the same folder with this form (or in a few lines at the bottom of the form).

7. Provide Feedback to the Coordinator Regarding His/her Performance  

7a. Review the Coordinator’s professional development plan. Use checklists for supervising Coordinators, monthly reports and training post-test scores, and evaluate district movement toward indicator targets to evaluate the Coordinator’s progress toward identified program and personal objectives.

7b. Counsel the Coordinator, identify outstanding performance, document unacceptable behaviour and specify improvements expected.

TOTAL YES:  

PERCENT YES:  

Lesson 13 Handout 4: Categories in the Supervisor’s Checklist for Supervising Promoters

1. Observe Promoter teaching Nurturing Care Group Volunteers
2. Review the Promoter’s register of Nurturing Care Group Volunteers and Neighbour Caregivers
3. Review the Promoter’s monthly reports
4. Observe the Promoter’s equipment
5. Visit Nurturing Care Group Volunteers
6. Visit Neighbour Caregivers
7. Visit community leaders or participate in a community leadership meeting
8. Visit the health worker at the nearest health facility and the head teacher at the nearest school
9. Visit the Promoter’s home
### Lesson 13 Handout 5: Supportive Supervision Table

<table>
<thead>
<tr>
<th>Person Supervising</th>
<th>Person being Supervised</th>
<th>Location/ Meetings</th>
<th>Frequency</th>
<th>Supportive Supervision Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>Each Coordinator</td>
<td>Observes all locations and meetings listed below</td>
<td>Two times every 3 months, including one surprise visit per year</td>
<td>Supportive supervision checklist</td>
</tr>
<tr>
<td>Coordinator (supervising 3–6 Supervisors)</td>
<td>Each Supervisor</td>
<td>Office, bi-monthly meeting and those listed below</td>
<td>Once per month (every third visit is a surprise visit)</td>
<td>Supportive supervision checklist and QIVC</td>
</tr>
<tr>
<td>Supervisor (supervising 4–6 Promoters)</td>
<td>Each Promoter</td>
<td>Promoter’s home, Care Group meeting and those listed below</td>
<td>Twice per month: one scheduled visit and one surprise visit; QIVC at least once per quarter</td>
<td>Supportive supervision checklist and QIVC</td>
</tr>
<tr>
<td>Promoter (supervising 50–135 Nurturing Care Group Volunteers [NCGVs])</td>
<td>Each NCGV</td>
<td>NCGV’s home, during home visits and Neighbour Group (NG) meeting</td>
<td>One NCGV from each Care Group (NCG) every 2 weeks</td>
<td>QIVC</td>
</tr>
</tbody>
</table>
Lesson 13 Flip Chart 2: Blank Supportive Supervision Table

<table>
<thead>
<tr>
<th>Person Supervising</th>
<th>Person being Supervised</th>
<th>Location/Meetings</th>
<th>Frequency</th>
<th>Supportive Supervision Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordinator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promoter</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Lesson 13 Handout 6: Activities to Plan

The Promoter
- Teach all eight Nurturing Care Groups (NCGs) every 2 weeks.
- Spend at least a ½ day writing reports before meeting with the Supervisor.
- Attend two of the meetings held every two weeks with the Supervisor (about a ½ day per meeting).
- Supervise eight or more Nurturing Care Group Volunteers (NCGVs) every 2 weeks.
- Receive a supportive supervision visit twice each month during his normal activities.
- Attend the community development committee meeting once per month (½ day).
- Visit the health facility and school at least once per month.

The Nurturing Care Group Volunteer
- Teach 10–15 neighbour caregivers every 2 weeks (either through a household visit or as a group in a Neighbour Group meeting). This meeting is about 1 ½ hours when in a group and ½ hour during the home visit.
- Attend a 2-hour training once every 2 weeks.
- Receive a supportive supervision visit at least once every 6 months.

The Supervisor
- Be in charge of five Promoters (in this example).
- Train the five Promoters every 2 weeks with a ½ day training (training meeting held every two weeks).
- Compile the data from the Promoters after the training meeting held every two weeks (½ day of reporting).
- Supervise each of the Promoters twice per month.
- Spend 3 days per month writing and completing reports.
**Lesson 13 Handout 7: Example Work Plans**

**Example Monthly Work Plan for Nurturing Care Group Volunteers**
(Reminder: Volunteers do not work an 8-hour day! Never plan a meeting longer than 2 hours with volunteers.)

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Attend training #1 with the Promoter</td>
<td>Teach Neighbour Caregiver #1 Lesson 1</td>
<td>Teach Neighbour Caregiver #2 Lesson 1</td>
<td>Teach Neighbour Caregiver #3 Lesson 1</td>
<td>Teach Neighbour Caregiver #4 Lesson 1</td>
</tr>
<tr>
<td>Week 2</td>
<td>Teach Neighbour Caregiver #5 Lesson 1</td>
<td>Teach Neighbour Caregiver #6 Lesson 1</td>
<td>Teach Neighbour Caregiver #7 Lesson 1</td>
<td>Teach Neighbour Caregiver #8 Lesson 1</td>
<td></td>
</tr>
<tr>
<td>Week 3</td>
<td>Attend training #2 with the Promoter</td>
<td>Teach Neighbour Caregiver #1 Lesson 2</td>
<td>Teach Neighbour Caregiver #2 Lesson 2</td>
<td>Teach Neighbour Caregiver #3 Lesson 2</td>
<td>Teach Neighbour Caregiver #4 Lesson 2</td>
</tr>
<tr>
<td>Week 4</td>
<td>Teach Neighbour Caregiver #5 Lesson 2</td>
<td>Teach Neighbour Caregiver #6 Lesson 2</td>
<td>Teach Neighbour Caregiver #7 Lesson 2</td>
<td>Teach Neighbour Caregiver #8 Lesson 2</td>
<td></td>
</tr>
</tbody>
</table>

**Example Monthly Work Plan for Promoters**

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Teach Care Group #1</td>
<td>Supervise two NCGV with QIVC</td>
<td>Teach Care Group #3</td>
<td>Prepare reports for meetings held every two weeks</td>
<td>Regular meeting Supervise one NCGV</td>
</tr>
<tr>
<td></td>
<td>Teach Care Group #2</td>
<td></td>
<td>Teach Care Group #4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Week 2</td>
<td>Supervise two NCGVs</td>
<td>Supervise two NCGVs</td>
<td>Teach Care Group #5</td>
<td>Supervise two NCGVs</td>
<td>Teach NCG #7 Teach NCG #8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Teach Care Group #6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Week 3</td>
<td>Vaccination day</td>
<td>Supervise two NCGVs</td>
<td>Teach Care Group #3</td>
<td>Supervise one NCGV</td>
<td>Community meeting Supervise one NCGV</td>
</tr>
<tr>
<td></td>
<td>Teach Care Group #1</td>
<td></td>
<td>Teach Care Group #4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Week 4</td>
<td>Supervise two NCGVs with QIVC</td>
<td>Supervise two NCGVs</td>
<td>Teach Care Group #5</td>
<td>Supervise two NCGVs</td>
<td>Teach Care Group #7 Teach Care Group #8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Teach Care Group #6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Example Monthly Work Plan for Supervisor

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Supervise Promoter #5</td>
<td>Prepare for training held every two weeks</td>
<td>Regular meeting Reporting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Week 2</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervise Promoter #1</td>
<td>Supervise Promoter #2</td>
<td>Supervise Promoter #3</td>
<td>Supervise Promoter #4</td>
<td>Supervise Promoter #5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Week 3</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccination day</td>
<td>Report writing</td>
<td>Supervise Promoter #4</td>
<td>Prepare training held every two weeks</td>
<td>Bi-monthly meeting Reporting</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Week 4</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervise Promoter #1</td>
<td>Supervise Promoter #2</td>
<td>Supervise Promoter #3</td>
<td>Report writing</td>
<td>Report writing</td>
<td></td>
</tr>
</tbody>
</table>
Lesson 14: Quality Improvement and Verification Checklists (QIVCs) and Giving Feedback

[NOTE: This lesson plan is important but can be skipped if there is not enough time in the WV/Ghana NCG training. This information can be covered separately through a webinar and then cascaded down, if necessary.]

Achievement-Based Objectives
By the end of this lesson participants will have:

- Reviewed two quality improvement and verification checklists (QIVCs)
- Observed a simulated use of the QIVC
- Completed and scored two QIVCs
- Reviewed the steps for giving positive feedback

Duration
2 hours

Materials Needed

- Lesson 14 Handout 1: Quality Improvement and Verification Checklist (QIVC) for Meeting Facilitation
- Lesson 14 Handout 2: Quality Improvement and Verification Checklist (QIVC) for Giving Feedback
- Lesson 14 Handout 3: Role Play Part 1: Meeting/Education Event
- Lesson 14 Handout 4: Role Play Part 2: Giving Feedback
- Lesson 14 Flip Chart 1: How to Score the Quality Improvement and Verification Checklist (QIVC)
- Lesson 14 Handout 5: Steps for Giving Effective Feedback
- Flip chart paper and markers

Facilitator’s Notes

Prepare to present a short role play of a Nurturing Care Group Volunteer (NCGV) demonstrating a behaviour, such as how to make oral rehydration solution (ORS). If there are two facilitators at a training, it would be best if they did the role play together, with one facilitator playing the role of the NCGV and the other playing the role of the Promoter. If there is only one facilitator, choose a very competent participant to play the role of the NCGV. Either way, practice the role play ahead of time. You also will need to ask a few female participants to play the role of Neighbour Caregivers (NC) who are attending the education session.

Review Lesson 14 Handout 1: Quality Improvement and Verification Checklist (QIVC) for Meeting Facilitation, Lesson 14 Handout 2: Quality Improvement and Verification Checklist (QIVC) for Giving Feedback, Lesson 14 Handout 3: Role Play Part 1: Meeting/Education Event, Lesson 14 Handout 4: Role Play Part 2: Giving Feedback and the role play instructions in Step 4 so the person playing the NCGV knows what good things to do and can choose two or three things deliberately to do wrong. This way the person playing the Promoter knows how to give appropriate feedback.
It is very important that the person playing the NCGV role not try to act like a clown during the skit to entertain the audience. This needs to be a learning activity that shows the good and poor things NCGVs could do and how the Supervisor works with them to improve. Remember that if you model a poor example of giving appropriate feedback, the participants will do exactly what they saw you do. Practice, practice, practice! Make sure you have practiced giving appropriate feedback before training others. In terms of discussing the QIVC, a group discussion is not usually possible in normal work situations but is a good way to help staff learn how to score and evaluate an observation fairly. In many cultures, Supervisors are more prone to mark “no” for very tiny faults instead of marking “yes” if the facilitator in general completed the given task. Remind participants that this is a tool to encourage and improve the ability of workers. The QIVC is not a tool used to fail a worker or shame them into change.

**Steps**

1. **Introduction**
   - Tell participants: Now that we have discussed the supportive supervision checklist, we need to introduce the other supervision tool, the quality improvement and verification checklist.
   - Explain: Although the Care Group approach has been proven to be very effective as a behaviour change strategy, if it isn’t executed with a high level of quality, it won’t produce the desired results and levels of malnutrition won’t decline. Also, when we monitor implementation, we tend to focus on quantity rather than quality.
   - Ask participants: What quantitative things do you think a Care Group program would monitor? Answers could include how many meetings were held and how many people attended.
   - Tell participants: How well the meeting was facilitated and how well the NCGV participated also are critical elements. To focus our attention on how well tasks and activities are implemented, Food for the Hungry has developed a tool called the quality improvement and verification checklist, or QIVC. This session is divided into two parts. For part of this lesson we will look at the QIVC, how to use it, how to give effective feedback and how to use the results of the QIVC to make programmatic decisions.

2. **The Quality Improvement and Verification Checklist Tool and How It Is Used**
   - Refer participants to Lesson 14 Handout 1: Quality Improvement and Verification Checklist (QIVC) for Meeting Facilitation and Lesson 14 Handout 2: Quality Improvement and Verification Checklist (QIVC) for Giving Feedback. Explain that while we will be using these QIVCs during this session, there are many other QIVCs that focus on other aspects of the Nurturing Care Group (NCG) program. Other QIVCs created by Food for the Hungry (FH) can be found at http://www.caregroupinfo.org/docs/QIVC_Files.zip.
   - Explain that the QIVC for educational session facilitation has three main purposes:
     - To encourage a facilitator
     - To monitor a facilitator
     - To improve a facilitator’s performance
• Write these on a flip chart.

• **Ask participants:** Who are the facilitators in the Nurturing Care Group program? Answers should include that facilitators are those who teach others, including Managers, Supervisors, Coordinators, Promoters, and NCGV. This means that the QIVC can be used to encourage, monitor and improve the work of each one of these NCG team members.

• Explain to participants that the QIVC is the ONLY tool used to supervise NCGVs. The Promoter does not use a supportive supervision checklist at this level since NCGVs are not employees.

• Explain to participants: The QIVC rapidly increases facilitation performance. For example, in the Dominican Republic, health promoters’ performance improved by 38% in months when QIVCs were used. Small improvements in performance can cause large changes in impact. However, QIVCs are only useful for tasks that can be observed and have multiple steps.

• **Nurturing:** What are some activities in our program that you can observe? Which of these activities is a process with multiple steps? Answers include teaching NCG lessons to Neighbour Caregivers (NC), teaching NCG lessons to NCGVs, teaching NCG lessons to Promoters, teaching NCG lessons to Supervisors, growth monitoring and promotion, and individual counselling sessions.

3. **Review the Quality Improvement and Verification Checklist**

• Go through each point on **Lesson 14 Handout 1** with participants. Make sure that they understand what each question means.

• Explain to participants that most questions have a yes or no answer. After reading the question, they should decide if the answer is “yes” or “no” and mark the corresponding box.

• If the question is not relevant for a particular training, then draw a line through the YES or NO boxes. For example:
  
  o In question 11, if the topic was exclusive breastfeeding (EBF), the facilitator would have a difficult time demonstrating this activity. It is possible for the facilitator to demonstrate proper breastfeeding attachment, but EBF is not something that needs to be demonstrated during the lesson. You would mark a line through the yes or no.
  
  o In question 16, if participants do not mention any barriers, cross out this line when monitoring the worker.

• Tell participants: QIVCs should be adapted to fit the culture and design of each NCG program. After using the QIVC for 3 or 4 months, ask staff and volunteers to meet together to discuss the checklist. If specific questions are not appropriate or applicable to your situation, adapt or revise them as needed. However, be cautious. The QIVC was designed to ensure participatory teaching methods are used in each lesson. Make sure your final version continues to reinforce the key principles of participatory learning.

• Explain that the QIVC can be used during regularly planned supervisory visits along with the supportive supervision checklist. It can also be used on its own.

---

4. **Activity: Quality Improvement and Verification Checklists in Action**

- Explain to participants: Now we’re going to learn how the QIVC would be used in the field. You are going to watch a role play of the NCGV facilitating a meeting with her Neighbour Group and how the Promoter, who has come to watch, provides feedback to the volunteer. During the role play keep an eye on your copy of the QIVC and see for yourself how well the NCGV conducted the meeting. Then, when the Promoter gives feedback, use the other QIVC to see how well she does.

- Explain to participants that the QIVC is only completed after the event, not during. This is done so the person filling out the QIVC can be attentive during the event being evaluated and not be distracted by filling out the QIVC.

- Explain that the role play will be done in two parts. In the first part a NCGV facilitates a meeting with Neighbour Caregivers. In the second part the Promoter gives feedback to the NCGV. Instruct participants to fill out the pertinent QIVC after each role play. Answer any questions.

- After completing **Lesson 14 Handout 3: Role Play Part 1: Meeting/Education Event** ask each participant to fill out and score their copies of Lesson 12 Handout 1. Show the instructions in **Lesson 14 Flip Chart 1: How to Score the Quality Improvement Verification Checklist (QIVC)**. Ask some participants to share the scores they gave. Repeat this process after **Lesson 14 Handout 4: Role Play Part 2: Giving Feedback** using Lesson 12 Handout 2.

- **Ask the participants** the following questions. They should answer the questions based on what they saw in the skit. Write their responses on a flip chart.

  - **What should you say to the NCGV when you visit her and plan to use a QIVC?**
    - Don’t worry!
    - This is not a test, but a tool to help you improve.
    - Teach as you normally do.

  - **What comments did the Promoter make during the educational lesson?**
    - None! The Promoter should observe only and not interrupt or make comments to the facilitator.
    - After the session, the Promoter can address the participants as appropriate.

  - **Where did the Promoter talk about each of the points in the QIVC with NCGV?**
    - In private, not in front of other people.

  - **Why did the Promoter explain the checklist to the NCGV?**
    - Because it is also a method for improving and encouraging the worker’s performance.
    - The actions we consider to be perfect performance should not be kept secret from the worker.
Speaking in Love
Consider Colossians 3:
"15 Let the peace of Christ rule in your hearts, since as members of one body you were called to peace. And be thankful. 16 Let the message of Christ dwell among you richly as you teach and admonish one another with all wisdom through psalms, hymns, and songs from the Spirit, singing to God with gratitude in your hearts. 17 And whatever you do, whether in word or deed, do it all in the name of the Lord Jesus, giving thanks to God the Father through him.”

What does this passage teach us about how we are to teach others?

5. More on Giving Feedback

- **Ask participants** the following questions and discuss: We have talked a lot about positive feedback. What’s wrong with negative feedback? Wouldn’t the worker improve faster if we told her everything that she did wrong? What is your opinion?

- **Refer participants to** Lesson 14 Handout 5: Steps for Giving Effective Feedback. Tell participants that they will now review exactly how feedback should be given after an observation.

- Working in pairs, have participants review the handout and compare the points to what they observed in the role play. Ask some participants to share their observations.

- **Ask participants** and discuss responses: How is this way of giving feedback different from the way it is usually done? Which way do you think will result in improved performance? Which approach will result in sustained high motivation? Why?

---

### The Importance of Giving Positive Feedback

*(From “Positive Image, Positive Action: The Affirmative Basis of Organizing” by David Cooperrider)*

Most people worldwide believe that pointing out mistakes will eliminate failures and improve performance. However, studies have shown that the opposite is true especially when it comes to learning new tasks. In one experiment, for example, Kirschenbaum (1984) compared three groups of people bowling:

- **Group A** did not receive any lessons but tried to learn how to bowl on their own.
- **Group B** was videotaped. All of the good things they did while bowling were compiled on tape, and the mistakes were deleted from the tapes. These positive tapes were reviewed with each bowler, with everything they had done well was pointed out to help them improve.
- **Group C** also was videotaped. All of the mistakes they made were compiled on tape, and the good things they did were deleted from the tapes. The tapes of their mistakes were reviewed with this group, and the areas where they needed to improve were pointed out.

Group B improved significantly more than all the others, and the unskilled bowlers in Group B (average of 125 pins) improved substantially (more than 100%) more than all other groups. Since then, these results have been replicated with other athletic activities, giving the same results. Pointing out the things people do well helps them learn new skills and improves their performance in mastering new tasks.
6. Wrap Up

- Tell participants: Next we will look at how to use the results of the QIVC to make programmatic decisions.
Lesson 14 Handout 1: Quality Improvement and Verification Checklist (QIVC) for Meeting Facilitation

Name of Facilitator: ________________________________
Date: ____________________________________________
Evaluator: ________________________________________
Community: ______________________________________

<table>
<thead>
<tr>
<th>Methods</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the facilitator seat people so that all could see each other’s faces?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Did the facilitator sit at the same level as the other participants?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Did the facilitator introduce the topic well (who he/she is, topic, time)?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. Did the facilitator speak loud enough so that everyone could hear?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Did the facilitator use proper eye contact with everyone?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Did the facilitator changes his/her voice intonation (not monotone)?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. Did the facilitator speak slowly and clearly?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8. Did the facilitator ask about the current practices of the participants?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9. Did the facilitator read each caption aloud to the participants? (If the facilitator is not literate, did s/he state the key message correctly)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10. Did the facilitator explain the meaning of each picture?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11. Did the facilitator demonstrate any skills that he/she was promoting?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>12. Did the facilitator verify that people understood the main points using open-ended questions?</td>
<td>☐</td>
<td>☐</td>
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</table>

<table>
<thead>
<tr>
<th>Discussion</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>13. Did the facilitator ask the participants open-ended questions?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>14. Did the facilitator give participants adequate time to answer questions?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15. Did the facilitator ask participants if there were barriers that might prevent them from trying the new practices?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>16. Did the facilitator encourage discussion among participants to solve the barriers mentioned?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>17. Did the facilitator encourage comments by paraphrasing what people said (repeating statements in his/her own words)?</td>
<td>☐</td>
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</tr>
<tr>
<td>18. Did the facilitator ask participants if they agree with other participants’ responses?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>19. Did the facilitator encourage comments by nodding, smiling or other actions to show he/she was listening?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>20. Did the facilitator always reply to participants in a courteous and diplomatic way?</td>
<td>☐</td>
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</tbody>
</table>
Discussion (Continued)

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

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

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

24. Did the facilitator summarize the discussion? .................................................................. ☐ ☐

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

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

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

Content

28. Was the content of the messages correct? ........................................................................... ☐ ☐

29. Was the content of the messages relevant? ...................................................................... ☐ ☐

30. Was the content of the messages complete? .................................................................... ☐ ☐

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

Score: ____________________________
Comments: ________________________
Lesson 14 Handout 2: Quality Improvement and Verification Checklist (QIVC) to Evaluate Positive Feedback

Name of the person using this list: _______________________
Name of the person evaluated: _________________________
Community: ____________________ Date: ____________________
Number of yeses: _______ Number of lines: _______
Present grade: ____________% Previous grade: ____________%

Before the Evaluation Begins

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the evaluator explain the purpose of the QIVC (to improve and measure work quality)?</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>2. Did the evaluator tell the person evaluated not to fear, that this is not a test, but rather something to help him/her improve?</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>3. Did the evaluator advise the person being evaluated not to say anything to the evaluator while being observed?</td>
<td>☐ ☐</td>
</tr>
</tbody>
</table>

During the Observation

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>4. Did the evaluator avoid making comments to the person evaluated during the lesson?</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>5. Did the evaluator mark all the questions (yes or no) during or right after the observation?</td>
<td>☐ ☐</td>
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</table>

Feedback

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>6. Did the evaluator give the feedback in a private place?</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>7. Did the evaluator ask the person evaluated to note his/her comments?</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>8. Did the evaluator discuss each positive point on the form?</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>9. Did the evaluator encourage the person evaluated on to the things he/she did correctly?</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>10. Did the evaluator use positive body language when providing positive feedback to the person?</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>11. Did the evaluator use many encouraging words (e.g., excellent, very good) when providing positive feedback to the person?</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>12. Did the evaluator avoid the use of too many mixed comments (e.g., “This was excellent, but you have to ...”) when providing feedback?</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>13. Did the evaluator always respond to the comments from the person evaluated in a courteous and diplomatic manner?</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>14. Did the evaluator mention the area(s) where the performance of the person evaluated was better than the majority of other people?</td>
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### Feedback (Continued)

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<tbody>
<tr>
<td><strong>15.</strong> Did the evaluator discuss the most important negative points on the form?</td>
<td></td>
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<tr>
<td><strong>16.</strong> Did the evaluator often ask the person evaluated to discuss the negative points in his/her performance self-evaluation before providing an opinion?</td>
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<tr>
<td><strong>17.</strong> Did the evaluator use several examples to explain the correct manner of performing the parts of the process that were done incorrectly?</td>
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<tr>
<td><strong>18.</strong> Did the evaluator maintain control of the evaluation process in an appropriate manner?</td>
<td></td>
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<tr>
<td><strong>19.</strong> Did the evaluator help the person evaluated find solutions to the problems he/she has (e.g., in the community), where possible?</td>
<td></td>
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<tr>
<td><strong>20.</strong> Did the evaluator keep the attention of the person evaluated?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>21.</strong> Were the evaluator’s suggestions correct?</td>
<td></td>
<td></td>
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<tr>
<td><strong>22.</strong> Were the evaluator’s suggestions appropriate for the context of the person being evaluated?</td>
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<tr>
<td><strong>23.</strong> Were the evaluator’s suggestions complete?</td>
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</tr>
<tr>
<td><strong>24.</strong> Were the evaluator’s suggestions very specific?</td>
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### At the End of the Evaluation

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<tbody>
<tr>
<td><strong>25.</strong> Did the evaluator ask the person evaluated to give a summary of the things that should be improved?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>26.</strong> Did the evaluator complete this list if the person evaluated could not remember all the things that needed improvement?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>27.</strong> Did the evaluator ask the person evaluated to indicate his/her commitment to improve these things?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>28.</strong> Did the evaluator ask the person to give a summary of the positive things that he/she did?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>29.</strong> Did the evaluator complete this list if the person evaluated could not remember all the things he/she did that were positive?</td>
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</table>

**Score:** ________________

**Additional Comments:**

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Lesson 14 Handout 3: Role Play Part 1: Meeting/Education Event

The Nurturing Care Group Volunteer (NCGV) is in the middle of a group meeting. She is preparing to demonstrate (activity) how to make oral rehydration solution (ORS) for children with diarrhoea. (This means she has already shared the lesson objectives, a game or song, and completed the attendance and troubleshooting, and story and pictures steps.) She has the sugar, salt, container of drinking water, and container to mix the solution in (a 1 litre bottle). She has prepared a space for the Neighbour Caregivers (NC) to sit in front of her in a semi-circle so all the caregivers can see each other. As the NCGV is getting ready, the Promoter arrives, and they have the following discussion.

**Promoter:** Good morning Maria. How are you doing?
**NCGV:** Welcome! I’m fine. It’s good to see you.
**Promoter:** I’ve come to pay you a visit and to observe your meeting. During this visit I will be completing the QIVC for educational session facilitation. Remember the QIVC will help improve your work as a facilitator. It’s not a test, so there’s no need to be nervous. [She shows the QIVC to the CVG.] This is the same form that we have used before.
**NCGV:** Yes, I remember. I was just getting ready to show the caregivers how to prepare ORS. The caregivers will be joining me here. Since you are here, if I have any questions or problems, I’ll be sure to ask for your help.
**Promoter:** Actually, Maria, I will just be watching you and not participating at all. Just carry on as if I wasn’t here. Afterward we will talk about how the meeting went.

The NCGV sits down and calls the NCs to join her. The Promoter sits to the side holding her quality improvement and verification checklist (QIVC). Once all the NCs are sitting, one last caregiver arrives and sits behind everyone else, a little outside the group. The NCGV conducts a 5 to 10-minute instruction of how to prepare ORS, reminding the NCs what they learned from the story and the flip chart that were covered prior to the demonstration. She makes sure everyone but the mother sitting a little outside the group has a chance to participate. The NCGV does most everything well, but she does not ask the NCs if they have any prior experience making ORS, and she does not verify at the end if they all understood. The demonstration ends, and the NCGV thanks the NCs for coming.
Lesson 14 Handout 4: Role Play Part 2: Giving Feedback

The Nurturing Care Group Volunteer (NCGV) and the Promoter privately discuss the educational session. The Promoter uses the following outline to discuss the NCGV’s performance.

- Ask, “How do you think you did?”
- Agree with positive points and mistakes the NCGV mentions, as appropriate. Probe as needed: “What things did you do well? What things would you have done differently?”
- Review the positive things on the quality improvement and verification checklist (QIVC) (everything marked yes).
- If not mentioned earlier, ask the NCGV about areas that you marked “no”. For example, “Tell me about the caregiver who came in last, I thought she seems excluded from the group.” Or “How did you think you did in reviewing the mother’s prior experience in making ORS?”
- Reinforce things that the NCGV says that could help her improve in these areas. Do not concentrate too much on what the NCGV did wrong, but rather what she did well, helping her come up with ways to overcome areas where she did poorly.
- Ask the NCGV to summarize the things that you discussed today (positive things and areas to improve).
- Give the NCGV her score and summarize anything that was missed.
- Ask her to commit to changing these things.
- Thank the NCGV.
Lesson 14 Flip Chart 1: How to Score the Quality Improvement and Verification Checklist (QIVC)

1. Count the number of “yes” responses.

2. Divide the number of “yes” responses by the total number of answered questions (questions answered with either a “yes” or “no” response).

3. Do not count the questions that are not applicable (those that are crossed out).
Lesson 14 Handout 5: Steps for Giving Feedback to Workers

Consider printing these steps out for staff as a job aid. They could be laminated and/or printed on coloured paper.

1. Give feedback in private.
2. Ask the person being evaluated to take notes.
3. Discuss each positive point.
4. Encourage the worker on the things he/she did well.
5. Use positive body language.
6. Do not use mixed comments.
7. Respond to the worker in a courteous and diplomatic manner.
8. Mention the areas where the worker is doing better than others.
9. Discuss each negative point on the form but remember to give three positive comments for every one comment about an area to improve.
10. Ask the worker to discuss his/her performance before giving your opinion.
11. Offer several examples to explain the correct manner of performing the tasks where the worker received a “no” on the quality improvement and verification checklist (QIVC).
12. Maintain control of the evaluation.
13. Help the worker find solutions to problems when possible.
14. Keep the worker’s attention.
15. Focus on what is correct, appropriate, complete and specific.
16. At the end of the evaluation, ask the worker to summarize the things he/she will improve.
17. If he/she forgot any areas, remind him/her of them.
18. Ask the worker to make a commitment to improve these issues.
19. Ask the worker to give a summary of the things he/she did well.
20. Add to this list if the worker forgot any positive areas.
Lesson 15: Calculating Scores and Using Data from the Quality Improvement and Verification Checklist (QIVC)

[NOTE: See note for the previous lesson. This lesson can be omitted in the WV/Ghana training, if necessary. Staff coming in September 2019 may also be able to do this part of the training.]

Achievement-Based Objectives
By the end of this lesson participants will have practiced scoring and analysing the QIVC to evaluate staff and volunteer performance over a period of time.

Duration
1 hour 30 minutes

Materials Needed
- Lesson 15 Flip Chart 1: Individual and Program Performance Goals
- Lesson 15 Flip Chart 2: Quality Improvement and Verification Checklist (QIVC) Score Calculations
- Flip chart paper and markers
- Calculator (optional)
- Lesson 15 Handout 1: Analysing Quality Improvement and Verification Checklist (QIVC) Scores
- Answer Key to Lesson 14 Handout 1: Analysing Quality Improvement and Verification Checklist (QIVC) Scores
- Lesson 15 Flip Chart 3: Graph of Sarah’s Care Group Volunteers
- Lesson 15 Handout 2: Analysing Quality Improvement and Verification Checklist (QIVC) Scores
- Answer Key for Lesson 14 Handout 2: Analysing Quality Improvement and Verification Checklist (QIVC) Scores
- Lesson 15 Handout 3: Quality Improvement and Verification Checklist (QIVC) Results for Six Promoters

Steps

1. Introduction
   - Tell participants: Now that we have become familiar with QIVCs and seen how they are used, we need to see how their use would allow us to make decisions to improve the overall program.
   - Ask participants: Why isn’t it enough to just use the QIVCs to improve an individual’s performance? Answers should include, because if many individuals are having the same or similar problems or are performing very poorly, then this means that something bigger—something more systemic—is not going well.
   - Tell participants: In this lesson we will look into how to use the QIVC data to improve our programs.

2. Activity: Performance Targets and Calculations
Tell participants: In this session we will focus on monitoring workers’ performance. The QIVC is a representation of perfect performance. Very few people will reach perfection (100%) during an observation. We want all of our facilitators, including staff trainers, Promoters and Care Group Volunteers, to reach and maintain a score of 80% or above on each QIVC. We can’t expect all of the Care Group team members to get 80% or above on each QIVC, so our target is 80%.

Display and talk through Lesson 15 Flip Chart 1: Individual and Program Performance Goals.

Explain to participants that there are two types of calculations that programs need to make. Display Lesson 15 Flip Chart 2: Quality Improvement and Verification Checklist (QIVC) Score Calculations and explain the two calculations to participants.

Program performance score: Using Lesson 13 Flip Chart 2, explain how to calculate the program performance score. Then practice using the example of Maria’s Promoters in the text box. Write answers on a flip chart by step. Ask participants: What does this score tell us? They should answer the overall performance of a group.

- Number of individual QIVCs: 6
- Number of scores that are 80% or above: 3
- Program performance score: Number of scores that are 80% or higher divided by total number of individual QIVCs: $3 ÷ 6 = 50\%$

Average score for individuals: Then explain how to calculate the average score. Use the same example of Maria’s Promoters to practice. Write answers on a flip chart by step.

- All the scores added together: $80 + 50 + 60 + 85 + 75 + 82 = 432$
- The sum of all the scores divided by the number of scores: $432 ÷ 6 = 72\%$

Calculating QIVC scores: Refer participants to Lesson 15 Handout 1: Analysing Quality Improvement and Verification Checklist (QIVC) Scores and ask them to make the calculations for the three examples. Review the correct response using Answer Key to Lesson 15 Handout 1: Analysing Quality Improvement and Verification Checklist (QIVC) Scores.

Ask participants the following questions.

- Which one of these groups has reached our target? Why? Participants should answer that Abebe’s Promoters reached the target because more than 80% of Promoters in that group reached or exceeded an 80% score on their QIVCs.
- Why is it important to calculate the average score for individuals as well as the program performance score? Answers should include:
  - If you only look only at the average scores, it would appear that Tesfaye’s group is doing the best. However, half of his Promoters have not reached the target.
  - Abebe’s Promoters have an average that is 8 percentage points lower, but he has reached the target for his workers.
  - Moges’ Promoters have the same average score as Abebe’s group, but his workers are doing very poorly, with only 16% of them reaching the target.
• Averages do not give you enough information.
• We want all of our workers to improve, so we need to pay attention to the percentage of people reaching the target so we can spend more time helping them to improve.
• In order to monitor progress we need to record scores for all of our workers and check for problems regularly.

3. System Problems and People Problems

• Tell participants that there are two types of problems that QIVCs can detect: system problems and people problems. What is the difference?
  o System-wide problems are problems that all workers share. Most likely it is a problem with the way the workers were trained or a skill they are having trouble mastering (for example, storytelling or asking for commitments).
  o People problems are problems with individual workers. The QIVC shows which workers are not improving. People problems require that you work one-on-one to help them improve. One low score is not bad; we are looking for improvement over a long period of time. However, if you continue to see one worker doing poorly you will need to intervene. If a worker continues to score poorly, even after multiple observations and feedback, you need to remove that worker from the Care Group (NCG) (according to your organization and national policies).

• Ask participants: Why do we need to monitor system and people problems?
  o If staff is not teaching effectively (if they are poor facilitators) it will greatly impact the effectiveness of the messages shared during the NCGs.
  o If in turn, Care Group Volunteers (NCGVs) are modelling the poor teaching skills that they learned from the Promoter, then it will impact whether the Neighbour Caregivers (NC) hear the information and change their behaviours.
  o The success of the NCG program is dependent upon the strength of the workers.

• Refer to Lesson 13 Handout 2: Analysing Quality Improvement and Verification Checklist (QIVC) Scores. Explain how to read the charts on the handout.
  o The numbers refer to the questions on the QIVC for educational session facilitation.
  o A “1” means the response was “yes”, a “0” means the response was “no”, and “N/A” means the question wasn’t answered (not applicable).

• Ask participants to work in pairs to answer the last three questions at the bottom of Lesson 13 Handout 2. If they have extra time, they can answer the average score and percentage of score questions. Review the answers using Answer Key to Lesson 15 Handout 2: Analysing Quality Improvement and Verification Checklist (QIVC) Scores.

4. Frequency of Supervising with the QIVC

• Ask participants: How often should you use the QIVC?
For NCGVs, Promoters, Supervisors and Coordinators with unacceptable scores (less than 80%):

- Their supervisor should visit them every month until the score is 80% or above. These are our head facilitators.

For workers with acceptable scores (80% or above at least twice in a row):

- Use the QIVC less frequently to see if they are able to maintain this standard.
- For example, observe them once every quarter or every other quarter after they have a score 80% or above for two quarters in a row.

• **Ask participants:** Looking at Lesson 15 Handout 3, how frequently should each of these staff members be observed?

  - Gabriella is doing well. Use the QIVC at the next visit. If she scores above 80% again, observe her once each quarter or every other quarter.
  - Kwaasi is doing well. Use the QIVC next month, then decrease to once a quarter or every other quarter if he scores 80% or above again.
  - Dorothy is doing well. Use the QIVC at the next observation and then decrease if her scores stay about 80%.
  - We need to work on an improvement plan for Tom. Look at the questions on the QIVC where he scored poorly. Advise him on the things that he should improve. Retrain him if necessary. Make an action plan.
  - Mario and Joseph do not need any more QIVCs this quarter. Use QIVCs with them every other quarter.

5. **Recording QIVC Scores and Monitoring Progress**

• Share the following options for recording QIVC scores with participants.

  - Make a flip chart with Promoter (or Supervisor) scores listed for each quarter (the Manager needs to decide whether or not names should be included on this poster). Hang the poster in the Manager’s office or the district office.
  - The Supervisor keeps a record in his files using graph paper (or a MS Excel spreadsheet) to record scores after each observation.
  - Purchase a manila file folder for each worker. Include all of their QIVCs in this folder and add scores onto a simple chart in the inside cover so you can see improvements over time. Bring each worker’s file to all of his/her observations so you can share progress.

• Show participants the graph in Lesson 15 Flip Chart 3: Graph of Sarah’s Care Group Volunteers. Tell participants that this is one way they can monitor workers’ progress. The graph makes it very easy to understand at a glance how workers are performing. Ask participants to respond to the following two questions related to Sarah’s graph.

  - How many NCGVs have reached the standard score?
Participants should answer that two of them reached 80% (Jean and Desire), and that Vanessa is close behind, but Yvan is doing very poorly.

- Add that you do not need to calculate scores over time for individual workers if you put their scores on a graph. We can see the 80% line and find those who are above and below the line. Remember we are hoping that all workers improve to the point where they reach 80% or above. During the first months of observations, we can expect them to have lower scores, and that is OK because we are looking for improvement over time.

- What percentage of NCGVs reached the standard by quarter 4?
  - Participants should answer 50%.

6. **Wrap Up**

- Train all of the staff and volunteers who will be either using QIVC’s as the observer, or who will be observed with QIVCs, about the checklist’s purpose and how to use it (just as you received training here).

- Remind participants: When training Care Group Volunteers you will need to make the training extremely simple. It is best to develop a basic pictorial QIVC for monitoring and training them. That way, they can learn the pictures and their meaning and do not need to be literate to understand the monitoring tool.
Lesson 15 Flip Chart 1: Individual and Program Performance Goals

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

**Program Performance Goal**
Of all of the QIVCs done in a quarter, 80% of them to have a score of 80% or higher.
Lesson 15 Flip Chart 2: Quality Improvement and Verification Checklist (QIVC) Score Calculations

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

How to calculate:
1. Count the number of individual QIVC scores for that quarter.
2. Count the number of scores that are 80% or above during that quarter.
3. Divide the number of scores that are 80% or above by the total number of QIVC scores for that quarter.
4. Remember, do not add scores, just count them.

Average QIVC Scores
Definition: The average QIVC score among the ones conducted that quarter

How to calculate:
1. Add all the scores together.
2. Divide the sum of all scores by the total number of QIVCs completed that quarter.
Lesson 15 Handout 1: Analysing Quality Improvement and Verification Checklist (QIVC) Scores

For each example calculate both the individual averages and the Program Performance Scores.

Example 1: Tesfaye’s Promoters

<table>
<thead>
<tr>
<th>Name</th>
<th>Score</th>
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<tr>
<td>Abebe</td>
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<tr>
<td>Asnake</td>
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</tr>
<tr>
<td>Tesfaye</td>
<td>77%</td>
</tr>
<tr>
<td>Kebede</td>
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<td>60%</td>
</tr>
<tr>
<td>Yetayesh</td>
<td>55%</td>
</tr>
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- What is the Individual Average?
- What is the Program Performance Score (percentage of scores greater than or equal to 80%)?

Example 2: Abebe’s Promoters

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<tr>
<td>Alem</td>
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<tr>
<td>Gossa</td>
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<td>Maru</td>
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- What is the Individual Average?
- What is the Program Performance Score (percentage of scores greater than or equal to 80%)?

Example 3: Moges’ Promoters

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<td>Taye</td>
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- What is the Individual Average?
- What is the Program Performance Score (percentage of scores greater than or equal to 80%)?
Answer Key to Lesson 15 Handout 1: Analysing Quality Improvement and Verification Checklist (QIVC) Scores

Example 1: Tesfaye’s Promoters
- Average: 78%
- Percentage of scores greater than or equal to 80%: 50%

Example 2: Abebe’s Promoters
- Average: 70%
- Percentage of scores greater than or equal to 80%: 83%

Example 3: Moge’s Promoters
- Average: 70%
- Percentage of scores greater than or equal to 80%: 16%
Lesson 15 Flip Chart 3: Graph of Sarah’s Nurturing Care Group Volunteers

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Lesson 15 Handout 2: Monitoring Quality Improvement and Verification Checklist (QIVC) Scores

Quarter 1 QIVC Scores (1 = yes; 0 = no; Skip = N/A)

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Average score = ____________

Percentage of scores greater than or equal to 80% = ____________
1. What system problems are there?

2. What do you propose as solutions to these system problems?

3. What people problems do you see?

4. What do you propose as solutions to these people problems?
### Answer Key for Lesson 15 Handout 2: Analysing Quality Improvement and Verification Checklist (QIVC) Scores

**Quarter 1 QIVC Scores (1 = yes; 0 = no; Skip = N/A)**

<table>
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<th>Abebe</th>
<th>Kebede</th>
<th>Asnake</th>
<th>Bogale</th>
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<td>N/A</td>
<td>60%</td>
</tr>
<tr>
<td>17</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>71%</td>
</tr>
<tr>
<td>18</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>43%</td>
</tr>
<tr>
<td>19</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>86%</td>
</tr>
<tr>
<td>20</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>43%</td>
</tr>
<tr>
<td>21</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>86%</td>
</tr>
<tr>
<td>22</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>71%</td>
</tr>
<tr>
<td>23</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>86%</td>
</tr>
<tr>
<td>24</td>
<td>1</td>
<td>1</td>
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<td>1</td>
<td>1</td>
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<td>0</td>
<td>57%</td>
</tr>
<tr>
<td>25</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
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<td>1</td>
<td>1</td>
<td>71%</td>
</tr>
<tr>
<td>26</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>27</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>86%</td>
</tr>
<tr>
<td>28</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>43%</td>
</tr>
<tr>
<td>29</td>
<td>0</td>
<td>1</td>
<td>N/A</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>83%</td>
</tr>
<tr>
<td>30</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>71%</td>
</tr>
<tr>
<td><strong>Total yes</strong></td>
<td>19</td>
<td>25</td>
<td>23</td>
<td>25</td>
<td>23</td>
<td>24</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td><strong>Total questions</strong></td>
<td>30</td>
<td>29</td>
<td>29</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td><strong>Percentages</strong></td>
<td>63%</td>
<td>86%</td>
<td>79%</td>
<td>83%</td>
<td>77%</td>
<td>80%</td>
<td>59%</td>
<td></td>
</tr>
</tbody>
</table>

Average score = **75%**

Percentage of scores greater than or equal to 80% = **43%**
1. **What system problems are there?**
   - There are weaknesses in the QIVC for Meeting Facilitation Question Numbers 3, 5, 11, 14, 18, 20, 28.
   - #3 Did the facilitator introduce the topic well?
   - #5 Did the facilitator use the proper eye contact with everyone?
   - #11 Did the facilitator demonstrate skills that s/he was promoting?
   - #14 Did the facilitator give participants adequate time to answer questions?
   - #18 Did the facilitator ask participants if they agree with other participants’ responses?
   - #20 Did the facilitator always reply to participants in a courteous and diplomatic way?
   - #28 Was the content of the educational messages CORRECT?

2. **What do you propose as solutions to these system problems?**
   - Coach staff during the practice and coaching session to make sure they are 1) introducing the topic well, 2) using proper eye contact and 3) including the appropriate activity (#11).
   - During staff trainings, demonstrate (model) the best way to introduce a topic, proper use of eye contact and good discussion techniques (#3,5,14,18,20 and 28).
   - Set up a separate training where you teach facilitators how to deal with problem participants so that they can respond appropriately (#20).
   - Review your materials to find out why many workers are not sharing correct information (#28). Retrain all workers on technical information.
   - Review these questions specifically on the QIVC before the observation, reminding the facilitator to do these actions when “casting a vision” for performance.
   - Ask the facilitators to commit to making these changes.
   - Help facilitators develop ways to remember to do the new things. Ask them, “How will you remember?”
   - Reconsider your trainings: Are you rushing through the trainings so that people don’t understand? You may need to shorten the training and spend more time going over practical examples (increase discussion and allow for more questions).

3. **What people problems do you see?**
   - Abebe and Mesele are scoring poorly, worse than others.

4. **What do you propose as solutions to these people problems?**
   - Consult with the Promoter (if you are the Supervisor) to see what issues might explain the problems
• Observe the Promoter (if you are the Supervisor) teaching the NCGVs; identify any weaknesses.

• Find out the problem with each worker. Are they getting positive feedback from their observer? Why haven’t they improved?

• Review the questions they have missed. Are they scoring poorly on questions that were skipped (not applicable questions)?

• Is the worker unwilling to make changes?

• Ask the person for a plan of how they will improve and chart progress.
Lesson 15 Handout 3: Quality Improvement and Verification Checklist (QIVC) Scores for Six Promoters

After reviewing the data shown below, how often would you recommend that the Supervisor visit these Promoters?

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Gabriella</th>
<th>Kwaasi</th>
<th>Dorothy</th>
<th>Tom</th>
<th>Mario</th>
<th>Joseph</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>68%</td>
<td>74%</td>
<td>53%</td>
<td>47%</td>
<td>74%</td>
<td>89%</td>
<td>68%</td>
</tr>
<tr>
<td>Q2</td>
<td>74%</td>
<td>79%</td>
<td>68%</td>
<td>53%</td>
<td>79%</td>
<td>89%</td>
<td>75%</td>
</tr>
<tr>
<td>Q3</td>
<td>84%</td>
<td>89%</td>
<td>89%</td>
<td>53%</td>
<td>95%</td>
<td>100%</td>
<td>86%</td>
</tr>
</tbody>
</table>
Lesson 16: Care Group Monitoring Information System: Introduction to Registers

[NOTE: All of this content should be included in the NCG training in WV/Ghana since the Promoters and NCGVs will need to use the Registers to establish the NCGs and NGs.]

Achievement-Based Objectives
By the end of this lesson participants will have:

- Practiced completing a Nurturing Care Group (NCG) register
- Interpreted the information in the register
- Practiced teaching others how to use the NCG registers

Duration
2 hours

Materials Needed

- Lesson 16 Handout 1: Nurturing Care Group Management Information System Information Sources
- Lesson 16 Flip Chart 1 and Handout 2: Flow of Information in the Nurturing Care Group Monitoring Information System
- Lesson 16 Handout & Flip Chart 3: Blank Nurturing Care Group Register
- Lesson 16 Handout 4: Example Completed Nurturing Care Group Register
- Lesson 16 Handout 5: Blank Neighbour Group Register
- Lesson 16 Handout 6: Register Quiz
- Answer Key to Lesson 16 Handout 5: Register Quiz

Facilitator’s Notes
This is a relatively challenging lesson to facilitate. Be sure to take time to prepare well beforehand and ensure that all participants understand the information by the end of the lesson. When possible, try to have hard copies of a NCG register and a Neighbour Group (NG) register. And, be sure that participants have Lesson 16 Handout 3: Blank Nurturing Care Group Register and Lesson 16 Handout 5: Blank Neighbour Group Register at the beginning of the lesson. Be sure to go over both box by box. The register quiz at the end of this lesson may be particularly helpful for field staff.

Steps

1. Introduction

- One of the most important responsibilities of each of the NCG team members is the collection and sharing of data.

- **Ask participants:** Why is this such an important task? Tell them that collecting and sharing data helps us monitor the program and assess the effectiveness of each team member and the program as a whole. Therefore, data collection and reporting will be covered over two lessons.
2. Overview of the Nurturing Care Group Management Information System (NCGMIS)

- Refer participants to Lesson 16 Handout 1: Nurturing Care Group Management Information System Information Sources and explain it to them in detail.

- Tell participants: This information is critical to your Nurturing Care Group project as it allows you to monitor attendance at Neighbour Group and Nurturing Care Group meetings, which are the two most important aspects of the NCG approach. If caregivers are not attending these meetings, we know our program will not be successful. Collecting information on important events on all members of Neighbour Groups and Nurturing Care Groups also allows your program to track maternal, child and infant mortality—data that would otherwise be expensive and time intensive to collect.

- Display Lesson 16 Flip Chart 1 and Handout 2: Flow of Information in the Nurturing Care Group Monitoring Information System and have participants follow along on their copies. Describe the overall flow of information for the NCGMIS from the top of the diagram to the bottom. Explain that all of the information will come from the NG and NCG registers. This information will be compiled as it is passed down the chain of command and eventually given to the NC Coordinator and/or manager.

```
Collecting Information on Important Events

In most projects Care Group Volunteers (CGVs) collect data on important events (such as births, child deaths and maternal deaths, or other events tracked by the project). Medical Teams International also has them collect data on referrals at the household level in their CG project in Liberia. The project did this to see the number of referrals at the household level and compare it to the number recorded at the health facilities. It gave the project insights into the effectiveness of the referral process.

World Relief (WR) tracks new pregnancies, as well, to facilitate follow up with pregnant women on important behaviors during pregnancy.

Others have collected data on childhood illnesses and malnutrition. It is important to only collect data that is going to be used by the project for a specific purpose and to avoid overburdening the Volunteers with reporting on too many events. It is also important to only track events that happen in one point in time and are not repeated (like a birth) rather than things that may change a lot month to month (e.g., having a handwashing station).
```

- Explain to participants: In this lesson, we will teach you how to use and complete Neighbour Group and Nurturing Care Group registers. In the next lesson, we will teach you how to create Promoter, Supervisor and Coordinator reports from these registers.

3. How to Use the Registers

- Refer participants to Lesson 16 Handout 3: Blank Nurturing Care Group Register and Lesson 16 Handout 4: Blank Neighbour Group Register. Remind participants that the two registers are very similar.

- First review the NCG register in Lesson 16 Handout 3 with participants. Then refer participants to Lesson 16 Handout 4: Example Completed Nurturing Care Group Register for an example of the following information.
o The top two rows are the title and description of the register.
o On the upper left corner, write the number of the group using the code from the numbering system.
o On the top centre of the register is the key, which displays the meaning of the symbols and letters that will be used to fill out the register.
o In Column 1, write the letter of the Nurturing Care Group Volunteer (NCGV) of the NCG.
o In Column 2, write the name of the NCGV of the NCG.
o In Column 3, write the date the NCGV was registered to participate in this NCG.
o In the first cell of Column 4, the Promoter should fill out the date of that month’s meeting and the lesson taught that month. Each lesson has the module number and the lesson number. Therefore, 2.3 means that Module 2 Lesson 3 was taught.
  ▪ In the lines beneath this date the Promoter should indicate if the Volunteer attended the teaching session by placing a “✓” for attended, an “X” for absent, and a “∙” if the NCGV was visited at home.
  ▪ Next to this line, the Promoter should record any births or deaths that occurred this month. Use the codes from the key: “CB” for child born, “CD” for child death and “MD” for maternal death.

● Next review the NG register in Lesson 16 Handout 4 with participants.
o The top two rows are the title and description of the register.
o On the upper left corner, write the number of the group using the code from the numbering system.
o On the top centre of the register is the key, which displays the meaning of the symbols and letters that will be used to fill out the register.
o In Column 1, write the number of theighbour caregiver of the NG.
o In Column 2, write the name of theighbour caregiver of the NG.
o In Column 3, write the date the neighbour caregiver was registered to participate in this NG.
o In the first cell of Column 4, the NCGV fills out the date of that month’s meeting and the lesson taught. Use the same rules with this column as for the NCG register.

● Remind participants that if NCGVs cannot read and write, the Promoter will need to fill out both registers during NCG meetings. In this case, during the attendance step of a NCG meeting the Promoter would:
o First, take attendance of the NCGVs.
o Second, ask each NCGV to report on:
  ▪ Any new members in their NG
  ▪ The maternal age (i.e., months of pregnancy) or child age (if the mother has a young child) of any new members
- Attendance at the last NG meeting
- Any important events

- Tell participants: If other caregivers in the community become pregnant, they should be invited to join the group as long as the group size doesn’t exceed 15, which is the maximum size of Neighbour Groups. For this reason, you may want to design your Nurturing Care Group program to start with small Neighbour Groups of around 10 caregivers so there’s enough room in the groups for new caregivers to join.

- Tell participants: If a Nurturing Care Group Volunteer dies or wishes to drop out of the program, the Neighbour Group should quickly elect a caregiver from their group to replace her. The previous Volunteer’s name should be crossed off the Nurturing Care Group register, and the newly elected Nurturing Care Group Volunteer’s name should be added in an empty row. In the Neighbour Group register, the previous Care Group Volunteer’s name should be crossed off and replaced with the new Nurturing Care Group Volunteer. The letters continue sequentially.

4. **Activity: Check for Understanding: Register Quiz!**

- Divide participants into pairs then distribute Lesson 16 Handout 6: Register Quiz, and have participants complete the quiz in their groups using the example of the completed NCG register in Lesson 14 Handout 4. For more advanced groups, ask participants to come up with more difficult questions than are listed in Lesson 14 Handout 6.

- After a few minutes, tell the two groups to swap answers and grade the other’s quiz.

- Review answers together using Answer Key to Lesson 16 Handout 6: Register Quiz.

5. **Wrap Up**

Wrap up this lesson by explaining that learning to use the registers takes time and often is more easily learned on the job.
Lesson 16 Handout 1: Nurturing Care Group Management Information System
Information Sources

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

- Neighbour group (NG) register
- Nurturing Care Group (NCG) register

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

1. **Date** when the members joined (registration information)
2. **Attendance** at group meetings or home visits
3. **Important events** of group members (maternal deaths, deaths of children under 2 and child births)
4. **Lessons** in the NCG curriculum that have been covered

**Note on register variations:** Some NCG programs adapt these registers to collect more information (such as immunization coverage, antenatal care attendance and childhood illness). Before deciding whether to collect more information, the program should first consider the following:

- The registers should be as simple as possible. Adding additional fields to the registers will require Nurturing Care Group Volunteers (NCGVs) and Promoters to spend more time filling out the registers during their meetings held every two weeks with NGs and NCGs (respectively), which may take away time from teaching the curriculum. Detailed registers may also create a temptation to falsify information if the NCGVs and Promoters find the registers too burdensome to fill out each meeting.
- The denominator for indicators collected through the NCGMIS only can be caregivers participating in the groups or their children.
Lesson 16 Flip Chart 1 and Handout 2: Flow of Information in the Nurturing Care Group Monitoring Information System

Neighbour Group Registers
(NCGs per Promoter × NCGVs per NCG = 100)

The NCGV completes this during her bi-monthly neighbour group meetings or gives an oral report during regular NCG meetings held every two weeks.

Nurturing Care Group Registers
(5–9 NCGs per Promoter)

The Promoter completes this during her regular NCG meetings.

Promoter Report

Every month the Promoter compiles all of her NCG registers (5–9) and Neighbour Group Registers (depends on the total number of Neighbour Groups) and submits a summary report to the Supervisor.

Supervisor Report

Every month, the Supervisor compiles all of his/her Promoter reports and submits a summary report to the Coordinator.

Coordinator Report

Every month, the Coordinator or manager compiles all of her/his Supervisor reports. He/she shares this report with country leadership and headquarters technical staff and provides information that is later shared with donors.

Country and Donor Reports

Share with headquarters technical staff
Lesson 16 Handout 3: Blank Nurturing Care Group Register

Nurturing Care Group Register

This is a Nurturing Care Group (NCG) register: NCGs are led by Promoters; the members are Nurturing Care Group Volunteers (NCGVs).

<table>
<thead>
<tr>
<th>Group # (use the code from the numbering system):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key:</td>
</tr>
<tr>
<td>✓ Attended group meetings</td>
</tr>
<tr>
<td>CB Child Birth</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NCGV Letter</th>
<th>Promoter (group leader) name:</th>
<th>Date of Registry in NCGs</th>
<th>Month:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NCG Volunteer name:</td>
<td>Date:</td>
<td>Births or Deaths?</td>
<td>Lesson:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date:</td>
<td>Births or Deaths?</td>
<td>Lesson:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date:</td>
<td>Births or Deaths?</td>
<td>Lesson:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date:</td>
<td>Births or Deaths?</td>
<td>Lesson:</td>
</tr>
<tr>
<td></td>
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<td>Date:</td>
<td>Births or Deaths?</td>
<td>Lesson:</td>
</tr>
<tr>
<td></td>
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<td>Date:</td>
<td>Births or Deaths?</td>
<td>Lesson:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date:</td>
<td>Births or Deaths?</td>
<td>Lesson:</td>
</tr>
</tbody>
</table>

Total attended/visited (add all ✓ and *)
Total registered (add all NCGVs still in the NCG)
Maternal Deaths (add all MDs)
Deaths in Children Under 2 Years Old (add all CDs)
Child Births (add all CBs)
Lesson 16 Handout 4: Example Completed Nurturing Care Group Register

**Nurturing Care Group Register**

This is a Nurturing Care Group (NCG) register: NCGs are led by Promoters; the members are Nurturing Care Group Volunteers (NCGVs).

<table>
<thead>
<tr>
<th>NCGV Letter</th>
<th>NCG Volunteer name:</th>
<th>Date of Registry in NCG</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Leena Samuel</td>
<td>Apr 19, 2011</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>B</td>
<td>Martha Abdul</td>
<td>Apr 20, 2011</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>C</td>
<td>Anne Maria Andrews</td>
<td>Apr 20, 2011</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Mitzi Hanold</td>
<td>Apr 20, 2011</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>E</td>
<td>Anne Story</td>
<td>Apr 22, 2011</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>F</td>
<td>Janine Linda</td>
<td>Apr 22, 2011</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>G</td>
<td>Leonie Divine</td>
<td>Apr 22, 2011</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>H</td>
<td>Janet Learner</td>
<td>Apr 22, 2011</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>✓</td>
</tr>
<tr>
<td>I</td>
<td>Marie Leroy</td>
<td>Apr 23, 2011</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>J</td>
<td>Mary Smith</td>
<td>Apr 23, 2011</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>K</td>
<td>Leslie Jackson</td>
<td>Jul 2, 2011</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Key:**
- ✓ Attended group meetings
- X Absent
- CB Child Birth
- CD Under 2 child death
- MD → Maternal death

**Total attended/visited** (add all ✓ and X)

<table>
<thead>
<tr>
<th></th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10</td>
<td>9</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total registered** (add all NCGVs still in the NCG)

<table>
<thead>
<tr>
<th></th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Maternal Deaths** (add all MDs)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

**Deaths in Children Under 2 Years Old** (add all CDs)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Child Births** (add all CBs)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Neighbour Group Register

*This is a Neighbour Group (NG) register: NGs are led by Nurturing Care Group Volunteers (NCGVs); the members are (usually) mothers.*

<table>
<thead>
<tr>
<th>Group # (use the code from the numbering system):</th>
<th></th>
<th>Key:</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>✓</td>
<td>attended group meetings</td>
<td>X Absent</td>
<td>• received home visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CB</td>
<td>Child Birth</td>
<td>CD Under 2 child death</td>
<td>MD → Maternal death</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group #</th>
<th>NCGV (group leader) name:</th>
<th>Date of Registry in Neighbour Group</th>
<th>Month:</th>
<th>Births or Deaths?</th>
<th>Lesson:</th>
<th>Date:</th>
<th>Births or Deaths?</th>
<th>Lesson:</th>
<th>Date:</th>
<th>Births or Deaths?</th>
<th>Lesson:</th>
<th>Date:</th>
<th>Births or Deaths?</th>
<th>Lesson:</th>
<th>Date:</th>
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<th>Births or Deaths?</th>
<th>Lesson:</th>
<th>Date:</th>
<th>Births or Deaths?</th>
<th>Lesson:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NC #</td>
<td>Neighbour Caregiver (NC) name:</td>
<td></td>
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</tr>
</tbody>
</table>

**Total attended/visited** (add all ✓ and *)

**Total registered** (add all NCGVs still in the NCG)

**Maternal Deaths** (add all MDs)

**Deaths in Children Under 2 Years Old** (add all CDs)

**Child Births** (add all CBs)
Lesson 16 Handout 6: Register Quiz

1. What is the Promoter number for this Nurturing Care Group?

2. What lesson was taught on July 4, 2011?

3. Why is Mary Smith’s name crossed out?

4. When did Martha Abdul have her baby?

5. How many deaths of children under 2 years old happened during the period of time tracked by this register?

6. Why isn’t attendance filled out for Leslie Jackson until July 4, 2011?
**Answer Key to Lesson 16 Handout 6: Register Quiz**

1. **What is the Promoter number for this Nurturing Care Group?**
   
   8

2. **What lesson was taught on July 4, 2011?**

   1.5

3. **Why is Mary Smith’s name crossed out?**

   She died

   *Note: Since this project is targeting caregivers, then another caregiver in the home could become the point of contact and they could still participate in the project.*

4. **When did Martha Abdul have her baby?**

   *Between June 18 and July 4, 2011*

5. **How many child deaths happened during the period of time tracked by this register?**

   1

6. **Why isn’t attendance filled out for Leslie Jackson until July 4, 2011?**

   She joined the group later
Lesson 17: Nurturing Care Group Monitoring Information System: Promoter, Supervisor and Coordinator Reports

Achievement-Based Objectives
By the end of this lesson participants will have:
• Practiced completing Promoter, Supervisor and Coordinator reports
• Practiced teaching others to use these reports

Duration
2 hours 15 minutes

Materials Needed
• LCD projector, pointer and example reports (blank and completed) or flip charts of a blank register and a blank Promoter Report showing the first and second page
• Lesson 16 Flip Chart 1 and Handout 2: Flow of Information in the Nurturing Care Group Monitoring Information System
• Lesson 17 Handout 1: Blank Promoter Report
• Lesson 17 Handout 2: Blank Supervisor Report
• Lesson 17 Handout 3: Blank Coordinator Report
• Lesson 17 Handout 4: Example Completed Promoter Report
• Lesson 17 Handout 5: Example Completed Supervisor Report
• Lesson 17 Handout 6: Example Completed Coordinator Report
• Lesson 17 Handout 7: Report Quiz
• Answer Key to Lesson 17 Handout 7: Report Quiz

Facilitator’s Notes
For this session it might be useful to project (via LCD) the forms so that everyone is looking at the same report as you explain it. Be sure to have a pointer, as well.

Steps
1. Introduction

• Tell participants: Now that we’ve looked at the registers, we need to see how that information is used by the other members of the NCG team to create the reports.
• Refer participants back to the diagram from Lesson 16 Flip Chart 1 and Handout 2: Flow of Information in the Nurturing Care Group Management Information System. Explain: Now we’re going to learn how the paid staff members from a Nurturing Care Group program—Promoters, Supervisors and Coordinators—create their monthly reports using information from the Nurturing Care Group and Neighbour Group registers.
• **Ask participants**: Who can remind the group what four types of information are collected in the registers? They should answer registration, attendance, curriculum and important events. Explain that reports compile this information at different levels.

2. **The Promoter Report**

• Refer participants to *Lesson 17 Handout 1: Blank Promoter Report* and project the report using the LCD projector and pointer. Review each page of the report and explain that all information comes directly from the registers of the Nurturing Care Groups (NCGs) and Neighbour Groups (NGs) under that Promoter.

• Remind participants that Promoters are typically responsible for five to nine NCGs, each NCG contains 10–15 Nurturing Care Group Volunteers (NCGVs), and each NCGV leads a NG of 10–15 caregivers. This means that each Promoter may be responsible for tracking information from around 1,000 caregivers. Therefore, it is very important that project staff and Promoters know how to use the registers to complete their monthly reports.

• Explain that all reports, starting with the Promoter reports, are divided into two sections. The first page summarizes information from all NCGs under that staff member. This information comes from the NCG registers. The remaining pages of the report summarize the information from NGs under that staff member using the NG registers.

  o **Promoter Report: Page one (summarized information from all NCGs)**
    ▪ Review the content of the headings.
  
  o **NCG information: The Promoter**:
    ▪ Writes the numbers for each of her NCGs in the top row of the table
    ▪ Copies the summary information from the bottom of the NCG register in the column below each NCG number
    ▪ Records the number and average score of NCGVs observed with a quality improvement and verification checklist (QIVC)
    ▪ Reviews calculations for average QIVC score (the sum of each score divided by the total number of scores available)
  
  o **Page two through the end (summarized information from NG)**
    ▪ Each NCG has its own table. The first row includes the letters of the NCGVs within that NCG.
  
    o In the column under each NCGV letter, the Promoter copies the summary information from the bottom of the NG registers.

3. **The Supervisor Report**

• Refer participants to *Lesson 17 Handout 2: Blank Supervisor Report*. Tell participants that all information for this report comes from the Promoter reports.

• **Page one: NCG information: The Supervisor**:
• Writes the number for each Promoter he/she is responsible for in the top row of the table

• Copies the information from the “Total” column of the first page of the Promoter report, the NCG information table, into the columns below the Promoter numbers

• Records the number of times he/she supervised each Promoter, along with the QIVC for educational session facilitation score

• Reviews calculations for:
  o Percentage of attendance (number who attended divided by number registered)
  o Percentage of Promoters who completed the planned number of QIVCs
  o Average NCGV attendance
  o Expected number of NCGVs to be registered: This number will be different for each Supervisor. The Supervisor calculates the expected number NCGVs for each Promoter separately, then adds up all of the Promoters’ targets for the total. To calculate the Promoter target, the Supervisor multiplies the number of NCGs for which the Promoter is responsible by the expected number of NCGVs per NCG.
  o Percentage of intended attendance reached (number who attended divided by the planned number)

• Page two through the end—NG information: Each Promoter has his/her own table. The first row of the table includes the NCG numbers under that Promoter.

• The Supervisor:
  o Copies the “Total” column from the Promoter’s NG information tables (in pages two through the end of the Promoter report) into the column under each NCG
  o Reviews calculations for:
    ▪ Percentage of attendance (number who attended divided by number registered)
    ▪ Expected number of Neighbour Caregivers (NC) to be registered: This number will be different for each Supervisor. The Supervisor calculates the expected number of NC for each Promoter separately, then adds up all the Promoters’ targets for the total. To calculate the Promoter’s target, the Supervisor multiplies the number of NCGs for which the Promoter is responsible by the expected number of NCGVs per NCG by the expected number of NC per NCGV.
    ▪ Percentage of attendance target reached (attendance divided by the planned number)

4. The Coordinator Report

• Refer participants to Lesson 17 Handout 3: Blank Coordinator Report. Tell participants that all information for this report comes from Supervisor reports.

• Page one: NCG information: The Coordinator:
  o Writes the name of each Supervisor he/she supervises in the top row of the table
o Writes the NCG numbers under each Supervisor in the second row
o Copies the information from the “Total” column on the first page of the Supervisor report, in the NCG information table, into the columns below the Supervisors’ names
o Records the number of times he/she supervised each Supervisor, along with the QIVC for educational session facilitation score
o Reviews calculations for:
  ▪ Percentage of attendance (number who attended divided by number registered)
  ▪ Percentage of Promoters who completed the planned number of QIVCs
  ▪ Average NCGV attendance
  ▪ Target number of NCGVs to be registered, calculated adding up their Supervisors’ targets for NCGVs
  ▪ Percentage of attendance target reached

• Page two through the end—NG information: Each Supervisor has his/her own table. The first row of the table lists the numbers of the Promoters under that Supervisor.

• The Coordinator:
  o Copies the “Total” column from the Supervisor’s NG tables (in pages two through the end) into the column under each Promoter
  o Reviews calculations for:
    ▪ Percentage of attendance (number who attended divided by number registered)
    ▪ Intended NC to be registered, calculated by adding up the Supervisors’ targets for NC
    ▪ Percentage of attendance target reached (attendance divided by planned number)

5. Review Completed Reports


• Start with the Promoter report in Lesson 15 Handout 4. State that the report is for Promoter Rachel White (Promoter 8). The report includes information from NCG 8.5, the register we reviewed in Lesson 16 Handout 4: Example Completed Nurturing Care Group Register. Make sure participants understand how the information from NCG 8.5 appears in this Promoter report.
  o Ask participants: Where in the Promoter report do you think NCG register 8.5 will be recorded? Answers should include the first page because all NCG information is summarized on the first page.
  o Remind participants that the “Total” fields at the bottom of the NCG register supply the data needed for column 8.5 on the first page of the Promoter report (highlighted in green).
- Remind participants that the columns on the first page summarize information about other NCGs (8.1, 8.2, 8.3, etc.).
- Pages two through the end summarize information from the NG registers. Each table represents a different NCG. Each column within a table represents a different NCGV. Remind participants that the information for these tables comes from the “Total” fields from the bottom of each NG register.

- Next, review Lesson 17 Handout 5, the Supervisor report for Kelly Hughes. Show how the “Total” columns from Rachel White’s Promoter report are included in the two different sections of the Supervisor report. Rachel White’s NCG information is summarized on the first page of the Supervisor report, in a table on page 3. These columns and tables are highlighted in green.
  - Explain that the other Promoters’ NCG information is summarized in a column on the first page. The other Promoters’ NG information is summarized in a table in the second section of the report.
  - Review the calculations for:
    - Percentage of attendance (number who attended divided by number registered)
    - Percentage of Promoters who completed target QIVCs
    - Average NCGV attendance
    - Target number of NCGVs to be registered

- Finally, review Lesson 17 Handout 6, the completed Coordinator report. As with the Supervisor report, show participants the following.
  - The “Total” columns from Kelly Hughes’ Supervisor report are included in the two different sections of the Coordinator report.
    - Kelly Hughes’ NCG information is summarized on the first page of the Coordinator report.
    - Kelly Hughes’ NG information is summarized in the second section of the Coordinator Report, in a table on page 2.
    - These columns and tables are highlighted in green.
  - Explain that other Supervisors’ NCG information is summarized in a column on the first page, and other Supervisors’ NG information is summarized in a table in the second section of the report.
  - Review calculations for:
    - Percentage of attendance (number who attended divided by number registered)
    - Percentage of Promoters who completed target QIVCs
    - Average NCGV attendance
    - Target number of NCGVs to be registered
6. **Activity: Check for Understanding: Report Quiz**

- Divide participants into pairs. Distribute *Lesson 17 Handout 7: Report Quiz*.
- Have the participants complete the quiz using the completed reports in *Lesson 17 Handouts 4, 5 and 6*.
- After a few minutes, have participant pairs grade each other’s quiz. Review answers together using *Answer Key to Lesson 17 Handout 7: Report Quiz*.
- **Optional:** If some of the participants are already very experienced with reporting, ask them to review the completed reports (*Handouts 4, 5 and 6*) and develop additional quiz questions for the rest of the group.

7. **Wrap Up**

- Wrap up by telling participants: Mastering the registers and reports takes time. The more you work with them the better you will understand them.
Lesson 17 Handout 1: Blank Promoter Report

Promoter Monthly Report

*Note: This report template is modelled after a program with 8 NCG per Promoter and 14 NCGVs per NCG. It can be easily adapted to fit your program specifications. Additional copies of the second page will be needed for each promoter report, based on the size of your program.*

<table>
<thead>
<tr>
<th>Promoter Name:</th>
<th>Reporting Period:</th>
<th>Province/District:</th>
<th>Page #: ___</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoter #:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary of Nurturing Care Group Registers (Nurturing Care Group Volunteers [NCGVs])

<table>
<thead>
<tr>
<th>Nurturing Care Group Number</th>
<th>NCGVs attended 1st meeting/home visit</th>
<th>NCGVs registered 1st meeting/home visit</th>
<th>NCGVs attended 2nd meeting/home visit</th>
<th>NCGVs registered 2nd meeting/home visit</th>
<th>NCGV maternal deaths</th>
<th>NCGV under 2 child deaths</th>
<th>NCGV births</th>
<th># NCGVs observed with a QIVC*</th>
<th>Average QIVC score (%)</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
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</tbody>
</table>

*Note: Each Promoter should conduct a supportive supervision visit using the quality improvement and verification checklist (QIVC) for 1 NCGV in each NCG every 2 weeks. If a Promoter has 8 NCGs, then he/she would visit 16 NCGVs each month.*
Summary of Neighbour Group Registers (Neighbour Caregivers [NC])

<table>
<thead>
<tr>
<th>Nurturing Care Group #:</th>
<th>NCGV letter</th>
<th>NC attended 1st meeting/home visit</th>
<th>NC registered 1st meeting/home visit</th>
<th>NC attended 2nd meeting/home visit</th>
<th>NC registered 2nd meeting/home visit</th>
<th>NC maternal deaths</th>
<th>NC under 2 child deaths</th>
<th>NC births</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
Lesson 17 Handout 2: Blank Supervisor Report

**Supervisor Report**

*Note:* This template is modelled after a program with 4 Promoters per Supervisor and 8 NCG per Promoter. Additional copies of the second page will be needed for each supervisor report, based on the size of your program.

<table>
<thead>
<tr>
<th>MCHN Supervisor name:</th>
<th>Reporting period:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoter #s Supervisor is responsible for:</td>
<td>State/Province/District:</td>
<td></td>
</tr>
<tr>
<td>Communities:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Summary of NCGVs per Promoter**

<table>
<thead>
<tr>
<th>Promoter number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td># of supervision visits to this Promoter</td>
<td></td>
</tr>
<tr>
<td>QIVC score: Group education (%)</td>
<td>Average score:</td>
</tr>
<tr>
<td>Nurturing Care Group #s (1 through 8)</td>
<td>% attendance</td>
</tr>
<tr>
<td>NCGVs attended 1st meeting/home visit</td>
<td>A</td>
</tr>
<tr>
<td>NCGVs registered 1st meeting/home visit</td>
<td>B</td>
</tr>
<tr>
<td>NCGVs attended 2nd meeting/home visit</td>
<td>C</td>
</tr>
<tr>
<td>NCGVs registered 2nd meeting/home visit</td>
<td>D</td>
</tr>
<tr>
<td>NCGV maternal deaths</td>
<td></td>
</tr>
<tr>
<td>NCGV under2 child deaths</td>
<td></td>
</tr>
<tr>
<td>NCGV births</td>
<td></td>
</tr>
<tr>
<td># of NCGVs observed with QIVC</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

<table>
<thead>
<tr>
<th>% of Promoters who completed all 16 QIVCs this month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average NCGV attendance this month: (A + C) ÷ 2 E</td>
</tr>
<tr>
<td>Goal # of NCGVs to be registered by this Supervisor F</td>
</tr>
<tr>
<td>% of attendance goal reached this month: (E ÷ F) × 100</td>
</tr>
</tbody>
</table>
### Summary of Neighbour Caregivers (NC) by Promoter and NCG

<table>
<thead>
<tr>
<th>Promoter number</th>
<th>NCGs #s responsible for</th>
<th>NC attended 1st meeting/home visit</th>
<th>NC registered 1st meeting/home visit</th>
<th>NC attended 2nd meeting/home visit</th>
<th>NC registered 2nd meeting/home visit</th>
<th>NC maternal deaths</th>
<th>NC under 2 child deaths</th>
<th>NC births</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>% attendance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>A</td>
<td>(A ÷ B) × 100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>B</td>
<td>(C ÷ D) × 100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>C</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>D</td>
<td></td>
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</tr>
</tbody>
</table>

**Comments:**

- Average NC attendance this month: \((A + C) ÷ 2\)
- Goal # of NC to be registered by this Promoter
- % of attendance goal reached this month: \((E ÷ F) × 100\)
Lesson 17 Handout 3: Blank Coordinator Report

**Coordinator Report**

*Note: This report template is modelled after a program with 4 Supervisors reporting to the Coordinator and 4 Promoters per Supervisor. Additional copies of the second page will be needed for each coordinator report, based on the size of your program.*

<table>
<thead>
<tr>
<th>MCHN Coordinator name:</th>
<th>Reporting period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Supervisors the Coordinator is responsible for:</td>
<td>State/Province/District:</td>
</tr>
<tr>
<td>Communities:</td>
<td></td>
</tr>
</tbody>
</table>

**Summary of NCGVs per Supervisor**

<table>
<thead>
<tr>
<th>Supervisor name</th>
<th>Total</th>
<th>Average score:</th>
</tr>
</thead>
<tbody>
<tr>
<td># of supervision visits to this Supervisor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QIVC score: Group education (%)</td>
<td>Average score:</td>
<td></td>
</tr>
<tr>
<td>Promoter and NCGs #s responsible for</td>
<td>% attendance</td>
<td></td>
</tr>
<tr>
<td>NCGVs attended 1st meeting/home visit</td>
<td>A ( \frac{A}{B} \times 100 = )</td>
<td></td>
</tr>
<tr>
<td>NCGVs registered 1st meeting/home visit</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>NCGVs attended 2nd meeting/home visit</td>
<td>C ( \frac{C}{D} \times 100 = )</td>
<td></td>
</tr>
<tr>
<td>NCGVs registered 2nd meeting/home visit</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>NCGV maternal deaths</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCGV under2 child deaths</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCGV births</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of NCGVs observes with QIVC</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Promoters who completed all 16 QIVCs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

- Average NCGV attendance this month: \( \frac{A + C}{2} \)
- Goal # of NCGVs to be registered by this Coordinator: F
- % of attendance goal reached this month: \( \frac{E}{F} \times 100 \)
## Summary of Neighbour Caregivers (NC) by Supervisor and Promoter

<table>
<thead>
<tr>
<th>Supervisor name</th>
<th>Promoter #</th>
<th>Total</th>
<th>% attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>NC attended 1st meeting/home visit</td>
<td>A</td>
<td>(A ÷ B) × 100 =</td>
<td></td>
</tr>
<tr>
<td>NC registered 1st meeting/home visit</td>
<td>B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NC attended 2nd meeting/home visit</td>
<td>C</td>
<td>(C ÷ D) × 100 =</td>
<td></td>
</tr>
<tr>
<td>NC registered 2nd meeting/home visit</td>
<td>D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NC maternal deaths</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NC under 2 child deaths</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NC births</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**
- Average NC attendance this month: (A + C) ÷ 2
- Goal # of NC to be registered by this Supervisor
- % of attendance goal reached this month: (E ÷ F) × 100
Lesson 17 Handout 4: Example Completed Promoter Report

Promoter Monthly Report

Nota: This report template is modelled after a program with 8 NCGs per Promoter and 14 NCGVs per NCG. It can be easily adapted to fit your program specifications. Additional copies of the second page will be needed for each promoter report, based on the size of your program.

<table>
<thead>
<tr>
<th>Promoter Name:</th>
<th>Rachel White</th>
<th>Reporting Period:</th>
<th>May-11</th>
<th>Page #: 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoter #:</td>
<td>8</td>
<td>Province/District:</td>
<td>California, Los Angeles</td>
<td></td>
</tr>
</tbody>
</table>

Summary of Nurturing Care Group Registers (NCGVs)

<table>
<thead>
<tr>
<th>Nurturing Care Group Number</th>
<th>8.1</th>
<th>8.2</th>
<th>8.3</th>
<th>8.4</th>
<th>8.5</th>
<th>8.6</th>
<th>8.7</th>
<th>8.8</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCGVs attended 1st meeting/home visit</td>
<td>12</td>
<td>11</td>
<td>9</td>
<td>12</td>
<td>10</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>87</td>
</tr>
<tr>
<td>NCGVs registered 1st meeting/home visit</td>
<td>12</td>
<td>12</td>
<td>10</td>
<td>13</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>93</td>
</tr>
<tr>
<td>NCGVs attended 2nd meeting/home visit</td>
<td>12</td>
<td>12</td>
<td>10</td>
<td>10</td>
<td>9</td>
<td>11</td>
<td>12</td>
<td>10</td>
<td>86</td>
</tr>
<tr>
<td>NCGVs registered 2nd meeting/home visit</td>
<td>12</td>
<td>12</td>
<td>10</td>
<td>13</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>93</td>
</tr>
<tr>
<td>NCGV maternal deaths</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>NCGV under 2 child deaths</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>NCGV births</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td># NCGVs observed with a QIVC*</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Average QIVC score (%)</td>
<td>89</td>
<td>80</td>
<td>62</td>
<td>90</td>
<td>89</td>
<td>75</td>
<td>70</td>
<td>90</td>
<td>81</td>
</tr>
</tbody>
</table>

Comments:

Nota: Each Promoter should conduct a supportive supervision visit using the quality improvement and verification checklist (QIVC) for 1 NCGV in each NCG every 2 weeks. If a Promoter has 8 NCGs, then he/she would visit 16 NCGVs each month.
<table>
<thead>
<tr>
<th>Nurturing Care Group #:</th>
<th>8.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCGV letter</td>
<td>A B C D E F G H I J K L</td>
</tr>
<tr>
<td>NC attended 1st meeting/home visit</td>
<td>11 12 13 10 11 12 13 12 12 13 14 12</td>
</tr>
<tr>
<td>NC registered 1st meeting/home visit</td>
<td>11 12 14 12 12 13 13 12 12 15 15 15</td>
</tr>
<tr>
<td>NC attended 2nd meeting/home visit</td>
<td>10 12 10 11 11 14 12 12 11 14 13 14</td>
</tr>
<tr>
<td>NC registered 2nd meeting/home visit</td>
<td>11 2 14 11 12 12 16 12 12 15 15 15</td>
</tr>
<tr>
<td>NC maternal deaths</td>
<td>0 0 0 1 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>NC under 2 child deaths</td>
<td>1 0 0 0 0 0 1 0 0 0 0 0</td>
</tr>
<tr>
<td>NC births</td>
<td>0 0 0 0 0 1 0 0 0 0 0 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nurturing Care Group #:</th>
<th>8.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCGV letter</td>
<td>A B C D E F G H I J K L</td>
</tr>
<tr>
<td>NC attended 1st meeting/home visit</td>
<td>11 10 11 12 13 12 13 10 12 12 14 10</td>
</tr>
<tr>
<td>NC registered 1st meeting/home visit</td>
<td>12 12 12 15 13 12 15 10 14 12 15 15</td>
</tr>
<tr>
<td>NC attended 2nd meeting/home visit</td>
<td>10 12 10 11 11 13 12 12 11 14 13 14</td>
</tr>
<tr>
<td>NC registered 2nd meeting/home visit</td>
<td>11 12 14 11 12 14 16 12 12 15 15 15</td>
</tr>
<tr>
<td>NC maternal deaths</td>
<td>0 0 0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>NC under 2 child deaths</td>
<td>1 0 0 0 0 0 1 0 0 0 0 0</td>
</tr>
<tr>
<td>NC births</td>
<td>0 0 0 1 0 0 0 0 0 0 0 1</td>
</tr>
</tbody>
</table>
Promoter Name: Rachel White

Summary of Neighbour Group Registers (Neighbour Caregivers [NC])

<table>
<thead>
<tr>
<th>Nurturing Care Group #</th>
<th>8.3</th>
<th>8.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCGV letter</td>
<td>A  B  C  D  E  F  G  H  I  J  K  L</td>
<td>A  B  C  D  E  F  G  H  I  J  K  L</td>
</tr>
<tr>
<td>NC attended 1st meeting/home visit</td>
<td>11  10  11  12  13  12  13  10  12  12  14  10</td>
<td>14  13  10  12  14  12  12  14  12  13  14  12</td>
</tr>
<tr>
<td>NC registered 1st meeting/home visit</td>
<td>12  12  12  15  13  12  15  10  14  12  15  15</td>
<td>15  13  12  14  12  14  12  15  15  15  16  15</td>
</tr>
<tr>
<td>NC attended 2nd meeting/home visit</td>
<td>10  12  10  11  11  13  12  11  14  13  14</td>
<td>11  12  14  11  12  14  16  12  12  15  15  15</td>
</tr>
<tr>
<td>NC registered 2nd meeting/home visit</td>
<td>11  12  14  11  12  14  16  12  12  15  15  15</td>
<td>14  14  14  11  12  13  14  12  12  14  15  15</td>
</tr>
<tr>
<td>NC maternal deaths</td>
<td>0  0  0  0  0  0  0  0  0  0  0  0</td>
<td>0  0  0  0  0  0  0  0  0  0  0  0</td>
</tr>
<tr>
<td>NC under 2 child deaths</td>
<td>1  0  0  0  0  0  1  0  0  0  0  0</td>
<td>0  2  0  0  0  0  0  1  0  0  0  0</td>
</tr>
<tr>
<td>NC births</td>
<td>0  0  0  0  1  0  0  0  0  0  1  0</td>
<td>0  0  0  0  0  0  0  0  1  0  0  0</td>
</tr>
</tbody>
</table>
Promoter Name: Rachel White

Summary of Neighbour Group Registers (Neighbour Caregivers [NC])

<table>
<thead>
<tr>
<th>Nurturing Care Group #:</th>
<th>8.5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
</tr>
<tr>
<td>NCGV letter</td>
<td></td>
</tr>
<tr>
<td>NC attended 1st meeting/home visit</td>
<td>11</td>
</tr>
<tr>
<td>NC registered 1st meeting/home visit</td>
<td>11</td>
</tr>
<tr>
<td>NC attended 2nd meeting/home visit</td>
<td>10</td>
</tr>
<tr>
<td>NC registered 2nd meeting/home visit</td>
<td>11</td>
</tr>
<tr>
<td>NC maternal deaths</td>
<td>0</td>
</tr>
<tr>
<td>NC under 2 child deaths</td>
<td>1</td>
</tr>
<tr>
<td>NC births</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nurturing Care Group #:</th>
<th>8.6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
</tr>
<tr>
<td>NCGV letter</td>
<td></td>
</tr>
<tr>
<td>NC attended 1st meeting/home visit</td>
<td>11</td>
</tr>
<tr>
<td>NC registered 1st meeting/home visit</td>
<td>12</td>
</tr>
<tr>
<td>NC attended 2nd meeting/home visit</td>
<td>10</td>
</tr>
<tr>
<td>NC registered 2nd meeting/home visit</td>
<td>11</td>
</tr>
<tr>
<td>NC maternal deaths</td>
<td>0</td>
</tr>
<tr>
<td>NC under 2 child deaths</td>
<td>1</td>
</tr>
<tr>
<td>NC births</td>
<td>0</td>
</tr>
</tbody>
</table>
### Summary of Neighbour Group Registers (Neighbour Caregivers [NC])

<table>
<thead>
<tr>
<th>Nurturing Care Group #</th>
<th>8.7</th>
<th>8.8</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NCGV letter</strong></td>
<td>A  B  C  D  E  F  G  H  I  J  K  L</td>
<td>Total</td>
</tr>
<tr>
<td>NC attended 1st meeting/home visit</td>
<td>11 10 11 12 13 12 13 12 12 14 12</td>
<td>144</td>
</tr>
<tr>
<td>NC registered 1st meeting/home visit</td>
<td>12 12 12 15 13 12 16 12 12 15 12</td>
<td>155</td>
</tr>
<tr>
<td>NC attended 2nd meeting/home visit</td>
<td>10 12 10 11 11 13 12 12 11 14 13</td>
<td>143</td>
</tr>
<tr>
<td>NC registered 2nd meeting/home visit</td>
<td>11 12 14 11 12 14 16 12 12 14 15 15</td>
<td>158</td>
</tr>
<tr>
<td>NC maternal deaths</td>
<td>0 0 0 0 0 0 0 0 0 0 0</td>
<td>0</td>
</tr>
<tr>
<td>NC under 2 child deaths</td>
<td>1 0 0 0 0 0 1 0 0 0 0 0</td>
<td>2</td>
</tr>
<tr>
<td>NC births</td>
<td>0 0 0 0 1 0 0 0 0 1 0 0 0 2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nurturing Care Group #</th>
<th>8.8</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NCGV letter</strong></td>
<td>A  B  C  D  E  F  G  H  I  J  K  L</td>
</tr>
<tr>
<td>NC attended 1st meeting/home visit</td>
<td>12 13 12 12 12 14 12 13 12 10 11</td>
</tr>
<tr>
<td>NC registered 1st meeting/home visit</td>
<td>12 16 12 12 12 15 12 13 12 12 12</td>
</tr>
<tr>
<td>NC attended 2nd meeting/home visit</td>
<td>13 12 12 11 14 14 13 11 11 13 12 12</td>
</tr>
<tr>
<td>NC registered 2nd meeting/home visit</td>
<td>14 16 12 12 14 15 15 11 12 14 12 14</td>
</tr>
<tr>
<td>NC maternal deaths</td>
<td>0 0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>NC under 2 child deaths</td>
<td>0 1 0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>NC births</td>
<td>0 0 0 0 1 0 0 0 1 0 0 0 2</td>
</tr>
</tbody>
</table>
# Lesson 17 Handout 5: Example Completed Supervisor Report

**Supervisor Report**

*Note: This template is modelled after a program with 5 Promoters per Supervisor and 8 NCG per Promoter. Additional copies of the second page will be needed for each supervisor report, based on the size of your program.*

<table>
<thead>
<tr>
<th>MCHN Supervisor name:</th>
<th>Kelly Hughes</th>
<th>Reporting period:</th>
<th>May-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoter #s Supervisor is responsible for:</td>
<td>5 through 8</td>
<td>State/Province/District:</td>
<td>California, Los Angeles</td>
</tr>
<tr>
<td>Communities:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Summary of NCGVs per Promoter

<table>
<thead>
<tr>
<th>Promoter number</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td># of supervision visits to this Promoter</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>QIVC score: Group education (%)</td>
<td>83</td>
<td>85</td>
<td>62</td>
<td>80</td>
<td>Average score: 77</td>
</tr>
<tr>
<td>NCG #s (1 through 8)</td>
<td>1-7</td>
<td>1-5</td>
<td>1-7</td>
<td>1-8</td>
<td>% attendance</td>
</tr>
<tr>
<td>NCGVs attended 1st meeting/home visit</td>
<td>72</td>
<td>50</td>
<td>76</td>
<td>87</td>
<td>A</td>
</tr>
<tr>
<td>NCGVs registered 1st meeting/home visit</td>
<td>78</td>
<td>52</td>
<td>80</td>
<td>93</td>
<td>B</td>
</tr>
<tr>
<td>NCGVs attended 2nd meeting/home visit</td>
<td>70</td>
<td>48</td>
<td>79</td>
<td>86</td>
<td>C</td>
</tr>
<tr>
<td>NCGVs registered 2nd meeting/home visit</td>
<td>78</td>
<td>50</td>
<td>82</td>
<td>93</td>
<td>D</td>
</tr>
<tr>
<td>NCGV maternal deaths</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>NCGV under2 child deaths</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>NCGV births</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td># of NCGVs observed with QIVC</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>13</td>
<td>24</td>
</tr>
</tbody>
</table>

**Comments:** Goal # of NCGVs to be registered by this Supervisor:
- Promoter 5: 7 NCGs x 12 NCGVs
- Promoter 6: 5 NCGs x 12 NCGVs
- Promoter 7: 7 NCGs x 12 NCGVs
- Promoter 8: 8 NCGs x 12 NCGVs

- % of Promoters who completed all 16 QIVCs this month | 50 |
- Average NCGV attendance this month: (A + C) ÷ 2 | E | 284 |
- Goal # of NCGVs to be registered by this Supervisor | F | 288 |
- % of attendance goal reached this month: (E ÷ F) × 100 | 99 |
**Summary of Neighbour Caregivers (NC) by Promoter and NCG**

<table>
<thead>
<tr>
<th>Promoter number</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCGs #s responsible for</td>
<td>5.1 5.2 5.3 5.4 5.5 5.6 5.7</td>
</tr>
<tr>
<td>NC attended 1st meeting/home visit</td>
<td>145 140 155 125 150 161 170</td>
</tr>
<tr>
<td>NC registered 1st meeting/home visit</td>
<td>150 162 172 160 162 164 182</td>
</tr>
<tr>
<td>NC attended 2nd meeting/home visit</td>
<td>149 160 162 145 145 162 175</td>
</tr>
<tr>
<td>NC registered 2nd meeting/home visit</td>
<td>150 164 180 162 165 168 182</td>
</tr>
<tr>
<td>NC maternal deaths</td>
<td>0 0 1 0 0 0 1</td>
</tr>
<tr>
<td>NC under 2 child deaths</td>
<td>1 2 1 2 1 2 11</td>
</tr>
<tr>
<td>NC births</td>
<td>1 2 1 3 1 1 10</td>
</tr>
<tr>
<td>% attendance</td>
<td>A 1046 (A ÷ B) × 100 = 91%</td>
</tr>
<tr>
<td></td>
<td>B 1152</td>
</tr>
<tr>
<td></td>
<td>C 1098 (C ÷ D) × 100 = 94%</td>
</tr>
</tbody>
</table>

**Comments:** Attendance goal set during program design phase. This example: 12 NC per NCGV. Important to note it’s fine to exceed this number, so % of attendance goal can be > 100%. Promoter 5: 7 NCGs × 12 NCGVs × 12 NC = 1008.

Average NC attendance this month: (A + C) ÷ 2  E 1072
Goal # of NC to be registered by this Promoter  F 1008
% of attendance goal reached this month: (E ÷ F) × 100 > 100

<table>
<thead>
<tr>
<th>Promoter number</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCGs #s responsible for</td>
<td>6.1 6.2 6.3 6.4 6.5</td>
</tr>
<tr>
<td>NC attended 1st meeting/home visit</td>
<td>152 149 160 150 165</td>
</tr>
<tr>
<td>NC registered 1st meeting/home visit</td>
<td>162 155 172 190 182</td>
</tr>
<tr>
<td>NC attended 2nd meeting/home visit</td>
<td>155 161 171 172 181</td>
</tr>
<tr>
<td>NC registered 2nd meeting/home visit</td>
<td>163 165 175 189 185</td>
</tr>
<tr>
<td>NC maternal deaths</td>
<td>0 1 0 0 0 1</td>
</tr>
<tr>
<td>NC under 2 child deaths</td>
<td>2 0 2 1 1 6</td>
</tr>
<tr>
<td>NC births</td>
<td>2 1 2 1 1 7</td>
</tr>
<tr>
<td>% attendance</td>
<td>A 776 (A ÷ B) × 100 = 90%</td>
</tr>
<tr>
<td></td>
<td>B 861</td>
</tr>
<tr>
<td></td>
<td>C 840 (C ÷ D) × 100 = 96%</td>
</tr>
</tbody>
</table>

**Comments:** Goal # of NC to be registered by Promoter #6: 5 NCGs × 12 NCGVs × 12 NC = 720

Average NC attendance this month: (A + C) ÷ 2  E 808
Goal # of NC to be registered by this Promoter  F 720
% of attendance goal reached this month: (E ÷ F) × 100 > 100
### Summary of Neighbour Caregivers (NC) by Promoter and NCG

<table>
<thead>
<tr>
<th>Promoter number</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCGs #s responsible for</td>
<td>7.1</td>
</tr>
<tr>
<td>NC attended 1st meeting/home visit</td>
<td>170</td>
</tr>
<tr>
<td>NC registered 1st meeting/home visit</td>
<td>182</td>
</tr>
<tr>
<td>NC attended 2nd meeting/home visit</td>
<td>152</td>
</tr>
<tr>
<td>NC registered 2nd meeting/home visit</td>
<td>183</td>
</tr>
<tr>
<td>NC maternal deaths</td>
<td>0</td>
</tr>
<tr>
<td>NC under 2 child deaths</td>
<td>2</td>
</tr>
<tr>
<td>NC births</td>
<td>1</td>
</tr>
<tr>
<td>Comments: Goal # of NC to be registered by Promoter #7: 7 NCGs × 12 NCGVs × 12 NC = 1260</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total</th>
<th>% attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 1086</td>
<td>(A ÷ B) × 100 = 91%</td>
</tr>
<tr>
<td>B 1192</td>
<td></td>
</tr>
<tr>
<td>C 1035</td>
<td>(C ÷ D) × 100 = 86%</td>
</tr>
<tr>
<td>D 1204</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average NC attendance this month: (A + C) ÷ 2</th>
<th>E 1061</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target # of NC to be registered by this Promoter</td>
<td>F 1008</td>
</tr>
<tr>
<td>% of attendance goal reached this month: (E ÷ F) × 100</td>
<td>&gt; 100</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Promoter number</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCGs #s responsible for</td>
<td>8.1</td>
</tr>
<tr>
<td>NC attended 1st meeting/home visit</td>
<td>145</td>
</tr>
<tr>
<td>NC registered 1st meeting/home visit</td>
<td>160</td>
</tr>
<tr>
<td>NC attended 2nd meeting/home visit</td>
<td>143</td>
</tr>
<tr>
<td>NC registered 2nd meeting/home visit</td>
<td>159</td>
</tr>
<tr>
<td>NC maternal deaths</td>
<td>1</td>
</tr>
<tr>
<td>NC under 2 child deaths</td>
<td>2</td>
</tr>
<tr>
<td>NC births</td>
<td>2</td>
</tr>
<tr>
<td>Comments: Goal # for NC to be registered by Promoter #8: 8 NCG × 12 NCGVs × 12 NC = 1152</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total</th>
<th>% attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 1149</td>
<td>(A ÷ B) × 100 = 91%</td>
</tr>
<tr>
<td>B 1258</td>
<td></td>
</tr>
<tr>
<td>C 1145</td>
<td>(C ÷ D) × 100 = 90%</td>
</tr>
<tr>
<td>D 1274</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average NC attendance this month: (A + C) ÷ 2</th>
<th>E 1147</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal # of NC to be registered by this Promoter</td>
<td>F 1152</td>
</tr>
<tr>
<td>% of attendance goal reached this month: (E ÷ F) × 100</td>
<td>100</td>
</tr>
</tbody>
</table>
### Lesson 17 Handout 6: Example Completed Coordinator Report

**Coordinator Report**

*Note:* This report template is modelled after a program with 4 Supervisors reporting to the Coordinator and 4 Promoters per Supervisor. Additional copies of the second page will be needed for each coordinator report, based on the size of your program.

<table>
<thead>
<tr>
<th>MCHN Coordinator name:</th>
<th>Sara Smith</th>
<th>Reporting period:</th>
<th>May-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Supervisors the Coordinator is responsible for:</td>
<td>Carolyn, Kelly, Jen, and Emily</td>
<td>State/Province/District:</td>
<td>West, California, Los Angeles</td>
</tr>
</tbody>
</table>

#### Summary of NCGVs per Supervisor

<table>
<thead>
<tr>
<th>Supervisor name</th>
<th>Carolyn</th>
<th>Kelly</th>
<th>Jen</th>
<th>Emily</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td># of supervision visits to this Supervisor</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>QIVC score: Group education (%)</td>
<td>75</td>
<td>81</td>
<td>62</td>
<td>91</td>
<td>Average score: 77</td>
</tr>
<tr>
<td>Promoter and NCG #s responsible for</td>
<td>1.1-4.8</td>
<td>5.1-8.8</td>
<td>9.1-12.8</td>
<td>13.1-16.8</td>
<td></td>
</tr>
<tr>
<td>NCGVs attended 1st meeting/home visit</td>
<td>352</td>
<td>285</td>
<td>321</td>
<td>332</td>
<td>A = 1290 (A ÷ B) × 100 = 89.1%</td>
</tr>
<tr>
<td>NCGVs registered 1st meeting/home visit</td>
<td>392</td>
<td>303</td>
<td>352</td>
<td>401</td>
<td>B = 1448</td>
</tr>
<tr>
<td>NCGVs attended 2nd meeting/home visit</td>
<td>372</td>
<td>283</td>
<td>352</td>
<td>342</td>
<td>C = 1349 (C ÷ D) × 100 = 91.8%</td>
</tr>
<tr>
<td>NCGVs registered 2nd meeting/home visit</td>
<td>405</td>
<td>303</td>
<td>360</td>
<td>402</td>
<td>D = 1470</td>
</tr>
<tr>
<td>NCGV maternal deaths</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>NCGV under2 child deaths</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>NCGV births</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td># of NCGVs observes with QIVC</td>
<td>31</td>
<td>24</td>
<td>32</td>
<td>28</td>
<td>115</td>
</tr>
<tr>
<td># of Promoters who completed all 16 QIVCs</td>
<td>70</td>
<td>50</td>
<td>92</td>
<td>65</td>
<td>69</td>
</tr>
</tbody>
</table>

**Comments:** Goal # of NCGVs to be registered by this Coordinator: 4 Supervisors x 4 Promoters per Supervisor x 8 NCGs per Promoter x 12 NCGVs per NCG = 1536

- Average NCGV attendance this month: \((A + C) ÷ 2\) = E = 1320
- Goal # of NCGVs to be registered by this Coordinator: F = 1536
- % of attendance goal reached this month: \((E ÷ F) × 100\) = 86
### Summary of Neighbour Caregivers (NC) by Supervisor and Promoter

<table>
<thead>
<tr>
<th>Supervisor name</th>
<th>Carolyn Wilson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoter #</td>
<td>1   2   3   4</td>
</tr>
<tr>
<td>NC attended 1st meeting/home visit</td>
<td>921 872 801 941</td>
</tr>
<tr>
<td>NC registered 1st meeting/home visit</td>
<td>1001 902 821 851</td>
</tr>
<tr>
<td>NC attended 2nd meeting/home visit</td>
<td>923 840 821 856</td>
</tr>
<tr>
<td>NC registered 2nd meeting/home visit</td>
<td>1005 924 850 860</td>
</tr>
<tr>
<td>NC maternal deaths</td>
<td>0 1 0 1</td>
</tr>
<tr>
<td>NC under 2 child deaths</td>
<td>3 5 4 11</td>
</tr>
<tr>
<td>NC births</td>
<td>9 6 9 10</td>
</tr>
</tbody>
</table>

**Comments:** Goal # of NC to be registered by this Supervisor: 4 Promoters × 8 NCGs × 12 NCGVs = 4608

<table>
<thead>
<tr>
<th>Supervisor name</th>
<th>Kelly Hughes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoter #</td>
<td>5   6   7   8</td>
</tr>
<tr>
<td>NC attended 1st meeting/home visit</td>
<td>1046 776 1086 1149</td>
</tr>
<tr>
<td>NC registered 1st meeting/home visit</td>
<td>1152 861 1192 1258</td>
</tr>
<tr>
<td>NC attended 2nd meeting/home visit</td>
<td>1098 840 1035 1145</td>
</tr>
<tr>
<td>NC registered 2nd meeting/home visit</td>
<td>1171 877 1204 1274</td>
</tr>
<tr>
<td>NC maternal deaths</td>
<td>1 1 0 2</td>
</tr>
<tr>
<td>NC under 2 child deaths</td>
<td>11 6 7 16</td>
</tr>
<tr>
<td>NC births</td>
<td>10 7 8 15</td>
</tr>
</tbody>
</table>

**Comments:** Goal # of NC to be registered by this Supervisor: 4 Promoters × 8 NCGs × 12 NCGVs × 12 NC = 4608

Average NC attendance this month: (A + C) ÷ 2 | E 4088 |
Goal # of NC to be registered by this Supervisor | F 4608 |
% of attendance goal reached this month: (E ÷ F) × 100 | 89 |
### Summary of Neighbour Caregivers (NC) by Supervisor and Promoter

<table>
<thead>
<tr>
<th>Supervisor name</th>
<th>Jen Milner</th>
<th>Emily Hayes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Promoter #</strong></td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td><strong>NC attended 1st meeting/home visit</strong></td>
<td>800 901 954 776</td>
<td>962 852 951 801</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>A 3431</td>
<td>A 3566</td>
</tr>
<tr>
<td><strong>% attendance</strong></td>
<td>(A ÷ B) × 100 = 96%</td>
<td>(A ÷ B) × 100 = 95%</td>
</tr>
<tr>
<td><strong>NC registered 1st meeting/home visit</strong></td>
<td>820 950 998 802</td>
<td>982 872 1021 898</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>B 3570</td>
<td>B 3773</td>
</tr>
<tr>
<td><strong>NC attended 2nd meeting/home visit</strong></td>
<td>802 897 951 790</td>
<td>941 825 976 856</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>C 3440</td>
<td>C 3598</td>
</tr>
<tr>
<td><strong>NC registered 2nd meeting/home visit</strong></td>
<td>865 925 1001 823</td>
<td>1001 880 1025 912</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>D 3614</td>
<td>D 3818</td>
</tr>
<tr>
<td><strong>% attendance</strong></td>
<td>(C ÷ D) × 100 = 95%</td>
<td>(C ÷ D) × 100 = 94%</td>
</tr>
<tr>
<td><strong>NC maternal deaths</strong></td>
<td>0 1 0 0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>% attendance</strong></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>NC under 2 child deaths</strong></td>
<td>1 7 2 9</td>
<td>2 6 1 5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>19</td>
<td></td>
</tr>
<tr>
<td><strong>% attendance</strong></td>
<td>19</td>
<td></td>
</tr>
<tr>
<td><strong>NC births</strong></td>
<td>7 9 5 8</td>
<td>6 5 7 5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>29</td>
<td></td>
</tr>
<tr>
<td><strong>% attendance</strong></td>
<td>29</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:** Goal # of NC to be registered by this Supervisor: 4 Promoters × 8 NCGs × 12 NCGVs × 12 NC = 4608

Average NC attendance this month: (A + C) ÷ 2 | E 3436 | E 3582 |

Goal # of NC to be registered by this Supervisor | F 4608 | F 4608 |

% of attendance goal reached this month: (E ÷ F) × 100 | 75 | 78 |
Lesson 17 Handout 7: Report Quiz

   A. How many Nurturing Care Group Volunteers (NCGVs) were observed with a quality improvement and verification checklist (QIVC)?

   B. How many Nurturing Care Groups (NCGs) does Rachel White train and supervise?

   C. How many of Rachel’s NCGVs had babies during the month of May?

   D. In Nurturing Care Group 8.4, how many Neighbour Caregivers (NC) attended the first meeting/home visit?

2. Look at Supervisor Kelly Hughes’ report in Lesson 15 Handout 5.
   A. What percent of NCGVs under this Supervisor attended the second meeting?

   B. For all NC under Promoter 8, how many children under 2 years of age died?

3. Look at Coordinator Sarah Smith’s report in Lesson 15 Handout 6.
   A. What percentage of Sarah’s Promoters completed all six QIVCs this month?

   B. What percentage of Sarah’s target number of NCGVs were reached in May?

   C. Find the summary information of NC under Supervisor Emily Hayes. How many NC in total were registered during the second half of the month?
Answer Key to Lesson 17 Handout 7: Report Quiz

   A. How many Nurturing Care Group Volunteers (NCGVs) were observed with a quality improvement and verification checklist (QIVC)?
      13
   B. How many Nurturing Care Groups (NCGs) does Rachel White train and supervise?
      8
   C. How many of Rachel’s NCGVs had babies during the month of May?
      2
   D. In Nurturing Care Group 8.4, how many Neighbour Caregivers (NC) attended the first meeting/home visit?
      148

2. Look at Supervisor Kelly Hughes’ report in Lesson 15 Handout 5.
   A. What percent of NCGVs under this Supervisor attended the second meeting?
      93%
   B. For all NC under Promoter 8, how many children under 2 years of age died?
      16

3. Look at Coordinator Sarah Smith’s report in Lesson 15 Handout 6.
   A. What percentage of Sarah’s Promoters completed all six QIVCs this month?
      69%
   B. What percentage of Sarah’s target number of NCGVs were reached in May?
      86%
   C. Find the summary information of NC under Supervisor Emily Hayes. How many NC in total were registered during the second half of the month?
      3,818
Lesson 18: Planning for Sustainability

Achievement-Based Objectives
By the end of this lesson participants will have:
- Shared definitions of sustainability
- Identified aspects of the Nurturing Care Group (NCG) approach that realistically can be sustained
- Identified opportunities in their context to improve the likelihood of sustainability
- Identified design modifications and early steps to take to improve the likelihood of sustainability

Duration
1 hour 30 minutes

Materials Needed
- Flip chart paper and markers
- Lesson 18 Flip Chart 1: A Definition of Sustainability
- Lesson 18 Flip Chart 2: Categories of Sustainability
- Lesson 18 Flip Chart 3: Aspects of Nurturing Care Groups that Might be Sustained
- Lesson 18 Handout 1: Examples of Improving Nurturing Care Group Sustainability

Facilitator’s Notes

Ask participants to sit with others who are working on the same project or are in the same geographical area.

Steps

1. Introduction

- Tell participants: Now that we have discussed the details of how the Nurturing Care Group approach is implemented, we should take some time to discuss the important topic of sustainability.

- Ask participants to read Lesson 18 Flip Chart 1: A Definition of Sustainability and go over the definition with them.

- Ask participants: Why do you suppose the designers of this training decided to include a lesson about sustainability? Answers should include: because planning for sustainability should not be left until the end of the project, and there are many decisions made at the beginning of a project that will have a positive or negative impact on sustainability.

---

• **Ask participants:** Can anyone mention a decision that was made at the beginning of a project (any project) that ended up having a negative impact on sustainability?

• Tell participants: Since we would like the Nurturing Care Group approach to continue after the official project ends, we have to start thinking about sustainability from the very beginning of the project, or as soon as possible.

2. **Sustainability of Nurturing Care Group Activities**

• Tell participants: We know that not everything that a project can accomplish with paid staff and additional resources can continue in perpetual motion. However, it is helpful to identify from the beginning any activities or outcomes we do expect to continue or otherwise be sustained and how we realistically think that could be possible.

• Break participants into small groups of people working in the same or similar contexts. Ask participants to list the things they would realistically like to see sustained, identify who will be responsible for sustaining that activity or outcome, and order the list from most likely to be sustained to least sustainable in their context.

• Show participants Lesson 18 Flip Chart 2: Categories of Sustainability and Lesson 18 Flip Chart 3: Aspects of Nurturing Care Groups that Might be Sustained. Ask participants to compare their lists with the lists provided in the manual.

• Now that participants have prioritized the list of NCG aspects they think can be sustained, have each small group:
  
  • Select the top two elements they would like to see sustained
  
  • Discuss within the small group what specific actions should be taken from the beginning of the project to make sure those two elements are likely to continue without external support
  
  • Have one member of each small group present each group’s top aspect (or a different one from those already presented) to the rest of participants. Allow time for other participants to pose questions and make other suggestions.

• Refer participants to Lesson 18 Handout 1: Examples of Improving Nurturing Care Group Sustainability for ideas about sustainability from other projects implementing the NCG approach.

3. **Wrap Up**

• Explain that sustainability is not something that happens on its own. It is something that requires reflection and planning at the beginning of the project or as soon as possible.

• **Ask participants** to write in their notebooks the names of the people they will have to talk with about sustainability when the training is finished.
Lesson 18 Flip Chart 1: A Definition of Sustainability

Sustainability is a process that improves conditions that enable individuals, communities and local organizations to improve their functionality, develop mutual relationships of support and accountability, and decrease dependency on insecure (institutional, technical and financial) resources. Sustainability enables these local stakeholders to play their respective roles effectively, thus maintaining gains in health and development beyond the project period. The individuals, communities, health services and local organizations constitute a local system interacting with and embedded in a larger environment. The efforts and interactions of these actors in the local system are what lead to lasting health impact. Their efforts will be based on their own understanding of their community’s health and development.

Lesson 18 Flip Chart 1: Categories of Sustainability

1. Sustained improvement in household health behaviours and outcomes
   For example:
   - Breastfeeding
   - Hand washing
   - Care seeking

2. Enduring changes in social norms, capacity and social capital
   For example:
   - It is no longer socially acceptable to delay seeking care for suspected malaria.
   - Couples have improved communication and relationships from the experiences of jointly discussing sensitive topics, like family planning, for the first time.
   - Caregivers have the knowledge, confidence and support of their families to seek timely medical care for children when needed
   - Caregivers no longer believe it’s okay to use severe discipline with children
   - Mothers know they can check with their volunteer when they have a question about child feeding.
   - Nurturing Care Group Volunteers (NCGVs) and village health committees can collectively solve problems.

3. Continuation of specific program activities and services
   For example:
   - Home visits by NCGVs
   - Collecting and reporting community health information
Lesson 18 Flip Chart 3: Aspects of Nurturing Care Groups that Might be Sustained

- Nurturing Care Group Volunteers (NCGVs) continue to visit households
- Nurturing Care Groups (NCGs) continue to meet every two weeks
- NCGs receive new lessons
- Continued supervision of NCGs
- NCGVs continue to collect and report important events
- NCGVs continue to meet with NGs
- New Neighbour Caregivers (NC) are being included in the NG
- Behaviours continue to be practiced
Lesson 18 Handout 1: Examples of Improving Care Group Sustainability

Facilitation of Care Groups (Burundi Example)
In Burundi, Concern Worldwide was able to take advantage of the government’s community health workers (CHWs) to experiment with having Ministry of Health (MOH) staff and CHWs implement CGs in place of nongovernmental organization (NGO) staff. Operations research is on-going, but thus far has found similar achievements in areas where the CGs were facilitated directly by NGO staff versus the experimental area, where facilitation was done by CHWs. The latter has clear implications for sustainability that could include continuation of CG training and supervision. However, it should be noted that Concern Worldwide invested significantly in building the capacity of district and local MOH staff in order for this to be possible. The deeper the MOH system reaches into communities, the greater the opportunity for linking CGs to permanent MOH structures.

Community Performance-Based Financing
Community performance-based financing has created special opportunities for support and sustainability of CG activities in settings where MOH staff and/or CHWs receive compensation based on the achievement of community health indicators. Where these indicators align well with CG objectives, there is particular incentive for ongoing support of CGs, particularly once the CGs have demonstrated their effectiveness.

Savings and Income Generation
In response to Care Group Volunteers’ (CGVs’) request to do income generating activities, World Relief (WR)’s Umucyo Child Survival Project in Rwanda (2001–2006) turned its CGs into 202 formal associations recognized by the government. The groups were trained to save members’ individual contributions and income generated by group activities, including the subsidized sale of insecticide-treated bed nets (ITNs), a water purification product and other group-initiated activities. Unfortunately, the original CGs and CGV roles were hindered post-project by new MOH policy on CHWs that prevented NGOs from creating and working with any volunteers who were not part of the new CHW system. Despite this, 6 years after project end, 11% (23/202) of the CGs were still active, presumably because of the shared economic incentive they still had in coming together.

Done carefully, there is potential for savings activities to act as an ongoing incentive for groups to meet during and after a project has formally ended. Because savings groups should be self-selected and voluntary, WR Burundi has found success with giving well-established CGs the opportunity to participate in separate savings groups, to which they can invite additional members. Since the majority of savings group members are also members of the CG, they meet just before or just after the CG meeting, which creates additional incentive for CG meeting attendance and sustainability.

Community Health Information System
WR/Mozambique designed its Community Health Information System with sustainability in mind, using parallel data flow during the life of the project. This means that in addition to having data flow from household to CG to project staff and upwards via NGO personnel, the CGs also shared their data with village health committees and upwards to health facilities. During the life of the project, one method of quality control included comparing the community data that arrived at district level via the project staff with the independent, parallel channel. Post project, WR found that volunteer data collection and aggregation continued in the catchment areas of health facilities where the data manager had been trained by the NGO. Over time, as MOH staff changed post-project, the system weakened. For greater
sustainability, the community important events data ideally would be incorporated into the national system, formalizing its inclusion and the expectation for reporting, a challenge for future advocacy.

**Preparing Communities to take on responsibly**
What are additional ways that communities could be prepared to take ongoing responsibility for aspects of nurturing care by NCGs? Answering this question requires thinking a bit more specifically about preparing for handover, including anticipating the project end and planting seeds that can grow into the future. Answers could include the following.

- Tell the communities at the beginning when you expect the project will end. Explain that many people will be trained so they are able to continue the NCGs after the project finishes.
- In the second half of the project, when interventions are typically reviewed, rather than having paid Promoters conduct NCG training, build the capacity of the NCGVs to train their peers.
- Hold public graduation-type ceremonies honouring what NCGs have learned.
- Ask NCGVs, mothers, village health committee members and others to give public testimony about how they are stronger now. This will validate the growth and change that has taken place in the community.
- Acknowledge to staff the uncertainty that comes with project closeout. Discuss with them how community members may be experiencing related uncertainty and that staff should talk through opportunities communities have to continue the parts of the NCG program they value.
Lesson 19: Planning for Nurturing Care Groups

[NOTE to facilitator: This lesson is probably not necessary for WV/Ghana test of NCGs since the project plan has already been written. You can tell them about this lesson since they may want to use it in the future.]

Achievement Based Objectives

By the end this lesson participants will have completed the Nurturing Care Group (NCG) reference table.

Duration

1 hour

Materials Needed

- Flip chart paper and markers
- Lesson 19 Handout 1: Blank Nurturing Care Group Planning Table

Facilitator’s Notes

This lesson is most useful for people who are involved in writing a project proposal that includes the NCG approach. This lesson will help them create staffing plans and make budgeting decisions. If your trainees are not involved with this step or the project has already been planned and budgeted for, you can skip this lesson.

Steps

1. Introduction

- Tell participants: If you decide that the Nurturing Care Group approach is the most appropriate behaviour change activity for your project, you will want to plan carefully for its implementation. This means knowing what types of staff are needed, how long the implementation process takes, and how much to budget for staff, materials, supplies, transportation and other necessary aspects. We will discuss these issues in this session.

2. Planning Questions

- Ask the participants: Has anyone ever planned a behaviour change activity like Care Groups before? If yes, move participants around so that all tables have at least one experienced person.

- Ask the small groups to brainstorm a list of questions that they would need to answer in order to implement the NCG approach, develop a budget and write about it in a proposal. Give groups 15 minutes to write all their questions in a notebook. Write the following categories on a flip chart to guide their question development:
  - Key Management Staff and Level of Effort
  - Supervision Tasks at All Levels
  - Transportation
o Staff Training
o Formative Research
o Nurturing Care Group Materials Development
o Monitoring and Evaluation (Tools and Implementation)

- Give participants Lesson 19 Handout 1: Blank Nurturing Care Group Planning Table and ask the small groups to check the questions they listed against the information required in the table.

- Give each small group 30 minutes to try to complete the blank table.

- Have participants pair up with someone who was not in their small group. Give them 10 minutes to compare their planning tables.

- With the larger group, ask volunteers to share responses for different questions and key lessons learned, for example, the appropriate ratios of Coordinators to Supervisors and Supervisors to Promoters.

- Tell participants that there are two tools that have been developed to help project planners and budget developers to accurately plan to implement NCGs. These tools can be found (along with many other NCG resources) on the www.caregroupinfo.org website.

  - This Care Group budget template has been used by Food for the Hungry (FH) as a starting point for budget development for NCG projects. The template can help you remember important costs that should be included in most NCG projects. The template can be found at http://www.caregroupinfo.org/docs/NCG_Budget_Template.xls.

3. Wrap Up

- Remind participants that the NCG approach must be well planned from the start in order for it to work effectively. Using the Planning Table and the other tools is a good way to make sure that they will have all the necessary resources to make the NCG approach function optimally.
Lesson 19 Handout 1: Blank Nurturing Care Group Planning Table

**Instructions:** Compare your list of questions to the items listed in the left-hand column. Then insert potential responses in the right-hand column.

<table>
<thead>
<tr>
<th>Name of the Project:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Questions</strong></td>
</tr>
<tr>
<td><strong>1. Program Essentials</strong></td>
</tr>
<tr>
<td>List of key management staff and level of effort (%)</td>
</tr>
<tr>
<td># of Coordinators:</td>
</tr>
<tr>
<td># of Supervisor:</td>
</tr>
<tr>
<td># of Promoters:</td>
</tr>
<tr>
<td># of NCGs per Promoter:</td>
</tr>
<tr>
<td># of NCGVs per NCG:</td>
</tr>
<tr>
<td># of NC per NG:</td>
</tr>
<tr>
<td>NCGVs (gender, age and child status required):</td>
</tr>
<tr>
<td>NC (gender, age and child status required):</td>
</tr>
<tr>
<td><strong>2a. Coordinator Supportive Supervision</strong></td>
</tr>
<tr>
<td>Who do Coordinators report to?</td>
</tr>
<tr>
<td>Who, where and how often does the Coordinator supervise?</td>
</tr>
<tr>
<td>How often do Coordinators fill out the Supervisor supportive supervision checklist?</td>
</tr>
<tr>
<td><strong>2b. Supervisor Supportive Supervision</strong></td>
</tr>
<tr>
<td>Who does the Supervisor report to?</td>
</tr>
<tr>
<td>Who, where and how often does the Supervisor supervise?</td>
</tr>
<tr>
<td>How often do Supervisors fill out the Promoter supportive supervision checklist?</td>
</tr>
<tr>
<td>Name of the Project:</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Questions</td>
</tr>
<tr>
<td><strong>2c. Promoter Supportive Supervision</strong></td>
</tr>
<tr>
<td>Who do Promoters report to?</td>
</tr>
<tr>
<td>Who, where and how often does the Promoter supervise?</td>
</tr>
<tr>
<td>How often do Promoters fill out a QIVC for educational session facilitation?</td>
</tr>
<tr>
<td><strong>3. Training</strong></td>
</tr>
<tr>
<td>Who trains the Supervisor in the NCG curriculum and how often?</td>
</tr>
<tr>
<td>Who provides the Supervisor with refresher training about the NCG curriculum and how often?</td>
</tr>
<tr>
<td>Who trains Promoters in the NCG curriculum and how often?</td>
</tr>
<tr>
<td>Who trains NCGVs in the NCG curriculum and how often?</td>
</tr>
<tr>
<td>Who trains NC in the NCG curriculum and how often?</td>
</tr>
<tr>
<td><strong>4. Nurturing Care Group Curriculum</strong></td>
</tr>
<tr>
<td>Which modules and lessons are most pertinent for your NCG project?</td>
</tr>
<tr>
<td>How many months will it take to teach the NCG curriculum?</td>
</tr>
<tr>
<td>Who will or has developed the NCG curriculum?</td>
</tr>
<tr>
<td>What, if any, formative research is being used to adapt the NCG curriculum to the local context?</td>
</tr>
<tr>
<td>Name of the Project:</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
</tbody>
</table>

### Questions  
### Responses

#### 5. Monitoring & Evaluation

- **What information will be tracked by the NCGs themselves?**

- **Which surveys will you conduct as part of your NCG program? How often will you conduct them?**

#### 6. Other

- Additional questions:

- Additional questions:

- Additional questions:

- Additional questions:

- Additional questions:
Lesson 20: Introducing the Nurturing Care Group Approach to Others

**Achievement-Based Objectives**
By the end of this lesson participants will have:
- Listed the key aspects of the Nurturing Care Group (NCG) approach
- Composed a short laser talk about the NCG approach
- Practiced delivering the short talk about the NCG approach

**Duration**
1 hour 30 minutes

**Materials Needed**
- Flip chart paper and markers
- Lesson 20 Handout 1: Example Talking Points about the Nurturing Care Group Approach
- Lesson 20 Handout 1: Blank Nurturing Care Group Planning Table (filled out by participants with details about their projects)
- Lesson 20 Handout 2: Delivering a Laser Talk

**Steps**

1. **Introduction**
   - Tell participants: Now that you have a much clearer understanding of what the Nurturing Care Group approach is about, you will need to plan to explain it to your collaborating partners and to the community.
   - **Ask participants**: Who needs to be informed about the Nurturing Care Group approach even before you go to the community? Answers should include the Ministry of Health (MOH), local partners, community leaders and others, depending on location.
   - Explain to participants that if they intend for these groups to play important roles in the establishment and implementation of the NCG approach, they need to be prepared to explain it to these partners. Once projects have secured partner buy-in, they also will need to explain the NCG approach to the community.

2. **Activity: Brainstorming Important Information to Share with Collaborating Partners and Community Members**
   - Instruct participants, in small groups, to brainstorm what collaborating partners and communities need to know to understand the NCG approach and to write their ideas in their notebooks.
   - After about 15 minutes, have each table to contribute something that should be included in the explanation of the NCG approach and list these on flip chart. Go around the room until all the new ideas are listed.
• Refer participants to Lesson 20 Handout 1: Example Talking Points about the Nurturing Care Group Approach and compare the group’s master list to the handout. Ask participants: Is anything missing from our list?

3. Providing Monetary Incentives or Goods as Part of a Nurturing Care Group Program

• Tell participants that the NCG approach is a behaviour change program. It is best that community participants focus on long-lasting changes, such as reducing child deaths, rather than on short-term, material gains. It is best not to tell communities what material goods the program plans to provide, even if you are confident the project will provide the inputs.

• Tell participants that mentioning incentives during your talk can cause the following problems to arise.
  
  o People may become volunteers or participate in program activities to receive the incentives. After they receive the incentives they may stop participating because they were only motivated to receive material goods.
  
  o Once a promise is made to a community to provide something the community will consider the organization obligated to provide it. If, for various reasons, the material benefit does not arrive, the community will lose trust in the organization.

4. Activity: Presentation Practice

• Refer participants to Lesson 20 Handout 2: Delivering a Laser Talk and review it together. Give some examples of using talks related to NCGs. Explain to participants that the purpose of their talk is to get buy-in for the NCG approach.

• Divide participants into pairs. Ask them to write up some notes to follow when making a 2 to 4-minute presentation about the NCG approach. Participants can refer to Lesson 18 Handout 1 for this information, if they need to.

• Ask the pairs to practice explaining to each other key elements of the NCG approach, including program goals, methodology and the essential program details. Make sure that each participant gets a chance to practice his/her talk.

• Instruct participants that after they listen to their partner’s laser talk, they should give one positive comment and one suggestion for improving the talk. Suggestions should use “How about…” or “What if…” phrases. Because of time constraints, do not encourage a dialogue between the pairs.

Lessons Learned in Orienting Communities about the NCG Approach

In South Sudan, the Food for the Hungry (FH) NCG project manager-oriented communities to the project by coordinating with community leaders to have 30 men, 30 women and 30 youth present about the NCG approach. The manager led a discussion and encouraged community groups to discuss local challenges they faced. This was followed by a discussion about community resources (what they had to solve these problems) and time to brainstorm solutions to local challenges. Then the NCG project manager shared about FH’s work and how the NCG project intersected with some of their health challenges. It was a great way to position NCGs as a solution to the felt needs and challenges the community already acknowledged.
Instruct the participant receiving the feedback to just say “thank you”.

- If time permits, ask for volunteers or randomly choose a couple participants to give their Laser talks to the whole group.

5. **Wrap Up**

- Wrap up this session by explaining that everyone associated with the project implementing Nurturing Care Groups should be able to talk about it in the same way. This will avoid confusion.
Lesson 20 Handout 1: Example Talking Points about the Nurturing Care Group Approach

Make sure to adapt these talking points to your local context.

1. The Nurturing Care Group program’s goal is to improve child wellbeing.

2. The Nurturing Care Group program will focus on the following areas: [List the topics here that your Nurturing Care Group program will cover, such as Early Childhood Education, Child Protection, Essential Nutrition Actions (ENA) and Essential Hygiene Actions (EHA).]

3. Children’s brains are developing rapidly from pregnancy through three years of age. Interventions made during this time can have huge impacts for the rest of the child’s life, not only in their health but also their economic potential and future relationships.

4. Nurturing Care is a holistic approach that promotes good health, adequate nutrition, responsive caregiving, security and safety and opportunities for learning.

5. Half of child deaths can be prevented if families do very simple things to care for their children. These things include behaviours relating to hygiene, sanitation, child feeding and caring for children when they are sick. If families learn to do these things and make these changes, the program can make a lasting difference in the community.

6. To change these behaviours, the Nurturing Care Group program will train community volunteers so they can train all the families in the community. To do this we need your help.

7. The Nurturing Care Group program will provide the training and educational material, but we need the community to provide volunteers who are committed to improving the wellbeing of the children in this community. These volunteers will not receive a salary or subsidy. They will receive free education and an opportunity to improve and save the lives of the children in this community.

8. These volunteers will not be staff of this organization. They will be members of your community.

9. If volunteers attend the trainings, they share what they learn with the families in this community and the families adopt the new behaviours, malnutrition will be reduced. If the volunteers are not willing to learn and if families will not listen to the volunteers or adopt the behaviours, malnutrition will not decrease during the life of the program.

10. The Nurturing Care Group program is a development program, not an emergency and relief program. Many programs are meant to provide short-term relief to a problem like a famine or during times of civil unrest. Relief programs normally give away a lot of food or goods, like soap and tools, and these things help for a short period of time. However, the goal of this Nurturing Care Group program is more long term: to change behaviour and improve the community’s ability to care for their children in a holistic way.
Lesson 20 Handout 2: Delivering an Introductory Talk

Learning how to speak powerfully about our issues and our work is one of the most important tools in our toolkit. This format was created by RESULTS (www.results.org), an organization working to eliminating world hunger, to enable its volunteers to create powerful "laser talks", short and compelling talks that are the backbone of their work. Laser talks can be used during meetings or chance encounters with policy-makers at any level, community leaders, reporters or anyone you want to persuade about something you really care about.

The examples below are from a talk given to a journalist from a local newspaper.

- **Engage your audience:** Get your listener's attention with a dramatic fact or short statement. Keep this opening statement to one or two sentences, if possible.
  
  - For example: “In the past 30 years, the world has cut in half the number of children under 5 years old that die of preventable causes every year. In other words, we’ve cut the number to 7 million children. We’ve achieved this by increasing access to healthcare and education and by developing new health technologies, like vaccines that fight pneumonia and diarrhoea.”

- **State the problem or what is possible:** Present causes of the problem you introduced in the first section. Make sure to mention how widespread or serious the problem is.
  
  - For example: “But, it isn’t enough to cut child deaths in half when 20,000 children still die every day from completely treatable and preventable diseases.”

- **Informing about solutions:** Inform the listener about a solution to the problem you just presented.
  
  - For example: “On June 14 and 15, Ethiopia, India, the United States and UNICEF are co-hosting a call to action on child survival. At this meeting, world leaders will create a roadmap for ending preventable child deaths within a generation, a goal global health experts now think is possible.”

- **Call to action (the ask):** Once you have engaged your listener, presented the problem and told them about a solution, be specific about what you want them to do. This enables you to follow up to learn if they have taken this action. Present this action in the form of a yes or no question.
  
  - For example: “Will you write an editorial highlighting our child survival successes and our nation’s leadership opportunity to create a world where no child dies unnecessarily before their fifth birthday?

**Tips on Delivering Your Talk**

- Be sure to rehearse your talk. With practice you will discover where you need more practice or where you may want to change a part of your talk.

- Speak rather than read your talk. However, you can refer to notes when you are first learning to give your laser talk.

- Keep the talk short, at no more than 2 minutes.

- Update your talk as new information becomes available.
Lesson 21: Training Closing

Achievement-Based Objectives
By the end of this lesson participants will have:

- Completed the post-test
- Received certificates
- Given feedback to the facilitator for adaptation of future workshops

Duration
1 hour

Materials:
- Appendix 1: Pre-/Post-Test (including answer key)
- End of Training Feedback Form found in Appendix 3: Training Feedback Forms
- Training Certificates

Steps

1. **Introduction**
   - Tell participants: We have come to the end of the training. We need to do several things. We need to administer the post-test, evaluate the training as a whole and give out the training certificate.

2. **Activity: Post-Test**
   - Tell participants to put away all class notes. (Also remove flip chart pages from the walls if they have any answers to the post-test).
   - Give out the post-test, found in Appendix 1: Pre-/Post-Test (consider re-ordering the questions on the post-test). Remind participants how to fill it out.
     - Enter their names at the top of page one.
     - Circle “Post-“.
     - Choose and circle only one answer.
   - Collect papers when all participants have finished.

3. **Activity: Workshop Evaluation**
   - Hand out the End of Training Feedback Form found in Appendix 3: Training Feedback Forms. Ask participants to fill out the form and add any suggestions they have for improving future trainings.
4. **Activity: Training Certificates**

   - Give closing remarks encouraging the participants in their work. Hand out the certificates and call each participant by name.

5. **Optional Activity: Closing Circle**

   - You might choose not to do this activity, but this can be a very memorable and affirming way for participants to end the time together.

   - Form a circle and give participants the opportunity to share good wishes, thoughts and reflections about what the week has meant to them and their hopes, desires, commitments and thoughts on how they will use what they have learned.
Appendix 1: Pre-/Post-Test

Note For the initial WV/Ghana Training in 2019: If you skip the QIVC lessons, be sure to remove questions #7 and #8 below.

Name _______________________________________ Date _________________

Is this the pre-test or post-test? Circle one.

1. Which of the following is NOT a component of the WHO Nurturing Care Framework?
   A. Adequate nutrition
   B. Improved livelihoods
   C. Responsive caregiving
   D. Security and safety

2. When designing a Nurturing Care Group project, what percentage of the intended population should you plan to enrol in the project?
   A. 70% coverage with at least 50% monthly attendance
   B. 80% coverage with at least 60% monthly attendance
   C. 90% coverage with at least 70% monthly attendance
   D. 100% coverage with at least 80% monthly attendance

3. In Care Group projects, Neighbour Caregivers should choose/elect their group’s Nurturing Care Group Volunteer. Why is this important?
   A. People will choose someone that they respect, someone that they are willing to listen to. If an outsider chooses someone, it is more likely that person will not be accepted by the community.
   B. It would take a lot of time for project staff to choose Nurturing Care Group Volunteers. Therefore, it is more efficient for the Neighbour Caregivers to elect their own Nurturing Care Group Volunteer.
   C. This is a trick question. Caregivers should not elect their own Nurturing Care Group Volunteers. This is something that the Community Development Committee should do in partnership with the Ministry of Health.

4. When forming Neighbour Groups and Nurturing Care Groups, which of the following are important to consider?
   A. How well the families get along, if there are long-standing rivalries between families.
   B. How similar the households are to each other: economically, socially and religious background.
   C. How many of the households are already practicing the new positive behaviours.
   D. How close the households are in proximity to each other.
5. What are the four main types of information that registers in Nurturing Care Group programs collect?
   A. Immunization coverage, important events, registration and curriculum
   B. Attendance, registration, important events and curriculum
   C. Births, deaths, membership and household size

6. What information does a Promoter use to fill out his/her monthly report?
   A. Nurturing Care Group registers
   B. Neighbour group registers
   C. A and B
   D. None of the above

7. Which of the following is NOT one of the steps in a meeting with Nurturing Care Group Volunteers?
   A. Justifying the need for the lesson
   B. Coaching
   C. The activity
   D. Taking attendance

8. When giving feedback using the quality improvement and verification checklists for educational session facilitation, which of the following should NOT be done?
   A. Ask the worker to discuss how they think they performed before you begin giving feedback.
   B. Provide more positive feedback than negative feedback to encourage the worker.
   C. Ask the worker how they think they could overcome some of the difficulties that they had during the training.
   D. Ask the worker to commit to sharing their scores with the community leaders.

9. If the Promoter scored 70% on the QIVC for educational session facilitation, what should the Supervisor do?
   A. Use the QIVC less frequently because the worker scored above the target.
   B. Stop visiting this worker because they have scored above the target.
   C. Continue using the QIVC each time he/she visits the Promoter until the Promoter’s score is 80% or above.
   D. Continue using the QIVC each time he/she visits until the Promoter’s score reaches 100%.

10. How long should a typical Nurturing Care Group Meeting last?
A. No more than two hours  
B. About three hours  
C. Half a day  
D. The whole day if lunch is provided and the Nurturing Care Group Volunteers are having fun  

11. What is the recommended maximum number of Nurturing Care Groups a (full-time, paid staff) Promoter should have?  
A. 15  
B. 12  
C. 9  
D. 5  

12. What is the recommended maximum number of hours per week a Nurturing Care Group Volunteer should be asked to work?  
A. 6  
B. 8  
C. 12  
D. 20  

13. What are common motivators to volunteerism?  
A. Feeling connected, feeling valued and feeling effective  
B. Adequate compensation for one’s time, through gifts, money or public recognition  
C. The tasks are easy, fun and recognized by the community  
D. None of the above, people are either interested in volunteering or they are not  

14. Of the criteria below, which is NOT a component of supportive supervision?  
A. It is a continuous process, not a onetime event.  
B. It is an organic and spontaneous; it happens on-the-spot and cannot be planned for.  
C. The purpose is to mentor and coach a worker so he/she can effectively accomplish the job.  
D. Three things the worker will gain from supportive supervision are: independence, self-confidence and skills.
Answers to Pre-/Post-Test

1. C
2. D
3. A
4. D
5. B
6. C
7. A
8. D
9. C
10. A
11. C
12. A
13. A
14. B
Appendix 2: Learning Resource and Needs Assessment

1. Please describe your familiarity with the WHO’s Nurturing Care Framework. Have you attended a training on the framework or read any of the reference documents? Please tell us about it.

2. Please describe your previous experience working with Care Groups (a cascade behaviour change module that reaches all households through community volunteers).

3. Please describe training you have already received about Care Groups. List the name of the training and the organization that led the training.

4. Please describe your work experience supervising others. Also list tools you have used during supportive supervision.

5. Please describe your work experience organizing or working with community volunteers.

6. With your current training and experience, how comfortable do you feel training others about the set-up and management of Care Groups? (1 = not comfortable; 10 = extremely comfortable)
7. What do you hope to get out of this training?

8. If you have previous experience with Care Groups, would you be interested in participating in an evening of sharing? If yes, please plan to tell some stories and show any sample materials, such as a flip chart, photos or videos of your previous Care Group projects.
Appendix 3: Training Feedback Forms

Daily Feedback Form: Evaluation for Day _________

Please indicate below your overall satisfaction with each of the sessions that you attended today and offer any ideas you have on how to improve these sessions.

<table>
<thead>
<tr>
<th>Lesson number: _____ Lesson name: ____________________________</th>
</tr>
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<tbody>
<tr>
<td>A.</td>
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<td>1</td>
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<tr>
<td>B.</td>
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<td>----</td>
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<tr>
<td>1</td>
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<tr>
<td>C.</td>
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<tr>
<td>----</td>
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<tr>
<td>1</td>
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<tr>
<td>D.</td>
</tr>
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<td>----</td>
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<td>1</td>
</tr>
</tbody>
</table>

E. The most useful thing about today:

F. The thing I’m still confused about:
End of Training Feedback Form

Please provide your comments and offer suggestions for anything related to the workshop content, format or logistics.

1. What suggestions do you have for any future trainings?

2. How would you rate your satisfaction with the training content?

<table>
<thead>
<tr>
<th>Very Dissatisfied</th>
<th>Somewhat Dissatisfied</th>
<th>Neutral</th>
<th>Somewhat Satisfied</th>
<th>Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</table>

3. How would you rate your satisfaction with the facilitators?

<table>
<thead>
<tr>
<th>Very Dissatisfied</th>
<th>Somewhat Dissatisfied</th>
<th>Neutral</th>
<th>Somewhat Satisfied</th>
<th>Very Satisfied</th>
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4. What recommendations do you have to help the facilitators improve their training methods?
Appendix 4: The Care Group Approach: Definitions and Criteria

History
Staff from World Relief (WR) developed the Care Group (CG) 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. Since that time, the CORE Group has helped document and disseminate the model and it has been used by 20 (and counting) other nongovernmental organizations (NGOs) in more than 20 countries, largely through the support of the U.S. Agency for International Development (USAID). In particular, the USAID Child Survival and Health Grants Program (CSHGP) and the USAID Food for Peace (Title II Food Security) Program (FFP) have helped to fund programs using the CG model.

Definition
A CG is a group of 10–15 volunteers, community-based health educators, who regularly meet 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 neighbours, sharing what she has learned and facilitating behaviour change at the household level. CGs create a multiplying effect to equitably reach every beneficiary household with interpersonal behaviour change communication. They also provide the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits.

Why criteria?
Since 1995, WR, FH, and more than 24 other private voluntary organizations (PVOs) in more than 21 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 CG 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 CGs 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 CSHGP and Title II food security projects in terms of decreased child mortality and morbidity using CGs, it is important to define official criteria for the CG model.

During meetings between WR and FH staff on April 23, 2009, the CG criteria in the checklist below were agreed upon as a draft list. The list is divided into those that 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.

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49 For a detailed explanation of the criteria, please also visit [http://www.caregroupinfo.org/blog/criteria](http://www.caregroupinfo.org/blog/criteria).
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 CGs 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. By informing donors and others about these criteria, it is hoped that they will use the criteria to decide to what degree a proposed implementation strategy is really based on the CG model. The Food Security and Nutrition Network Social and Behavioural Change Task Force (SBCTF) and the CORE Social & Behavioural Change Working Group (SBCWG) helped to disseminate this document, which will further legitimize the checklist and will lead to better compliance with the recommended criteria.

### Care Group Criteria

<table>
<thead>
<tr>
<th>Criteria for Care Groups</th>
<th>Rationale</th>
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<tbody>
<tr>
<td><strong>Required</strong></td>
<td></td>
</tr>
<tr>
<td>1. The model is based on peer-to-peer health promotion (mother-to-mother for maternal and child health and nutrition [MCHN] behaviours.) Care Group Volunteers (CGVs; e.g., “Leader Mothers,” “Mother Leaders”) should be chosen by the mothers that are in the group the Volunteer will serve or by the leadership in the village.</td>
<td>CGs 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 neighbours. There is evidence that “block leaders” (like CGVs) can be more effective in promoting adoption of behaviours among their neighbours than others who do not know them as well. CGVs should be mothers of young children or other respected women from the community. CGVs who are chosen by their neighbours (or by a consensus of the full complement of [formal and informal] community leaders) will be the most dedicated to their jobs, 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.</td>
</tr>
<tr>
<td>2. The workload of CGVs is limited: No more than 15 households per CGV.</td>
<td>Having one volunteer trained to serve 30+ households is more in line with the traditional community health worker (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 CGV 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.</td>
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<tr>
<td>3. The CG size is limited to 16 members and attendance is monitored.</td>
<td>To allow for participatory learning, the number of CGVs in the CG should be between six 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 (less than 70%) at CG 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.</td>
</tr>
</tbody>
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51 Operations Research on NCGs in Sofala, Mozambique, showed that NCGVs chosen by the mothers that they serve were 2.7 times more likely to serve for the life of the project (p=0.009).
<table>
<thead>
<tr>
<th>Criteria for Care Groups</th>
<th>Rationale</th>
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<tbody>
<tr>
<td>4. CGV contact with her assigned beneficiary mothers—and CG meeting frequency—is monitored and should be at a minimum once a month, preferably twice monthly.</td>
<td>In order to establish trust and regular rapport with the mothers with which the CGV works, we feel it is necessary to have at least monthly contact with them. CGs should meet at least once monthly, as well. We also believe that overall contact time between the CGV and the mother (and other family members) correlates with behaviour change. We recommend twice a month contact between CGVs 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).</td>
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<tr>
<td>5. The plan is to reach 100% of 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.</td>
<td>In order to create a supportive social environment for behaviour change, it is important that many mothers adopt the new practices being promoted. Behaviour change is much more likely to happen when there is regular, direct contact with all 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 household visit. Household 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.</td>
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<tr>
<td>6. CGVs collect vital events data on pregnancies, births and death.</td>
<td>Regular collection of vital events data helps CGVs 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 CG 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.</td>
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<tr>
<td>7. The majority of what is promoted through the CGs creates behaviour change directed towards reduction of mortality and malnutrition (e.g., Essential Nutrition Actions [ENA], Essential Hygiene Actions [EHA]).</td>
<td>This requirement was included mainly for advocacy purposes. We want to establish that the CG 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 Millennium Development Goals. While the cascading or multiplier approach used in CGs 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”).</td>
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<tr>
<td>8. The CGVs use some sort of visual teaching tool (e.g., flip charts) to do health promotion at the household level.</td>
<td>We believe the provision of visual teaching tools to CGVs 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.</td>
</tr>
<tr>
<td>9. Participatory methods of behaviour change communication (BCC) are used in the CG with the CGVs and by the volunteers when doing health promotion at the household or</td>
<td>Principles of adult education should be applied in CGs and by CGVs since they have been proven to be more effective than lecture and more formal methods when teaching adults.</td>
</tr>
<tr>
<td>Criteria for Care Groups</td>
<td>Rationale</td>
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<tr>
<td>small-group level.</td>
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<tr>
<td>10. The CG instructional time (when a Promoter teaches CGVs) is no more than 2 hours per meeting.</td>
<td>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.)</td>
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<tr>
<td>11. Supervision of Promoters and at least one of the CGVs (e.g., data collection, observation of skills) occurs at least monthly.</td>
<td>For Promoters (who teach CGVs) and CGVs to be effective we believe that regular, supportive supervision and feedback is necessary on a regular basis (monthly or more). For supervision of CGVs, the usual pattern is for the Promoter to supervise through direct observation at least one volunteer following the CG meeting.</td>
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<tr>
<td>12. All of a CGV’s beneficiaries should live within a distance that facilitates frequent home visitation and all CGVs should live less than a 1-hour walk from the Promoter meeting place.</td>
<td>It is preferable that the CGV 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. Low ratios of CGV: Mother Beneficiaries and Promoter:CG 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 CG strategy may not be the most appropriate one to use.</td>
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<tr>
<td>13. The implementing agency needs to successfully create a project/program culture that conveys respect for the population and volunteers, especially women.</td>
<td>During operations research conducted near the end of the FH Sofala CG project, CGVs (“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 CGVs are sensing this respect.</td>
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</table>
### Criteria for Care Groups

<table>
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<tr>
<th>Suggested</th>
<th>Rationale</th>
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<tbody>
<tr>
<td>1. Formative research should be conducted, especially on key behaviours promoted.</td>
<td>A review of the most effective projects in terms of behaviour change for both exclusive breastfeeding and hand washing with soap (by the SBCWG) found that they included formative research (e.g., Barrier Analysis, Doer/Non-Doer Analysis) on the behaviours. We believe that more systematic use of formative research on behaviours will lead to the best adoption rates. Formative research also helps assure that the behaviours promoted by project staff are more feasible by community members.</td>
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<tr>
<td>2. The Promoter:CG ratio should be no more than 1:9.</td>
<td>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 six 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).</td>
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<td>3. Measurement of many of the results-level indicators should be conducted annually at a minimum.</td>
<td>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.</td>
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<tr>
<td>4. Social/educational differences between the Promoter and CGVs should not be too extreme (e.g., it is not a good match to have bachelor-degree level staff working with CGVs).</td>
<td>We believe that the less educational difference between the Promoter and CGVs, the more likely that the Promoters will use language/concepts that the CGVs can understand. It also helps keep the costs of the model low.</td>
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</table>
Appendix 5: Example Review Activities

Sing it!
Divide the participants into teams. Ask each team to reflect on things they have learned thus far in the training, to compose some lyrics to a song on one topic, and to prepare to perform their song. Give participants 10 minutes for preparation and 2 minutes each for performance.

Rock, Paper, Scissors
Ask each participant to reflect on things they have learned recently and to write a review question and put it in their pocket. Have participants form two lines facing each other. Show them the rock, paper, and scissor hand signals. Going down the line each pair of participants plays rock, paper, scissors. The one who wins gets to ask the other one their review question. All participants listen in case a help-line is needed. Continue down the line until each pair has asked/answered a question.

Unravel the Ball
Make a ball from used flip chart paper and tape. Form a circle of the participants and instruct them to toss the ball from participant to participant in such a way that it is not easy to catch the ball. When someone drops the ball, the thrower gets to ask that person a review question. Questions can be written by participants before the game starts or the facilitator can develop review questions.

Musical Chairs
Connect speakers to the computer or sound system and select a fun dance song to play. Place the chairs back-to-back in two rows. Remove two chairs so there are two chairs fewer than the number of participants. Tell participants that they need to march/dance to the music around the rows of chairs. When the music stops, each person needs to sit in a chair. There will be two people with no chairs; these people will answer review questions and sit out the remainder of the game. After this happens, remove two or more chairs and repeat the process until no one is left to march/dance around the chairs. The people who are sitting out ask the next review question.
Appendix 6: Curriculum Development and Overview

This appendix is broken into three parts.

**Part 1: Designing New Curriculum for Your Program** provides basic guidance to help you develop your own Nurturing Care Group (NCG) materials.

**Part 2: Proposed Nurturing Care Group Lesson Lists and Behaviours** provides sample lesson lists.

**Part 3: Sample Health, Nutrition, and WASH Care Group Lessons Grouped by Topic**

**Part 4: Considerations for Using Another Organization’s Materials for Your Program** provides basic guidance to help you if you are considering using another organization’s materials.

**Part 1: Designing New Curriculum for Your Program**

This section describes the principles of designing quality, new curriculum for your program. The core principles are:

1. Know your audience
2. Study your intended audience through formative research
3. Plan for sustained teaching
4. Develop materials that align with the principles of adult learning
5. Pretest the materials
6. Make your materials durable
7. Make your materials the appropriate size

**1. Know Your Intended Audience**

Make sure that you narrowly define your intended audience before you begin developing materials. Consider their age, social status, language, education level, current behaviours and practices, and the things that have prevented them from doing the “key practices” in the past. The more you understand the needs of your audience the easier it will be to develop materials for them.

Consider reading ability. Choose the grade level that best represents the majority (95%) of the intended audience. It is better to choose a lower level than assume a higher level of reading. Once you begin to develop materials, you should test the reading level of the materials to assess how well you wrote to the audience level.\(^{53}\)

**2. Study Your Audience through Formative Research**

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Once you have narrowly defined the people who will be receiving the messages (your intended audience), it is best to study them to test your assumptions. A baseline survey (e.g., standard Knowledge, Practice, and Coverage [KPC] surveys) is a great way to gather information about current practices.\footnote{For more information about how to conduct and analyse a KPC survey, a series of tools and resources are available on Maternal and Child Health Integrated Program (MCHIP)’s website at \url{http://mchipngo.net/}, then click on “TOOLS”, then select “Project Monitoring & Evaluation (M&E)”.

For more information about Barrier Analysis, please see the Barrier Analysis Facilitator’s Guide by Food for the Hungry (2004) available at \url{http://www.caregroupinfo.org/docs/Barrier_Analysis_Facilitator_Guide.pdf}.

The Local Determinants of Malnutrition Study is an expanded Positive Deviance inquiry, developed by Food for the Hungry (FH), to identify local associations between behaviours and malnutrition. A manual is currently being developed.


54} Barrier Analysis, a rapid assessment tool for community health and development projects, can be conducted to identify behavioural determinants associated with a particular behaviour.\footnote{The Local Determinants of Malnutrition Study is an expanded Positive Deviance inquiry, developed by Food for the Hungry (FH), to identify local associations between behaviours and malnutrition. A manual is currently being developed.} You also may consider in-depth focus groups, positive deviant inquiries (such as the Local Determinants of Malnutrition Study\footnote{The Local Determinants of Malnutrition Study is an expanded Positive Deviance inquiry, developed by Food for the Hungry (FH), to identify local associations between behaviours and malnutrition. A manual is currently being developed.}) and other formative research methods to gather more information about your intended audience and behaviours. Use this research to develop key practices for your audience.

For more information about defining intended audience and key practices (including guidelines for Barrier Analysis), please see the Designing for Behaviour Change curriculum.\footnote{The 2013 version of \textit{Designing for Behavior Change: For Agriculture, Natural Resource Management, Health and Nutrition} is available on the Food Security and Nutrition Network website, at \url{http://www.fsnnetwork.org/sites/default/files/combineddbc_curriculum_final.pdf}.}

3. **Plan for Sustained Teaching (Number of Modules)**

Determine how many lessons will be taught each month (usually about two lessons per month) and how long your program will last. Once you know how many lessons will be taught over the life of your program, you will be able to better budget for developing and producing materials.

For example, imagine you are managing a 3-year project and the NCGs will meet every 2 weeks for 2 of those years (the remaining year is for start-up workshops, hiring of staff and closeout activities). In this example, you could design approximately 50 lessons (26 lessons per year) to sustain 2 years of teaching. Alternatively, you could choose a smaller number of lessons that are repeated throughout the project. For example, you may want to focus on just 25 lessons that are repeated twice during the project. A sample NCG materials list can be found in Part 3: Considerations for using Another Organization’s Materials for Your Program.

4. **Develop Materials that Align with the Principles of Adult Learning**

Don’t assume that facilitators know how to teach in a participatory way. Include guidance and instructions in the text to enable facilitators to teach in a participatory way, with discussion questions, small group activities, demonstrations and time to discuss challenges to the new behaviours. For more information about adult learning theory, refer to the Adult Learning Theory trainings conducted by Freedom from Hunger (see website below).

The Community-Integrated Management of Childhood Illness (C-IMCI) Facilitators Guide has excellent lessons on facilitation skills as well, and can be found at \url{http://www.medicalteams.org/docs/learning-zone/C_IMCI_Facilitators_Guide.pdf}.}
Food for the Hungry (FH) uses a standard format for each lesson, including games, discussion about current practices, stories, activities, discussion of barriers and time for making commitments. For more about FH’s materials, see the main NCG website, [www.caregroupinfo.org](http://www.caregroupinfo.org).

5. **Pretesting Materials**

Once the first draft of materials is developed, test them with small groups or individual interviews (the latter work best for low-literacy reviews) for understanding, acceptance and amount they inspire action. The materials should promote particular behaviours or actions; make sure the audience receives the same message that you intended.

6. **Make Durable Materials**

NCG materials should be built to last so that teaching can continue in the community after a project closes. Ideally, teaching aids/tools (e.g., flip charts) should be printed on laminated cardstock bound at either the side or the top. This keeps the pages together and helps them resist mildew and deterioration.

7. **Size of Materials**

Because Neighbour Caregivers and Care Group Volunteers (NCGVs) will be meeting in small groups of approximately 12 caregivers, the materials need to be large enough so that each caregiver in the group can see the pictures (or other visuals) at a distance. We recommend A3 picture pages that are bound into a flip chart or flip book. This way, images will be large enough for the caregivers to see, but lightweight enough for the NCGVs to carry when walking in the community.


### Part 2: Proposed Nurturing Care Group Lesson List and Behaviours

<table>
<thead>
<tr>
<th>Sector</th>
<th>Lesson Number</th>
<th>Lesson Title</th>
<th>Behaviours Promoted</th>
</tr>
</thead>
</table>
| H&N    | 1             | Preparing for the big day | • Attend 4+ ANC sessions  
• Develop a birth plan, to include savings  
• Identify emergency transport |
| H&N    | 2             | I’m hungry! Nutrition during pregnancy | • Eat a balanced diet during pregnancy, including iodized salt  
• Eat more than usual you are eating for two!  
• That includes later when you are breastfeeding |
| H&N    | 3             | I’m tired! Avoiding or treating anaemia, and getting sufficient rest | • Take IFA per the instructions given during ANC  
• Reduce heavy work during pregnancy and ask for help so you can rest  
• Avoid smoking and alcohol  
• Protect yourself from infection (fibril illness, parasites etc.) |
| H&N    | 4             | I can’t sleep with all these mosquitos! | • Sleep under LLIN (mother and child)  
• Accept indoor residual spraying if this is offered in your area |
| H&N | 5 | HIV is not the end of life or of pregnancy | Test for HIV & TB during pregnancy, get the results
If HIV+, ensure institutional delivery
If HIV+, then early infant HIV diagnosis (EID)
If HIV+, condom use to avoid reinfection |
| H&N | 6 | Danger! | Danger signs during pregnancy
Danger signs during labour and delivery
Identify emergency transport (repeat message) |
| H&N | 7 | You are in good hands | Skilled birth delivery
Clean birthing supplies |
| H&N | 8 | The most critical time of all | Unobstructed airway
Keep baby warm/Kangaroo
Don’t bathe 24 hours
Cord care |
| H&N | 9 | Hungry baby | Immediate BF
Exclusive, on-demand BF, day and night
Not giving pre-lacteal feeds |
| H&N | 10 | Keeping a close eye on baby and mother this week (NCGV visits) | Newborn and postpartum danger signs
Seek a postnatal visit
Identify emergency transport (repeat message) |
| H&N | 11 | Keeping baby healthy | Routine clinic visits for immunization, GMP
Clinic or outreach campaigns for Vitamin A and deworming |
| H&N | 12 | Take illness seriously! | Danger signs in children
Timely care seeking for diarrhoea, fever and rapid breathing
Increase fluid intake during illness, including more frequent BF
Encourage child to eat soft, varied, appetizing, favourite foods
After illness, give food more often than usual and encourage child to eat more |
| H&N | 13 | I’m not ready to get pregnant again! | Choosing an appropriate FP method
Healthy child bearing years 18-35
Wait two years from last birth |
| H&N | 14 | What to feed my child now: 6-8 months old | Continued BF
2-3 meals/snacks per day
Iron-rich and vitamin A-rich foods
Proper consistency
Active or responsive feeding |
| H&N | 15 | What to feed my child now: 9-23 months old | Continued BF
3-4 meals/snacks per day
Iron-rich and vitamin A-rich foods
Diet diversity
Active or responsive feeding |
| H&N | 16 | My child is rambunctious, I don’t want him/her to get hurt | Injury prevention: drowning/bucket drowning
Burns
Snakes |
<table>
<thead>
<tr>
<th>H&amp;N</th>
<th>17</th>
<th>Will my child get into trouble in life?</th>
<th>• Talking to one's child about harm of alcohol, drug and tobacco abuse, and how they can hurt their ability to have a happy life</th>
</tr>
</thead>
</table>
| H&N | 18 | My child's happiness and wellbeing | • Violence prevention  
• Early stimulation |
| WASH | 1 | Be aware of safe and unsafe water sources | • Know and use safe water sources for household water supply |
| WASH | 2 | Keep your water safe from the source to your house | • Practice water safe collection and transportation in clean, covered containers,  
• Choose safe water storage containers  
• Keep water safe at home (storage of drinking water, clean water containers)  
• Improved water conservation and reuse practices  
• Households timely pay for water services |
| WASH | 3 | Make your water safe and healthy | • Households select and use adapted point of use water treatment (chlorination, boiling, filtration)  
• Households practice point of use water treatment |
| WASH | 4 | Our family has clean Hands | • Households practice handwashing with soap at critical times  
• Households possess, use and maintain handwashing station |
| WASH | 5 | Hygiene for women and girls | • Establishing accurate facts around menstrual hygiene  
• Personal hygiene needs  
• Proper use of menstrual supplies (access)  
• Proper disposal or cleaning of menstrual supplies (privacy, means of disposal)  
• Pain management (if not in H&N lessons) |
| WASH | 6 | Keeping food safe and clean | • Safe food preparation  
• Safe food storage  
• Safe food serving and consumption  
• Safe dish washing and storage |
| WASH | 7 | Ending open defecation | • All human faeces are safely disposed in a sanitation facility |
| WASH | 8 | Safe disposal of human waste | • Construction, use and maintenance of a household latrine  
• All household members only defecate in the latrine. |
| WASH | 9 | Proper disposal of child faeces, and the cat method of faeces disposal and when to use it | • Safely collect child faeces,  
• Safe disposal of child faeces (including "cat method" for all family members when not using latrine) |
| WASH | 10 | Clean and maintain household latrines | • Clean household latrine every day  
• Maintain latrine usability, safety and privacy |
| WASH | 11 | Safe management of animal waste | • Culturally appropriate animal 'penning'  
• Culturally appropriate and safe handling of animal waste |
| WASH | 12 | Household environmental cleanliness | • Household cleanliness  
• Household solid waste management  
• Household liquid waste management  
• Prevention of mosquito breeding grounds |
### WASH 13
- Giving babies and young children a safe place to play
  - Separating children from animal and human faeces (why and how) and handling child mouthing behaviour
  - Providing a clean play space and play objects
  - Washing babies hands with soap

### WASH 14
- Supporting mothers' health
  - Minimizing pregnant women's water carrying burden

### WASH 15
- Talk and act together
  - Peer-to-peer discussion on WASH behaviours and practices
  - Self-assessment and quality improvement

### Educ. 1&2
- Sensitive and responsive caregiving
  - Primary caregivers learn and gain skills in risk and resiliency factors for child development (health, growth, learning, protection) and how they are interrelated; how child communicates and how caregiver should provide sensitive & responsive caregiving; secure baby-caregiver attachment

### Educ. 3, 4 & 5
- Promoting early learning and stimulation
  - Primary caregivers learn the importance of early stimulation how to promote age appropriate, holistic development (physical, socio-emotional, cognitive) through: eye contact, talking, reading, showing objects and naming them, talking about them (e.g. colours, shapes), rhyming or singing songs, preparing and using age appropriate play materials

### Educ. 6
- Nurturing child physical development
  - Primary caregivers provide practices to nurture age-appropriate physical development

### Educ. 7&8
- Nurturing child social-emotional development
  - Primary caregivers provide practices to nurture age-appropriate social-emotional development

### Educ. 9&10
- Nurturing child cognitive development
  - Primary caregivers provide practices to nurture age-appropriate cognitive development

### Educ. 11&12
- Primary caregiver self-care and mental health
  - Primary caregiver self-care practices

### Child Prot. 1
- Understanding how to report incidents of Violence Against Children (VAC)
  - Articulate what are different types of violence against children and the short- and long-term impact it has on children and adolescents
  - Articulate ways to report incidents of emotional, physical or sexual forms of abuse, neglect, exploitation or other forms of violence
  - Explain what will happen to a child after an incident of violence is reported

### Child Prot. 2
- Understanding parent stress
  - Identify their own psychosocial and emotional needs
  - Articulate the impact of their stress on their children’s and adolescents’ well-being
  - Name techniques to manage their stress

### Child Prot. 3
- Coping and healing strategies
  - Identify their own positive coping strategies

### Child Prot. 4
- Positive parental time for healthy growth and development and creating spaces for dialogue (for adolescents)
  - List and use techniques to encourage positive behaviour such as playing, praising and spending quality time
  - Name and use techniques to build positive parent–adolescent relationships such as spending quality time and positive attention
| Child Prot. | 5 | Empathy – respecting your child’s and teen’s opinions and thoughts | • Articulate the key principles of effective communication  
• List and use the 4 steps of empathetic communication |
| Child Prot. | 6 | Encouraging responsibility – family rules and routines | • Articulate how to support their children and adolescents to make good decisions and be responsible family members  
• List and use the steps of family meetings and agreements |
| Child Prot. | 7 | Discipline with dignity | • Name positive parenting techniques such as praise, consequences and family agreements and rules |
| Child Prot. | 8 | Discipline with dignity | • Name and use non-violent discipline approaches with their children, such as ignoring or time-out |
| Child Prot. | 9 | Discipline with dignity | • Name and use positive parenting techniques like creating an age-appropriate, child-friendly home environment |
| Child Prot. | 10 | Talking, storytelling and playing games | • Name and use techniques to engage and stimulate their children  
• Articulate how they can help their children learn and perform well in school |
| Child Prot. | 11 | Respecting adolescents and their changing bodies | • Articulate why it is important to talk to their adolescents about their changing bodies  
• List key information about puberty to share with their adolescents |
| Child Prot. | 12 | Protecting the health, well-being and dignity of adolescents—reproductive health and early marriage | • List key information to share with their children about reproductive health and sexually transmitted diseases  
• Articulate the negative effects of early marriage using empathetic communication skills |
| Child Prot. | 13 | Promoting the value of education for girls and boys—Addressing child labour | • Describe the benefits of education for girls and boys  
• Articulate what is acceptable and what are hazardous forms of child labour  
• Articulate the negative effects of child labour on long-term outcomes for their children |
| Child Prot. | 14 | Healthy relationships and community safety | • Articulate the risks their adolescents may face in relationships and in the community  
• List and use the steps to helping their teenagers make safe, healthy decisions |
| Child Prot. | 15 | Understanding and providing support for children’s and adolescents’ psychosocial needs | • Articulate the psychosocial impact of a crisis on children and adolescents  
• List psychological symptoms of children and adolescents affected by a crisis  
• List and use techniques to provide support to their children and adolescents affected by a crisis, such as talking, listening and engaging them in activities  
• Identify severe psychosocial needs and make appropriate referrals if necessary |
Part 3: Sample Health, Nutrition, and WASH Care Group Lessons Grouped by Topic

Food for the Hungry prints its teaching aids/flip charts as a series of modules, as listed below. Each module contains six to 12 lessons and addresses a specific health topic. Sample flip charts can be found at http://www.caregroupinfo.org/blog/narrated-presentations-on-care-groups-and-care-group-tools/care-group-curricula. Please note that the recommendations for Essential Nutrition Actions have been updated, refer to the World Health Organization’s site for the latest information. http://www.who.int/nutrition/publications/infantfeeding/essential_nutrition_actions/en/

- **Module 1: Essential Nutrition Actions (ENA): Prenatal Nutrition and Breastfeeding**
  - Lesson 1: Nutrition for Pregnant and Lactating Mothers: Supplements, Use of Iodized Salt and Anaemia Prevention
  - Lesson 2: Antenatal Care, Advantages of Delivery at the Health Centre and Maternal Danger Signs
  - Lesson 3: Preparing for Delivery and Birth
  - Lesson 4: Early Initiation of Breastfeeding
  - Lesson 5: Newborn Care
  - Lesson 6: Maternal Postpartum Care
  - Lesson 7: Exclusive Breastfeeding

- **Module 2: Essential Nutrition Actions (ENA): Complementary Foods and Micronutrients**
  - Lesson 1: Complementary Feeding of Children 6–8 Months
  - Lesson 2: Complementary Feeding of Children 9–12 Months
  - Lesson 3: Complementary Feeding and Continued Breastfeeding of Children 13–23 Months
  - Lesson 5: Sanitary Meal Preparation for Young Children and Hygiene
  - Lesson 6: Importance of Vitamin A-Rich Foods and Vitamin A Supplementation
  - Lesson 8: Growth Monitoring and Promotion, Nutrition Counselling, and Referral for Growth Faltering

- **Module 3: Essential Hygiene Actions (EHA)**
  - Lesson 1: Diarrhoea Definition, Transmission, and Signs and Symptom, Including Danger Signs
  - Lesson 2: Hand Washing with Soap or Ash
  - Lesson 3: Creation of Household Hand Washing Stations, Including Tippy Tap and Dish Drying Racks
- **Lesson 4: Disposal of Faeces, Latrines and De-Worming of Children and Pregnant Women**
- **Lesson 5: Point-of-Use Water Purification and Proper Water Storage**
- **Lesson 6: Proper Feeding of Sick Children: Oral Rehydration Solution (ORS)/Recommended Home Fluids (RHF), Increased Breastfeeding and Complementary Feeding During and After Illness**

**Module 4: Malaria and Parasites**
- **Lesson 1: Malaria Transmission and Effects for Children, Pregnant Women and Food Security**
- **Lesson 2: Prevention using Insecticide-Treated Bed nets (ITNs), Household Spraying and Intermittent Preventive Treatment (IPT) for Pregnant Women**
- **Lesson 3: Early Recognition of Malaria, Care Seeking and Artemisinin-Based Combination Therapy (ACT)**
- **Lesson 4: Parasites (Intestinal and Liver) Defined and Their Effects on Food Security**
- **Lesson 5: Parasite Transmission and Prevention using Essential Hygiene Actions (EHA)**
- **Lesson 6: Promotion of Regular Treatment of Parasites (Intestinal and Liver)**

**Module 5: Acute Respiratory Infections**
- **Lesson 1: Acute Respiratory Infections: Definition, Transmission, Signs and Symptoms**
- **Lesson 2: Acute Respiratory Infections Prevention**
- **Lesson 3: Prompt Treatment of Acute Respiratory Infections and Early Recognition of the Danger Signs of Pneumonia**
- **Lesson 4: Recognizing Tuberculosis and Promoting Prompt and Complete Treatment**
- **Lesson 5: Proper Feeding of Sick Children and General Danger Signs**
- **Lesson 6: Preparing for Graduation and How to Maintain Your Care Group and Your Results**

**Module 6: HIV/AIDS and Preventing Mother-to-Child Transmission**
- **Lesson 1: HIV and AIDS Symptoms and Transmission**
- **Lesson 2: HIV Prevention**
- **Lesson 3: HIV Stigma Effects on Food Security and Decreasing that Stigma**
- **Lesson 4: Promotion of HIV Testing and Treatment**
- **Lesson 5: Prevention of Mother-to-Child Transmission of HIV**
- **Lesson 6: Proper Nutrition for HIV-Positive Children and Adults**

**Module 7: Family Planning**
- **Lesson 1: Family Planning Introduction (Including Benefits)**
- **Lesson 2: The Lactational Amenorrhea Method**
- **Lesson 3: The Two-Day Method**
Lesson 4: Cycle Beads
Lesson 5: Health Facility Options
Lesson 6: Talking with Your Partner about Family Planning (Including Negotiation Skills)

8. Sample Health, Nutrition and WASH Care Group Lessons Grouped by Stage in Pregnancy

- Module 1: Essential Nutrition Actions (ENA), Essential Hygiene Actions (EHA) and Other Important Care during Pregnancy (Part 1)
  - Lesson 1: Introduction to Care Groups
  - Lesson 2: Teaching Techniques
  - Lesson 3: Care Group Volunteer Responsibilities
  - Lesson 4: Watching for Change and Monitoring Groups

- Module 2: Essential Nutrition Actions (ENA), Essential Hygiene Actions (EHA) and Other Important Care during Pregnancy (Part 2)
  - Lesson 1: Antenatal Care and Health Centre Births
  - Lesson 2: Maternal Nutrition and Anaemia Prevention
  - Lesson 3: Iodized Salt and Iron-Rich Foods
  - Lesson 4: Hand Washing with Soap or Ash
  - Lesson 5: Creation of Household Hand Washing Stations
  - Lesson 6: Preventing Malaria in Pregnant Women
  - Lesson 7: Preparing for Birth and Delivery
  - Lesson 8: Immediate Breastfeeding
  - Lesson 9: Newborn Care Practices

- Module 3: Essential Nutrition Actions (ENA) and Essential Hygiene Actions (EHA) during Early Infancy
  - Lesson 1: Importance of Postpartum Care
  - Lesson 2: Exclusive Breastfeeding: Benefits, Breastfeeding on Demand and Breastfeeding while HIV-Positive
  - Lesson 3: Exclusive Breastfeeding: Overcoming barriers
  - Lesson 4: General Danger Signs during Childhood Illness
  - Lesson 5: Breastfeeding Problems and Care of the Breasts
  - Lesson 6: Importance of Clinical Services
  - Lesson 7: Men’s Involvement in Breastfeeding and Child Care
  - Lesson 8: Child Spacing
  - Lesson 9: Point-of-Use Water Purification
  - Lesson 10: Proper Disposal of Faeces
Lesson 11: Malaria Transmission and Prevention

Lesson 12: When a Child has Malaria: First Response and Home Care
• Module 4: ENAs and EHAs during Late Infancy and Childhood
  o Lesson 1: Good Complementary Feeding of Children 6–8 Months
  o Lesson 2: Good Complementary Feeding of Children 9–11 Months
  o Lesson 3: Complementary Feeding of Children 13–23 Months
  o Lesson 4: Recipes: Proper Use of Rations
  o Lesson 5: Vitamin A-Rich Foods and Vitamin A Supplementation (for Children and Postpartum Women)
  o Lesson 6: Worms and Deworming
  o Lesson 7: Proper Food Storage and Sanitary Food Preparation

• Module 5: Management of Common Childhood Infections
  o Lesson 1: Signs of Dehydration and Why Dehydration is Deadly
  o Lesson 2: Prevention of Dehydration with Oral Rehydration Solution (ORS)
  o Lesson 3: Proper Feeding of Sick Children
  o Lesson 4: Deadliest Types of Diarrhoea: Dysentery and Persistent Diarrhoea
  o Lesson 5: Prevention of Pneumonia and Care Seeking
  o Lesson 6: Home Vegetable Gardening

Part 4: Considerations for using Another Organization’s Materials for Your Program

Ask other non-profit organizations (e.g., Food for the Hungry, Tear Fund, Freedom from Hunger [FH], World Relief [WR], CARE, Save the Children, Compassion International) if they will share their materials. The following are a few online resources where NCG curriculum is publicly posted.

• Care Group Information http://www.caregroupinfo.org (view the curriculum page)
• Media Materials Clearinghouse http://www.m-mc.org/: Search by topic and media type. Materials will have to be adapted to fit the Care Group setting.
• Knowledge for Health (K4Health) http://www.k4health.org/

Use the guidance below to guide you through deciding whether to use existing materials/resources.

1. Find out if the materials can be reprinted and used with no cost for non-profit proposes. Some organizations require that you request permission. Contact the author of the materials if the copyright information is not clear in the manual.

2. Read the main objectives of the curriculum. Look at the objectives for each lesson. Compare this list with the objectives your program (those outlined in the proposal). Identify the proposal objectives
that are not covered and write them down. Write down a few ideas of how you could overcome this discrepancy if you were to adapt the materials.

3. Consider the design (or theory) of the materials. Write down the differences that you see in the following areas.

   o How is the subject matter taught? Do they use non-formal or formal teaching techniques? For example, if the proposal says the nongovernmental organization (NGO) will use non-formal education techniques to teach beneficiaries, but the manual uses lectures and large group presentations (formal education techniques), this is a difference in theory that you should document.

   o How are the beneficiaries changed by the materials? If the proposal says that the NGO will use behaviour change theory (behavioural determinants) to prevent HIV, but the manual uses information and facts to persuade beneficiaries, then this is a difference that needs to be documented.

4. Identify for whom the curriculum was developed (the intended audience). Compare this with the intended group as written in the proposal. If they are not the same, make a note of the differences between the two groups. For example, if the manual is designed for orphans and vulnerable children when our program targets pregnant and lactating women (PLW), this is a difference that should be noted. Write down a few ideas of how you could overcome this discrepancy if you were to adapt the materials.

5. Identify the time needed for each lesson and the entire training. Compare this with the time allotted for these activities as described in the program proposal. For example, are the sessions 2 hours in length when the NGO planned for 30-minute sessions? Is the entire training 3 weeks when the NGO planned for 6 months of training? Write down the differences that you see. Write down a few ideas of how you could overcome this discrepancy if you were to adapt the materials.

6. Review the reading level of the materials by asking the following.

   o Is this written for a small child (easy to understand) or a college professor (with many large words and complicated sentences)? If the reading level is not the same as the reading level of the beneficiaries in the program, write down an explanation of what needs to be changed so that the reading level can be adapted to the level of the beneficiaries.

   o Is the format of the manual easy to follow? Based on the literacy level of the teachers in your program, will they be able to follow the formatting in the manual with ease? Write down any problems that you see. Write down a few ideas of how you could overcome the formatting difficulties if you were to adapt the materials.

7. Review the cultural references in the materials. Write down the stories, activities or discussions that are not appropriate to the beneficiary culture. Write down a few ideas of how you could adapt the materials to overcome these problems.

   o Do the people in the pictures look like our beneficiaries? For example, if all of the illustrations are of Nigerians, and your organization is using the materials created for Burundi, it would not be appropriate for the local culture.
Are the people, discussions and situations in the manual similar to the people, discussions and situations of beneficiaries in your community? For example, if examples in the manuals include references to upper-class citizens who struggle purchasing a new car, this example would not be relevant to a Burundian caregiver who does not have money to send her child to school.

Now review the notes that you took on the above questions.

- Questions 2, 3 and 4 are the most important questions. If for these questions you listed large differences between the materials and your program goals, you should look for other materials. If the differences are small, you may consider deleting a few activities or adding supplemental lessons and activities so that the materials will match your program needs. However, if the worldview and theory are not the same (or at least very similar), you will have a very difficult time meeting your program objectives and justifying the differences between your proposal intent and the materials you chose. Make sure that you seek outside approval (and assistance) before making a decision when questions 2, 3 and 4 have large differences.

- Differences listed for questions 5, 6, 7 and 8 can be resolved with some work on your part. This requires someone who is willing and able (has the time) to work on adapting the materials so they match the intent of your program.

List the main things that need to be changed in order to make these materials appropriate for the program.

- List the names of people on staff who are capable (and available) to do this.

- Confirm that you are able (check copyright information) to adapt the materials for your program. Contact the author or publisher if you are not sure. Some authors require that they approve the materials first, which may delay your efforts. Consider making a supplemental booklet to go along with the materials.

- Consider the time it will take to make these changes.

- Decide if you are able to adapt the materials or simply add supplemental text or if you need to find new materials.

Remember the objectives of your program! Do not choose new materials because they seem “fine”. Choose the materials that are proven to work and that match the intent of your program. Do not attempt to change the proposal to match your materials; your materials need to match the proposal.
Appendix 7: How to Hire Nurturing Care Group Promoters

The best Nurturing Care Group (NCG) Promoters already live in the communities where they will work and only have a secondary school education (or less in some countries), and they are the most likely to be willing to spend their days visiting groups of mothers and/or visiting caregivers in their homes. They speak the local dialect of the caregivers they are working with and are held accountable for their actions and behaviour as they go about their daily activities since they are surrounded by their friends and extended family members. The disadvantage to working with such locally based staff is that they may have to go through a process of change in themselves before they are convinced of the new information and practices they are being paid to promote. However, experience has proven that locally hired NCG Promoters do try out the new practices they are taught, and as they experience the benefits, they become powerful agents of change.

Many rural NCG projects make the mistake of announcing NCG Promoter positions through local newspapers and in city centres. This can lead to a pool of professional candidates who have high expectations regarding salary and the benefits of working for a nongovernmental organization (NGO). Often these people expect to work in an office and they desire to spend the majority of their time in the city, where they may have a house and their children may attend school. Such candidates may have more knowledge about the technical behaviours the NCG project will promote, but typically they do not make the best NCG Promoters.

The basic NCG Promoter qualifications are:

1. Able to read and write
2. Good reading comprehension in the language the flip charts are produced in
3. Basic math skills: addition, subtraction and able to calculate percentages
4. Nominated by the community he/she will serve for the position
5. Fluent in the local dialect and the professional language of the country
6. Able and willing to be in the community 5 days per week (normally, in a rural community this requires living in the community)
7. Physically able to use the transport provided by the project (bicycle or motorcycle) to move around the project area
8. Able to travel to the provincial capital for 1 to 2-week periods for training
9. Willing to model practices taught in the NCG curricula (e.g., using a latrine, hand washing station or mosquito net)
10. Able to speak confidently in front of groups of 12 people and facilitate discussion
11. Respectful and considerate of others

For a complete list of qualifications and the NCG Promoter job description see Lesson 7, particularly Lesson 7 Handout 2: Care Group Team Essential Responsibilities.
Should Promoters be male or female?

Some NCG projects only hire female Promoters. Food for the Hungry has found that although Promoters work with groups of caregivers, both men and women can make excellent NCG Promoters. Advantages to having a male Promoter include that they tend to stay longer with the program, can easily leave their families to attend trainings, handle bicycles and motorcycles well, and when conflicts arise in households because of new practices taught by the NCG program, male Promoters can advocate with other men on behalf of the women.

There is also an advantage to hiring female NCG Promoters, and some of the best Promoters in Food for the Hungry projects have been women. Female Promoters can model new behaviours specific to women, more easily speak about sensitive subjects that normally only are discussed among peers of the same gender and encourage Care Group Volunteers (NCGVs) to be leaders by modelling how to be a strong female community leader.

What if no one at the community level has the basic NCG Promoter qualifications?

Occasionally, no one at the community level will be qualified to work as a NCG Promoter. If this is the case, grown children or extended family members of community members who have moved to larger cities for education or work can be nominated by the community. This way, the Promoter will still have ties to the community. If hired, such candidates would be expected to move back to the community for their period of employment.

Adapting to Administrative Challenges: GOAL’s Experience in Ethiopia

GOAL implemented NCGs as part of its Child Survival Program in Awassa, Ethiopia. It was a very useful intervention and GOAL plans to expand it to other country programs. Involving the Ministry of Health (MOH) in the design and planning phase from the outset and ensuring that MOH and Woreda (district) staff understood the intervention were important steps.

At the same time, the Government of Ethiopia was promoting a community health army approach, which was a strategy to try to get community health activities disseminated across the community. The Woreda Health Staff saw the NCG approach as part of this approach and felt that GOAL was assisting them in the implementation of the set-up of the health army approach.

A few months after each NCG was established, GOAL involved health extension workers (HEWs) at Kebele/Health Post, asking them to take on facilitating the care groups, with GOAL staff mantling some support and supportive supervision, but not directly implementing the NCGs. HEWs had a responsibility to work in the community, so the NCG approach also supported their work.

Again, GOAL found that by working with the MOH at district and facility levels from the outset and explaining how this intervention could be used to attain its program objectives, the NCG approach had good support and buy-in throughout.
Recommended Steps for Hiring NCG Promoters

1. Hire your manager, coordinator(s), supervisor(s) and any other management staff specific to your project.

2. Train them about NCGs and how to start up a NCG project using the lessons in this manual.

3. The manager, coordinator(s), supervisor(s) and any other management staff specific to the project then orient communities about the program. Once communities understand what NCGs are and how the project will operate, ask them to nominate two or three men and women from their community who they think will make good Promoters. Make it very clear to community leaders that the NGO will select the best candidates through interviews and the results of reading and math tests.

4. A team of NCG project personnel and human resources staff should interview candidates.

5. It is very important that candidates’ reading comprehension and math skills be tested. A sample test is available later in this appendix. (Note that this reading comprehension test was designed for students who have completed grade 6 in the United States. You can find tests online for lower grade levels if you think this test is too challenging for the majority of people in your country who have completed 6 grades of schooling.)

6. Occasionally none of the candidates nominated by the community will meet the qualifications. In this case, return the community and ask for additional nominations.

7. After you have selected all your NCG Promoters, train them about NCGs and project start-up.

If possible, projects should have 20 or more NCG Promoters and hire one or two Promoter “floaters”. These extra Promoters will not be assigned to a specific community but fill in for a set period of time when Promoters with permanent placements go on maternity leave or fall sick.
Sample Math and Reading Comprehension Test for Care Group Promoters (with Answers)

**Directions:** Answer the following mathematical problems. You may use a calculator, if you like.

1. You are working with five (5) groups of caregivers. Each group has ten (10) caregivers in it. How many caregivers in total are you working with?
   
   **Answer:** $5 \times 10 = 50$

2. What is the sum of the following ten numbers? 10, 15, 8, 12, 40, 43, 9, 11, 12, 45
   
   **Answer:** 205

3. $12 \times 12 = ___$?
   
   **Answer:** 144

4. $120 \div 30 = ___$?
   
   **Answer:** 4

5. If 25 out of 75 children are malnourished, what percentage of children are malnourished?
   
   **Answer:** $25 \div 75 = \frac{1}{3} = \text{about 33\%}$

6. If two (2) out of four (4) households have a latrine, what percent of households have a latrine?
   
   **Answer:** $\frac{2}{4} = \frac{1}{2} = 50\%$

7. Your goal is that at least 80% of women would exclusively breastfeed their 0 to 6-month old children. You do a survey and find that 60 women out of 80 women sampled do exclusively breastfeed their children. Have you met your goal?
   
   **Answer:** No, only 75% of women are exclusively breastfeeding

8. You have four (4) Care Groups. Each Care Group has twelve (12) Care Group Volunteers in it. Each Care Group Volunteer reaches out to ten (10) Neighbour Caregivers. How many Neighbour Caregivers are being reached by your four Care Groups?
   
   **Answer:** $4 \times 12 \times 10 = 480$ caregivers

9. You are told to visit each of your Care Group Volunteers once every three (3) months. You have a total of ninety (90) Care Group Volunteers. Each month you have fifteen (15) days available to visit your Care Group Volunteers. To reach your goal, how many volunteers must you visit each day you have available to do visits?
   
   **Answer:** $90 \div (3 \times 15) = 2$ visits per day

**Directions:** Read the following passage then answer the questions afterward about what you read.

**Passage: Spotted Cats**

Several members of the cat family have spotted fur. Do you know the difference between a leopard, a jaguar and a cheetah? From a distance they may appear somewhat similar. However, examined at closer range, they are clearly different cats. They differ in various ways, including where they live, how big they are, how they move and hunt, and how their fur is marked.

Of all the big cats in the wild, the true leopard is found across the largest area. Leopards live in much of Asia and Africa. A leopard grows to be 3 to 6 feet long, with an added 3 feet of tail. Leopards are skilled climbers that can hunt monkeys in trees. They can also lie in wait and pounce on passing prey. When food sources are scarce, they might eat fruit, field mice and large insects. Leopard spots are not actually solid spots; they are broken circles.

The jaguar is native to the Americas. Its natural range is from the southern United States to northern Argentina, with the largest concentration of jaguars being in Brazil and Central America. The beauty and power of the jaguar inspired worship among ancient peoples. It measures from 3 and 6 feet long without the tail, which adds another 1 ½ to 2 ½ feet. Possessing a large head and body, the jaguar has legs that are shorter and thicker than a leopard’s. Jaguars are excellent climbers and can swim well. They dine on a variety of land, tree and water creatures. Their fur can be a vivid yellow colour or a rusty shade. Their “spots” are called rosettes. Each rosette
Most cheetahs live in the wilds of Africa. There are also some in Iran and northwestern Afghanistan. The cheetah’s head is smaller than the leopard’s, and its body is longer. This cat is built for speed. Its legs are much longer than the leopard’s, allowing it to run at speeds of up to 120 kilometres per hour! This incredible ability helps the cheetahs catch their dinner, which is usually an unfortunate antelope. A cheetah’s spots are simply black spots, not rosettes or circles.

Other spotted cats include the smaller ocelot, mainly of Central and South America, and the lynx or bobcat, mainly of North America. What all of these cats have in common is that they are wild, powerful animals of tremendous grace and beauty.

1. All of these are ways to tell the difference between spotted cats except:
   A. How big they are
   B. What their spots look like
   C. Where they live
   D. How beautiful they are

   **Answer**: D

2. Which words from the passage are used as persuasion, in that they express an attitude of sympathy for animals that are prey to big cats?
   A. “how they move and hunt”
   B. “might eat fruit, field mice and large insects”
   C. “dinner, which is usually an unfortunate antelope”
   D. “that they are wild, powerful animals”

   **Answer**: C

3. Which of these statements best summarizes this passage?
   A. All spotted cats are powerful, beautiful and graceful.
   B. Spotted cats may look similar, but they are different in many ways.
   C. There are many different spotted cats in the world.
   D. Spotted cats in the wild hunt many different kinds of animals.

   **Answer**: B
Sample Nurturing Care Group Promoter Job Description

<table>
<thead>
<tr>
<th>GROUP:</th>
<th>IPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOCATION:</td>
<td>Ghana, Multiple Locations</td>
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<tr>
<td>REPORTS TO:</td>
<td>TBD</td>
</tr>
<tr>
<td>PROVIDES SUPERVISION TO:</td>
<td>Nurturing Care Group Volunteers (NCGVs)</td>
</tr>
<tr>
<td>EFFECTIVE DATE:</td>
<td>1st July 2019</td>
</tr>
<tr>
<td>GRADE LEVEL:</td>
<td>Hay 10</td>
</tr>
<tr>
<td>FINANCIAL AUTHORITY / BUDGET:</td>
<td>NA</td>
</tr>
</tbody>
</table>

Purpose of the position:

The purpose of this position is to facilitate Nurturing Care Group activities with an objective of promoting sustained behaviour change in the WASH & Child Protection sectors (Northern and Southern Operations). The position holder will be responsible to lead behaviour change interventions that will improve practices of key community/household level behaviours as per the gaps identified during the recent program evaluation by the study led by the University of North Carolina (UNC). This position is also critical to the achievement of the NCG Pilot Project Model which may be institutionalized as a core project model within WV’s Area Development Program (ADP) upon successful implementation of the pilot and further scale up in other WV countries. The NCG project model is based on the highly successful Care Group approach (see www.CareGroupInfo.org).

The successful candidate will as well observe mission and core values of World Vision and demonstrate a quality of spiritual life that is an example to others.
**Major Responsibilities: (please define in output format – 1-10 things of what you expect to see as a result of this position)**

<table>
<thead>
<tr>
<th>Key Outputs/Responsibilities (Accountabilities and results)</th>
<th>Weight (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Facilitating community level census to establish Neighbour Groups (NGs), and to assist each NG to select their Nurturing Care Group Volunteer. Help conduct baseline survey in the communities assigned.</td>
<td>10%</td>
</tr>
<tr>
<td>2. Facilitate/organize participatory learning sessions every two weeks with each of their NCGs using the biweekly lesson plans in the educational materials provided (NCG curricula).</td>
<td>30%</td>
</tr>
<tr>
<td>3. Visits, monitors and evaluates at least one NCGV from each CG each month, and supervises NCGVs’ work by accompanying them on home visits, observe them lead group meetings, use Quality Improvement and Verification Checklists (QIVCs), and provide support and counselling to NCGVs when needed</td>
<td>10%</td>
</tr>
<tr>
<td>4. Ensure availability of quantitative data for effective and timely reporting based on Nurturing Care Group Volunteer registers and other formative research in the course of implementation (e.g., Barrier Analysis studies).</td>
<td>10%</td>
</tr>
<tr>
<td>5. Coordinates local-level activities and maintains cooperation with other community-level institutions, such as the community political, traditional education, health and interfaith structures.</td>
<td>10%</td>
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<tr>
<td>6. Complete monthly Reports of District level NCG activities based on the NCGV register and Neighbour Circle (NC) register</td>
<td>10%</td>
</tr>
<tr>
<td>7. Models WASH and Child Protection behaviours taught to Nurturing Care Group Volunteers in in the community, and monitors behaviour change for NCGVs.</td>
<td>5%</td>
</tr>
<tr>
<td>8. Attends training and reporting meeting provided by the supervisor, and the module training sessions, to accurately replicate the training with the NCGVs, sharing correct information and demonstrating skills learned.</td>
<td>10%</td>
</tr>
<tr>
<td>9. Meet monthly with the local leadership/traditional leadership committee in each community for coordination, monitoring &amp; evaluation</td>
<td>5%</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
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</table>
**PROFILE: Core Capabilities:** (proficiency levels; 1=developing 2=proficient 3=advanced)

<table>
<thead>
<tr>
<th>Core Capability</th>
<th>Proficiency level (1, 2, 3)</th>
<th>Examples of advanced proficiencies (A full list of indicators available in Core Capabilities into Job Descriptions – A Manager’s Guide)</th>
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<tbody>
<tr>
<td><strong>Achieving Capabilities</strong></td>
<td></td>
<td></td>
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<tr>
<td>Achieving quality results and service</td>
<td>2 1</td>
<td>Example:</td>
</tr>
<tr>
<td>Practicing accountability and integrity</td>
<td>2 1</td>
<td></td>
</tr>
<tr>
<td><strong>Communicating</strong> information effectively</td>
<td>2 1</td>
<td></td>
</tr>
<tr>
<td>Provides supportive supervision and counsel on an appropriate basis</td>
<td>2 1</td>
<td></td>
</tr>
<tr>
<td><strong>Thinking Capabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking clearly, deeply and broadly</td>
<td>2 1</td>
<td></td>
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<td>Understanding the Humanitarian industry</td>
<td>2 1</td>
<td></td>
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<tr>
<td>Understanding WV’s mission &amp; operations</td>
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<td></td>
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<tr>
<td>Practicing innovation &amp; change</td>
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<tr>
<td><strong>Self-managing Capabilities</strong></td>
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<tr>
<td>Demonstrating Christ-centred life and work</td>
<td>2 1</td>
<td>Example:</td>
</tr>
<tr>
<td><strong>Learning</strong> for growth and development</td>
<td>2 1</td>
<td></td>
</tr>
<tr>
<td>Maintaining work/life balance</td>
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<tr>
<td><strong>Relational Capabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Building collaborative relationships</td>
<td>2 1</td>
<td>Example:</td>
</tr>
<tr>
<td>Practicing gender &amp; cultural diversity</td>
<td>2 1</td>
<td></td>
</tr>
<tr>
<td><strong>Influencing</strong> individuals &amp; groups</td>
<td>2 1</td>
<td></td>
</tr>
</tbody>
</table>

**Qualifications: Education/Knowledge/Technical Skills and Experience**
The following may be acquired through a combination of formal or self-education, prior experience or on-the-job training:

- Educational level required: Diploma in behavioural science, community health promotion, teaching, sociology, public health or any related field.
- Technical Training qualifications required: in Community mobilization and group facilitation
- Experience: Two years’ experience working in the WASH Sector
Other Competencies/Attributes:
1. Able to speak, read, and write in the local languages (Dagbani and Twi)
2. Excellent in Microsoft Word and Excel
3. Deep understanding of community-based approaches, including clear involvement of children, women and people with disabilities in hygiene promotion.
4. Must be a committed Christian, able to stand above denominational diversities.
5. Proven ability to communicate on WASH topics with diverse groups.
6. Strong interpersonal and communication skills.
7. Good development and facilitation skills, including catalysing, connecting, and building the capacity of community groups/partners.
8. Strong communicator at all levels with interpersonal skills, ability and commitment to listen to others.
9. Demonstrate commitment to the empowerment of the poor in rural communities.
10. Ability to maintain effective working relationships with staff and key partners.
11. Experience in community entry and mobilization and development facilitation.
12. Monitoring and reporting
13. Should be able to ride a moto bike
14. should possess a driver license class A
15. Perform other duties as required

Working Environment / Conditions:
- Work environment: Community based with occasional travel to base office
- Travel: 90% Domestic travel (nearby communities) is required.
- On call: 10 %

Approved by:

<table>
<thead>
<tr>
<th>Employee (printed)</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Supervisor (printed)</td>
<td>Signature</td>
<td>Date</td>
</tr>
<tr>
<td>People &amp; Culture Director (printed)</td>
<td>Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>
Appendix 9: Monitoring the Impact of Nurturing Care Group Projects

What are mini-KPCs?
Mini-Knowledge, Practice and Coverage surveys (mini-KPCs) are short surveys of 12–20 questions that are conducted every 4–6 months. The survey can be easily analysed by field offices and the results quickly obtained to inform program decisions. Performance by district can be determined with a small sample (e.g., 19 interviews per district) using Lot Quality Assurance Sampling (LQAS) survey methodology.

Why use mini-KPCs?
Development projects typically measure their impact and result-level indicators at baseline and midterm, when only 40% of the project is left to be completed, allowing little time to adjust strategy and focus on hard-to-change behaviours. Food for the Hungry (FH) has used mini-KPCs in Title II, U.S. Presidents Emergency Plan for AIDS Relief and Child Survival programs to improve program effectiveness by targeting indicators that are not improving as expected within individual supportive supervision areas.

Table 1 explains the differences between using Mini-KPCs and traditional/full KPCs.

Table 1: Traditional/Full KPCs versus Mini-KPCs

<table>
<thead>
<tr>
<th></th>
<th>Traditional/Full KPC</th>
<th>Mini KPC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of questions</td>
<td>About 60 questions</td>
<td>12–20 questions</td>
</tr>
<tr>
<td>Timing</td>
<td>Conducted at baseline, midterm and final</td>
<td>Conducted frequently, every 4–6 months</td>
</tr>
<tr>
<td>Sample size required</td>
<td>Normally about 300–500 caregivers of children under 5 years of age</td>
<td>Normally about 100 caregivers of children under 6 months and about 100 caregivers of children 6–24 months</td>
</tr>
<tr>
<td>Who is surveyed</td>
<td>Population-based sample</td>
<td>Beneficiary-based sample</td>
</tr>
<tr>
<td>Staff time required</td>
<td>Requires a large amount of staff time for training, implementation and analysis</td>
<td>Once staff are trained in the methodology, only short refresher and new questionnaire trainings are needed</td>
</tr>
<tr>
<td>Staff expertise required</td>
<td>Advanced statistical analysis skills required</td>
<td>Staff with little statistical training can do the analysis and quickly use the results</td>
</tr>
<tr>
<td>Type of information provided</td>
<td>Attempts to provide information that allows for a program (or program area) to be completely assessed or evaluated</td>
<td>Attempts to provide frequent feedback about specific aspects of a program</td>
</tr>
<tr>
<td>Staffing requirements</td>
<td>Requires large team of staff operating full time for multiple weeks</td>
<td>After a one-day training about a new questionnaire, staff can conduct the surveys as part of their normal community work</td>
</tr>
</tbody>
</table>

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58 Access the blank Microsoft Excel file used to prepare this plan at http://www.caregroupinfo.org/blog/narrated-presentations-on-care-groups-and-care-group-tools/planning-m-e-tools.
Benefits of Mini-KPCs

- LQAS survey methodology is used to determine progress at the supportive supervision area level, allowing each supportive supervision area to focus on its problem indicators.

- Regular monitoring using LQAS and a simple-to-use Microsoft Excel spreadsheet for data analysis allows for field-based monitoring and evaluation (M&E). This allows staff, with only a little training necessary, to quickly analyze data and provide survey results to program management.

- Because results are quickly obtained at the project level, they can be immediately used to inform programming decisions.

- Frequent and regular monitoring by supportive supervision area allows program managers to identify slow moving indicators and tailor programming to focus on problem areas, both technically and geographically.

Implementing Mini-KPCs

- Mini-KPCs should be scheduled every 4–6 months, considering the timing of the baseline, midterm and final evaluations. If a larger evaluation is planned, there is no need to do a Mini-KPC. Table 2 provides a breakdown of when Mini-KPCs and other important surveys could be scheduled throughout the course of the program, and which indicators to collect during each survey.

- The Mini-KPC should track the indicators listed in the project proposal. If during the length of activity you decide you want to track additional indicators, you will not have baseline data with which to compare your results.

- Survey questionnaires should be designed to measure only those indicators listed in the project proposal (the specific indicators the program is targeting and hopes to improve).

- Keep in mind that Mini-KPCs are beneficiary-based surveys, not population-based surveys. The results of one type of survey cannot be compared to the other. For example, if your baseline survey was population-based and you found that 35% of mothers were exclusively breastfeeding their under 6-month-old children, you could not say that exclusive breastfeeding (EBF) had improved if you found that 65% of your beneficiaries were exclusively breastfeeding during your first Mini-KPC. The Mini-KPC results indicate that your beneficiaries are practicing EBF more than the general population of the area, but you have not yet measured program results.
### Table 2: Mini-KPC Schedule (Example)

<table>
<thead>
<tr>
<th>Program Year:</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter: Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Survey Type:</td>
<td>Baseline KPC</td>
<td>Mini KPC 1</td>
<td>Mini KPC 2</td>
<td>Midterm KPC</td>
<td>Mini KPC 3</td>
</tr>
<tr>
<td>Indicator 1</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Indicator 2</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Indicator 3</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Indicator 4</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Indicator 5</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Indicator 6</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Indicator 7</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Indicator 8</td>
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<td>Indicator 9</td>
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<td>Indicator 11</td>
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<td>X</td>
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<td>Indicator 12</td>
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<td>Indicator 19</td>
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<td>Indicator 20</td>
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<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

### Using LQAS in the Nurturing Care Group Setting to Select Survey Respondents

**Note:** This section is not intended to be a primer on LQAS, but how to use LQAS in an area where the population you desire to sample is already organized into NCG. For training manuals on LQAS please go to [www.coregroup.org/our-technical-work/working-groups/monitoring-and-evaluation](http://www.coregroup.org/our-technical-work/working-groups/monitoring-and-evaluation).

LQAS is the sampling method used for Mini-KPCs for three reasons.

1. **LQAS allows for small sample sizes.**
   
   NCG projects try to keep the cost per beneficiary low, so as many people as possible can be reached with life-saving information. It is important to invest time and resources into M&E, but the majority of staff time and resources should be focused on creating behaviour change. LQAS methodology uses a...
randomly chosen sample that is spread throughout each supportive supervision area; thus it has a design effect of one. This allows a small sample to provide reasonably specific results with a low investment in time and money.

2. **LQAS provides management with information to inform program decisions.**
   LQAS divides the population to be sampled into supportive supervision areas. A sample of at least 19 respondents is taken from each supportive supervision area, and survey results indicate if a region of the project is performing below the acceptable program average, allowing program management to know where resources and efforts need to be focused in order to reach program goals.

3. **LQAS allows for a point estimate to be calculated for the total project area (not each supportive supervision area) to measure project progress toward an indicator.**
   This allows program management to track indicator progress at the project level.

Consider the following criteria to determine whether you should use LQAS in your NCG project.

- The sample population demographic of interest must be contained within the NCG participants. For example, if you wish to sample pregnant women, you could use NCG participants since this demographic is contained within the NCG participants. If you wish to sample all women with children 6–23 months of age, you also could use NCG participants. However, if you wish to sample men 18–55 years of age, you cannot use NCGs.

- Existing NCGs must include all caregivers in a geographic area that fit the criteria for inclusion in NCGs.

- A list of all NCG participants is required so that beneficiaries may be randomly chosen properly for inclusion in LQAS. These lists should be made according to the numbering system described in Lesson 6: Organizing Communities into Care Groups and Numbering.

You must answer the following two questions before setting up your sampling frame.

1. What is the total sample size you want to collect? Normally, aim to collect a total sample of 96. To allow room for error, try to collect about 10% more samples than needed. Therefore, a total sample size of 106 will likely result in at least 96 good samples being collected.

2. How many supportive supervision areas will you divide your project into? A sample between 19 and 50 should be collected in each supportive supervision area. Therefore, if your total desired sample is 96, you should consider a minimum of three to a maximum of five supportive supervision areas.

Take the following steps to use LQAS in a NCG project.

1. Divide your project area into supportive supervision areas.

2. List all the NCGs in each district.

3. Divide the total number of NCGs in a district by the number of interviews scheduled to be done in each district to obtain the sampling interval.

4. Select a random number between 1 and the sampling interval. The first NCG with the corresponding number will be the first NCG selected for random sampling. Add the sampling interval to this random number to select the second NCG to be randomly sampled. From this point
on, simply add the sampling interval to the previous NCG number to choose each NCG to be randomly sampled until all the NCGs where interviews should occur have been identified.

5. To determine the number of interviews needed in each area, divide the total number of desired samples by the number of supportive supervision areas in the project.

6. Table 3 provides examples for how to sample in a NCG project. Area A has 50 NCGs. It is determined that 36 interviews need to be conducted in this area. For Area A, the sampling interval was calculated by dividing the number of NCGs (50) by the sample size needed for this supportive supervision area (36). The random number chosen in this example was 1, as can be seen by the fact that the sampling interval is 1.38. Notice that for Area C, more than one interview is done in the first, fifth, tenth, etc. NCG because the number of interviews needed from this supportive supervision area is greater than the number of NCGs in this supportive supervision area.

Table 3: Selecting Care Groups in Each Area for Interviews

<table>
<thead>
<tr>
<th>Area A</th>
<th>Area B</th>
<th>Area C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care groups</td>
<td>50</td>
<td>Care groups</td>
</tr>
<tr>
<td>Interviews per area</td>
<td>36</td>
<td>Interviews per area</td>
</tr>
<tr>
<td>Sampling interval</td>
<td>1.38</td>
<td>Sampling interval</td>
</tr>
<tr>
<td>Random #</td>
<td>1</td>
<td>Random #</td>
</tr>
<tr>
<td>Samples needed</td>
<td>Selected groups (always round down)</td>
<td>Care group number</td>
</tr>
<tr>
<td>1</td>
<td>1.00</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>2.38</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>3.75</td>
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<tr>
<td>4</td>
<td>5.13</td>
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</tr>
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<td>5</td>
<td>6.50</td>
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<td>6</td>
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<td>7</td>
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<td>13</td>
<td>17.51</td>
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<td>14</td>
<td>18.89</td>
<td>14</td>
</tr>
<tr>
<td>15</td>
<td>20.27</td>
<td>15</td>
</tr>
<tr>
<td>16</td>
<td>21.64</td>
<td>16</td>
</tr>
<tr>
<td>17</td>
<td>23.02</td>
<td>17</td>
</tr>
<tr>
<td>18</td>
<td>24.39</td>
<td>18</td>
</tr>
<tr>
<td>19</td>
<td>25.77</td>
<td>19</td>
</tr>
</tbody>
</table>
7. In each randomly chosen NCG that was selected for one or more interviews, a random number is used to determine which Nurturing Care Group Volunteers (NCGVs) to interview. A list of the selected NCGVs and all their Neighbour Caregivers (NC) is then produced, and a random number is used to determine which NC to interview. If the first caregiver selected had a child under 6 months of age, then another random number is drawn until a mother with a child 6–23 months of age is selected. Table 4 illustrates a process for selecting caregivers to be interviewed.

<table>
<thead>
<tr>
<th>Area A</th>
<th>Area B</th>
<th>Area C</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>27.15</td>
<td>20</td>
</tr>
<tr>
<td>21</td>
<td>28.52</td>
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</tr>
<tr>
<td>22</td>
<td>29.90</td>
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<td>24</td>
<td>32.65</td>
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<td>25</td>
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<td>26</td>
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<td>27</td>
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<tr>
<td>36</td>
<td>49.17</td>
<td>36</td>
</tr>
</tbody>
</table>

| 37     | X      |
| 38     | X      |
| 39     | X      |
| 40     | X      |
| 41     |        |
| 42     | X      |
| 43     | X      |
| 44     |        |
| 45     | X      |
| 46     | X      |
| 47     | X      |
| 48     |        |
| 49     | X      |
| 50     |        |
### Table 4: Selecting Caregivers to be Interviewed in the Randomly Selected NCGs

<table>
<thead>
<tr>
<th>NCG number</th>
<th>Groups selected for sampling</th>
<th>Nurturing Care Group 1</th>
<th>Nurturing Care Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>NCGVs</td>
<td>Random number</td>
</tr>
<tr>
<td>1</td>
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<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>12</td>
<td></td>
</tr>
</tbody>
</table>

NCG 1 is selected for an interview. All the NCGVs are listed. Because there are 12 NCGVs, a random number between 1 and 12 is selected. In this example, NCGV 3 is selected.

NCGV 3 is listed with all her NCs. Because there are 13 NCs, a random number between 1 and 13 is chosen. In this example, NC 13 is selected, and the NCGV is chosen for the interview.

### Conducting Interviews in the Field

1. **Before the survey, set a protocol for the number of times you will return to find NCGVs who are not at the meeting or NCs who are not in their homes.** Only after returning this set number of times unsuccessfully to interview this NCGV or neighbour caregiver may you choose another NCGV or neighbour caregiver. Also, a selection bias may be introduced if you only interview caregivers from NCGVs who come to the central meeting place or NC who are home from, for example, 12 to 5 pm.

2. **Determine which NCGs and NCGVs are selected for interviews in each area.** Then, call the selected NCGVs and use their registers to choose the NC to interview by selecting another random number, which will determine the NC to interview. (Remember to assign the NCGV a random number, as well, so she has as an equal a chance of being selected as her NC.) Then, have the NCGV lead you to the randomly selected NC.

3. **Interviews should be conducted by project personnel who do not directly supervise the work of the NCG promoter, NCGV or NC, but who fluently speak the language of the**
respondents. Enumerators may be hired, but, for example, FH usually switches NCG project personnel from one project area to another.

4. It is important that the supervisor reviews the surveys before the team leaves the village where the interviews were conducted. Many errors can be caught and corrected if a review is done in the field.

For more on conducting LQAS surveys, including LQAS using parallel sampling please visit http://www.coregroup.org/our-technical-work/working-groups/monitoring-and-evaluation.
Appendix 10: Using the Care Group Approach in Low Social Capital Settings: The Example of Curamericas in Guatemala\textsuperscript{59}

Social capital has been conceptualized in diverse ways. Leading contemporary social epidemiologist Ichiro Kawachi defines social capital as “access to network-based resources such as trust, norms, and reciprocity exchanges”\textsuperscript{60} and includes those features of social relationships—such as levels of interpersonal dependence and norms of mutual aid—that promote collective action for shared benefit.\textsuperscript{61} An expanding literature base indicates that social capital plays an important role in community engagement across a variety of domains, ranging from individual health (e.g., social capital has been found to be associated with child nutritional status across four countries\textsuperscript{62}) to community health status variables through mechanisms such as promoting healthful practices, providing health education and increasing responsibility for the well-being of others.\textsuperscript{63} Although individual and community wellbeing must be contextualized within the broader political, historical, social and cultural milieu, the bonds and connectedness of people within a community facilitate the achievement of community health goals through mechanisms of trust, cooperation, connectedness and reciprocity. Social scientists know that communities that possess deep reserves of social capital can enhance the success of projects designed to empower vulnerable populations.

Field experience with Care Groups (NCGs) suggests that high social capital is favourable for the success of the NCG approach. Experience in post-conflict settings also has demonstrated that this can also be an advantageous outcome of the approach as NCGs enhance the rebuilding of social capital in areas of social destruction and make communities more resilient against future challenges.

For example, the indigenous Mayan population in Guatemala is one such group with a history of social capital destroyed (and, in NCGs project areas, rebuilt). The past century in Guatemala has been characterized by authoritarianism, violence and instability. Most recently, a 36-year long civil war, including unimaginable human rights violations, brought widespread physical and human destruction and resulted in lasting social fragmentation and a culture of deep mistrust. Four hundred and forty villages were completely annihilated, and close to 200,000 Mayan men, women and children were either massacred outright or thrown from helicopters into the Pacific Ocean. Many families lived for decades as refugees in northern Mexico, displaced from their traditional lands and homes. In the midst of violent raids, Mayan communities dispersed, social networks were fractured and trust was abolished. Community members were so traumatized by over 30 years of violence and displacement and as returning refugees that they did not trust their own neighbours and deeply feared outsiders. The experience of Curamericas Global and its implementing partner Curamericas/Guatemala in implementing NCGs in this context of low social capital is shared to encourage and assist other implementers dealing with similar challenges.

\textsuperscript{59} This appendix was authored by Erin Pfeiffer (Food for the Hungry [FH], formerly Curamericas Global; epfeiffer@fh.org), Sarah Bauler (FH, formerly Samaritans Purse; sbauler@fh.org) and Mary DeCoster (FH, formerly Curamericas Global; mdecoster@fh.org).

\textsuperscript{60} I. Kawachi, S.V. Subramanian and D. Kim. 2007. \textit{Social Capital and Health}. Springer.


\textsuperscript{63} S. Folland. 2007. Does “community social capital” contribute to population health? \textit{Social Science Medicine} 64: 2342–2354.
Curamerica/Guatemala’s first experience with NCGs (2002–2007) was in a project area in three isolated municipalities of the highlands of Huehuetenango as part of a U.S. Agency for International Development (USAID)-funded child survival (CS) project. The area was so difficult to work in that several other nongovernmental organizations (NGOs) attempted to work in the project area but gave up and left the area after persistent rejection from the communities. Even attempts to deliver food and basic medical aid were refused out of distrust.

Curamerica/Guatemala aimed to use the NCG approach to empower women and rebuild the social connectedness that had disintegrated. The lack of trust made it extremely difficult to recruit Care Group Volunteers (NCGVs). Field staff noted that men frequently prohibited their wives from participating under the assumption that no good thing could come from meeting with outsiders. Projections were to recruit 400 NCGVs, but there was continued resistance even when the women themselves began to express interest. The project director took care to hire staff who spoke the local Mayan languages and, when possible, to hire from within the project area, which helped tremendously in gaining trust. By the end of the project, there were over 300 active groups, each lead by a NCGV.

As time went by, trust increased through meetings and community mobilization. The NCGVs held meetings with the Neighbour Women (NW) in their group and made home visits. Many of the groups are still active and still meet the needs of new mothers for information and support. Mothers interviewed in focus group discussions stated, “This is great help for us. It is hard to get to the health post. They [NCGVs] come to visit us and now we know them and trust them.” Two years later, by the project’s midterm evaluation, there was a “growing trust and confidence” among the communities. Project staff stated, “Currently the Care Groups are formed. One of the strengths that we have with them is that in the community there are now women leaders.” As the project came to an end, there was a visible sense of enthusiasm and an impressive mobilization of women, even in the most unapproachable communities. Much of this interest and involvement can be directly linked to the use of the NCG networks.

The breakthrough in community trust through NCGs was tremendous, but the process was slow and arduous. Curamerica/Guatemala is currently starting up another CS project including the NCG approach and now knows to expect that building social capital can take time and patience. Some communities responded more quickly than others. The different degree of trust and experience with community-based activities in the three project municipalities in the past showed that it takes time to earn trust and reach the point where most community members accept services and participate.

The Guatemala experience using NCGs led to several lessons learned. General conditions that favour NCG implementation include:

- A socially cohesive community: that is, a community that is reasonably stable, has established mechanisms for social support and problem resolution, and has a commonly shared culture and language

- A population that is relatively stable, with minimum and/or predictable migration patterns

Conditions that make NCG implementation more difficult to introduce are when:

- A community is unstable due to severe social, political or economic disruption
• Social cohesiveness has been destroyed, social capital is low and a culture of reciprocal trust is lacking

To overcome challenging conditions of low social capital, Curamericas/Guatemala used the following steps for building social trust and cohesiveness.

1. Develop a relationship between the health program and the potential intended area population through a series of meetings, discussions and visits between project staff and traditional and formal community leaders (CLs). Mutual trust and confidence are prerequisites for progress, and this is best gained through patient, respectful dialogue at the pace of the CLs.

2. During the early, exploratory meetings, guard against raising false expectations, which may lead to long-term negative consequences between the program and communities. An ongoing, candid self-appraisal of what NCGs can offer the communities, together with a clearly positive response to this question from key community representatives, will be essential for further program development.

3. One means to develop good working relationships, particularly if the implementing entity is external to the communities in which it intends to work, is to identify a high community perceived priority health need that can be addressed using NCGs and to agree to carry out this work mutually until measurable success is achieved. This activity should further develop the relationship of trust between health program staff and community members.

4. Be sure staff members are prepared to give clear and consistent messages about the purpose and design of the NCG project (see Lesson 20: Introducing the Care Group Approach to Others).

The post-conflict context of Guatemala was a major effort, particularly in light of the isolation and difficult terrain of the project area and the initial distrust and suspicion encountered in the communities. However the NCG model demonstrated itself as an effective approach to building social cohesiveness. Now people know and trust their neighbours and project staff more, and there are active village health committees. Although it is a more difficult outcome to measure, this is a clearly valuable result—not just reductions in child malnutrition and death, but the fact that NCGs appeared to be very successful in rebuilding the social capital lost in this area.

Finally, the impact of increased social capital appeared to improve the community’s resilience in coming together to deal with a variety of challenges and natural disasters, as communities continue to mobilize themselves to form local committees and advocate for local government resources and the groups continue to meet and support new mothers long after the CS project ended.

Building resilience by strengthening social capital as a mechanism to improve post-disaster recovery also is strongly supported by recent research findings. Daniel Aldrich64, a researcher from Purdue University, studied four disasters in developed and developing countries over the last 100 years and found that social capital is the greatest predictor of resilient disaster recovery. These findings contradict commonly believed theories that increasing levels of aid and rebuilding physical infrastructure are the most critical

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factors in the recovery process. In other words, Aldrich’s research found that rebuilding social infrastructure was much more important than rebuilding the physical infrastructure in post-disaster and population recovery.

The NCGV mobilization strategy rebuilds social infrastructure by strengthening social capital bonds between family and friends and across different religious and ethnic groups and by linking marginalized mothers with people in power by giving them a stronger voice with local decision-makers. The NCG structure also mobilizes “collective action” to overcome barriers and obstacles to good maternal and child health services and behaviours. Collective action also was found to be strongly associated with higher levels of trust and deeper social networks. The effect of the NCG approach on rebuilding social capital has tremendous potential and should be measured and studied in the future, not only as a mechanism to improve post-disaster recovery but also as a protective measure to mitigate against disasters in the future.
Appendix 11: Integrating NCGs with WV Core Project Models

Go Baby Go! (GBG)

- Consider altering the ECD lesson format and content to meet that of the ten GBG group meetings.
- The vulnerability assessment could be completed by the Promoter. The NCGVs are not required to be literate, so it would be a difficult tool for them to use. Given the number of households assigned to each Promoter, I suggested that this be done every six months.
- Consider altering the home visits to include psychological first aid.
- Consider training NCGVs on the Developmental Milestones Cue Card and make them available to each NCGV.

Community Management of Acute Malnutrition (CMAM)

- The CMAM approach is comprised of four components:
  1. Community outreach and mobilization;
  2. Outpatient management of SAM without medical complications;
  3. Inpatient management of SAM with medical complications; and
  4. Services or programs to manage moderate acute malnutrition (MAM), such a supplementary feeding program.
- Care Groups have been used to help implement the first component of CMAM in a number of countries by multiple organizations.
- NCGVs and Promoters can mobilize the community for growth monitoring, educate families about the importance for stunting and underweight, and teach healthy behaviours that promote adequate child growth.
- Other organizations, such as FH, have given every NCGV a MUAC strip for arm circumference measurement and taught them to use it on every child during home visits. In this capacity, they serve as a first line of defence in identifying malnourished children and referring them to the nearest health facility.
- When working with the health facility staff, NCGVs can help to ensure children receiving outpatient treatment continue to attend. They can also follow up with the family afterwards to monitor if recommendations are being followed and growth seen.

Positive Deviance / Hearth Nutritional Rehabilitation

- Both WR and FH adapted the PD/Hearth approach to fit within the context of Care Groups in Rwanda and saw great success.
o “The Nutrition Weeks strategy targets all households with pregnant women and mothers of children under two years for prevention of malnutrition, unlike the PD/Hearth strategy, which targets only malnourished children and their caregivers for community-based recuperation.

o The Nutrition Weeks strategy also involves fathers and alternate caregivers in some activities.

o Nutrition Weeks were conducted by Village Nutrition Committees (VNC), comprised of CHWs (which were also NCGVs in the project structure) and village leaders.

o Households with pregnant women or children under two were invited to attend a two-hour participatory group education session every day for one week, three times per year, each group consisting of 10-12 participants. At the conclusion of the week, participants also received a poster as a reminder for meal frequencies, food variety, and other nutritional messages."

- “Results from the OR study are impressive ... A statistically higher proportion of children 6-23 months achieved a Minimum Acceptable Diet (MAD) when exposed to the Nutrition Week intervention, compared to those not exposed... the probability of achieving the MAD was 23% greater when a child was exposed to Nutrition Weeks (p<0.001).

- Results for Minimum Dietary Diversity and Responsive Feeding were similarly statistically significant. Minimum Meal Frequency increased to over 60% from baseline levels less than 10% in both intervention and comparison areas.

- Age appropriate introduction of complementary foods also increased.”

**Note: This intervention is time and resource intensive, careful consideration should be used in planning where and how this will be implemented.**


**Timed and Targeted Counselling (ttC)**

- After the NCGVs have received all the lessons, she can choose lessons based on the age of the youngest child in the home or the mothers’ stage of pregnancy (*timed*). She can also visit the most vulnerable children’s households more often (*targeted*).

- Consider include icons on the flip charts and lesson plans that reflect the stage of pregnancy and age of child (small, medium, big belly on a pregnant woman; child sitting, standing, etc. for child).

- If budget is available, give ttC booklets to every family. If not, consider adding a section to the Model Family Poster that would track commitments made and commitments kept.

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