

Technical Advisory Group Meeting Summary on Care Groups

December 8, 2010

Overview

The Technical Advisory Group (TAG) meeting brought together practitioners of the Care Group (CG) model from a variety of organizations in order to consider what is currently known about the effectiveness of the model and implications for scaling up. Critical questions for the group to consider included whether Care Groups should be scaled up, and if so, how, when, and where does it fit into the types of systems governments are looking at for community health workers around the world.

The meeting started with a review of the Care Group definition and minimum criteria followed by a presentation on the comparison of experiences and evaluations across Care Groups. Care Groups are implemented by over 14 NGOs in 16 countries. Final evaluation data of Care Group projects estimate on average a 30% reduction in under-five mortality (using the Bellagio Lives Saved Calculator) for a population of 92,000 beneficiaries at a cost of \$5.75 per beneficiary, demonstrating that the Care Group methodology, when implemented well, is highly effective and cost-effective. The review of experiences included final evaluations conducted of six projects using the Care Group model and results from a Survey Monkey conducted prior to the meeting to solicit experiences with the Care Group model. Following these presentations, the group explored:

- Issues related to scaling up Care Groups through NGOs and/or governments in order to develop lists of barriers and enablers for scale and identify the replication and scale up challenges
- Advocacy needs, audiences, and approaches
- The experience in Rwanda with integration of Care Groups and government CHWs with a focus on challenges and needs
- Research gaps
- How to better diffuse the model across organizations including identification of any needed tools for quality implementation

Key Messages

- Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication.
- Care Groups are not meant to replace Community Health Workers (CHWs) but rather provide a means to extend the reach of CHWs to achieve high levels of household level behavior change associated with mortality reduction.
- Implementation of Care Groups at scale requires partnership with MOH, NGOs and communities.

Definition of Care Groups

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. Each volunteer is responsible for regularly visiting 10-15 of her neighbors (at least monthly), sharing what she has learned and facilitating behavior change at the household level.

The complete list of minimum criteria and rationale can be found on the Care Group Info website: caregroupinfo.org. The full meeting report and appendices can be found at www.coregroup.org

Key Points

- Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication.
- The goal of the CGs is to saturate an area and reach every household, including the most marginalized, with information. Since every home is being reached with the same message, nearly at the same time, there is a “kind of shock and awe” effect which is very powerful and helps to create an impressive uptake.
- The ideal context for Care Groups is one where the households are in close proximity to each other.
- It is a basic principle of Care Group effectiveness to maintain a workload that is reasonable for a volunteer. This guides criteria related to limiting the number of households and keeping training and meeting times and locations reasonable.
- Care Groups provide the structure for a community health information system that reports on new pregnancies, births, and deaths detected during home visits.
- The home visit component is important so that volunteers know what is happening in the home and can help mothers negotiate behavior adoption. Home visits ensure 100% coverage and provide an opportunity to reach other decision makers and care givers with information.
- The creation of a project/program culture that conveys respect for the population and volunteers, especially women is one of the most important criteria for success of the program. This criteria is about the ethos and culture around the Care Group model - the success of the approach is based on women and their ability to share and support change. Without this ethos, it is not imaginable how the volunteers would be successful.
- Care Groups apply several principles for good behavior change: simplicity of messages, high coverage, formative research on key behaviors, and the strength of peer education.

Scaling up Care Groups

While significant evidence exists demonstrating the effectiveness of the Care Group model in changing health behaviors and improving child health statistics, most of the work to-date has been in sub-national areas with up to 220,000 project beneficiaries (women of reproductive age and children under five years) . The TAG participants discussed barriers and enablers to scaling up Care Groups in order to develop recommendations for expanding the health benefits to a larger population.

Scale was defined as reaching greater geographic coverage in order to make an impact on improving child health statistics. Care Groups are not intended to be a model to cover the whole country, but rather could be an effective approach to reach targeted underserved communities. Implementation of Care Groups at scale requires partnership with MOH, NGOs and communities.

The majority of the discussion focused on the increase in government use of Community Health Workers and how the Care Group Volunteers and Care Group structure could complement and extend the work of the CHWs. Care Groups are not meant to replace CHWs, but provide a means to extend the reach of CHWs to achieve high levels of household level behavior change associated with mortality reduction. The group did not feel that it was reasonable to expect the Ministry of Health to be able to organize and manage Care Groups on their own.

From the perspective of NGOs, there were several challenges to increasing the scale of Care Group programming:

1. Expanding beyond the size where an interpersonal-driven management strategy is feasible. NGOs thrive on an intimate, respectful culture and see this as an essential component to quality program implementation. As programs expand in size, there is the need for increasing bureaucracy and the organizational culture changes with the expansion to serve a larger population.
2. Along with the expansion in program staff to serve a larger geographic area, there is a concomitant increase in the educational level, pay scale, and understanding of “community” among staff. While smaller projects tend to hire staff directly from the community, larger projects need to rely on an increasingly complex workforce. Those with greater education tend to be further away from understanding communities and connecting with volunteers.
3. NGOs generally have a good understanding of a specific district/region in which they have worked and this context-specific knowledge is not directly transferable to different geographic areas. Overcoming this challenge underscores the importance of good quality formative research, or a national program with standardized systems that would tap into multiple NGOs for implementation.

4. Financing mechanism must enable scale.

The following table captures the barriers and enablers to scaling up Care Groups for NGOs and MOH.

	Barriers	Enablers
NGOs	<ul style="list-style-type: none"> • CG approach and results are not widely known, especially at national level • Low investment in BCC approaches (as compared to health facilities) • No standardized NGO policy regarding health volunteer workload and incentives • Long term systems needed for sustainability of approach including supervision in case NGO leaves area. • Pre-service and on-the-job training for community health workers and volunteers need to be part of government system • Minimal pre-service community health training within academic settings • Little attention paid to building CGs into a national system • Limited data on retention factors and expected turnover in volunteers 	<ul style="list-style-type: none"> • Easy to use CG guide with essential criteria for successful application • CG approach fits well within FBO country-level structure • CG approach enables MOH CHW to reach household level • MHealth technology can make community data more widely accessible and easy to uptake by ministry of health • Analysis and use of data at local level enables appropriate community level response • Creating a national-level standardized data collection and reporting system with a standardized curriculum, training, coaching and supervision system would enable scale-up by multiple NGOs • Use of non-financial incentives reduces cost and ensures that the approach is community-based • The approach is compatible with other participatory community health approaches
Ministry of Health	<ul style="list-style-type: none"> • Government decision makers are not aware of the evidence base surrounding the CG approach or other community approaches 	<ul style="list-style-type: none"> • The MDGs hold governments accountable for meeting targets and increase openness to considering community-based solutions • Decentralization brings decision making

	<ul style="list-style-type: none"> • The number of volunteers involved in a CG at a national level is overwhelming • The health care worker crisis impacts negatively on supervision and referral. 	<p>and resources to the district level</p> <ul style="list-style-type: none"> • Existing CHWs can be shown to be more effective when linked to CG volunteers and community infrastructure
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Care Group Advocacy Needs, Audiences and Approaches

Given that only a limited, mostly NGO, audience is aware of the Care Group approach and its evidence base, the group prioritized an advocacy and community strategy as a next step to donors, multilaterals, ministry of health, local NGOs and local government.

They recommended packaging the definition of Care Groups, minimum criteria, and outcome data so that there are consistent messages highlighting the value added of a Care Group approach across all of these audiences.

Key components of an advocacy message included being able to describe:

- When a Care Group is the better strategy for the specific context vis-à-vis other community health volunteer models or community mobilization strategies
- When a Care Group should be considered as a complement to a MOH CHW strategy that is not performing effectively because of certain characteristics of the population
- How the “Care Group” strategy and key components (inputs and cost) are different from other community health volunteer and/or community mobilization strategies
- The key role of the “Care Group” in solving health problems important to the MOH (i.e. community mobilization strategy; health promotion/prevention only)

Participants felt that field-based NGO staff were best positioned to advocate to ministries of health if they had the necessary training in advocacy and communications, and had messaging tools and materials on Care Groups. Messages for the MoH should stress the elements of data collection, vital events, utilization of services, and how the MoH can help scale-up this approach.

NGOs implementing Care Groups needed to further educate their USAID colleagues on the value of Care Groups as part of an integrated maternal, newborn and child health effort. A reframing of messages, based on discussion from this meeting, was recommended in order to reach out to USAID decision makers.

Integration of the Care Group Model with Government CHWs

Several projects are currently experimenting with developing formal linkages between Care Group volunteers and government Community Health Workers.

In Rwanda, the government model provides four CHWs (expanding to six) per village. World Relief, which works in six districts in Rwanda, has been actively supporting the CHWs and connecting them with Care Groups. The CHWs are integrated with the Care Groups and provide support and supervision to them with assistance from World Relief.

Challenges:

Skill Sets: While the supervisors for CHWs provide training in Community Case Management, they are not trained in community mobilization and they do not know how to effectively work with community structures such as Care Groups. While the CHWs have a variety of skills, and may have bachelor's level degree in some areas, they generally do not have a health background.

Data Attribution: Rwanda has adopted performance-based indicators which are measured at the mayoral level related to community case management. While the Care Group volunteers extend the reach of the CHW, providing health education, health information, and increasing the use of the health facility, there is not a way to disaggregate the statistics to be able to attribute changes in indicators to the work of Care Group volunteers versus the work of CHWs. The CHW gets the credit and benefit when indicator targets are reached and the work of the Care Group volunteers is not visible.

Potential Solutions:

- Conduct targeted discussions on why some CHWs are more effective than others in order to illuminate the key roles and impact of the CGs
- Conduct research comparing the roll out of CCM in areas with CGs and areas without them

In Burundi, Concern Worldwide is experimenting with implementation of a less-resource intensive model of Care Groups with Community Health Workers supervising Care Groups. In this model, CHWs will be responsible for training and supporting only two to three Care Groups (versus 10-15 in the traditional model with NGO staff). NGO staff are redirecting their time to instead build the capacity of CHWs to train Care Groups directly and build the capacity of MOH staff to provide training, supervision, and support to CHWs in the facilitation of Care Groups. Concern Worldwide is implementing a quasi-experimental design to compare areas with the integrated versus the traditional Care Group model in order to test for any differences in improving knowledge and practice of key child health and nutrition behaviors along with any differences in functionality and sustainability of the Care Group structure.

Care Group Research

The need was identified for increased research and publication by independent sources and a consolidation of the existing evidence. Improved partnerships with research institutions are needed. Current research underway was captured in the survey conducted prior to the TAG.

Areas of potential research:

- Explore the social impact of CGs (ex. self-efficacy, reductions in gender-based violence, increased respect of women)
- Document the process that led to CGs that were successful in changing behavior and social dynamics. Are there some shortcuts some organizations have taken that work, or that have made the approach less effective?
- Explore the impact of home visitation. What is the value-added of home visitation that would likely not exist through other contact methods?
- Explore the minimal intensity needed (number of times, or perhaps “contact times”) for behavior change through home visits: consider two weeks, four weeks, once per quarter, couple times a year. Look at the amount of time needed for an effective home visit. Could that intensity taper off over time as norms change, perhaps as an exit strategy, or for sustainability, or phasing in a large project area?
- Develop a methodology to estimate cost-effectiveness. Develop a tool for estimating the cost of a large-scale CG program. Provide information suitable for making choices dependent on the funding available.
- Document how the CG model has been and can be used effectively for maternal newborn care.
- Invest in publishable mortality impact studies using a comparison group. Conduct a sustainability analysis of behavior change perhaps two or five years after the NGO inputs are no longer there.
- Compare the CG to other peer group and community mobilization approaches.
- Conduct prospective operations research of CGs integrated into the MoH in order to define best practices for sustainable strategies.
- Define appropriate exit strategies using supportive structures. CGs are not part of the health system, but are supervised by paid NGO or CBO staff. What is the appropriate turn-over of this responsibility either to the MOH, a local NGO, a community or other organization? Test different models to learn what can work. Compare different supervision modalities including peer group supervision, use of mHealth applications, and supervision through community governance structures.

Recommendations / Next Steps

For Scaling Up Care Groups

1. Build stronger connections between health facilities and communities in order to provide a system to sustain the volunteer structure in the future.
 - Add Care Group support into the job descriptions of government Community Health Workers so they are seen as a community extension for CHWs
 - Create a Care Group curricula for health workers so they can provide ongoing health message education to CG volunteers
 - Seek out opportunities for pre-service trainings in order to insert volunteer management, health education, and/or participatory methods and adult education into appropriate academic programs so that future health facility staff are prepared to support Care Groups
2. Focus NGO programming efforts in an entire health district or provincial area so that impact is statistically visible. Grow the evidence-base.
3. Experiment with adaptations to improve scalability, addressing key barriers and building on enablers.
 - Think about the minimum elements that need to be involved in a Care Group – think “simple” and do the minimum required so that the model is easier for government to maintain
 - Consider new technology options to connect data to MoH
 - Explore different models of supervision including super leader mothers or some kind of peer-to-peer methods. Consider if the work of a supervisor can be standardized. Focus more on training supervisors to coach and mentor volunteers.
4. Build the capacity of Community-Based Organizations (CBOs) and CBO networks to support Care Groups.
 - Create easy formative research methods that CBOs can use
 - Create easy-to-use guides and capacity building training on conducting formative research
 - Support the creation of Care Group Associations at the national level who could advocate for their own rights and provide a collective platform.
5. Support integration of the Care Group model with government CHWs in Rwanda.
 - Document the difference in district level indicators in areas with and without Care Groups

- Engage with the mayor/district leadership as they make decisions about staff, including about CHWs
 - Advocate at the national level to the Minister of Health
 - Advocate for CHWs to work as a group, to share experiences and jointly examine deaths
8. Consider the creation of the following tools to support quality scale up.
- Step by step facilitators guide on:
 - When and how to set up CG
 - How to maintain CG
 - How to monitor the program with different options (including monitoring forms for CGs), the “model family poster” for recording behavior at the HH level, and the danger signs/newborn follow-up checklist, the C-IMCI form, etc.
 - How to supervise Promoters and CG volunteers
 - FAQ, trouble shooting guides
 - A program design tool, on when it would be best to use a CG vs. another methodology
 - List of “certified” consultants and trainers experienced with the Care Group model
 - Tools and guides on formative research and verbal autopsy for use by Care Groups
 - Develop a standard presentation on Care Groups for use with schools of public health

For Advocacy on Care Groups

1. Advocate for increased government funding for community-based programming:
 - Advocate for governments to franchise or contract with NGOs (addresses government concern about managing large numbers of volunteers.) Since CGs also do civil society building, explore other sources of funds for support.
 - Advocate for a government employee at the district level responsible for community programming who could serve as a liaison for NGOs, CBOs, and other community-based entities.
2. Expand understanding of CGs within USAID.
 - Include brown bag within the upcoming MCHIP series
 - Write evidence-based briefing paper or policy paper targeted to groups that have influence at Congress and USAID.
 - Advocate for inclusion of Care Groups in the upcoming Congressional Report

3. Advocate with Multilaterals:
 - Follow-up with UNICEF based on the inclusion of CGs in the 2008 report.
 - Work with WHO and the Global Health Workforce Alliance
4. Build the capacity of field programs to advocate with MoH and local government for increased support and funding.

For Increasing Awareness of Care Groups

1. Share results of Care Group evaluations at various forums and in peer-reviewed journals.
 - Global Health Council and APHA
 - Rwanda CHW meeting
 - Global Fund CCM presentations, talking about linkages to ATM
2. Conduct presentations to important partners such as Dfid, UNICEF, and Food for Peace.
3. Set up links to caregroupinfo.org from other relevant websites:
 - Healthy Newborn Network
 - MCHIP
 - K4Health: include a discussion board
 - BASICS
 - HCI CHW portal
 - Health2010
4. Maximize use of CareGroupInfo site by increasing meta-tabs that prioritize the website when Googling Care Groups, consider a hosted link, and solicit guest bloggers.
5. Approach schools of public health for inclusion in courses and curricula. Opportunities include Tulane, UNC-CH, and Johns Hopkins. The Essentials of Global Health, for which there is a chapter on Care Groups, can be shared as a textbook resource.
6. Request World Relief document how Cascade Groups were used for TB and HIV in order to reach out to HIV organizations.
7. Conduct regional workshops on CHWs, CGs and community strategies.