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Care Groups I: An Emerging Innovative Community-based Delivery Strategy for Improving Maternal, Neonatal and Child Health in High-mortality, Resource-constrained Settings

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Abstract

In view of the slow progress being made in many priority countries in reducing maternal and child mortality, new approaches are urgently needed that can be applied in settings with weak health systems and a scarcity of human resources for health. The Care Group approach uses low-level facilitators to work with groups of 12 or so volunteers (the Care Group) who are each responsible for 15-20 households. Messages for promoting important health behaviors and for utilization of key health services can then reach all households at low cost. This article describes the Care Group approach in more detail, its history, and the current experience that now has reached more than 27 countries. So far, Care Group implementation is largely limited to NGOs that have received support from the United States Agency for International Development.

The Care Group approach is an important innovation in utilizing local volunteer resources, in community and women's empowerment, and expanding evidence-based interventions at low cost. The widespread application of this approach by more than 23 different organizations around the world, and the uniform enthusiasm for the approach among implementers provides strong evidence that the approach is feasible and effective. A follow-up article summarizes the evidence regarding the effectiveness of the Care Group approach. The Care Group approach deserves broader recognition as a promising alternative to current strategies for intervention delivery and application at scale in government health systems with rigorous evaluation.

Introduction

There is a recognized need to accelerate progress in reducing maternal and child mortality in the 75 countries of the world where 95% of the world's maternal and child deaths take place.[1] The Millennium Development Goals (MDGs) established in the year 2000, called for achieving by the year 2015 reductions of three-fourths and two-thirds, respectively, in maternal and child mortality based on 1990 levels.[2] This goal will not be achieved by the great majority of these countries, particularly in sub-Saharan Africa, where only 5 of 44 countries are on track to achieve the maternal MDG and only 14 are on track to achieve the child health MDG.[3]

One of the important reasons for lack of progress has been the low population coverage of key evidence-based interventions for reducing maternal and child deaths. Although the median population coverage of immunizations and vitamin A supplementation is in the range of 80%, the coverage of other key interventions is 60% or less and for a number of interventions, the median range of coverage is 30% of less.[3] In some countries, levels of coverage are less than 10%.[3] Interest in and experience with community health workers (CHWs) is growing rapidly, and CHW programs are expanding in many countries.[4, 5] CHW programs in some countries (such as Bangladesh, Brazil, Ethiopia and Nepal) have been widely credited with achieving high levels of population coverage of key maternal and child health interventions and marked improvements in child survival, while in other countries such as India and Pakistan progress has lagged behind others in spite of large-scale CHW programs.[3]

Delivery systems need to ensure high levels of population coverage of key maternal and child health interventions in order to accelerate progress in reducing maternal and child mortality.[1, 6, 7] The inability of facility-based services by themselves to achieve high levels of population coverage and mortality impact is well-documented.[8-10] Expanding coverage of key interventions and achieving documented reductions in maternal, neonatal and child mortality will require low-cost approaches that engage the community as partners, empower women and communities, and reach a high proportion of households with health education messages that encourage healthy behaviors and appropriate utilization of health facilities.[11]

This report describes the Care Group approach – a delivery strategy for expanding coverage of evidence-based maternal and child health interventions. We describe what Care Groups are, their history, the field experience with the use of this delivery strategy, modifications that are emerging in Care Group implementation, how Care Groups might be integrated into government health programs, and Care Groups as one example of the growing importance of participatory women's groups in improving maternal and child health.

What Are Care Groups?

The formal definition of a Care Group is the following:

> 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.[12]

A representation of a Care Group intervention delivery system is shown in Figure 1. The system is established initially by identifying one volunteer (called a Care Group Volunteer) who can be responsible for about 12 mothers (pregnant women and mothers of young children, either 0-59 months of age or 0-23 months of age). The Care Group Volunteer is often selected by the mothers themselves; sometimes community leaders participate in the selection process. Supervisory field staff are recruited and trained to set up Care Groups in collaboration with community leaders so that (1) Care Group Volunteers are in place and are responsible for about 12 mothers who are their neighbors and (2) all pregnant women and mothers of young children are linked to a Care Group Volunteer.

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Figure 1 about here

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Depending on the size of the population covered by the project or program, several layers of paid program staff are required so that a Care Group Facilitator (referred to in Figure 1 as a Promoter) can meet with each Care Group every 2-4 weeks for 2 hours or so. At that time, the Care Group Facilitator teaches one or a small number of health promotion messages for the Care Group Volunteers to share with the women for whom she is responsible. During the following 2-4 weeks (depending on the schedule established by the program), each Care Group Volunteer meets with each of the women for whom she is responsible (and other family members present, such as grandmothers and daughters) – either by visiting the woman at her home or meeting with them in groups. At the subsequent Care Group meeting, the Care Group Volunteers discuss their experience in sharing the previous messages, troubleshoot on health promotion, and learn a new set of messages. In most Care Group programs, the Care Groups Volunteers also report births and deaths to the Care Group Promoters, who report this information upward through the health information system.

The Promoters along with higher-level supervisory staff meet together every few months to learn the health promotion messages that they will convey to the Care Group Volunteers. They are also taught participatory activities for behavior promotion, including demonstrations, role plays, stories and songs (often composed by the Care Group Volunteers themselves) to convey these messages.

The educational content focuses on key knowledge about maternal and child health, important household practices for promoting maternal and child health, and indications for

utilization of health facilities including danger signs for which medical care should be sought. Messages are often based on results of formative research such as positive deviance studies and Barrier Analysis[13] studies that identify behavioral determinants of key behaviors.

Further details regarding what are considered to be essential criteria for the Care Group model are shown in Table 1. Additional suggested criteria are shown in Table 2. The rationale for this list is described in greater detail elsewhere.[12]

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Tables 1 and 2about here

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How did Care Groups emerge as an important community-based intervention delivery system?

The Care Group approach was first developed in 1995 in Gaza Province of Mozambique by staff members of World Relief (Pieter Ernst and Muriel Elmer, later with support from Warren and Gretchen Berggren) as they were developing an implementation plan for a child survival project funded by the United States Agency for International Development (USAID) Child Survival and Health Grants Program. This program proved to be highly successful and led to a subsequent USAID child survival project from 1999-2003 in the Chokwe District of Gaza Province that also proved to be highly successful. A grant was obtained from the CORE Group[14] to carry out an independent assessment of the mortality impact of the project and to prepare a manual describing the Care Group delivery strategy.[15]

As evidence of the effectiveness of the Care Groups began to accumulate, other NGOs began to try the approach, most notably Food for the Hungry in Sofala Province of Mozambique and Curamericas Global in Huehuetenango, Guatemala – both under the leadership of Tom Davis. World Relief, Food for the Hungry, and Curamericas Global soon thereafter began to apply the Care Group approach at their other project sites in different countries. The success of these projects, the technical support offered to other organization by Melanie Morrow (then working with World Relief) and Tom Davis (then working with Food for the Hungry), and the availability of a very useful implementation all guide fueled the adoption of the approach by other NGOs funded by the USAID Child Survival and Health Grants Program. Other early adopters of the Care Group approach included the America Red Cross in Cambodia, Plan International in Kenya, Salvation Army World Service Organization in Zambia, Concern Worldwide in Burundi, and Medical Teams International in Liberia.

The fact that most of the projects were funded by the USAID Child Survival and Health Grants program meant that most projects had baseline measurements of population coverage of key interventions obtained from household surveys as well as end-of-project measures using the similar survey instruments. The projects were therefore able to assess changes in practice

and coverage over the lives of the projects. This success was shared with the NGO community through a workshop led by World Relief in Mozambique in 2005 and through presentations at CORE Group meetings, leading to adoption of the strategy by a number of other NGOs with funding from a variety of sources.

What is the experience so far with Care Group implementation?

As continued success in achieving high levels of intervention coverage was demonstrated by a small number of NGOs working in a variety of different countries and settings, enthusiasm for the approach began to grow. Now, more and more other NGOs have adopted the approach, as shown in Table 3. In 2010, 14 NGOs had experience in implementing Care Group projects in 16 countries. Only four years later, that number had grown to 27 organizations in 23 different countries in all regions of the world. In all cases, NGOs have implemented Care Groups in collaboration with MOH programs and in accordance with MOH policies and strategies. In all cases Care Group projects promote the utilization of MOH services and programs, including facility-based services. At present, an estimated 1.3 million households have been reached using the Care Group implementation system, and at least 106,000 Care Group Volunteers have been trained.

All of the Care Group projects implemented so far have been in rural areas of low-income countries. To our knowledge, there is only one example of Care Group implementation in an urban or peri-urban setting,[16] though several rural projects have had "pockets" of peri-urban populations.

International NGOs have initiated implementation of all known Care Group projects to date. The major donors for these projects have been the USAID Child Survival and Health Grants Program, the USAID Food for Peace (Title II) programs, and the USAID Office of Foreign Disaster Assistance. However, donor support is expanding now to include the World Bank (for Care Group projects in Malawi and Mozambique), the Canadian International Development Agency (CIDA), the British Department for International Development (DfID), the European Commission: Humanitarian Assistance and Civil Protection (formerly called the European Community Humanitarian Aid Office and still referred to as ECHO), UNICEF, and private NGO funds.

There is now an early experience in applying the Care Group delivery strategy within MOH rural health care delivery systems. Concern Worldwide has carried out an operations research project in Burundi comparing the effectiveness of the traditional NGO Care Group project structure (in which the Care Group Promoters are paid by the NGO) with an alternative approach in which Care Group Promoters are MOH CHWs (who are unpaid volunteers). The findings indicate that – with NGO engagement – the effectiveness of the Care Group strategy using MOH CHWs as Care Group Promoters is similar to the traditional NGO implementation model.[17] In this case, the MOH CHWs each supervised only two Care Groups.

Modifications of the Care Group model that are emerging

One important example of a modified Care Group approach is in Rwanda. There, three international NGOs (Concern Worldwide, The International Rescue Committee, and World Relief) worked with the MOH to modify the Care Group delivery system to fit within the current role and functions of government CHWs there. In this case, there were four CHWs in each village. Two (one male and one female) were assigned to carry out integrated community case management of childhood illness; another was responsible for maternal health (a female CHW), and the fourth was responsible for social affairs (either a male for female). The four CHWs were responsible together for the entire village of 60-80 households, but each focused on his/her specialty area. The Care Group methodology was modified so that the CHWs from 2-5 neighboring villages were organized into CHW Peer Support Groups with each group having up to 20 members, about half of whom were men. The CHWs divided up households so each CHW was responsible for 15-20 households, and they visited each household monthly to provide behavior change communication. The project helped to organize and oversaw training of the CHW Peer Support Groups in behavior change interventions. CHW Peer Support Groups elected unpaid CHW Cell Coordinators to help with the training and supervision of the CHW Peer Support Groups.

There were about 100 CHWs working in a health center's catchment area. Each health center had someone in charge of supervising the CHWs working in the health center's catchment area. This Community Health In-Charge at the health center also functioned as a CHW Peer Support Group Facilitator. This approach was been implemented in 18% of Rwanda's population, reaching 1.7 million people.[18]

Another example of a modified Care Group approach is in Mozambique, where World Relief has just completed a 5-year Care Group project focused on tuberculosis (TB) control using many of the same Care Group Volunteers and similar supervisory structures as those that had been established over the past two decades in six districts of Gaza Province. The project was able to achieve marked improvements in awareness about TB, its treatable nature, and the availability of free treatment at government health centers.[19]

Considerations regarding integration of Care Groups into ministry of health delivery systems

As previously mentioned, the field experience with Care Groups has been primarily with projects implemented by NGOs. Opportunities for incorporating the Care Group model into existing MOH programs would help to give the approach a long-term, sustainable "home" that NGOs are not often able to provide. There is room for new creative partnerships between NGOs and MOHs to implement the Care Group, from contracting out service delivery to engaging NGOs for training, monitoring, or quality assurance.

The essential link needed in MOH programs is the creation of formal postings for what we refer to in Figure 1 as Promoters (who meet with, teach and support Care Group members)

and Supervisors (who meet with, teach and support Promoters). Simply adding the duty of the Care Group Supervisor to the existing duties of currently functioning CHWs would seem to be fraught with high risk of failure, as would adding the duty of the Promoter to the MOH supervisor of MOH CHWs since these persons are already likely overburdened with too many responsibilities. However, the Concern Worldwide experience in Burundi revealed that in a situation in which CHWs were already overloaded with responsibilities that included community mobilization, integrated community case management (for pneumonia, diarrhea and malaria) and home visits, giving them responsibility for supervising Care Groups actually lightened their workload.[17] The options – aside from creating new posts specifically for these functions (which we acknowledge is quite difficult within the government system) – might include recruiting more MOH CHWs and supervisors of CHWs so that the additional workload produced by including responsibilities required for implementing the Care Group model would be manageable. Whatever strategy might be adopted, there would need to be additional resources devoted to high-quality, community-based delivery. Even though the costs of Care Group programs are quite modest (as is discussed in the subsequent article[20]), the success of Care Group implementation rests in large part on having well-trained and well-supported field workers.

Care Groups as an example of participatory women's groups

Care Groups are an example of how programs are gradually learning to harness the power of women working together to improve their own health and the health of their children. Women's groups have been in use now for decades, but well-delineated methods for engaging them and mobilizing them to deliver key evidence-based interventions that result in scientifically demonstrated improvements in either population coverage of these interventions or improved population-level health outcomes have been lacking until recently.

A similar but nonetheless distinct approach to engaging the power of groups of women is women's participatory learning and action (PLA) groups. In this approach, a facilitator meets with pregnant women in a village and together they discuss health recommendations for pregnancy, birth and neonatal care and how they could apply them in their own particular situation.[21] This approach has benefitted from rigorous implementation research in a variety of settings, all being led initially by the same research group based at the University of London. The evidence is now robust that the approach can reduce maternal and neonatal mortality if there are an adequate number of facilitators to ensure high levels of service coverage.[22] The key difference between Care Groups and PLA Groups is that with Care Groups, women visit homes of all pregnant women or women with a young child every 2-4 weeks to convey a key health education message, while with PLA Groups there is no systematic approach to reaching every household with specific, carefully crafted messages. Rather, the focus is on the PLA group discussing key health messages, formulating how they might incorporate these messages in

their context, and then through spontaneous dissemination, engaging other women who do not attend the facilitated sessions.[23]

Most certainly, other approaches are emerging now or will emerge in the future to harness the potential of participatory women's groups. The enthusiasm for and the demonstrated results of Care Groups and PLA Groups indicate that this is a fruitful area for further field experimentation with rigorous evaluation and broader implementation.

Conclusions

Although not widely known about outside of NGO child survival and food security networks, Care Groups are a rapidly growing innovative approach to implementing maternal, neonatal and child health and nutrition interventions. Care Groups are a low-cost approach to motivating women volunteers to assist their neighbors in adopting health behaviors and seeking health care from the formal health system when needed. The NGOs that have implemented the Care Group approach in a variety of field settings throughout the world have been uniformly enthusiastic about the effectiveness of the approach in changing behaviors, improving appropriate health care utilization, achieving demonstrable benefits in the health of mothers, neonates and children, and empowering women and their communities. A summary of the available evidence regarding Care Group effectiveness is discussed in the subsequent article of this issue of the Bulletin of the World Health Organization.[20] The time has now arrived for further studies of Care Groups. More rigorous studies are needed of Care Group effectiveness and how the approach can be integrated at scale in existing MOH delivery systems.

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Figures and Tables

Figure 1: Structure of a traditional Care Group delivery strategy[24]

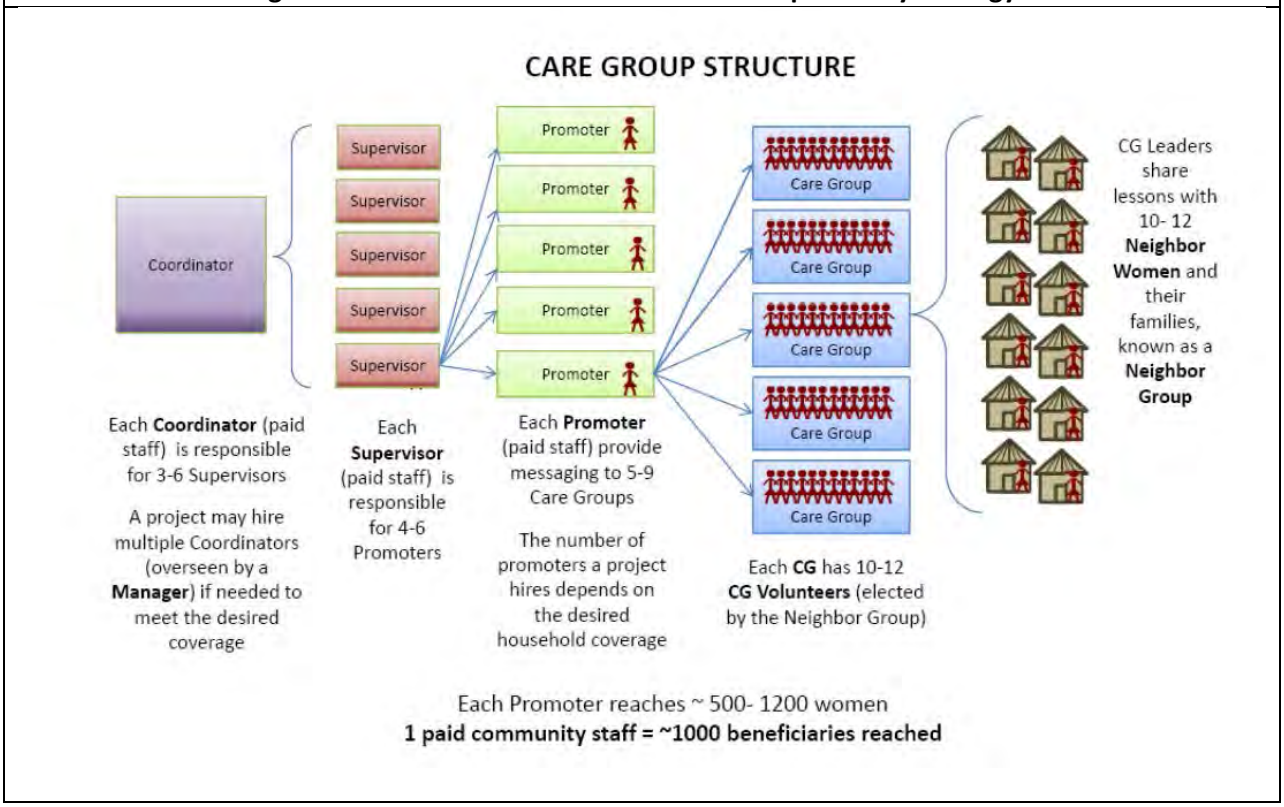

Table 1. Essential criteria for application of the Care Group model
1. Peer-to-peer (mother-to-mother for maternal child health and nutrition behaviors) health promotion is essential.
2. Care Group Volunteers are selected by mothers within the group of households they will serve or by the leadership in the village.
3. Because they are volunteers, the Care Group Volunteers must limit their workload. There should be no more than 15 households per Care Group Volunteer. The terrain and distance between households may affect the number of households for which Care Group Volunteers can take responsibility. In settings where households are dispersed or the terrain is difficult to traverse, Care Group Volunteers may need to take responsibility for fewer households.
4. There should be between 6-16 members in a Care Group.
5. The Care Group Volunteer contact with her assigned beneficiary mothers is monitored and should be at a minimum once a month, but preferably twice monthly.
6. The plan is to reach 100% of the households in the targeted group on at least a monthly basis and attain at least 80% monthly coverage of households within the target group. Coverage is monitored.
7. Care Group Volunteers collect vital events (data on pregnancies, births and deaths). This is very important as they can discuss and problem solve as a group on what kind of follow up is needed and how similar deaths might be prevented in the future.
8. The majority of what is promoted through the Care Group is directed towards reduction of maternal and child mortality and malnutrition (e.g., Essential Nutrition Actions and Essential Hygiene Actions). It could be a useful strategy to include other topics but this is what Care Groups were originally intended to do.
9. Care Group Volunteers should use some sort of visual teaching tool (job aids, flip charts) for health promotion at the household level.
10. Participatory methods of behavior change communication (BCC) are important. This is not specific only to Care Groups, but Care Groups should use best practices for behavior change.
11. No more than 1-2 hours should be spent in a meeting of Care Group Volunteers. “Drip training” involves small amounts of information, and then it is applied. The Care Groups can fit the time needed for the meeting into their schedule. Care Group Volunteers then bring the information and messages to the women in their catchment area as they have time.
12. Supervision of Promoters and of at least one of the Care Group Volunteers should occur at least monthly. This is an important part of the model and part of the cascade. It needs to occur at least monthly.
13. All of a Care Group Volunteer’s beneficiaries should live less than a 1 hour’s walk from the Volunteer’s home.
14. The implementing agency needs to successfully create a project/program culture that conveys a respect for women, the Care Group Volunteers, and the beneficiaries.

Table 2. Suggested additional criteria for optimal functioning of the Care Group approach
1. Formative research should be conducted, especially on the key behaviors promoted. If the key behaviors promoted are not the leading causes of child death in the program area, an impact on mortality may not be achieved.
2. Care Group Promoters are paid staff who meet with and directly train Care Group Volunteers. Care Group Promoters should have no more than 9 Care Groups for which they are responsible. This is particularly important when Care Groups meet every 2 weeks. For a Care Group Promoter to develop a personal relationship and really know those with whom s/he is working, the Promoter should not work with more than about 150 people. This can be achieved if a Care Group Promoter is not responsible for more than 9 Care Groups.
3. Measurement of many of the results-level indicators should be conducted annually at a minimum. This is achieved by carrying out a survey of a random sample of households in the project or program area. Assuming households are selected at random, 96 households are needed for the survey. Supervisory staff can carry out this survey in the course of their regular field supervision activities. These data are needed to manage any program well.
4. Differences between Care Group Promoters and Care Group Volunteers in their social characteristics and in educational levels should not be too great. For example, an extreme difference is when a Care Group Promoter has a bachelor-level university degree and her Care Group Volunteers are illiterate. A great social distance makes it difficult for Care Group Promoters to connect with Care Group Volunteers in an effective way.

Table 3. Organizations and countries with experience to date with Care Group implementation[25]	
Organizations with experience in implementing Care Groups	**Countries in which Care Group projects have been or currently are being implemented**
ACDI/VOCA	Bangladesh
ADRA	Bolivia
Africare	Burkina Faso
American Red Cross	Burundi
CARE	Cambodia
Concern Worldwide	Democratic Republic of Congo
Catholic Relief Services	Ethiopia
Curamericas	Guatemala
Emmanuel International	Haiti
Feed the Children	Indonesia
Food for the Hungry	Kenya
Future Generations	Liberia
GOAL	Malawi
International Aid	Mozambique
International Medical Corps	Nicaragua
International Rescue Committee	Niger
Living Water International	Peru
Medair	Philippines
Medical Teams International	Rwanda
Pathfinder	Senegal
PLAN	Sierra Leone
Project Concern International	Somalia
Salvation Army World Service	Zambia
Save the Children	
World Renew	
World Relief	
World Vision	