

# Reflections on Evaluation of 6 Care Group Projects

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# Care Group Projects I Have Evaluated

- World Relief/Rwanda 2004 (MTE)
- Curamericas/Guatemala 2005 (MTE)
- World Relief/Cambodia 2005 (MTE)
- World Relief/Mozambique 2009 (FE)
- Food for the Hungry/Mozambique 2010 (FE)
- SAWSO/Zambia 2010 (FE)

# Personal Epiphany after World Relief/Mozambique Evaluation



PERGAMON

Social Science & Medicine 48 (1999) 1053–1067

SOCIAL  
SCIENCE  
— & —  
MEDICINE

Attaining health for all through community partnerships:  
principles of the census-based, impact-oriented (CBIO)  
approach to primary health care developed in Bolivia,  
South America

Henry Perry<sup>a,\*</sup>, Nathan Robison<sup>b</sup>, Dardo Chavez<sup>c</sup>, Orlando Taja<sup>d</sup>, Carolina Hilari<sup>b</sup>, David Shanklin<sup>e</sup>, John Wyon<sup>f</sup>

Expert Panel: Great concept, but too expensive (\$9 per capita for comprehensive PHC and 50% reduction in under-5 mortality) and fosters dependency

(cont.)

- Care Groups use many CBIO principles (and have the potential for incorporating more)
- Care Groups are the response to the limitations of the CBIO model (as implemented in Bolivia by ARHC/Curamericas) raised by the Expert Panel in 1993
  - Less costly
  - Fosters empowerment, not dependency
  - Home visitors are local volunteers, not paid staff

# General Observations about Care Groups

- Effective in promoting behavior change that improves the health of women, their children and their families
- Can begin in entire project area early on
- Produce changes quickly (“shock and awe”) once underway (and even more quickly in 2<sup>nd</sup> phase of projects)
- The concept and application are quite simple
- The changes seem to be sustainable
- Empowering for women

(cont.)

- Provide the opportunity (because paid staff are in all communities periodically and can visit randomly selected HHs) for mini-KPCs – a very powerful M&E tool
- Provide the opportunity for vital events registration (all 6 projects except SAWSO made use of this capability) and potential to monitor mortality rates on a MONTHLY basis
- Provides communities (especially leaders and women) with a sense of ownership of project activities

# Cost Savings Achieved By

- Fewer supervisory layers
- Having supervisors live in the villages
- Lower salaries for supervisors (hire village people with limited educational skills)
- Limiting Care Group members to pregnant women and mothers of children <2 years of age
- Beginning in one-half of project area and expanding to the other half during the second stage of the project
- (Note: highly qualified people who are not originally from the area are willing to serve as field supervisors)

# Vital Events Registration

- Data not usually analyzed by the projects while they are ongoing (lack of confidence and uncertainty about validity)
- Cause of death capability not fully utilized (WR/Mozambique made use of this the best)
- Must begin at the VERY beginning to get useful data (lesson from FH-Moz this year)
- Shouldn't this be a first priority (including collection of cause of death data?)



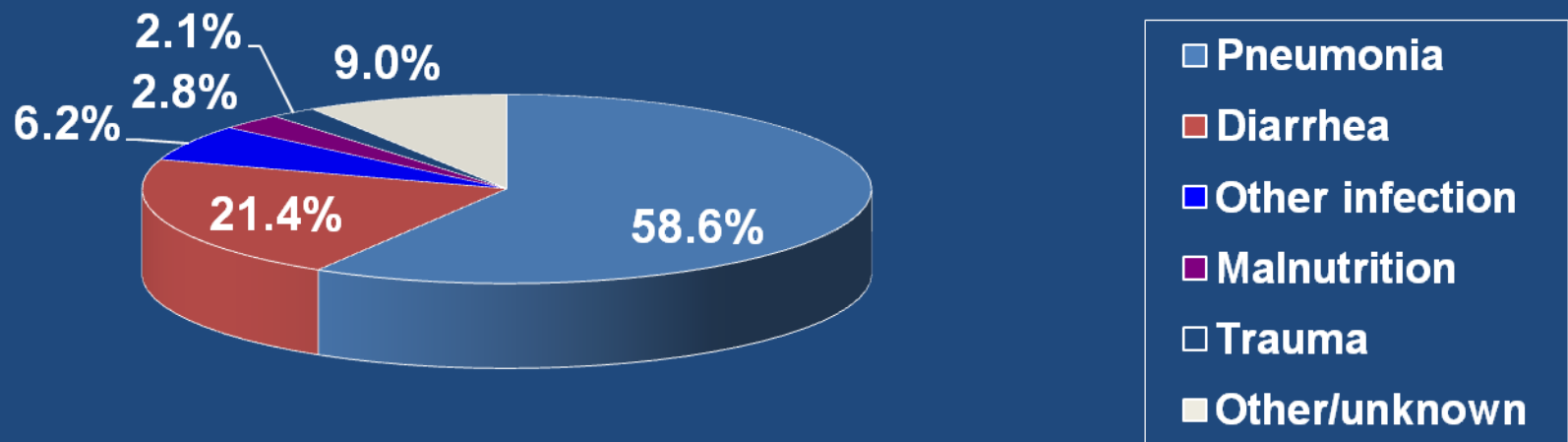
# Cause of Death Data

- Can/should guide programming
- FH found neonatal deaths a leading cause of death but neonatal care was not an original part of its program design/DIP, so it modified its program to include lessons in home-based neonatal care and increased home visiting to newborns (great application of a CBIO principle!)

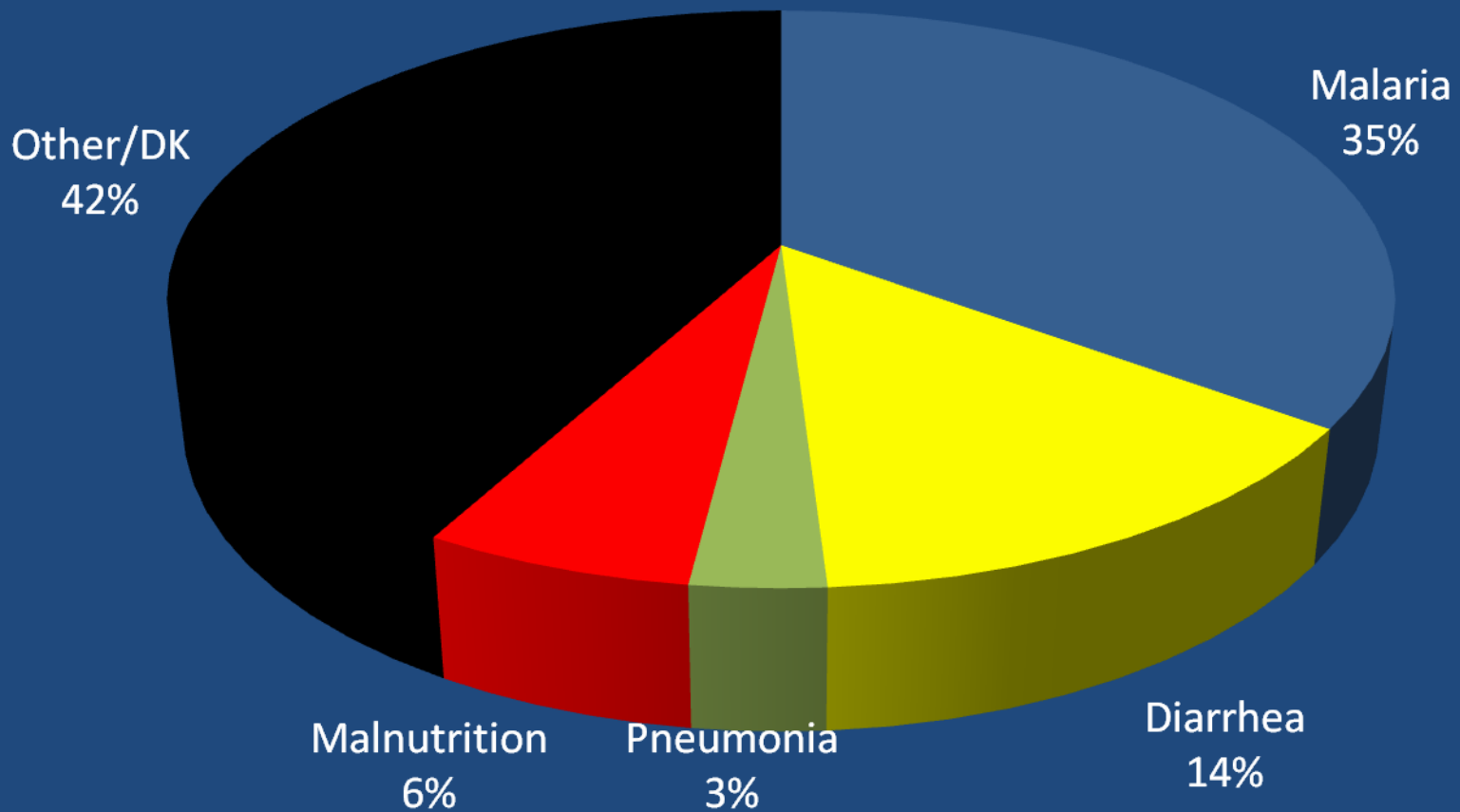
# Use of Locally Acquired Data to Guide Programming (CBIO Principle)

- In Guatemala, pneumonia THE leading cause of death
- In Mozambique (Gaza Province) malaria THE leading cause of death
- (But programs were not aware of this and did not use this information for program modification)

# Causes of Under-five Deaths in the Curamericas/ Guatemala Child Survival Project Area, 2002-2005



# Causes of Under-5 Deaths Recorded by Animators, 2007-8, Mozambique



# Issues

- Ministries of Health not set up to make full use of the Care Group methodology, to fully appreciate its impact and importance, and to ensure its long-term sustainability
- Lack of staff with interest in and local knowledge of communities within the district
  - Not in job description
  - High turnover of staff
  - “Upward” orientation, rather than community-orientation of staff
  - Pieter Ernst – Each district should have someone dedicated to this

(cont.)

- Need to work on ways to link MOH CHW programs with Care Groups (so that CHWs can be Care Group supervisors?)



available at [www.sciencedirect.com](http://www.sciencedirect.com)



journal homepage: [www.elsevierhealth.com/journals/trst](http://www.elsevierhealth.com/journals/trst)



## Examining the evidence of under-five mortality reduction in a community-based programme in Gaza, Mozambique

Anbrasi Edward<sup>a</sup>, Pieter Ernst<sup>b</sup>, Carl Taylor<sup>a,\*</sup>, Stan Becker<sup>c</sup>,  
Elisio Mazive<sup>d</sup>, Henry Perry<sup>e</sup>

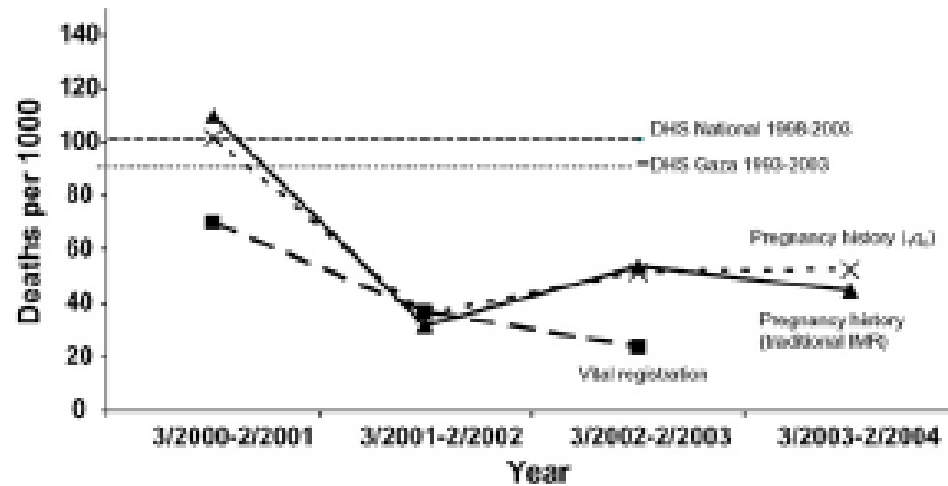


Figure 2 Infant mortality in Chokwe district, 2000–2004. DHS: Demographic and Health Survey; IMR: infant mortality rate.

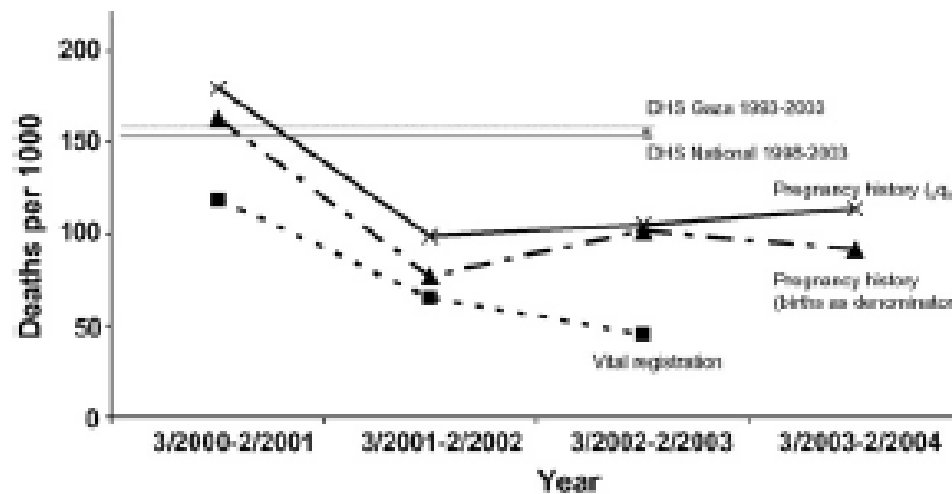
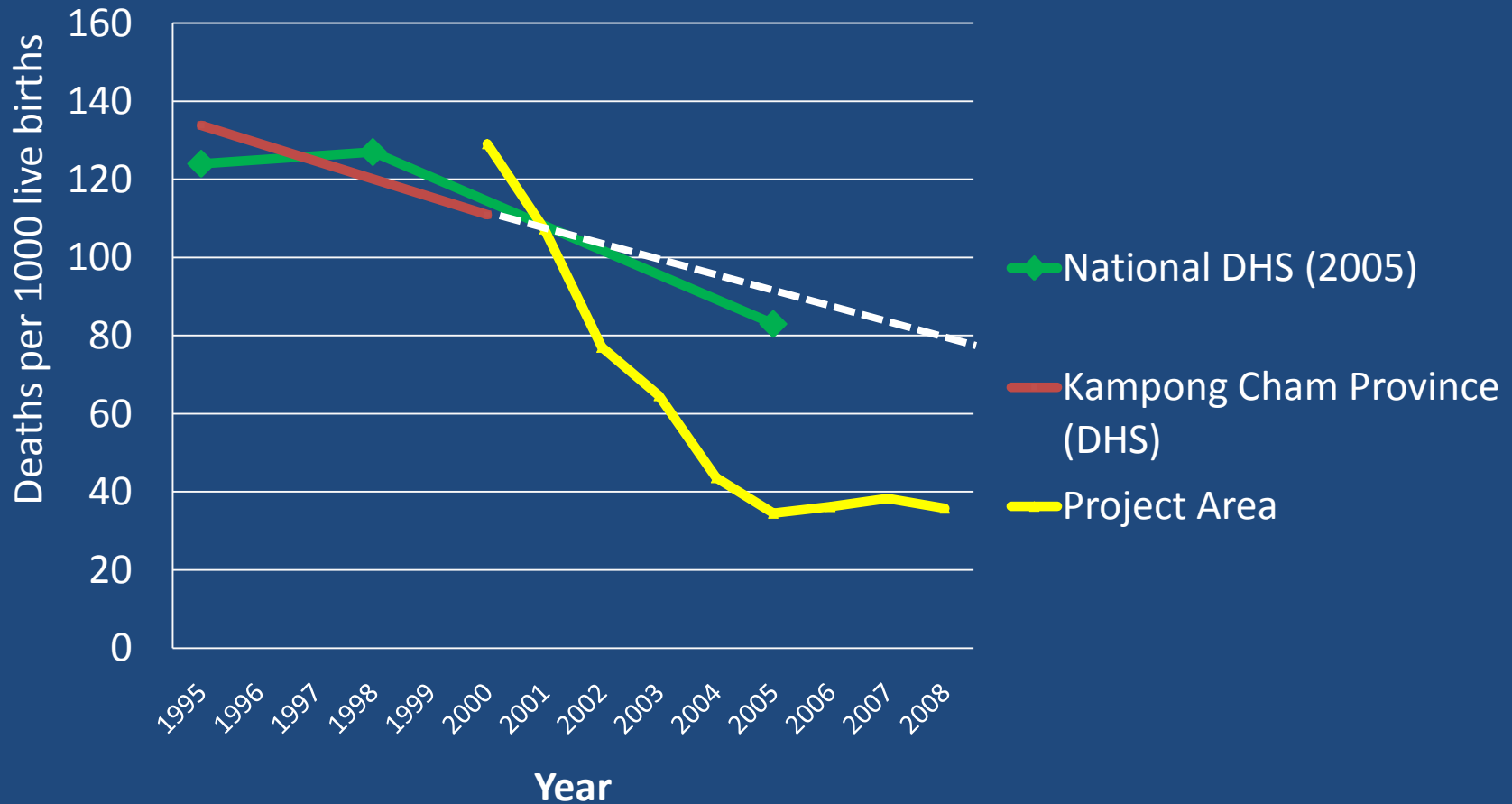


Figure 3 Under-five mortality in Chokwe district, 2000–2004. DHS: Demographic and Health Survey.



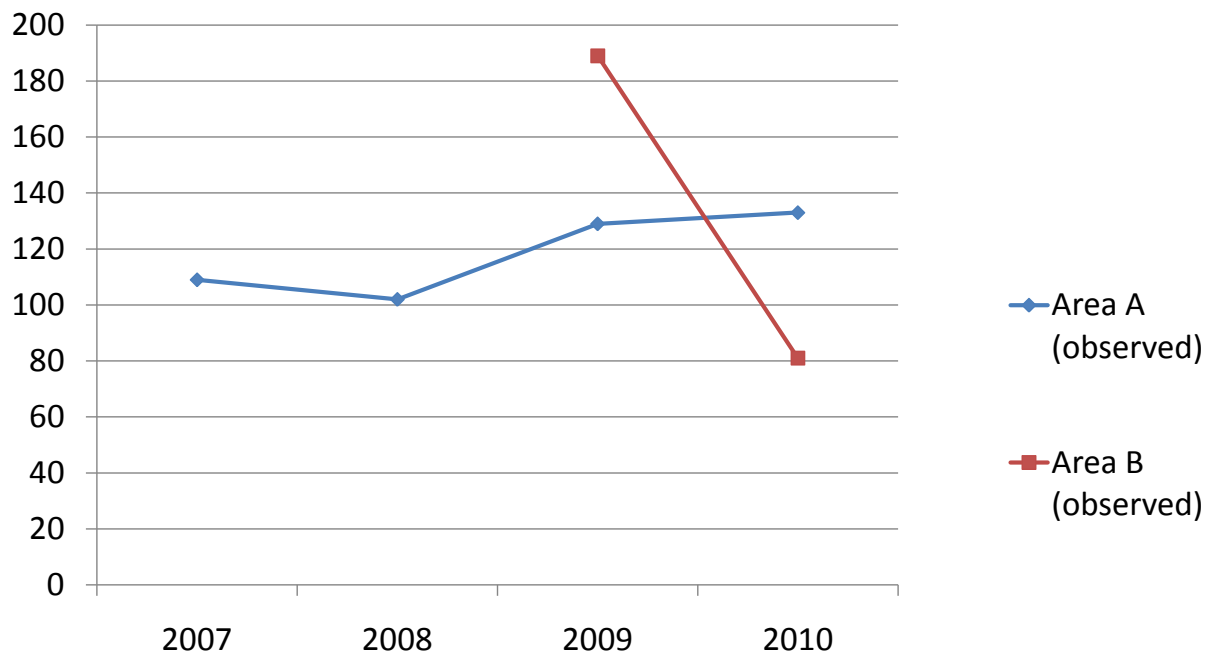
# Changes in Under-5 Mortality in Cambodia Nationally (1995-2005), in Kampong Cham Province (1995-2005), and in the Project Area (2000-2008)



Note: (1) Dotted lines are a projection based on previous trend. (2) Project Area data are for the Original Area and the Extension Area combined. (3) DHS refers to data from the national demographic and health survey.

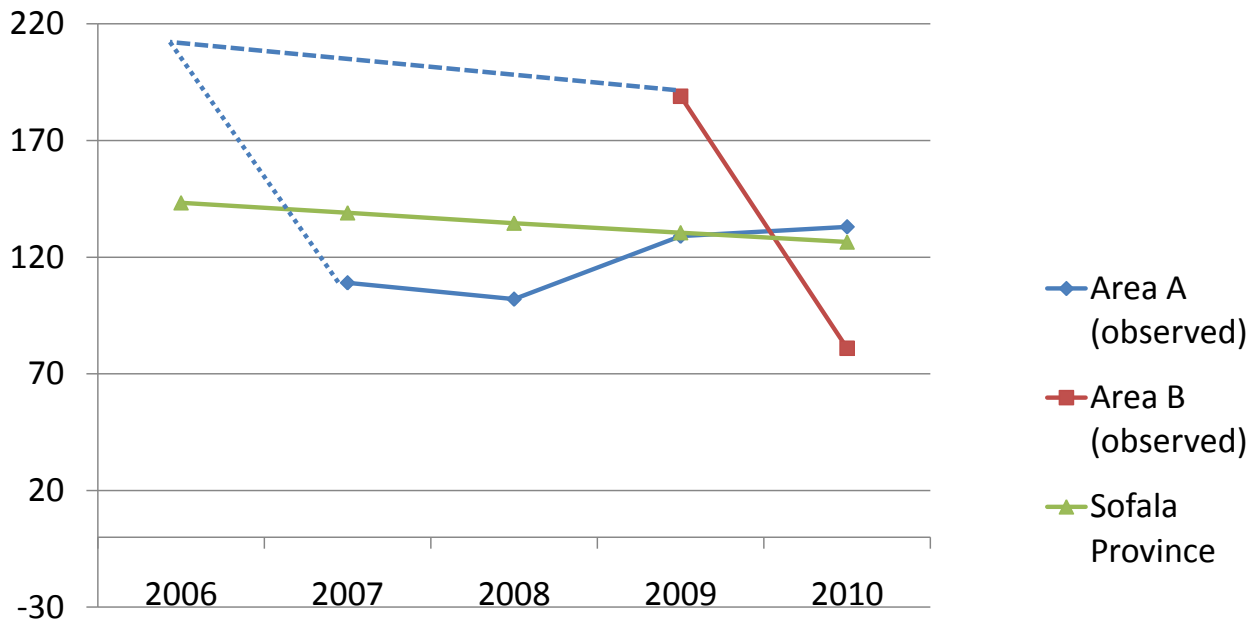
# Mortality Rates from Food for the Hungry Vital Events Data, Sofala Province, Mozambique

Observed Changes in the Under-2 Mortality Rate in Food for the Hungry Project Areas A and B



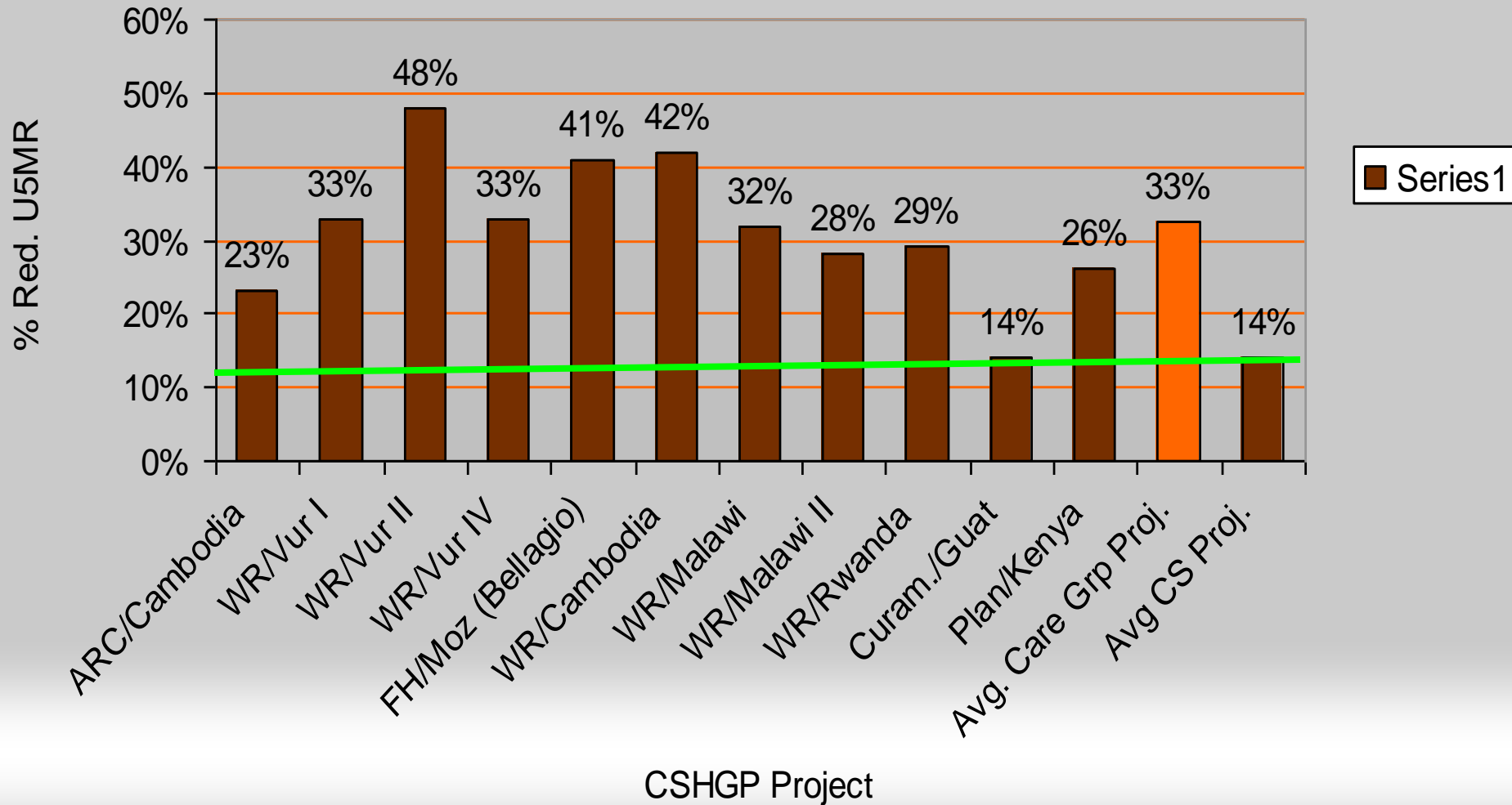
# One Interpretation of Vital Events Data

Estimated Changes in the Under-2 Mortality Rate  
in Food for the Hungry Project Areas A and B  
Using Project Vital Events Data

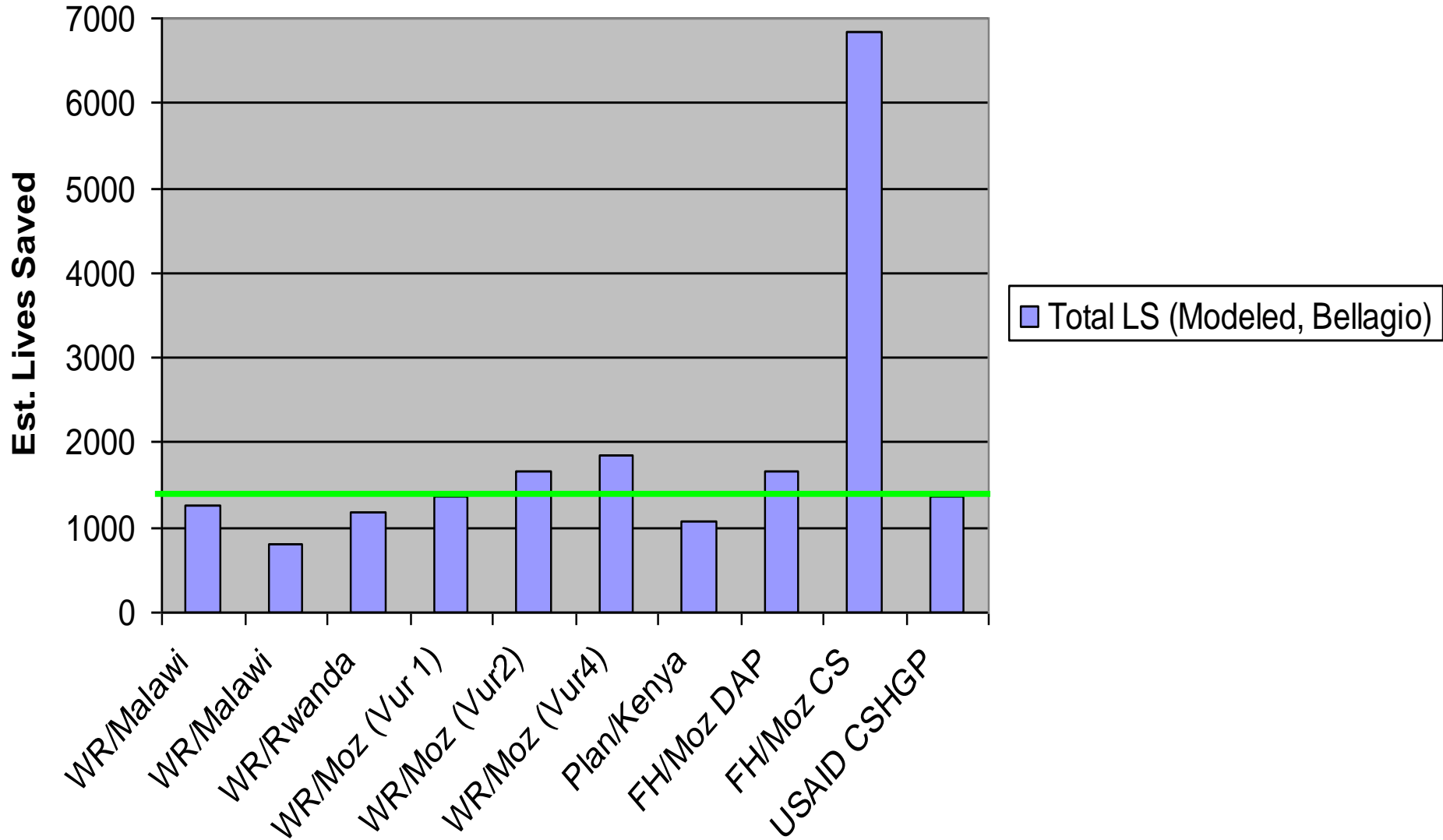


The estimated 0-23m mortality rates for Sofala Province have been calculated by assuming that they are 80% of the estimated under-5 mortality rates

**Care Group Performance: Perc. Reduction in Child Death Rate (0-59m)  
in Eleven CSHGP Care Group Projects in Six Countries  
(Green line = average of USAID child survival programs)**






# Total Est. Lives Saved, CG Projects (modeled, with similar \$2.5M budget)



# Publications So Far

Transactions of the Royal Society of Tropical Medicine and Hygiene (2007) 101, 814–822

available at [www.sciencedirect.com](http://www.sciencedirect.com)

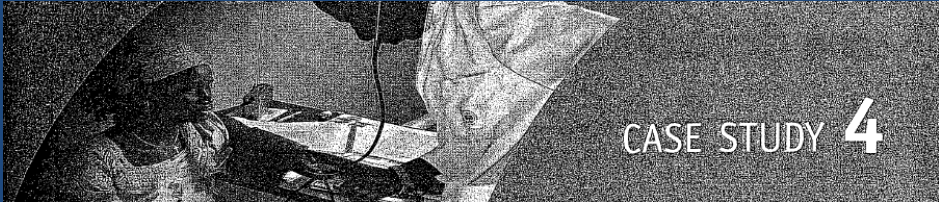
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## *Essentials of* Global Community Health

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CASE STUDY 4

## Averting Childhood Deaths in Resource-Constrained Settings Through Engagement with the Community: An Example from Cambodia

Henry Perry, Oun Sivan, Geoff Bowman, Lary Casazza, Anbrasi Edward, Kay Hansen, and Melanie Morrow

# Lessons

- Continued rapid uptake of Care Group methodology by PVOs in different countries indicates the robust effectiveness of the Care Group model
- It is an empowering, effective, low-cost strategy that promotes equity and appears to be sustainable with strong evidence of mortality impact

# Next Steps

- Need to document, analyze, and publish in peer-reviewed journals the accumulated experience
- Need more independent assessments of the mortality impact of Care Group projects similar to the one carried out for WR/Mozambique project
- Need to strengthen use of vital events data and to pilot ways to ensure high-quality of data (and need a practical mortality assessment manual!!)
- Need more studies of sustained impact after projects stop (Care Group functioning, coverage, and mortality impact)



# Next Steps

- Has enormous potential for application beyond child survival interventions
- Community-based maternal and reproductive health (misoprostol distribution for prevention of post-partum hemorrhage, prevention and detection pre-eclampsia through calcium sprinkles and BP/proteinuria monitoring, family planning)
- Voluntary counseling and testing for HIV
- Detection of TB (including collection of sputum and integration into home-based treatment strategy)

# Next Steps

- Need pilot projects for more directly linking Care Group methodology to MOH programs in ways that ensure long-term sustainability of Care Group functioning
- Need Care Group projects at larger scale for longer time periods that integrate child survival interventions with maternal/reproductive health, HIV/AIDS, TB and malaria interventions

# Conclusion

- Communities are a resource, not a target!!
- Care Groups are one effective way of accessing and activating this resource