Care Groups: Implications of Current Innovations, Scale-up and Research

Summary Report of a CORE Group Technical Advisory Group meeting

May 28-29 2014

ACKNOWLEDGEMENTS

Many thanks to the meeting organizer and facilitator, Lynette Friedman (independent consultant), and the Care Group Steering Committee who worked with her to provide input on participants and the agenda: Henry Perry, JHU; Tom Davis, Feed the Children; Alexandra Rutishauser-Perera, IMC; Carolyn Wetzel, Food for the Hungry; Jennifer Burns, IMC; Cindy Pfitzenmaier, PCI; Mary DeCoster, Food for the Hungry; Jenn Weiss, Concern Worldwide; and Karen LeBan, CORE Group.

Many thanks to the presenters for sharing their learning and experience: Henry Perry, JHU; Christine Marie George, JHU; Elizabeth Arlotti-Parish, ACDI/VOCA; Jenn Weiss, Concern Worldwide; Delphin Sula, Concern/Burundi; Melanie Morrow, ICF; Melene Kabadege, WR/Rwanda; Ayan Shankar Seal, PCI/Bangladesh. All presentations can be found at http://www.coregroup.org/resources/meetingreports

Many thanks to the note-taker, Sharon Tobing, independent consultant; and, to the lead editor of the report, Mary Hennigan, CRS, for bringing a Working Committee together to ensure the recommendations were actionable.

Many thanks to the USAID Food for Peace funded - Technical and Operational Program Support Project for providing the microgrant funding that enabled this meeting to take place.

RECOMMENDED CITATION

Care Groups: Implications of Current Innovations, Scale-up and Research. Summary Report of a Technical Advisory Group meeting, May 28-29 2014, CORE Group: Washington D.C.

DISCLAIMER

The Care Groups Technical Advisory Group Meeting and this subsequent report were made possible by a grant from the USAID Technical and Operational Performance Support (TOPS) program. The TOPS Micro Grants Program is made possible by the generous support and contribution of the American people through the United States Agency for International Development (USAID). The contents of the materials produced through the TOPS Micro Grants Program do not necessarily reflect the views of TOPS, USAID or the United States Government.

ACRONYMS

Adventist Development and Relief Agency	ADRA
Catholic Relief Services	CRS
Child Survival Health Grant Program	CSHGP
Community Health Worker	CHW
Community Health Volunteer	CHV
Development Food Assistance Program	DFAP
Early Childhood Development	ECD
Food Aid and Food Security Assessment	FAFSA
Food for the Hungry	FH
Food for Peace	FFP
International Medical Corps	IMC
Johns Hopkins University	JHU
Ministry of Health	MOH
Non-Governmental Organizations	NGOs
Project Concern International	PCI
Technical Advisory Group	TAG
Technical and Operational Performance Support Program	TOPS
Tuberculosis	TB
Quality Improvement & Verification Checklist	QIVC
United States Agency for International Development	USAID
United States Government	USG
Under 5 Mortality Rate	U5MR
United Nations Children Fund	UNICEF
World Vision	WV

Table of Contents

SUMMARY OF CARE GROUP TAG MEETING

CORE Group received a micro-grant (Award number 999000426) from the USAID Food for Peace (FFP)-funded Technical and Operational Performance Support (TOPS) Program. The purpose of the micro-grant was to conduct an expert review on the scale-up of Care Groups (CG) as a behavior change strategy for improving nutrition and maternal and child health.

Care Groups have been used by 27 Non-Governmental Organizations (NGOs) across a total of 23 countries that trained over 106,000 peer educators reaching an estimated 1.275 million households.[1] Tools and manuals available at www.caregroupinfo.org; http://www.coregroup.org/our-technical-work/initiatives/diffusion-of-innovations/50, and http://www.fsnnetwork.org/resource-library/social-and-behavioral-change/care-groups-training-manual-program-design-and-impleme, have enabled their widespread use. Care Groups have, on average, doubled the estimated under-5 mortality reduction as compared to non-Care Group projects in USAID child survival projects. Behavior change on projects using Care Groups is better than average, with 54% higher performance on Rapid CATCH indicators.[2] A recent publication by Tom Davis on the use of Care Groups in Mozambique demonstrated the potential of Care Groups to substantially reduce under-5 mortality in priority countries at very low cost/ beneficiary. [3]

The TAG had the following objectives:

1. Review the evidence base regarding the Care Group approach
2. Explore experiences with national adoption and scaling up especially in the food security context
3. Explore the implications of recent innovations and evaluations for programming efforts
4. Identify recommendations for effective training and quality control approaches to ensure that Care Groups maintain a participatory, peer learning environment for achieving behavior change
5. Identify next steps, including recommendations for a research agenda and opportunities for informing donor and implementer audiences about experiences with Care Groups in various contexts and sectors.

The Technical Advisory Group (TAG) meeting brought together 33 practitioners from implementing agencies, USG representatives, and researchers in the Care Group approach. The meeting began with a review of the current evidence base and the results of a recent comparison of mortality reduction in child survival projects with and without Care Groups. Participants then explored experiences scaling up and integrating the approach with Ministries of Health. Concern Worldwide presented the results of their cluster randomized control trial of integrating Care Groups into national MOH system in Burundi, and World Relief provided

[1] http://www.caregroupinfo.org/blog/implementors

[2] George C, Vignola E, Ricca J, Perin J, Perry H.2014. Livest Saved Tool (LiST) Analysis of Care Group versus Non-Care Group Child Survival Projects. Washington, DC. 29-30 May 2014

[3] Davis et al. Global Health: Science and Practice. 2013. 1(1):35-51

implications and lessons learned of adapting the Care Group model to MOH specifications from their Rwanda Expanded Impact project. Participants developed recommendations related to national adoption, advocacy and communication. The two-day meeting was held at the conference facilities of FHI 360.

Key Outputs of the Meeting

1. Formation of a steering committee to follow up on TAG findings and recommendations
2. Plans to host a follow-on research needs meeting with Jim Tielsch, Chair of Global Health, George Washington University (GWU)
3. Plans for further dissemination of the Care Group TAG results, including development of a policy paper on the Care Group approach
4. Agreement to pursue a partnership with UNICEF on the Care Group approach.

BACKGROUND

Description of a Care Group

A Care Group is a group of 10-15 volunteer, community-based health educators who regularly meet together with project staff for training and supervision. They are different from typical mother's groups in that each volunteer is responsible for regularly visiting 10-15 of her neighbors, sharing what she has learned and facilitating behavior change at the household level. Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication. They also provide the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits.

Key milestones in scaling up Care Groups

CORE Group supported the development of a Care Group Difference: A guide to mobilizing community-based health educators in 2004 and has continued to lead diffusion efforts since this time. In December 2010, CORE Group organized a TAG meeting through the USAID Maternal and Child Health Integrated Program to bring together practitioners of the Care Group model from a variety of organizations in order to consider what is currently known about the effectiveness of the approach and implications for its scale up. In 2014 the latest manual Care Groups: A Training Manual for Program Design and Implementation was published under the auspices of TOPS /FSN.

External evaluations

The recent FAFSA-2[4] (second food aid and food security assessment) report highlighted that the Care Group model is promising for achieving the outreach and frequent contact in the

[4] http://www.usaid.gov/sites/default/files/documents/1866/FAFSA-2%20Full%20Report_July2013.pdf

community with women and children in the 1,000 day period (conception through age 2) that are critical to successful growth and development. They acknowledged that the approach is experimental in Title II programs and is being used for implementation in a number of projects. There are several adaptations and evaluations currently underway or planned that provide the opportunity to significantly advance the current understanding and practice of Care Groups and provide program managers and donors with information to further improve program outcomes for beneficiaries of food security and child survival projects**.** These include:

- PCI/Bangladesh Care Group "Trios" that involve fathers and mother-in-laws;
- Concern Worldwide/Burundi integrating Care Groups into MOH systems
- Concern Worldwide/Niger that looks at Care Group leader mother characteristics for delivery of integrated community case management;
- PCI/Liberia and World Relief/Rwanda looking at integration of Care Groups and savings groups;
- World Relief/Mozambique to incorporate TB programming into Care Groups;
- IMC/Sierra Leone looking at adding an ECD module into Care Groups
- Food for the Hungry/Haiti using Care Groups in an emergency setting;
- Food for the Hungry and Feed the Children staff have developed a plan for a cluster randomized controlled trial of using Interpersonal Therapy for Groups (IPT-T) in a Care Group project to treat maternal depression as a way to improve behavior change and child growth.

METHODOLOGY

Meeting participants (see Annex 2) were selected based on their experience implementing or researching Care Groups in Title II or Child Survival programs. All organizations that had implemented Care Groups and were listed on the caregroupinfo.org website were invited to send a representative. The Steering Committee worked with the meeting organizer and facilitator to provide input on additional participants as well as the agenda. Four participants (one each from Bangladesh, Burundi, Rwanda and Uganda) were provided with travel scholarships to share their expertise with Care Group innovations. Several invited participants were unable to attend.

MEETING FINDINGS

The two-day meeting (see Annex 1 for agenda) resulted in the following key findings and recommendations.

1. Review the evidence base

The meeting began with a review of the current evidence base and the results of a recent comparison of changes in health behaviors in USAID funded child survival projects with and without Care Groups. The following table summarizes the current evidence on Care Groups:

Table 1: Summary table of the evidence

Study / Findings	Date / Researchers
42% decline in under-5 mortality in the World Relief/Mozambique Vurhonga (Dawn) II child survival project according to independently collected retrospective vital events data, and 62% according to prospective vital events collected by Care Group Volunteers	Edward A, Ernst P, Taylor C, Becker S, Mazive E, Perry H. Examining the evidence of under-five mortality reduction in a community-based programme in Gaza, Mozambique. *Trans R Soc Trop Med Hyg* 2007; **101**(8): 814-22
71.9% decline in under-5 mortality in the World Relief/Cambodia Light for Life child survival project according to vital events collected by Care Group Volunteers (9.0% per year over a 10-year period, 2000-2008) compared to a 39.7% decline in the same province during a similar period (4.0% per year over a 10-year period, 1995-2005)	Perry H, Sivan O, Bowman G, et al. Averting childhood deaths in resource-constrained settings through engagement with the community: an example from Cambodia. In: Gofin J, Gofin R, eds. Essentials of Community Health. Sudbury, MA: Jones and Bartlett.; 2010: 169-74
In a Care Group child survival project carried out in a population of 1.1 million people in central Mozambique, the average annual rate of decline of undernutrition (2.2%) was approximately 4 times greater than the underlying secular decline (0.4-0.6%)	Davis TP, Wetzel C, Avilan EH, et al. Reducing child global undernutrition at scale in Sofala Province, Mozambique, using Care Group Volunteers to communicate health messages to mothers. *Global Health: Science and Practice* 2013; **1**: 35-51
A cluster-randomized study by Concern Worldwide Burundi found that an "Integrated" Care Group model that shifted responsibility for Care Group facilitation and supervision from NGO staff to CHWs and MOH staff, was as effective as the traditional model in achieving child health and nutrition outcome; and that both models achieved the same level of participation and coverage.	Weiss J, Makonnen R, Sula D. 2013. Testing the Effectiveness and Sustainability of an Integrated Care Group Model as Compared to the Traditional Care Group Model. Final Report. Concern Worldwide: New York.
A comparison of CSHGP-funded Care Group Projects with non-Care Group child survival projects from the same countries using LiST, indicates that the Care Groups projects have an annual rate of decline in under-5 mortality that is 49% greater than other CSHGP child survival projects. LiST estimates child survival impact from changes in population coverage in key child survival interventions.	George C, Vignola E, Ricca J, Perin J, Perry H.2014. Livest Saved Tool (LiST) Analysis of Care Group versus Non-Care Group Child Survival Projects. Washington, DC. 29-30 May 2014

A randomized controlled trial demonstrated that behavior change communicated focused on diarrhea prevention through Care Groups reduced the prevalence of diarrhea in a Bolivian peri-urban setting to 14%, compared to a level of 42% in the control group	Lindquist ED, George CM, Perin J, et al. A Cluster Randomized Controlled Trial to Reduce Childhood Diarrhea Using Hollow Fiber Water Filter and/or Hygiene-Sanitation Educational Interventions. *Am J Trop Med Hyg* 2014; **91**(1): 190-7

Key Recommendations:

Participants identified two levels of current research needs: a rigorous evaluation of Care Groups with a randomized control design; and a series of operations research questions to inform current programming. (Please see Annex 1)

2. Explore experiences with national adoption and scaling up especially in the food security context

Concern Worldwide reported on the results of their operations research to evaluate the integration of the Care Group model into the national health system in Burundi. The integrated model was designed to reduce the dependence of Care Group implementation on full-time, paid NGO staff, while increasing integration with the local MOH structure. This is accomplished through task shifting of Care Group facilitation and supervision duties from project staff to appropriate MOH staff and CHWs, while still satisfying the established Care Group Criteria.

Suggested criteria for national adoption by MOH:

- Viable working relationship with a stable government structure
- Paid government staff that is the focal point at the district level or below
- Designated cadre (like a CHW) or a community development worker
- Existing or evolving community development strategy of government in which to integrate CG.
- Coordinating "desk", such as a community health desk, if the Ministry is divided into different intervention areas
- Budget for promoter/trainer/ supervisor person and strategy
- Way to integrate data collected at community level into the Health Information System (HIS)

Concern concluded that:

- Traditional Care Groups have been proven to be effective in achieving coverage of key health and nutrition behaviors in numerous settings
- CHWs are a growing part of Ministry of Health systems, however it is often difficult for CHWs alone to attain complete household coverage
- the Integrated Care Group model holds promise as a way to scale-up proven practices at the household level while leveraging existing structures and building local capacity

World Relief, Concern Worldwide and IRC implemented an Expanded Impact project in six districts in Rwanda covering a population of 1.67 million (18% of the national population). The project focused on supporting the MOH to scale up integrated CCM and promotion of key family practices using the Care Group model. Since the MOH insisted on using only government CHWs instead of project volunteers, the NGO partners modified the Care Group approach to respond to MOH needs and to fit within the national system.

While this project applied as many principles from Care Groups as possible, it was forced to violate many of the criteria in order to fit with the MOH system. What started out as Care Groups became so heavily modified that it is now referred to in Rwanda as CHW Peer Support Groups.

The key characteristics were that:

- CHWs from 2-5 neighboring villages organized into "Peer Support Groups" at cell level with up to 20 members, about half of whom were male.
- CHWs of all types were "cross-trained" in BCC, while maintaining their specialized functions.
- CHWs from the same village divided up households (15-20 per CHW) to better support monthly home visits for BCC.
- Three project promoters per district built capacity of CHW Cell Coordinators (elected by their peers) to help with training and supervision of groups.

Key Points Emerging from Discussion:

- In order to be effective, there needs to be a focal paid staff of the government as close to community as possible. While CHWs could be volunteer or paid, TAG participants felt strongly that there needs to be a paid person in the system to provide supervision to Care Group activities.
- The Ministry needs an active role in the design, scale up and maintenance of the approach. It is important to be aware of changing environments and adapt to the country context.
- More information is needed on accurate costing for the Care Group approach in order to provide information for MOH decision making. The model may show excellent results, but needs to be at a cost that an MOH can afford. While cost-per-beneficiary data on many Care Group projects is available, very little is currently known about the costs to the Ministry for use of this integrated model
- More experiences are needed on integrating Care Groups into MOHs in order to build the evidence base. Concern Worldwide provided a draft Care Group protocol that provides a step-by-step description for implementing the integrated model. Suggestions for increasing NGO testing included:

Key Recommendations:

1. Organizations could consider adaptations that could be made to existing projects to bring the MOH on board
    a. Concern could develop a narrated slide show on their protocol
    b. IMC's Development Food Aid Program (DFAP) in Zimbabwe was suggested as a potential test place for the integrated model.
2. A working group of NGOs involved in Care Groups at the country level can coordinate efforts and provide a unified voice to the government. Ministries see many NGOs promoting their own models and need to determine the best model for the country. A working group enables NGOs to form a critical mass of organizations that have applied and tested the Care Group approach in a specific country setting and collected local results to influence MOH decision making.
3. Consider implications for integration with the private sector instead of only focusing on the traditional government structure since there are many places where the vast majority of health care is delivered privately.
4. Explore opportunities for NGO areas or project sites that could be centers of excellence or visitation sites.
5. Explore opportunities for a broader dialogue on how the Care Groups can complement and integrate with UNICEF approaches.

3. Explore the implications of recent innovations and evaluations for programming efforts

Presentations by ACDI/VOCA and PCI provided input respectively to discussions on integrating Care Groups with Food Aid and engaging fathers and grandmothers into the Care Group structure. Participants also discussed effective training and quality control approaches to ensure that Care Groups maintain a participatory, peer learning environment for achieving behavior change.

Participants discussed experiences with integrating Care Groups with the Food For Peace PM2A (Preventing Malnutrition Among Children Under Two Years) approach / Food Aid environment. Specific issues discussed were: a) the integration of food aid and Care Groups; and b) the current conditionality of food aid integrated with Care Groups.

Care Groups: A Training Manual for Program Design and Implementation

Appendix 8 provides detailed recommendations for using Care Groups and PM2A in the same project.

Key Recommendations:

1. Food aid should be decoupled from Care Groups.

2. On the Title II RFA guidance related to PM2A, it would be helpful to have linkages to the Care Group manuals and references. This would be especially helpful for external evaluation teams who not familiar with Care Groups.
3. Since the first group of PM2 A projects is reaching either their final evaluations or mid-term evaluations, FFP could consider using some standard questions on Care Groups in order to collect information on integration and implications.

PCI in Bangladesh is implementing the Trios approach to incorporate mothers, fathers and grandmothers into the Care Group model. Based on their program evaluations, PCI concluded that the Care Group Trios (CGT) is a "promising practice" that makes a significant difference in changing behaviors among pregnant and lactating women (PLW) and their family members. Participants explored questions related to the role of men and grandmothers in Care Groups.

Key points:

- Formative research, including Barrier Analysis and doer/non-doer analysis, are essential to determine whether to engage various influencers .
- There are cost implications to increasing the number of influencers addressed through the Care Group approach including staff time and materials. This cost needs to be balanced with the expected behavior change. Context is extremely important to consider. . In Bangladesh, where many women may not have the ability to make the needed decisions alone incorporating influencers may be necessary despite additional costs.
- The same structure of home visitation may not be effective for fathers. In Bangladesh, fathers chose to focus on hand-washing and decided to build tippy taps.
- It may be culturally appropriate to have male volunteers and supervisors work with the men.
- Fathers and grandmothers may not need to receive the same level of information as the mothers on various health topics. The level of information should be specific to the local context. In many settings, grandmothers might need as much information as a mother.
- Periodic meetings across various types of influencer groups provide an opportunity to identify barrier to change, discover solutions to these barriers and provide accountability for change in families and communities.

Follow-up Action:
Based on meeting discussions, Dr. Henry Perry, Johns Hopkins University, will be writing a policy paper that reviews the implications of current innovations, scale up and research on Care Groups in Title II programs and other programs

4. Identify recommendations for effective training and quality control approaches to ensure that Care Groups maintain a participatory, peer learning environment for achieving behavior change

Maintaining the Participatory, Peer Learning and Support Environment

The participatory, peer learning and support environment in Care Groups has been identified as a key aspect in ensuring behavior change. However, training volunteers and staff in participatory techniques can be challenging and some projects have been critiqued for focusing too much on simple messaging. Maintaining the peer-learning and support environment will be an on-going challenge as more projects look at implementation with MOH and scaling up. Participatory training techniques are not a skill that is taught or considered in many Ministries of Health and those who have graduated from medical programs tend to do well personally in the didactic, classroom environment. Sufficient time needs to be spent on this topic when training MOH counterparts and it is essential to model the appropriate behaviors at all levels.

There are limited materials on how to teach people in participatory training however there are materials and resources developed for Care Groups. Most notably the newly published Care Groups: A Training Manual for Program Design and Implementation provides guidance on using participatory techniques. The CORE Group and TOPS' Social and Behavior Change (SBC) Working Group are working on a "Make Me a Change Agent" manual. This manual includes a number of short lessons designed for community workers and program staff. Topics include communication skills, facilitation skills, and storytelling.

Quality Assurance

Quality assurance is important in all projects related to training, supervision, and on-going implementation. Participants discussed effective strategies for supervision and quality assurance to ensure that Care Groups maintain a participatory, peer learning environment for behavior change. PCI/Bangladesh has developed a quality score card that they use to rank the performance of different Care Groups and Promoters in order to prioritize technical assistance and training efforts. There are also supervision checklists and a Quality Improvement & Verification Checklist (QIVC) included in the new FSN Network Care Group manual (Lessons 11 and 12).

Key Recommendations:

1. Consider developing a simplified, pared-down supervisory checklist that could be used at scale; continue using the existing supervisory checklist for smaller programming efforts.
2. Consider providing sub-scores or weighting the existing scores for the QIVCs in order to identity the issues of greatest importance for quality assurance.

3. Ensure that the lag time between problem identification and feedback is as short as possible.

5. Identify next steps, including recommendations for a research agenda and opportunities for informing donor and implementer audiences about experiences with Care Groups in various contexts and sectors

Advocacy and Communication:

In order to mainstream the Care Group approach, both advocacy and communication strategies need to be employed to influence a variety of audiences. Care Groups could have been better articulated in the past as a mechanism to build peer support. Better articulation would aid with recognition of Care Groups among SBC practitioners and USAID. High-level advocacy needs to be directed at the MOH, CSOs, donors, multilaterals, research institutions and the media. Specific ideas emerged on how to improve advocacy and communications to USAID and MOHs.

USAID:

One challenge raised was the current perception of Care Groups within some parts of USAID. Some USAID staff have suggested that there is an erroneous perception that Care Groups focus predominantly on caring for the community health volunteers and providing peer support to them, and that behavior change at the household level is then mainly accomplished through home visits (rather than a combination of group meetings and home visits). This may lead to concerns within USAID about the level of peer support that is being encouraged among beneficiaries. Language that explains how Care Groups build peer support among beneficiaries is now included in the new Care Group manual (see pp. 10 and 91).

> *There are hundreds of ways to do health promotion, but we have to pick one and promote it heavily. There may be other things that work just as well, but focusing on a single, well-defined model that is supported with manuals and tools helps with scale up.*
>
> *TAG participant*

Ministries of Health:

Advocacy with MOH was seen as an important avenue for country and global efforts. Based on experiences in countries, the following suggestions were made:

- Verify that CGs will fit with the local context. It is not the case that CGs can be used everywhere (e.g. in very low population density settings)
- Direct information (packaging and dissemination to all levels (district, community as well as national) of the MOH.
- Advocate for the inclusions of the model into the MOH strategic plan.

- Develop a good communication package that includes evidence on how Care Groups work and retention of volunteers in order to counteract concerns about using volunteers.
- Consider organizing exchange visits, conferences and site visits.
- Conduct a pilot in the country for data to demonstrate local effectiveness.
- Identify an advocate within the Ministry and an academic institution that endorses CGs.
- Engage USAID and UN agencies as advocates.
- Engage other international and national NGOs on the Care Group approach and inform practitioners on alternatives so they can answer why the Care Group approach is unique.
- Top-level staff members need to be trained in advocacy initiation.

Please see Annex 4 for additional suggestions related to the development of communication materials and advocacy efforts at the global level.

Research Directions

The current Title II RFAs have a scored component for a learning agenda. This provides an opportunity for NGOs to ask for funding to address specific operations research questions in the context of a learning agenda.

One important aspect of mainstreaming the Care Group approach is identifying the additional evidence base that is needed to validate the approach and positively influence decision makers to invest in the approach. Participants identified two levels of current research needs: a rigorous evaluation with a randomized control design; and a series of important operations research questions to inform programming.

A **rigorous evaluation** with a randomized control design could be submitted for publication to a peer-reviewed journal and influence global and national decision makers. Similar to recent work on Women's Participatory and Action Groups, such an evaluation should incorporate a series of coordinated and commonly conceptualized trials in different regions with different NGOs in partnership with objective academic researchers. Jim Tielsch volunteered to host a meeting at George Washington University during the summer of 2014 to bring together researchers and practitioners to develop a research proposal.

There are a number of **operations research** questions, the answers to which could help inform and improve Care Group implementation. Participants brainstormed the list in Annex 3, and a committee was suggested to review, prioritize, and post the list for consideration when organizations are preparing proposals.

Specific Assignments

Working committee: At the conclusion of this meeting, a Working Committee was established to steer Care Group directions and advance recommendations made at this meeting. One task

suggested for the Working Committee, or a subcommittee thereof, is to review, prioritize, and post the list of potential research questions above for consideration when organizations are preparing proposals.

- The committee is composed of:
  - Mary Hennigan, CRS (chair)
  - Tom Davis, Feed the Children
  - Cindy Pfitzenmaier, PCI
  - Elizabeth Arlotti-Parish, ACDI/VOCA
  - Sarah Borger, Food for the Hungry
  - Rachel Hower, World Relief
  - Sonya Funna Evelyn, ADRA
  - Jennifer Weiss, Concern Worldwide
  - Mary DeCoster, FH/TOPS
  - Melanie Morrow, ICFI

Dissemination of TAG Findings: CORE Group and TOPS will disseminate the results of the TAG meeting by:

- Posting the meeting report and presentations online at: CORE Group, TOPS/FSN Network, CareGroupinfo.org, and USAID "Where We Work"
- Writing and posting a blog on meeting results on CareGroupinfo.org
- Exploring opportunities for holding a "Brown Bag" at USAID to present Care Group data.

Individual actions:

Care Group Policy Paper: Henry Perry, Johns Hopkins University, will write a policy paper that reviews the implications of current innovations, scale up and research on Care Groups in Title II programs and other programs for policy makers and donors. He will also lead the development of another paper intended to be submitted for publication to a peer reviewed journal.

Development of a research proposal: Jim Tielsch, George Washington University (GWU), volunteered to host a meeting at GWU during the late summer of 2014 to bring together researchers and practitioners to discuss the merits of developing a research proposal on te Care Group approach.

UNICEF and Care Groups: Patricia Souza, UNICEF, suggested setting up a meeting with UNICEF to explore opportunities to integrate the Care Group approach within the UNICEF system. Pursuing further partnership with UNICEF was strongly supported.

PLA Women's Groups and Care Groups: Jean Capps volunteered to help draft a document with Henry Perry comparing and contrasting PLA Women's Groups and Care Groups that could inform the GWU meeting.

Annexes

Annex 1. Agenda

CARE GROUP TECHNICAL ADVISORY GROUP (TAG) MEETING

FHI360 Conference Center, 1825 Connecticut Avenue NW, Washington, DC 20009 , 8th Floor VISTA Room

May 29 – 30, 2014

Objectives:

1. Review the evidence base regarding the Care Group approach
2. Explore experiences with national adoption and scaling up especially in the food security context
3. Explore the implications of recent innovations and evaluations for programming efforts
4. Identify recommendations for effective training and quality control approaches to ensure that Care Groups maintain a participatory, peer learning environment for achieving behavior change
5. Identify next steps, including recommendations for a research agenda and opportunities for informing donor and implementer audiences about experiences with Care Groups in various contexts and sectors

THURSDAY, MAY 29 2014	
9:00am – 9:30am	**Welcome/Introductions;** *Lynette Friedman*
9:30am – 11:00am	**Review of the Evidence:** • Status of global implementation and research related to Care Groups; *Henry Perry, JHU* • Results from recent review of CSHGP programs on mortality impact; *Christine Marie George, JHU* • Results from ACDI/VOCA experience in Haiti; *Elizabeth Arlotti-Parish, ACDI/VOCA* • Discussion and brainstorming of research gaps
11:00am – 11:15am	**Break**
11:15am – 11:45am	**Review of Care Group Minimum Criteria Checklist;** Melanie Morrow, ICFI
11:45am – 12:30pm	**Explore implications for national adoption and programming at scale** • Results of Concern/Burundi operations research on integrating Care Groups into national MOH systems; *Jenn Weiss, Concern Worldwide; Delphin Sula, Concern/Burundi* • Implications and lessons learned from Rwanda Expanded Impact project; *Melanie Morrow, ICFI; Melene Kabadege, WR/Rwanda*
12:30pm – 1:30pm	**Lunch**
1:30pm – 2:30pm	**Explore implications for national adoption and programming at scale** **Small Group Discussion:** • What do we know about merging traditional CGs into government structures? • What specific issues are problematic for MOH and need to be resolved in order to facilitate national adoption (ex. who serves as the promoter, who pays the promoter)? • How do the Care Groups relate to other national Community Health Worker programs? • At what point do the modifications for national adoption evolve into a different approach from Care Groups? What are the implications of this (if any)? • How do we build MOH capacity to implement and expand Care Groups? • What would be the role of NGOs as the MOH incorporates Care Groups? • What is the vision for Care Group scale-up? • What are the overall recommendations related to national adoption and scale-up?
2:30pm – 3:30pm	**Report back from small groups; large group discussion and refinement of recommendations**
3:30pm – 3:45pm	**Break**
3:45pm – 4:45pm	**Explore the implications of recent innovations and evaluations for programming efforts (Part 1)** • Incorporation with PM2A/Food Aid; *Elizabeth Arlotti-Parish, ACDI/VOCA* • Incorporation of influencers (fathers and grandmothers); *Ayan Shankar Seal, PCI/Bangladesh*
4:45pm – 5:00pm	**Wrap up from Day 1; Preview of Day 2**
	END OF DAY ONE

FRIDAY, MAY 30, 2014	
9:00am – 9:15am	**Summary from Day 1; Overview of Day 2**
9:15am – 11:15am	**Explore the implications of recent innovations and evaluations for programming efforts (Part II)**
	Small Group Discussion (pick one): 1. Incorporation with Food Aid/PM2A: • What are the issues, challenges, and successful strategies related to using Care Groups in conjunction with Food Aid / PM2A? • What recommendations does the group have for programmers? Donors? 2. Incorporation of fathers and grandmothers: • What is the role of men in Care Groups? • If father leaders are part of the mother care group does this decrease the peer-to-peer support of the group? • What guidance should be available related to the degree of creativity to encourage and the cost/benefit of focusing on various influencers? **Presentations from each small group with time for large group questions/additions** **Large group discussion and summary questions:** • What guidance would the group provide related to the cost/benefit of innovation vs. scale? • Any implications for research agenda
11:15am – 11:30am	**Break**
11:30am – 12:30pm	**Plenary Discussion: Maintaining the participatory, peer learning environment in order to achieve behavior change as Care Groups scale up or partner with MOH**
	Small group discussion (Pick one): 1. Peer learning: • What are effective strategies for training Leader Mothers in participatory techniques for peer education and avoidance of top-down messaging • What are the implications for incorporation with the MOH system and programming at scale 2. Quality control: • What are effective strategies for supervision and quality control to ensure that Care Groups maintain a participatory, peer learning environment for behavior change? • What are the implications for incorporation with the MOH system and programming at scale **Report out of key points from discussion**
12:30pm – 1:30pm	**Lunch**
1:30pm – 2:30pm	**Mainstreaming the Care Group Approach: Research and advocacy needs and opportunities**
	Small group questions: In order to mainstream the Care Group approach and take it beyond the NGO community: • What additional evidence base is needed? • What type of communication and advocacy is needed?
2:30pm – 3:45pm	**Report back from small groups; large group discussion and refinement of recommendations**
3:45pm – 4:00pm	**Break**
4:00pm – 5:00pm	**Recommendations for Next Steps**
	Identification of presentations and venues for informing both donor and implementer audiences about experiences with Care Groups in various contexts and sectors.
	END OF DAY TWO

Annex 2. Participants

Elizabeth Arlotti-Parish, ACDI/VOCA
Gillian Bath, ADRA
Sarah Borger, Food for the Hungry
Jennifer Burns, IMC
Judy Canahuati, USAID
Jean Capps, Consultant
Esther Choo, Food for the Hungry/Uganda
Megan Christensen, Concern Worldwide
Tom Davis, Feed the Children
Mary DeCoster, TOPS
Anbrasi Edwards, Johns Hopkins University School of Public Health
Lynette Friedman, Consultant
Sonya Funna Evelyn, ADRA
Christina Marie George, Johns Hopkins University School of Public Health
Mary Hennigan, CRS
Rachel Hower, World Relief
Melene Kabadege, World Relief/Rwanda
Nazo Kureshy, USAID
Karen LeBan, CORE Group
Amie Lompri Karama, Freetown WASH Consortium/Sierra Leone
Melanie Morrow, ICFI
Henry Perry, Johns Hopkins University School of Public Health
Cindy Pfitzenmaier, PCI
Kathryn Reider, WV
Ayan Shankar Seal, PCI/Bangladesh
Ken Sklaw, USAID
Patricia Souza, UNICEF C4D Unit
Delphin Sula, Concern Worldwide/Burundi
Jim Tielsch, George Washington University
Sharon Tobing, Consultant
Jennifer Weiss, Concern Worldwide
Carolyn Wetzel, Food for the Hungry

Annex 3. Areas of Potential Research

- **Costing** and cost benefit analysis

- **Sustainability**
  - Sustainability of both caregiver behavior change and volunteer meetings
  - Sustainability regarding new cohorts of Leader Mothers transitioning post-project

- **Scale**
  - Review the experience of Pastoral da Crianza going to scale in Brazil and 19 other countries. What are the results and lessons learned for going to scale?

- **Community Systems**
  - How do Care Groups strengthen the overall community health system and increase the demand for curative services? How can this be encouraged and documented?
  - What are the effects of Care Groups on increasing trust in the health system and providers, especially in post-conflict settings?

- **Integration with Government**
  - What is needed to get Care Groups integrated into the government system?

- **Behavior Change and Empowerment**
  - How important is it to incorporate fathers or grandmothers?
  - Increase the evidence base related to empowerment and integration strategies
  - To what extent does community engagement and empowerment lead to actual health outcomes?
  - Minimum targeted population coverage needed for significant behavior change

- **New health areas:**
  - Effectiveness of the Care Group model with incorporating different diseases or technical interventions (ex. environmental solutions, early childhood development, chronic diseases, environmental enteropathy)
  - Ability to treat maternal depression and enable mothers to be ready to receive health promotion messages
  - Reduction of gender-based violence using Care Groups, either through the group structure or with targeted messages
  - Uptake of family planning as a result of Care Group implementation.

- Relevance and targeting for subsets of women of reproductive age (WRA) specifically adolescents.

- **Different environments**:
  - Effectiveness of the Care Group model with different target audiences and environments (ex. non-pregnant women; urban slum settings; emergencies, disasters, or other difficult circumstances)

- **Volunteer task expectations and Motivation**
  - What is the optimal level of task expectations per volunteer, the number of households per volunteer and the management of the Care Group post-project?
  - Implementation research on volunteer motivations

- **Training**
  - Length of training needed to go through the Care Group series with all the modules
  - Effectiveness of various materials used to train CHWs and engage mothers in behavior change (ex. will small cards work as well as larger flip charts?)
  - What is the exact time needed to go through the Care Group series with all the modules?
  - Impact of adding a newborn care module on total time.

- **Title II Specific Questions**
  - Comparison of results of Title II programs with Care Groups versus other programs that do not use Care Groups.
  - A rigorous study on how effective Care Group programs can be with and without food
  - Is there a difference between targeting under-twos versus under-fives?
  - Effective strategies for integrating PD/Hearth and Care Groups so that recuperating malnourished children would be introduced to a context where other children are better nourished

Annex 4. Communication materials and advocacy ideas

Additional suggestions related to the development of communication materials and advocacy efforts at the global level:

- Explore opportunities to provide a TED talk or create a 2-6 minute co-branded video giving the story of Care Groups using both HQ and field people.
- Explore opportunities to engage more with the Penn Center for High Impact Philanthropy at the University of Pennsylvania based on their earlier interest in promoting the model.
- Consider developing an RSA-type video, or the "active data" sort of data presentation done by Hans Rosling in Switzerland.
- Modify the CORE Group's two-page document into a business case document that pulls information from current publications, provides the latest developments and data, and includes costing for scale up using a sample country.
- Interview key people in multilaterals who have helped the multilateral adopt the model, like Dr. Zydher, the champion in Mozambique at the World Bank.
- Organize site visits to Care Group projects. There are 23 active agencies among which to find sites.
- Identify focus countries for joint efforts. Consider countries where governments are already working with UNICEF, World Bank and the Global Fund.
- Organize an event such as a half-day presentation for U.S. based-multilateral staff, similar to what the SUN initiative did.
- Invite a celebrity or government champion to get involved