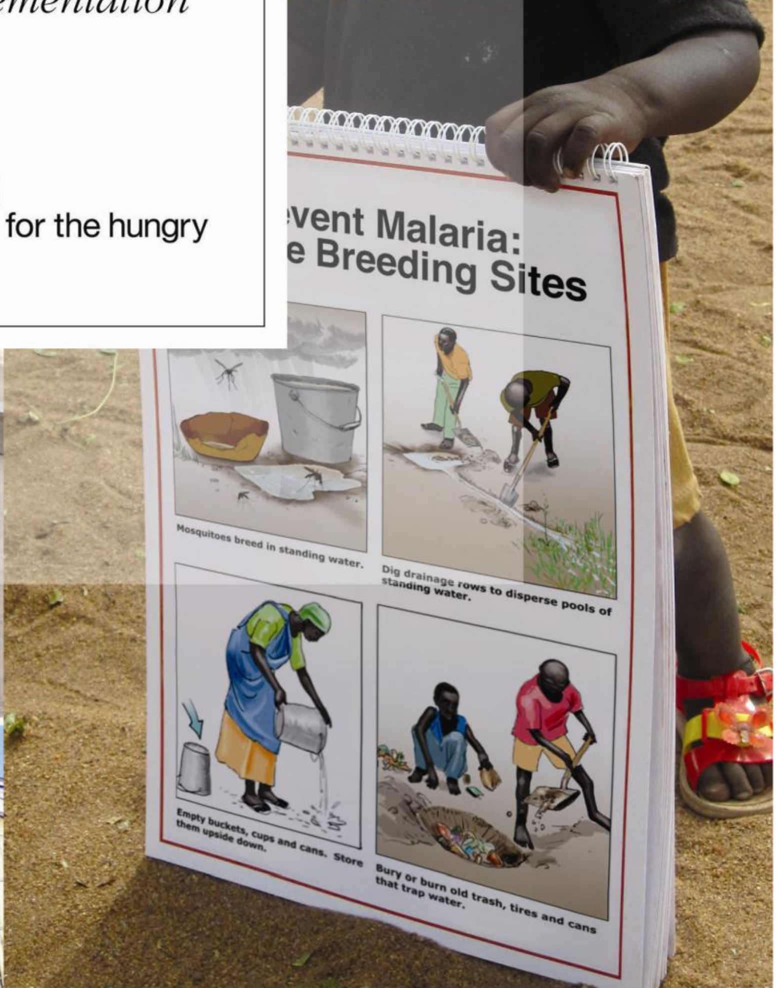
CARE GROUPS

A Training Manual for Program Design and Implementation



Preface

Objectives of this Guide: This guide was developed as a training resource and toolkit to aid in the design, training, implementation and monitoring of Care Group programs. This guide should be used by organizations that have *already* decided that Care Groups are the right approach for their program/context. If you still need to decide whether the Care Group model is appropriate for particular health project's contexts and needs, the 'Care Group Difference', published by World Relief in 2004, provides useful guidance.

Intended Audience: Maternal and Child Health and Nutrition program staff including: implementers, designers, technical staff and program managers who will or plan to implement a Care Group program.

Ideal Timing for a Care Group Training: In most cases, this training should take place after funds for the health program are secured and after key health management personnel have been hired, but before community staffs are hired.

Authors: This manual was produced in March 2012 by members of Food for the Hungry's Resource and Program Development Unit.

Acknowledgements:

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Glossary of Key Care Group Terms

Term	Definition
Care Group (CG):	A group of Care Group Volunteers led by a Care Group Promoter
Care Group Promoter (CGP)	One community member hired to train and supervise the Care Group Volunteers in their community
Care Group Volunteer (CGV)	Volunteers who meet with the Promoter in Care Groups, usually nominated for that position by the Neighbor Women
Maternal and Child Health & Nutrition (MCHN) Coordinator	Hired to be the direct supervisor and trainer of the Promoters in each community
Maternal and Child Health & Nutrition (MCHN) Supervisor	Hired to be the direct supervisor of the coordinators and monitor the Care Group program.
Neighbor Groups (NG):	The 8-10 women who meet with one of their peers (the Care Group Volunteer) whom they selected to share new health lessons with them every two weeks.
Neighbor Women (NW)	Women who meet with the Care Group Volunteer once every two weeks to hear a new health lesson.

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Care Group Orientation Agenda

Training Day #1: Day, Date		
Time	***Hr:Min***	***Activity***
8:30	0:30	Optional Devotions
9:00	1:30	Lesson 1: Training Overview & Pre-Test (2 hours, 5 min)
10:30	0:30	Morning Break
11:00	0:35	Lesson 1: Training Overview & Pre-Test (cont)
11:35	1:00	Lesson 2: Program Overview Lesson Plan Template (1 hour)
12:35	1:00	Lunch
13:35	1:50	Lesson 3: Introduction to Care Groups (1 hour, 50 min)
15:25	0:30	Afternoon Break
15:55	2:00	Lesson 4: Care Group Characteristics (2 hours)
17:55	0:10	End of the Day Evaluation
Training Day #2: Day, Date		
Time	***Hr:Min***	***Activity***
8:30	0:30	Optional Devotions
9:00	2:00	Lesson 5: Organizing Communities into Care Groups (2 hours)
11:00	0:30	Morning Break
11:30	1:00	Lesson 6: Job Descriptions (1 hour, 45 min)
12:30	1:00	Lunch
13:30	0:45	Lesson 6: Job Descriptions (cont)
14:15	1:00	Lesson 7: Numbering Care Groups (1 hour, 30 min)
15:15	0:30	Afternoon Break
15:45	0:30	Lesson 7: Numbering Care Groups cont)
16:15	1:10	Lesson 8: CG Monitoring / Registers (2 hours, 10 min)
17:25	0:10	End of Day Evaluation
Training Day #3: Day, Date		
Time	***Hr:Min***	***Activity***
8:30	0:30	Optional Devotions
9:00	1:00	Lesson 8: CG Monitoring / Registers (cont)
10:00	0:30	Morning Break
10:30	2:15	Lesson 9: CG Monitoring / Reports (2 hours, 15 min)
12:45	1:00	Lunch
13:45	1:40	Lesson 10: Curriculum Training Schedule (1 hour, 40 min)
15:25	0:30	Afternoon Break
15:55	1:30	Lesson 11: Checklists for Supervising (2 hours, 30 min)
17:25	0:10	End of Day Evaluation

Training Day #4: Day, Date		
Time	***Hr:Min***	***Activity***
8:30	0:30	Devotions
9:00	1:00	Lesson 11: Checklists for Supervising (cont)
10:00	0:30	Morning Break
10:30	1:30	Lesson 12: Supervision Responsibilities (1 hour, 30 min)
12:00	0:20	Lesson 13: QIVCs - Purpose and How to Use (1 hour, 20 min)
12:20	1:00	Lunch
13:20	1:00	Lesson 13: QIVC- Purpose and How to Use (cont)
14:20	1:15	Lesson 14: QIVC- Principles of Giving Positive Feedback (1 hour, 15 min)
15:35	0:30	Afternoon Break
16:05	1:00	Lesson 15: QIVC - Calculating Scores and Using Data (1 hour, 45 min)
17:05	0:30	End of Day Evaluation
Training Day #5: Day, Date		
Time	***Hr:Min***	***Activity***
8:30	0:30	Devotions
9:00	0:45	Lesson 15: QIVC - Calculating Scores and Using Data (cont)
9:45	1:00	Lesson 16 : Volunteer Motivation and Incentives (2 hours, 10 min)
10:45	0:30	Morning Break
11:15	1:10	Lesson 16 : Volunteer Motivation and Incentives (cont)
12:25	1:00	Lunch
13:25	1:40	Lesson 17:Community Program Orientation (1 hour, 40 min)
15:05	1:35	Lesson 18: Workshop Closing (1 hour, 35 min)

Lesson 1: Training Overview & Pretest

Objectives:

1. Trainer and participants will discuss training expectations.
2. Trainer and participants will agree on:
    a. What will be covered (and/or added) to the agenda;
    b. What is expected of participants during the training.
3. Participants will feel at ease and get to know the background and experience of others in the training.
4. Participants will complete their pretest.

Summary: 2 hours, 5 minutes	**Materials:**
• Activity 1: Getting to know one another (40 min) • Training Expectations (10 min) • Training Objectives (10 min) • Review the Agenda (10 min) • Training Rules or Guidelines (10 min) • Pretest (45 min)	☐ Attendance sheet ☐ Name tags for each participant or cardstock for table tents ☐ Agenda ☐ Flipchart and markers ☐ Animal cards ☐ Handout 1A: Pre- and Posttest

Activity 1: Getting to know one another (40 minutes)

Play a game that allows the group to meet one another and learn something about other members from the group. Possible activities are below. Depending on how well the participants know each other, you may want to select only one, both, or a new game of your choosing.[1]

1. **Taxi Station:** In this game the facilitator yells out a question such as, "Which program site do you work in?" All of the participants must yell out their program site and group together with others who work in the same location. The responsibility of the participants is to YELL the answer to the question and to MOVE QUICKLY to find others in the training that are "like them" (i.e. yelling out the same answers that they are).

    Sample questions:
    - ? What is the first language you spoke as a child?
    - ? What is your sex?
    - ? What is the name of the city where you were born?
    - ? How many siblings (brothers and sisters) do you have?
    - ? What is the color of your socks?
    - ? How many minutes did it take you to come to this training?
    - ? What is your favorite fruit?

[1] The International HIV/AIDS Alliance *100 Ways to energise groups: Games to use in workshops, meetings and in the community* (2003) is a good resource for participatory games. This publication can be downloaded here: http://www.icaso.org/vaccines_toolkit/subpages/files/English/energiser_guide_eng.pdf.

- ? What is the name of the university that you attended?
- ? What time did you wake up this morning?
- ? *Then, ask a few participants to yell out their own questions.*

2. **Stand up if**: In this game, the facilitator asks participants to stand up if participants meet a specific criteria (see sample questions below). The facilitator asks the question, and participants stand up if they meet the specified criteria. If the facilitator did not receive sufficient information from the Needs Assessment (see Annex 1 for the LRNA—Learning Resources and Needs Assessment) this is a way for the facilitator to rapidly gather key information. This activity also allows the participants to visually see the relevant experience in the room.

> **Note to the Trainer:** A higher energy variation could be used, called ***That's Me!*** – Have participants stand, throw both hands up overhead, and shout "That's Me!"

Sample criteria

- Worked on Care Group programs before
- Have more than 1 year of MCH experience; keep standing if more than 2; 5; 10; 15?
- Speak more than 1 language; 2; 5; 10?
- Comfortable speaking English?
- *Others as needed*
- *Note: be sure to include at least one question that most of the group can say yes* to.

Training Expectations (10 minutes)

If the facilitator has already received the LRNAs from all participants:

- Write a summary of the expectations listed on the LRNAs on the flipchart.
- Ask participants to review this list and ask whether they would add anything to the list. Update the list as the participants list additional expectations.

If the facilitator has not received LRNAs from the participants:

- Solicit expectations from the participants, listing each one on the flipchart.

Training Objectives (10 minutes)

On a separate flipchart, the facilitator should write out the training objectives and contrast their expectations with this list. *If there are expectations that will not be met during the training, the facilitator must decide if there is room to add a short session/discussion on those topics or whether the topic is not relevant to the training.* Address each topic; summarize all those that will be addressed. Ask if participants are comfortable with the objectives.

Review the Agenda (10 minutes)

Explain how the agenda will allow the participants to meet their training expectations and objectives. Discuss any questions about the agenda. Make sure that participants agree upon the start and end time of each day.

Training Rules or Guidelines (10 minutes)

Ask participants to generate a list of behaviors or guidelines to help guide both the trainers and participants during the training. This should be a list of "social norms" that will help to make the training successful. Suggest any of the following that are not mentioned.

- Turn off all cell phones during the training.
- Arrive on time each day.
- Trainers should end on time each day.
- Participants should participate in all training activities, and not take days off for other activities.

Pretest (45 minutes)

Tell participants that everyone will take a pre-test and posttest so we, the trainers, can gauge if we have met all of our objectives. Remind participants that the pretest will be difficult since they are new to the material. *If only aggregated scores will be shared with their managers, be sure to let them know that to reduce test-anxiety among the group.*

Facilitators should review how to fill out the form:

- Remind participants to enter their name at the top of page one.
- Circle PRETEST.
- Multiple choice questions – choose only one answer unless it says you can choose more than one. Circle only the letter (a, b, c or d).
- Fill in the blank – write clearly so we can read it.

Collect papers when all participants have finished or after 45 minutes have passed.

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Handout 1A: Pre- and Posttest

Name ____ Date __________________

Is this the pretest or post-test? Circle one.

Program Overview

CG Trainer: Once you complete your lesson using the Program Overview Template, create 1-2 test questions to verify the content was learned. Two example questions are listed below. The answers will depend upon management decisions.

1. Answer the four questions below:

How many women are in each Neighbor Group?	
How many women are in each Care Group?	
Each Promoter oversees how many Care Groups?	
Each Supervisor oversees how many Promoters?	

2. Which of the following activities will achieve Intermediate Result 2: *[Insert Intermediate Result].*
   A. List an activity not included in your Care Group program
   B. List an activity from another Intermediate Result
   C. List an activity from another Intermediate Result
   D. List an activity from Intermediate result 2. (Correct Answer)

Care Group Effectiveness

3. Which of the following statements is FALSE about Care Groups?
   A. A Care Group is a group of 20-30 community-based volunteers who regularly meet together with project staff for training and supervision.
   B. 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.
   C. Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication.
   D. Care Groups provide the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits

4. Why do Care Group programs focus on pregnant women and children under two?

A. They are the easiest target groups for NGOs to work with
B. Pregnant women are more likely to volunteer than other members of the community
C. The right nutrition during this period (pregnancy and the first two years of life) can have a profound impact on a child's ability to grow, learn, and rise out of poverty. It can also shape a society's long-term health, stability and prosperity.

Care Group Characteristics

5. In Care Group programs, mothers (also known as Neighbor Women) should choose/elect their Care Group Volunteer. Why is this important?
   A. People will choose someone that they respect – someone that they are willing to "listen to." If an outsider chooses someone – it is more likely that person will not be accepted by the community.
   B. It would take a lot of time for project staff to choose CG Volunteers, and therefore it is more efficient for the mothers (i.e. Neighbor Women) to elect their own CG Volunteer.
   C. Trick question. Mothers should not elect their own CG Volunteers – this is something that the Community Development Committee should do in partnership with the Ministry of Health.

6. In Care Group programs, Neighbor Groups should have around 10-12 members, and no more than 15. Circle the answer that is NOT a reason why this is important.
   A. Neighbor Groups are led by volunteers. If you ask too much of the volunteers time, they will not stay in the program.
   B. If a group is larger than 15 members, other members of the community might become jealous of that group because it attracted so many members.
   C. CG Volunteers should form strong bonds with their Neighbor Group members. Large groups will make it difficult to form this bond.

Organizing the Community into Care Groups

7. Of the responses below, what is the most important factor when assigning households into groups (Neighbor Groups)?
   A. The women in these households are friends and enjoy meeting together.
   B. The households are close together.
   C. The children are all the same age.
   D. The households are similar; one is not wealthier than the other.

8. Write the approach you would use to organize the community into Neighbor Groups and Care Groups based on the descriptions below. Possible answers include: Census, Community lists, or Community gatherings.

   A. In Community A, the block leaders are well organized and already maintain a list of residents or can recall by memory where all the PLW and U2 children live. ______________________

B. In Community B, community participation and communication is high. If the community leaders called for all women who are pregnant or have children less than 24 months of age to a central meeting place on a particular day they would all show up. ______________________

C. Community C is new to you. When you ask around, the leaders and members of the community do not know all the PLW and U2 children or where they live. ______________________

Job Descriptions

9. Write the CG Team Member who is responsible for the following responsibilities: The choices are CG Volunteer, CG Promoter, MCHN Supervisor or MCHN Coordinator:

   A. Models leadership to all staff and intentionally develops the leadership potential of the MCHN Supervisors. ______________________

   B. Visit 10 Neighbor Women and their families at least once a month to promote behavior change using an educational flip-chart. ______________________

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

   D. Facilitate organized, participatory learning sessions with each of their 10-12 CG Volunteers (in Care Groups) groups every two weeks, following the lesson plans in the educational materials provided. ______________________

10. Write three essential traits or characteristics of a Care Group Volunteer.

1. ____
2. ____
3. ____

Numbering Care Groups

11. How would you interpret the following code found in the Care Group Information System? 3.4.A

    ____

12. One of the following codes represents a Neighbor Woman. Which one is it? **Circle your answer.**

A. 3.4
B. 3.4.C
C. 3.4.C.1
D. 10

Registers and Reports

13. What are the four main types of information that registers in Care Group programs collect?
    A. Immunization coverage, vital events, registration, and curriculum
    B. Attendance, registration, vital events, and curriculum
    C. Births, deaths, membership, household size

14. What information does a Promoter use to fill out her/his monthly report?
    A. Care Group Registers
    B. Neighbor Group Registers
    C. A & B
    D. None of the above

Curriculum Training Schedule

15. What three things happen during **the Bi-Monthly (Twice Monthly) Training Meeting** between the Supervisor and the Promoters?

    A. 1) Training Promoters on the Flipchart Lesson, 2) Supervising Promoters in their home and 3) Supervising the Promoters as they teach CG Volunteers.
    B. 1) Training Ministry of Health Staff on the new health materials, 2) Sharing work plans with the Community Leaders and 3) Collecting Registers from Promoters
    C. 1) Training Care Group volunteers on the flipchart Lesson, 2)Observing them teaching others and 3) Collecting the Care Group and Neighbor Group Registers
    D. 1) Planning Supervision Visits with each Promoter, 2) Collecting and Discussing the Promoter Reports and 3)Coaching the Promoters as they practice the new flipchart lesson

16. **Four of the five statements are TRUE**. Circle the Letter of the statement which i**s FALSE.**

    A. The MCHN Manager will lead a one-week training on each new flipchart module (group of lessons) with all supervisors, coordinators and promoters.
    B. The MCHN Supervisor with review the current flipchart lesson with all of the CG Promoters every two weeks.
    C. The Care Group Promoters will train the Care Group Volunteers one flipchart lesson every four weeks.
    D. The Care Group volunteers will train the Neighbor Women on flipchart lesson every two weeks in (either in a small group or during a household visit to each neighbor woman's house).

E. Every time a new flipchart lesson is taught to a person responsible for training others (Supervisor, Coordinator, Promoter or Care Group volunteer), he or she will practice the new flipchart lesson in pairs while the Training Facilitator observes and coaches them on their performance.

Supervision Responsibilities and Work plans

17. Three of the four statements are TRUE. Circle the Letter of the statement which is FALSE.
    A. The MCHN Manager will supervise each MCHN Coordinator with a surprise visit once each month.
    B. The MCHN Coordinator will use both the QIVC and the Supervision checklist to supervise the MCHN Supervisor.
    C. The MCHN Supervisor will visit the Promoter's home, the Care Group Meeting and the homes of Neighbor women when supervising.
    D. The CG Promoter will supervise at least six different Care Group volunteers every two weeks.

18. Which of the following statements is true about work plans? Choose only ONE answer.
    A. A work plan is used to report to your supervisor on tasks you accomplished in the past.
    B. Only the Care Group Promoters should keep work plans. It is not necessary for Supervisors or Coordinators to plan their activities each month.
    C. Work plans help staff to organize their work responsibilities so that they can work efficiently and complete all of their tasks during normal working hours.
    D. Supervisors will use the Promoter work plans to compile the attendance and vital event information for the monthly reports.

Supervision Checklists

19. How does a MCHN Supervisor review a CG Promoter's monthly report?
    a. Look at a completed report and make sure every box is filled in.
    b. Make sure the CG Promoter has a copy of every monthly report s/he has turned in.
    c. Select 2 or 3 pieces of information on the report and ask the CG Promoter to show you how s/he determined the number using her CGV and NW Registers.
    d. Look at your copy of the CG Promoter's monthly report and the copy s/he has and make sure all the numbers match.

20. Please fill out the table below with X's, ✓, or *based on the following situation:
    The MCHN Supervisor visited the nurse at the nearest health post to the CG Promoter during his 3rd visit of the quarter. He found out that the nurse did not know the CG Promoter's name and no patient had ever made mention of a CG Promoter working in the area. On the 4th visit of the quarter the Promoter went back to the Health Post and found that the nurse knew the CG Promoters name and the CG Promoter had told the nurse about an activity that happened a month ago. The nurse said two patients had mentioned being sent by the CG Promoter in the last two weeks.

	Visits per Quarter							
	1	2	3	4	5	6	7	8
8. Visit the Health Worker at the nearest Health Facility								
a. Verify the CG Promoter has been coordinating with him/her and discuss ways to improve coordination.								
b. Verify that the CG Promoter has been referring patients to the health center for care as needed.								

Quality Improvement Verification Checklists (QIVCs)

21. The QIVC has 3 purposes. Which of the following is NOT one of the main goals of the QIVC?
    A. Encourage the worker
    B. Evaluate the worker's knowledge or intelligence
    C. Monitor the performance of the worker over a period of time
    D. Improve the workers performance

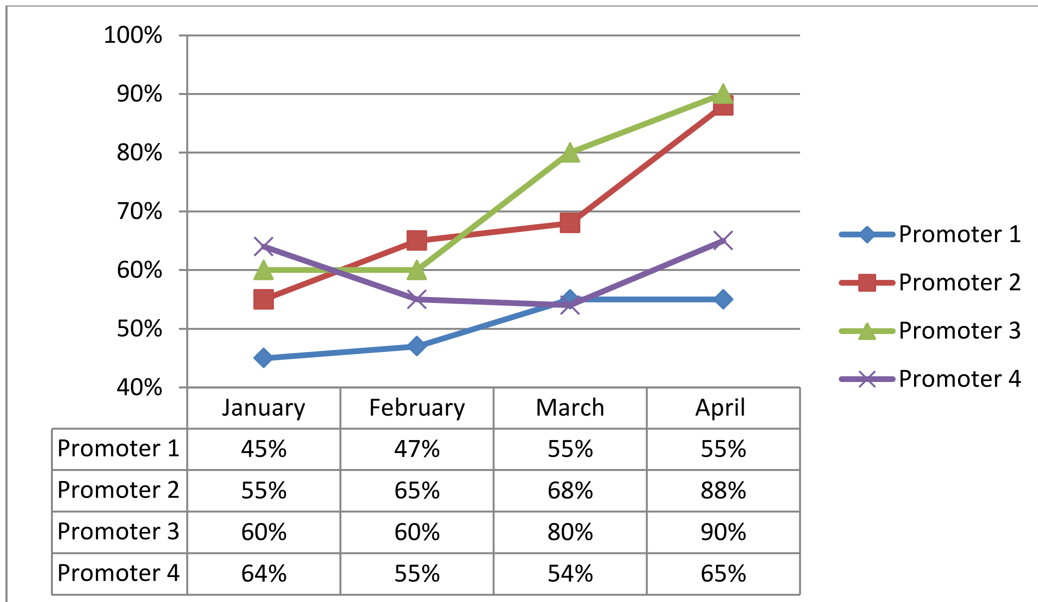
22. When giving feedback using the QIVC for Educational Methods which of the following should NOT be done:
    A. Ask the person to discuss how *they think* they performed before you begin giving feedback.
    B. Provide more positive feedback than negative feedback to encourage the worker.
    C. Ask the worker how *they think* they could overcome some of the difficulties that they had during the training.
    D. Ask the worker to commit to sharing their QIVC scores with the community leaders.

23. If the Promoter scored 70% on the QIVC for Educational Methods what should the Supervisor do?
    A. Use the QIVC less frequently because the worker scored above the target.
    B. Stop visiting this worker because they have scored above the target.
    C. Continue using the QIV Checklist each time you visit until their score is 80% or above.
    D. Continue using the QIV Checklist each time you visit until their score reaches 100%.

24. Calculate the percentage of scores ≥80% below.
    The percentage of scores ≥80% = ___________
    Promoter 1: 54%
    Promoter 2: 85%
    Promoter 3: 80%
    Promoter 4: 95%
    Promoter 5: 85%
    Promoter 6: 74%

25. Review the scores below. As the MCHN Supervisor, which of the following recommendations would you suggest? Choose only ONE answer.

A. Review the questions on the QIVC that Promoter #1 and #4 have missed on the QIVC. Ask each promoter what they should be doing to overcome these problems.
B. Make sure that both Promoters #1 and #4 are committed to improve. Ask them what has prevented them for making larger improvements.
C. Talk with the Coordinator about the policy for putting a worker on probation. Plan ahead, giving your workers time to improve before starting a plan for probation if needed.
D. All of the above.



	January	February	March	April
Promoter 1	45%	47%	55%	55%
Promoter 2	55%	65%	68%	88%
Promoter 3	60%	60%	80%	90%
Promoter 4	64%	55%	54%	65%

Volunteer Motivation

26. When people are given extrinsic rewards (like cash or food) to do something good (like donating blood), which of the following are likely to happen. Put an X before the sentences which are the potential negative results. Choose all that apply.
    _____ They are no longer motivated because their sense of altruism, or doing something of a higher value has been removed.
    ______ Cheating, shortcuts and unethical behavior can be encouraged.
    ______ People become competitive and try to outperform their colleagues

27. When people have autonomy over tasks this means that they are able to decide _________ and _________. (Circle the correct answer)
    A. What and where they will do a task.
    B. Who they will do the task with and understand why they are doing the task.
    C. When they will do it and who they will do it with
    D. Where they will do it and how they will do it.

28. Which is NOT a principle for motivating volunteers? Circle your answer.
    A. Volunteers need to feel like they are making a difference—they need to feel effective.

B. Volunteers need to feel like they have something to offer the program—that their personal skills and life experiences are valued.
C. Volunteers need to feel like they are part of a group—they need to feel connected.
D. Volunteers need to feel like they are doing something that will contribute to the well-being of their family.

Practice Presentations and Community Program Orientation:

29. When Care Group Coordinators and/or Supervisors orient the community to the CG program all of the following topics will be covered, except one. Which of the following topics should not be included in the Community Orientation? (Circle the answer that is NOT correct.)
    A. Explain the length of time FH will be in the community running the program and who is the donor.
    B. Discuss that we are partners in the program and we must work together (not wait for a strong man to come) to solve our problems.
    C. Explain the incentives that will be given to the Care Group Volunteers such as vegetables, seeds, cement to build latrines, etc to encourage their participation.
    D. Discuss how the CG project works to prevent malnutrition in children two years of age and younger.

30. If your Care Group projected has budgeted to provide each CG Volunteer and Neighbor Woman household a mosquito net when should you tell the community the project will provide the mosquito nets? (Circle the correct answer.)
    A. At project start up, during the community orientation meetings.
    B. During the census so that women will be interested to register as part of the program.
    C. Before the rainy season starts so that families know they will be receiving a mosquito net and don't buy one of their own.
    D. After you have received the mosquito nets into your offices warehouse and about a week before you have organized to transport the mosquito nets to the community for distribution.

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Lesson 2: Program Overview Lesson Plan Template

<table>
<tr><td colspan="2">Objectives:
1. Participants will be able to state how the Care Group methodology contributes to the project's strategic objectives and/or results.
2. Participants will be able to state key information about the project (e.g. donor, timeframe, location).
3. Participants will be able to explain how project success will be measured.
4. Participants will be able to answer questions about the structure of their Care Group program (e.g. number of staff, supervision levels, training, and curriculum).
5. Participants will be able to identify their position on an organizational chart.</td></tr>
<tr><td>Summary: 1 hour
• Activity 1: Overview of Project Information (20 min)
• Activity 2: Completing the CG Reference Table (25 min)
• Activity 3: Matching Activities to Their Intermediate Results (15 min)</td><td>Materials:
☐ Print Handout 2A
[Print one per participant unless noted]
☐ Print Handout 2B (includes org. chart and project map)
☐ Tape and butcher/flipchart paper
[Print one set for every 3-5 participants]
☐ Immediate Results printed on blue strips of paper and Project Activities printed on white paper and cut into strips. [Print and cut one set for every 3-4 participants]
☐ Prizes for winning groups</td></tr>
</table>

Note to CG Facilitator! *The Program Overview Lesson Plan will need to be tailored to the specific project in which Care Groups will operate. This Lesson Plan template is a tool to guide project management on how to orient their staff to the larger project context in a fun and participatory way. It can be used not only at project start-up, but also when new staffs are hired. Ideally, the majority of the information needed to fill out this Lesson will be found in your project proposal. If the information requested isn't found in your proposal, this Lesson Plan template identifies the key questions that should be answered about Care Groups before the project begins.*

Activity 1: Overview of Project Information

PREPARATION: Complete information required for Handout 2A: Project Information. Save it as a separate file.

Option #1 Instructions: Distribute Handout 2A: Project Information with the tables completed and review the information in lecture format.
Option #2 Instructions: Distribute Handout 2A: Project Information with the tables blank. Divide participants into small groups and have them answer general questions that will guide them through information in the handouts.

Activity 2: Completing the CG Reference Table

PREPARATION: Complete table in Handout 2B: CG Reference Table. Save it as a separate file.

Instructions: Give participants Handout 2B: CG Reference Table with the tables blank. Have them fill in the information as trainer provides it and gives the explanation. The following table is an example of a filled table.

Care Group Reference Table

CARE GROUP REFERENCE TABLE FOR THE PROJECT: NGO NO NAME PROJECT		
1. Program Essentials	**List Key Management Staff and % Effort:**	1 MCHN Manager 50% 1 BCC Coordinator (100%) 1 M&E Coordinator 50% 1 M&E Officer (100%)
	# of MCHN Coordinators:	3
	# of MCHN Supervisors:	15
	# of CG Promoters:	90
	# of CG's per Promoter:	6
	# of CGV per CG:	12
	# of NW per Neighbor Group:	10
	CGVs (gender, age, and child status required):	Must have been a mother at one time, any age, child can be any age or deceased, must be elected by NW
	NW (gender, age, and child status required):	Any women above 15 years of age (married or unmarried), pregnant women, women with children 0-23m
2a. Coordinator Supervision	**Who do MCHN Coordinators report to?**	MCHN Manager
	Who does the MCHN Coordinator supervise? Where, and how often?	MCHN Supervisors; at least once a month in the community
	How often do they fill out the Supervisor Supervision checklist?	One checklist per supervisor per quarter.
2b. Supervisor Supervision	**Who do MCHN Supervisors report to?**	MCHN Coordinator
	Who does the MCHN Supervisor supervise? Where, and how often?	CG Promoter: at least twice a month in the community
	How often do they fill out the CG Promoter Supervision checklist?	Once checklist per Promoter per quarter.
Promoter Super	**Who do CG Promoters report to?**	MCHN Supervisors
	Who does the CG Promoter supervise? Where, and how often?	CGVs, one a quarter in the community teaching their NW

	How often do Promoters fill out a Group Education QIVC?	Six per month
3. Training	**Who trains Supervisors in CG curriculum and how often?**	The MCHN Manager and BCC Coordinator train MCHN Coordinators and Supervisors on new curriculum every 3-6m at the start of a new module.
	Who does refresher trainings with Supervisors about CG curriculum and how often?	The MCHN Coordinators, once a month (2 lessons covered in each refresher training)
	Who trains Promoters in CG curriculum and how often?	The MCHN Supervisor, 2Xmonth (1 lesson covered in each refresher training)
	Who trains CGV in CG curriculum and how often?	CG Promoters train Care Groups 2Xmonth
	Who trains NW in CG curriculum and how often?	CGV train NW 2Xmonth
4. Care Group Curriculum	**What are the Modules and Lesson titles for your Care Group project?**	See CG Curricula Annex
	How many months will it take to teach the Care Group curriculum?	Module 1 = 3 months Module 2 = 3 months Module 3 = 4 months Module 4 = 3 months Module 5 = 3.5 months 16.5 months, increased to 25 months to give a chance for holidays, vacation, bad weather, etc.
	Who will or has developed the CG curriculum?	HQ Curricula Specialist and BCC Coordinator
	What if any formative research is being used to adapt the CG curriculum to the local context?	Local Determinants of Malnutrition Study and Barrier Analysis
5. Monitoring & Evaluation	**What information will be tracked by Care Groups?**	CGV Attendance at Care Groups, NW visited, deaths, births, child deaths
	What surveys will you conduct as part of your Care Group project? How often will you conduct them?	Baseline, Midterm, Final, Mini-KPC every 4 months
6. Other	**Additional Questions:**	
	Additional Questions:	
	Additional Questions:	
	Additional Questions:	
	Additional Questions:	

Activity 3: Matching Activities to Their Intermediate Results

PREPARATION: Print your intermediate results on colored paper and cut them into strips with one result on each strip. Print your activities on white paper and cut them into strips with one activity on each strip. Make enough sets so participants can work in groups of 3 or 4.

Instructions: Divide participants into groups of 3 or 4 and give each group of piece of butcher paper and role of tape. Give each group a set of blue intermediate results and a set of white activities. Explain the activity using the following instructions:

1. When I say "go" turn over your papers and match the activities (white strips of paper) to the right Intermediate Result (blue strips of paper).
2. When you are pretty sure you have finished matching up the activities with the intermediate results, tape them onto the butcher paper, with the activities taped below the Intermediate Results.
3. As soon as you finish bring your butcher paper to me.
4. Scoring – Each activity placed under the correct Intermediate Result will receive 2 points and each activity under the wrong Intermediate Result will receive a negative 2 points. The first group to finish will receive 6 extra points.
5. Give a prize to the winning group and a smaller prize to all groups.

Handout 2A: Project Information

Donor:
Type of Project:
Length of Project:
Project Start Date:
Project End Date:
Project Title:

Program Goal:		
Strategic Objective 1:		
Intermediate Result 1.1	Activities	Targets
	2.1.1	
	2.1.2	
	2.1.3	
	2.1.4	
	2.1.5	
	2.1.6	
Intermediate Result 1.2	Activities	Targets
	2.2.1	
	2.2.2	
	2.2.3	
	2.2.4	
	2.2.5	
	2.2.6	
Intermediate Result 1.3	Activities	Targets
	2.3.1	
	2.3.2	
	2.3.3	
	2.3.4	
	2.3.5	
	2.3.6	
Strategic Objective 2:		
(Fill in as Strategic Objective 1)		
Strategic Objective 3:		
(Fill in as Strategic Objective 1)		
Cross Cutting Issues (if any)		
1.		
2.		
3.		

Beneficiaries

	Community	Promoter	Target Population Total	Women Eligible for CG participation	# of Care Groups	# of CGV	# NW
MCHN Supervisor 1 (District X)		1					
		2					
		3					
		4					
		5					
	Subtotal						
MCHN Supervisor 2 (District X)		6					
		7					
		8					
		9					
		10					
	Subtotal						
MCHN Supervisor 3 (District Y)		11					
		12					
		13					
		14					
		15					
	Subtotal						
MCHN Supervisor 4 (District Z)		16					
		17					
		18					
		19					
		20					
	Subtotal						
	Totals						

Indicator Project Tracking Table (IPTT) (or relevant M&E table)– *list all impact and results level indicators. If there are not too many, include outcome indicators as well.*

Impact Indicator 1:
Impact Indicator 2:

Results Indicator 1:
Results Indicator 2:
Results Indicator 3:
Results Indicator 4:
Outcome Indicator 1:

Don't forget to include in this Handout:

1. An Organizational Chart that includes the positions of CG Promoter, MCHN Supervisor, MCHN Coordinator, MCHN Manager and his/her supervisor.
2. A map with project areas highlighted – if possible indicate geographic areas to be covered by each MCHN Supervisor.

Handout 2B: Care Group Reference Table

CARE GROUP REFERENCE TABLE FOR THE PROJECT:		
2. Program Essentials	List Key Management Staff and % Effort:	
	# of MCHN Coordinators:	
	# of MCHN Supervisors:	
	# of CG Promoters:	
	# of CG's per Promoter:	
	# of CGV per CG:	
	# of NW per Neighbor Group:	
	CGVs (gender, age, and child status required):	
	NW (gender, age, and child status required):	
2a. Coordinator Supervision	Who do MCHN Coordinators report to?	
	Who does the MCHN Coordinator supervise? Where, and how often?	
	How often do they fill out the Supervisor Supervision checklist?	
2b. Supervisor Supervision	Who do MCHN Supervisors report to?	
	Who does the MCHN Supervisor supervise? Where, and how often?	
	How often do they fill out the CG Promoter Supervision checklist?	
2c. Promoter Supervision	Who do CG Promoters report to?	
	Who does the CG Promoter supervise? Where, and how often?	
	How often do Promoters fill out a Group Education QIVC?	

3. Training	**Who trains Supervisors in CG curriculum and how often?**	
	Who does refresher trainings with Supervisors about CG curriculum and how often?	
	Who trains Promoters in CG curriculum and how often?	
	Who trains CGV in CG curriculum and how often?	
	Who trains NW in CG curriculum and how often?	
4. Care Group Curriculum	**What are the Modules and Lesson titles for your Care Group project?**	
	How many months will it take to teach the Care Group curriculum?	
	Who will or has developed the CG curriculum?	
	What if any formative research is being used to adapt the CG curriculum to the local context?	
5. Monitoring & Evaluation	**What information will be tracked by Care Groups?**	
	What surveys will you conduct as part of your Care Group project? How often will you conduct them?	
6. Other	**Additional Questions:**	
	Additional Questions:	
	Additional Questions:	
	Additional Questions:	
	Additional Questions:	

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Lesson 3: Introduction to Care Groups
What are Care Groups? What makes them so effective?

Objectives:
1. Participants will be able to list three characteristics of Care Groups.
2. Participants will be able to explain and draw a diagram illustrating the Care Group model.
3. Participants will be able to state two reasons why Care Groups are effective.
4. Participants will be able to state why Care Groups focus on pregnant women and children under two years of age.
5. Participants will be able to state why Care Groups focus on household behavior change.

Summary: 1 hour, 50 min	Materials
• Activity 1: What are Care Groups? (10 min) • Activity 2: Care Group Video and discussion (15 min) • Activity 3: Diagramming Care Groups (20 min) • Activity 4: Frequently Asked Questions (15 min) • Activity 5: How Effective Are Care Groups? (20 min) • Activity 6: Why do Care Groups focus on pregnant and lactating women? (15 min) • Activity 7: Why do Care Groups focus on HH behavior change? (15 min)	☐ One printed copy of World Relief's publication "The Care Group Difference" ☐ Projector and laptop (if possible) ☐ Handout 3A: Care Group Diagrams [Print one per participant unless noted] ☐ Handout 3B: Care Group Efficacy ☐ Handout 3C: Results from Care Group Operations Research ☐ Handout 3D: Causes of Death in Children less than Five Years of Age, Lancet ☐ Butcher/ Flipchart paper ☐ Markers

Activity 1: What are Care Groups? (10 min)

Ask participants "What have you heard about Care Groups"? Ask for a volunteer to summarize participants' thoughts on flip chart paper. Encourage people with a lot of experience with Care Groups to let others speak first. Add the following points if not previously covered:

- The Care Group Model is a community-based strategy for improving coverage and behavior change.
- Developed by Dr. Pieter Ernst with World Relief/ Mozambique, and pioneered by FH and WR for the past decade.
- Now used by at least 22 organization in 20 countries.
- A Care Group is a group of 10-15 community-based volunteers 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.

- For more information, encourage participants to refer to "The Care Group Difference" published by World Relief in 2004. Have one printed copy available for them to see during breaks. http://www.k4health.org/system/files/Care%20Group%20Manual.pdf
- Also encourage participants to visit www.caregroupinfo.org for a wide variety of resources on Care Groups.

Activity 2: FH's Care Group Video and discussion (15 minutes)

If possible, download this 5 minute video (English language) ahead of time onto your laptop or computer, so that you are not dependent on fast internet connectivity. *(If you are working with non-English speaking groups consider using this video anyway and translating as you go.)* http://www.caregroupinfo.org/blog/narrated-presentations-on-care-groups-and-care-group-tools/care-group-media

Discussion: Ask participants what caught their attention or stood out for them about the video. Are there any words or images that were particularly memorable? This could be done in small groups or in the larger group.

Ask participants if they think the video would help them to introduce the Care Group model to people who are not familiar with it. Ask them to use a page near the back of their notebooks and label it "Ideas to Remember". Suggest that they might use this to write down their ideas about how they would use the video, and other ideas that come up throughout the training.

Activity 3: Diagramming Care Groups (20 minutes):

Pass out Handout 3A: Care Group Diagrams. Give participants 10 minutes in small groups to look over the handouts. Ask them to try to estimate how many mothers they could reach with 30 total promoters in a program, 6 Care Groups per Promoter, 10 Care Group Volunteers (also sometimes known as Leader Mothers) per Care Group, and 12 Neighbor Women per Care Group Volunteer.

Give out markers and a sheet of flip chart paper to each small group. Ask the groups to draw their own representation of the Care Group model in **one village**, using 5 CG Promoters, 6 Care Groups per Promoter, 10 CGVs per Care Group, and 10 Neighbor Women per CGV. Ask participants to diagram this in a different way than what's shown in Handout 3A.

Activity 4: Frequently Asked Questions (15 minutes):

Ask participants "What questions do you have about Care Groups and the Care Group model, so far?" Listen to the questions, and respond, or let group members respond to the questions. Some questions will refer to material that will be covered later on, if so, let participants know that is coming up. If you don't know the answer, it is better to say so, and also tell the participants that you will try to find out by the next day. Then share some FAQs about Care Groups with the participants, saying here are some other questions that frequently come up (if they haven't already been asked).

FAQS:

- How do women find time to be Care Group Volunteers?
    - The time commitment for Care Group Volunteers varies among projects but generally they are expected to attend a 2 hour Care Group Volunteer Meeting with the Promoter twice a month, and to meet 2 times a month with the Neighbor Women they serve, either in a group meeting or through home visits.
    - The Care Group Volunteers are women who are usually nominated for the position by other women in their Neighbor Group. If more than one woman is nominated, the group should vote to select their CGV. The elected/chosen mother should be given the choice to become a CGV. Some women may decline because they are too busy.
- Why do women become CGVs?
    - Women become CGVs for a variety of reasons. Since they are chosen by their peers they may feel it is an honor as well as a responsibility or opportunity to be of service to others.
    - They may wish to learn many new skills that will be beneficial for themselves and their families.
- What incentives are used?
    - We recommend giving CG volunteers "tools for the job" such as flipcharts and other messaging materials. Some Care Group program use incentives that improve nutrition and sanitation, such as small animals, vegetable seeds, and/or materials to make latrines. We strongly recommend that incentives be given in an equitable manner to both CGVs and NW. If only CGV receive incentives it can create jealousy between the NW and the CGVs who aim to serve them.
- How are CGVs motivated without the use of incentives? (Refer to Handout 3C: Results from Operational Research.)
    - There is consistently **high attendance and low turnover** of CGVs in most countries which could indicate high motivation.
    - CGVs have reported **decreases in domestic violence**, and receiving **more respect from their spouses, parents, community leaders and in-laws.**
    - **CGVs want to help others and be useful** in their communities. (***Purpose***)
    - **CGVs learn new things. (*Mastery*)**
    - **Community Leaders' public recognition and praise** of the CGVs during community meetings.
    - **Feelings of pride** in the fact that the community recognizes their work, trust them and seeks advice from them.
    - **CGVs say their husbands are happier** that they are learning new and helpful things, that their houses are cleaner, and that their children are healthier

Activity 5: How Effective Are Care Groups? (20 min)

- Give out copies of Handout 3B: CG Effectiveness
- Say: Here's the best proof I've seen of the effectiveness of Care Groups. Go through some of these points, depending on the comfort level of the participants with graphs and charts.

- Look at **Table One:**
  - On this table, we have compared how child survival projects perform on 14 different RapidCATCH indicators[2]. One of these is an impact indicator (underweight), but most are results-level behavioral indicators or coverage indicators.
  - The bars show the amount of gap closure for each indicator. For example, if you started at 20% EBF and increased that to 40%, you would have closed 20 of 80 possible points – that 25% gap closure. Looking at gap closure is one of the best ways to compare performance across projects.
  - The red bars show the average indicator gap closure for each of these indicators for 58 child survival projects NOT using CGs ending between 2003 and 2009.
  - The white bars show the average indicator gap closure for each of these indicators for 9 Care Group projects. What can you see about the difference? (Wait for answers)
  - Care Groups projects out-performed the average child survival project in terms of indicator gap closure on <u>all indicators</u> except HWWS where there was a slight non-significant difference. The average gap closure was in the 35-70% range for the nine Care Group projects as compared with 25-45% with all the other CSHGP projects.
  - There were only 9 CG projects to compare, but the difference between those 9 projects and the 58 other projects is statistically-significant for EBF.
  - So what this shows is that Care Groups are outperforming the other methods we generally use for behavior change. We are still looking for other similarities among more successful programs, but this is an important one.
- Now look at **Table Two:**
  - In case you might think that these results are atypical, here's a graph showing the estimated mortality reduction in 13 CSHGP-funded Care Group Projects in eight different countries.
  - The average estimated reduction in under-five mortality was 30% in Care Group projects, and this is almost double what non-CG projects often achieve.
  - Most of these are five year projects. We see this as compelling evidence that these volunteer CHWs (Care Group Volunteers) – coached and trained by paid CHWs (Promoters) – make a dramatic difference.

Ask the group: Why do you think Care Groups are so effective? If not mentioned, add any of these: multiplied effort, complete coverage, peer support, peer motivation, changed communities, cost effectiveness, sustainability, behavior change in large part of community, reduced child death and malnutrition. Put this information on a flipchart and keep this up for the remainder of the training.

Activity 6: Why to Care Groups focus on pregnant women and children under two, or the first 1000 days? (15 min)

Tell participants, 'Most Care Groups focus on pregnant women and mothers of children under

[2] Rapid CATCH indicators are a set of priority health indicators, as defined by USAID, for their Child Survival and Health Grants Program (CSHGP) portfolio.

two, also known as the ‘first 1,000 days’. Why do you think it’s important that we focus on this age group?’ Have participants discuss this question as a group and the report back. Write correct answers on a flipchart, and add the following points if not previously covered. (Note this information comes from The First 1000 Days Initiative: http://www.thousanddays.org/about/)

- The 1,000 days between a woman’s pregnancy and her child’s 2nd birthday offer a unique window of opportunity. The right nutrition during this 1,000 day window can have a **profound impact on a child’s ability to grow, learn, and rise out of poverty**. It can also shape a **society’s long-term health, stability and prosperity**.
- For infants and children under the age of two**,** the consequences of undernutrition are particularly severe, often **irreversible.**
- During pregnancy, undernutrition can have a devastating impact on the healthy growth and development of a child. Babies who are malnourished in the womb have a higher risk of dying in infancy and are more likely to face lifelong cognitive and physical deficits and chronic health problems.
- For children under the age of two, undernutrition can be life-threatening. It can weaken a child’s immune system and make him or her more susceptible to dying from common illnesses such as pneumonia, diarrhea and malaria.

Activity 7: Why do Care Groups focus on household behaviors? (15 min)

Pass out Handout 3D: Causes of Death in Children less than Five Years of Age, Lancet. Ask participants to spend 10 minutes looking at the diagram and to discuss, as a table, what the diagram means. After 10 minutes, request a volunteer to share their tables interpretation. Mention the following points if not already discussed:

- The diagram shows the proportion of all under 5 deaths that could be prevented with a specific intervention.
- 57% of U5 deaths could have been prevented with interventions that rely on household behavior change – including breastfeeding, insecticide treated material, complementary feeding, zinc, clean delivery, WASH, newborn temperature management, vitamin A, and ORS.

Ask participants to share questions they have about why Care Groups focus on the first thousands days and household behavior change.

Thank the group for their comments and say that in future sections we will continue to learn more about these and then say that now we are going to get a preview of some the things that make Care Groups so effective. Throughout this training you will continue to learn more about Care Groups and what makes them effective.

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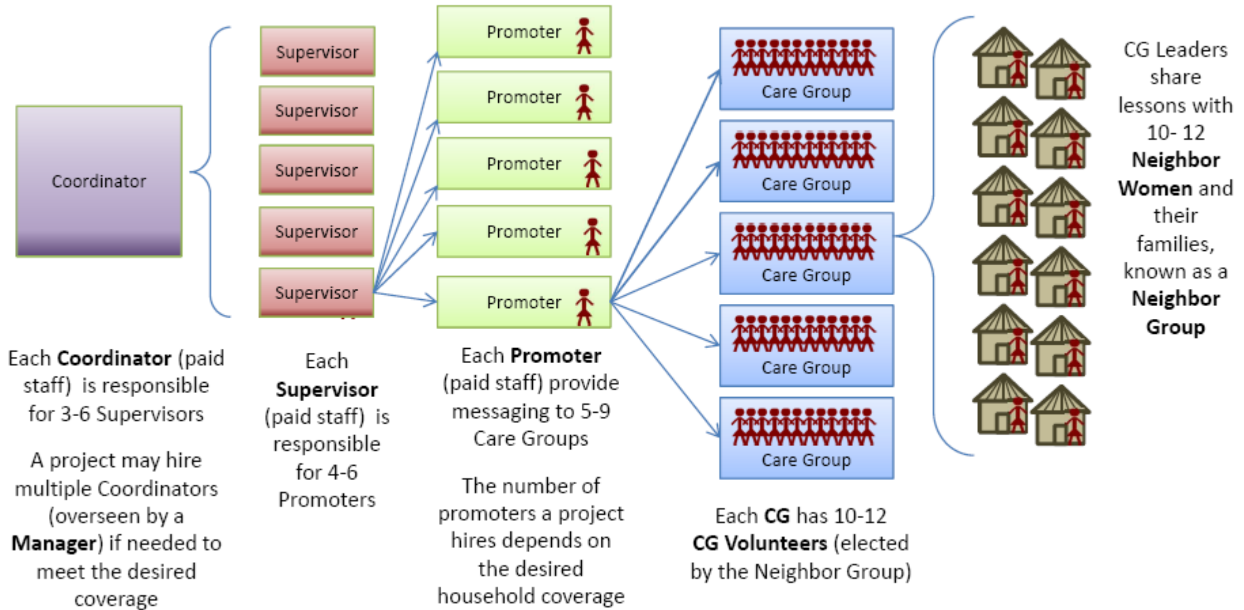
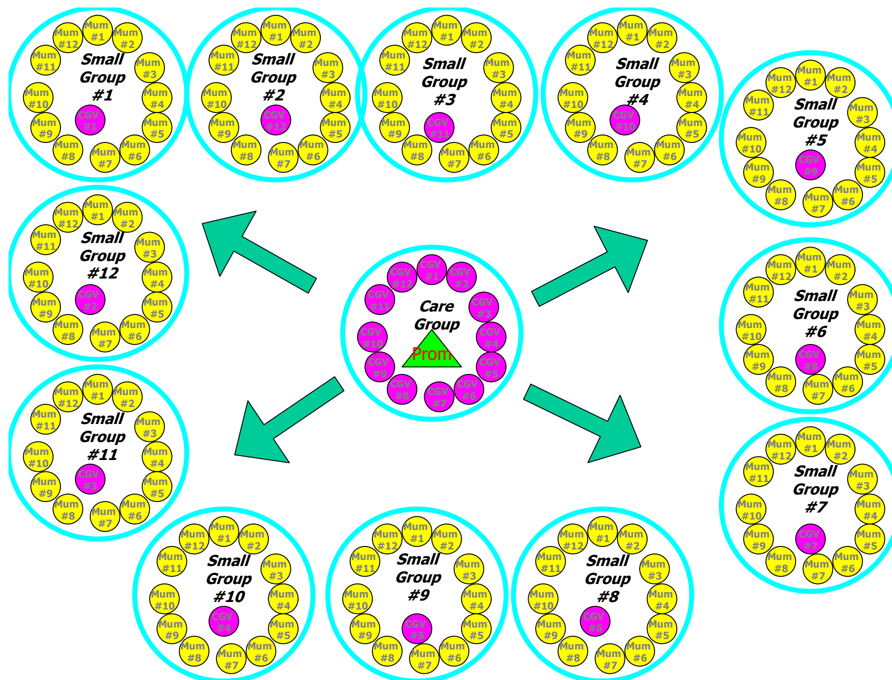
Handout 3A: Care Group Diagrams

CARE GROUP STRUCTURE

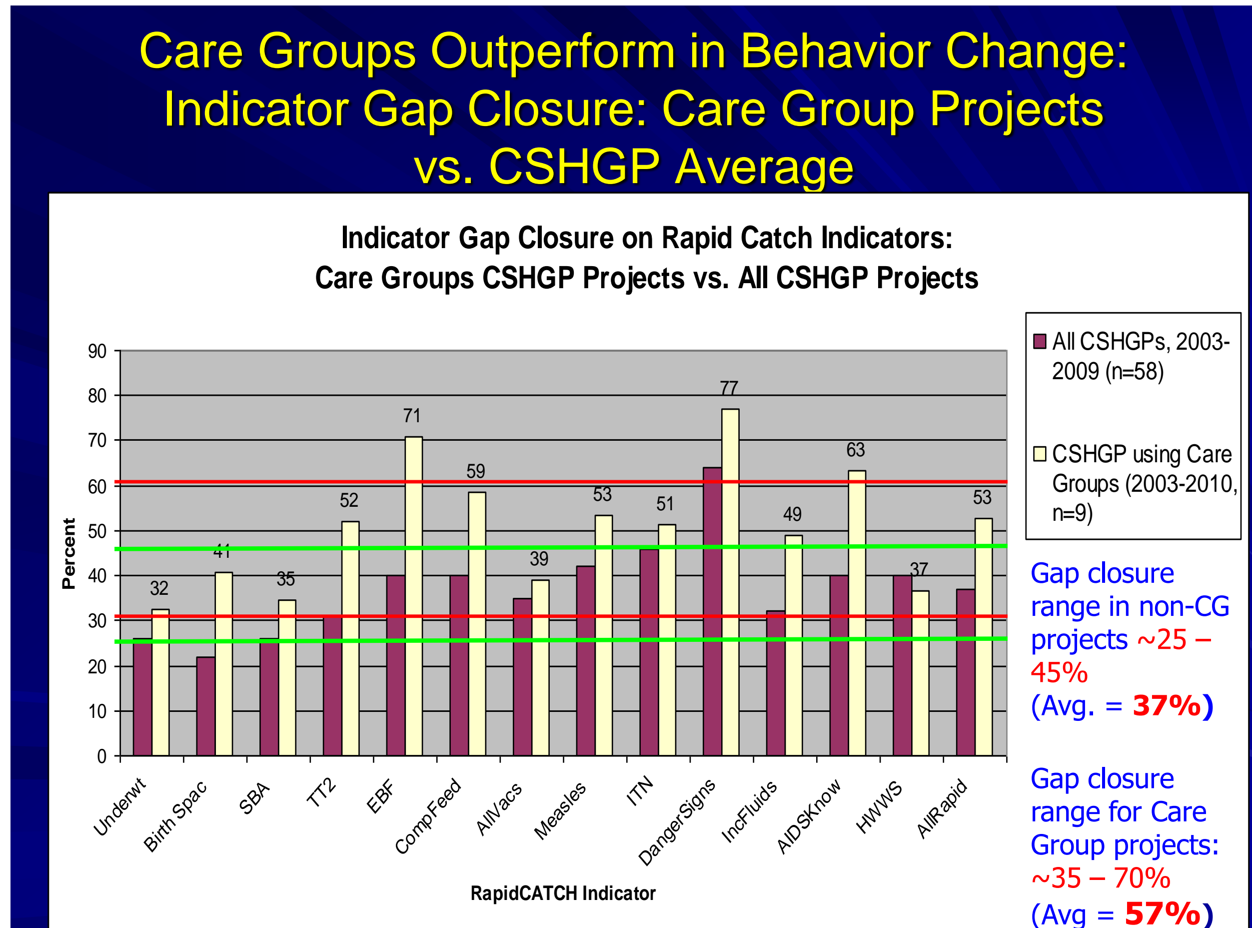


Each Promoter reaches ~ 500- 1200 women
1 paid community staff = ~1000 beneficiaries reached



Handout 3B: CG Effectiveness

Table One



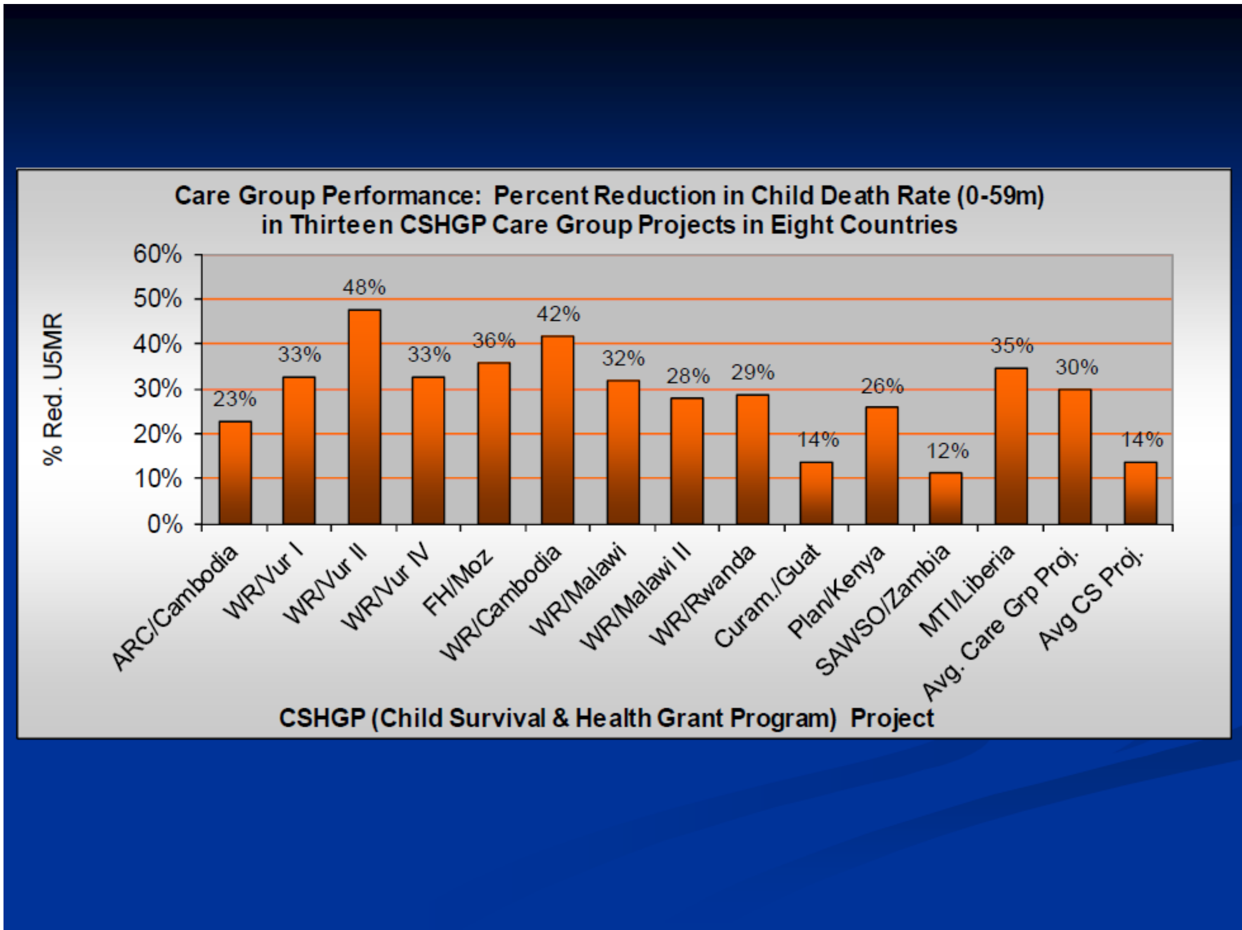
Notes:

- USAID's Child Survival and Health Grants Program (CSHGP) has supported community-oriented health projects implemented since 1985. The purpose of this program is to contribute to sustained improvements in child survival and health outcomes by supporting the innovations of PVOs/NGOs and their in-country partners in reaching vulnerable populations.
- Rapid CATCH Indicators are priority health indicators as defined by USAID for the Child Survival and Health Grants Program (CSHGP) portfolio. For a full list of Rapid CATCH indicators and their definitions, please see: http://mchipngo.net/controllers/link.cfc?method=tools_mande
- Acronyms used above include:
  - SBA = skilled birth attendant; TT2 = two tetanus toxoid vaccines; AllVacs = youngest child received all childhood vaccines; EEB = exclusive breastfeeding; ITN = child slept under insecticide treated bednet last night; Danger Signs = maternal knowledge of child danger signs ; AIDS Know = maternal knowledge of HIV risk

reduction; HWWS = Handwashing washing with soap. For the complete definition of indicators, please see:

- Data are drawn from final evaluations from all CSHGPs that *ended* in 03-10 (reported and collated by MCHIP).

Table Two



Notes:

- Data drawn from final evaluations from all CSHGPs that *ended* in 03-10. Morality estimated using the LiST: the Lives Saved Tool, an evidence-based tool for estimating intervention impact, JHSPH; http://www.jhsph.edu/dept/ih/IIP/list/index.html.
- All LiST calculators used for this study are publically posted on: http://www.caregroupinfo.org/docs/PVO_Lives_Saved_Calculators_Bellagio.zip

Handout 3C: Results from Care Group Operations Research

% of Care Group Volunteers who say they have gained more respect from [each group] since they began participating in the project	**% of CGVs**
… from **health facility personnel**	**25%**
…from their **extended family**	**41%**
… from their **parents or husbands' parents**	**48%**
… from their **husbands**	**61%**
… from their **community leaders**	**64%**
… from their **mothers / other women / mother beneficiaries**	**100%**
% of CGVs who say that it is **okay for a husband to hit his wife if he is not satisfied with her (final level shown; baseline was ~64%)**	**3%**

Wetzel, C, Davis Jr., T. Results of Care Group Operational Research conducted April to May 2010 as part of the project: Achieving Equity, Coverage, and Impact through a Care Group Network. Funded by USAID, Cooperative Agreement: GHS-A-00-05-00014-00. (OR conducted in Sofala Province, Mozambique. LQAS used to sample Care Group Volunteers. Questionnaire developed by FH to gather data on motivation for volunteering.)

Handout 3D: Causes of Death in Children less than Five Years of Age, Lancet

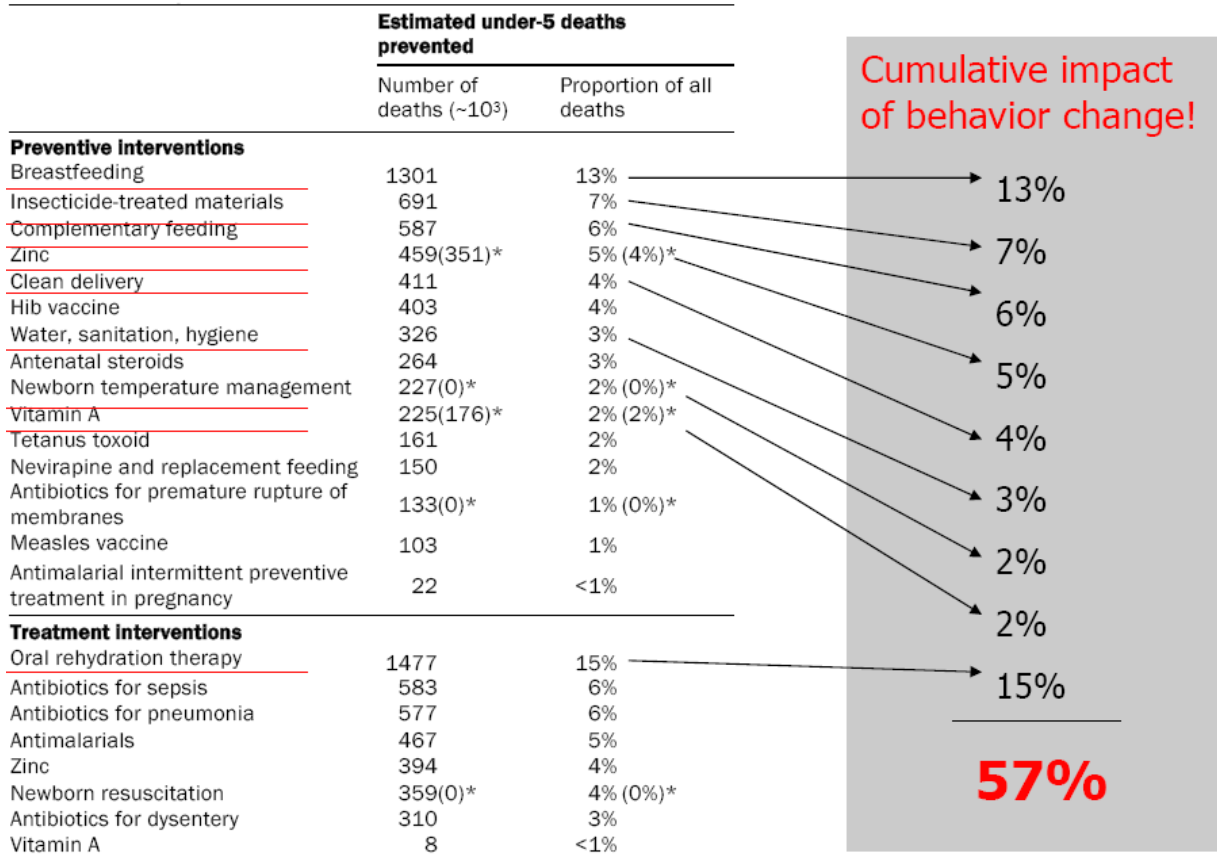


Table 2: **Under-5 deaths that could be prevented in the 42 countries with 90% of worldwide child deaths in 2000 through**

	Estimated under-5 deaths prevented: Number of deaths (~10³)	Estimated under-5 deaths prevented: Proportion of all deaths
Preventive interventions		
Breastfeeding	1301	13%
Insecticide-treated materials	691	7%
Complementary feeding	587	6%
Zinc	459(351)*	5% (4%)*
Clean delivery	411	4%
Hib vaccine	403	4%
Water, sanitation, hygiene	326	3%
Antenatal steroids	264	3%
Newborn temperature management	227(0)*	2% (0%)*
Vitamin A	225(176)*	2% (2%)*
Tetanus toxoid	161	2%
Nevirapine and replacement feeding	150	2%
Antibiotics for premature rupture of membranes	133(0)*	1% (0%)*
Measles vaccine	103	1%
Antimalarial intermittent preventive treatment in pregnancy	22	<1%
Treatment interventions		
Oral rehydration therapy	1477	15%
Antibiotics for sepsis	583	6%
Antibiotics for pneumonia	577	6%
Antimalarials	467	5%
Zinc	394	4%
Newborn resuscitation	359(0)*	4% (0%)*
Antibiotics for dysentery	310	3%
Vitamin A	8	<1%

Jones G, Steketee R, Bhutta Z, Morris S. and the Bellagio Child Survival Study Group. "How many child deaths can we prevent this year?" Lancet 2003; 362: 65-71.

Lesson 4: Care Group Characteristics

<table>
<tr><td colspan="2">Objectives:
1. Participants will be able to explain why each Care Group characteristic is important.</td></tr>
<tr><td>Summary: 2 hours
• Activity 1: Characteristics for Your Care Group Program (2 hours)</td><td>Materials:
☐ Flipchart and markers
☐ Handout 4A: Care Group Program Characteristics – Blank (With Column C left blank)
☐ Handout 4B: Care Group Program Characteristics – Completed (with Column C information included)</td></tr>
</table>

***Note to the CG facilitator**! In preparation for this exercise, you must create your Care Group Characteristics Table to match your program design (Handout 4A). Before the training, you should replace the information in Column B with the actual design of your program. The text currently in Column B is the criteria for Care Group programs. Therefore, in order for your program to be a 'true' Care Group program, the design of your program must fit within the parameters of the text currently in Column B. If you want to learn more about the Care Group Criteria (how it was developed and what it contains), please see Annex 2: Care Group Criteria Lesson Plan, Handout Annex 2B: The Complete Care Group Criteria.*

You should also remove the information from Column C 'Why is this important?' in the handout provided to the participants, as the purpose of this exercise is to allow the participants to think and determine why these characteristics are important for the program. Participants should fill out Column C during their discussion with their table.

Activity 1: Characteristics for Your Care Group Program (2 hours)

Instructions:

- Give each participant Handout 4A Care Group Program Characteristics – *Blank*
- Assign each table 3-5 characteristics to review
- Tell each table that they need to fill in Column C: 'Why is this important?' for their assigned characteristics. At their tables (or in pairs, depending on what the facilitator decides) the participants should spend time discussing how their characteristic makes their CG program more effective and other reasons the characteristic might be important. They should note their response in Column C. Give each table/group 10 minutes per characteristic to complete this.
- Once everyone has completed their group work, discuss each characteristic one by one as a full group. Have each table/group report on their group's findings. As the facilitator, offer some ideas from the 'Facilitator Notes: CG Characteristics' if the group doesn't mention these ideas on their own.
- To wrap up the discussion, tell participants that all of these characteristics allow their program to fit the 'Care Group Criteria' which was developed between FH and World Relief staff in 2009 to

give practitioners a clear definition of what is a Care Group project and what is not. Participants can read more about these criteria in *Annex 2B: The Complete Care Group Criteria* of *Annex 2: Care Group Criteria Lesson Plan.*

- Finally, give each participant Handout 4B Care Group Program Characteristics – *Filled* so everyone has a full, completed table for reference.

Facilitator Notes: CG Characteristics

1. The Target Group should be pregnant women and mothers with children under two

? Why do you think this is important?

  - Targeting women and children under two is a ‘window of opportunity’ where pregnant women and young children are most vulnerable to death and disease and where health interventions can have the greatest impact.

2. At least 80% of all households in the community (with pregnant women and children under two) will be reached by Care Groups.

? Why is this important?

- In order to create a “new social norm” (not one person changing behavior, but many encouraging each other), we need to reach 80-100% of all households with pregnant mothers and children under two.
- People are more likely to change when others around them are hearing the same message and talking about making their own changes.
  - The World Relief Care Group manual says, *“Changed communities: In a participating community, there is at least one Care Group volunteer for every 10-15 households who is leading the way to better health practices. Behavior change becomes more than an individual decision — it becomes a social movement involving the entire community.”*
- Create a new social norm; everyone is hearing the message together. The community as a whole can make changes together.
- Community learning helps to increase change.

? Think about changes you have made in your life, is there anything that you changed in your own life because you felt some peer pressure from others – everyone else around you was doing it so you wanted to join in?

? You may ask, “How can we reach 80-100% of all households if Care Group Volunteers can only reach 10-15 houses”?

- We need to make sure that we have a sufficient number of CG Volunteers so that we can effectively reach 80-100% of households in our target group.
- Don’t overburden your CG Volunteers with too many households. Be sure your budget includes the right number of CG Volunteers to account for the size of your community.

3. Care Group volunteers (CG Volunteers) should visit no more than 15 households (neighbors that they visit).

? Why is this important?

- They are volunteers; they must be able to sustain the activities required by the program. If you ask too much of them, they will not stay in the program.
- The more burden you put on their shoulders, the larger the burden they will put on you for $$$ incentives.

<u>We want CG Volunteers to form strong bonds with those that they meet.</u>

Example

- How many digits are there in your (local) phone number? Why? Because it has been found that the human mind has a natural limit to remembering certain types of information.
- If phone numbers were 8 digits or 9 digits, we would have a much harder time remembering them.
- Seven is the general capacity of our brains to remember numbers.

Example 2

- Psychologist talk about a "sympathy group." This is the group that is made up of our friends and relatives – the ones that we feel closest too.
- Psychologists say that for ALL humans, if we were to list the names of people in their lives whose death would leave you truly devastated… chances are you would come up with about 12 names.
- These names make up the "sympathy group".
- To be someone's close friend requires a certain amount of time and emotional energy. At somewhere between 10 to 15 people we begin to overload. We can't take the emotional strain and energies needed to care for more than 15 people.

? What do you think of this idea? Does it sound true to you?

- In the same manner, we want our CG Volunteers to invest in the people that they meet and have time and energy to get involved in the lives of those she visits.
- Sixteen households (from the research) is too many. We suggest 10-15 households.
- If you exceed this number, then the quality of your CG Volunteer interactions greatly reduces. Don't do it. The limit is 15 households.
- And the more households you add, the greater the drop out and the greater the reduction of change.

4. The Care Group <u>(groups of CG Volunteers) should have no more than 16 members.</u>

? Why do you think this is important?

- The larger the group the less time there is to ask questions, to discuss and interact with participants.
- If there are 16 or less people, you can see each of them and talk with each of them in a group. Larger than 16 makes it much more difficult to encourage, discuss address the issues of others, or have good facilitation and participation.
- After 16, a few people begin dominating conversation, and others stop talking.

Group size and participation *Source: Jenny Rogers 1989*

3-6 people:	everyone speaks
7-10 people:	almost everyone speaks Quieter people say less One or two may not speak at all
11-18 people:	5 or 6 people speak a lot 3 or 4 others join in occasionally
19-30 people:	3 or 4 people dominate
30 + people:	little participation is possible

For example: In one of FH's HIV programs in Ethiopia, the local partner already had a group of 20 people meeting every week. So he began teaching some of the health messages to large group – 20 up to 50 people at a time.

- Do you think there was a lot of behavior change in these groups? (No. Why not?)
- Because they were too big that people weren't able to interact, ask questions, or relate to the facilitator.
- They couldn't "see changes" in the facilitator's own life (they were not his 10 closest neighbors).

5. Care Group volunteers (CG Volunteers) should be chosen by the mothers

? Why do you think this is important?

- People will choose someone that they respect – someone that they are willing to "listen to." If an outsider chooses someone – it is more likely that person will not be accepted by the community.
- The community will be somewhat reluctant to listen to their ideas. If it is "one of their own" they are already comfortable and ready to hear.
- Also, using a neighbor has been found through research to be more effective.

A recycling example *(explain recycling).*

- An experiment was designed to find out who could bring about the greatest change in recycling habits.
- Citizens who consistently recycled in their own home were approached and asked to be "recycling neighborhood (block) leaders." Those who agreed were asked to talk with 10 non-recycling neighbors and to give a message to them about recycling - also giving them special recycling bags.

- A second group (of non-recycling households) had bags and the communication left at their door. They did not receive a person message from a neighbor. However, the INFORMATION was left at their door.

Who recycled the most?

- The group with the block leader group. More than those with information and more than those who received nothing.

- We use this same philosophy with CG Volunteers, instructing a CG Volunteer and giving her the tools to give persuasive messages to her neighbors.
- The important thing to remember here is that the CG Volunteers have to believe what they are promoting. This is the biggest difference between the Block Leader approach and the Care Group Approach.

? Will the chosen CG Volunteers already be practicing the behaviors that we want them to? (probably not).

? Whose responsibility is it to help CG Volunteers to change their own behavior? (the Promoter!)

- It is important for the promoters to really invest in sharing and encouraging the CG Volunteers to change.

"Peer to peer" promotion. Chosen women are "role models" (early adapters) of the behavior.

- If the CG Volunteers have made changes in their own lives (as witnessed by their neighbors), they will be much more effective than those who "don't practice what they preach."

Story from Haiti –

- Abstinence promoter who told his Leader Youth that his sex life was "none of their business."
- He often wore one of our program t-shirts that said "Abstinence you can do it!"
- However, he was unwilling to be honest about his own behavior and struggles in being abstinent.
- Do you think this promoter was an effective teacher of Leader Youth? (Probably not).
- It is very important that we work first to in the lives of our leaders and once they are convinced, their "believability" in the community will greatly increase.
- It will take time; it won't happen overnight.

- We will not force CG Volunteers to commit to our practices, but it does help that each week they share the key messages with others.
- The more you talk about changing behavior the more likely YOU will change yourself. (more about this later)

6. All of a CG Volunteer's beneficiaries should live within a distance that facilitates frequent home visitation and all CG volunteers should live < 1 hour walk from the Promoters meeting place.
    - Make sure that this will work within their current structure.

- Again this makes sure we respect the time and workload of the volunteer.

7. Each promoter should supervise no more than 9 Care Groups

- For Promoters to know and have the trust of those with which they work, it is best to limit the number of volunteers with which they work to about 150, or nine groups (assuming a CG size of between 6 and 16 members). Some social science research confirms that our maximum "social channel capacity" – the maximum number of people with whom we can have a genuinely social relationship – is about 150 people (and 9 groups x 16 people/group = 144).

8 & 9. Promoters will supervise at least one CG Volunteer teaching her neighbors each month.

If they are volunteers why should we supervise them?

- Volunteers sharing inaccurate information can do more harm than good.
- We are responsible to our "donors" to make sure we meet our program goals.
- Promoters will supervise with a QIVC.

10. Care Group volunteers (CG Volunteers) will visit the neighbor households twice each month

? Why is it important for them to visit their neighbors TWICE each month?

- To build trust and "sympathy" (refer to the sympathy groups above).
- We believe that the better relationship that the CGV has with the beneficiary, the greater the behavior change.

? Can you think of an example from your own life where trusted relationships brought about greater influence than other relationships?

- (Perhaps when relationships between parents and children are strong, children are more likely to listen to their parents;
- When relationship between the pastor/priest and parishioners is strong, people are more likely to believe;
- When relationship between the local government is strong – people are more likely to support the person) etc.

- This allows CG Volunteer to follow up on previous lessons; allows for greater encouragement and monitoring of activities.
  - Two weeks ago you committed to wash your hands after using the latrine. Have you been able to do this every time you wash your hands?
- Allows for a good relationship over an extended period of time. The more often they meet and develop deep relationships the more sustainable the program. It becomes part of the fabric of the community.
- Builds strong relationships between LM and her neighbors
- Strong relationships increase behavior change as the LM walks them through stages of change.
- Makes meeting and discussing health a habit in the community.
- Helps to build community ownership of the groups after the program is over.

11. The Care Group meeting (when promoters come to teach the CG Volunteers) should last no more than two hours.

? Why is this important?

- Shorter meetings improve attendance.
- Long meetings discourage volunteers.
- We need to respect the other responsibilities of the CG Volunteers – they are volunteers and we must not take too much of their time away.

12. Care Group volunteers (CG Volunteers) use visual aids (flipcharts) to promote health and nutrition at each household.

? Why is this important?

- Flipcharts are a guide to make sure that consistent messages are being shared.
- The pictures serve as reminders. The words help the literate to remember the key messages for each picture.
- The visual images attract others and make them curious. It not only aids the CG Volunteers in teaching, but it also encourages the beneficiaries to listen, learn and watch.

13. Care Group volunteers (CG Volunteers) use participatory methods of teaching (non-formal education) when doing health promoter at each household.

? What is non – formal?

- It means we are not in a school setting or a university. It is not formal training.

? What is participatory learning?

- It is not – giving information only. It is a two way dialogue between the facilitator and the participants. It includes seeing, hearing and doing.
- Helping participants INTERACT with the learning by discussion, drawing, writing, acting or verbally responding is a better teaching method than just telling people what to do. It is more effective than being told information.
- The 20.40.80 rule states that participants remember 20 percent of what they hear, 40% of what they hear and see, and 80% of what they hear see and do.

? What can we do to encourage participants to remember 100%?

Even a well trained staff person will not remember 100% of what they learn at this training or any other educational event. Our hope is that they take small steps – one at a time to reduce malnutrition.

Each practice will reduce risk – we cannot ensure CG Volunteers will recall 100% - we are happy if they recall 80% and do as many of these practices as they can.

14. Care Group volunteers (CG Volunteers) will collect information on pregnancies, births and deaths at each household.

? Why is this important?

- Will help the CG Volunteers to become more "attuned" to epidemics and health behavior in your community as well as how their work affects others.
- CG Volunteers report the information to the promoters; this can be used to help alert local health clinics and communities of areas that need more assistance or interventions.
    - (Care Group Manual says) *In addition, the MOH can rely on Care Groups to help with their community mobilization efforts. For example, MOH staff call on volunteers to rally households in a village for immunization campaigns or weighing sessions. After the MOH communicates to the Care Group leaders, all volunteers spread the news to their assigned households, generating a greater turnout for the event.*
- Working together, the Care Group (with the promoters support) identifies what the volunteer can do to respond to a situation.

- (optional) CG Volunteers may also conduct a verbal autopsy (discussing circumstances around the event and signs of illness) if a child or woman dies. This helps CG Volunteers to determine the probable cause of death.
- <u>The Care Group needs to be designed so that CG Volunteers are trained by the promoter's example to problem solve and understand the health statistics that they gather in the community.</u>
- This way when the program is over, the CG Volunteer know exactly how to interpret the information that they receive on their own.

CG Volunteers

- During a home visit/group meeting, ask about family members' health.
- Take note of births, deaths or pregnancies of beneficiaries.
- Ask about circumstances surrounding the event, such as symptoms, family's response, etc.
- At one Care Group meeting a month, verbally report vital events.
- Illiterate volunteers can easily recall all vital statistics because these events are generally infrequent among their 10 to 15 assigned households.
- A literate volunteer (often the Care Group leader/promoter) records the information.
- The Care Group leader turns in the form to the promoter.

Promoters:

- Immediately discuss the household vital statistics with volunteers as they report the information.
- Ask the reporting volunteer to give a possible reason for the event.
- Invite the other volunteers to share their understanding of the event.
- Discuss with volunteers, learning from their insight and correct any false information, if necessary.
- Help volunteers link health practices or environmental factors to effects on health and disease.
- Identify actions volunteers can take in the future, based on lessons learned from the discussion.

Example of Problem Solving:

- Reminding the CG Volunteer: "You remember that your neighbor had a lot of bleeding in her last pregnancy. We will have to watch her."
- Asking the Care Group: "We had two children die and another 22 are sick. What's happening here?"

- This reporting process is discussed in depth in Lessons 8 and 9 (Care Group Monitoring Information

System and introduction to Registers and Reports)

If Community Development Committee exist in the community:

- Often one or more Care Group leaders become members. She is able to provide updates on vital statistics and health information gathered by her Care Group.
- This data equips CDCs to make well-informed decisions regarding issues affecting community members' health.

15. Formative research could be used to help target your BCC activities

- Local Determinants of Malnutrition & Barrier analysis scheduled for 2012 may allow our program to focus on the specific barriers the community faces in changed the behaviors of interest. More systematic use of formative research on behaviors will lead to the best adoption rates. Formative research also helps assure that the behaviors promoted by project staff are more feasible by community members.

Handout 4A: Care Group Program Characteristics- Blank

Note to the facilitator: in preparation for this exercise, replace the information in Column B with the actual design of your program. The text currently in Column B is the criteria for Care Group programs. Therefore, in order for your program to be a 'true' Care Group program, the design of your program must fit within the parameters of the text currently in Column B. If you want to learn more about the Care Group Criteria (how it was developed and what it contains), please see Handout Annex 2B: The Complete Care Group Criteria of Annex 2: Care Group Criteria Lesson Plan.

You should also remove the information from Column C 'Why is this important?' in the handout provided to the participants, as the purpose of this exercise is to allow the participants to think and determine why these characteristics are important for the program. Participants should fill out Column C during their discussion with their table.

A. Characteristic		*B. Program Name*	*C. Why is this important?*	*D. Care Group Criteria #?*
1. Essential Information				
1	Target Group?	*Pregnant women and mothers with children under two*	Targeting women and children under two is a 'window of opportunity' where pregnant women and young children are most vulnerable to death and disease and where health interventions can have the greatest impact.	7
2	Coverage of target group?	*Plan for 100% HH coverage, attain at least 80% within target group*	In order to create a supportive social environment for behavior change, it is important that many mothers adopt the new practices being promoted. Behavior change is much more likely to happen when there is regular, direct contact with all mothers of young children (rather than reaching only a small proportion of mothers), and probably more likely when there is contact with all households in a community (but this approach will probably be more costly).	5
3	How many members of a Neighbor Group (i.e. groups of Neighbor Women)	*Ideally 10-12, but no more than 15*	We want to ensure this number is low (maximum of 15, 10-12 is better) to assure volunteer is not overworked.	2

A. Characteristic		B. Program Name	C. Why is this important?	D. Care Group Criteria #?
4	How many members of a Care Group (i.e. groups of Care Group Volunteers)?	*No more than 16*	As with focus group discussions, with fewer than six members, dialogue is often not as rich and with more than 16, there may not enough time for everyone to fully contribute and participate.	3
5	How a CG Volunteers chosen?	*CG Volunteers are selected by Neighbor women*	People will choose someone that they respect – someone that they are willing to "listen to." If an outsider chooses someone – it is more likely that person will not be accepted by the community. The community will be somewhat reluctant to listen to their ideas. If it is "one of their own" they are already comfortable and ready to hear.	1
6	Distance between CG Volunteer and her Neighbor women	*No more than 45 minutes (walking)*	It is preferable that the CG volunteer not have to walk more than 45 minutes to get to the furthest house that she visits so that regular visitation is not hindered. (In many CG projects, the average travel time is much less than this.) This also makes it more likely that she will have a prior relationship with the people that she is serving	12
2. Supervision				
7	How many Care Groups does a Promoter supervise?	*No more than 9*	For Promoters to know and have the trust of those with which they work, it is best to limit the number of volunteers with which they work to about 150, or nine groups (assuming a CG size of between 6 and 16 members). Some social science research confirms that our maximum "social channel capacity" – the maximum number of people with whom we can have a genuinely social relationship – is about 150 people (and 9 groups x 16 people/group = 144).	(Suggested #2)
8	Supervision of CG Volunteers	*Each month, the Promoter should supervise at least one CG Volunteer from each of her Care Groups*	This should be done through direct observation of skills following the CG meeting	11

A. Characteristic		B. Program Name	C. Why is this important?	D. Care Group Criteria #?
9	Supervision of Promoters	*Supervisor should supervise all of their Promoters at least once a month plus one surprise visit*	For Promoters to be effective, regular, supportive supervision and feedback is necessary on a regular basis (monthly or more).	11
3. Training				
10	How often does the CG Volunteer contact and teach her assigned neighbor women?	*Recommended 2x/month, but at least monthly*	In order to establish trust and regular rapport, the CG Volunteer should have at least monthly contact with Neighbor Women. Overall contact time between the CG Volunteer and the Neighbor Woman (and other family members) correlates with behavior change.	4
11	Instructional time when Promoters teach Care Group Volunteers	*No more than two hours per meeting*	CG members are volunteers, and as such, their time needs to be respected. We have found that limiting the CG meeting time to 1-2 hours helps improve attendance and limits their requests for financial compensation for their time. (This instruction should include interactive and participatory methods.)	10
4. Care Group Curriculum				
12	Educ. Materials used by CG Volunteers to communicate health messages	*Pictorial flipcharts*	Providing visual teaching tools to Volunteers helps guide health promotion, gives them more credibility in the households and communities, and helps to keep them “on message” during health promotion. The visual nature of the teaching tool also helps mothers to receive messages by both hearing it and seeing it.	8
13	Education Methods (for Care Group & Neighbor Group Meetings)	*Participatory*	Principles of adult education should be used since they have been proven to be more effective than lecture and more formal methods when teaching adults	9

5. Monitoring & Evaluation & Formative Research				
14	What information do the Care Group Volunteers program collect?	*Registration, attendance, and vital events*	Regular collection of vital events data helps CG volunteers to discover pregnancies and births in a timely way, and to be attentive to deaths happening in their community (and the causes of those deaths) A low attendance rate (<70%) at Care Group meetings is often an indication that something is wrong somewhere, either with the teaching methodology or the promoter attitude, and helps the organization to identify problems early in the project.	6 & 12
15	Formative research	*Suggested: Local Determinants of Malnutrition & Barrier analysis scheduled for 2012*	These formative research tools will allow our program to focus on the specific barriers the community faces in changed the behaviors of interest. More systematic use of formative research on behaviors will lead to the best adoption rates. Formative research also helps assure that the behaviors promoted by project staff are more feasible by community members.	Suggested #1

A Blank Care Group Characteristic Table ready to be distributed for the training might look like this…

	A. Characteristic	***B. Program Name***	***C. Why is this important?***	***D. Care Group Criteria #?***
1. Essential Information				
1	Target Group?	Pregnant women and mothers with children under two		7
2	Coverage of target group?	90% coverage – about 10% of HH are too distant to be reached.		5
3	How many members of a Neighbor Group (i.e. groups of Neighbor Women)	12		2
4	How many members of a Care Group (i.e. groups of Care Group Volunteers)?	12		3
5	How a CG Volunteers chosen?	CG Volunteers are selected by Neighbor women		1
6	Distance between CG Volunteer and her Neighbor women	15-45 minutes		12
2. Supervision				
7	How many Care Groups does a Promoter supervise?	6		(Suggested #2)

A. Characteristic		B. Program Name	C. Why is this important?	D. Care Group Criteria #?
8	Supervision of CG Volunteers	Every CGV should be supervised at least 2X year.		11
9	Supervision of Promoters	1 planned supervision visit per month and 1 surprise visit		11
3. Training				
10	How often does the CG Volunteer contact and teach her assigned neighbor women?	2X a month		4
11	Instructional time when Promoters teach Care Group Volunteers	1-2 hour meetings		10
4. Care Group Curriculum				
12	Educ. Materials used by CG Volunteers to communicate health messages	Pictorial flipcharts		8
13	Education Methods (for Care Group & Neighbor Group Meetings)	Participatory, Games, Songs, Theater		9

5. Monitoring & Evaluation & Formative Research				
14	What information do the Care Group Volunteers program collect?	Attendance Births Deaths of CGV, NW or children <2		6 & 12
15	Formative research	Barrier Analysis		Suggested #1

Handout 4B: Care Group Program Characteristics- Completed

A FILLED Care Group Characteristic Table (Handout 3.1.B) ready to be distributed for the training might look like this…

	A. Characteristic	***B. Program Name***	***C. Why is this important?***	***D. Care Group Criteria #?***
1. Essential Information				
1	Target Group?	Pregnant women and mothers with children under two	Targeting women and children under two is a 'window of opportunity' where pregnant women and young children are most vulnerable to death and disease and where health interventions can have the greatest impact.	7
2	Coverage of target group?	90% coverage – about 10% of HH are too distant to be reached.	In order to create a supportive social environment for behavior change, it is important that many mothers adopt the new practices being promoted. Behavior change is much more likely to happen when there is regular, direct contact with all mothers of young children (rather than reaching only a small proportion of mothers), and probably more likely when there is contact with all households in a community (but this approach will probably be more costly).	5
3	How many members of a Neighbor Group (i.e. groups of Neighbor Women)	12	We want to ensure this number is low (maximum of 15, 10-12 is better) to assure volunteer is not overworked.	2
4	How many members of a Care Group (i.e. groups of Care Group Volunteers)?	12	As with focus group discussions, with fewer than six members, dialogue is often not as rich and with more than 16, there may not enough time for everyone to fully contribute and participate.	3

A. Characteristic		B. Program Name	C. Why is this important?	D. Care Group Criteria #?
5	How a CG Volunteers chosen?	CG Volunteers are selected by Neighbor women	People will choose someone that they respect – someone that they are willing to "listen to." If an outsider chooses someone – it is more likely that person will not be accepted by the community. The community will be somewhat reluctant to listen to their ideas. If it is "one of their own" they are already comfortable and ready to hear.	1
6	Distance between CG Volunteer and her Neighbor women	15-45 minutes	It is preferable that the CG volunteer not have to walk more than 45 minutes to get to the furthest house that she visits so that regular visitation is not hindered. (In many CG projects, the average travel time is much less than this.) This also makes it more likely that she will have a prior relationship with the people that she is serving	12
2. Supervision				
7	How many Care Groups does a Promoter supervise?	6	For Promoters to know and have the trust of those with which they work, it is best to limit the number of volunteers with which they work to about 150, or nine groups (assuming a CG size of between 6 and 16 members). Some social science research confirms that our maximum "social channel capacity" – the maximum number of people with whom we can have a genuinely social relationship – is about 150 people (and 9 groups x 16 people/group = 144).	(Suggested #2)
8	Supervision of CG Volunteers	Every CGV should be supervised at least 2X year.	This should be done through direct observation of skills following the CG meeting	11
9	Supervision of Promoters	1 planned supervision visit per month and 1 surprise visit	For Promoters to be effective, regular, supportive supervision and feedback is necessary on a regular basis (monthly or more).	11
3. Training				

A. Characteristic		B. Program Name	C. Why is this important?	D. Care Group Criteria #?
10	How often does the CG Volunteer contact and teach her assigned neighbor women?	2X a month	In order to establish trust and regular rapport, the CG Volunteer should have at least monthly contact with Neighbor Women. Overall contact time between the CG Volunteer and the Neighbor Woman (and other family members) correlates with behavior change.	4
11	Instructional time when Promoters teach Care Group Volunteers	1-2 hour meetings	CG members are volunteers, and as such, their time needs to be respected. We have found that limiting the CG meeting time to 1-2 hours helps improve attendance and limits their requests for financial compensation for their time. (This instruction should include interactive and participatory methods.)	10
4. Care Group Curriculum				
12	Educ. Materials used by CG Volunteers to communicate health messages	Pictorial flipcharts	Providing visual teaching tools to Volunteers helps guide health promotion, gives them more credibility in the households and communities, and helps to keep them “on message” during health promotion. The visual nature of the teaching tool also helps mothers to receive messages by both hearing it and seeing it.	8
13	Education Methods (for Care Group & Neighbor Group Meetings)	Participatory, Games, Songs, Theater	Principles of adult education should be used since they have been proven to be more effective than lecture and more formal methods when teaching adults	9
5. Monitoring & Evaluation & Formative Research				
14	What information do the Care Group Volunteers program collect?	Attendance Births Deaths of CGV, NW or children <2	Regular collection of vital events data helps CG volunteers to discover pregnancies and births in a timely way, and to be attentive to deaths happening in their community (and the causes of those deaths) A low attendance rate (<70%) at Care Group meetings is often an indication that something is wrong somewhere, either with the teaching methodology or the promoter attitude, and helps the organization to identify problems early in the project.	6 & 12

A. Characteristic		B. Program Name	C. Why is this important?	D. Care Group Criteria #?
15	Formative research	Barrier Analysis	These formative research tools will allow our program to focus on the specific barriers the community faces in changed the behaviors of interest. More systematic use of formative research on behaviors will lead to the best adoption rates. Formative research also helps assure that the behaviors promoted by project staff are more feasible by community members.	Suggested #1

food for the hungry
Meeting physical and spiritual needs worldwide

Lesson 5: Organizing Communities into Care Groups

<table>
<tr><td colspan="2">Objectives:
1. Participants will be able to state the top priorities in forming Care Groups.
2. Participants will be able to organize the beneficiary population into Neighbor Groups and Care Groups through a census, community list or community gathering.</td></tr>
<tr><td>Summary: 2 hours
• Priorities when Organizing CGs (15 minutes)
• Three Approaches to Forming Care Groups (30 minutes)
• Activity 1: Creating a Community Map (45 minutes)
• Activity 2: Forming Care Groups Role Play (30 minutes)</td><td>Materials:
☐ Butcher/flipchart paper, markers, pens for participants
☐ Handout 5A: Creating a Community Map [Print one copy for every 4 participants]
☐ Handout 5B: Community Census [Print one copy for every 4 participants]</td></tr>
</table>

Priorities when Organizing Care Groups and Neighbor Groups (15 minutes)

Now we're going to learn about how you form Care Groups. One of the most important things to keep in mind when forming Care Groups is to make sure that the CGVs and NW live close together.

? Why is this important? Why do we need CGVs and NW need to live close to each other?
It is preferable that the CG Volunteer does not have to walk more than 45 minutes to get to the furthest house that she visits so that regular visitation is not hindered. (In many CG projects, the average travel time is much less than this.) This also makes it more likely that she will have a prior relationship with the people that she is serving this will help to foster behavior change. It is also important that CGVs not have to walk over 1 hour to get to the Care Group Meeting. Whatever way you decide to form CG's, it is a high priority to ensure that the method you use groups women by geographic proximity.

? If after attempting to form CGs, you find that women are walking more than one hour to attend CG meetings. What should you do?
If women are walking more than 1 hour to attend CG meetings, the problem should be brought to project management. They can review the coverage strategy and adjust it to allow for smaller CG's.

Another important factor in forming Care Groups is to make sure that all (or nearly all) of our target beneficiaries (PLW) are in Care Groups.

? Why is this important? Why do we need to ensure that nearly all of our target beneficiaries are a part of a Care Group?
In order to create a supportive social environment for behavior change, it is important that many mothers adopt the new practices being promoted. Behavior change is much more likely to happen when there is regular, direct contact with all mothers of young children (rather than reaching only a small proportion of mothers), and probably more likely when there is contact with all households in a community (but this approach will probably be more costly).

Have the participants turn to their neighbor (in groups of two) and brainstorm for two minutes:

? What would you do in the community to organize Care Groups and Neighbor Groups with members that live close to each other and that include all the beneficiaries are in a CG or Neighbor Group?

Come back to the larger group and discuss the techniques/methods mentioned in their small groups.

Three approaches to forming Care Groups (30 minutes)

To decide which approach is best for your program there are some key questions to consider. Write the questions down on flipchart paper and have a participant fill in the answers as you discuss them.

1. Can you, or do you have staff on the ground, that can identify all the PLW in the project area?
2. When was the last census conducted in the project area?
3. Is there a list of every household in the project area?
4. Is there another active program(s) in the project area that works with PLW?
5. If a community leader called all the PLW to meet on a specific day and time, how many would be willing and able to show up?

Based on our experience from other countries, we'd like to suggest three different approaches: 1) Census, 2) Community list, and 3) Community gathering.

A **census** requires a lot of work, but is necessary to form Care Groups in areas where you and other members of the community don't know who the PLW are in your community. This may be the case in many of the communities you'll work in.

If there are already active programs in your geographic areas that work with PLWs, they might have a recent census or list you could use. In some communities, community or block leaders are well organized and already maintain a list of residents or can recall by memory where all the PLW live. We call this second option **community lists.**

If community participation <u>and</u> communication is high, community leaders could call ALL women who are pregnant or have children less than 24 months of age to a central meeting place on a particular day for a **community gathering**.

<u>OPTION 1: CENSUS</u>

1. The first step is to select your census takers and provide assistant census takers with the materials they need to take a census and create maps. (In this case, the facilitator will select the all the participants as the census takers and hand out materials).
2. Make a map of the entire community, with the neighborhoods subdivided into sections of (50 to 100 houses).
3. After the map is created, we then need to add details and identify houses, neighborhood boundaries, community boundaries, roads, landmarks of interest (rivers), and buildings of interest (schools, churches, clinics, etc.).
4. Then, identify the households that have a pregnant woman or child less than two years of age.
5. There are two methods for creating a community map:
    a. Maps can be created by walking through the community and visiting houses,
    b. OR by meeting with a group of people who know neighborhoods well can create a map of their neighborhoods.
6. Give each house where PLW live a number.
7. Write the mother's name and household information on a community census list, making sure that the number of her house on the map is the same as her number on the census list. *See the example below: Leena Samuel's house is marked #1 on the map and #1 on the Community Census list.*

Number	Mother's Name	Pregnant (Yes/No)	HH has a child U2? (Yes/No)	Community Area	Temporary Group #	Elected Mother Leader
1	Leena Samuel	Yes	No	Kivo	1	
2	Niragira Regine	No	Yes	Kivo	1	
3	Nicole Nduwayo	No	Yes	Kivo	1	
4	Nzoyisenga Claudine	Yes	No	Kivo	2	
5	Alice Nzomukunda	No	Yes	Kivo	2	✓A

8. When the number of women you wish to form into a Neighbor Group have been identified based on their geographic proximity, gather them together. Review the profile and job description of a Mother Leader and ask the women to elect a Mother Leader from among them.
9. Mark the woman elected as the Mother Leader by placing a "check" in the column

titled "Elected Mother Leader" and assign her a letter. *You'll learn more about how we give codes, and therefore track, all of these volunteers and health workers later today.*

10. *If you wish to form a Neighbor Group with ten PLW (for example), then you should organize the women into groups of 11. One will be elected as the CGV and ten will remain as Neighbor Women.*

OPTION 2: FORMING CARE GROUPS BASED ON LISTS

1. If community leaders do not feel it's necessary to use a map to group women into NW Groups because they know or have accurate lists of all women eligible for participation they can simply use those lists.
2. It is important to verify the existence of all women listed by community leaders.
3. It is more difficult to tell how close the CGVs and NW are to each other using this method.

OPTION 3: COMMUNITY GATHERINGS TO CREATE CARE GROUPS

1. If community participation and communication is high, community leaders can call ALL women who are pregnant or have children less than 24 months of age to a central meeting place on a particular day.
2. If a woman is ill or cannot attend they could appoint someone to represent them (taking their prenatal visit card or child's health card with them).
3. Women could be asked to group themselves first into neighborhoods and then into smaller groups.

Activity 1: Creating a Community Map (45 minutes)

1. Split the participants into groups of four. Assign two participates as Community Leaders (CL) and two as census takers.
2. Sub-Divide the community
    a. Pass out the blank outline of a Community (Handout 5A: Creating a Community Map, page 1) to the census takers and the sub-divided map to the CLs (page 2). The CLs should NOT let the census takers see their sub-divided map.
    b. The census takers should interview the CLs and find out if there are naturally existing neighborhoods within this area and if there are where they are located.
    c. CLs should describe where the boundaries are to the best of their ability, using words, hand motions or by drawing in the dirt.
    d. After the boundaries are drawn, the CLs should identify major landmarks such as rivers, churches, schools, swamps, etc.
3. Once the community is divided into small sub-sections or neighborhoods, the census workers will create a more specific map of one area that includes individual households. (For time, we have made this map for you.)
4. Distribute the detailed map (page 3) to the census workers and the detailed map with PLW and U2 HHs circled (page 4).

5. Using the detailed map, the census workers should interview the CLs to identify those households with a PLW or U2 child. Mark the map to help you remember which houses the CLs identified.

   For the next steps all members of the groups will be project staff/census takers.

6. Using the census takers' map (with a PLW or U2 child marked), go through and assign a HH number to every house with a PLW or U2 child.
7. Group the households with PLW and/or a U2 child into groups of 11, and draw a circle around them.
8. Pretend you have conducted an election and assign one woman from each group of 11 to be the CGV. The remaining ten households become one Neighbor Group.
9. If you have eight Neighbor Groups on your map, draw a big circle around all eight Neighbor Groups to indicate that their CGV's have been organized into Care Group.

   Now that we have mapped the community and gathered women into Neighbor Groups and Care Groups we need to record this information on the Community Census form.

10. Pass out Handout 5B: Community Census and have the groups fill out the census for one group of 10 HHs (Neighbor Group) plus the one CGV.
11. Fill in the household number (HH #) that corresponds the houses in your Neighbor Group.
12. Complete the columns that include mother's name, pregnancy status, if there is a child U2, and the community area where the mother lives. Use your imagination to fill this in ☺
13. For the household where the elected CGV lives, assign a letter between A-F and place that letter next to the corresponding house on the map.
14. Then, give your Neighbor Group (including the CGV who is leading them) a temporary number (1-11).

Activity 2: Forming Care Groups Role Play (20 minutes)

1. Request two participants to come to the front of the room
2. Read the scenario prompts below and have the participants respond (allow the two a few minutes to discuss).
3. Request feedback from the remaining participants.

? Would they have done something different?

Scenario 1: You are a CG Promoter and you were just hired by FH 3 weeks ago. You've attended your Care Group Training, and are now ready to form Care Groups. You know you will be responsible to oversee 8 CG Groups, so 96 CG Volunteers in total. This means you'll have around 960 PLW in your area!

You know for certain that one of your villages, known as Hollywood, has no community health programs. In fact, there are no programs operating in the community at all.

- ? How will you organize the community into Care Groups?
- ? Will you conduct a census, look for community lists or hold a community gathering? Why?
- ? Who will you ask to assist you to take a census?

Scenario 2:
You are also a CG Promoter and you were just hired by FH 3 weeks ago. You've attended your Care Group Training, and are now ready to form Care Groups. You know you will be responsible to oversee 8 CG Groups, so 96 CG Volunteers in total. This means you'll have around 960 PLW in your area!

You've worked in many of your assigned villages before. In fact, you grew up here. Last year, the government conducted a census in this area. You remember since your cousin actually helped count people.

- ? How will you organize the community into Care Groups?
- ? Will you conduct a census, look for community lists or hold a community gathering? Why?
- ? How will you ensure the lists are accurate? (Could you sample a small area to confirm?)

Scenario 3:

You are also a CG Promoter and you were just hired by FH 3 weeks ago. You've attended your Care Group Training, and are now ready to form Care Groups. You know you will be responsible to oversee 8 CG Groups, so 96 CG Volunteers in total. This means you'll have around 960 PLW in your area!

You're excited about this job because it allows you to work in your home community where you grew up. In several of your villages, you know that an NGO called Heal the World is working on breastfeeding and complementary feeding. However in recent years, their trainings have been infrequent and they don't seem to have a big presence in your community.

- ? How will you organize the community into Care Groups?
- ? Will you conduct a census, look for community lists or hold a community gathering? Why?
- ? Which houses on your map will receive a number?

Scenario 4: In one of the four localities where you will be working, you work with community leaders to take a census. After the census is done you find you have 265

mothers that meet the requirements for program registration (PLW). You wish to form Neighbor Groups with nine NW plus one woman who will be elected to be the CGV.

- **?** Around how many NG groups do you hope to have?
  [265/10= 26.5, so between 26 and 27] If participants have trouble with this example, make up more problems and have them do the math.

Other questions for the group:

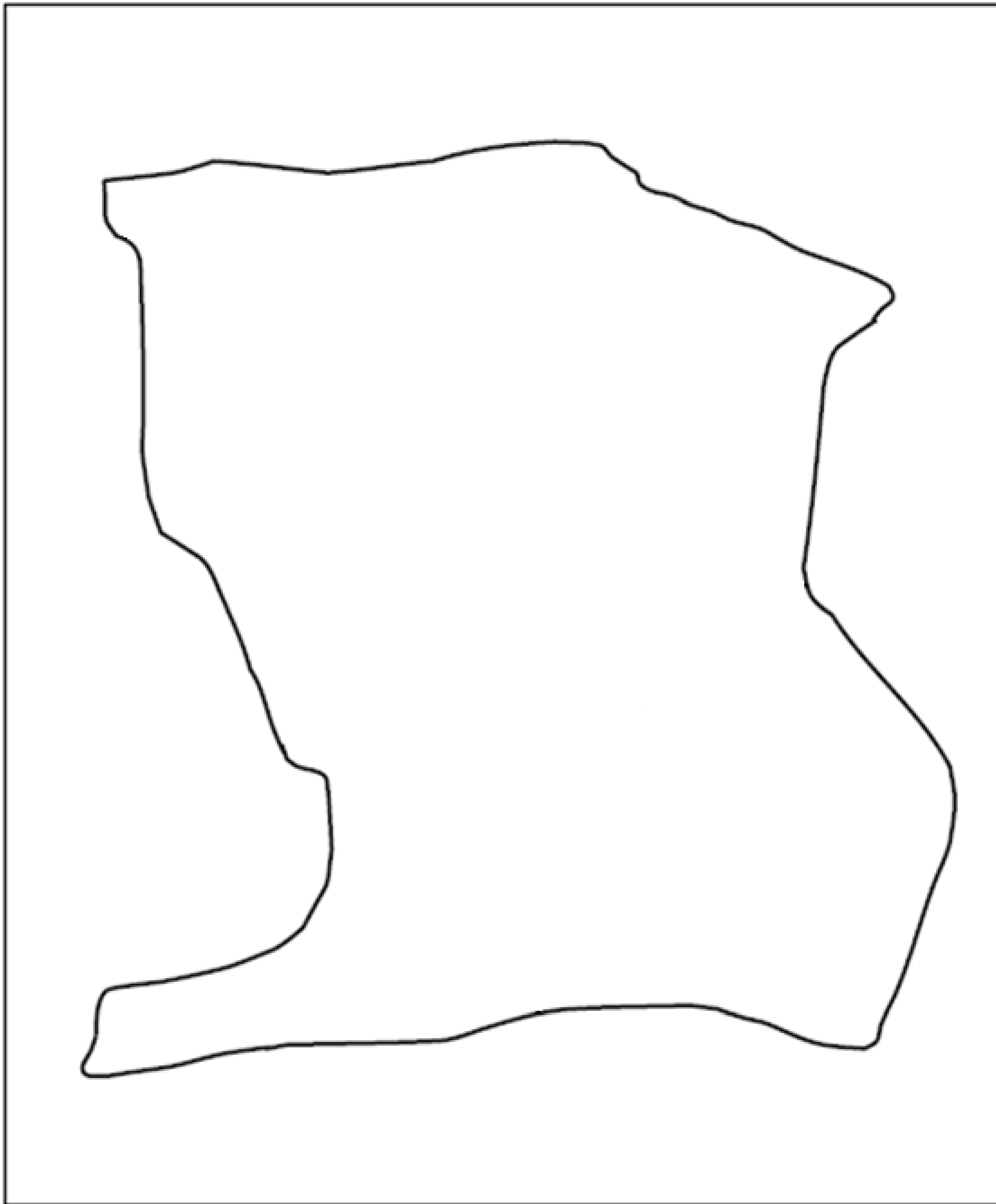
- **?** What if a locality doesn't have enough women eligible to participate in the CG program to form NG with at least 8-13 women?
  If there are not enough women to form a Neighbor Group and elect a CGV then the CG Promoter should report this problem to his/her Supervisor. It could be that another CG Promoter has too many eligible women in his or her area (requiring that he form groups larger than the targeted number). In that case, the CG Promoter coverage may need to be adjusted.

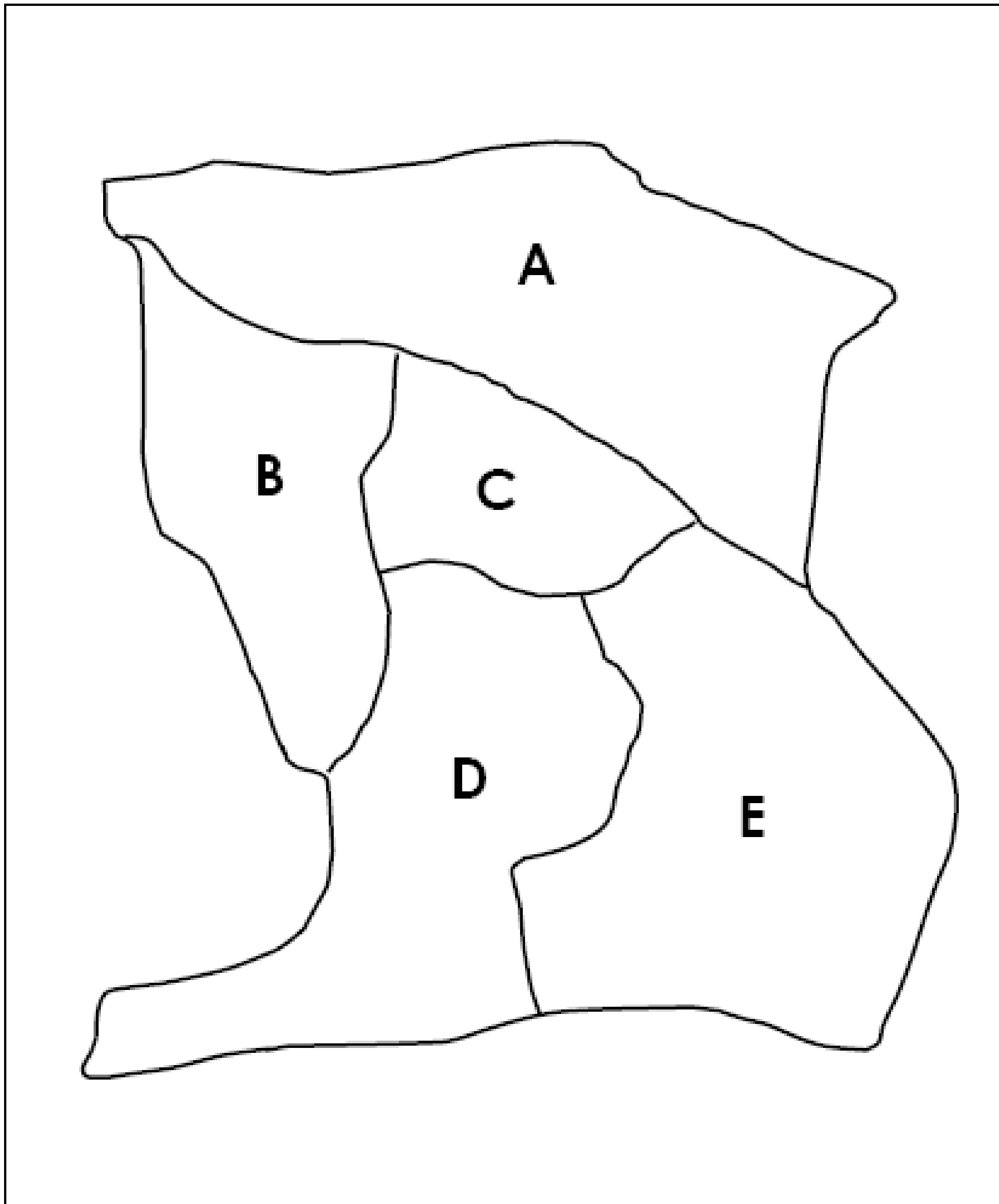
- **?** What if after forming women into groups of 10 there are 5 women left? Should these women make their own CG? Be added to another CG?
  Five women are too few to make up one CG. If there is a nearby CG it would be best to split them up to different CGs since 15 is too many.

Note below participants decisions on how they would like to form Care Groups:

food for the hungry
Meeting physical and spiritual needs worldwide

Handout 5A: Creating a Community Map




A
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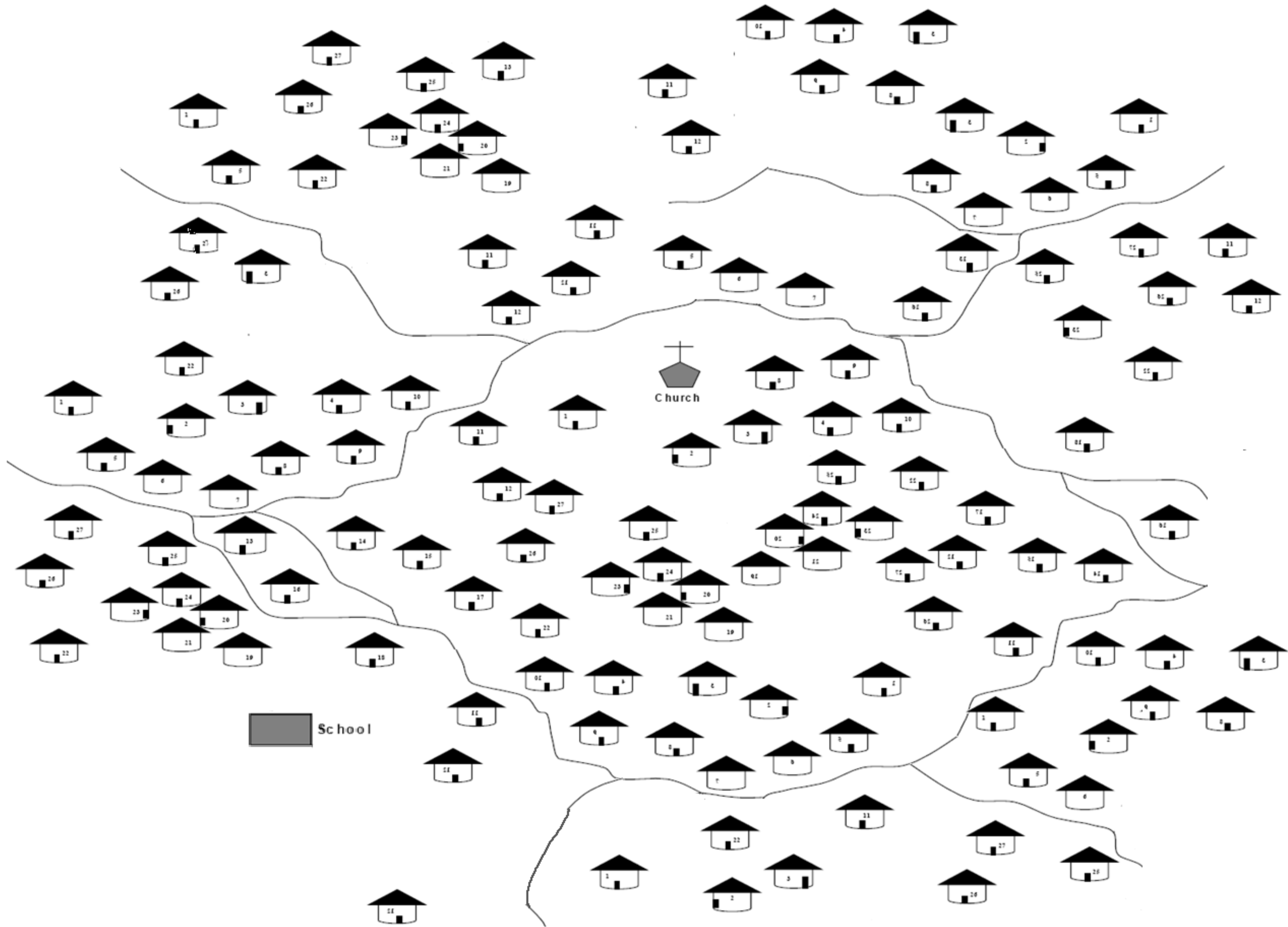
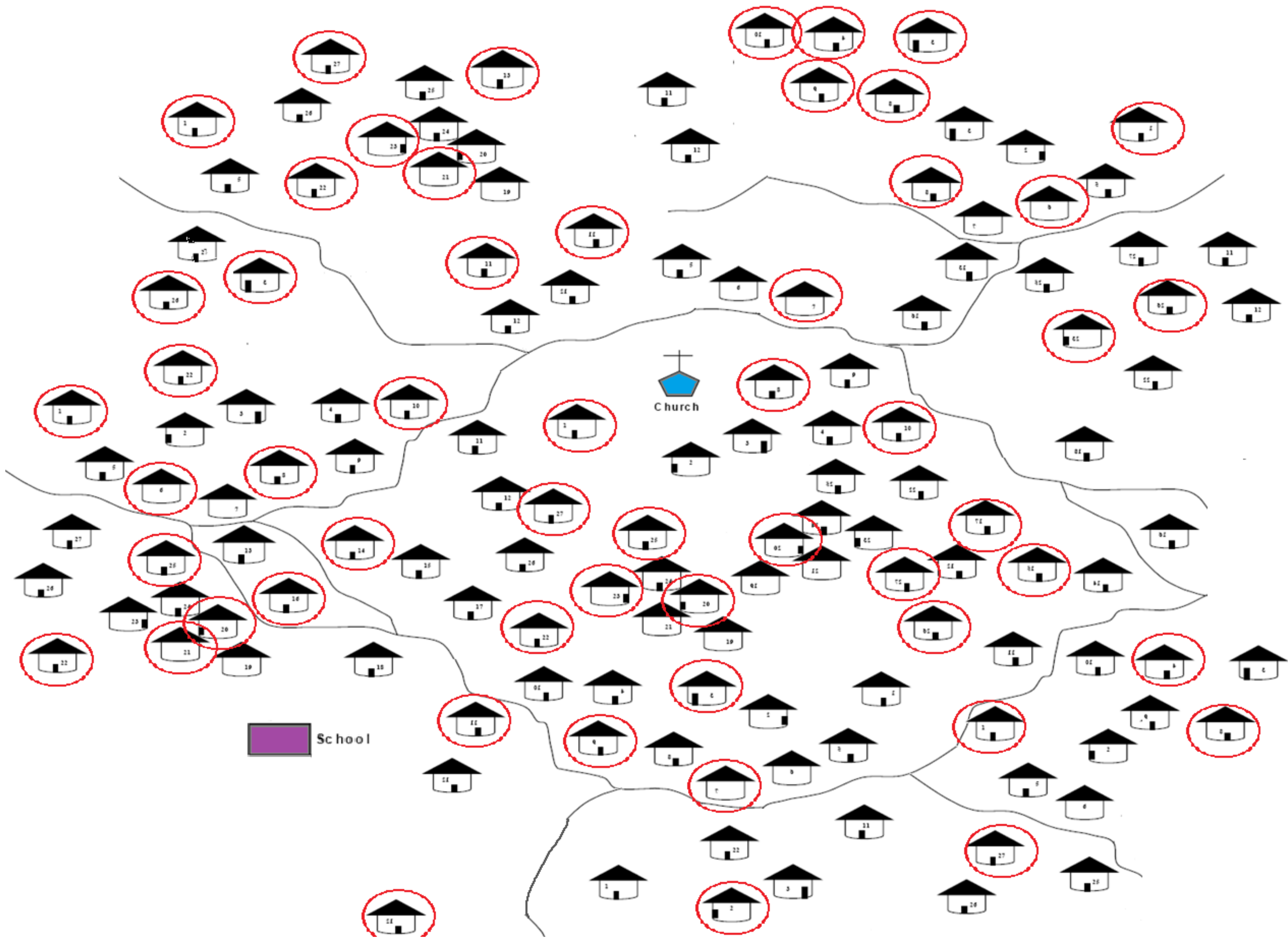
E


Church
School


Church
School

Handout 5B: Community Census

HH#	Mother's Name	Pregnant (Y/N)	HH has a child U2? (Y/N)	Community Area	Temporary CG #	Elected CGV
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						

fh food for the hungry
Meeting physical and spiritual needs worldwide

Lesson 6: Job Descriptions, the Role of CG Volunteers, CG Promoters, MCHN Supervisors and MCHN Coordinators

<table>
<tr><td colspan="2">Objectives:
pants will be able to differentiate between the essential responsibilities for CG Volunteers, CG
oters, MCHN Supervisors, and MCHN Coordinators.
pants will be able to the list essential characteristics of CG Volunteers for this project.</td></tr>
<tr><td>Summary: 1 hour, 45 minutes
• The Responsibilities of the Care Group Team (30 min)
• Activity 1: CG Team Responsibilities (45 min)
• Activity 2: Characteristics of CG Volunteers (15 min)
• Activity 3: Creating a Final List of CG Volunteer Characteristics (15 min)</td><td>Materials:
☐ Scissors, markers, tape and butcher/flipchart paper.
☐ Handout 3A: Care Group diagram [Already printed in CG Intro Lesson]
☐ Handout 6A: Care Group Team Essential Responsibilities Jumble (cut into strips) [Print one set for each group of 3-4 people]
☐ Handout 6B: Care Group Team Essential Responsibilities [Print one for each participant]
☐ Handout 6C: Characteristics of Care Group Volunteers (cut into strips) [Print one set for each group of 3-4 people]</td></tr>
</table>

Note: Trainers may choose to adapt Essential Responsibilities for each position to be specific to their Care Group Program design. For example the CG Volunteer Essential Responsibilities below indicates CG Volunteers visit should do one home visit each month and lead on group teaching session each month. If your program has decided all CG Volunteer behavior change promotion will occur via home visits, then you would change the Essential Responsibilities to reflect this.

The Responsibilities of the Care Group Team (30 minutes)

Using Handout 3A: Care Group Diagram, ask participants:

? What do you think are the major activities the CG Volunteer will do?
Lead a discussion focusing on the CG Volunteer essential responsibilities listed below. Ask questions to help participants think through what responsibilities might be. If they do not come up with the responsibilities listed below, mention those they have not.

CG Volunteer Essential Responsibilities

1. Visit 10 Neighbor Women and their families at least once a month to promote behavior change using an educational flip-chart.
2. Meet once a month with a group of 10 Neighbor Women to share behavior change messages using an education flip-chart.

3. Report to the CG Promoter on a bi-weekly basis the number of Neighbor Women they have visited or who attended the behavior change meeting.
4. Monitor and report significant events such as births, deaths, and severe illness that have occurred within the community.
5. Mobilize Neighbor Women to participate in community activities that will benefit their families such as Immunization Campaigns, food distribution, and/or latrine construction.
6. Attend Care Group meetings (the bi-weekly trainings) provided by the CG Promoter.
7. Report problems that cannot be solved at the household level to the local leadership and request support and collaboration from the CG Promoter.
8. Model the health, nutrition, and sanitation behaviors they are teaching Neighbor Women.

? What do you think are the major activities the CG Promoter will do?
Lead a discussion focusing on the CG Promoter essential responsibilities listed below.

CG Promoter Essential Responsibilities

1. Coordinate activities at the local level and maintain cooperation with other institutions at community level such as the village council, churches and schools.
2. Meet with the local leadership committee in each community bi-weekly for coordination, monitoring and evaluation (if these committees exist).
3. Facilitate organized, participatory learning sessions with each of their Care Groups (made up of 10-12 CG Volunteers) every two weeks, following the lesson plans in the educational materials provided.
4. Attend Bi-Weekly Training and Reporting Meetings provided by the MCHN Supervisor and the Module Training Sessions to accurately replicate trainings received with CG Volunteers, sharing correct information and demonstrating skills learned.
5. Model the health, nutrition, and sanitation behaviors they are teaching to CG Volunteers in their own homes, located in the community.
6. Visit, monitor, and evaluate each CG Volunteer at least quarterly. Supervise the work of CG Volunteers by accompanying them on home visits to Neighbor Women and observing them providing group instruction.
7. Assist with other program activities such as: National Vaccination Days, distribution of Vitamin A and deworming medicine, weighing of children <5years of age, etc.
8. Attend training and coordination meetings at the district office, providing verbal and written reports of activities completed.

? What do you think are the major activities the MCHN Supervisor will do?
Lead a discussion focusing on the MCHN Supervisor essential responsibilities listed below.

MCHN Supervisor Essential Responsibilities

1. Coordinates with project partners, project staff, the MOH, and other stakeholders regarding upcoming activities and needs at the community and provincial levels.
2. Responsible for the performance and professional development of the CG Promoters who report to him/her.

3. Review Flipchart Lesson Plans with CG Promoters every two weeks and assure they understand the information well and can teach back the information in a participatory manner.
4. Collect CG Promoter reports on a monthly basis, review the reports and assure the information presented is reasonable and complete.
5. Prepare a monthly report using the information provided by CG Promoters.
6. Maintain a filing system in the project office so copies of CG Promoter Reports, MCHN Supervisor Reports and QIVCs are easily accessible.
7. Responsible to supervise each CG Promoter who reports to him or her in the field at least twice a month, conducting QIVCs and completing all sections of the CG Promoter Supervision Checklist every quarter.
8. Responsible to liaison with the appropriate people in a timely and professional manner to ensure the financial, logistical and procurement issues required to implement project activities.

? What do you think are the major activities the MCHN Coordinator will do?
Lead a discussion focusing on the MCHN Coordinator essential responsibilities listed below.

MCHN Coordinator Essential Responsibilities

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

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

We are now going to do a short activity to reinforce each of these roles.

Activity 1: CG Team Responsibilities (45 minutes)

1. Using the Handout 6A: CG Team Essential Responsibilities Jumble, cut the paper into strips with one responsibility on each strip and mix them up. [Print a set for each group of 3-4 people attending the training.]

2. Divide the participants into groups of 3-4 people.
3. Hand out two flipchart pages to each group. Ask them to make two columns on each flipchart page and label each column with one of the four positions (MCHN Coordinator, MCHN Supervisor, CG Promoter, and CG Volunteer).
4. Hand out and one set of mixed up responsibilities to each group. Have each group read the responsibilities on the slips of paper and post them under the position they refer to.
5. Let groups know that the first group to finish first will receive an extra 5 points. Each correctly placed responsibility will receive 2 positive points. Each incorrectly placed responsibility will receive 1 negative point. The group that does the best will receive a prize.
6. After the groups have finished, distribute Handout 6B: CG Team Essential Responsibilities.
7. Each group will use this handout to grade another group's work. If one of the responsibilities is placed in the wrong column the team should mark negative 1 on that responsibility.
8. Give all the correct responsibilities 2 positive points.
9. Total up all positive and negative points, along the bonus points given to the team that finished first and give them a positive number score at the top of their flipchart.
10. Give a prize to the group that does the best and a smaller prize to the other groups.

❓ Ask if there are any questions regarding what each member of the Care Group team will be doing and respond to them.

Activity 2: Characteristics of CG Volunteers (15 minutes)

1. Using the Handout 6C: Characteristics of CG Volunteers, cut the paper into strips with one characteristic on each strip and mix them up. [Print a set for each group of 3-4 people attending the training.]
2. Divide participants into groups of 3-4 people.
3. Hand out one flipchart page to each group. Ask them to make three columns on the flipchart page and label each column with "Required", "Desired", and "Not Necessary".
4. Hand out and one set of mixed up characteristics to each group. Have each group read the characteristics on the slips of paper and decide if the trait is required, desired or not necessary and post them under the corresponding column.

Activity 3: Creating a Final List of CG Volunteer Characteristics (15 minutes)

1. When all the groups are finished (and their choices are taped down), ask one group to read off their required traits to the other groups. *Encourage discussion.*
2. Ask if any of the other groups had other traits listed, that were not mentioned.
3. Go through the "Desired" and "Not Required" columns in the same manner.
4. Ask one of the participants to write down the Final List of CG Volunteer Characteristics based on the work during this lesson.

For further discussion, ask participants:

❓ How do you think the community should choose CG Volunteers?
❓ How should the CG staff guide this process?

Tell the participants that they may decide they want to do this activity with the community leaders before CG Volunteers are selected.

Trainer Note:
Each program should develop their own list of CG Volunteer traits which they will use as their guide when recruiting CG Volunteers, orienting community leadership, and when discussing the project with stakeholders/ government officers.

There are a few traits that are essential and should be on every list of CG Volunteer traits. Other traits may be significant in one culture but not in another. It is important to review the Care Group Criteria and ensure that the traits chosen are consistent with the key CG principles.

Possible CG Volunteer traits with the essential traits starred:
1. To be willing to work as a volunteer*
2. Desire to serve their neighbors*
3. Female*
4. Positive Attitude*
5. Has been or once was a mother (this allows mother's whose children have died to serve as CGVs.)*
6. Having children <6 months or is pregnant
7. Models good hygiene, sanitation, and nutrition practices
8. Respected by the community *
9. Capable of leading a discussion with 8-12 women*
10. Expressing an interest in health issues
11. Is not addicted to alcohol
12. Children of the mother are more than 24 months or no longer live
13. Active member of a political party
14. Does not smoke
15. To be married or widow after legal marriage
16. Knowing to read and write (This **should not** be made an essential traits unless the majority of women in the community know how to read and write. We do not want to make the CGV position appear to be one you must "qualify for")
17. Religious and devoted (of any religion)
18. Has a bicycle
19. Has children in good health
20. At least 3 years of primary education
21. Her husband is a good (moral) man
22. Has a good social relationships with community (churches, pastors, regional chiefs) leaders
23. Has between 18 and 40 years of age
24. Has a good relationship with existing community health workers
25. Midwife or traditional healer

Care Group Criteria that apply to Care Group Volunteer traits:

REQUIRED: The model is based on peer-to-peer health promotion (mother-to-mother for MCH and nutrition behaviors.) CG Volunteers should be chosen by the mothers within the group of households that they will serve or by the leadership in the village.	Care Groups are not the same as Mothers Clubs where mothers are simply educated in a group. An essential element is having women serve as role models (early adopters) and to promote adoption of new practices by their neighbors. There is evidence that “block leaders” (like CG Volunteers) can be more effective in promoting adoption of behaviors among their neighbors than others who do not know them as well. CG Volunteers should be mothers of young children or other respected women from the community. CG Volunteers who are chosen by their neighbors (or by a consensus of the full complement of [formal and informal] community leaders) will be the most dedicated to their jobs, and we believe they will be more effective in their communication, trusted by the people they serve, and most willing to serve others with little compensation.
REQUIRED: All of a CG Volunteer’s beneficiaries (Neighbor Women) should live within a distance that facilitates frequent home visitation and all CG Volunteers should live < 1 hour walk from the CG Promoter meeting place.	It is preferable that the CG Volunteer not have to walk more than 45 minutes to get to the furthest house that she visits so that regular visitation is not hindered. (In many CG projects, the average travel time is much less than this.) This also makes it more likely that she will have a prior relationship with the people that she is serving. Before starting up CGs, the population density of an area should be assessed. A low CG Volunteer: Mother Beneficiaries (Neighbor Women) and low CG Promoter: CG ratio should be used when setting up CG in rural, low population density areas. If an area is so sparsely populated that a CG Volunteer needs to travel more than 45 minutes to meet with the majority of her beneficiary mothers then the Care Group strategy may not be the most appropriate one to use.
SUGGESTED: Social/educational differences between the Promoter and CG volunteer should not be too extreme (e.g., having bachelor-degree level staff working with CG Volunteers).	We believe that keeping the educational difference between the CG Promoter and CG Volunteers to a minimum is useful in that it makes it more likely that the Promoters will use language/concepts that the CG Volunteers can understand. It also helps to keep costs of the model low.

Below is a final characteristic list created by Burundian staff in a CG project:

Essential Traits	Desired Traits	Undesirable Traits
Models good hygiene, sanitation, and nutrition practices	Has a good relationship with existing community health workers	Children of the mother are more than 24 m or no longer live
Desire to serve their neighbors	To be married or widow after legal marriage	Active member of a political party
Having children <6 months or is pregnant	Religious and devoted (of any religion)	Midwife or traditional healer (all practice things contrary to health)
Positive Attitude	Knowing to read and write	
Female	Has a bicycle	
Respected by the community	Has children in good health	
To be willing to work as a volunteer	At least 3 years of primary education	
Is not addicted to alcohol	Does not smoke	
Expressing an interest in health issues	Has a good social relationships with community (churches, pastors, regional chiefs) leaders	
Capable of leading a discussion with 12 women	Has between 18 and 40 years of age	
	Her husband is a good (moral) man	

Handout 6A: Care Group Team Essential Responsibilities Jumble
[Print one set for each group of 3-4 people]

Visit 10 Neighbor Women and their families at least once a month to promote behavior change using an educational flip-chart.
Meet once a month with a group of 10 Neighbor Women to share behavior change messages using an education flip-chart.
Report to the CG Promoter on a bi-weekly basis the number of Neighbor Women they have visited or who attended the behavior change meeting.
Monitor and report significant events such as births, deaths, and severe illness that have occurred within the community.
Mobilize Neighbor Women to participate in community activities that will benefit their families such as Immunization Campaigns, food distribution, and/or latrine construction.

Attend Care Group meetings (the bi-weekly trainings) provided by the CG Promoter.
Report problems that cannot be solved at the household level to the local leadership and request support and collaboration from the CG Promoter.
Model the health, nutrition, and sanitation behaviors they are teaching Neighbor Women.
Coordinate activities at the local level and maintain cooperation with other institutions at community level such as the village council, churches and schools.
Meet with the local leadership committee in each community bi-weekly for coordination, monitoring and evaluation (if these committees exist).

Facilitate organized, participatory learning sessions with each of their 10-12 CG Volunteers (in Care Groups) groups every two weeks, following the lesson plans in the educational materials provided.
Attend Bi-Weekly Training and Reporting Meetings provided by the MCHN Supervisor and the Module Training Sessions to accurately replicate trainings received with CG Volunteers, sharing correct information and demonstrating skills learned.
Model the health, nutrition, and sanitation behaviors they are teaching to CG Volunteers in their own homes, located in the community.

Visit, monitor, and evaluate each CG Volunteer at least quarterly. Supervise the work of CG Volunteers by accompanying them on home visits to Neighbor Women and observing them providing group instruction.
Assist with other program activities such as: National Vaccination Days, distribution of Vitamin A and deworming medicine, weighing of children <5years of age, etc.
Attend training and coordination meetings at the district office, providing verbal and written reports of activities completed.
Coordinates with project partners, project staff, the MOH, and other stakeholders regarding upcoming activities and needs at the community and regional levels. Responsible for the performance and professional development of the CG Promoters who report to him/her.

Review Flipchart Lesson Plans with CG Promoters every two weeks and assure they understand the information well and can teach back the information in a participatory manner.
Collect CG Promoter reports on a monthly basis, review the reports and assure the information presented is reasonable and complete.
Prepare a monthly report using the information provided by CG Promoters.
Maintain a filing system in the project office so copies of CG Promoter Reports, MCHN Supervisor Reports and QIVCs are easily accessible.
Responsible to supervise each CG Promoter who reports to him or her in the field at least twice a month, conducting QIVCs and completing all sections of the CG Promoter Supervision Checklist every quarter.

Responsible to liaison with the appropriate people in a timely and professional manner to ensure the financial, logistical and procurement issues required to implement project activities.
Lead program planning and provide strategic direction to program managers.
Ensure internal and external reporting and documentation requirements are on-time and accurate.
Assess staff capacities and coordinate initial or ongoing trainings based on need and program goals.
Play a lead role in the recruitment, orientation and training of new technical program staff.
Models leadership to all staff and intentionally develops the leadership potential of the MCHN Supervisors.

Prepare a monthly report using the information provided by MCHN Supervisors.
Responsible to supervise each MCHN Supervisor who reports to him or her in the field at least once a month, conducting QIVCs and completing all sections of the MCHN Supervisor Supervision Checklist every quarter.
Ensure that the project is well represented in regular provincial/state/national level meetings and forums.

Handout 6B: Care Group Team Essential Responsibilities

<u>CG Volunteer Essential Responsibilities</u>

1. Visit 10 Neighbor Women and their families at least once a month to promote behavior change using an educational flip-chart.
2. Meet once a month with a group of 10 Neighbor Women to share behavior change messages using an education flip-chart.
3. Report to the CG Promoter on a bi-weekly basis the number of Neighbor Women they have visited or who attended the behavior change meeting.
4. Monitor and report significant events such as births, deaths, and severe illness that have occurred within the community.
5. Mobilize Neighbor Women to participate in community activities that will benefit their families such as Immunization Campaigns, food distribution, and/or latrine construction.
6. Attend Care Group meetings (the bi-weekly trainings) provided by the CG Promoter.
7. Report problems that cannot be solved at the household level to the local leadership and request support and collaboration from the CG Promoter.
8. Model the health, nutrition, and sanitation behaviors they are teaching Neighbor Women.

<u>CG Promoter Essential Responsibilities</u>

1. Coordinate activities at the local level and maintain cooperation with other institutions at community level such as the village council, churches and schools.
2. Meet with the local leadership committee in each community bi-weekly for coordination, monitoring and evaluation (if these committees exist).
3. Facilitate organized, participatory learning sessions with each of their 10-12 CG Volunteers (in Care Groups) groups every two weeks, following the lesson plans in the educational materials provided.
4. Attend Bi-Weekly Training and Reporting Meetings provided by the MCHN Supervisor and the Module Training Sessions to accurately replicate trainings received with CG Volunteers, sharing correct information and demonstrating skills learned.
5. Model the health, nutrition, and sanitation behaviors they are teaching to CG Volunteers in their own homes, located in the community.
6. Visit, monitor, and evaluate each CG Volunteer at least quarterly. Supervise the work of CG Volunteers by accompanying them on home visits to Neighbor Women and observing them providing group instruction.
7. Assist with other program activities such as: National Vaccination Days, distribution of Vitamin A and deworming medicine, weighing of children <5years of age, etc.
8. Attend training and coordination meetings at the district office, providing verbal and written reports of activities completed.

<u>MCHN Supervisor Essential Responsibilities</u>

1. Coordinates with project partners, project staff, the MOH, and other stakeholders regarding upcoming activities and needs at the community and regional levels.

2. Responsible for the performance and professional development of the CG Promoters who report to him/her.
3. Review Flipchart Lesson Plans with CG Promoters every two weeks and assure they understand the information well and can teach back the information in a participatory manner.
4. Collect CG Promoter reports on a monthly basis, review the reports and assure the information presented is reasonable and complete.
5. Prepare a monthly report using the information provided by CG Promoters.
6. Maintain a filing system in the project office so copies of CG Promoter Reports, MCHN Supervisor Reports and QIVCs are easily accessible.
7. Responsible to supervise each CG Promoter who reports to him or her in the field at least twice a month, conducting QIVCs and completing all sections of the CG Promoter Supervision Checklist every quarter.
8. Responsible to liaison with the appropriate people in a timely and professional manner to ensure the financial, logistical and procurement issues required to implement project activities.

MCHN Coordinator Essential Responsibilities

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

Handout 6C: Characteristics of Care Group Volunteers

[Print one set for each group of 3-4 people]

To be willing to work as a volunteer
Desire to serve their neighbors
Female
Positive Attitude
Having children <6 months or is pregnant
Models good hygiene, sanitation, and nutrition practices
Respected by the community
Capable of leading a discussion with 12 women
Expressing an interest in health issues

Is not addicted to alcohol
Children of the mother are more than 24 months or no longer live
Active member of a political party
Does not smoke
To be married or widow after legal marriage
Knowing to read and write
Religious and devoted (of any religion)
Has a bicycle
Has children in good health
At least 3 years of primary education
Her husband is a good (moral) man

Has a good social relationships with community (churches, pastors, regional chiefs) leaders
Has between 18 and 40 years of age
Has a good relationship with existing community health workers
Midwife or traditional healer

Lesson 7: Numbering Care Groups

<table>
<tr><td colspan="2">Objectives:
1. Participants will be able to interpret codes for the Care Group Numbering System.
2. Participants will be able to appropriately number Neighbor Women, CG Volunteers, CGs and Promoters for their Care Group Project.</td></tr>
<tr><td>Summary: 1 hour 30 minutes
• Introduction to Numbering (30 min)
• Activity 1: Check for Understanding (30 min)
• Activity 3: Act it Out! (30 min)</td><td>Materials:
☐ Handout 7A: Care Group Numbering System [Print one copy for each participant]
☐ Flip chart and markers
☐ Handout 7B: Participatory learning for numbering Care Groups! [Print one copy or handwrite on separate paper]</td></tr>
</table>

Introduction to Numbering (30 min)

Explain: FH created a simple system to develop codes for all of the Neighbor Women, Care Group Volunteers, CG Promoters and MNCH Supervisors. These codes are critical in the Care Group monitoring system, as it allows project staff to track the performance of individuals and specific groups in the program.

Ask participants to turn to the *Handout 7A: Care Group Numbering System.*

As you review each column, explain:

- Each digit has a specific meaning. These codes allow us to track each CG Promoter, CG Volunteer, and Neighbor Woman reached by our program.
- *The **first** digit is a <u>number</u> and stands for the CG Promoter Number.*
    - Each CG Promoter has his/her own number.
    - If a program employed 37 promoters, the 1st digit would range from 1-37
- *The **second** digit is a <u>number</u> and stands for the Care Group Number*
    - Each Promoter will number all the Care Groups he/she is responsible for.
    - In most programs, Promoters are responsible for 5-9 Care Groups (but no more than 9). Therefore, the 2nd digit should range from 1-5/9 (depending on the program design).
    - For example, if Promoter #2 has 8 Care Groups then his CGs would be numbered: 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, and 2.8.
- *The **third** digit is a <u>letter</u> and stands for the Care Group Volunteer.*
    - Each CG Volunteer in a Care Group will receive a separate letter.
    - In most programs, Care Groups are comprised of 6-15 CG Volunteers. Therefore, the 3rd digit should range from A - F through O (depending on the program design).
    - For example, in Care Group #4 supported by Promoter #3 there are twelve CG Volunteers- 3.4.A, 3.4.B, 3.4.C, 3.4.D, 3.4.E, 3.4.F, 3.4.G, 3.4.H, 3.4.I, and 3.4.J.

- *The final, **fourth** digit is a <u>number</u> and stands for the Neighbor Woman.*
    - Each NW who reports to a CG Volunteer will receive her own number.
    - In most programs, the Neighbor Group is comprised of 6-12 Neighbor Mothers (15 members is the absolute maximum). Therefore, the 4th digit will range from 1-6 through 12 (depending on the program design).
    - For example, CGV F in CG #6, supported by Promoter #1 there are 8 NW- 1.6.G.1, 1.6.G.2, 1.6.G.3, 1.6.G.4, 1.6.G.5, 1.6.G.6, 1.6.G.7, and 1.6.G.8.

Activity 1: Check for Understanding (30 min)

Write out a series of codes on a flipchart that would be found in your program. List only the code, and ask participants to state what the code indicates. Sample codes and interpretation are below.

Code	**Meaning**
7	Promoter #7
7.1	Promoter # 7's *first* Care Group
7.1.C	The third Care Group Volunteer (letter C), in Promoter # 7's first Care Group
7.1.C.1	The first Neighbor Woman, in Care Group Volunteer Letter C (the third registered in her group), of Promoter # 7's *first* Care Group

Depending on the level of understanding of the participants, the facilitator can continue this exercise by writing other feasible codes on a flipchart and request participants (either individually or in tables/pairs) to interpret the codes.

Activity 2: Participatory learning for numbering Care Groups (30 min)

1. Using Handout 7B: Participatory learning for numbering Care Groups, give 3-4 papers to each participant.
2. The facilitator will then 'start' the cascade training by asking Promoter #3 (i.e. whoever received the Promoter paper) to come to the front of the room.
3. The Promoter will then call a meeting with all of his/her Care Group Volunteers (i.e. everyone who has a Care Group Volunteer number associated with Promoter #3 should come to the front of the room).
4. Care Group Volunteer 3.3.C will then call a meeting of Neighbor Women (i.e. everyone who has a Neighbor Woman number associated with that Care Group Volunteer should come to the front of the room).
5. Then, CG Volunteer 3.3.F will call her meeting of Neighbor Women in the same way.

This activity will allow participants to visually see how the coding logically follows and tracks the cascade groups. Color code the papers as necessary if that helps visually depict this.

Handout 7A: Care Group Numbering System

This example is for a Care Group Program with the following ratios/group sizes. You should adapt this tool to match your program specifications

9 Total Supervisors
Supervisor: Promoter ratio = 1:4
Promoter: Care Group ratio = 1:6
Each Care Group has 12 CG Volunteers
Each Neighbor Group has 13 Nighbor Women members

MCHN Supervisor #	Promoter (Name & Number)			Care Group #
MCHN Supervisor 1	Promoter	Leonie	1	1-6
	Promoter	Sylvestre	2	1-6
	Promoter	Yves	3	1-6
	Promoter	Janine	4	1-6
MCHN Supervisor 2	Promoter	Dieudonne	5	1-6
	Promoter	Jean-Claude	6	1-6
	Promoter	Janine	7	1-6
	Promoter	Leonie	8	1-6
MCHN Supervisor 3	Promoter	Mamadou	9	1-6
	Promoter	Raphael	10	1-6
	Promoter	Sylvestre	11	1-6
	Promoter	Yves	12	1-6
MCHN Supervisor 9	Promoter	Anne-Marie	34	1-6
	Promoter	Sylvestre	35	1-6
	Promoter	Yves	36	1-6
	Promoter	Mitzi	37	1-6

Promoter # 7
Care Group #7.6

Care Group	
7.6.A	CG Volunteer
7.6.B	CG Volunteer
7.6.C	CG Volunteer
7.6.D	CG Volunteer
7.6.E	CG Volunteer
7.6.F	CG Volunteer
7.6.G	CG Volunteer
7.6.H	CG Volunteer
7.6.I	CG Volunteer
7.6.J	CG Volunteer
7.6.K	CG Volunteer
7.6.L	CG Volunteer

CGV 7.6.F	Neighbor Group	
	7.6.F.1	Neighbor Woman
	7.6.F.2	Neighbor Woman
	7.6.F.3	Neighbor Woman
	7.6.F.4	Neighbor Woman
	7.6.F.5	Neighbor Woman
	7.6.F.6	Neighbor Woman
	7.6.F.7	Neighbor Woman
	7.6.F.8	Neighbor Woman
	7.6.F.9	Neighbor Woman
	7.6.F.10	Neighbor Woman
	7.6.F.11	Neighbor Woman
	7.6.F.12	Neighbor Woman
	7.6.F.13	Neighbor Woman

Supervisors are not included in the coding system	*Promoters* are identified by their individual **number**	*Care Groups* are identified by the Promoter **number** and the Care Group **number.**	*CG Volunteers* are identified by the Promoter **number**, the Care Group **number**, and the CG Volunteer **letter**	*Neighbor Women* are identified by the Promoter **number**, the Care Group **number**, the CG Volunteer **letter**, and the Neighbor Women **number**

Handout 7B: Participatory learning for numbering Care Groups

Print the handout and cut out each rectangle or replicate each rectangle below on a separate A4/letter paper.

Promoter # 3

CG Volunteer **3.3.A**

CG Volunteer 3.3.B

CG Volunteer 3.3.C

CG Volunteer 3.3.D

CG Volunteer
3.3.E

CG Volunteer
3.3.F

CG Volunteer
3.3.G

CG Volunteer

3.3.H

CG Volunteer

3.3.I

CG Volunteer

3.3.J

Neighbor Woman
3.3.C.1

Neighbor Woman
3.3.C.2

Neighbor Woman
3.3.C.3

Neighbor Woman
3.3.C.4

Neighbor Woman
3.3.C.5

Neighbor Woman
3.3.C.6

Neighbor Woman
3.3.C.7

Neighbor Woman
3.3.C.8

Neighbor Woman
3.3.C.9

Neighbor Woman
3.3.F.1

Neighbor Woman
3.3.F.2

Neighbor Woman
3.3.F.3

Neighbor Woman
3.3.F.4

Neighbor Woman
3.3.F.5

Neighbor Woman
3.3.F.6

Neighbor Woman
3.3.F.8

Neighbor Woman
3.3.F.9

Neighbor Woman
3.3.F.10

Lesson 8: Care Group Monitoring Information System, Introduction to Registers

<table>
<tr><td colspan="2">Objectives:
1. Participants will be able to state the purpose of the Care Group MIS.
2. Participants will be able to accurately fill out Registers (Neighbor & Care Groups).
3. Participants will be able to read and interpret all registers.
4. Participants will be able to teach others how to use Registers (Neighbor & Care Groups).</td></tr>
<tr><td>Summary: 2 hours, 10 minutes
• MIS Overview (15 min)
• Activity 1: Purpose of Registers (Neighbor Groups and Care Groups) (15 min)
• Activity 2: How to use the Registers (30 min)
• Activity 3: Check for Understanding–Register Quiz! (30 min)
• Activity 4: Act it Out (40 min)</td><td>Materials
☐ Flip chart and markers
☐ Handout 8A: Flow of Information [Print one per participant, unless stated otherwise]
☐ Handout 8B: Comparing NG and CG Registers
☐ Handout 8C: NG Register, blank
☐ Handout 8D: CG Register, blank
☐ Handout 8E: CG Register, Filled Example
☐ Handout 8F: Register Quiz
☐ Handout 8G: Register Quiz (Answers) [Print one per Training Facilitator]
☐ Full Register and Report Binders as an example</td></tr>
</table>

MIS Overview (15 minutes)

Explain: the Care Group Management Information System (MIS) is based on two basic information sources: 1) Neighbor Group Registers and 2) Care Group Registers. These registers are very similar to one another and collect four types of information: 1) Registration information (when the members of the group joined): 2) attendance at group meetings or home visits; 3) vital events of group members (maternal death, under two deaths, and child births) and 4) curriculum (the progress groups have made through the Care Group Curriculum.

Write on a Flip Chart

Four types of information in CG MIS

1. **Registration** (to know **who** is registered in the group)
2. **Attendance** (to know **how often** women are receiving the lessons! If no one's attending meetings, then no one is receiving messages and behaviors won't be changed.)
3. V**ital events** (child births, child deaths, and maternal deaths).
4. **Curriculum** (to know which lesson/modules are being taught to mothers. This allows program staff to know how far their groups are progressing in the curriculum.)

*** Note: The facilitator only needs to write the information in bold on the flipchart. He/she can explain the content of the parentheses.*

This information is *critical* to your Care Group project as it provides the single most important monitoring indicator for the Care Group Programs: attendance at Neighbor Group and Care Group meetings. If women are not attending these meetings, we know our program will not be successful. Collecting information on vital events of all members of Neighbor Groups and Care Groups also allows your program to track maternal, child, and infant mortality – data that would otherwise be expensive and time intensive to collect.

Draw the following diagram on a flipchart or pass our copies as a handout (Handout 8A). Describe the overall flow of information for the MIS from the bottom of the diagram to the top. Describe that all of our information will come from the register books (Neighbor Groups and Care Groups). This information will be compiled as it's passed up the chain of command and eventually given to the MCHN Coordinator/ Program Manager.

Explain that in this session, we'll teach you how to use/fill in Registers for the Neighbor Groups and Care Groups. In the next session, we'll teach you how to create Promoter, Supervisor, and Coordinator reports from these registers.

Note on Register Variations: Some Care Group programs adapt these registers to collect more information (e.g. immunization coverage, ANC attendance, childhood illness, etc.). Before deciding whether to collect more information, the program should first consider the following:

1) *The registers should be as simple as possible*. Adding additional fields to the registers will require CG Volunteers/Promoters to spend more time filling out the registers during their bi-monthly meetings with Neighbor Groups/Care Groups, which may take away time from teaching the curriculum. Detailed registers may also create a temptation to falsifying information if the CG Volunteers/Promoters find the registers too burdensome to fill each meeting.

2) *The denominator for indicators collected through the CG MIS can only be women participating in the groups or their children*. If a CG program includes nearly all pregnant women in the project area, then the MIS can be used to measure a proxy of maternal mortality during the life of the project. On the other hand, a CG program could not easily track use of modern family planning methods since it's unlikely that all WRA would participate in a CG program.

Activity 1: Purpose of Registers (Comparing NGs and CGs) (15 min)

Distribute Handout 8B: Comparing Neighbor Group & Care Group Registers (or write the information on a Flipchart). Read through this table that compares the NG Registers and the CG Registers taking time to explain and answer any questions.

Activity 2: How to use the Registers (30 minutes)

Request all participants to take out their Blank Neighbor Group and Care Group Registers (Handout 8C and 8D). Review the two registers and clarify the following:

1. The Neighbor Group Registers and Care Group Registers are very similar.

2. Let's review the **Care Group Registers** first….
    a. The top two rows are the title and description of the register
    b. On the upper left corner, write the number of the group (using the code from the numbering system)
    c. On the top center of the register is the Key – which displays the meaning of the symbols and letters that will used to fill out the Register
    d. Column 1: the *letter* of the CG Volunteer within the Care Group
    e. Column 2: name of the CG Volunteer of the Care Group
    f. Column 3: The date the CG Volunteer was registered to participate in this Care Group

g. Column 4: In the first cell, the Promoter should fill out the date of that month's meeting and the lesson taught. Each lesson has the module number and the lesson number. Therefore, 2.3 means Module 2 Lesson 3 was taught.
    i. In the lines beneath this date the Promoter should indicate if the volunteer attended the teaching session by placing a "✓" for attended, an "X" for absent, and an "·" if the CG Volunteer received the message at home, since she was absent from the group meeting.
    ii. Next to this line, the Promoter should fill where there were any births or deaths this month. Use the codes from the key: **CB =** child born; **CD =** child death; **MD =** maternal death.

3. The **Neighbor Group Register** is very similar.
    a. The top two rows are the title and description of the register
    b. On the upper left corner, write the number of the group (using the code from the numbering system)
    c. On the top center of the register is the Key – which displays the meaning of the symbols and letters that will used to fill out the Register
    d. Column 1: the number of the Neighbor Woman within the Neighbor Group
    e. Column 2: name of the Neighbor Woman of the Neighbor Group
    f. Column 3: The date the Neighbor Woman was registered to participate in this Neighbor Group
    g. Column 4: In the first cell, the CG Volunteer would fill out the date of that month's meeting and the lesson taught. Same rules as above.

4. Remember, if your CG Volunteers are not literate, the promoter will need to fill out BOTH registers during Care Group meetings. In this case, during the attendance section of a CG Meeting the Promoter would:
    a. First, take attendance of the CG Volunteers
    b. Second, ask each CG Volunteer to report on
        i. Any new members to their Neighbor Group;
        ii. The maternal age (i.e. months of pregnancy) or child age (if a mother of a child under two) of the new members (if any);
        iii. Attendance at the last Neighbor Group meeting; and
        iv. Any vital events.

Adding new women to Neighbor Groups: If other women in the community become pregnant, they should be invited to join the group as long as the group size doesn't exceed 15 (the maximum size of Neighbor Groups). For this reason, you may want to design your Care Group program to start with small Neighbor Groups (around 10 woman) so there's enough room in the groups for new women to join during the project.

Replacing Care Group Volunteers: If a CG Volunteer dies or wishes to drop out of the program, the Neighbor Group should quickly elect a woman from their group to replace her. The previous CG Volunteer's name should be crossed off the Care Group Register, and the newly elected CG Volunteer's name should be added in an empty row. In the Neighbor Group Register, the previous CG Volunteer's name should be crossed off and replaced with the new CG Volunteer.

Activity 3: Check for Understanding – Register Quiz! (30 minutes)

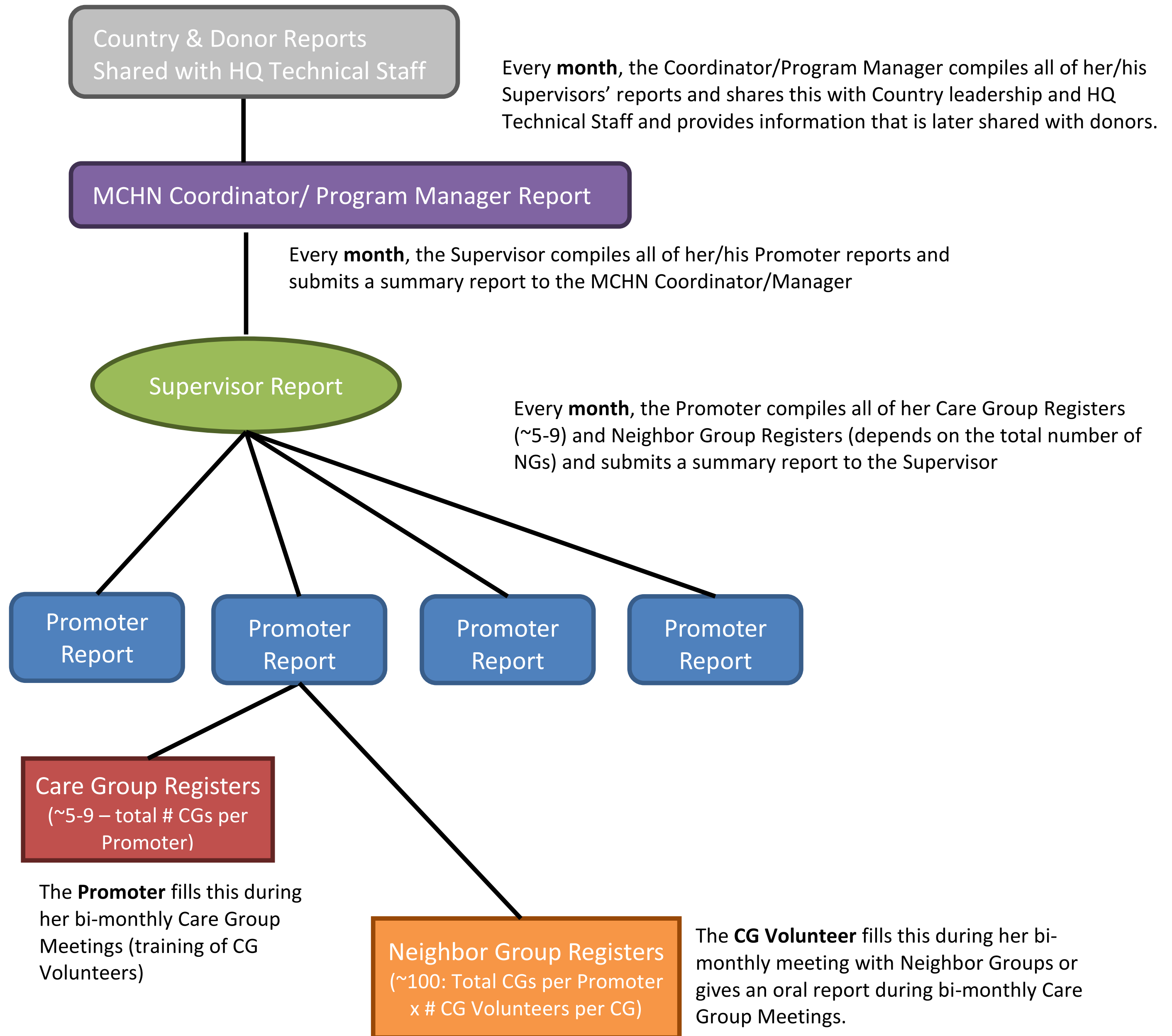
1. Divide into groups of two.
2. Distribute Handout 8F: Register Quiz.
3. Using Handout 8E: Care Group Filled Register Example, have the participants complete the quiz.
4. Swap answers – grade each other's!
5. Review answers together (Handout 8G: Register Quiz Answers)
6. Prize to highest scores.

Activity 4: Act it Out – registering Volunteers into Care Groups! (40+ minutes)

This final exercise allows the participants to fill in their own registers and reports. Hand out an extra set of blank Care Groups Registers (Handout 8D).

- Ask for 10 Volunteers to act as CG Volunteers in a Care Group.
- Tell the group that you are Promoter # 1, and that you're registering 10 Women to be CG Volunteers in your Care Group
- Tell the full group your Care Group Code (e.g. 1.5). As you give them this information, tell them they must write this information in their own blank register.
- Register the 10 women by asking their name – write down a letter, the woman's name, and today's date (i.e. the date of registration).
- Tell the group that since everyone's here at the same time, you (the Promoter) will go ahead and teach Lesson 1.1 Write down today's date. Take attendance. Ask if there were any births or deaths this month. Dismiss the group.
- Now tell the audience that two weeks have passed and you, the Promoter, are ready to call for another CG meeting.
- Call all of the CG Volunteers to the front.
  - Say that today we'll be going over Lesson 1.2
  - Take attendance; ask if there were any births or deaths this month.
  - Dismiss the group
- All participants should now have a full Care Group registered in their Care Group Register, and two weeks of attendance and vital events filled.
- Review 'correct' Care Group Register as a group (that one of the facilitator fills) to check for understanding
- *Note that in the field, CGVs (if they are illiterate) will also be asked to report on attendance, lesson taught, and vital events from their NG. The promoters would fill out the Neighbor Group Register as they give their report. S*

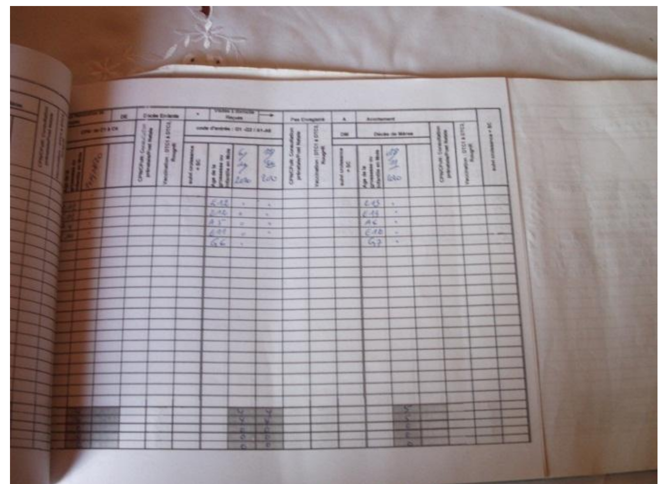
Handout 8A: Flow of Information in the Monitoring Information System



Handout 8B: Comparing Neighbor Group & Care Group Registers

	Neighbor Group Register Books	**Care Group Register Books**
How many?	Each Neighbor Group AND each Care Group have their own register book. The register book should have enough pages to last for 1 year.	
What information?	Registration, attendance and vital events for each group member.	
Who fills?	• **Illiterate CG Volunteers:** In many Programs, most CG Volunteers not literate so they orally report registration, attendance, and vital events of their Neighbor Group during her Care Group meeting with the Promoter. The Promoter will fill out the Neighbor Group Register as the CG Volunteer gives her oral report. • **Literate CG Volunteers:** If the CG Volunteer is literate, she can fill out this register at the beginning of each Neighbor Group Meeting.	Promoters fill out these registers at the beginning of each Care Group Meeting.
How to store?	The registers should be made into binders and stored in a safe and cool space. Show the photos below (Figure 1) as an example of printed registers. As you'll see here, it's helpful to make very long pages (by stapling two pages together) so you only need 1 sheet for a full year of registration/attendance. Bring full Register Books/Binders to show and pass around to participants!	

Figure 1. Photos of registries in Burundi!



Handout 8C: Neighbor Group Register, Blank

Neighbor Group Register

This is a **Neighbor Group (NG) Register**: Neighbor Groups are led by CG Volunteers; the members are (usually) mothers

Group #:
Use the code from the numbering system

✔	Attended Group Meeting	X	Absent	•	Received Home Visit
CB	Child Birth	CD	U2 Child Death	MD →	Maternal death

	CG Volunteer (Group Leader) Name:		Month:				Month:				Month:				Month:				Month:
Neighbor Woman number	*Neighbor Woman name*	Date of Registry in Program	Date: Lesson:	Births or Deaths?	Date: Lesson:	Births or Deaths?	Date: Lesson:	Births or Deaths?	Date: Lesson:	Births or Deaths?	Date: Lesson:	Births or Deaths?	Date: Lesson:	Births or Deaths?	Date: Lesson:	Births or Deaths?	Date: Lesson:	Births or Deaths?	Date: Lesson:
1																			
2																			
3																			
4																			
5																			
	Total Attended/Visited *(add all √ and •)*		Attended		Attended		Attended		Attended		Attended		Attended		Attended		Attended		Attended
	Total Registered *(add all women still in group)*		Registered		Registered		Registered		Registered		Registered		Registered		Registered		Registered		Registered
	Maternal Deaths *(add all MDs during 2 visit)*		MD				MD				MD				MD				MD
	Child <2 years old Deaths *(add all CDs during 2 visits)*		CD				CD				CD				CD				CD
	Births *(add all CBs during 2 visits)*		CB				CB				CB				CB				CB

Handout 8D: Care Group Register, Blank

Care Group Register

This is a Care Group (CG) Register: Care Groups are led by Promoters; the members are Care Group Volunteers

Group #:
Use the code from the numbering system

✔	Attended Group Meeting	X	Absent	•	Received Home Visit
CB	Child Birth	CD	U2 Child Death	MD ⟶	Maternal death

CG Volunteer Letter	Promoter (Group Leader) Name: / *CG Volunteer name*	Date of Registry in Program	Month:				Month:				Month:				Month:				Month:
			Date: Lesson:	Births or Deaths?	Date: Lesson:	Births or Deaths?	Date: Lesson:	Births or Deaths?	Date: Lesson:	Births or Deaths?	Date: Lesson:	Births or Deaths?	Date: Lesson:	Births or Deaths?	Date: Lesson:	Births or Deaths?	Date: Lesson:	Births or Deaths?	Date: Lesson:
Total Attended/Visited *(add all √ and •)*			Attended		Attended		Attended		Attended		Attended		Attended		Attended		Attended		Attended
Total Registered *(add all CG Volunteers still in Care Group)*			Registered		Registered		Registered		Registered		Registered		Registered		Registered		Registered		Registered
Maternal Deaths *(add all MDs during 2 visit)*			MD				MD				MD				MD				MD
Child <2 years old Deaths *(add all CDs during 2 visits)*			CD				CD				CD				CD				CD
Births *(add all CBs during 2 visits)*			CB				CB				CB				CB				CB

Handout 8E: Care Group Register, Filled Example

This is a Care Group (CG) Register: Care Groups are led by Promoters; the members are Care Group Volunteers

Group #: 8.5 *Use the code from the numbering system*

✔	Attended Group Meeting	X	Absent	•	Received Home Visit
CB	Child Birth	CD	U2 Child Death	MD ⟶	Maternal death

CG Volunteer Letter	Promoter (Group Leader) Name: Rachel White / CG Volunteer name	Date of Registry in Program	Month: May				Month: June				Month: July				Month: Aug			
			Date: May 3		Date: May 15		Date: June 1		Date: June 18		Date: July 4		Date: July 20		Date: Aug 6		Date: Aug 2	
			Lesson: 3.1	Births or Deaths?	Lesson: 1.2	Births or Deaths?	Lesson: 1.3	Births or Deaths?	Lesson: 1.4	Births or Deaths?	Lesson: 1.5	Births or Deaths?	Lesson: 1.6	Births or Deaths?	Lesson: 1.3	Births or Deaths?	Lesson: 2.0	Births or Deaths?
A	Leena Samuel	April 19 2011	✔		•		✔		•		✔		•		✔		•	
B	Martha Abdul	April 20 2011	✔		•		✔		•		•	CB	•		✔		•	
C	Anne Maria Andrews	April 20 2011	✔		X		X		•		✔		•		✔		•	
D	Mitzi Hanold	April 20 2011	✔		•		✔		•		✔		•		✔		•	
E	Anne Story	April 22 2011	✔	CB	•		✔		•		✔		•		✔		•	
F	Janine Linda	April 22 2011	✔	CD	•		•		•		✔		•		✔		•	
G	Leonie Devine	April 22 2011	✔		•		✔		•		✔		•		✔		•	
H	Janet Learner	April 22 2011	✔		•		✔		X		✔		•		✔		•	
I	Marie Leroy	April 23 2011	✔		•		✔		•		✔		•		✔		•	
J	~~Mary Smith~~	~~April 23 2011~~	✔		•		✔			MD ⟶								
K	Leslie Jackson	July 2 2011									✔		•		•	CB	•	
	Total Attended/Visited *(add all √ and •)*		Attended	10	Attended	9	Attended	9	Attended	8	Attended	10	Attended	10	Attended	10	Attended	10
	Total Registered *(add all CG Volunteers still in Care Group)*		Registered	10	Registered	10	Registered	10	Registered	9	Registered	10	Registered	10	Registered	10	Registered	10
	Maternal Deaths *(add all MDs during 2 visit)*		MD	0			MD	1			MD	0			MD	0		
	Child <2 years old Deaths *(add all CDs during 2 visits)*		CD	1			CD	0			CD	0			CD	0		
	Births *(add all CBs during 2 visits)*		CB	1			CB	0			CB	1			CB	1		

Handout 8F: Register Quiz

1. What is the Promoter number for this Care Group?

2. What lesson was taught on July 4th 2011?

3. Why is Mary Smith's name crossed out?

4. When did Martha Abdul have her baby?

5. How many child deaths happened during the period of time tracked by this register?

6. Why isn't attendance filled out for Leslie Jackson until July 4, 2011?

Handout 8G: Register Quiz (Answers)

1. What is the Promoter number for this Care Group? *10*

2. What lesson was taught on July 4th 2011? *1.5*

3. Why is Mary Smith's name crossed out? *She died*

4. When did Martha Abdul have her baby? *July 2011*

5. How many child deaths happened during the period of time tracked by this register? *1*

6. Why isn't attendance filled out for Leslie Jackson until July 4, 2011? *She joined the group late – after Mary Smith died and there was room for another group member.*

Lesson 9: Care Group Monitoring Information System, Care Group Reports (Promoters, Supervisors, and Coordinator Reports)

Objectives:

1. Participants will be able to accurately fill out Reports (Promoter, Supervisor, and Coordinator Reports).
2. Participants will be able to read and interpret all Reports.
3. Participants will be able to teach others how to use Reports (Promoter, Supervisor, and Coordinator).

Summary: 2 hours, 15 minutes

- Intro to Promoter, Supervisor, and Coordinator Reports (30 min)
- Review Filled Reports (45 min)
- Activity 1: Check for Understanding – Report Quiz! (30 min)
- Activity 2: Act it Out – fill out your own reports (30 min)

Materials

[Print one per participant, unless stated otherwise]

- ☐ Flip chart and markers
- ☐ Handout 8A: Flow of Information [Already printed in Lesson 8]
- ☐ Handout 8C: Neighbor Group Register, Blank [Already printed in Lesson 8]
- ☐ Handout 9A: Blank Promoter's Report [Print two per participant]
- ☐ Handout 9B: Blank Supervisor's report [Print two per participant]
- ☐ Handout 9C: Blank Coordinator's Report [Print two per participant]
- ☐ Handout 9D: Example Promoter's Report
- ☐ Handout 9E: Example Supervisor's Report
- ☐ Handout 9F: Example Coordinator's Report
- ☐ Handout 9G: Report Quiz
- ☐ Handout 9H: Report Quiz Answers [Print one per Training Facilitator]
- ☐ Handout 9I: Act it Out! Handouts

Note to the facilitator: you will need to prepare the following for each table/team:

- ☐ 5 *filled* Promoter Reports
- ☐ 1 *filled* Supervisor Report (compiling information from the 5 filled Promoter Reports)
- ☐ Full Register and Report Binders as an example

Intro to Reports (Promoter, Supervisor, and Coordinator Reports) (30 min)

1. Refer to the diagram from Handout 8A: Flow of Information
2. Explain that we're going to learn how all of the *paid staff* from a Care Group Program (Promoter, Supervisors, and Coordinators) create their monthly reports using information from the registers (Care Groups and Neighbor Groups).

- ? **Check for understanding, ask:** who can remind me what four types of information registers collect? (Answer: registration, attendance, curriculum, and vital events). Explain that reports compile this same information at different staff levels.

3. Pass out BLANK copies of all three reports. Explain Promoter Reports first, then Supervisor Reports, and finally Coordinator Reports (Handout 9A, 9B, and 9C).
4. Review each page of the reports, starting with the Promoter Report. Explain:
    a. For PROMOTER Reports (Handout 9A): all information comes directly from the Registers of the Care Groups and Neighbor Groups under that Promoter
        i. Remember, Promoters are typically responsible for 5-9 Care Groups, each CG contains 6-14 CG Volunteers, and each CGV lead a Neighbor Group of around 10-12 women. This means that each Promoter may be responsible to track the information (registration, attendance, vital events, and curriculum status) for around 1000 women. Therefore, it's very important that the project staff and Promoters know exactly how to use the registers to complete their monthly reports
        ii. Explain that all reports are broken into two sections. The first page summarizes information from all Care Groups under that staff member. This information comes from the CG Registers. The rest of the report summarizes information from all Neighbor Groups under that staff member using the Neighbor Group Registers.
        iii. Page One – Care Group Information
            1. In the top row of the table, the Promoter writes down the number of each of her Care Groups
            2. In the column below that number, the Promoter will copy the summary information from the bottom of the Care Group Registers
            3. The Promoter also records the number of CGVs observed with a QIVC and their average score
            4. Review calculations for:
                a. Average QIVC Score (the sum of each % divided by the number of scores available)
        iv. Page Two through End – Neighbor Group Information
            1. Each Care Group has its own table. The first row of that table includes the letters of the Care Group Volunteers within that Care Group.
            2. In the column under each CGV Letter, the Promoter will copy the summary information from the bottom of the Neighbor Group Registers.
    b. For SUPERVISOR Reports (Handout 9B): all information comes from Promoter Reports
        i. Page One – Care Group Information
            1. In the top row of the table, the Supervisor writes down the numbers of each Promoter he/she is responsible for.

2. In the columns below the Promoter numbers, the Supervisor will copy the information from the 'TOTAL' column from the first page of the Promoter Report, the Care Group Information table
3. The Supervisor also records the number of times they supervised each Promoter (along with the QIVC score for group education)
4. Review calculations for:
    a. % attendance (attended divided by registered)
    b. % of Promoters who completed target QIVCs
    c. Average CGV attendance
    d. Target CGVs to be registered: this number will be different for each Supervisor. The Supervisor should calculate the target CGVs for each Promoter separately, and then add up all Promoters' targets for the final figure. To calculate the Promoter target, the Supervisor should: multiply the number of Care Groups the Promoter is responsible for by the target number of CGVs per Care Groups.
    e. % attendance target reached (attended divided by target)

ii. Page Two through End – Neighbor Group Information
1. Each Promoter has her own table. The first row of that table includes the CG numbers under that Promoter.
2. In the column under each Care Group, the Supervisor will copy the 'TOTAL' column from the Promoter's Neighbor Group Information Tables (in pages two through the end of the Promoter Report).
3. Review calculations for:
    a. % attendance (attended divided by registered)
    b. Target NWs to be Registered: this number will be different for each Supervisor. The Supervisor should calculate the target NW for each Promoter separately, and then add up all Promoters' targets for the final figure. To calculate the Promoter target, the Supervisor should: multiply the number of Care Groups the Promoter is responsible for by the target number of CGVs per Care Groups by the target number of NW per CGV.
    c. % Attendance Target reached (attendance divided by target)

c. For the COORDINTOR Reports (Handout 9C): all information comes from Supervisor Reports
1. In the top row of the table, the Coordinator writes down the names of each Supervisor he/she supervises.
2. In the second row, the Coordinator writes down the Care Group Numbers under each Supervisor.

3. In the columns below the Supervisor names, the Coordinator will copy the information from the 'TOTAL' column from the first page of the Supervisor Report, the Care Group Information table
4. The Coordinator also records the number of times they supervised each Supervisor (along with the QIVC score for group education).
5. Review calculations for:
    a. % attendance (attended divided by registered)
    b. % of Promoters who completed target QIVCs
    c. Average CGV attendance
    d. Target CGVs to be registered: to calculate this figure, the Coordinator should add up their Supervisors' targets for CGVs.
    e. % attendance target reached

ii. Page Two through End – Neighbor Group Information
1. Each Supervisor has her own table. The first row of that table lists the Promoters' number under that Supervisor.
2. In the column under each Promoter, the Coordinator will copy the 'TOTAL' column from the Supervisor's Neighbor Group Tables (in pages two through end).
3. Review calculations for:
    a. % attendance (attended divided by registered)
    b. Target NWs to be Registered: to calculate this figure, the Coordinator should add up their Supervisors' targets for NW.
    c. % Attendance Target reached (attendance divided by target)

Review filled Reports (45 min)

1. Pass out filled examples of Promoter, Supervisor & Coordinator Reports (Handout 9D, 9E, and 9F).
2. Start with the **Promoter Report** (Handout 9D). State that the report for this Promoter, Rachel White (Promoter #8. The report includes information from Care Group 8.5 – the register we just reviewed during the last session (Handout 8E). Make sure the group understands how the information from Care Group 8.5 is included in this Promoter Report.
    a. ASK participants: Where, in the Promoter Report, do you think the Care Group Register (8.5) will be recorded? Answer, the *first page* because all CG information is summarized in the first page.
    b. Remind participants that the 'TOTAL fields' at the bottom of the Care Group register feed into the specific column # 8.5 on the first page of the Promoter Report (highlighted in green).
    c. Remind participants that column on the first page summarizes information of other Care Groups (8.1, 8.2, 8.3 etc.)

    d. Pages two through the end summarize information from Neighbor Group Registers. Each table represents a different Care Group. Each column within each table represents a different CGV. Remind participants that the information for these tables comes from the 'TOTAL fields' from the bottom of the Neighbor Group Register.
3. Next, review the Supervisor Report for Kelly Hughes (Handout 9E). Show how the 'Total Columns' from Rachel White's Promoter Report are included in the two different sections in the Supervisor Report. Rachel White's Care Group Information is summarized in the *first page* of the Supervisor's Report. Rachel White's Neighbor Group information is summarized in the *second section* of the Supervisors Report, in a table on page 3. These columns/tables are highlighted in green.
    a. Explain that other Promoters' Care Group information is summarized in a *column* on the *first page;* and other Promoters' Neighbor Group information is summarized in a *table* in the *second section* of the report.
    b. Review calculations for:
        - % attendance (attended divided by registered)
        - % of Promoters who completed target QIVCs
        - Average CGV attendance
        - Target CGVs to be registered
        - % attendance target reached
4. Finally review the Coordinator Report (Handout 9F). Just like with the Supervisor Report, show how:
    a. The 'Total Columns' from Kelly Hughes' Supervisor Report are included in the two different sections in the Coordinator Report.
        i. Kelly Hughes' *Care Group* Information is summarized in the *first page* of the Coordinators' Report.
        ii. Kelly Hughes' *Neighbor Group* information is summarized in the *second section* of the Coordinator's Report, in a table on page 2.
        iii. These columns/tables are highlighted in green.
    b. Explain that other Supervisors' Care Group information is summarized in a *column* on the *first page;* and other Supervisors' Neighbor Group information is summarized in a *table* in the *second section* of the report.
    c. Review calculations for:
        - % attendance (attended divided by registered)
        - % of Promoters who completed target QIVCs
        - Average CGV attendance
        - Target CGVs to be registered
        - % attendance target reached

Activity 1: Check for Understanding – Report Quiz! (30 min)

1. Pair up in your same teams from the Register Quiz
2. Distribute Handout 9G: Report Quiz.

3. Using Handout 9D, 9E, and 9F: Example Reports, have the participants complete the quiz.
4. Swap answers – grade each other's!
5. Review answers together (Handout 9H Register Quiz Answers)
6. Prize to highest scores.

Activity 2: Act it Out – fill out your own reports (30 min).

See Handout 9I.

This final exercise allows the participants to fill in their own reports.

1. Divide into teams of two.
2. Hand out five filled Promoter Reports to each team and 1 blank Supervisor Report from Handout 9B. **(Note to the facilitator: you will need to prepare additional example Promoter Reports for this exercise.)**
3. In pairs, have teams fill out the Supervisor Report using the five Promoter reports that are already filled in. Walk around and provide feedback.
4. Distribute the completed Supervisor's Report with the correct answers. **(Note to the facilitator: you will need to prepare the completed Supervisor Report based upon information in the Promoter Reports.)**
5. Swap answers – grade each other's!
6. Give prizes to those with the highest scores and smaller prizes to others.

Handout 9A: Blank Promoter's Report

Promoter Monthly Report

Note: This template is modeled after a program with 10 Care Groups per Promoter and 14 CG Volunteers per Care Group.
The template can be easily adapted to fit your program specifications.

Promoter Name:		Reporting Period:	
Promoter #:		Province/District:	

Summary of Care Group Registers (CG Volunteers)

Care Group Number											**TOTAL**
CGVs Attended 1st Meeting/ Home Visit											
CGVs Registered 1st Meeting/ Home Visit											
CGVs Attended 2nd Meeting/ Home Visit											
CGVs Registered 2nd Meeting/ Home Visit											
CGV Maternal Deaths											
CGV U2 Child Deaths											
CGV Births											
Newest Module and Lesson # numbers taught											Newest
# CGVs observed with QIVC*											
Average QIVC Score											

**Note: each Promoter should conduct a supervision visit for one CGV in each CG every two weeks. If a Promoter has 8 CGs then this would be 16 CGVs visited each month.*

Promoter Name:	

Summary of Neighbor Group Registers (Neighbor Women)

Care Group #:																
CGV Letter	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Total	
NW Attended 1st Mtg/HV																
NW Registered 1st Mtg/HV																
NW Attended 2nd Mtg/HV																
NW Registered 2nd Mtg/HV																
NW Maternal Deaths																
NW U2 Child Deaths																
NW Births																
Newest Mod/Lssn taught															Newest	

Care Group #:																
CGV Letter	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Total	
NW Attended 1st Mtg/HV																
NW Registered 1st Mtg/HV																
NW Attended 2nd Mtg/HV																
NW Registered 2nd Mtg/HV																
NW Maternal Deaths																
NW U2 Child Deaths																
NW Births																
Newest Mod/Lssn taught															Newest	

Promoter Name:	

Summary of Neighbor Group Registers (Neighbor Women)

Care Group #:															
CGV Letter	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Total
NW Attended 1st Mtg/HV															
NW Registered 1st Mtg/HV															
NW Attended 2nd Mtg/HV															
NW Registered 2nd Mtg/HV															
NW Maternal Deaths															
NW U2 Child Deaths															
NW Births															
Newest Mod/Lssn taught															Newest

Care Group #:															
CGV Letter	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Total
NW Attended 1st Mtg/HV															
NW Registered 1st Mtg/HV															
NW Attended 2nd Mtg/HV															
NW Registered 2nd Mtg/HV															
NW Maternal Deaths															
NW U2 Child Deaths															
NW Births															
Newest Mod/Lssn taught															Newest

Promoter Name:	

Summary of Neighbor Group Registers (Neighbor Women)

Care Group #:																
CGV Letter	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Total	
NW Attended 1st Mtg/HV																
NW Registered 1st Mtg/HV																
NW Attended 2nd Mtg/HV																
NW Registered 2nd Mtg/HV																
NW Maternal Deaths																
NW U2 Child Deaths																
NW Births																
Newest Mod/Lssn taught															Newest	

Care Group #:																
CGV Letter	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Total	
NW Attended 1st Mtg/HV																
NW Registered 1st Mtg/HV																
NW Attended 2nd Mtg/HV																
NW Registered 2nd Mtg/HV																
NW Maternal Deaths																
NW U2 Child Deaths																
NW Births																
Newest Mod/Lssn taught															Newest	

Promoter Name:	

Summary of Neighbor Group Registers (Neighbor Women)

Care Group #:															
CGV Letter	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Total
NW Attended 1st Mtg/HV															
NW Registered 1st Mtg/HV															
NW Attended 2nd Mtg/HV															
NW Registered 2nd Mtg/HV															
NW Maternal Deaths															
NW U2 Child Deaths															
NW Births															
Newest Mod/Lssn taught															Newest

Care Group #:															
CGV Letter	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Total
NW Attended 1st Mtg/HV															
NW Registered 1st Mtg/HV															
NW Attended 2nd Mtg/HV															
NW Registered 2nd Mtg/HV															
NW Maternal Deaths															
NW U2 Child Deaths															
NW Births															
Newest Mod/Lssn taught															Newest

Promoter Name:	

Summary of Neighbor Group Registers (Neighbor Women)

Care Group #:																
CGV Letter	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Total	
NW Attended 1st Mtg/HV																
NW Registered 1st Mtg/HV																
NW Attended 2nd Mtg/HV																
NW Registered 2nd Mtg/HV																
NW Maternal Deaths																
NW U2 Child Deaths																
NW Births																
Newest Mod/Lssn taught															Newest	

Care Group #:																
CGV Letter	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Total	
NW Attended 1st Mtg/HV																
NW Registered 1st Mtg/HV																
NW Attended 2nd Mtg/HV																
NW Registered 2nd Mtg/HV																
NW Maternal Deaths																
NW U2 Child Deaths																
NW Births																
Newest Mod/Lssn taught															Newest	

Handout 9B: Blank Supervisor's Report

MCHN Supervisor Report

Note: This template is modeled after a program with 5 Promoters per Supervisor & 10 CGs per Promoter

Page 1 of 4

MCHN Supervisor Name:		Reporting Period:	
Promoter #s Supervisor is Responsible for:		State/Province/District:	
Communities:			

Summary of Care Group Volunteers per Promoter

Promoter Number						Total		
# of Supervision Visits to this Promoter								
QIVC Score: Group Education						Average Score:		
Care Group #'s (1 thru 8)						Percent Attendance		
CGVs Attended 1st Meeting/Home visit						A		A/B x 100 =
CGVs Registered 1st Meeting/Home Visit						B		
CGVs Attended 2nd Meeting/Home Visit						C		C/D x 100 =
CGVs Registered 2nd Meeting/Home Visit						D		
CGV Maternal Deaths								
CGV U2 Child Deaths								
CGV Births								
Newest Module and Lesson # numbers taught						Newest		
Oldest Module and Lesson # numbers taught						Oldest		
# of CGVs observed with QIVC								
Average QIVC Score								

	% of Promoters who completed all 6 QIVC's this month		
	Average CGV Attendance this Month (A+C)/2	E	
	Target # of CGV to be registered by this Supervisor	F	
	% of Attendance Target reached this month E/F x 100		

MCHN Supervisor Name:	

fh food for the hungry
Meeting physical and spiritual needs worldwide

Summary of Neighbor Women by Promoter and Care Group

Promoter Number													
CG #s Responsible for												Total	Percent Attendance
NW Attended 1st Mtg/HV											A		A/B x 100 =
NW Registered 1st Mtg/HV											B		
NW Attended 2nd Mtg/HV											C		C/D x 100 =
NW Registered 2nd Mtg/HV											D		
NW Maternal Deaths													
NW U2 Child Deaths													
NW Births													
Newest Mod/Lesson taught											Newest		
Oldest Mod/Lesson taught											Oldest		
Comments:										Avg NW Attendance this Month (A+C)/2	E		
										Target # of NW to be Registered by this Promoter	F		
										% Attendance Target reached E/F x 100			

Promoter Number													
CG #s Responsible for												Total	Percent Attendance
NW Attended 1st Mtg/HV											A		A/B x 100 =
NW Registered 1st Mtg/HV											B		
NW Attended 2nd Mtg/HV											C		C/D x 100 =
NW Registered 2nd Mtg/HV											D		
NW Maternal Deaths													
NW U2 Child Deaths													
NW Births													
Newest Mod/Lesson taught											Newest		
Oldest Mod/Lesson taught											Oldest		
Comments:										Avg NW Attendance this Month (A+C)/2	E		
										Target # of NW to be Registered by this Promoter	F		
										% Attendance Target reached E/F x 100			

Handout 9C: Blank Coordinator's Report

MCHN Coordinator Report

Note: This template is modeled after a program with 5 Supervisors reporting to the Coordinator& 5 Promoters per Supervisor

MCHN Coordinator Name:		Reporting Period:	
Supervisors the Coordinator is Responsible for :		State/Province/District:	
Communities:			

Summary of Care Group Volunteers per Supervisor

Supervisor Name						Total		
# of Supervision Visits to this Supervisor								
Promoter and CG#s Responsible for								
QIVC Score: Group Education						Average Score		
CGVs Attended 1st Meeting/ Home visit						Percent Attendance		
CGVs Registered 1st Meeting/ Home Visit						A		A/B x 100 =
CGVs Attended 2nd Meeting/ Home Visit						B		
CGVs Registered 2nd Meeting/ Home Visit						C		C/D x 100 =
CGV Maternal Deaths						D		
CGV U2 Child Deaths								
CGV Births								
Newest Module/Lesson # numbers taught						Newest		
Oldest Module/Lesson # numbers taught						Oldest		
# of CGVs observed with QIVC								
Average QIVC Score								
% of Promoters who completed all 6 QIVCs:								

Comments:	% of Promoters who completed all 6 QIVC's this month		
	Average CGV Attendance this Month (A+C)/2	E	
	Target # of CGV to be registered for this Coordinator	F	
	% of Attendance Target reached this month E/F x 100		

MCHN Coordinator Name:	

Summary of Neighbor Women by Supervisor & Promoter

Supervisor Name								
Promoter #						Total		Percent Attendance
NW Attended 1st Meeting/ Home visit						A		A/B x 100 =
NW Registered 1st Meeting/ Home Visit						B		
NW Attended 2nd Meeting/ Home Visit						C		C/D x 100 =
NW Registered 2nd Meeting/ Home Visit						D		
NW Maternal Deaths								
NW U2 Child Deaths								
NW Births								
Newest Mod/Lesson taught						Newest		
Oldest Mod/Lesson taught						Oldest		
Comments:		Average NW Attendance this Month (A+C)/2				E		
		Target # of NW to be registered by this Supervisor				F		
		% of Attendance Target reached this month E/F x 100						

Supervisor Name								
Promoter #						Total		Percent Attendance
NW Attended 1st Meeting/ Home visit						A		A/B x 100 =
NW Registered 1st Meeting/ Home Visit						B		
NW Attended 2nd Meeting/ Home Visit						C		C/D x 100 =
NW Registered 2nd Meeting/ Home Visit						D		
NW Maternal Deaths								
NW U2 Child Deaths								
NW Births								
Newest Mod/Lesson taught						Newest		
Oldest Mod/Lesson taught						Oldest		
Comments:		Average NW Attendance this Month (A+C)/2				E		
		Target # of NW to be registered by this Supervisor				F		
		% of Attendance Target reached this month E/F x 100						

MCHN Coordinator Name:	

Summary of Neighbor Women by Supervisor & Promoter

Supervisor Name								
Promoter #						Total		Percent Attendance
NW Attended 1st Meeting/ Home visit						A		A/B x 100 =
NW Registered 1st Meeting/ Home Visit						B		
NW Attended 2nd Meeting/ Home Visit						C		C/D x 100 =
NW Registered 2nd Meeting/ Home Visit						D		
NW Maternal Deaths								
NW U2 Child Deaths								
NW Births								
Newest Mod/Lesson taught						Newest		
Oldest Mod/Lesson taught						Oldest		
Comments:	Average NW Attendance this Month (A+C)/2					E		
	Target # of NW to be registered by this Supervisor					F		
	% of Attendance Target reached this month E/F x 100							

Supervisor Name								
Promoter #						Total		Percent Attendance
NW Attended 1st Meeting/ Home visit						A		A/B x 100 =
NW Registered 1st Meeting/ Home Visit						B		
NW Attended 2nd Meeting/ Home Visit						C		C/D x 100 =
NW Registered 2nd Meeting/ Home Visit						D		
NW Maternal Deaths								
NW U2 Child Deaths								
NW Births								
Newest Mod/Lesson taught						Newest		
Oldest Mod/Lesson taught						Oldest		
Comments:	Average NW Attendance this Month (A+C)/2					E		
	Target # of NW to be registered by this Supervisor					F		
	% of Attendance Target reached this month E/F x 100							

Handout 9D: Example Promoter's Report

Promoter Monthly Report

Promoter Name:	Rachel White	Reporting Period:	May-11
Promoter #:	8	Province/District:	California, Los Angeles

Summary of Care Group Registers (CG Volunteers)

Care Group Number	8.1	8.2	8.3	8.4	8.5	8.6	8.7	8.8			**TOTAL**	
CGVs Attended 1st Meeting/ Home Visit	12	11	9	12	10	10	11	12			87	
CGVs Registered 1st Meeting/ Home Visit	12	12	10	13	10	11	12	13			93	
CGVs Attended 2nd Meeting/ Home Visit	12	12	10	10	9	11	12	10			86	
CGVs Registered 2nd Meeting/ Home Visit	12	12	10	13	10	11	12	13			93	
CGV Maternal Deaths	0	0	1	0	0	0	0	0			1	
CGV U2 Child Deaths	1	0	0	0	1	0	0	0			2	
CGV Births	0	0	0	0	1	1	0	0			2	
Newest Module and Lesson # numbers taught	3.4	3.4	3.2	3.5	3.1	3.4	3.4	3.5			Newest	3.5
Oldest Module and Lesson # numbers taught	2.9	3.1	3.1	3.1	3.1	3.2	3.1	3.1			Oldest	2.9
# CGVs observed with QIVC*	2	3	2	1	2	1	1	1			13	
Average QIVC Score	89%	80%	62%	90%	89%	75%	70%	90%			81%	

**Note: each Promoter should conduct a supervision visit for one CGV in each CG every two weeks. If a Promoter has 8 CGs then this would be 16 CGVs visited each month.*

Comments:

Promoter Name:	Rachel White

Summary of Neighbor Group Registers (Neighbor Women)

Care Group #:	8.1													
CGV Letter	A	B	C	D	E	F	G	H	I	J	K	L		Total
NW Attended 1st Mtg/HV	11	12	13	10	11	12	13	12	12	13	14	12		145
NW Registered 1st Mtg/HV	11	12	14	12	12	14	16	12	12	15	15	15		160
NW Attended 2nd Mtg/HV	10	12	10	11	11	13	12	12	11	14	13	14		143
NW Registered 2nd Mtg/HV	11	12	14	11	12	14	16	12	12	15	15	15		159
NW Maternal Deaths	0	0	0	1	0	0	0	0	0	0	0	0		1
NW U2 Child Deaths	1	0	0	0	0	0	1	0	0	0	0	0		2
NW Births	0	0	0	0	0	1	0	0	0	0	0	1		2
Newest Mod/Lssn taught	2.9	3.4	3.1	3.1	3.2	3.2	3.4	3.1	3.2	3.2	3.2	3.2		Newest 3.4
Oldest Mod/Lssn taught	2.9	3.1	3.1	3.1	3.1	3.1	3.2	2.9	3.1	3.1	3.1	3.1		Oldest 2.9

Care Group #:	8.2													
CGV Letter	A	B	C	D	F	G	H	I	J	K	L	M		Total
NW Attended 1st Mtg/HV	11	10	11	12	13	12	13	10	12	12	14	10		140
NW Registered 1st Mtg/HV	12	12	12	15	13	12	15	10	14	12	15	15		157
NW Attended 2nd Mtg/HV	10	12	10	11	11	13	12	12	11	14	13	14		143
NW Registered 2nd Mtg/HV	11	12	14	11	12	14	16	12	12	15	15	15		159
NW Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0		0
NW U2 Child Deaths	1	0	0	0	0	0	1	0	0	0	0	0		2
NW Births	0	0	0	0	1	0	0	0	0	0	0	1		2
Newest Mod/Lssn taught	3.2	3.4	3.1	3.1	3.1	3.1	3.4	3.3	3.1	3.1	3.1	3.1		Newest 3.4
Oldest Mod/Lssn taught	3.1	2.9	2.9	2.9	2.9	2.9	3.2	3.2	2.9	2.9	2.9	2.9		Oldest 3

Promoter Name:	Rachel White

Summary of Neighbor Group Registers (Neighbor Women)

Care Group #:	8.3														
CGV Letter	A	B	C	D	F	G	H	I	J	K	L	M		Total	
NW Attended 1st Mtg/HV	11	10	11	12	13	12	13	10	12	12	14	10		140	
NW Registered 1st Mtg/HV	12	12	12	15	13	12	15	10	14	12	15	15		157	
NW Attended 2nd Mtg/HV	10	12	10	11	11	13	12	12	11	14	13	14		143	
NW Registered 2nd Mtg/HV	11	12	14	11	12	14	16	12	12	15	15	15		159	
NW Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0		0	
NW U2 Child Deaths	1	0	0	0	0	0	1	0	0	0	0	0		2	
NW Births	0	0	0	0	1	0	0	0	0	0	0	1		2	
Newest Mod/Lssn taught	3.2	3.4	3.1	3.1	3.1	3.1	3.4	3.3	3.1	3.1	3.1	3.1		Newest	3.2
Oldest Mod/Lssn taught	3.1	2.9	2.9	2.9	2.9	2.9	3.2	3.2	2.9	2.9	2.9	2.9		Oldest	3.0

Care Group #:	8.4														
CGV Letter	A	B	C	D	F	G	H	I	J	K	L	M		Total	
NW Attended 1st Mtg/HV	14	13	10	13	10	12	15	10	13	12	14	12		148	
NW Registered 1st Mtg/HV	15	13	12	14	12	12	14	10	13	12	15	12		154	
NW Attended 2nd Mtg/HV	10	12	12	9	9	12	12	12	12	14	14	13		141	
NW Registered 2nd Mtg/HV	14	14	14	11	12	13	14	12	12	14	15	15		160	
NW Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0		0	
NW U2 Child Deaths	0	2	0	0	0	0	0	0	1	0	0	0		3	
NW Births	0	0	0	0	0	0	0	0	0	1	0	0		1	
Newest Mod/Lssn taught	3.2	3.4	3.1	3.1	3.1	3.1	3.4	3.3	3.1	3.1	3.1	3.1		Newest	3.5
Oldest Mod/Lssn taught	3.1	2.9	2.9	2.9	2.9	2.9	3.2	3.2	2.9	2.9	2.9	2.9		Oldest	3.0

Promoter Name:	Rachel White

Summary of Neighbor Group Registers (Neighbor Women)

Care Group #:	8.5														
CGV Letter	A	B	C	D	F	G	H	I	J	K	L	M		Total	
NW Attended 1st Mtg/HV	11	12	13	10	11	12	13	12	12	13	14	12		145	
NW Registered 1st Mtg/HV	11	12	14	12	12	14	16	12	12	15	15	15		160	
NW Attended 2nd Mtg/HV	10	12	10	11	11	13	12	12	11	14	13	14		143	
NW Registered 2nd Mtg/HV	11	12	14	11	12	14	16	12	12	15	15	15		159	
NW Maternal Deaths	0	0	0	1	0	0	0	0	0	0	0	0		1	
NW U2 Child Deaths	1	0	0	0	0	0	1	0	0	0	0	0		2	
NW Births	0	0	0	0	0	1	0	0	0	0	0	1		2	
Newest Mod/Lssn taught	3.2	3.4	3.1	3.1	3.1	3.1	3.4	3.3	3.1	3.1	3.1	3.1		Newest	3.1
Oldest Mod/Lssn taught	3.1	2.9	2.9	2.9	2.9	2.9	3.2	3.2	2.9	2.9	2.9	2.9		Oldest	2.9

Care Group #:	8.6														
CGV Letter	A	B	C	D	F	G	H	I	J	K	L	M		Total	
NW Attended 1st Mtg/HV	11	10	11	12	13	12	13	10	12	12	14	10		140	
NW Registered 1st Mtg/HV	12	12	12	15	13	12	15	10	14	12	15	15		157	
NW Attended 2nd Mtg/HV	10	12	10	11	11	13	12	12	11	14	13	14		143	
NW Registered 2nd Mtg/HV	11	12	14	11	12	14	16	12	12	15	15	15		159	
NW Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0		0	
NW U2 Child Deaths	1	0	0	0	0	0	1	0	0	0	0	0		2	
NW Births	0	0	0	0	1	0	0	0	0	0	0	1		2	
Newest Mod/Lssn taught	3.3	3.4	3.4	3.4	3.3	3.3	3.4	3.3	3.1	3.3	3.1	3.1		Newest	3.4
Oldest Mod/Lssn taught	3.2	3.2	3.3	3.2	3.3	3.3	3.2	3.2	3.2	3.2	3.2	3.2		Oldest	3.2

Promoter Name:	Rachel White

Summary of Neighbor Group Registers (Neighbor Women)

Care Group #:	8.7													
CGV Letter	A	B	C	D	F	G	H	I	J	K	L	M		Total
NW Attended 1st Mtg/HV	11	10	11	12	13	12	13	12	12	12	14	12		144
NW Registered 1st Mtg/HV	12	12	12	15	13	12	16	12	12	12	15	12		155
NW Attended 2nd Mtg/HV	10	12	10	11	11	13	12	12	11	14	14	13		143
NW Registered 2nd Mtg/HV	11	12	14	11	12	14	16	12	12	14	15	15		158
NW Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0		0
NW U2 Child Deaths	1	0	0	0	0	0	1	0	0	0	0	0		2
NW Births	0	0	0	0	1	0	0	0	0	1	0	0		2
Newest Mod/Lssn taught	3.3	3.4	3.4	3.4	3.3	3.3	3.4	3.4	3.4	3.3	3.1	3.1		Newest 3.4
Oldest Mod/Lssn taught	3.2	3.2	3.3	3.2	3.1	3.2	3.2	3.3	3.2	3.1	2.9	2.9		Oldest 3.0

Care Group #:	8.8													
CGV Letter	A	B	C	D	F	G	H	I	J	K	L	M		Total
NW Attended 1st Mtg/HV	12	13	12	12	12	14	12	12	13	12	10	11		145
NW Registered 1st Mtg/HV	12	16	12	12	12	15	12	15	13	12	12	12		155
NW Attended 2nd Mtg/HV	13	12	12	11	14	14	13	11	11	13	12	10		146
NW Registered 2nd Mtg/HV	14	16	12	12	14	15	15	11	12	14	12	14		161
NW Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0		0
NW U2 Child Deaths	0	1	0	0	0	0	0	0	0	0	0	0		1
NW Births	0	0	0	0	1	0	0	0	1	0	0	0		2
Newest Mod/Lssn taught	3.3	3.4	3.4	3.4	3.3	3.3	3.4	3.4	3.4	3.3	3.1	3.1		Newest 3.5
Oldest Mod/Lssn taught	3.2	3.2	3.3	3.2	3.1	3.2	3.2	3.3	3.2	3.1	2.9	2.9		Oldest 3.0

Handout 9E: Example Supervisor's Report

MCHN Supervisor Report

MNCH Supervisor Name:	Kelly Hughes	Reporting Period:	May-11
Promoter #s Supervisor is Responsible for:	5 thru 8	State/Province/District:	California, Los Angeles
Communities:			

Summary of Care Group Volunteers per Promoter

Promoter Number	5	6	7	8		Total		
# of Supervision Visits to this Promoter	2	3	4	3		12		
QIVC Score: Group Education	82%	85%	62%	80%		Average Score:		77%
Care Group #'s (1 thru 8)	1 thru 7	1 thru 5	1 thru 7	1 thru 8		Percent Attendance		
CGVs Attended 1st Meeting/Home visit	72	50	76	87		A	285	A/B x 100 =
CGVs Registered 1st Meeting/Home Visit	78	52	80	93		B	303	94%
CGVs Attended 2nd Meeting/Home Visit	70	48	79	86		C	283	C/D x 100 =
CGVs Registered 2nd Meeting/Home Visit	78	50	82	93		D	303	93%
CGV Maternal Deaths	0	0	0	1		1		
CGV U2 Child Deaths	2	1	0	2		5		
CGV Births	0	0	2	2		4		
Newest Module and Lesson # numbers taught	3.3	3.2	3.4	3.4		Newest	3.4	
Oldest Module and Lesson # numbers taught	3.0	2.8	2.9	2.9		Oldest	2.9	
# of CGVs observed with QIVC	6	5	4	9		24		
Average QIVC Score	79%	65%	82%	81%		77%		

Comments: (Target= Promoter 1: 8 CGs X 12 CGVs; Promoter 2: 7 CGs v 12 CGVs; Promoter 3: 9 CGs x 12 CGVs: Promoter 4: 8 CGs X 12 CGVs)			
	% of Promoters who completed all 6 QIVC's this month		50%
	Average CGV Attendance this Month (A+C)/2	E	284
	Target # of CGV to be registered by this Supervisor	F	384
	% of Attendance Target reached this month E/F x 100		74%

MCHN Supervisor Name:	Kelly Hughes

Summary of Neighbor Women by Promoter and Care Group

Promoter Number	5											
CG #s Responsible for	5.1	5.2	5.3	5.4	5.5	5.6	5.7				Total	Percent Attendance
NW Attended 1st Mtg/HV	145	140	155	125	150	161	170				A 1046	A/B x 100 =
NW Registered 1st Mtg/HV	150	162	172	160	162	164	182				B 1152	91%
NW Attended 2nd Mtg/HV	149	160	162	145	145	162	175				C 1098	C/D x 100 =
NW Registered 2nd Mtg/HV	150	164	180	162	165	168	182				D 1171	94%
NW Maternal Deaths	0	0	1	0	0	0	0				1	
NW U2 Child Deaths	1	2	1	2	1	2	2				11	
NW Births	1	2	1	3	1	1	1				10	
Newest Mod/Lesson taught	3.3	3.3	3.2	3.1	3.1	3.3	3.3				Newest 3.3	
Oldest Mod/Lesson taught	3.0	3.0	3.0	3.0	3.1	3.1	3.0				Oldest 3.0	

Avg NW Attendance this Month (A+C)/2	E	1072
Target # of NW to be Registered by this Promoter	F	1152
% Attendance Target reached E/F x 100		93%

Comments:
(Target= Promoter 1: 8 CGs X 12 CGVs X 12 NW; Promoter 2: 7 CGs v 12 CGVs X 12 NW; Promoter 3: 9 CGs x 12 CGVs X 12 NW: Promoter 4: 8 CGs X 12 CGVs X 12 NW)

Promoter Number	6											
CG #s Responsible for	6.1	6.2	6.3	6.4	6.5						Total	Percent Attendance
NW Attended 1st Mtg/HV	152	149	160	150	165						A 776	A/B x 100 =
NW Registered 1st Mtg/HV	162	155	172	190	182						B 861	90%
NW Attended 2nd Mtg/HV	155	161	171	172	181						C 840	C/D x 100 =
NW Registered 2nd Mtg/HV	163	165	175	189	185						D 877	96%
NW Maternal Deaths	0	1	0	0	0						1	
NW U2 Child Deaths	2	0	2	1	1						6	
NW Births	2	1	2	1	1						7	
Newest Mod/Lesson taught	3.1	3.2	3.2	3.1	3.1						Newest 3.2	
Oldest Mod/Lesson taught	2.8	2.9	3.0	3.0	3.1						Oldest 2.8	

Avg NW Attendance this Month (A+C)/2	E	808
Target # of NW to be Registered by this Promoter	F	1152
% Attendance Target reached E/F x 100		

Comments:
(Target= Promoter 1: 8 CGs X 12 CGVs X 12 NW; Promoter 2: 7 CGs v 12 CGVs X 12 NW; Promoter 3: 9 CGs x 12 CGVs X 12 NW: Promoter 4: 8 CGs X 12 CGVs X 12 NW)

MNCH Supervisor Name:	Kelly Hughes

Promoter Number	7											
CG #s Responsible for	7.1	7.2	7.3	7.4	7.5	7.6	7.7				Total	Percent Attendance
NW Attended 1st Mtg/HV	170	164	154	134	149	134	181				A 1086	A/B x 100 = 91%
NW Registered 1st Mtg/HV	182	180	172	160	152	155	191				B 1192	
NW Attended 2nd Mtg/HV	152	163	162	135	132	120	171				C 1035	C/D x 100 = 86%
NW Registered 2nd Mtg/HV	183	179	172	170	150	160	190				D 1204	
NW Maternal Deaths	0	0	0	0	0	0	0				0	
NW U2 Child Deaths	2	0	1	2	1	0	1				7	
NW Births	1	2	0	2	1	2	0				8	
Newest Mod/Lesson taught	3.1	3.2	3.2	3.4	3.4	3.3	3.3				Newest 3.4	
Oldest Mod/Lesson taught	3.0	2.9	3.0	3.0	3.1	3.1	3.0				Oldest 3.0	
Comments: (Target= Promoter 1: 8 CGs X 12 CGVs X 12 NW; Promoter 2: 7 CGs v 12 CGVs X 12 NW; Promoter 3: 9 CGs x 12 CGVs X 12 NW: Promoter 4: 8 CGs X 12 CGVs X 12 NW)					Avg NW Attendance this Month (A+C)/2						E 1061	
					Target # of NW to be Registered by this Promoter						F 1152	
					% Attendance Target reached E/F x 100						92%	

Promoter Number	8											
CG #s Responsible for	8.1	8.2	8.3	8.4	8.5	8.6	8.7	8.8			Total	Percent Attendance
NW Attended 1st Mtg/HV	145	140	142	148	145	140	144	145			A 1149	A/B x 100 = 91%
NW Registered 1st Mtg/HV	160	157	160	154	160	157	155	155			B 1258	
NW Attended 2nd Mtg/HV	143	143	143	141	143	143	143	146			C 1145	C/D x 100 = 90%
NW Registered 2nd Mtg/HV	159	159	159	160	159	159	158	161			D 1274	
NW Maternal Deaths	1	0	0	0	1	0	0	0			2	
NW U2 Child Deaths	2	2	2	3	2	2	2	1			16	
NW Births	2	2	2	1	2	2	2	2			15	
Newest Mod/Lesson taught	3.4	3.4	3.2	3.5	3.1	3.4	3.4	3.5			Newest 3.5	
Oldest Mod/Lesson taught	2.9	3.0	3.0	3.0	3.0	3.2	3.0	3.0			Oldest 3.0	
Comments: (Target= Promoter 1: 8 CGs X 12 CGVs X 12 NW; Promoter 2: 7 CGs v 12 CGVs X 12 NW; Promoter 3: 9 CGs x 12 CGVs X 12 NW: Promoter 4: 8 CGs X 12 CGVs X 12 NW)					Avg NW Attendance this Month (A+C)/2						E 1147	
					Target # of NW to be Registered by this Promoter						F 1152	
					% Attendance Target reached E/F x 100						100%	

Handout 9F: Example Coordinator's Report

MCHN Coordinator Report

MCHN Coordinator Name:	Sarah Smith	Reporting Period:	May-11
Supervisors the Coordinator is Responsible for :	Carolyn, Kelly, Jen, snd Emily	State/Province/District:	West, California, Los Angeles
Communities:			

Summary of Care Group Volunteers per Supervisor

Supervisor Name	Carolyn	Kelly	Jen	Emiliy		Total		
# of Supervision Visits to this Supervisor	4	3	2	3		12		
Promoter and CG#s Responsible for	1.1 thru 4.8	5.1 thru 8.8	9.1 thru 12.8	13.1 thru 16.8				
QIVC Score: Group Education	75%	81%	62%	91%		Average Score		77%
CGVs Attended 1st Meeting/ Home visit	352	285	321	332		Percent Attendance		
CGVs Registered 1st Meeting/ Home Visit	392	303	352	401		A	1290	A/B x 100 =
CGVs Attended 2nd Meeting/ Home Visit	372	283	352	342		B	1448	89.1%
CGVs Registered 2nd Meeting/ Home Visit	405	303	360	402		C	1349	C/D x 100 =
CGV Maternal Deaths	1	1	0	0		D	1470	91.8%
CGV U2 Child Deaths	3	5	2	1		11		
CGV Births	5	3	3	4		15		
Newest Module/Lesson # numbers taught	3.3	3.4	3.4	3.5		Newest	3.5	
Oldest Module/Lesson # numbers taught	2.9	2.9	3.1	3.1		Oldest	2.9	
# of CGVs observed with QIVC	31	24	32	28		115		
Average QIVC Score	85%	77%	92%	69%		81%		
% of Promoters who completed all 6 QIVCs:	70%	50%	92%	65%		69%		

Comments: For Target: Added up numbers from all Supervisor reports			
	% of Promoters who completed all 6 QIVC's this month	69%	
	Average CGV Attendance this Month (A+C)/2	E	1320
	Target # of CGV to be registered for this Coordinator	F	1536
	% of Attendance Target reached this month E/F x 100	86%	

MCHN Coordinator Name:	Sarah Smith

Summary of Neighbor Women by Supervisor & Promoter

Supervisor Name	Carolyn Wilson							
Promoter #	1	2	3	4		Total		Percent Attendance
NW Attended 1st Meeting/ Home visit	921	872	801	941		A	3535	A/B x 100 =
NW Registered 1st Meeting/ Home Visit	1001	902	821	851		B	3575	99%
NW Attended 2nd Meeting/ Home Visit	923	840	821	856		C	3440	C/D x 100 =
NW Registered 2nd Meeting/ Home Visit	1005	925	850	860		D	3640	95%
NW Maternal Deaths	0	1	0	1		2		
NW U2 Child Deaths	3	5	4	11		23		
NW Births	9	6	9	10		34		
Newest Mod/Lesson taught	3.3	3.2	3.2	3.3		Newest	3.3	
Oldest Mod/Lesson taught	3.0	3.1	3.2	3.3		Oldest	2.9	
Comments: *For Target: Added up numbers from all Supervisor reports*	Average NW Attendance this Month (A+C)/2					E	3487.5	
	Target # of NW to be registered by this Supervisor					F	4608	
	% of Attendance Target reached this month E/F x 100					76%		

Supervisor Name	Kelly Hughes							
Promoter #	5	6	7	8		Total		Percent Attendance
NW Attended 1st Meeting/ Home visit	1046	776	1086	1149		A	4057	A/B x 100 =
NW Registered 1st Meeting/ Home Visit	1152	861	1192	1258		B	4463	91%
NW Attended 2nd Meeting/ Home Visit	1098	840	1035	1145		C	4118	C/D x 100 =
NW Registered 2nd Meeting/ Home Visit	1171	877	1204	1274		D	4526	91%
NW Maternal Deaths	1	1	0	2		4		
NW U2 Child Deaths	11	6	7	16		40		
NW Births	10	7	8	15		40		
Newest Mod/Lesson taught	3.3	3.2	3.4	3.4		Newest	3.3	
Oldest Mod/Lesson taught	3.0	2.8	2.9	2.9		Oldest	2.9	
Comments: *For Target: Added up numbers from all Supervisor reports*	Average NW Attendance this Month (A+C)/2					E	4088	
	Target # of NW to be registered by this Supervisor					F	4608	
	% of Attendance Target reached this month E/F x 100					89%		

MCHN Coordinator Name:	Sarah Smith

Summary of Neighbor Women by Supervisor & Promoter

Supervisor Name	Jen Milner							
Promoter #	9	10	11	12		Total		Percent Attendance
NW Attended 1st Meeting/ Home visit	800	901	954	776		A	3431	A/B x 100 =
NW Registered 1st Meeting/ Home Visit	820	950	998	802		B	3570	96%
NW Attended 2nd Meeting/ Home Visit	802	897	951	790		C	3440	C/D x 100 =
NW Registered 2nd Meeting/ Home Visit	865	925	1001	823		D	3614	95%
NW Maternal Deaths	0	1	0	0		1		
NW U2 Child Deaths	1	7	2	9		19		
NW Births	7	9	5	8		29		
Newest Mod/Lesson taught	3.3	3.2	3.4	3.3		Newest	3.4	
Oldest Mod/Lesson taught	3.1	3.1	3.2	3.3		Oldest	3.1	
Comments: *For Target: Added up numbers from all Supervisor reports*	Average NW Attendance this Month (A+C)/2					E	3436	
	Target # of NW to be registered by this Supervisor					F	4608	
	% of Attendance Target reached this month E/F x 100					75%		

Supervisor Name	Emily Hayes							
Promoter #	13	14	15	16		Total		Percent Attendance
NW Attended 1st Meeting/ Home visit	962	852	951	801		A	3566	A/B x 100 =
NW Registered 1st Meeting/ Home Visit	982	872	1021	898		B	3773	95%
NW Attended 2nd Meeting/ Home Visit	941	825	976	856		C	3598	C/D x 100 =
NW Registered 2nd Meeting/ Home Visit	1001	880	1025	912		D	3818	94%
NW Maternal Deaths	1	0	0	0		1		
NW U2 Child Deaths	2	6	1	5		14		
NW Births	6	5	7	5		23		
Newest Mod/Lesson taught	3.3	3.5	3.4	3.3		Newest	3.5	
Oldest Mod/Lesson taught	3.1	3.3	3.2	3.3		Oldest	3.1	
Comments: *For Target: Added up numbers from all Supervisor reports*	Average NW Attendance this Month (A+C)/2					E	3582	
	Target # of NW to be registered by this Supervisor					F	4608	
	% of Attendance Target reached this month E/F x 100					78%		

Handout 9G: Report Quiz

1. Look at Promoter Rachel White's Monthly Report.
    a. How many CG Volunteers were observed with a QIVC?

    b. How many Care Groups does Rachel White train and supervise?

    c. How many of Rachel's CG Volunteers had babies during the month of May?

    d. In Care Group 10.4 – how many Neighbor Women attended the first meeting/home visit?

2. Now look at MCHN Supervisor Kelly Hughes' Report
    a. What percent of CG Volunteers under this Supervisor attended the second meeting?

    b. For all neighbor women under Promoter # 8 – how many children less than two years of age died?

3. Finally, look at the MCHN Coordinator Sarah Smith's Report
    a. What percentage of Sarah's Promoters completed all 6 QIVCs this month?

    b. What percentage of Sarah's target CG Volunteers were reached in May?

    c. Find the Summary Information of Neighbor Women under Supervisor Emily Hayes. How many total neighbor women were registered during the second half of the month?

Handout 9H: Report Quiz Answers

1. Look at Promoter Rachel White's Monthly Report.
   a. How many CG Volunteers were observed with a QIVC? *13*
   b. How many Care Groups does Rachel White train and supervise? *8*
   c. How many of Rachel's CG Volunteers had babies during the month of May? *2*
   d. In Care Group 8.4 – how many Neighbor Women attended the first meeting/home visit? *148*

2. Now look at MCHN Supervisor Kelly Hughes' Report
   a. What percent of CG Volunteers under this Supervisor attended the second meeting? *93%*
   b. For all Neighbor Women under Promoter # 8 – how many children less than two years of age died? 1*6*

3. Finally, look at the MCHN Coordinator Sarah Smith's Report
   a. What percentage of Sarah's Promoters completed all 6 QIVCs this month? *69%*
   b. What percentage of Sarah's target CG Volunteers were reached in May? 86%
   c. Find the Summary Information of Neighbor Women under Supervisor Emily Hayes. How many total neighbor women were registered during the second half of the month? *3818*

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Handout 9I: Act it Out!

Each table/team will require:

- Five filled Promoter Reports (reminder: Facilitator needs to prepare these before the training using Handout 9A (Blank Promoter Report) as a guide
- One blank Supervisor Report: Handout 9B
- Completed Supervisor Report (answers will depend on the Promoter reports prepared – the Facilitator should prepare this at the same time he/she prepares the five filled Promoter Reports)

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Lesson 10: Curriculum Training Schedule

<table>
<tr><td colspan="2">Objectives:
1. Participants will be able to describe the trainings which they are responsible for and how often those training will happen as well as the length of the meetings.
2. Participants will be able to list the things that will take place during the Bi-Monthly Training Meeting and the purpose of these activities.</td></tr>
<tr><td>Summary: 1 hour, 40 minutes
• Telephone Game (20 min)
• Training Race (20 min)
• Training Discussion (20 min)
• Agenda Assembly Activity (20 min)
• Agenda Discussion (20 min)</td><td>Materials needed:
☐ Flipchart or whiteboard with markers
☐ Handout 10A: Training Table [Print one copy for every 4-6 participants]
☐ Handout 10B: Training Table Answer Key [Print one group of papers cut into strips for every 4-6 participants]
☐ Handout 10C: Agenda Assembly Game [Print 1 for every 3-4 participants; cut into squares]
☐ Handout 10D: Agenda Overview Answers
☐ Rocks to hold down papers (or tin cans or baskets to hold the slips of paper for each team).
☐ Masking tape (a strip for each team)
☐ Prize for the winning team</td></tr>
</table>

We will begin today's session on training with a short game. It's called the telephone game.

Telephone Game (20 minutes)

1. Ask the participants to sit in a circle.
2. The facilitator thinks of a long sentence. For example, "The importance of training is that you learn something new that changes your life and want to transmit that message to others."
3. He whispers this sentence into the ear of the person sitting on his/her right.
4. He cannot repeat the sentence and the person listening cannot ask for clarification.
5. The listener must whisper the sentence that he heard into the ear of the person on his/her right.
6. The message should be passed by whispering from one person to the next until it reaches the last person in the circle.
7. The last person in the circle then shares aloud the message that he/she heard.
8. The facilitator then shares his original message aloud.

Discussion questions:

- ? Did the message stay the same from beginning to end? Why not?
- ? What could help the message "stay true" to its original meaning? What could we have done differently

Add any of the following points of they are not mentioned:

- The whisperer could ask the listener to repeat it back to him and confirm if what he heard was correct.
- If the whisperer could ask questions, it would help clear up confusion that he had.

? What can we learn from this game that might help us when we train and teach others?

- We can't assume that the learners comprehend and understand everything that we say the first time that we say it.
- During trainings, we must spend a lot of time asking others to repeat what they have heard so we can be sure they understand the message.
- Note: This is why our lesson plans prioritize a time of practice and coaching whenever training trainers. We must watch EACH trainer/participant teach the lesson just as he/she was taught and coach and correct him/her until they can teach well.

(Optional) Telephone Game #2
• Repeat the telephone game again with a new message. • This time, the listener repeats the message that he heard, whispering it back to the person on their left. That person who either confirms or corrects the message by whispering it back and clarifying parts that were misunderstood. • Continue passing the message around the circle allowing each listener to confirm the message with the person before them. • Compare the messages at the end. • Discuss the difference between this telephone game and the first one.

Training Race (20 minutes)

You will need a large area to play this game. If necessary, move outside or move chairs away from the center of the room to give more room.

Next we will do an activity to review the different trainings that will happen in the Care Group program. You will in teams to try to fill out a chart of Care Group trainings.

Explain:
We have NOT discussed in detail the types of training, or how long trainings will last. However, we are looking at the 5 different layers of staff. And the point is to discover the answers by using your common knowledge and understanding.

For example, (point to a blank chart from the Training Race)

? Which of these people have the greatest responsibility for the program?

? Which of these people have the least amount of responsibility (in terms of hours)?

? How do you think the level of responsibility affects the trainings given?

Add: Would a training given by a MCHN Supervisor be longer or shorter (in hours) than a training given by a CG Volunteer?

Answer: Those with more responsibility will give very detailed trainings that are more intense and longer than the trainings for those who have less responsibility. Volunteers also have less time devoted to the project, so they will be training in very short segments compared to the others.

Use this information when trying to arrange the slips in the proper place!

Preparing for the Game

1. Split the participants into teams of 4-6 people.
2. At the far side of the room, place one blank Training Handout (Handout 10A) for each team in a row. Place a long strip of masking tape on the wall, or in the grass so the participants can tape down the slips of paper.
3. On the opposite side of the room, each team will line up across from one of the training handouts. The teams must be equally spaced from the handouts and each other.
4. Place one set of the small squares of paper at the start of each team line. If outdoors, place a rock on top of the stack of papers so they do not fly away as the times run back and forth.

Explaining the Rules – referring to a blank handout

5. The handout lists the different trainings that each staff member is responsible for as a part of the Care Group model. The first column lists the trainers. The second column lists the participants (those who will receive the training). The third column is the length of the training (is it one day or 7 days or 2 hours). The next column lists the frequency (how often the training occurs) and the last column lists what materials are used for this training.
6. The first 3 or 4 people may have a hard time placing their slip of paper on the chart. So you may want to tape the ones where you are not sure to the side, until you can get all of the pieces together.
7. However it is a race, the first team to finish their handout must pick it up and bring it to the facilitator who will review it.
8. The team that finishes CORRECTLY first will win a prize.
9. Each team must stand in a line. The first member of each team will pick up ONE slip of paper from their tin can (or basket) and run to the other side of the room where their team handout is placed.
10. They will put the slip of paper in the correct category and tape it down (or tape it to the side if they are not sure).
11. When they are finished they will run back to their team, tag the next person who will take the next slip of paper, race to the other side of the room and tape it to the correct place on the handout.
12. Only one person can look at the handout at a time.

13. Your team must be tagged (you cannot run ahead before your team member has tagged you).

Answer questions.
Begin the game.

When one of the teams completes the handout correctly, stop the game and award the prize. Distribute the Answer Key Handout 10B and review the corrected table.

Training overview / Discussion (20 minutes)

Review the correct answers with the participants.
Add more details as needed when questions arise.

Lead Trainer	People receiving the training	Length of the Training	Frequency	Materials
MCHN Manager	Supervisors, Coordinators, Promoters	5-7 days	Before each module distribution	New Flipchart & Lesson Plan

- The MCHN Manager conducts a 5-7 day training for the Coordinators, Supervisors, and Promoters on each new module before it is distributed to the community.
- Depending on the level of expertise the MCHN Manager and/or Coordinators have about the topics covered in the module, it may be helpful to invite an experienced community health practitioner to co-facilitate the training and/or be available to answer questions that arise.
- This training includes the technical basis for the module, training on the use of the lesson plan and several days of coaching and practicing of the lessons by each Coordinator, Supervisor, and Promoter.
- Normally this training happens about every 3 months (assuming each module is about six lessons), or before the distribution of each module.
- Inviting personnel who work in the health facilities where the CG Program is operating to attend the 5-7 day module training is an excellent way to promote collaboration between the government health system and the Care Group community health system. It also equips health facility staff with knowledge and tools to share the same behavior change messages when community members seek facility services.
- In larger Care Group programs the distances required for staff to travel to bring all the Coordinators, Supervisors and Promoters together may be prohibitive or there may be too many staff members to run an effective training. (It is not recommended to train people in groups larger than 25.) In these cases it is advisable for the MCHN Manager to train the Coordinators and Supervisors in the module content and then have the Coordinators and Supervisors train the Promoters in their region.

Lead Trainer	People receiving the training	Length of the Training	Frequency	Materials
MCHN Supervisors	CG Promoters	½ day	Every 2 weeks	Review of this week's lesson in flipchart and lesson plan

- The Supervisors review this current lesson with the Promoters every two weeks and spend time coaching them so they are ready to replicate the lesson with the Care Group Volunteers.
- Remember this is the second time the Promoters will receive training on the module.
- The first training they received was the week long training from the MCHN Manager and/or Health & Nutrition Coordinators.
- Every two weeks they receive refresher training from their Supervisor and spend more time practicing the lessons together.

Lead Trainer	People receiving the training	Length of the Training	Frequency	Materials
CG Promoters	CG Volunteers	2 hours	Every 2 weeks	Flipchart and Lesson Plan

- The Promoters will teach a new lesson to the Care Group Volunteers every two weeks, and spend time coaching them so they are ready to teach others.
- This includes discussion, games, activities and a time for discussing barriers and making commitments. Everything that they learned from their Supervisor and MCHN Manager, they will repeat with the Care Group volunteers.
- The materials needed are a flipchart and a lesson plan. FH has a detailed lesson plan that gives literate staff extensive details about games to play with each lesson, activities to include, and the procedure for the facilitator to go through each time they teach.
- The lesson plan is like a teacher's manual that guides the literate facilitator when training.

Lead Trainer	People receiving the training	Length of the Training	Frequency	Materials
CG Volunteers	Neighbor Women	1-1.5 hours	Every 2 weeks	Flipchart

- The Care Group Volunteers teach a new lesson to their neighbor groups every two weeks. This includes discussion, games, activities and a time for discussing barriers and making commitments.

- Most Care Group Volunteers are not literate, so their only tool is the flipchart. However, they will model everything they saw and heard the promoter say – so it's important that the Promoters model the correct behavior during each training.

  Answer Questions.

Bi-Monthly Training Meeting (20 minutes)

Let's review in details a possible plan for the Training that takes place every two weeks between the Supervisor and the CG Promoters.

We have put together a sample agenda. Instead of reviewing it with you, I want you to interact with the items on the agenda.

Setting up the Activity

1. Put participants into groups of 3-4.
2. Give each group a cut-out stack of the different sections on the agenda (Handout 10C).
3. Ask each group to find the activities and match them with the purpose for that activity and the materials needed (or ideas for teaching).
4. Explain that the last column gives a few more details to explain how to plan for the activity.
5. Ask them to arrange the items in the order of what should happen first, second, third etc.
6. Give them 15-20 minutes to complete the activity.

Put the following on a flipchart to clarify how to set up the items.

Activities (8)	Purpose (8)	Materials and/or Ideas for Teaching (8)
1. 2. 3. Etc.		

Agenda Assembly Discussion (20 minutes)

After all the groups have finished, encourage the groups to walk around to each table and compare their results with the results of the others tables.

Lead a discussion of the following:

- ? What did you group have in common with the other groups?
- ? What did you group do differently than the other groups?
- ? What is the purpose of this meeting?

? Is there anything you would add to this agenda if you were running the meeting?

Give out Handout 10D; the Bi- Monthly Training Meeting (overview and agenda)

Add:
- The order of the items on the agenda is somewhat subjective. The one thing that must be prioritized is that the teaching of the module is done first (when the promoters are "fresh"). If the training is done at the end of the lesson, it may be cut short because of time or the energy of the participants.
- Review the agenda, purpose and materials as needed.

Answer questions.

Additional Discussion when Training Trainers:
What is the purpose of doing a sorting and arranging activity in a small group?

It forces participants to talk to each other, stand up, read and discuss and reflect on the information. Whatever your role as a teacher or trainer, you must always remember to be intentional about *how* you teach others. A successful training is one where the students learn by discovering things on their own, learning from their colleagues as well as from the facilitator. If the only person they hear from is the facilitator, a great learning opportunity will be lost. When preparing a Bi-Monthly Training Meeting or your next Care Group Training, always plan for and encourage interaction and discussion amongst participants.

Handout 10A: Training Table (page 1-2) Do not cut this page.

Training	Lead Trainer	People receiving the training	Length of the Training	Frequency	Materials
	MCHN Manager				
	MCHN Supervisors				
	CG Promoters				
	CG Volunteers				

Handout 10A: **Training Table Answers (Page 2 of 2)**

Cut the squares out, mix them up and place in a pile at the start of each team's line (under a rock or in a small tin).

MCHN Manager	Super, Coordinators, Promoters	5-7 days	Before each module distribution	New Flipchart & Lesson Plan
MCHN Supervisors	CG Promoters	½ day	Every 2 weeks	Review of this week's lesson in flipchart and lesson plan
CG Promoters	CG Volunteers	2 hours	Every 2 weeks	Flipchart and Lesson Plan
CG Volunteers	Neighbor Women	1-1.5 hours	Every 2 weeks	Flipchart

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Handout 10B: Training Table ANSWER KEY

Training	Lead Trainer	People receiving the training	Length of the Training	Frequency	Materials
	MCHN Manager	Super, Coordinators, Promoters	5-7 days	Before each module distribution	New Flipchart and Lesson Plan
	MCHN Supervisors	CG Promoters	½ day	Every 2 weeks	Review of this week's lesson in flipchart and lesson plan
	CG Promoters	CG Volunteers	2 hours	Every 2 weeks	Flipchart and Lesson Plan
	CG Volunteers	Neighbor Women	1-1.5 hours	Every 2 weeks	Flipchart

Handout 10C: Agenda Assembly

Cut along the lines. Mix up the papers. Make one group of papers for every 3-4 participants.

Devotional or Reflection (30 min)	• To strengthen and encourage Promoters • To orient Promoters to a worldview that facilities development.	• Devotional Materials • Invite Leaders / pastors to facilitate this part of the meeting.
Review of the flipchart lesson (20 minutes)	• To reinforce key health messages • To reinforce activities which accompany the teaching of the lesson.	• Use the Lesson Plan Template to help you remember each part of the lesson. • Demonstrate / model the teaching of the entire lesson. • Practice all demonstrations with the Promoter.
Practice and Coaching (60-90 min)	• To ensure Promoter are able to teach the lessons effectively.	• In pairs, the Promoters teach the lessons to each other; the Supervisor watches and coaches them.
Collect and review Promoter reports (20 minutes)	• To gather information for quarterly reports on vital events and attendance. • To meet monthly and quarterly targets.	• Promoters fill out the report, using their completed registers. Registers track attendance, vital events, and other key program elements. • Supervisor and Promoter create a commune or district level report.
Discuss solutions to problems that have risen. (30 minutes)	• To help staff overcome problems (poor attendance or vital events that need intervention [ex. Cholera]).	• Discuss good things that are happening as well as the challenges. • Work together to solve challenges and find a way forward.
Discuss plans for upcoming events (community or organization events) (20 min)	• To prepare staff and the community for upcoming events. • To ensure that no other events are planned that conflict with activities.	• Consider possible problems that could arise during these events. Create plans with Promoters' input to overcome these problems. • If a conflict is found, work together to reschedule events.
Review of Promoter's 4-week work plan (5 min)	• To ensure that Promoter are preparing all of their given activities and scheduled them in advance.	• Promoter share 4-week plan (prepared in advance). The Supervisor makes a copy of the plan (both have one copy).

Supervision Scheduling (5 min)	• To let each Promoter know when the Supervisor will come for a planned visit.	• The Supervisor informs Promoters of when they will receive their scheduled visit over the next month. • Ensure both the Promoters and the Supervisor note the visit time and place.

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Handout 10D: Bi-Monthly Training Meeting

Objectives of the Meeting:

- To encourage and improve the work of the Promoter
- To review this month's health lesson
- To discuss troubles or problems that the Promoter have encountered: to coach and mentor them, giving them the ability to overcome these problems.
- To alert the Promoter to upcoming program events.
- To gather attendance and vital event information from the Promoter from their last meeting with the Care Group Volunteers.

Who attends?

- The Supervisor and his (or her) Promoters.

Where is it held?

- At the office or another quiet place where 9-10 people can sit comfortably

How often does this meeting happen?

- Twice a month

Length of meeting?

- 3.5 - 6 hours
- Meeting should be worth the Promoter's time (some must travel great distances).
- Some Promoter may have to arrive the day before and return home the day after.
- If the project office is far from the communities where Promoter's work it may be advisable for the Supervisor to travel to where the Promoters work. In some projects the Promoter's host the meeting in a rotating fashion.

Costs?

- Refer to your staff budget
- A day-long meeting might include lunch (if budgeted).

What should the Supervisor bring?

- Devotional Material as appropriate*
- Flipchart (for this month's health lesson) and Lesson Plan
- A schedule of upcoming program information
- The Supervisor's work plan for the next month
- Regional Monthly Report form (to be filled out during the meeting – taking information from the Promoter).

What should the Promoter bring?

- Flipchart (for this month's health lesson) and Lesson Plan
- Attendance Registers from their last meeting
- QIVCs she used in the last month
- Completed Monthly Report from their last meeting
- Promoter' work plan for the next month

Sample Meeting: (3.5 hours) Activity	**Objective**	**Ideas/Materials/Activities**
1. Devotional or Reflection (30 min)	• To strengthen and encourage Promoter • To orient Promoter to a worldview that facilities development.	• Devotional Materials • Invite Leaders / pastors to facilitate this part of the meeting.
2. Review of the flipchart lesson (20 minutes)	• To reinforce key health messages • To reinforce activities which accompany the teaching of the lesson.	• Use the Lesson Plan Template to help you remember each part of the lesson including the game, discussion of barriers and activity. • Demonstrate / model the teaching of the entire lesson.
3. Practice and Coaching (60-90 min)	• To ensure Promoter are able to teach the lessons effectively.	• In pairs, the Promoters teach the lessons to each other; the Supervisor watches and coaches them.
4. Collect and review Promoter reports (20 minutes)	• To gather information for quarterly reports on vital events and attendance. • To meet monthly and quarterly targets.	• Promoters fill out the report, using their completed registers.[3] Registers track attendance, vital events, and other key program elements. • Supervisor and Promoter create a commune or district level report.
5. Discuss solutions to problems that have risen. (30 minutes)	• To help staff overcome problems (poor attendance or vital events that need intervention [ex. Cholera]).	• Discuss good things that are happening as well as the challenges. • Work together to solve challenges and find a way forward.
6. Discuss plans for upcoming events (community or organization events) (20 min)	• To prepare staff and the community for upcoming events. • To ensure that no other events are planned that conflict with activities.	• Consider possible problems that could arise during these events. Create plans with Promoters' input to overcome these problems. • If a conflict is found, work together to reschedule events.
6. Review of Promoter's 4-week work plan. (5 min)	• To ensure that Promoter are preparing all of their given activities and scheduled them in advance.	• Promoter share 4-week plan (prepared in advance). The Supervisor makes a copy of the plan (both have one copy).

[3] Registers that are made with carbon copies, can allow the promoter to turn in one copy of their report and retain a copy.

7. Supervision Scheduling (5 min)	• To let each Promoter know when the Supervisor will come for a planned visit.	• The Supervisor informs Promoters of when they will receive their scheduled visit over the next month. • Ensure both the Promoters and the Supervisor note the visit time and place.

Lesson 11: Checklists for Supervising the Care Group Promoters, Maternal and Child Health Supervisors and Maternal and Child Health Coordinators

<table>
<tr><td colspan="2">

Objectives:

1. Participants will be able to define supervision: the process designed to mentor and coach a worker to gain the independence, self-confidence and skills needed to effectively accomplish the job.
2. Participants will be able to fill out the Checklists for Supervision appropriately.
3. Participants will be able to describe why the Checklist and specific actions are necessary.

</td></tr>
<tr><td>

Summary: 2 hours 30 minutes

- Introduction to Supervision (15 minutes)
- Review of Supervision Checklists (45 minutes)
- Activity: Supervision Actions Game (45 minutes)
- Activity: Checklist for Supervision Quiz (45 minutes)

</td><td>

Materials:

☐ Butcher/flipchart paper, markers, pens for participants
☐ Handout 11A: MCHN Supervisor's Checklist for Supervising a CG Promoter [Print one per participant]
☐ Handout 11B: MCHN Coordinator's Checklist for Supervising a MCHN Supervisor [Print one per participant]
☐ Handout 11C: Program Manager's Checklist for Supervising a MCHN Coordinator [Print one per participant]
☐ Handout 11D: Supervision Actions Game [Print one copy]
☐ Handout 11E: Checklist for Supervision Quiz [Print one per participant]
☐ Handout 11F: Checklist for Supervision Quiz Answers [Print one for each Facilitator]

</td></tr>
</table>

Introduction to Supervision - 15 minutes

? How would you define supervision?

Turn to the person next to you and write a short definition… (2-3 minutes)

Listen to definitions given, write them on a flipchart. Summarize the definitions given – then ask them to consider this definition:

<u>The process designed to mentor and coach a worker</u> to gain the independence, self-confidence and skills needed to effectively accomplish the work.

Review the meaning of the definition, underlining key phrases as noted below.

It's a process – not a onetime event.

It is a planned process – a designed process

The purpose is to mentor and coach a worker so he or she can effectively accomplish the job. Three things the worker will gain – independence, self-confidence and skills

- ? ***What are the experiences that you have had with supervisors? Which of these aspects was missing?***
- ? ***Do you think YOU could be a supervisor who did these things?***

Remember: in order to change others – we have to first change ourselves. I would encourage you to write this definition on the wall of your office and practice doing these things with those you supervise.

Review of Supervision Checklists (45 minutes)

? For those of you who have supervised field workers before, what are the different things that you need to watch, observe and review on a supervision visits?

Pass out Handout 11A: MCHN Supervisor's Checklist for Supervising a CG Promoter[4]

On this checklist for supervision, there are nine categories that we suggest the MCHN Supervisor reviews while conducting a supervision visit to a CG Promoter.

1. Observe CG Promoter Teaching CG Volunteers
2. Review the CG Promoter's Register of CG Volunteers and Neighbor Women
3. Review the CG Promoter's Monthly Reports
4. Observe the CG Promoter's Equipment
5. Visit CG Volunteers
6. Visit Neighbor Women
7. Visit Community Leaders or participate in a Community Leadership Meeting
8. Visit the Health Worker at the nearest Health Facility
9. Visit the CG Promoter's house

? How do these actions compare to the CG Promoter's essential responsibilities?
These categories should be reflective of the duties presented in Lesson 5, Job Descriptions. Refer back to this lesson and discuss if the staff are confused or if they feel that there is any disconnect between the two.

In summary, during supervision visits the MCHN Supervisor should:

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[4] The checklists included below are formatted for letter (8.5" x 11"). A separate file with these documents, formatted for A4 printing, is available in the electronic version.

- WATCH what staff are doing
- LOOK AT what staff are reporting (registers and reports)
- TALK TO those the staff work with including local community leaders and health center staff
- OBSERVE the staff's own/ household actions

? Why is the observation of the CG Promoter's household important?
If we don't practice what we are teaching, no one will listen to us.
Someone may say, well that's a lot to ask the CG Promoter. If it is a lot to ask of the CG Promoter, then it is a lot to ask the mother in the community. To be effective facilitators and leaders in the CG program the CG program staff must "practice what they preach" by putting into practice what they are learning.
? Do you have mosquito nets in your home?
? Do you have a handwashing station with soap near the latrine in your home?
? Did you wash your hands with soap before your last meal?

<u>Personal Stories (Adjust as appropriate):</u>
When I visit our project offices in the field, I am always surprised when I go to the latrine and see there is no soap – or when I look for a place to wash hands and see that they have no hand washing station in the office compound. I can tell the minute I walk into the compound how the program is doing by the cleanliness and the health actions taken by the leaders of the program.

Story from Haiti: An abstinence health worker was a youth leader and taught youth about the importance of abstaining from sex before marriage. He wore the FH program T-shirt which said, "Abstinence – you can do it!" However, when the youth that he taught asked him if he was abstinent, he responded, "it is none of your business!"

? Do you think the Leader Youth were effective teachers?
We listen to people we trust – who are vulnerable about their own lives.
We listen to people have tried the new practices and can tell us personally about them.

One of the strengths of the Care Group model has been that the CG Volunteers try the new practices first, and then share with others their own experience and encourage them to try the new practice too.

If someone comes to you trying to sell something that they do not believe it (or have not tried) they will not be effective. In fact, it's a waste of time.

Read the introduction at the top of Handout 11A: MCHN Supervisor's Checklist for Supervising a CG Promoter.

Care Group Program
MCHN Supervisor's Checklist for Supervising a CG Promoter

- *All activities listed here should be completed on a quarterly basis for each CG Promoter.*
- *Each CG Promoter should be visited at least two times each month; one scheduled visit and one surprise visit.*
- *Check off what you do in each visit, starting with a new form every quarter.*

CG Promoter being supervised: ______________________________

MCHN Supervisor completing the form: ______________________________

Year: ______________

Quarter: ☐ 1 (OCT-DEC) ☐ 2 (JAN-MAR) ☐ 3 (APRIL-JUNE) ☐ 4 (JULY-SEPT)

Place an "X" if results are poor, a "✓" if results are adequate, and a "★" if results are excellent. Check on poor or adequate results until performance is excellent.	Visits per Quarter					
	1	2	3	4	5	6
Date of visit						

? Why is it important to have a checklist for supervision visits?

- A supervision checklist makes it clear what a supervisor is expected to do when they visit program staff.
- Having a checklist helps us to remember. There are too many tasks for a MCHN Supervisor to do in just one supervision visit. The checklist helps the Supervisor remember what s/he did last time and what still needs to be done. Recording behaviors over time helps us to see how we are improving and can provide encouragement to staff. It also helps us to see where there is more room to grow.
- They help us identify and troubleshoot smaller problems before they become larger issues.

Pass out Handout 11B: MCHN Coordinator's Checklist for Supervising a MCHN Supervisor and Handout 11C: Program Manager's Checklist for Supervising a MCHN Coordinator.

Review the activities on these forms, pointing out the similarities.
Refer back to Lesson 5, Job Descriptions for any questions or concerns about the essential responsibilities for each staff member.

Activity: Supervision Actions Game (45 minutes)

1. Using Handout 11D: Supervision Charades, cut the sections into strips, fold them and place them in a bowl.
2. Split the participants into 3-4 larger groups. Have the teams name themselves and create a score card on a flipchart page.
3. Randomly select the first team to draw a situation.
4. The presenting team will have one minute to create a plan. They will then have 3 minutes to use words and actions to perform all the correct supervision activities listed on the paper they selected.
5. If a word appears in the supervision category (such as "Observe the CG Promoter Teaching

CG Volunteers") it is not allowed to be said out loud. The presenting team will need to use different words to describe the people, objects and actions. If the presenting team accidently uses a word in the supervision category they receive negative 1 point.

6. The remaining teams will compete to be the first to guess the supervision category.
7. The first to answer correctly receives 2 points.
8. After all the pieces of paper are completed, the team with the most points wins.
9. Distribute prizes (if available) to the winning team.

Activity: Checklist for Supervision Quiz (45 minutes)

1. Ask each everyone to work in pairs.
2. Pass out Handout 11E: Checklist for Supervision Quiz
3. The Facilitator should have a copy of Handout 11F: Checklist for Supervision Quiz Answers.
4. Give the participants 20 minutes to complete the quiz.

After everyone has finished or the 20 minutes are completed:

5. Have the participants correct their own quizzes.
6. Review the answers with the participants.
7. Discuss their questions and suggestions for changing the checklists.
8. Ask someone in the room to take responsibility for recording the changes to the Checklists.

Handout 11A: MCHN Supervisor's Checklist for Supervising a CG Promoter

- *All activities listed here should be completed on a quarterly basis for each CG Promoter.*
- *Each CG Promoter should be visited at least two times each month; one scheduled visit and one surprise visit.*
- *Check off what you do in each visit, starting with a new form every quarter.*

CG Promoter being supervised: ____.
MCHN Supervisor completing the form: ____.
Year: ____________________
Quarter: ☐☐1 (OCT-DEC) ☐ 2 (JAN-MAR) ☐ 3 (APRIL-JUNE) ☐ 4 (JULY-SEPT)

*Place an "**X**" if results are poor, a "☐" if results are adequate, and a "☐" if results are excellent.* *Check on poor or adequate results until performance is excellent.*	Visits per Quarter					
	1	2	3	4	5	6
Date of visit						
EVERY VISIT: Take time to find out how the CG Promoter is doing, how you can pray for him/her, and what challenges or success he/she has encountered since your last visit.						
1. Observe CG Promoter Teaching CG Volunteers						
a. Fill out Group Teaching QIVC check-list.						
b. Review QIVC with the CG Promoter in private after teaching is done.						
c. Talk to some of the Neighbor Women to access their participation level, interest in program, quality and consistency of the CG Promoters work.						
d. Ask to visit some of the NW that the CGV reported teaching to verify they received the lessons as the CGV reported.						
2. Review the CG Promoter's Registers of CG Volunteers and Neighbor Women (One time per quarter)**						
a. Ensure the CGV and NW Registers are being kept is a safe, dry place.						
b. Ensure attendance has been marked for the CGVs over the last three months.						
c. Ensure attendance has been marked for the NW over the last three months.						
3. Review the CG Promoter's Monthly Reports						
a. Ensure promoter understands how to fill them in correctly.						
b. Make sure he/she has kept copies for himself in his folder by reviewing previous reports.						
4. Observe the CG Promoter's Equipment						
a. The CG Promoter has a functioning motorbike (or bicycle).						
b. The weighing scale is working.						
c. Ask if s/he is storing reports and materials in a safe and dry place.						
d. Other materials (flip charts, MUAC, lesson plans, blank reporting forms, etc.) are stored properly.						
5. Visit CG Volunteers						

a. Using the CG Promoters register, randomly select a few CG Volunteers to visit, verify that they exist, that they attending the teaching lessons and understanding what they learn.						
b. Check NW's understanding of what they have learned.						

6. Visit Neighbor Women						
a. Using the CG Promoters register, randomly select a few NW to visit. Verify that they exist, that they attending the teaching lessons and understanding what they learn.						
b. Verify that their children are being weighed regularly.						
7. Visit Community Leaders or participate in a Community Leadership Meeting						
a. Verify the community leaders are aware of the CG Promoter's activities in the community.						
b. Verify the CG Promoter has been coordinating with Community Leaders.						
c. Verify that community leaders are actively resolving problems that arise related to the program.						
d. Evaluate the ownership level of the community related to the program. Do they consider it their program or something FH is doing?						
8. Visit the Health Worker at the nearest Health Facility						
c. Verify the CG Promoter has been coordinating with him/her and discuss ways to improve coordination.						
d. Verify that the CG Promoter has been referring patients to the health center for care as needed.						
9. Visit the CG Promoter's house						
a. Verify that s/he has a latrine, with a lid and a roof.						
b. Verify that s/he has a hand washing station with water, soap, and/or ash.						
c. Verify that s/he is drinking purified water.						
d. Verify that s/he has a dish drying rack.						
e. Verify that s/he has a mosquito net for every bed or sleeping mat.						
f. Verify that his/her children are regularly vaccinated, dewormed, receive vitamin A, and have good nutrition.						

Providing Feedback:

- Thank and encourage the CG Promoter for his or her good work; according to the performance you have observed using this checklist.
- Review areas for improvement based on observations.
- Signs of respect:
    - Be careful to correct the CG Promoter in private and not embarrass or humiliate him/her in front of the people he/she works with.
    - Respect the CG Promoter and what he/she already knows and does
    - Always ask before telling

Handout 11B: MCHN Coordinator's Checklist for Supervising a MCHN Supervisor

- *All activities listed here should be completed on a quarterly basis for each MCHN Supervisor.*
- *Each MCHN Supervisor should be visited three times each quarter, with every third visit a surprise.*
- *Check off what you do in each visit, starting with a new form every quarter.*

MCHN Supervisor being supervised: ____.
MCHN Coordinator completing the form: ____.
Year: ___________________
Quarter: □□1 (OCT-DEC) □ 2 (JAN-MAR) □ 3 (APRIL-JUNE) □ 4 (JULY-SEPT)

*Place an "**X**" if results are poor, a "□" if results are adequate, and a "□" if results are excellent.*
Check on poor or adequate results until performance is excellent.

	Visits per Quarter		
	1	2	3
Date of Visit			
EVERY VISIT: Take time to find out how the MCHN Supervisor is doing, how you can pray for him/her, and what challenges or success he/she has encountered since your last visit.			
1. Observe the MCHN Supervisor reviewing a lesson with CG Promoters (Once a quarter)			
a. The MCHN Supervisor reviews the CG Promoter Lesson Plan and clearly explains stories, games, and activities that accompany the information.			
b. The MCHN Supervisor facilitates practice sessions with the CG Promoters to ensure high quality behavior change promotion.			
c. Check lesson comprehension of the MCHN Supervisor by asking review questions.			
d. Check lesson comprehension of the CG Promoters by asking review questions.			
2. Check MCHN Supervisor's Reporting and File System			
a. Using the latest MCHN Supervisor Report, Promoter Reports, CGV Registers and Neighbor Group Registers, make sure the reported numbers are supported and consistent.			
b. Review the MCHN Supervisor's filing system. Ensure it is well organized, has copies of all reports sent and received, including the MCHN Supervisor reports, CG Promoter reports, QIVC's, and Checklists for Supervising the CG Promoter.			
c. Review the MCHN Supervisor Report and ensure s/he understand each section clearly.			
d. Check to see if the MCHN Supervisor has up-to-date bi-weekly work plans for all CG Promoters			
e. If a surprise visit, verify if the MCHN Supervisor is following his/her own bi-weekly work plan and CG Promoter visit plan.			
3. Check the MCHN Supervisor's Equipment and Office Supplies			
a. Check computer and flash drive for viruses and up-to-date virus protection.			
b. Ensure that the MCHN Supervisor is regularly backing up files.			

c. Make sure the printer works well, ink is well supplied, printer disk is stored safely.			
d. Check power set up - make sure a surge protector is in place and cables clear of dust, moisture, and exposed connections.			
e. Check the MCHN Supervisor's motorcycle and inquire of condition of promoter motorcycles and repair processes.			
f. Ensure office has purified drinking water, hygienic waste disposal, a handwashing station (for when water is not running), no standing water to attract mosquitoes, etc.			
4. Follow a MCHN Supervisor supervising a CG Promoter			
a. Ensure MCHN Supervisor is using the Checklist for Supervising the CG Promoter and using it correctly.			
b. Ensure the MCHN Supervisor is using the Group Teaching QIVC form.			
c. Select at random one of the CG Promoter's Care Groups to visit. Find 1 to 3 of the CG Volunteers listed as a member of the group. Talk to the CGV to determine frequency of teaching and comprehension of her role.			
d. Ensure CGV can name all the NW in their groups and their memory list corresponds with the CG Volunteer and Neighbor Group Registers.			
e. Ask CGV to explain the flip chart pictures and age-specific counseling card images and ensure the can associate the correct messages with the images.			
f. Note the familiarity the MCHN Supervisor has with the roads and paths in the area, if s/he is visiting every promoter at least 1 time every 2 weeks, s/he will easily be able to take you to the CG Promoter's location.			
5. Visit the Community MOH (Once per quarter)			
a. Ensure that key MOH personnel are aware of project objectives and activities.			
b. Ensure that, as possible, program activities are done in coordination with the MOH.			
c. Determine if monthly or quarterly reports are being provided to the District office by the Supervisor.			
d. Update key MOH personnel of project achievements, impact, challenges, and solutions.			
6. Visit the Community MOH (Once per quarter)			
a. In a private area assist the MCHN Supervisor to develop and follow-up on staff development plans.			
b. Using the Supervision Checklists for CG Promoters, CG Promoter Reports, QIVCs, training post-test scores, and attendance records evaluate the CG Promoters' progress toward identified program and personal objectives.			
c. If necessary, counsel CG Promoters with the MCHN Supervisor, document unacceptable behavior, and specify improvements expected.			
7. Visit Local Businesses that the MCHN Supervisor has provided receipts for and check reported vs. actual costs (Once per quarter)			
a. Using receipts provided for commune level activities, visit local business and verify prices and if necessary business activity.			
b. Inquire of CG Promoters and other staff to determine that goods and services reported to have been rendered through the program have reached intended beneficiaries.			
8. Receive suggestions from the MCHN Supervisor on program activities, communication, and support services			

a. Request feedback, ideas and suggestions from the MCHN Supervisor on how to improve programming and support services.			
9. Provide feedback to the MCHN Supervisor regarding his/her performance			
a. Review the MCHN Supervisor's professional development plan.			
b. Using the Supervision Checklists for MCHN Supervisors, Monthly Reports, training post-test scores, and evaluating district movement toward indicators evaluate the MCHN Supervisor's progress toward identified program and personal objectives.			
c. Counsel the MCHN Supervisor, identify outstanding performance, document unacceptable behavior, and specify improvements expected.			

Providing Feedback:

- Thank and encourage the MCHN Supervisor for his or her good work; according to the performance you have observed using this checklist.
- Review areas for improvement based on observations.
- Signs of Respect:
    - Be careful to correct the MCHN Supervisor in private and not embarrass or humiliate him/her in front of the people he/she works with.
    - Respect the MCHN Supervisor and what he/she already knows and does
    - Always ask before telling

Handout 11C: Program Manager's Checklist for Supervising a MCHN Coordinator

- *All activities listed here should be completed on a quarterly basis for each MCHN Coordinator.*
- *Each MCHN Coordinator should be visited one to two times each quarter, plus one surprise visit.*
- *Check off what you do in each visit, starting with a new form every quarter.*

MCHN Coordinator being supervised: ____.
Program Manager completing the form: ____.
Year: ___________________
Quarter: 1 (OCT-DEC) 2 (JAN-MAR) 3 (APRIL-JUNE) 4 (JULY-SEPT)

*Place an "**X**" if results are poor, a "" if results are adequate, and a "" if results are excellent.* *Check on poor or adequate results until performance is excellent.*	Visits per Quarter	
	1	2
Date of visit		
EVERY VISIT: Take time to find out how the MCHN Coordinator is doing, how you can pray for him/her, and what challenges or success he/she has encountered since your last visit.		
1. Ensure the MCHN Coordinator manages his/her team of MCHN Supervisors well		
a. Ask if there are any personnel problems the MCHN Coordinator is managing and provide support and/or suggestions to resolve difficulties.		
b. Talk to one or two MCHN Supervisors and ensure the MCHN Coordinator is communicating instructions related to project implementation clearly and in a timely manner.		
c. Ensure the MCHN Coordinator is meeting quarterly with his or her team and visiting them at least once a month in the field.		
d. Ask the MCHN Coordinator what s/he is doing to build team unity and develop the MCHN Supervisors' capacity.		
e. In a private area assist the MCHN Coordinator to develop and follow-up on MCHN Supervisors' development plans.		
f. Using the Checklists for Supervising the MCHN Supervisors, Monthly Reports, QIVC, training post-test scores, and attendance records evaluate the MCHN Supervisors' progress toward identified program and personal objectives.		
g. If needed counsel a MCHN Supervisor with the MCHN Coordinator present, document unacceptable behavior, and specify improvements expected.		
2. Check MCHN Coordinator's Reporting and File System		
a. Using the latest report you have received from the MCHN Coordinator have him/her show you the MCHN Supervisors' reports s/he used to create the report. Make sure the reported numbers are supported by the local documents.		
b. Review the MCHN Coordinator's filing system. Assure it is well organized, has copies of all reports sent and received. Folders should exist for MCHN Supervisor's reports, QIVC's, Checklists for Supervising the MCH Supervisor, etc.		

c. Review the MCHN Coordinator's last monthly report, review issues of poor CG performance and/or errors in filling out the format. Document plans/ideas to improve CG performance.		
d. Check to see if the MCHN Coordinator has bi-weekly up-to-date workplans on file for his/her MCHN Supervisors.		
e. If a surprise visit, verify if the MCHN Coordinator is following his or her own bi-weekly work plan and MCHN Supervisor's visit plan.		
f. Ensure that the MCHN Coordinator is using the Checklist for Supervising a CG Promoter and using it correctly.		
3. Visit Regional MOH		
a. Ensure that key MOH personnel are aware of project objectives and activities.		
b. Ensure that, as possible, program activities are done in coordination with the MOH.		
c. Determine if monthly or quarterly reports are being provided to the County MOH by the Coordinator.		
d. Update key MOH personnel of project achievements, impact, challenges, and solutions.		
4. Attend a meeting between a MCHN Coordinator and his/her MCHN Supervisors (1/Year)		
a. Ensure the Coordinator communicates respectfully to his/her MCHN Supervisors.		
b. Prior to the meeting ask the MCHN Coordinator for an agenda and check to see if s/he follows the agenda.		
c. Ensure technical and program information is communicated correctly to the MCHN Supervisors.		
5. Visit Care Groups (once a year)		
a. Select at random one Care Groups to visit. Find 1 to 3 of the CGCs listed as a member of the group. Talk to the CGVs to determine frequency of teaching and comprehension of her role.		
b. Assure CGV can name all the NW in their groups and their memory list corresponds with the CG Promoter's register.		
c. Ask CGV to explain the flip chart pictures and ensure that she can associate the correct messages with the images.		
d. Note the familiarity the MCHN Supervisor has with the roads and paths in the area, if s/he is visiting every promoter at least once every 2 weeks, s/he will easily be able to take you to the CG Promoter's location.		
6. Receive suggestions from Coordinator on program activities, communication, and support services		
a. Request feedback, ideas and suggestions from the MCHN Coordinator on how to improve programming and support services.		
7. Provide feedback to the Coordinator regarding his/her performance		
a. Review Coordinator professional development plan.		
b. Using Checklists for Supervising MCH Coordinators, Monthly Reports, training post-test scores, and evaluating district movement toward indicators evaluate MCHN Coordinators progress toward identified program and personal objectives.		
c. Counsel MCHN Coordinator, identify outstanding performance, document unacceptable behavior, and specify improvements expected.		

Providing Feedback:

- Thank and encourage the MCHN Coordinator for his or her good work; according to the performance you have observed using this checklist.
- Review areas for improvement based on observations.
- Signs of Respect:
    - Be careful to correct the MCHN Coordinator in private and not embarrass or humiliate him/her in front of the people he/she works with.
    - Respect the MCHN Coordinator and what he/she already knows and does
    - Always ask before telling

Handout 11D: Supervision Actions Game

[Print one copy]

The other teams will try to guess the supervision category: "**Observe CG Promoter Teaching CG Volunteers"**
a. Fill out Group Teaching QIVC check-list.
b. Review QIVC with the CG Promoter in private after teaching is done.
c. Talk to some of the Neighbor Women to access their participation level, interest in program, quality and consistency of the CG Promoters work.
d. Ask to visit some of the NW that the CGV reported teaching to verify they received the lessons as the CGV reported.

The other teams will try to guess the supervision category: "**Review the CG Promoter's Registers of CG Volunteers and Neighbor Women"**
d. Ensure the CGV and NW Registers are being kept is a safe, dry place.
e. Ensure attendance has been marked for the CGVs over the last three months.
f. Ensure attendance has been marked for the NW over the last three months.

The other teams will try to guess the supervision category: "**Visit CG Volunteers"**
a. Using the promoters register, randomly select a few ML to visit, verify that they exist, that they attending the teaching lessons and understanding what they learn.
b. Check NW's understanding of what they have learned.

The other teams will try to guess the supervision category: "**Visit the Health Worker at the nearest Health Facility**"
a. Verify the CG Promoter has been coordinating with him/her and discuss ways to improve coordination.
b. Verify that the CG Promoter has been referring patients to the health center for care as needed.

The other teams will try to guess the supervision category: **"Visit Community Leaders or participate in a Community Leadership Meeting"**
a. Verify the community leaders are aware of the CG Promoter's activities in the community.
b. Verify the CG Promoter has been coordinating with Community Leaders.
c. Verify that community leaders are actively resolving problems that arise related to the program.
d. Evaluate the ownership level of the community related to the program. Do they consider it their program or something FH is doing?

The other teams will try to guess the supervision category: **"Visit the CG Promoter's house"**
a. Verify that s/he has a latrine, with a lid and a roof.
b. Verify that s/he has a hand washing station with water, soap/ash.
c. Verify that s/he is drinking purified water.
d. Verify that s/he has a dish drying rack.
e. Verify that s/he has a mosquito net for every bed or sleeping mat.
f. Verify that his/her children are regularly vaccinated, dewormed, receive vitamin A, and have good nutrition.

The other teams will try to guess the supervision category: **"Attend a meeting between a MCHN Coordinator and his/her MCHN Supervisors"**
a. Ensure the Coordinator communicates respectfully to his/her MCHN Supervisors.
b. Prior to the meeting ask the MCHN Coordinator for an agenda and check to see if s/he follows the agenda.
c. Ensure technical and program information is communicated correctly to the MCHN Supervisors.

The other teams will try to guess the supervision category: **“Observe the MCHN Supervisor reviewing a lesson with CG Promoters“**
a. The MCHN Supervisor reviews the CG Promoter Lesson Plan and clearly explains stories, games, and activities that accompany the information.
b. The MCHN Supervisor facilitates practice sessions with the CG Promoters to ensure high quality behavior change promotion.
c. Check lesson comprehension of the MCHN Supervisor by asking review questions.
d. Check lesson comprehension of the CG Promoters by asking review questions.

The other teams will try to guess the supervision category: **“Check MCHN Supervisor's Reporting and File System”**
a. Using the latest MCHN Supervisor Report, Promoter Reports, CGV Registers and Neighbor Group Registers, make sure the reported numbers are supported and consistent.
b. Review the MCHN Supervisor's filing system. Ensure it is well organized, has copies of all reports sent and received, including the MCHN Supervisor reports, CG Promoter reports, QIVC's, and Checklists for Supervising the CG Promoter.
c. Review the MCHN Supervisor Report and ensure s/he understand each section clearly.
d. Check to see if the MCHN Supervisor has up-to-date bi-weekly work plans for all CG Promoters
e. If a surprise visit, verify if the MCHN Supervisor is following his/her own bi-weekly work plan and CG Promoter visit plan.

The other teams will try to guess the supervision category: **“Follow a MCHN Supervisor supervising a CG Promoter”**
a. Ensure MCHN Supervisor is using the Checklist for Supervising the CG Promoter and using it correctly.
b. Ensure the MCHN Supervisor is using the Group Teaching QIVC form.
c. Select at random one of the CG Promoter's Care Groups to visit. Find 1 to 3 of the CG Volunteers listed as a member of the group. Talk to the CGV to determine frequency of teaching and comprehension of her role.
d. Ensure CGV can name all the NW in their groups and their memory list corresponds with the CG Volunteer and Neighbor Group Registers.
e. Ask CGV to explain the flip chart pictures and age-specific counseling card images and ensure the can associate the correct messages with the images.
f. Note the familiarity the MCHN Supervisor has with the roads and paths in the area, if s/he is visiting every promoter at least 1 time every 2 weeks, s/he will easily be able to take you to the CG Promoter's location.

food for the hungry
Meeting physical and spiritual needs worldwide

Handout 11E: Checklist for Supervision Quiz

Encourage participants to refer to the Checklist for Supervising a CG Promoter to answer the following questions.

1. A MCHN Supervisor has three CG Promoters. How many copies of the Checklist for Supervising CG Promoters does he/she need for one quarter?
    a. 3
    b. 6
    c. 10
    d. 12

2. How often does a MCHN Supervisor need to conduct a supervisory visit to a CG Promoter during one quarter?
    a. 1 planned visit per quarter and 1 surprise visit per quarter
    b. 4 planned visits per quarter and 2 surprise visit per quarter
    c. 1 planned visit per month and 1 surprise visit per month
    d. 2 planned visits per month and 2 planned visits per month.

3. When a MCHN Supervisor conducts a supervisory visit with his/her CG Promoters, she/he will do all of the following tasks every visit **except** for which one?
    a. Find out how the CG Promoter is doing
    b. Find out how you can pray for him/her
    c. Determine what challenges or success s/he has encountered since your last visit.
    d. Using the Promoters register, randomly select a few ML to visit, verify that they exist and are attending the teaching lessons
    e. The MCHN Supervisor will do all the tasks above every visit.

4. A MCHN Supervisor visits the CG Promoter and discovers she has not taken attendance for the Neighbor Women (NW) in the last month. The next time you visit what you should the MCHN Supervisor do?
    a. Wait until the following quarter to check NW attendance.
    b. Pretend you are checking CG Volunteer attendance, but look to see if she has started keeping NW attendance instead
    c. Review CG Promoter's Monthly Reports because that is the next task on the checklist
    d. Tell the CG Promoter you want to see if she has started taking NW attendance and check her register to see if she has.

5. Task #6 is to "Visit Neighbor Women". Below are possible reasons why this task is important. **Select the one reason that is NOT correct.**
    a. To be able to mark off the task as done on the checklist.
    b. To encourage the CG Promoter, so she/he will feel his/her work has value if

he/she sees that it matters enough to the MCHN Supervisor to talk to her/his Neighbor Women.

c. To verify that the CGV who reported the NW attendance did so accurately.
d. To verify that the CG Promoter marked the NW attendance based on the CGV report and did not falsify the registers.

6. How does a MCHN Supervisor review a CG Promoter's monthly report?
   a. Look at a completed report and make sure every box is filled in.
   b. Make sure the CG Promoter has a copy of every monthly report s/he has turned in.
   c. Select 2 or 3 pieces of information on the report and ask the CG Promoter to show you how s/he determined the number using her CGV and NW Registers.
   d. Look at your copy of the CG Promoter's monthly report and the copy s/he has and make sure all the numbers match.

	Visits per Quarter							
	1	2	3	4	5	6	7	8
2. Review the CG Promoter's Registers of CG Volunteers and Neighbor Women								
g. Ensure the CGV and NW Registers are being kept is a safe, dry place.		★						
h. Ensure attendance has been marked for the CGVs over the last three months.		**X**	✓	★				
i. Ensure attendance has been marked for the NW over the last three months.		✓	✓					

7. Which of the following statements is **NOT** a true assumption based on the performance ratings of the Checklist for Supervising CG Promoters pasted above?
   a. The MCHN Supervisor started reviewing the Promoter's Register during his second visit.
   b. The MCHN Supervisor verified that the CG Promoter was keeping her Care Group Register in a safe and dry place on the second visit.
   c. The CG Promoter was not marking attendance of the CGVs during the second visit and that is why the MCHN Supervisor marked this with an "X" for poor performance.
   d. The CG Promoter was doing a great job of keeping NW attendance so the Supervisor did not need to follow-up any more on this activity after Visit 3.

8. Please fill out the table below with X's, ✓, or *based on the following situation:

The MCHN Supervisor visited the nurse at the nearest health post to the CG Promoter during his 3rd visit of the quarter. He found out that the nurse did not know the CG Promoter's name and no patient has ever made mention of a CG Promoter working in the area. On the 4th visit of the quarter the Promoter went back to the Health Post and found that the nurse knew the CG

Promoters name and the CG Promoter had told the nurse about an activity that happened a month ago. The nurse said two patients had mentioned being sent by the CG Promoter in the last two weeks.

	Visits per Quarter							
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
8. Visit the Health Worker at the nearest Health Facility								
c. Verify the CG Promoter has been coordinating with him/her and discuss ways to improve coordination.								
d. Verify that the CG Promoter has been referring patients to the health center for care as needed.								

9. Consider the scenario in the question above. What should the MCHN Supervisor do on his 5th visit?
    a. Visit the health post again to see if the CG Promoter's performance has improved.
    b. Send a warning letter to the CG Promoter for failure to comply with job expectations.
    c. Ask the CG Promoter if she has been coordinating with the health facility and if she says "yes" put a star in for visit 5.

10. In order for the MCHN Coordinator to observe the MCHN Supervisor reviewing the Lesson Plans and flipchart messages with the CG Promoters, when should he/she visit the MCHN Supervisor?
    a. When the MCHN Supervisor is in the community supervising the CG Promoters.
    b. When the MCHN Supervisor is working one on one with a CG Promoter.
    c. During module trainings done by the expert trainers.
    d. During the Bi-monthly Training and Reporting Meeting led by the MCHN Supervisor with the CG Promoters s/he supervises.

11. Why does the MCHN Coordinator check the CG Promoters comprehension of the lessons (after being taught by the MCHN Supervisor)?
    a. If the CG Promoters understand and can clearly explain the materials, this shows that the MCHN Supervisor has taught them well.
    b. If the CG Promoters do not understand the lesson, he can reprimand the CG Promoters in front of the MCHN Supervisor.
    c. This helps the MCHN Coordinator to learn the key messages from the flipchart.

12. If the MCHN Coordinator finds during his visit that the MCHN Supervisor's office does not have purified drinking water and a handwashing station what should he do?
    a. Place an "X" in the visit box to indicate poor results on the Checklist as seen below.

	Visits per Quarter			
	1	**2**	**3**	**4**
f. Ensure office has purified drinking water, hygienic waste disposal, a handwashing station (for when water not running), no standing water to attract mosquitoes etc.	**X**			

    b. Ask the MCHN Supervisor why he hasn't made purified drinking water available or set up a handwashing station and assist him to make a plan to make these services available to employees and visitors.
    c. The MCHN Coordinator should do both A and B.

13. The following statements are about the Checklist for Supervising the MCHN Coordinator. Mark true if this is part of the MCHN Coordinator role. Write False if this is not part of the coordinator's role.
    a. ________ The MCHN Coordinator should ensure that the MCHN Supervisor is using the Checklist for Supervising the CG Promoters and the Group Teaching QIVC correctly.
    b. ________ The MCHN Coordinator does not need to talk to CG Volunteers to determine their frequency of teaching because that information is available on the CG Promoter's CGV and NW Registers.
    c. ________ If the CGV is able to associate the correct message with the image on the flipchart, the MCHN Coordinator should place a "★" in the visit box to signify excellent results.
    d. ________ The MCHN Coordinator does not need to talk to MOH personnel because it's the MCHN Supervisor responsibility to coordinate activities with the MOH and inform them of project results.

14. If CG Promoter is not providing accurate reports, what should the MCHN Supervisor do to let the MCHN Coordinator know?
    a. Chastise the CG Promoter in front of the MCHN Coordinator.
    b. Show the MCHN Coordinator the CG Promoter reports that are poorly prepared and discuss how the MCHN Supervisor can correct the behavior. Ask the MCHN Coordinator to come to the meeting when the MCHN Supervisor corrects the CG Promoter.
    c. Show the MCHN Coordinator the CG Promoter reports that are poorly prepared and ask the MCHN Coordinator to fix the issue.
    d. Wait for the MCHN Coordinator to ask about the reports before discussing the problem.

15. According to local culture and customs, are there any questions that you would change on the Checklists for Supervising? If yes, which ones and why?

16. According to what you know about the program so far, are there any questions (or categories) that you would add to the Checklists for Supervision?

Handout 11F: Checklist for Supervision Quiz Answers

1. A MCHN Supervisor has three CG Promoters. How many copies of the Checklist for Supervising CG Promoters does he/she need for one quarter?
    a. 3
    b. 6
    c. 9
    d. 12

2. How often does a MCHN Supervisor need to conduct a supervisory visit to a CG Promoter during one quarter?
    a. 1 planned visit per quarter and 1 surprise visit per quarter
    b. 4 planned visits per quarter and 2 surprise visit per quarter
    c. 1 planned visit per month and 1 surprise visit per month
    d. 2 planned visits per month and 2 planned visits per month.

3. When a MCHN Supervisor conducts a supervisory visit with his/her CG Promoters, she/he will do all of the following tasks every visit **<u>except</u>** for which one?
    a. Find out how the CG Promoter is doing
    b. Find out how you can pray for him/her
    c. Determine what challenges or success s/he has encountered since your last visit.
    d. Using the Promoters register, randomly select a few ML to visit, verify that they exist and are attending the teaching lessons
    e. The MCHN Supervisor will do all the tasks above every visit.

4. A MCHN Supervisor visits the CG Promoter and discovers she has not taken attendance for the Neighbor Women (NW) in the last month. The next time you visit what you should the MCHN Supervisor do?
    a. Wait until the following quarter to check NW attendance.
    b. Pretend you are checking CG Volunteer attendance, but look to see if she has started keeping NW attendance instead
    c. Review CG Promoter's Monthly Reports because that is the next task on the checklist
    d. Tell the CG Promoter you want to see if she has started taking NW attendance and check her register to see if she has.

5. Task #6 is to "Visit Neighbor Women". Below are possible reasons why this task is important. **Select the one reason that is <u>NOT</u> correct.**
    a. To be able to mark off the task as done on the checklist.
    b. To encourage the CG Promoter, so she/he will feel his/her work has value if he/she sees that it matters enough to the MCHN Supervisor to talk to her/his Neighbor Women.
    c. To verify that the CGV who reported the NW attendance did so accurately.

    d. To verify that the CG Promoter marked the NW attendance based on the CGV report and did not falsify the registers.

6. How does a MCHN Supervisor review a CG Promoter's monthly report?
    a. Look at a completed report and make sure every box is filled in.
    b. Make sure the CG Promoter has a copy of every monthly report s/he has turned in.
    c. Select 2 or 3 pieces of information on the report and ask the CG Promoter to show you how s/he determined the number using her CGV and NW Registers.
    d. Look at your copy of the CG Promoter's monthly report and the copy s/he has and make sure all the numbers match.

	Visits per Quarter							
	1	2	3	4	5	6	7	8
2. Review the CG Promoter's Registers of CG Volunteers and Neighbor Women								
j. Ensure the CGV and NW Registers are being kept is a safe, dry place.		★						
k. Ensure attendance has been marked for the CGVs over the last three months.		**X**	✓	★				
l. Ensure attendance has been marked for the NW over the last three months.		✓	✓					

7. Which of the following statements is <u>**NOT**</u> a true assumption based on the performance ratings of the Checklist for Supervising CG Promoters pasted above?
    a. The MCHN Supervisor started reviewing the Promoter's Register during his second visit.
    b. The MCHN Supervisor verified that the CG Promoter was keeping her Care Group Register in a safe and dry place on the second visit.
    c. The CG Promoter was not marking attendance of the CGVs during the second visit and that is why the MCHN Supervisor marked this with an "X" for poor performance.
    d. The CG Promoter was doing a great job of keeping NW attendance so the Supervisor did not need to follow-up any more on this activity after Visit 3.

8. Please fill out the table below with X's, ✓, or *based on the following situation:

The MCHN Supervisor visited the nurse at the nearest health post to the CG Promoter during his 3rd visit of the quarter. He found out that the nurse did not know the CG Promoter's name and no patient has ever made mention of a CG Promoter working in the area. On the 4th visit of the quarter the Promoter went back to the Health Post and found that the nurse knew the CG Promoters name and the CG Promoter had told the nurse about an activity that happened a month ago. The nurse said two patients had mentioned being sent by the CG Promoter in the last two weeks.

	Visits per Quarter							
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
8. Visit the Health Worker at the nearest Health Facility								
e. Verify the CG Promoter has been coordinating with him/her and discuss ways to improve coordination.			**X**	✓				
f. Verify that the CG Promoter has been referring patients to the health center for care as needed.			**X**	✓				

9. Consider the scenario in the question above. What should the MCHN Supervisor do on his 5th visit?
    a. Visit the health post again to see if the CG Promoter's performance has improved.
    b. Send a warning letter to the CG Promoter for failure to comply with job expectations.
    c. Ask the CG Promoter if she has been coordinating with the health facility and if she says "yes" put a star in for visit 5.

10. In order for the MCHN Coordinator to observe the MCHN Supervisor reviewing the Lesson Plans and flipchart messages with the CG Promoters, when should he/she visit the MCHN Supervisor?
    a. When the MCHN Supervisor is in the community supervising the CG Promoters.
    b. When the MCHN Supervisor is working one on one with a CG Promoter.
    c. During module trainings done by the expert trainers.
    d. During the Bi-Monthly Training and Reporting Meeting led by the MCHN Supervisor with the CG Promoters s/he supervises.

11. Why does the MCHN Coordinator check the CG Promoters comprehension of the lessons (after being taught by the MCHN Supervisor)?
    a. If the CG Promoters understand and can clearly explain the materials, this shows that the MCHN Supervisor has taught them well.
    b. If the CG Promoters do not understand the lesson, he can reprimand the CG Promoters in front of the MCHN Supervisor.
    c. This helps the MCHN Coordinator to learn the key messages from the flipchart.

12. If the MCHN Coordinator finds during his visit that the MCHN Supervisor's office does not have purified drinking water and a hand washing station what should he do?
    a. Place an "X" in the visit box to indicate poor results on the Checklist as seen below.

	Visits per Quarter			
	1	**2**	**3**	**4**
f. Ensure office has purified drinking water, hygienic waste disposal, a hand washing station (for when water not running), no standing water to attract mosquitoes etc.	**X**			

    b. Ask the MCHN Supervisor why he hasn't made purified drinking water available or set up a hand washing station and assist him to make a plan to make these services available to employees and visitors.
    c. The MCHN Coordinator should do both A and B.

13. The following statements are about the Checklist for Supervising the MCHN Coordinator. Mark true if this is part of the MCHN Coordinator role. Write False if this is not part of the coordinator's role.

    a. ________ The MCHN Coordinator should ensure that the MCHN Supervisor is using the Checklist for Supervising the CG Promoters and the Group Teaching QIVC correctly. **(True)**
    b. ________ The MCHN Coordinator does not need to talk to CG Volunteers to determine their frequency of teaching because that information is available on the CG Promoter's CGV and NW Registers. **(False)**
    c. ________ If the CGV is able to associate the correct message with the image on the flipchart, the MCHN Coordinator should place a "★" in the visit box to signify excellent results. **(True)**
    d. ________ The MCHN Coordinator does not need to talk to MOH personnel because it's the MCHN Supervisor responsibility to coordinate activities with the MOH and inform them of project results. **(False)**

14. If CG Promoter is not providing accurate reports, what should the MCHN Supervisor do to let the MCHN Coordinator know?
    a. Chastise the CG Promoter in front of the MCHN Coordinator.
    b. Show the MCHN Coordinator the CG Promoter reports that are poorly prepared and discuss how the MCHN Supervisor can correct the behavior. Ask the MCHN Coordinator to come to the meeting when the MCHN Supervisor corrects the CG Promoter.
    c. Show the MCHN Coordinator the CG Promoter reports that are poorly prepared and ask the MCHN Coordinator to fix the issue.
    d. Wait for the MCHN Coordinator to ask about the reports before discussing the problem.

fh food for the hungry
Meeting physical and spiritual needs worldwide

Lesson 12: Supervision Responsibilities and Work plans

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Objectives:

1. Participants will be able to list the different supervision responsibilities of their position and those they supervise.
2. Participants will be able to prepare a "sample" four week work plan for their position including:
   - Trainings that they will receive
   - Training they will conduct
   - Supervision visits they will receive
   - Supervision visit they will give

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Summary: 1 hour, 30 minutes

- Supervision Race (30 min)
- Small Group Work plan Activity & Discussion (60 min)

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Materials needed:

- ☐ Flipchart or whiteboard with markers
- ☐ Handout 12A: Supervision Table and Slips [Print one copy for every 4-6 participants]
- ☐ Handout 12B: Supervision Answer Key
- ☐ Handout 12C: Blank Work plan
- ☐ Rocks to hold down papers (or tin cans or baskets to hold the slips of paper for each team).
- ☐ Masking tape (a strip for each team)
- ☐ Prize for the winning team

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Supervision Race (30 minutes)

Now that we have reviewed all of the checklists, we will be looking at an overview of the supervision responsibilities of each staff member.

We will be repeating the game that we played earlier. This time we are filling out the supervision chart for the Care Group program.

Preparing for the Game

1. Split the participants into teams of 4-6 people.
2. At the far side of the room, place one blank Training Handout (Handout 12A) for each team in a row. Place a long strip of masking tape on the wall, or in the grass so the participants can tape down the slips of paper.
3. On the opposite side of the room, each team will line up across from one of the training handouts. The teams must be equally spaced from the handouts and each other.
4. Place one set of the small squares of paper (Handout 12B) at the start of each team line. If outdoors, place a rock on top of the stack of papers so they do not fly away as the teams run back and forth.

Explaining the Rules – referring to a blank handout.

5. The handout lists the different trainings that each staff member is responsible for as a part of the Care Group model. The first column lists the trainers. The second column lists the participants (those who will receive the training). The third column is the length of the training (is it one day or 7 days or 2 hours). The next column lists the frequency (how often the training occurs) and the last column lists what materials are used for this training.
6. The first 3 or 4 people may have a hard time placing their slip of paper on the chart. So you may want to tape the ones where you are not sure to the side, until you can get all of the pieces together.
7. However it is a race, the first team to finish their handout must pick it up and bring it to the facilitator who will review it.
8. The team that finishes CORRECTLY first will win a prize.

9. Each team must stand in a line. The first member of each team will pick up ONE slip of paper from their tin can (or basket) and run to the other side of the room where their team handout is placed.
10. They will put the slip of paper in the correct category and tape it down (or tape it to the side if they are not sure).
11. When they are finished they will run back to their team, tag the next person who will take the next slip of paper, race to the other side of the room and tape it to the correct place on the handout.
12. Only one person can look at the handout at a time.
13. Your team must be tagged (you cannot run ahead before your team member has tagged you).

Answer questions.
Begin the game.

When one of the teams completes the handout correctly, stop the game and award the prize. Distribute Handout 12B and review the corrected table using the information below.

One Supervising	Person Receiving the Observation	Location/ Meetings	Frequency	Supervision Tools
MCHN Manager	Each MCHN Coordinator	Observes all locations/meetings listed below	1-2 times every three months; including one surprise visit each year	Supervision Checklist

- The MCHN Manager will supervise the MCHN Coordinator once or twice each quarter (that's about once every 6 weeks).
- Once a year, you will visit one of the Coordinators without scheduling the visit; this is called a surprise visit.
- The Manager will visit the MCHN Coordinator while s/he is carrying out all of his regular activities.

- S/He will visit him or her in the office to review his/her work.
- S/He will observe the bi-monthly meetings led by the Supervisor.
- S/He will visit the CG Promoter's homes and talk with them about the program.
- S/He will observe the Neighbor Group meetings and the Care Group meetings.
- EVERY time s/he visits the Coordinator, he will use the appropriate Supervision Checklist.
- S/He should know how to use the Group Education QIVC and should observe others using the Group Education QIVC, but is not required to use this on his or her visits.

One Supervising	Person Receiving the Observation	Location/ Meetings	Frequency	Supervision Tools
MCHN Coordinator	Each MCHN Supervisor	Office, Bi-Monthly Mtg, and those listed below	Once each month (every third visit is a surprise visit)	QIVC and Supervision Checklist

- The MCHN Coordinator will visit the Supervisor one each month. Every third visit is a surprise.

? What's the purpose of surprise visits?

To make sure the work is being done appropriately even when no one is looking. Workers can prepare for a meeting and make it just right when they know someone is coming to visit. However, we want our workers to prepare and make it just right each and every meeting.

The working environment of a community worker is unstructured and depends a lot on personal discipline and motivation. Even the best employee may have a rough week and feel tempted to do personal tasks when s/he should be meeting with Care Groups or visiting a CG Promoter. Knowing that surprise visits could occur at any time can provide that additional motivation a community worker needs to accomplish his or her assigned task.

- The Coordinator will visit the Supervisors in the office to review his reporting and filing systems, office supplies, etc. (as listed on the Supervision Checklist).
- He will observe the bi-monthly meetings done by the supervisor, using a QIVC as he trains his promoters.
- He will visit the promoter's homes and talk with them about the program.
- He will observe the neighbor group meetings and the Care Group meetings.
- EVERY time he visits the Supervisor, he will use the appropriate Supervision Checklist and QIVC.

One Supervising	Person Receiving the Observation	Location/ Meetings	Frequency	Supervision Tools

MCHN Supervisor	Each CG Promoter	Promoter's home, Care Group Meeting and those listed below	Twice each month; one scheduled visit and one surprise visit	QIVC and Supervision Checklist

- Almost all of the promoter's work is done in the community so 90% of the observations will be done in the community.
- Supervisor will visit the Promoter in his home for that section of the Supervision Checklist.
- S/He will visit them as they teach the Promoters, using a QIVC for Educational Sessions to help them improve.
- S/He will visit the sometimes observe the neighbor group meetings and the Care Group meetings.
- EVERY time s/he visits the Promoter, he will use the appropriate Supervision Checklist and/or the QIVC.

Remember! There are other sections on the Supervision Checklist. The supervisor for instance will also visit the health facility and the community leaders. Use the checklist to guide you in planning your work responsibilities.

One Supervising	Person Receiving the Observation	Location/ Meetings	Frequency	Supervision Tools
CG Promoter	Each CG Volunteer	Home and Neighbor Group Meeting	Once every six months	QIVC

- The promoter will visit the home of the Care Group Volunteer in their home.

  ? What will he be looking for?

  - Remember this is your "model" mother in the community.
  - You should be able to see by her home and her practices that she is following the things she is teaching.
  - If not, you need to help her overcome the barriers that she is facing that prevent her from practicing the new behaviors.
  - It is not a requirement to be a volunteer, but you will need to really help your C G Volunteers to try the new behaviors and "practice what they teach."

- You will also supervise the CG Volunteer as she teaches her neighbors using a QIVC.

- After the observation return to her home to give feedback using the QIVC. It is during this home visit that you can also ask about her nutrition, health and hygiene practices and observe her home.
- We would like you to visit each CG volunteer more often than once every 6 months, but because you will have up to 96 CG Volunteers that you are supervising, it is not possible.
- EVERY time you observe the CG Volunteer use a QIVC to improve, encourage and monitor the Volunteers work.

Answer questions.

Small Group Work plan Activity (60 minutes)

Next we are going to be putting your work into a work plan.

? What is a work plan?

Very simply, it is a plan that gives details on the tasks that you will be doing over a period of time in the future.

All the tasks that are given to you as a worker in the Care Group program can seem overwhelming, however, planning your time out for a four week period helps you to do the work effectively and efficiently.

Care Group Work plans should include:

- Time for reporting / gathering data for monthly or quarterly reports
- Trainings (those you are receiving as well as conducting)
- Supervision Visits (those you are receiving as well as conducting)
- Dates of special health events (vaccination days, etc)
- Visits to health facilities and other work related tasks

Give out Handout 12C: Blank Work plan

Put the following assumptions on a flipchart (or print it out for each group):

Basic Assumptions:
The promoter:
- Teaches all 8 Care Groups every two weeks.
- Spends at least ½ day preparing for the promoter training each month.
- Supervises 8 or more CG volunteers every two weeks.
- Receives a supervision visit twice each month during his normal activities.
- Attends the Community Development Committee Meeting once a month (1/2 day).
- Visits the health facility at least once a month.

The CG Volunteer:
- Teaches eight neighbors in a neighbor group every two weeks; followed by teaching one-on-one in each neighbor's home during the next two weeks (alternating). This meeting is about 1 and ½ hours when in a group and 1 hour during the home visit.
- Attends a 2 hour training once every two weeks.
- Receives a supervision visit at least once every 6 months.

The supervisor:
- Is in charge of five promoters (in this example)
- Trains the 5 Promoters every two weeks with a ½ day training (Bi-Monthly Training Meeting).
- Compiles the data from the Promoters after the Bi-Monthly meeting (1/2 day of reporting).
- Supervises each of the promoters twice each month.
- Spends three days each month writing and completing reports.

Instructions:
1. Group the staff together by their job roles – all supervisors together; all coordinators together. Managers may visit both groups and help them as they develop a sample work plan.
2. Ask the participants to copy the schedule onto a blank flipchart.
3. Fill up your schedule – working only 5 days a week, 8 hours each day with the activities which you know you will be participating in. Use the assumption list to guide you if you need help.
4. If an activity takes only 2 hours, then you need to add 2-3 other activities on that day! Remember to fill up each day with a full day's work. Be realistic about which activities can be done in a period of time.
5. Work on a piece of notebook paper first, and then copy your final plan onto the flipchart. When you are finished, paste your work plan on the wall for everyone to see.

Additional Information for the Trainer:
The facilitator should visit each group and help them with the plan. It may take some time for them to organize their responsibilities this way. If one group is faster than other groups, ask them to develop a schedule for the Care Group Volunteers. (If the participants are having trouble, work through the Care Group Volunteer schedule together at the front of the class).

Below are several sample agendas. Use these as guides as you review and discuss the participants work plans.

Once all work plans are posted, review them as a group, adding any items which are missing.

Review:

- ? When should the promoter fill out the work plan?
- ? How will the promoter know when the supervisor is going to come visit him for supervision?

Sample Month Calendar for Care Group Volunteers (reminder – volunteers do not work an 8 hour day! Never plan a meeting longer than 2 hours with volunteers)

Monday	Tuesday	Wednesday	Thursday	Friday
Attend training #1 with the Promoter		Teach my neighbor group Lesson 1		
Attend training #2 with the Promoter	Teach Neighbor Women #1 Lesson 2	Teach Neighbor Women #2 Lesson 2	Teach Neighbor Women #3 Lesson 2	Teach Neighbor Women #4 Lesson 2
Teach Neighbor Women #5 Lesson 2	Teach Neighbor Women #6 Lesson 2		Teach Neighbor Women #7 Lesson 2	Teach Neighbor Women #8 Lesson 2

Sample Calendar Month for Promoters

Monday	Tuesday	Wednesday	Thursday	Friday
Teach CG #1 Teach CG #2	Supervise two CGV with QIVC	Teach CG#3 Teach CG#4	Prepare Reports for Bi-Monthly Meeting	Bi-Monthly Meeting Supervise one CGV
Supervise two CGV with QIVC	Supervise two CGV	Teach CG #5 Teach CG #6	Supervise two CGV	Teach CG #7 Teach CG #8
Vaccination Day Teach CG #1	Supervise two CGV	Teach CG #3 Teach CG #4	Supervise one CGV Teach CG #2	Community Meeting Supervise one CGV
Supervise two CGV with QIVC	Supervise two CGV	Teach CG #5 Teach CG #6	Supervise two CGV	Teach CG #7 Teach CG #8

Sample Calendar Month for Supervisors

Monday	Tuesday	Wednesday	Thursday	Friday
		Supervise Promoter #5	Prepare for Bi-Monthly Training	Bi-Monthly Meeting & Reporting
Supervise Promoter #1	Supervise Promoter #2	Supervise Promoter #3	Supervise Promoter #4	Supervise Promoter #5
Vaccination Day	Report Writing	Supervise #4	Prepare for Bi-Monthly Training	Bi-Monthly Meeting & Reporting
Supervise Promoter #1	Supervise Promoter #2	Supervise Promoter #3	Report Writing	Report Writing

Handout 12A: Supervision Table (1 of 2) Do not Cut this page.

Supervision	One Supervising	Person Receiving the Observation	Location/Meetings	Frequency	Supervision Tools

Handout 12A: Supervision Answers (Page 2 of 2)

Cut the squares out, mix them up and place in a pile at the start of each team's line (under a rock or in a small tin).

MCHN Manager	Each MCHN Coordinator	Observes all locations/meetin gs listed below	1-2 times every three months; including one surprise visit each year	Supervision Checklist
MCHN Coordinator	Each MCHN Supervisor	Office, Bi-Monthly Mtg, and those listed below	Once each month (every third visit is a surprise visit)	QIVC and Supervision Checklist
MCHN Supervisor	Each CG Promoter	Promoter's home, Care Group Meeting and those listed below	Twice each month; one scheduled visit and one surprise visit	QIVC and Supervision Checklist
CG Promoter	Each CG Volunteer	Home and Neighbor Group Meeting	Once every three months	QIVC

Handout 12B: Supervision Table ANSWER KEY

	One Supervising	Person Receiving the Observation	Location/Meetings	Frequency	Supervision Tools
Supervision	MCHN Manager	Each MCHN Coordinator	Observes all locations/meetings listed below	1-2 times every three months; including one surprise visit each year	Supervision Checklist
	MCHN Coordinator	Each MCHN Supervisor	Office, Bi-Monthly Mtg, and those listed below	Once each month (every third visit is a surprise visit)	QIVC and Supervision Checklist
	MCHN Supervisor	Each CG Promoter	Promoter's home, Care Group Meeting and those listed below	Twice each month; one scheduled visit and one surprise visit	QIVC and Supervision Checklist
	CG Promoter	Each CG Volunteer	Home and Neighbor Group Meeting	Once every three months	QIVC

Handout 12C: Sample Workplan

Workplan for ______________________________

Month _________________________

Add tasks such as supervision, training, teaching, days for reporting, etc. Include length of time for each activity and starting time. This is just a sample – but you should use this as you sketch out the details of your month.

Monday	Tuesday	Wednesday	Thursday	Friday

Lesson 13: QIVCs - Their Purpose and How to Use Them

One to two days in advance:

- *Choose a volunteer to give a short educational message. Give them one copy of the Volunteer Handout and a blank Educational Session QIVC to review. Review the instructions on how they should act during the presentation. It is very important that they do not try to act like a clown during the skit to entertain the audience. This needs to be a learning activity where the facilitator does some good things and some poor things and the supervisor works with them to improve.*
- *Review Handout 13B. These are all the steps that you as the facilitator should take when giving feedback to the volunteer in part 3 of the skit. Practice in advance so you will model well the giving of positive feedback.*

Objectives:

1. Participants will be able to list the three purposes of the QIVC: to improve, monitor and encourage the worker's performance.
2. Participants will be able to list the staff who will be supervised with the QIVC.
   a. MCHN Managers
   b. MCHN Supervisors and Coordinators
   c. Care Group Promoters
   d. Care Group Volunteers
3. Participants will be able to describe how the QIVC is used after watching a three part skit.

Summary: 1 hour, 20 minutes	**Materials needed:**
• Introducing QIVCs (20 min) • Skit Parts I and II (30 min) • Skit Part III (30 min)	☐ Flipchart or whiteboard with markers ☐ One Volunteer for skit ☐ Handout 13A: QIVC for Educational Sessions [Print one per participant] ☐ Handout 13B: Skit Volunteer [Print one per participant]

Introducing the QIVC (20 minutes)

Instructions: Lead a discussion that covers the following points.

FH developed a tool to help us monitor and improve educators teaching methods. The tool is called the Quality Improvement and Verification Checklist.

It has three goals:

- To encourage a facilitator
- To monitor a facilitator
- To improve a facilitator's performance.

Who are the "facilitators" in our program?

Facilitators are those who are teaching. All of the following people have a teaching role in this program:

MCHN Managers
MCHN Supervisors and Coordinators
Care Group Promoters
Care Group Volunteers

This means that the QIVC can be used to *encourage, monitor,* and *improve* the work of each one of these workers.

QIVC Effectiveness

The QIVC rapidly increases facilitation performance.
In the Dominican Republic, health Care Group Promoters' performance improved by 38% in 7 months while using QIVCs.[5]
Small improvements in performance can cause large changes in impact.

Write the numbers on a flipchart to make it easier for the participants to follow.
For example let's say your Care Group Volunteers encourage mothers to come to vaccination posts. Your Care Group Volunteers reach 24,000 mothers every six months.
If this process is improved 10% (i.e. they are reaching their mothers more effectively with behavior change messages), and as a result there are 10% more mothers who bring their child to the post, how will this affect the number of children who are immunized?
There would be as many as 2,400 more children who are immunized and who receive vitamin A. Getting Vitamin A to children in this project area will probably cut child deaths by 25% all by itself!

REMEMBER: Small changes in often repeated tasks can cause large changes in impact.

QIVCs are ONLY useful for tasks that <u>can be observed and have multiple steps.</u>

What are some activities in our program that you can OBSERVE? Which of these activities are a PROCESS with multiple steps?

Teaching Care Group lessons to Neighbor Groups
Teaching Care Group lessons to Care Groups
Teaching Care Group lessons to Care Group Promoters

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[5] Davis, T. (1991). Report data, International Child Care (1992).

Teaching Care Group lessons to MCHN Supervisors

List other MCHN activities that include multiple steps in your program. This may include:
Growth monitoring and Promotion
Individual Counseling Sessions

Additional Information for the Trainer:
QIVCs can be used for any activity that can be observed and has multiple steps. In this training we will only discuss the educational session QIVC and the QIVC for Giving Positive Feedback. To view other QIVCs created by Food for the Hungry see the following website:
http://www.caregroupinfo.org/docs/QIVC_Files.zip

Handout out one copy of each of the following QIVCs:
Handout 13A: QIVC for Educational Sessions

GO THROUGH each point on the *QIVC for Education Sessions* with the participants. Ensure that they understand what each question means.

Explain:

MOST questions have a yes or no answer. After reading the question, decide if the answer is "yes" or "no," and mark the corresponding box.

If the question is NOT RELEVANT for a particular training, then ~~draw a line through the YES or NO boxes.~~

- *On the QIVC for Education Sessions, #11. If the topic was exclusive breastfeeding – it is difficult to demonstrate this activity. It is possible for the facilitator to demonstrate proper breastfeeding attachment, but exclusive breastfeeding is not something that needs to be demonstrated during the lesson. You would mark a line through the ~~yes or no.~~*
- *Or #16 if participants do not mention any barriers –you would ~~mark out this line~~ when you are monitoring your worker.*

- A few questions have responses with the numbers 1 through 10.
  - *(See #11 on the QIVC for Educational Sessions)* You could choose to answer yes or no and give more information by ranking participant comments on a scale of 1 to 10.
  - Some questions have BOTH a scale and a yes or no option. Choose the response that works best for you.
  - See questions 28-31 on the Educational Session QIVC.
  - Your staff can decide which is easier for you (use the scale only; use the yes or no only; or use both).

Additional Information for the Trainer:

QIVCs should be adapted to fit the culture and design of each Care Group program. After using the QIVC checklist for 3-4 months, ask staff and volunteers to meet together to discuss the checklist. If specific questions are not appropriate or applicable to your situation, adapt or revise them as needed. However, be cautious. The QIVC was designed to ensure participatory teaching methods are used in the teaching of each lesson. Make sure your final version continues to reinforce the key principles of participatory learning. For more information on key practices of adult learning, see *Freedom From Hunger's* Adult Education Materials (http://www.ffhtechnical.org/resources/education-modules).

And now let's learn more about what happens from this skit.

Skit Parts I and II (30 minutes)

Take out the QIVC for Educational Sessions.
Watch the skit and listen carefully. After the skit is completed, evaluate the facilitator using your own QIVC.

Why after the skit?

If you fill out the QIVC during the skit you will not WATCH and LISTEN. You need to observe and interact with the facilitator.
If you see anything serious during the skit – you might want to make a few notes on your paper so you won't forget things that you should comment on.
However, I suggest you complete the form after the presentation is complete.

Begin the skit – (Facilitator make sure you have two copies of the QIVC).

Remember! If you model a poor example of giving appropriate feedback, the participants will do exactly what they saw you do. Practice, practice, practice! Make sure you have practiced giving appropriate feedback before training others.

Facilitator Directions for Skit

PART I

1. *Greet the facilitator.*
2. *Inform the facilitator of the purpose of your visit. Include the following:*
    - I will be using a QIVC with you today.
    - The QIVC is used to monitor, encourage and improve your work as a facilitator.
    - Don't worry. This is not a test; the purpose of this observation is to help you improve.
3. *Show the facilitator the QIVC you will be using with them. Cast a vision of what you expect them to do during the training, reviewing part of the QIVC. For example:*
    - Each of the steps on the QIVC will help you to teach in a participatory way. For example the first thing you will do is to seat people in a circle, then you will sit down with them. Then you will introduce the topic, making sure you speak loud and clear.
    - You will look at the mothers, not stare at the flipchart… etc.
    - Do you have any questions about the QIVC?
4. *Remind the facilitator of your role:*
    - I am only here to observe. Do not talk with me during the session or ask me questions during the lesson. Please teach as your normally do.
5. *Thank the volunteer and walk together to the "educational site."*

PART II

6. *Volunteer Facilitator does a 5-10 minute presentation to a small group of the participants from the training.*

To be continued…..

1. *Stop skit, ask each participant to fill out the Handout 13A: QIVC for Educational Sessions.*
2. *Discuss participants' responses using the QIVC form.*
3. *Ask each participant to score the QIVC. Write the following instructions on a flipchart.*
    a. Count the # of yes responses.
    b. Divide the # of yes responses by the total number of answered questions (questions answered with a yes or no response).
    c. Remind them to SKIP (don't count) questions that are not appropriate.
4. *Compare scores – if scores have a range larger than 15% - then go through each question together.*
5. *Come to a consensus on responses.*
6. *Continue the skit.*

Additional Information for the Trainer:
A group discussion is not usually possible in normal work situations, however it is a good way to help staff learn how to score and evaluate an observation fairly. We have found in many cultures, supervisors are more prone to mark "no" for very tiny faults instead of marking "yes" if the

facilitator in general completed the given task. Remind participants that this is a tool to encourage and improve workers. The QIVC is not a tool used to fail a participant or shame them into change.

SKIT Part III (30 minutes)

SKIT PART III

7. *Meet the facilitator in his home. Use the following outline to discuss the facilitator's performance:*
    - *Ask,* "How do you think that you did?"
    - *Agree with positive points that he mentions and mistakes that he mentions as appropriate. Probe as needed:* "What things did you do well? What things would you have done differently?"
    - *Review the positive things on the QIVC (everything marked yes).*
    - If not mentioned earlier, ask the facilitator about areas that you marked "no." for example, "Tell me about the activity, I don't remember you including that section." Or "How did you think you did dealing with conflict in the group?"
    - *Reinforce things that the facilitator says that could help them improve these areas. Do not concentrate too much on what the person did wrong, but rather what she did well, helping the facilitator come up with ways to overcome areas where they did poorly.*
    - Ask the facilitator to summarize the things that you discussed today (positive things and areas to improve).
    - *Share the facilitator's score and summarize anything that was missed.*
    - *Ask him to commit to changing these things.*
    - *Thank the volunteer.*

Ask the participants the following questions. They should answer the questions based on what they saw in the skit. Write the responses on the flipchart.

What should you say to the health worker when you visit him or her and plan to use a quality checklist?

- *Don't worry!*
- *This is not a test, but a tool to help you improve.*
- *Teach as you normally do.*

What comments did the Supervisor make during the educational lesson?

- *Nothing!*

- *The supervisors should observe only and not interrupt or make comments to the facilitator.*
- *After the session, the supervisor can address the participants as appropriate.*

Where did the Supervisor talk about each of the points in the checklist?

- In private with the development worker, not in front of other people.

Why did the Supervisor explain the checklist to the worker if it is being used to monitor the worker?

- Because it is also a method for improving and encouraging the worker's performance.
- The thing that we consider to be perfect performance should not be a secret.
- All workers should know exactly what is expected of them.

Did the Supervisor speak to the person in a threatening or reprimanding way? Why?

- No.
- The Supervisor needs to be gentle so the worker does not feel shame.
- Even if the development worker did very poorly on the checklist, emphasize areas where he has shown some improvement.

Why did the Supervisor go over what the health worker was going to do, "First you will sit your group in a circle, then you will introduce the topic…"?

- You are presenting the *vision* of what he or she is going to do.
- It's better to speak in terms of what s/he is going to do, rather than what she should do.
- Help the person develop the vision of perfect performance.

We have talked a lot about positive feedback. What's wrong with negative feedback? Wouldn't the worker improve faster if we told him everything that he did wrong? What is your opinion?

Discuss.

We will use a game to OBSERVE how FEEDBACK influences the performance of a worker.

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Handout 13A: QIVC for Education Sessions

Name of facilitator:__________________________ Date: _________________
Evaluator:________________________
Community: ____________________

METHODS	**YES**	**NO**
1. Did the facilitator seat people so that all could see each other's' faces?	❐	❐
2. Did the facilitator sit at the same level as the other participants?	❐	❐
3. Did the facilitator introduce the topic well (who s/he is, topic, time)?	❐	❐
4. Did the facilitator speak loud enough so that everyone could hear?	❐	❐
5. Did the facilitator use proper eye contact with everyone?	❐	❐
6. Did the facilitator use changes in voice intonation (not monotone)?	❐	❐
7. Did the facilitator speak slowly and clearly?	❐	❐
8. Did the facilitator ask about the current practices of the participants?	❐	❐
9. Did the facilitator read each caption aloud to the participants?	❐	❐
10. Did the facilitator explain the meaning of each picture?	❐	❐
11. Did the facilitator demonstrate any skills that s/he was promoting?	❐	❐
12. Did the facilitator verify that people understood the main points using open-ended questions?	❐	❐
DISCUSSION		
13. Did the facilitator ask the participants lots of (non-rhetorical) questions?	❐	❐
14. Did the facilitator give participants adequate time to answer questions?	❐	❐
15. Did the facilitator ask participants if there were barriers that might prevent them from trying the new practices?	❐	❐
16. Did the facilitator encourage discussion amongst participants to solve the barriers mentioned?	❐	❐
17. Did the facilitator encourage comments by paraphrasing what people said (repeating statements in his or her own words)?	❐	❐
18. Did the facilitator ask participants if they agree with other participants' responses?	❐	❐

19. Did the facilitator encourage comments by nodding, smiling, or other actions to show s/he was listening? .... ❒ ❒
20. Did the facilitator always reply to participants in a courteous and diplomatic way? ❒ ❒
21. Did the participants make lots of comments? .... ❒ ❒

1 2 3 4 5 6 7 8 9 10
Poor Excellent

22. Did the facilitator prevent domination of the discussion by 1 or 2 people? .... ❒ ❒
23. Did the facilitator encourage timid participants to speak/participate? .... ❒ ❒
24. Did the facilitator summarize the *discussion*? .... ❒ ❒
25. Did the facilitator reinforce statements by sharing relevant personal experience, or asking others to share personal experience? .... ❒ ❒
26. Did the facilitator ask each person to make a commitment? .... ❒ ❒
27. Did the facilitator ask each person about previous commitments? .... ❒ ❒

CONTENTS

28. Was the content of the educational messages CORRECT? .... ❒ ❒

1 2 3 4 5 6 7 8 9 10
Poor Excellent

29. Was the content of the educational messages RELEVANT? .... ❒ ❒

1 2 3 4 5 6 7 8 9 10
Poor Excellent

30. Was the content of the educational messages COMPLETE? .... ❒ ❒

1 2 3 4 5 6 7 8 9 10
Poor Excellent

31. OVERALL EVALUATION of the Facilitator's performance:

1 2 3 4 5 6 7 8 9 10
Poor Excellent

Comments: ____

____

____

____

Handout 13B: For the Skit Volunteer

Prepare an educational talk that will last about 3-5 minutes. Speak on any topic (health related topic is best) – but only for five minutes. We want you to be both a good and bad example, so I am asking you to make some mistakes in your presentation.

Please do the following during your presentation:

- Speak loudly so that everyone can hear.
- Introduce the topic well.
- Demonstrate the skill that you are teaching (if possible).
- Encourage discussion amongst the participants.
- Listen to questions and responses from the other participants, nodding and smiling (showing them respect).

You must also demonstrate POOR Practices!

- Speak quickly
- Choose one or two people to avoid during the presentation – do not look at them; do not answer or acknowledge their questions or comments (do not show them respect).
- Ask questions, but do not leave time for the participants to answer the questions.

Skit PART I

1. Facilitator greets you. He explains the purpose of the QIVC.
   Facilitator will tell you, “Don’t worry. Not a test, purpose is to help you improve.”
2. You respond, “Yes I remember discussing the QIVC. However, I’m very nervous. I didn’t know you were evaluating me with the QIVC.”
3. You ask, “Will you be able to help me during the presentation – I have a lot of questions.”
4. Facilitator responds, “No, I am I am there to observe. I can answer questions at the end of the lesson if someone has a question. However, you need to teach as if you were alone.”
5. You agree. You say, “It is time, we should leave for the session.”

Skit PART II

6. *Do the educational session in front of a small group of participants.*

After this, the trainer will review your performance on the QIVC form and come to a consensus.

Skit PART III

7. Facilitator goes back to your house to discuss the QIVC.
8. Be responsive to the supervisor – do not argue with him or her.
9. Admit one or two of the things that you did wrong, but not all of them.

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Lesson 14: QIVC - Principles of Giving Positive Feedback

Objectives:

1. Participants will be able to explain the effects of positive feedback on worker's performance as compared to negative feedback or receiving no feedback.
2. Participants will be able to give effective positive feedback to a colleague:
   a. Ask, "How do you think you performed?"
   b. Affirm the things that they say
   c. Give positive feedback on questions marked with "yes."
   d. Review some of the questions (or all if very few) marked "no," asking the facilitator to offer ideas on how he can improve these areas.
   e. Offering instruction on ways to improve (if additional input is needed)
   f. Ask participant to summarize the discussion
   g. Ask the facilitator for a commitment to change

Summary: 1 hour, 15 minutes

- Coin Toss Activity (30 min)
- Steps for Giving Feedback (45 min)

Materials needed:

- ☐ Flipchart or Whiteboard with Markers
- ☐ One Bucket or basket
- ☐ One Flipchart paper cut to extend about 15 cm around the bucket
- ☐ Six coins or small stones
- ☐ One Blindfold
- ☐ Scripture verses on slips of paper (see text for verses)
- ☐ Handout 14A: QIVC for Giving Positive Feedback [Print one for each participant]

Preparations for the Coin Toss (30 minutes)

- *Choose an area outside where there is plenty of room to move around. It is best to set up the stations in grass or dirt so the participants cannot hear if the stone or coin bounces or lands inside the bucket.*
- *Set the bucket on ground, about 1.5 meters away draw a line for volunteers to stand behind.*
- *Put the flipchart paper under the bucket or basket so it extends about 15 cm around the edges of the container.*
- *Set up a flipchart paper like this:*

Volunteer	Feedback	Missed	Paper	Bucket
Vol. #1	Positive			
Vol. #2	Positive			
Vol. #3	Negative			
Vol. #4	Negative			
Vol. #5	None			

Vol. #6	None			

Select volunteers:

- Select six volunteers to toss coins.
- Select one volunteer to count points.
- Select two “supervisors” to give feedback.

Explain to the “supervisors”:

- Give only negative feedback to the first two people,
- Only positive feedback to the next two people
- Give no feedback to the last two people.

Explain to everyone:

- ***Each volunteer will be blindfolded.***
- ***He (or she) will try to toss his six coins into the bucket.***
- ***After he tosses, he will wait to hear feedback from the two monitors before tossing again.***
- ***Some volunteers will receive no feedback for their efforts.***
- ***Some volunteers will receive positive feedback for their efforts.***
- ***Some volunteers will receive only negative feedback; pointing out the things they did not do well.***
- ***We will compare their performance and see if we can tell which feedback brings the best performance.***
- ***If their coin lands in the bucket it is 2 points. If the coin lands on the paper it is 1 point. If the coin misses the bucket and the paper it is 0 points.***

? ***What are some examples of positive feedback?***

- ***Good aim! If you toss a bit more to your right you will make it.***
- ***That was the perfect amount of force, but move to the right.***
- ***Excellent aim! Throw another like that and you will make it***

Offer specific, positive feedback, “great job, you are a few centimeters from the basket” “excellent throw, that’s just enough force,” affirm their effort and give advice to help them improve “move to the left,” “toss a little harder,” etc.

? ***What are examples of negative feedback?***

- ***You can’t throw at all – that was a mile away.***
- ***You are never going to make it.***
- ***You are way off; you didn’t even get close to the bowl.***

Negative feedback means we criticize them pointing out all of the things that they did wrong, "that was terrible" "you are a terrible thrower," etc.

Ask each monitor to practice giving positive feedback to ensure they know what to do! Giving POSITIVE feedback is often a challenge for workers. In order for this activity to work, the feedback must be given appropriately. If workers are unable to give positive feedback, then the facilitator should model appropriate feedback.

Begin the coin toss

1. ***Call up the first volunteer. Blindfold them.***
2. ***Remind the audience to say NOTHING during the coin toss, but let only the "mentors" give the appropriate feedback.***
3. ***Ask the "recorder" to record where the coin lands for each toss on the flipchart.***

Following the game ask the following discussion questions:

? Which tossers did the best?

? How did the feedback affect performance?

? What can we learn from this exercise?

- Without feedback, people have no idea how well they are doing.
- Negative feedback hurts performance. People are more likely to be discouraged and continue to throw poorly.
- Only positive feedback brings improvement and improved scores!

? As Christians, what does scripture teach us about interacting with others? Does it reinforce what we have learned?
Hand out slips of paper with the following scripture references on them. Discuss them.
  - Colossians 4:8
  - I Thessalonians 3:2, 5:11, 5:14
  - 2 Timothy 4:1-2
  - Acts 4:6 (being "sons of encouragement")
  - Acts 20:2 (Paul as encourager)
  - Romans 15:5 (God gives encouragement)
  - I Corinthians 14:3
  - Philippians 1:7 (Paul encouraged by others. How we are encouraged by others, especially when we teach others how to encourage through our example.)

Add:

- To use a new skill, a person has to have self-confidence, which is usually nurtured by other people.
- Self-confidence is key to behavior change in mothers, health workers, and ourselves. If a health worker feels shame after an evaluation, s/he may not have the confidence to change his or her behavior (i.e., performance).
- We are often working with volunteers, people who are donating their time to the project and will not continue to work for us unless they are made to feel good about their work.
- If s/he does not take the work seriously, that's a different situation which may require a reprimand.

Final note:

- The development workers in your charge will teach and instruct in the way that they are taught and instructed. If you give positive feedback, they will also give positive feedback. Be a role model.

Additional Information for the Trainer:

From, "Positive Image, Positive Action: The Affirmative Basis of Organizing" by David Cooperrider.

Most people (worldwide) believe that pointing out mistakes will eliminate failures and improve performance. However, studies have shown that the opposite is true especially when it comes to learning new tasks.

In one experiment, for example, Kirschenbaum (1984) compared three sets of bowlers:

- Group A: this group did not receive any lessons but tried to learn how to bowl on their own.
- Group B: this group of bowlers was videotaped. All of the "good things they had done" while bowling were compiled (the mistakes were deleted from the tapes). These positive tapes were reviewed with each bowler pointing out the things they had done well to help them improve.
- Group C: this group of bowlers was also videotaped. All of the "bowling mistakes" they had made were compiled (the good things they had done were deleted off the tapes). The "mistake tapes" were reviewed with this group pointing out areas they needed to improve.

Group B improved significantly more than all the others, and the unskilled bowlers in Group B (average of 125 pins) improved substantially (more than 100 percent) more than all other groups.

Since then, these results have been replicated with other athletic activities, giving the same results. Pointing out the things people do *well* helps them learn new skills and improves their performance in mastering new tasks.

Steps for Giving Feedback to FH Workers (45 minutes)

Let's now review exactly how feedback is given to the health worker after an observation.

? What are the things that you observed in the skit? What steps did I go through when talking with the worker?

Write the comments on a flipchart. Go over each of their points.

Pass out Handout 21A: QIVC for Giving Positive Feedback

This is a handout that was made to help MCHN Manager, Coordinators and Supervisors remember the key actions to take when giving feedback. Lets' focus on the third section of the QIVC which is feedback.

If we put each of these questions into a sentence it will tell us exactly how to give positive feedback with the QIVC.
Starting with #7, go over each question – making it into a statement and reinforcing what the one supervising should say and do when giving feedback.

7. Give feedback in private

8. Ask the person to take notes

- Why?
- So they will remember what they need to do differently next time.
- If you are dealing with a CG Volunteer who cannot write, ask her to think of a token which will remind her of what she will commit to do. She may say, "I will take a blade of grass and put it in my book. It will remind me to ask those who are quiet to be part of the discussion."

9. Discuss each positive point

- Why? Because this is meant to encourage the worker!
- Positive feedback needs to outweigh negative feedback about 3 to 1. Be encouraging. Seek out good things to say about the person's performance. Encourage the worker mentioning all the places where he or she is already doing a good job.

10. Encourage the worker with respect to the things they have done well.

- Be gentle with the health worker, and give compliments wherever possible.
- We may be saying "good things" but have a poor attitude or demeanor. Make sure you are acting in a way that matches the positive things you are saying.
- This includes #11, 12 and 13.

11. Use positive body language.

- *Ask for two volunteers to say, "That was a great presentation! Your introduction was very clear and helped build anticipation for the lesson."*
- *Ask one volunteer to use their body language to show disapproval while saying it.*
- *Ask another volunteer to use their body language to demonstrate approval while saying it.*
- Body language often speaks louder than the words you say.

13. Do not use mixed comments.
- Give all positive comments without adding negative things on the end.
- Don't say," I like your introduction except you talked too quietly."
- Mention ALL of the positive things together, not mentioning any of the things they need to improve (that will come later).

14. Respond to the person evaluated in a courteous and diplomatic manner.
- This is a conversation, not a time for you to speak your mind.
- Encourage discussion and conversation.
- If the evaluator is doing all the talking, he is not doing a good job of giving feedback.

15. Mention the areas where the person evaluated is doing better than others.
- To say, "You handled the conflict well." is not the same as saying, "The way that you handled the conflict in your lesson was excellent; your skills in dealing with conflict are the best I have observed amongst all of the promoters!"
- Which comment means the most? The second one.
- As often as possible point out areas where the worker excels compared to others.

16. Discuss each negative point on the form.
- There is a caveat to this point.
- In the beginning the workers may do very poorly. If they did 15 things poorly, you should not mention all 15 things to them. It will be too discouraging. Remember our rule of 3 positive comments to every one area to improve.
- If there are many faults, choose 4-5 that are the most important and should be worked on first.
- As they master these skills, focus on the other areas (in future times of giving feedback).

17. Ask the person being evaluated to discuss <u>his or her performance before giving your opinion.</u>
- When you come to a "NO" on the form, ask the participant, "How did you think you did on this item?"
- It is much easier emotionally for a person to identify his own mistakes than to have someone else point them out. This also encourages reflection.

18. Offer several examples to explain the correct manner of performing the areas where they received a NO on the form.

- If you point out an area that the worker needs to improve. Discuss with them ways to improve that area.
- For example is they are not speaking loudly enough, ask them how they can improve this.
- Offer additional ideas such as, "Talk as if you are speaking to someone standing in the distance," "Tell the Mothers to speak up if they can't hear you," etc.
- If the person forgot to take attendance, ask them how they will remember next time.
- Offer additional ideas such as, "Give your attendance register to a woman in the group and ask her to remind you to fill it out," or "Ask for a volunteer to take attendance for you each week so you will remember."
- Just as mothers experience obstacles when they are trying a new behavior (like remembering to wash their hands after using the latrine) we need to help our workers troubleshoot the facilitation areas that they struggle with.

19. Maintain control of the evaluation.

- What does this mean?
- If the worker becomes very downhearted (feels shame) or becomes very belligerent (feels anger), the evaluator needs to help the person feel more at ease and make sure the conversation turns more positive.
- If you aren't sure if you are giving positive feedback, look at the person you are evaluating. If they look frightened, angry, scared or sad, then you are not doing a good job.
- Be aware of how the review is going and shift gears if it begins to go in the wrong direction.

20. Help the person evaluated find solutions to the problems when possible.

- As we mentioned before, the Evaluator should not assume he has all the answers.
- Ask the person evaluated how they can overcome the areas where they need improvement.
- Listen to their ideas. Only offer your suggestions if they can't come up with ideas on their own.

21. Keep the attention of the person evaluated.

- Again if the person you are evaluating is bored or not paying attention, then you need to engage them in discussion.
- This should be a dialogue, not a monologue from the evaluator.

As an evaluator, you needs to focus on what is correct (#22), appropriate (#23), complete (#24) and specific (#25).

- Often we need someone watching us to tell us if we are off task.
- This is why when we first begin giving feedback it is useful to discuss our ideas with someone else first.
- It helps us to understand how to score someone accurately.

? What happens at the end of the Evaluation?

26. Ask the person to give a summary of the things that they will improve.

27. If they have forgotten areas, add those.

28. Ask them to make a commitment to improve these issues.

29. Ask the person to give a summary of the things they did well.

30. Add to this list if they have forgotten some positive areas
- End on the positive things!

? Did you see these things during the skit earlier in the day?

? Which of these things did I do well?

? In which of these areas do you think I need improvement?

Briefly the first two sections of the QIVC.

As we discussed in the last session, the first two sections of this QIVC discuss what the Evaluator should do when he meetings with the worker prior to the observation.

1. The Evaluator begins **by explaining the purpose of the QIVC (to encourage, Improve and monitor his work).**
- Remind the worker of the purpose of the QIVC: to improve, monitor and encourage. This helps to ease their stress and also helps the facilitator to make sure he works on encouraging and helping the worker improve.

2. The Evaluator tells the worker not to fear, this is not a test…

3. The Evaluator reminds the worker not to talk with him during the observation.

Steps 4-6 cover what will happen during the observation.

4. Do not make comments to the person you are evaluating during the presentation
5 & 6. Fill out the entire QIVC during or right after the observation and score it.

Now, we have used this QIVC as a checklist to remind you what to do when supervising.

? When would you use it as a QIVC to evaluate someone else?

- As a supervisor when you are supervising your Promoter as he observes a Care Group Meeting. Use this QIVC to evaluate how well he gives feedback to the Care Group Volunteer.
- As a Manager supervising the MCHN Supervisor observing the Promoter!
- Use this form often in the beginning of the program to help encourage, improve and monitor the positive feedback that your workers are giving!

Remember the coin toss! No feedback and negative feedback leads to poor performance. If you want your workers to excel, practice giving positive feedback!

Handout 14A: QIVC to Evaluate Positive Feedback

Use this form when supervising someone giving feedback to a health worker with the QIVC.

Name of the Person Using this List: ___________________________________

Name of the Person Evaluated: ______________________________________

Community: ___________________________ Date: ____________________

Number of YES: __ Number of lines: __ Present Grade: ___% Previous Grade: ___%

<u>Did the Evaluator</u>	**YES**	**NO**
1. Explain **the purpose** of the QIVC (to improve and measure the quality of his/her work)?	☐	☐
2. Tell the person evaluated **not to fear**, that this is **not a test**, but rather something to help **him/her improve**?	☐	☐
3. Advise the person being evaluated **not to say anything** to the evaluator during the health lesson?	☐	☐
<u>During the Observation</u>		
4. Did the Evaluator **avoid making comments** to the person evaluated during the health lesson?	☐	☐
5. Did the Evaluator **mark all the questions (yes or no)** during or right after the observation?	☐	☐
6. Mark all the questions on the list correctly?.....	☐	☐

1 2 3 4 5 6 7 8 9 10
All Incorrectly All Correctly

<u>Feedback</u>		
7. Did the Evaluator **give the feedback in a private place**?	☐	☐
8. Did the Evaluator ask the person evaluated **to take notes** on his/her comments?.....	☐	☐
9. Did the Evaluator discuss **each positive point** on the form?	☐	☐
10. Did the Evaluator **encourage the person evaluated** with respect to the things he/she did correctly?	☐	☐
11. Did the Evaluator **use positive "body language"** when providing positive feedback to the person?	☐	☐
12. Did the Evaluator **use many encouraging words** (e.g., excellent, very good) when providing positive feedback to the person?	☐	☐
13. Did the Evaluator **avoid the use of too many mixed comments** (e.g., "This was excellent, but you have to …") when providing feedback?	☐	☐

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YES NO

14. Did the Evaluator always **respond** to the comments from the person evaluated in a **courteous and diplomatic manner** all the time?.. ☐ ☐
15. Did the Evaluator mention the area(s) where the performance of the person evaluated was **better than the majority** of other people? .... ☐ ☐
16. Did the Evaluator discuss **each negative point** on the form? .... ☐ ☐
17. Did the Evaluator often **ask the person** evaluated to discuss the negative points in his/her performance self-evaluation **before providing an opinion**? .... ☐ ☐
18. Did the Evaluator **use several examples** to explain the correct manner of performing the parts of the process that were done incorrectly? .... ☐ ☐
19. Did the Evaluator **maintain control of the evaluation process** in an appropriate manner? .. ☐ ☐
20. Did the Evaluator assist the person evaluated **find solutions** to the problems s/he has (e.g., in the community) where possible? .... ☐ ☐
21. Did the Evaluator **keep the attention** of the person evaluated? .... ☐ ☐
22. Were the **suggestions of the Evaluator** correct? .... ☐ ☐

1 2 3 4 5 6 7 8 9 10
All Incorrect   All Correct

23. Were the suggestions of the Evaluator **appropriate** for the context of the person evaluated? ☐ ☐

1 2 3 4 5 6 7 8 9 10
Not appropriate   100% Appropriate

24. Were the Evaluator's suggestions **complete**? .... ☐ ☐

1 2 3 4 5 6 7 8 9 10
Not appropriate   100% Appropriate

25. Were the Evaluator's suggestions **very specific**? .... ☐ ☐

1 2 3 4 5 6 7 8 9 10
Not specific   Very specific

<u>At the End of the Evaluation</u>

26. Did the Evaluator **ask the person** evaluated **to give a summary** of the things that should be improved? .... ☐ ☐
27. Did the **Evaluator complete this list i**f the person evaluated could not remember all the things that needed improvement? .... ☐ ☐
28. Did the Evaluator ask the person evaluated to **indicate his/her commitment to improve** these things? .... ☐ ☐

29. Did the Evaluator ask the person evaluated **to give a summary of the positive things th**at s/he did? .... ☐ ☐
30. Did the Evaluator **complete this list** if the person evaluated could not remember all the things he/she did that were positive? .... ☐ ☐

GENERAL EVALUATION OF THE EVALUATOR'S PERFORMANCE
1 2 3 4 5 6 7 8 9 10
POOR EXCELLENT

Additional Comments:

____

____

____

____

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Lesson 15: QIVC - Calculating Scores and Using Data

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Objectives:

1. Participants will be able to score the QIVC and evaluate staff and volunteer performance over a period of time.
2. Participants will be able to list the QIVC target in the Care Group program: 80% of all staff will score 80% or above.
3. Participants will be able to average QIVC scores and give the % of scores greater or equal to 80%.
4. Participants will be able to analyze QIVC data to find people problems and system problems.
5. Participants will be able to give three suggestions to solve people and system problems.

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Summary: 1 hour, 45 minutes

- Review (5 min)
- Targets and Calculations (40 min)
- System and People Problems (60 min)

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Materials:

- ☐ Flipchart or whiteboard with markers
- ☐ Calculator (optional)
- ☐ Handout 15A: Analyzing QIVC Scores [Print one for each participant]
- ☐ Handout 15B: Monitoring QIVC Data [Print one for each participant]

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Review (5 minutes)

? How are scores calculated?

- Count the # of yes responses.
- Divide the # of yes responses by the total number of answered questions (questions answered with a yes or no response).
- Remember to SKIP (don't count) questions that are not appropriate.

? What is the purpose of the QIVC?

- To monitor facilitation skills
- To encourage the workers
- To improve facilitation skills

Performance Targets and Calculations (40 minutes)

- In this session we will focus on MONITORING workers performance.
- The QIVC is a representation of perfect performance.
- Very few people will reach perfection (100%) during an observation.

- For all of our trainers (staff trainers, Care Group Promoters as well as Care Group Volunteers) **we <u>want</u> them to reach and maintain a score of 80% or above.**

- We can't expect 100% to reach it – so our target is **80% (most) of all staff to perform 80% or above each quarter.**

Explain how to calculate the following scores, writing equations on the flipchart.

Calculating percentages ≥80%

- COUNT the number of scores.
- COUNT the number of scores that are 80 or above.
- Divide that number by the number of total scores.
- DO NOT ADD SCORES – just count them.

Calculating the average score

- ADD all the scores together.
- DIVIDE the sum by the NUMBER of scores.

Refer participants to Handout 15A: Analyzing QIVC Scores
Do example 1 together with the participants. Then ask them to work in pairs to complete the other examples.

Example 1: Tesfaye's Promoters

Abebe – 90%
Kebede – 85%
Asnake – 100%
Bogale – 60%
Tesfaye – 77%
Yetayesh – 55%

What is the average? = 77.8 or 78%
What is the percentage of scores greater or equal to 80% = 3/6 = 50%

Example 2: Abebe's Promoters

Meseret – 81%
Alem – 85%
Mihret – 80%
Gossa – 83%
Hiwot– 10%
Maru – 82%

What is the average? = 70.1 = 70%
What is the % of scores greater or equal to 80%? 5/6 = 83%

Example 3: Moges' Promoters

Lulu – 75%
Fantansh – 55%
Misrak –65%
Belete – 75%
Assefa – 70%
Taye – 68%

What is the average? = 68%
What is the percentage of scores greater or equal to 80%? 1/6= 17%

? Which one of these groups has reached our target? Why?

- The answer is the second group. 80% of the people have reached 80% or above.

? Why is it important to take the average AND the percentage of workers who have reached 80%? *Encourage them to review the last three examples to find the answer.*

- If you only look only at the average scores, it would appear that Tesfaye's group is doing the best. However, half of his promoters have not reached the target.
- Abebe's promoters have an average that is 8% points lower, but he has reached the target for his workers!
- Moges' promoters are only 2% points behind Abebe's group, but his workers are doing very poorly with only 17% of them reaching the target!
- Averages do not give you enough information.
- Remember! We want all of our workers to improve – pay attention to % of workers reaching the target so we can spend more time helping them to improve.

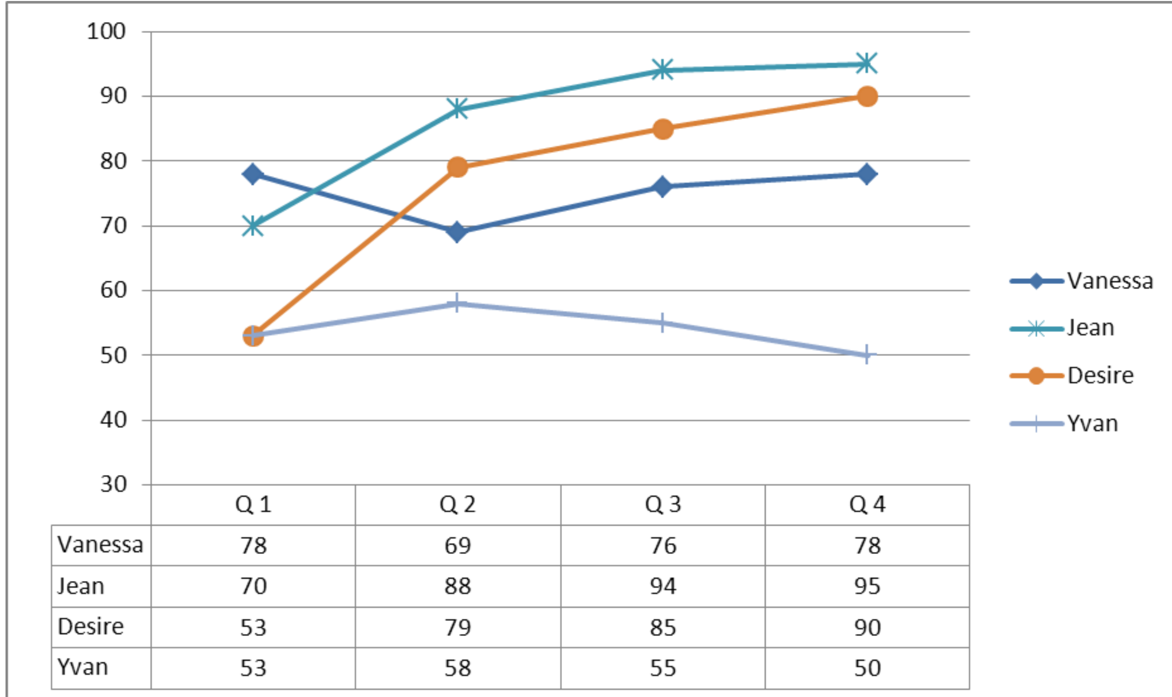
In order to monitor progress we need to RECORD scores for all of our workers, and check for problems regularly.

Options for Recording

- Make a flipchart poster which is posted in the manager's office or the district office with promoter (or supervisor) scores listed for each quarter (the manager needs to decide whether or not names should be included on this poster).
- The Supervisor keeps a record in his files – using graph paper (or an excel spreadsheet) to record scores after each observation.
- Purchase a manila file folder for all of the workers, include all of their QIVCS and add scores to the inside cover so you can see improvements over time. Bring this file to all observations of the worker so you so you can share progress.
- Refer to the graph on the back on Handout 23A. You can also draw a graph to help you monitor progress of workers. It makes it very easy to understand at a glance how workers are performing.

Ask participants to respond to the two questions related to Sarah's graph.

Example 1 – Sarah's Care Group Volunteers



	Q 1	Q 2	Q 3	Q 4
Vanessa	78	69	76	78
Jean	70	88	94	95
Desire	53	79	85	90
Yvan	53	58	55	50

? How many Care Group Volunteers have reached the standard score?

- Two of them reached 80% (Jean and Desire).
- Vanessa is close behind but Yvan is doing very poorly.

Add:

- You do not need to calculate scores over time for individual workers if you put their scores on a graph.
- We can see the 80% line and find those who are above and below the line.
- Remember we are hoping that all workers IMPROVE to the point where they reach 80% or above. During the first months of observations, we can expect them to have lower scores. We are looking for improvement over time.

? What percentage of Care Group Volunteers reached the standard by Quarter 4? (50%)

System and People Problems (60 minutes)

There are two types of problems that QIVCs can detect:

1. System problems
2. People problems

? What is the difference?

- **System-wide Problems are p**roblems that all workers share. A problem with the way the workers have been trained.
- It might be a problem with the way they were trained, or a skill which they are having trouble mastering (ex. Story telling or asking for commitments).

- ***People Problems are p***roblems with individual workers. The QIVC shows which workers are not improving.
- People problems require that you work one-on-one to help them improve. One low score is not bad; we are looking for improvement over a long period of time.
- However, if you continue to see one worker doing poorly you will need to intervene. If a worker continues to score poorly (even after multiple observations and feedback) you need to remove them from the Care Group (according to your organization and national policies).

? Why do we need to monitor system and people problems?

- If our staff are not teaching effectively (if they are poor facilitators) it will greatly impact the effectiveness of the messages shared during the Care Groups.
- If in turn, our Care Group Volunteers are modeling the poor teaching skills that they learned from the Care Group promoter, then it will impact whether the neighbor women hear the messages and change their behaviors.
- The success of the Care Group program is dependent upon the strength of your workers.

REMEMBER: Small changes in often repeated tasks can cause large changes in impact.

Refer to Handout 15B: Monitoring QIVC Scores
Worksheet #1

Explain how to read the charts on the handout.
- *The numbers refer to the questions on the QIVC for Educational Sessions.*
- *Ask participants to work in pairs to answer the LAST THREE QUESTIONS at the bottom of Worksheets 1 (if they have extra time they can answer the average score and percentage of score questions).*

- *Give them approximately 15 minutes for this exercise.*
- *Review the answers using the answer key at the end of this lesson.*

Worksheet #2

- *Ask participants to work in pairs to complete Worksheet #2 and complete the last three questions.*
- *Give approximately 15 minutes for this exercise.*
- *Discuss answers using the answer key.*

Using the QIVC - Frequency
Example 3

Ask the discussion questions – letting participants work in pairs if needed to come up with their answers.

? After reviewing this data, what is your plan as the supervisor of these workers?

	Gabriella	Kwaasi	Dorothy	Tom	Mario	Joseph	Total
Q 1	68%	74%	53%	47%	74%	89%	68%
Q 2	74%	79%	68%	53%	79%	89%	75%
Q 3	84%	89%	89%	53%	95%	100%	86%

Solutions might include:

- Tom is not improving enough. Everyone else is making an improvement.
- Tom needs a refresher training
- Ask him to review the checklist before each session.
- Put him on probation and replace him if he does not improve. However, if this is the FIRST time you are giving feedback – then you need to give him more time. Begin reviewing his work more often giving feedback at every observation.
- Ask him to work with (or observe) someone with higher scores (like Joseph).
- Ask yourself, "As a manger, am I giving good feedback? Have I told Tom the areas that he needs to improve?"
- Make sure Tom commits to improve. If he is not "working to improve" then set a deadline.

? How do you know when it is a good decision to fire someone?

- After giving them at least four opportunities to improve their score (with feedback) and they are still scoring poorly, think about replacing them.
- When you see constant resistance.

- After you put them on probation they make no improvement.
- After you follow the country protocol for firing….

Supervising with the QIVC / Frequency

? How often do you use the QIVC?

- **For Care Group Volunteers, Promoters, Supervisors and Coordinators with unacceptable scores (<80%):** their supervisor should use the checklist each time the worker is visited/observed until they reach the target.
- If it is a Promoter, Supervisor or Coordinator, visit them every month until the score is 80% or above. These are our head trainers.
- **For workers with acceptable scores (80% or above at least twice in a row):** Use the QIVC less frequently (you can monitor them less frequently) to see if they are able to maintain this standard.
- For example observe them once every quarter or every other quarter after they have a score 80% or above for two quarters in a row.

Referring to the back of HANDOUT 15B: Monitoring QIVC Scores

? Looking again at the chart, how frequently should each of these staff members be observed?

	Gabriella	Kwaasi	Dorothy	Tom	Mario	Joseph	Total
Q 1	68%	74%	53%	47%	74%	89%	68%
Q 2	74%	79%	68%	53%	79%	89%	75%
Q 3	84%	89%	89%	53%	95%	100%	86%

- Gabriella is doing well; use the QIVC at the next visit; if she scores > 80% again, observe her once each quarter or every other quarter.
- Kwaasi is doing well, use the QIVC next month and then decrease to once a quarter or every other quarter if he scores 80% or above again.
- Dorothy is doing well, may use it at the next observation and then decrease if her scores stay about 80%.
- We need to work on an improvement plan for Tom. Look at the questions on the QIVC where he scored poorly. Advise him on the things that he should improve. Retrain him if necessary. Make an action plan.
- Mario and Joseph do not need any more QIVCs this quarter; could use QIVCs with them every other quarter.

FINAL NOTE:

Introducing the QIVC to your Workers:

- Train all of the staff and volunteers who will be monitoring (or observed with QIVCs) their purpose and how to use them (just you received training here)!

When training the Care Group Volunteers you will need to make the training extremely simple. It is best to develop a basic pictorial QIVC for monitoring and training them. That way, they can learn the pictures and their meaning and do not need to be literate to understand the monitoring tool.

Answer Key for Handout 15B: Analyzing QIVC Scores Worksheet 1

Quarter 1 – QIVC Scores (1 = yes; 0 = no; Skip = N/A)

Question	Abebe	Kebede	Asnake	Bogale	Tesfaye	Yetayesh	Mesele	Total
1	1	0	1	1	1	0	1	71%
2	1	1	1	1	1	1	0	86%
3	0	1	1	0	0	0	1	43%
4	1	0	1	1	1	1	0	71%
5	1	1	0	1	0	0	0	43%
6	0	1	1	1	1	1	1	86%
7	1	1	1	0	1	1	0	71%
8	0	1	1	1	0	0	1	57%
9	1	1	0	1	1	1	1	86%
10	1	1	1	1	1	1	1	100%
11	0	0	0	0	0	0	0	0%
12	1	1	1	1	0	1	1	86%
13	1	1	1	1	1	1	1	100%
14	0	1	1	0	1	0	0	43%
15	1	1	0	1	1	1	0	71%
16	0	n/a	1	1	0	1	n/a	60%
17	0	1	0	1	1	1	1	71%
18	0	1	1	1	0	0	0	43%
19	1	1	0	1	1	1	1	86%
20	0	1	1	0	0	1	0	43%
21	0	1	1	1	1	1	1	86%
22	1	0	1	1	1	1	0	71%
23	0	1	1	1	1	1	1	86%
24	1	1	0	1	1	0	0	57%
25	1	0	1	0	1	1	1	71%
26	1	1	1	1	1	1	1	100%
27	1	1	1	1	1	0	1	86%
28	0	0	0	1	1	1	0	43%
29	0	1	n/a	1	1	1	1	83%
30	1	1	1	0	1	1	0	71%
Total YES	19	25	23	25	23	24	17	
Total Questions	30	29	29	30	30	30	29	
Percentages	**63%**	**86%**	**79%**	**83%**	**77%**	**80%**	**59%**	

Average score = 75%;

Percentage of scores ≥ 80% = 50%

System problems = QIVC Educational Session Question Numbers 3, 5, 11, 14, 18, 20, 28

- *#3. Did the facilitator introduce the topic well?*
- *#5 Did the facilitator use the proper eye contact with everyone?*
- *#11 Did the facilitator demonstrate skills that s/he was promoting?*
- *#14 Did the facilitator give participants adequate time to answer questions?*
- *#18 Did the facilitator ask participants if they agree with other participants' responses?*
- *#20 Did the facilitator always reply to participants in a courteous and diplomatic way?*
- *#28 Was the content of the educational messages CORRECT?*

Possible solutions to system problems

- Coach staff during the practice and coaching session to make sure they are 1) introducing the topic well, 2) using proper eye contact and 3) including the appropriate activity (#11)..
- During staff trainings, demonstrate (model) the best way to introduce a topic, proper use of eye contact and good discussion techniques (#3,5,14,18,20, and 28).
- Set up a separate training where you teach facilitators how to deal with problem participants (so that they can respond appropriately) #20.
- Review your materials to find out why many workers are not sharing correct information (#28). Retrain all workers on technical information.
- Review these questions specifically on the QIVC before the observation, reminding the facilitator to do these actions when "casting a vision" for performance.
- Ask the facilitators to commit to making these changes.
- Help facilitators develop ways to remember to do the new things – ask them, "How will you remember?"
- Reconsider your trainings: Are you rushing through the trainings so that people don't understand? You may need to shorten the training and spend more time going over practical examples (increase discussion, and allow for more questions).

People problems = Abebe and Mesele are scoring poorly – worse than others.

Possible Solutions for People Problems

- Find out the problem with each worker. Are they getting positive feedback from their observer? Why haven't they improved?
- Review the questions they have missed. Are they scoring poorly on questions that were skipped (not applicable questions)?
- Is the worker unwilling to make changes?
- Ask the person for a plan of how they will improve and chart progress.

Answer Key for Handout 15B: Analyzing Data Worksheet #2

Quarter 2 - QIVC Scores (1 = yes; 0 = no; Skip = N/A)

Question	Abebe	Kebede	Asnake	Bogale	Tesfaye	Yetayesh	Mesele	Total
1	0	0	0	1	0	0	1	29%
2	1	1	1	1	1	1	0	86%
3	1	1	1	0	0	0	1	57%
4	0	0	1	1	1	1	0	57%
5	1	1	0	1	1	1	1	86%
6	1	1	1	1	1	1	0	86%
7	1	1	1	1	1	1	0	86%
8	0	1	0	0	0	0	1	29%
9	0	1	0	0	1	1	1	57%
10	1	0	1	1	1	1	0	71%
11	1	1	0	1	1	0	0	57%
12	1	1	1	0	1	1	1	86%
13	1	1	1	1	1	1	1	100%
14	0	1	1	1	1	1	1	86%
15	1	1	1	1	1	1	0	86%
16	1	1	1	1	1	1	1	100%
17	0	1	1	1	1	1	0	71%
18	1	0	1	1	0	1	1	71%
19	0	1	n/a	1	1	1	1	83%
20	0	1	1	1	0	1	0	57%
21	0	1	1	1	1	1	1	86%
22	1	0	1	1	1	1	1	86%
23	1	1	1	1	1	1	1	100%
24	1	1	1	1	1	0	0	71%
25	n/a	0	0	0	0	1	n/a	20%
26	1	1	1	1	1	1	0	86%
27	0	0	1	0	1	0	1	43%
28	0	1	1	1	0	1	1	71%
29	0	1	1	1	1	1	1	86%
30	1	1	0	1	1	1	0	71%
Total YES	17	23	22	24	23	24	17	
Total Questions	29	30	29	30	30	30	29	
Score	**59%**	**77%**	**76%**	**80%**	**77%**	**80%**	**59%**	

The average score = 76%

The percentage of scores ≥ 80% = 2/7 = 29%

System problems = #1, 8, 25 27

Refer to the Educational Session QIVC

- #1 Did the facilitator seat people so that all could see each other's faces?

Answer Key for Handout 15B: Analyzing Data Worksheet #2

- #8 Did the facilitator ask about the current practices of the participants?
- #25 Did the facilitator reinforce statements by sharing relevant personal experience, or asking others to share personal experience?
- #27 Did the facilitator ask each person about previous commitments?

People problems = Mesele and Abebe still need help.

- Review suggestions for people problems from worksheet #1.

System Problems Solutions

- Explain the reason why asking about current practices is important. Review the principles of adult learning theory so that they understand the reason for this practice. Show them where the questions are listed in the lesson plan and model the behavior for multiple lessons. Give time so that each worker can practice this skill during a training lesson.
- Do the same with other missed practices – giving reasons, explaining, modeling the key behavior and giving time for each staff person to practice until they can do it well.

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Handout 15A: Analyzing QIVC Scores

1. Count the # of yes responses.
2. Divide the # of yes responses by the total number of answered questions (questions answered with a yes or no response).
3. Remember to SKIP (don't count) questions that are not appropriate.

Calculating percentages ≥80%

- COUNT the number of scores. DO NOT ADD SCORES – just count them.
- COUNT the number of scores that are 80 or above.
- Divide that number by the number of total scores.

Calculating average scores

- Add all the scores together.
- Divide by the number of scores to get the average.

Example 1: Tesfaye's Promoters

Abebe – 90%
Kebede – 85%
Asnake – 100%
Bogale – 60%
Tesfaye – 77%
Yetayesh – 55%

What is the average? =
What is the percentage of scores greater or equal to 80% =

Example 2: Abebe's Promoters

Meseret – 81%
Alem – 85%
Mihret – 80%
Gossa – 83%
Hiwot– 10%
Maru – 82%

What is the average? =
What is the % of scores greater or equal to 80%?

Example 3: Moges' Promoters

Lulu – 75%
Fantansh – 55%
Misrak –65%

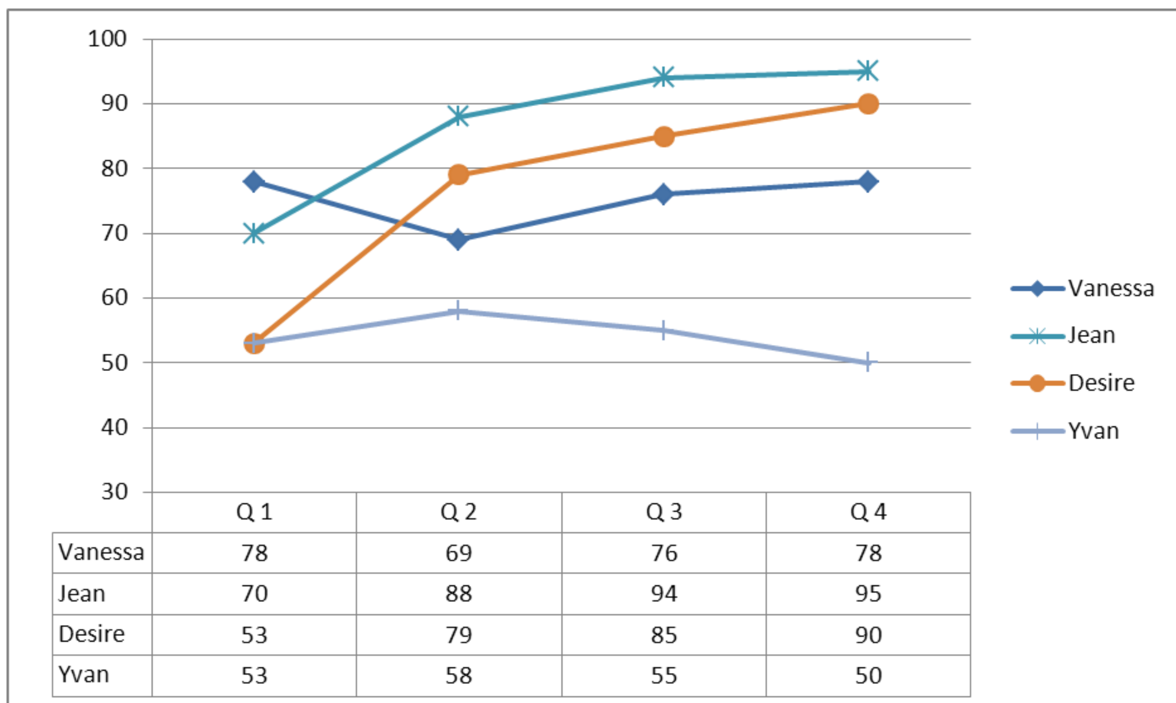
Belete – 75%
Assefa – 70%
Taye – 68%

What is the average?
What is the percentage of scores greater or equal to 80%?

Monitoring Progress over Time
Example 1 – Sarah's Care Group Volunteers

? How many Care Group Volunteers have reached the standard score?

? What percentage of Care Group Volunteers reached the standard by Quarter 4?



	Q 1	Q 2	Q 3	Q 4
Vanessa	78	69	76	78
Jean	70	88	94	95
Desire	53	79	85	90
Yvan	53	58	55	50

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Handout 15B: Monitoring QIVC Scores

Quarter 1 – QIVC Scores (1 = yes; 0 = no; Skip = N/A)

Question	Abebe	Kebede	Asnake	Bogale	Tesfaye	Yetayesh	Mesele	Total
1	1	0	1	1	1	0	1	71%
2	1	1	1	1	1	1	0	86%
3	0	1	1	0	0	0	1	43%
4	1	0	1	1	1	1	0	71%
5	1	1	0	1	0	0	0	43%
6	0	1	1	1	1	1	1	86%
7	1	1	1	0	1	1	0	71%
8	0	1	1	1	0	0	1	57%
9	1	1	0	1	1	1	1	86%
10	1	1	1	1	1	1	1	100%
11	0	0	0	0	0	0	0	0%
12	1	1	1	1	0	1	1	86%
13	1	1	1	1	1	1	1	100%
14	0	1	1	0	1	0	0	43%
15	1	1	0	1	1	1	0	71%
16	0	n/a	1	1	0	1	n/a	60%
17	0	1	0	1	1	1	1	71%
18	0	1	1	1	0	0	0	43%
19	1	1	0	1	1	1	1	86%
20	0	1	1	0	0	1	0	43%
21	0	1	1	1	1	1	1	86%
22	1	0	1	1	1	1	0	71%
23	0	1	1	1	1	1	1	86%
24	1	1	0	1	1	0	0	57%
25	1	0	1	0	1	1	1	71%
26	1	1	1	1	1	1	1	100%
27	1	1	1	1	1	0	1	86%
28	0	0	0	1	1	1	0	43%
29	0	1	n/a	1	1	1	1	83%
30	1	1	1	0	1	1	0	71%
Total YES	19	25	23	25	23	24	17	
Total Questions	30	29	29	30	30	30	29	
Percentages	**63%**	**86%**	**79%**	**83%**	**77%**	**80%**	**59%**	

Average score = __________________________________

Percentage of scores ≥ 80% = __________________________________

System problems = __________________________________

What exactly are the workers forgetting to do? *Refer to the questions on the QIVC*

____

____

What do you propose as solutions to these system problems?

____

____

____

What people problems do you see? ____

What do you propose as solutions to these people problems?

____

____

____

Example 3

? After reviewing this data, what is your plan as the supervisor of these workers?

____

____

____

? How often will you supervise each of the workers next month?_________________________

____

____

	Gabriella	Kwaasi	Dorothy	Tom	Mario	Joseph	Total
Q 1	68%	74%	53%	47%	74%	89%	68%
Q 2	74%	79%	68%	53%	79%	89%	75%
Q 3	84%	89%	89%	53%	95%	100%	86%

Quarter 2 - QIVC Scores (1 = yes; 0 = no; Skip = N/A)

Question	Abebe	Kebede	Asnake	Bogale	Tesfaye	Yetayesh	Mesele	Total
1	0	0	0	1	0	0	1	29%
2	1	1	1	1	1	1	0	86%
3	1	1	1	0	0	0	1	57%
4	0	0	1	1	1	1	0	57%
5	1	1	0	1	1	1	1	86%
6	1	1	1	1	1	1	0	86%
7	1	1	1	1	1	1	0	86%
8	0	1	0	0	0	0	1	29%
9	0	1	0	0	1	1	1	57%
10	1	0	1	1	1	1	0	71%
11	1	1	0	1	1	0	0	57%
12	1	1	1	0	1	1	1	86%
13	1	1	1	1	1	1	1	100%
14	0	1	1	1	1	1	1	86%
15	1	1	1	1	1	1	0	86%
16	1	1	1	1	1	1	1	100%
17	0	1	1	1	1	1	0	71%
18	1	0	1	1	0	1	1	71%
19	0	1	n/a	1	1	1	1	83%
20	0	1	1	1	0	1	0	57%
21	0	1	1	1	1	1	1	86%
22	1	0	1	1	1	1	1	86%
23	1	1	1	1	1	1	1	100%
24	1	1	1	1	1	0	0	71%
25	n/a	0	0	0	0	1	n/a	20%
26	1	1	1	1	1	1	0	86%
27	0	0	1	0	1	0	1	43%
28	0	1	1	1	0	1	1	71%
29	0	1	1	1	1	1	1	86%
30	1	1	0	1	1	1	0	71%
Total YES	17	23	22	24	23	24	17	
Total Questions	29	30	29	30	30	30	29	
Score	**59%**	**77%**	**76%**	**80%**	**77%**	**80%**	**59%**	

Average score = ________________________________

Percentage of scores ≥ 80% = ________________________________

System problems = ________________________________

What exactly are the workers forgetting to do? (refer to the questions on the QIVC)

____

____

What do you propose as solutions to these system problems?

____
____
____

What people problems do you see? ____

What do you propose as solutions to these people problems?

____
____
____

food for the hungry
Meeting physical and spiritual needs worldwide

Lesson 16: Volunteer Motivation and Incentives

<table>
<tr><td colspan="2">Objectives:
Participants will be able to state when extrinsic rewards produce better performance and when intrinsic rewards produce better performance.
Participants will be able to list intrinsic motivators of good performance.
Participants will be name at least three ways to keep volunteer motivation high.
Participants will have discussed the action steps they will take to fulfill the three “motivators” for volunteers.</td></tr>
<tr><td>Summary: 60 – 130 minutes
Activity 1: Quiz – What do you think? (15 min)
OPTIONAL Activity 1B: Watch the Drive video - if participants understand English and your training venue is set up for video and audio presentations. (10 min)
Activity 2: Reviewing the Quiz and sharing information about Motivation (45 min)
End the lesson here or continue to Part B:
Activity 3: Presentation about Volunteer Value and Motivation (15 min)
Activity 4: Group work and presentations (45 min)</td><td>Materials:
☐ Print Quiz, Hand Out 16A [Print one per participant]
☐ Print Lesson Plan 16 [Print one per participant]
☐ 3 pieces of butcher paper and 3 markers
☐ (Optional) Cue up the video: http://www.youtube.com/watch?v=u6XAPnuFjJc)
☐ Television or LCD Projector + Speakers that connect to the internet.</td></tr>
</table>

The information in Activity 1, 1A and 2 comes from Daniel Pink’s book Drive, published in 2009 and is adapted from a presentation done by Thomas Davis, MPH at the CORE Fall 2011 meeting.

Deciding which Activities to Use: Lessons 1, 1A and 2 are designed for management staff who have had some experience with research and can easily understand the results of the studies shared in the quiz. If participants have never been exposed to the idea of a simulated situation to test a theory or a control group, Activity 3 and 4 would be more appropriate.

Activity 1: Quiz – What do you think?

Before we begin to talk about motivation and working with volunteers let’s find out what you already know and think. I’m going to pass out a quiz. Please answer the questions based on your experience.

Instructions:

A. Pass out Handout 16A and give participants 15 minutes to read and answer the questions.

Lessons Learned: In Mozambique, some Neighbor Women refused to receive visits from Care Group Volunteers (CGV) or attend group meetings after CGV received skirts as an incentive to identify them as leaders. This might have been avoided if Neighbor Women (NW) had elected their CGVs or if NW were made more aware of the benefits they were receiving from participation in CGs. Another strategy to avoid this conflict is to provide incentives that can benefit both CGVs and NW, like instruction on how to make fuel conserving stoves using local materials or small animals, with the offspring being passed on.

OPTIONAL Activity 1B: Watch the Drive video

Instructions: If your participants understand English well, cue up the You Tube video:

http://www.youtube.com/watch?v=u6XAPnuFjJc

This video dynamically covers some of the information presented in the following activity.

Activity 2: Reviewing the Quiz and sharing information about Motivation

A. When everyone has finished bring the group back together and introduce the topic by explaining:

This quiz asked questions about different types of motivation.

There are 3 Levels of Motivations:

1. Biological Motivation
2. Extrinsic Motivation
3. Intrinsic Motivation

Number 1 is the most basic while level 3 is the most complex.

Biological Motivation

Examples of Level 1 **Biological** Motivations are hunger, thirst and sex. They don't require a lot of cognitive thought. They drive us to take action. It is not something we learn to do, but something that is part of our design.

Extrinsic Motivation

Extrinsic (or external) motivation is motivation that prompts us to take action because of a desired reward. For example, studies have been done with rats using (food and drink) rewards that teach them to take certain actions such as pushing a lever, or turning a wheel. The rat is motivated by the reward, something given to them by someone else (external or extrinsic reward). It is the same with humans, that external rewards can sometimes prompt us to take action.

Intrinsic Motivation

The third basic human drive is **Intrinsic motivation.** This is when the joy/satisfaction of completing a task motivates us to complete it.

Dan Pink in his book, *Drive*, talked about some of the examples of intrinsic motivation:

1. Twenty years ago almost every house in the US had at least one dictionary and a set of encyclopedias where children and adults could access spelling, grammar and

information about every topic imaginable around the world. All of these books had to be purchased from companies whose sole purpose was to develop and update volumes of information. Today, 90,000 unconnected volunteers (from all over the globe) create and continually update a free, open source website which contains more information than any dictionary and encyclopedia ever provided.   Why do these volunteers contribute? Intrinsic motivations.

2. Another example of a product created by volunteers that is competing on the world market with products developed by for profit by paid employees is Lenox. Lenox is a computer operating system similar to Microsoft Windows or Apple – it's free to use and install and many computer users prefer it to other available operating systems. The volunteers who created Lenox wanted to provide a free alternative to computer users.   They didn't think it was right that big companies like Microsoft and Apple were making $200-$400 for every computer sold for basic word and communication software, they were intrinsically motivated to solve what they considered a problem and a challenge.

Now, let's look at the answers to our quiz:

1. A sociologist named Duncker gave participants three things – a box of tacks, a book of matches, and a candle.   They were asked to attach the candle to the wall so that the wax doesn't drop on the table. Duncker randomized people into two groups (i.e. put them into groups by random selection). Group 1 was told that they would be timed to find out how long it typically takes someone to complete the puzzle. Group 2 was told that the fastest 25% of participants would receive $5, and if they are the fastest of all, they get $20. Who do you think completed the puzzle faster, the people in group A or group B?   **GROUP A – those who were not offered a financial incentive.**

Explanation: Group B - the group that is offered the performance-based incentive on average takes 3 ½ minutes LONGER to solve the puzzel. The problem is that rewards narrow our focus, when sometimes we really need to be thinking "outside of the box." That is, "outside the box" or complex thinking brings the best performance when NO financial incentives are given. Complex thinking yields the best results with intrinsic motivations.

2. In Sweden a study was done where they randomized people into groups and offered to pay one group $7 to donate blood.   One group received payment. One group did not. Which group do you think donated more blood? **THE GROUP WHO WAS NOT PAID.**

Explanation: In the group that was offered the payment, fewer people showed up to donate. The reason? It tainted an altruistic act and "crowded out" the intrinsic desire to do something good.

Some of the problems with extrinsic motivation (Rewarding good behavior and punishing bad behavior) is that extrinsic rewards can:

A. Crowd out good behavior.
B. Encourage cheating, shortcuts, and unethical behavior.
C. Can become addictive.
D. Foster short-term thinking.

Can you think of some examples of this from your own country?
Encourage discussion and offering of examples where this has been found. The facilitator should also share an example from his experience if possible.

3. The Italian government gave people time off to donate blood. Did donations increase after time off was offered or decrease? **YES, DONATIONS INCREASED.**

Explanations: Removing barriers to good behavior is not the same thing as rewarding the good behavior. In this example, when the Italian government gave blood donors paid time off to donate blood they basically said, we will not penalize you for taking time out of your day to donate.

By offering a reward, we often signal to people that the task is undesirable. As one researcher put it, Rewards are addictive in that -- once offered -- a contingent rewards makes an agent expect it whenever a similar task is faced." When we give a mother an incentive to come to the clinic for antenatal care, we are signaling that there's not a very good reason for her to do so other than the incentive. And when we stop giving that incentive for showing up for antenatal care, you can bet that the likelihood of them doing it on their own is reduced. MRI imaging has shown that when you offer someone a chance to win cash, dopamine surges into a part of the brain called the nucleus accumbens. Interestingly, this is the same mechanism of most addictive drugs. The MRI imaging reveals disturbingly similar images when people are promised monetary rewards and when given cocaine, nicotine, or amphetamines."

4. Students at MIT were instructed to do activities that were mechanical in nature, requiring only rudimentary cognitive skills. Did increasing the amount of financial award offered improve performance or result in worse performance? **IT IMPROVED PERFORMANCE**.

Explanation: Research has shown that when tasks only require mechanical skills or low cognitive functioning rewards can increase performance. So there are times that Extrinsic Motivatons are useful. For example: Tasks that are inherently unpleasant (e.g., cleaning out latrines) or tasks only require mechanical skills (e.g.assembling a machine).

5. People in Madurai, rural India were offered financial incentives equal to perform tasks that required complex cognitive thinking. Some were offered 2 weeks salary as a reward, others 1 month salary and others 2 months salary. Which group do you think had the poorest performance on the assigned tasks? **THOSE OFFERED THE HIGHEST INCENTIVE, 2 MONTHS SALARY.**

Explanations: Those offered 2 weeks salary and 1 month salary did about the same, but those offered the highest incentive performed worse. Since the task required complex cognitive thinking the financial incentive was not helpful, but actually decreased performance.

6. Have you ever volunteered to do something? (Meaning you received no pay but you spent time and energy to support a cause, organization, person or event.)?
OPEN ANSWER

7. If yes, what were 3 things that motivated you to volunteer despite the fact you were not being paid. HOPEFULLY PEOPLE WILL MENTION THINGS LIKE: **AUTONOMY, MASTERY, and PURPOSE** and you can include the information below in the discussion.

Explanation: Now let's talk about intrinsic motivation. In order for intrinsic motivation to succeed, people need **autonomy**. People work better when they are given an adequate degree of autonomy over tasks. This means they have:
1. choice (what they do)
2. time (when they do it)
3. team (who they do it with)
4. technique (how they do it).

Secondly, people are motivated by achieving **Mastery**. Mastery is becoming better at something that matters to you. Progress in one's work turns out to be the single most motivating aspect of many jobs. It is the capacity to see your abilities not as limited but continually improving. This means that we need to have a focus on participatory quality improvement with CGVs. We need to work to continuously improve their skills, help them to learn new things and obtain "mastery" over the issues of maternal and child health.

We also need to set high goals for quality performance and help people progressively work towards those goals, while helping them to keep some autonomy. We need to talk about those goals in meaningful ways. It's not the volunteers helping the managers to meet project targets. It's the volunteers learning how to achieve excellence.

We also need to help volunteers to discover **purpose** in what they do. People, by nature, seek to make a contribution and to be part of a cause greater and more enduring than themselves. We need to help CGVs connect with what is important to them, to see changes in their own lives, in their family, and in their communities. This is one reason we have volunteer CGVs count births and deaths in their communities. We want them to see the results and impact for themselves, to be able to see a man who no longer beats his wife and say, "I had something to do with that." To see a woman with a thriving child after she lost three in infancy and say, "I was part of that."

8. Based on your own experience, what are some non-financial ways you think volunteers could be motivated? **OPEN ANSWER – MAY MENTION KEEP WORKLOAD LIGHT or ACTIVITIES THAT INCREASE AUTONOMY, MASTERY or PURPOSE.**

Explanation: Volunteers can be called upon to do many things, but a common mistake is to ask CGVs to do too much. If the work load is kept light (e.g., < 8 hours/week) we have found in Burundi, South Sudan, Ethiopia, DRC, Mozambique and Uganda that people have been willing to volunteer as CGVs.

When asking whether a CGV needs to be paid or given any extrinsic rewards or not, the first question should be "what's the work load you are expecting of them?" If you are expecting more than about 8 hours a week, you probably need to think about providing a fair wage. Research has shown that paying people too little can decrease motivation and even stop people from doing something they would have done otherwise for the intrinsic benefit. It's like having a friend who asks if you will take him to the airport for $2. You may have been willing to take him to the airport just as a friend, but if he offers to pay you an amount that is far below what it will actually cost you to take him the airport (considering your time and gas) you may find it insulting. A very small incentive has the dual disadvantage of not being enough to motivate the person to work while knocking out their internal motivations for doing the task. For example in Mozambique Operations Research was done around Care Groups and the results of a KPC survey indicated CGV's continued volunteering because of respect they gained from their female peers, community leaders, husbands, parents or in-laws and extended family. A follow-up study of the first CG project done in Mozambique by World Relief found that twenty months following project completion Care Group volunteers were continuing their work with local leaders taking initiative to replace positions if a volunteer were not able to continue.[6] In the Care Group Model, workers are given a "light load" and will perform at their best without external motivations. However, if the work expected of a CGV is beyond that of 8 hours a week a financial incentive could be considered.

The results of these studies should have helped you understand a few key points:

1. People are not only motivated by extrinsic factors. Intrinsic motivation is important to consider when deciding how to incentivize and reward CG Volunteers.
2. Financial rewards can actually decrease motivation to perform complex tasks (like those done by CG Volunteers) because they shift the focus to the extrinsic reward.
3. If CG Volunteers are motivated by intrinsic factors such as to prevent children in their village from becoming malnourished, to gain respect from their peers or to help their neighbors, giving them extrinsic (financial) rewards remove the intrinsic motivation.

[6] "Retention of Community Health Volunteers Using Care Groups" presented by W. Meredith Long, Melanie Morrow, Pieter Ernst, Adele Dick. APHA 2002

Activity 3: Presentation about Volunteer Value and Motivation

Explain to particpants:
Care Group Volunteers (CGVs) are the strength of a CG program.

- They work for free allowing greater multiplication of messages with low cost.
- They provide sustainable service (don't require new grants or income sources).
- They are already intimately involved with their neighbors - they will always be part of this community, they have a long-term investment in the community and people they will serve.
- They have children of their own and know the local practices
- They have a common language, history and experiences with their neighbors
- They are learners along with their neighbors. What they learn can be easily shared (and observed) by their neighbors.

Four reasons why it is important to keep volunteers happy

1. **Intellectual capital.** You have spent time, money and effort training Care Group Volunteers. When the CGV leaves (or stops working for the program), the organization loses all of the CGV's experience, training, and skills. Her colleagues in the Care Group loses their continuity. Just as a family feels "loss" when someone dies or goes away on a long trip, a Care Group loses something when a CGV stops attending.
2. **Financial investment.** When CGVs leave the program, promoters and the Care Group colleagues must reinvest time, money and energy to retrain a new person. New materials might be needed (flipcharts). The new time and energy puts a strain on the organization (or Care Group) lowering satisfaction.
3. **Beneficiary satisfaction**. If they know their Care Group Volunteer has been working in their community for 5 years they are more likely to believe her, have seen her bring change in the community and made a difference. New CGVs lack the same trust, time and relationship with FH making it harder to reach program goals.
4. **Reaching our program goals of reducing malnutrition /stunting child death.** With each staff turnover, we have to refocus time or retraining, this moves us away from our target of focusing on behavior change for the reduction of malnutrition.

Removing Volunteers when necessary: However, an ineffective volunteer must be removed. Sometimes turnover can be good. Our goals should be to retain high quality volunteers, mentor those who are weak, and remove those who are long-term low-quality performers. For example, if you are teaching about exclusive breastfeeding and the CGV is teaching incorrect information to the neighbor women, malnutrition might increase! Volunteers should be watched and helped to grow, making sure they are regularly retrained and equipped with correct information.

Based on the research of McCurley and Lynch, there are three common motivators to volunteerism:

1) the need to feel **connected,**
2) the need to feel uniquely **valued**
3) the need to feel **effective**

Connectedness
Volunteers need to feel like they are part of a group—they need to feel connected.

The three relationships that affect connectedness are
1) the relationship shared between a CGV and the CG Promoter
2) the relationship between CGV and NW and
3) the relationship shared between CGVs.

Uniquely Valued / Valuable

Volunteers need to feel like they have something to offer the program—that their personal skills and life experiences are valued.

We all know the importance of treating each person as a unique individual. By viewing volunteers as individuals, it becomes easier to recognize that no volunteer is going to be good at everything, just as no volunteer is going to be bad at everything. In order for volunteers to feel like productive individuals, CG Promoters must be encouraging of a volunteer's strengths and understanding of their weaknesses. Praise must be regularly given at an individual level, it must be sincere and it should focus on a volunteer's personal qualities. People feel valued when someone knows them, and praises them specifically for the things they do well.

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

What tool could the CG program use to help STAFF know if the program is effective?
- Program evaluations; monitoring visits by partners and staff
- Quality Improvement Verification Checklists (QIVCs)
- Pre- and post-tests of trainings
- Baseline and follow up surveys

Activity 4: Group work and presentations

Instructions: Divide participants into 3 groups and give each group a marker and butcher paper. Assign each group to brainstorm **ACTIONS to help CGVs and NW be more CONNECTED, VALUED and EFFECTIVE.** Remind them that the program budget is limited and they should focus on ideas that are free or very low cost. After about 10 minutes call the groups back and have them share ideas.

Below are ideas for ways to make volunteers feel connected, valued and effective.

1. What ACTIONS would you suggest to improve **connectedness** among volunteers (Care Group Volunteers and / or Neighbor Mothers)?

   Some possible activities to promote CONNECTEDNESS include:

- Celebrating group achievements (no CGV has missed a meeting!)
- Inviting special guests to meetings who can speak on how the program has impacted them personally; testimonies from people in the community who have seen malnutrition decrease in their home.
- Providing materials (e.g. hats and shirts) that identify the volunteer as part of a larger group
- Staff meeting together regularly so that volunteers have the opportunity to ask questions, clarify their roles and participate in decision making
- Following up on concerns raised during meetings with higher management so that volunteers feel like their voices are important.
- Developing a program identity through the use of slogans, team phrases, program name etc.
- Sharing life events (e.g. attending wedding or funerals) together.
- Arranging site visits to other programs so that they have a better understanding of the "big picture"

2. What ACTIONS would you suggest to improve the feeling of **value** among volunteers (Care Group Volunteers and / or Neighbor Mothers)?

   Possible activities:

- Identifying a "volunteer of the month" to be recognized at a monthly meeting and the specific reason why that person receives the award
- Rotating special roles so that more people have the opportunity to hold unique positions (e.g. committee secretary)
- Expressing concern for the individual needs of volunteers
- Spending time each year to discuss the positive things you have seen in the lives of the Promoters.
- Providing a special reward annually
- Saying thank you and addressing the volunteer by name
- Praising volunteers for who they are as a person
- Provide training in new skills to help volunteers feel like the program is investing in them

- Organizing support groups so that volunteers have the opportunity to voice their individual experiences
- Learning all of the names of the volunteers
- Providing certificates/awards that highlight special qualities (e.g. most inspirational)
- Conducting retreats that provide a different setting for interaction
- Supporting a volunteer during certain life events (e.g. funerals, weddings etc.)

3. What ACTIONS would you suggest to improve the feeling of **effectiveness** among volunteers (Care Group Volunteers and / or Neighbor Mothers)?

   Possible answers include:

- Have CGV or NW come and share their testimonies – how the program has changed their life.
- Providing consistent and objective feedback on each volunteer's performance
- Holding annual celebrations to recognize what has been accomplished over the year
- Inviting local leaders to provide words of encouragement
- Asking for opinions from volunteers when deciding how to address any special needs of a beneficiary
- Creating posters that show their progress toward targets
- Putting up a banner to celebrate major accomplishments
- Letting volunteers know when a person from outside of the community notices their work
- Have quarterly updates at each CGV training of recent evaluations, field visits, or surveys.
- Have discussions where CGV can share their "success stories" with each other. We often focus on the troubles that we are having – we need a balance. Many times we need the "success" to keep us motivated.

Hand Out 16A: Volunteer Motivation Quiz

1. A sociologist named Duncker gave participants three things – a box of tacks, a book of matches, and a candle. They were asked to attach the candle to the wall so that the wax doesn't drop on the table. Duncker randomized people into two groups (i.e. put them into groups by random selection).
Group 1 was told that they would be timed to find out how long it typically takes someone to complete the puzzle.
Group 2 was told that the fastest 25% of participants would receive $5, and if they are the fastest of all, they get $20. Who do you think completed the puzzle faster, the people in group A or group B?
____

2. In Sweden a study was done where they randomized people into groups and offered to pay one group $7 to donate blood. One group received payment. One group did not. Which group do you think donated more blood?
____

3. The Italian government gave people time off to donate blood. How did giving "time off" affect the number of donations?
____

4. Students at Massachusetts Institute of Technology (a University that attracts some of the smartest students in the U.S.) were instructed to do activities that were mechanical in nature (repetitive actions), requiring only basic thought and processing skills. Students were offered financial rewards, some received a small reward, others a medium reward and others a big reward. Did increasing the amount of financial award offered improve performance or result in worse performance?
____

5. People in Madurai, rural India were offered equal financial incentives to perform tasks that required complex cognitive thinking. Some were offered 2 weeks' salary as a reward, others 1 month salary and others 2 months' salary. Which group do you think had the poorest performance on the assigned tasks?
____

6. Have you ever volunteered to do something? (Meaning you received no pay but you spent time and energy to support a cause, organization, person or event.)?
____

7. If yes, what were 3 things that motivated you to volunteer despite the fact you were not being paid.
____
____

8. Based on your own experience, what are some non-financial ways you think volunteers could be motivated? ____

Lesson 17: Practice Presentations and Community Program Orientation Lesson Plan

<table>
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Objectives

1. Participants will be able to present key project information and methods in pairs and to a larger group.
2. Participants will be able to explain the importance of household behavior change in the CG Project and in reducing child deaths.
3. Participants will be able to explain the importance of community volunteers and the benefit of being a volunteer.
4. Participants will be able to present principles of development through the skit: Crossing the River.

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Summary: 1 hour, 40 minutes

- Activity One: Participants Brainstorm Important messages to share with the Community (20 min)
- Activity Two: Small & Large Group Presentation Practice (80 min)

</td><td>

Materials:

Option 1:

☐ "KEY TALKING POINT" Handout that includes the Crossing the River Skit. (One for each participant.)

Option 2:

☐ Computer and projector to take notes during discussion.

☐ Printer and enough printer paper to print the adapted KEY TALKING POINT handout for each participant.

Both options require:

☐ A watch or timer for at least ½ of the participants.

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</table>

Activity 1: Participants Brainstorm Important messages to share with the Community and How to Share Messages

A Note to the Trainer:
During this discussion, take notes on your computer (or on a flipchart for all to see) of the participant responses of what should be covered during their practice presentations. Ideally, you will print copies for participants to use as soon as the discussion is finished (Option 2 above). If your facilities do not allow for this, brainstorm key points prior to teaching this lesson and make Handouts (Option 1 above). Participants can take notes on the Handout during the discussion. The Handouts should include the "Crossing the River" skit and discussion questions (see Handout 17A for an example).

Tell participants:

1. Take a minute to think about what the community needs to know to understand the CG project.
2. Think about possible problems that could occur in the CG project. What information could be provided at project start-up to avoid these problems?
3. Write participant ideas on a flipchart or white board. If they are having trouble coming up with ideas ask the following:
   - ? What problems have you encountered doing development work in communities?
   - ? What can we share with the community to avoid repeating these problems in this project?
   - ? What has worked well in past development projects?
   - ? How should we orient the community to project goals, activities and methods? Should it be a simple community meeting or should we use drama, participatory activities or games?
   - ? Who should do the presentations? Who should attend?

Lessons Learned: *In South Sudan, CG Project Management oriented communities to the project by coordinating with community leadership to have 30 men, 30 women and 30 youth present. The manager led a discussion and encouraged the community groups to discuss local challenges they faced. This was followed by a discussion of the community resources (what they had to solve these problems) and time to brainstorm solutions to local challenges. Then the CG Project Management shared about the work of Food for the Hungry and how the CG Project intersected with some of their health challenges. It was a great way to position Care Groups as a solution to the felt needs and challenges they already acknowledged as being a problem.*

Suggested Points to Cover (adapt to your project context) in your "Key Talking Points" Handout 17A:

A. Program Goals and Methodology

1. The goal of the CG project is to prevent malnutrition in under two children.

2. The program will focus on the following areas:

- *List the topics here that your Care Group program will cover such as essential nutrition actions, essential hygiene actions, etc.*

3. Half of child deaths can be prevented by families doing very simple things to care for their children related to hygiene, sanitation, child feeding, and caring for children when they are sick.[7] If families do not make these changes, then after the project ends things will go back to how they were before the project started.

[7] Jones G, Steketee R, Bhutta Z, Morris S. and the Bellagio Child Survival Study Group."How many child deaths can we prevent this year?" Lancet 2003; 362: 65-71.

5. Right now nearly half of all children in this community suffer from chronic malnutrition. In order to change this situation, families have to change household practices.

6. To change these behaviors the CG Project will train community volunteers so they can train all the families in the community. To do this we need your help.

7. The CG Project will provide the training and educational material, but we need the community to provide volunteers who are committed to improving the health of the children in this community. These volunteers will not receive a salary or subsidy. They will receive free education and an opportunity to improve and save the lives of the children in this community.

8. These volunteers will not be the NGO's volunteers; they will be your community's volunteers. If they attend the trainings, share what they learn with the families in this community and the families adopt the new behaviors, malnutrition will be reduced. If the volunteers aren't willing to learn or if the families won't listen to the volunteers or adopt the behaviors then malnutrition will not decrease during the life of the project.

9. The CG Project is a development project, not an emergency and relief project. Many projects are meant to provide short term relief to a problem like a famine or during times of civil unrest. Relief projects normally give away a lot of food or things (like soap, tools, etc…) and these things help for a short period of time. The goal of this CG Project is to change behavior and improve the community's ability to prevent their children from dying of malnutrition. Let's watch this skit to better understand how development works:

Note: It is best not to tell communities what material goods the program plans to provide, even if you are confident the project will provide the inputs. Mentioning incentives at the start of a program can cause the following problems to arise:

- *The Care Group program is primarily a behavior change program, it is best that community participants focus on long lasting changes, such as reducing child deaths, rather than on short term, material gains.*
- *People may become volunteers or participate in program activities to receive the incentives. After they receive the incentive they may stop participating because they were only motivated to receive a material good.*
- *Once a promise is made to a community to provide something the community will consider the organization obligated to provide it. If, for various reasons, the material benefit doesn't arrive the community will lose trust.*

It is best to tell community leadership and beneficiaries a material benefit will come to the community ***the day it is arriving or shortly before*** *if help is needed to organize and prepare the beneficiaries to receive the benefit.*

Skit: Crossing the River
Need: 4 actors – they should all be around the same age and gender. The strong young man should be strong in appearance and the think young man should be thinner in appearance. The two friends can be anyone.

Two friends are heading to town to vote. They come up what is normally a slow moving river and find that the water level has risen and the water is moving faster. They discuss what they can do, since neither of them know how to swim. They really need to get to the voting station, but they are afraid to cross the river. As they are discussing their dilemma, a strong young man comes along. The two friends explain their problem and the strong young man offers to carry them across the river. The water is deep and fast, so it's not an easy task but the young man manages and reassures the two friends as he carries them across that they don't have to worry he's taking care of them. After the two friends leave the young man, the young man congratulates himself saying, "I really did a good thing today. Those poor people would never have gotten to the voting station without my help. I thank God he made me so strong and courageous that I could help those who can't help themselves!"

Later that day the two friends are returning home from voting when they encounter the river again. They discuss how they can't swim, that the current is so strong and that they are afraid to cross the river. They decide the only thing to do is to wait for another strong young man to carry them across. They sit down by the river bank and start to complain that no one is coming, they are hungry and they need to get home. Finally a young man comes along, but he is thin and weak. The two friends tell the young man that they need him to carry them across the river. The young man is a bit nervous about doing this and asks the two friends if they are sure they can't cross the river themselves. The two friends assure the young man they cannot swim and they cannot do it themselves. They say, "God made you young and fit. You should help us cross the river. Come on now, carry us across!" (The friends should be insistent, like it's the young man's duty.) The weak young man tries to hoist one of the friends onto his back, but they are both wobbly and before they reach the river bank the young man falls over dumping the friend on the ground. The two friends are disgusted. They tell the young man, "What good are you, you can't carry even carry us across the river!" The young man thinks about their accusations and says, "You are men just like me, made with the same intelligence and abilities, why is it my responsibility to carry you across the river? You can cross the river by yourselves, just like I can. This river is not moving too fast or high for a man to cross it. You must take courage and cross steadily, I will show you how." The two friends need more encouragement but eventually are convinced to cross along with the thin young man. The young man shows them how to plant their foot firmly, hold onto each other's hands and move steadily across. They get to the other side and the two friends are really excited. They exclaim we did it, we crossed the river! They say, that wasn't easy but it wasn't as hard as I thought it would be. They thank the young man for teaching them how to do it.

B. Questions for reflection:

- Which young man helped the two friends more: the strong young man or the thin young man?

- ? Did the strong young man think he was doing the two friends a favor? Was he really?
- ? Were the two friends right to expect the thin young man to carry them across the river?
- ? *If your project includes food distribution or the provision of some other good, as the following question,* "The CG Project will provide behavior change education about nutrition, health and sanitation and [food]. Which of these two types of assistance will do more good?"

D. Share CG Project Essential Program Details (may want to refer to Lesson 2: Program Overview)

- Donor:
- Type of Project:
- Length of Project:
- Project Start Date:
- Project End Date:
- Project Title:
- Program Goal:
- How will CG's be formed and function?

Activity 2: Small & Large Group Presentation Practice

1. Divide the participants into pairs. Ask them to practice explaining to each other key elements of the CG Project (including program goals, methodology as well as the essential program details). Explain that they need to time each other and each person should practice talking for 10 minutes. If they run out of things to say they can look at their notes or their partner can suggest things to include, but that they need to talk for at least ten minutes. Let participants know that they will be asked later on to share what they practice in front of the group and will be required to stand before the group and talk for 10 minutes.

2. Come back as a group and draw four names out of a hat. Ask these four volunteers to present the key CG project information in eight minutes.   If you notice that many individuals are having trouble sharing appropriate information, you may choose to divide into smaller groups so more people can practice presenting before a group.

Handout 17A: Talking Points for Community Meetings about CG Projects

Adapt to the project context prior to, or during the discussion of Lesson 17, Activity 1.

A. Program Goals and Methodology

1. The goal of the CG project is to prevent malnutrition in under two children.
2. The program will focus on the following areas: *List the topics here that your Care Group program will cover such as essential nutrition actions, essential hygiene actions, etc.*
3. Half of child deaths can be prevented by families doing very simple things to care for their children related to hygiene, sanitation, child feeding, and caring for children when they are sick. If families do not make these changes, then after the project ends things will go back to how they were before the project started.
5. Right now nearly half of all children in this community suffer from chronic malnutrition. In order to change this situation, families have to change household practices.
6. To change these behaviors the CG Project will train community volunteers so they can train all the families in the community. To do this we need your help.
7. The CG Project will provide the training and educational material, but we need the community to provide volunteers who are committed to improving the health of the children in this community. These volunteers will not receive a salary or subsidy. They will receive free education and an opportunity to improve and save the lives of the children in this community.
8. These volunteers will not be the NGO's volunteers; they will be your community's volunteers. If they attend the trainings, share what they learn with the families in this community and the families adopt the new behaviors, malnutrition will be reduced. If the volunteers aren't willing to learn, if families won't listen to the volunteers or adopt the behaviors then malnutrition will not decrease during the life of the project.
9. The CG Project is a development project, not an emergency and relief project. Many projects are meant to provide short term relief to a problem like a famine or during times of civil unrest. Relief projects normally give away a lot of food or things (like soap, tools, etc…) and these things help for a short period of time. The goal of this CG Project is to change behavior and improve the community's ability to prevent their children from dying of malnutrition. Let's watch this skit to better understand how development works:

B. Skit: Crossing the River

Need: 4 actors – they should all be around the same age and gender. The strong young man should be strong in appearance and the think young man should be thinner in appearance. The two friends can be anyone.

Two friends are heading to town to vote. They come up what is normally a slow moving river and find that the water level has risen and the water is moving faster. They discuss what they can do, since neither of them know how to swim. They really need to get to the voting station, but they are afraid to cross the river. As they are discussing their dilemma, a strong young man comes along. The two friends explain their problem and

the strong young man offers to carry them across the river. The water is deep and fast, so it's not an easy task but the young man manages and reassures the two friends as he carries them across that they don't have to worry he's taking care of them. After the two friends leave the young man, the young man congratulates himself saying, "I really did a good thing today. Those poor people would never have gotten to the voting station without my help. I thank God he made me so strong and courageous that I could help those who can't help themselves!"

Later that day the two friends are returning home from voting when they encounter the river again. They discuss how they can't swim, that the current is so strong and that they are afraid to cross the river. They decide the only thing to do is to wait for another strong young man to carry them across. They sit down by the river bank and start to complain that no one is coming, they are hungry and they need to get home. Finally a young man comes along, but he is thin and weak. The two friends tell the young man that they need him to carry them across the river. The young man is a bit nervous about doing this and asks the two friends if they are sure they can't cross the river themselves. The two friends assure the young man they cannot swim and they cannot do it themselves. They say, "God made you young and fit. You should help us cross the river. Come on now, carry us across!" (The friends should be insistent, like it's the young man's duty.) The weak young man tries to hoist one of the friends onto his back, but they are both wobbly and before they reach the river bank the young man falls over dumping the friend on the ground. The two friends are disgusted. They tell the young man, "What good are you, you can't carry even carry us across the river!" The young man thinks about their accusations and says, "You are men just like me, made with the same intelligence and abilities, why is it my responsibility to carry you across the river? You can cross the river by yourselves, just like I can. This river is not moving too fast or high for a man to cross it. You must take courage and cross steadily, I will show you how." The two friends need more encouragement but eventually are convinced to cross along with the thin young man. The young man shows them how to plan their foot firmly, hold onto each other's hands and move steadily across. They get to the other side and the two friends are really excited. They exclaim we did it, we crossed the river! They say, that wasn't easy but it wasn't as hard as I thought it would be. They thank the young man for teaching them how to do it.

C. Questions for reflection:

- ? Which young man helped the two friends more: the strong young man or the thin young man?
- ? Did the strong young man think he was doing the two friends a favor? Was he really?
- ? Were the two friends right to expect the thin young man to carry them across the river?
- ? *If your project includes food distribution or the provision of some other good, as the following question,* "The CG Project will provide behavior change education about nutrition, health and sanitation and [food]. Which of these two types of assistance will do more good?"

D. **Share CG Project Essential Program Details (may want to refer to Lesson 2: Program Overview)**
- Donor:
- Type of Project:
- Length of Project:
- Project Start Date:
- Project End Date:
- Project Title:
- Program Goal:
- How will CG's be formed and function?

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Lesson 18: Workshop Closing

<table>
<tr><td colspan="2">Objectives:
1. Participants will complete the posttest and receive certificates.
2. Participants will give feedback to the facilitator for adaptation of future workshops.</td></tr>
<tr><td>Summary: 1 hour, 35 minutes
• Activity 1: Posttest (45 min)
• Activity 2: Workshop Evaluation (30 min)
• Activity 3: Certificates (20 min)</td><td>Materials:
☐ Handout 1A: Pre and Posttest
☐ Handout 18A: Pre and Posttest Answers
☐ End of Training Evaluation (Annex 4)
☐ Handout 18A: Certificates</td></tr>
</table>

Activity 1: Posttest (45 minutes)

Tell participants to put away all class notes (if appropriate also remove flipchart pages on the walls which have answers to the posttest). Give out the posttest. *Posttest answers are found at the end of this lesson.*

Remind participants how to fill out the form:

- Enter their name at the top of page one.
- Circle POSTTEST.
- Multiple choice questions – choose only one answer unless it says you can choose more than one. Circle only the letter (a, b, c or d).
- Fill in the blank – write clearly so we can read it.

Collect papers when all participants have finished or after 45 minutes have passed.

Activity 2: Workshop Summary (30 minutes)

1. Hand out the End of Training Evaluation (Handout 18A). Ask participants to fill out the form adding any suggestions they have for improving the training in the future.

2. **(Optional) Verbal Discussion of Training Outcomes.** The purpose of this time is to learn how the participants perceived the training. Speaking their thoughts out loud also helps participants reflect on all that they have learned. Set a time limit on the discussion (20 minutes or so). Affirm criticism – don't manipulate the conversation to get a favorable evaluation. Choose your own questions to gather feedback or use one or more of the following:
   - What is something new that you learned during this training?
   - Which activity was the most meaningful for you?

- How could I as a trainer better adapt the training for future workshops?
- On a scale of 1 to 10, how equipped do you feel to set up Care Groups in your communities?

Activity 3: Certificates (20 minutes)

Give closing remarks encouraging the participants in their work. Hand out the certificates and call each participant by name.

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Pre- and Posttest ANSWERS

Name ____ Date _________________

Is this the pretest or post-test? Circle one.

Program Overview

CG Trainer: Once you complete your lesson using the Program Overview Template, create 1-2 test questions to verify the content was learned. Two example questions are listed below. The answers will depend upon management decisions.

1. Answer the four questions below:

How many women are in each Neighbor Group?	
How many women are in each Care Group?	
Each Promoter has how many Care Groups?	
Each Supervisor has how many Promoters?	

2. Which of the following activities will achieve Intermediate Result 2: *[Insert Intermediate Result].*
   A. *List an activity not included in your Care Group program*
   B. *List an activity from another Intermediate Result*
   C. *List an activity from another Intermediate Result*
   D. *List an activity from Intermediate result 2. (Correct Answer)*

Care Group Effectiveness

3. Which of the following statements is FALSE about Care Groups?
   A. **A Care Group is a group of 20-30 community-based volunteers who regularly meet together with project staff for training and supervision.**
   B. 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.
   C. Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication.
   D. Care Groups provide the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits

4. Why do Care Group programs focus on pregnant women and children under two?

A. They are the easiest target groups for NGOs to work with
B. Pregnant women are more likely to volunteer than other members of the community
C. **The right nutrition during this period (pregnancy and the first two years of life) can have a profound impact on a child's ability to grow, learn, and rise out of poverty. It can also shape a society's long-term health, stability and prosperity.**

Care Group Characteristics

5. In Care Group programs, mothers (also known as Neighbor Women) should choose/elect their Care Group Volunteer. Why is this important?
   A. **People will choose someone that they respect – someone that they are willing to "listen to." If an outsider chooses someone – it is more likely that person will not be accepted by the community.**
   B. It would take a lot of time for project staff to choose CG Volunteers, and therefore it is more efficient for the mothers (i.e. Neighbor Women) to elect their own CG Volunteer.
   C. Trick question. Mothers should not elect their own CG Volunteers – this is something that the Community Development Committee should do in partnership with the Ministry of Health.

6. In Care Group programs, Neighbor Groups should not have around 10-12 members, and no more than 15. Circle the answer that is NOT a reason why this is important.
   A. Neighbor Groups are led by volunteers. If you ask too much of the volunteers time, they will not stay in the program.
   B. **If a group is larger than 15 members, other members of the community might become jealous of that group because it attracted so many members.**
   C. CG Volunteers should form strong bonds with their Neighbor Group members. Large groups will make it difficult to form this bond.

Organizing the Community into Care Groups

7. Of the responses below, what is the most important factor when assigning households into groups (Neighbor Groups)?

   A. The women in these households are friends and enjoy meeting together.
   B. **The households are close together.**
   C. The children are all the same age.
   D. The households are similar; one is not wealthier than the other.

8. Write the approach you would use to organize the community into Neighbor Groups and Care Groups based on the descriptions below. Possible answers include: Census, Community lists, or Community gatherings.

A. In Community A, the block leaders are well organized and already maintain a list of residents or can recall by memory where all the PLW and U2 children live. — Community lists

B. In Community B, community participation and communication is high. If the community leaders called for all women who are pregnant or have children less than 24 months of age to a central meeting place on a particular day they would all show up. — Community gathering

C. Community C is new to you. When you ask around, the leaders and members of the community do not know all the PLW and U2 children or where they live. — Census

Job Descriptions

9. Write the CG Team Member who is responsible for the following responsibilities: The choices are CG Volunteer, CG Promoter, MCHN Supervisor or MCHN Coordinator:

A. Models leadership to all staff and intentionally develops the leadership potential of the MCHN Supervisors. — MCHN Coordinator

B. Visit 10 Neighbor Women and their families at least once a month to promote behavior change using an educational flip-chart. — CG Volunteer

C. Review Flipchart Lesson Plans with CG Promoters every two weeks and assure they understand the information well and can teach back the information in a participatory manner. — MCHN Supervisor

D. Facilitate organized, participatory learning sessions with each of their 10-12 CG Volunteers (in Care Groups) groups every two weeks, following the lesson plans in the educational materials provided. — CG Promoter

10. Write three essential traits or characteristics of a Care Group Volunteer.

1. ____________________

2. ____________________

3. ____________________

This answer is dependent on what participants decide.

Numbering Care Groups

11. How would you interpret the following code found in the Care Group Information System? 3.4.A
    __________**Promoter 3, Care Group 4, Leader Mother A**______

12. One of the following codes represents a Neighbor Woman. Which one is it? **Circle your answer.**
    A. 3.4
    B. 3.4.C
    C. **3.4.C.1**
    D. 10

Registers and Reports

13. What are the four main types of information that registers in Care Group programs collect? Choose only one answer.
    A. Immunization coverage, vital events, registration, and curriculum
    B. **Attendance, registration, vital events, and curriculum**
    C. Births, deaths, membership, household size

14. What information does a Promoter use to fill out her/his monthly report? Choose only one answer.
    A. Care Group Registers only
    B. Neighbor Group Registers only
    C. **A & B**
    D. None of the above

Curriculum Training Schedule

15. What three things happen during **the Bi-Monthly (Twice Monthly) Training Meeting** between the Supervisor and the Promoters?

    A. 1) Training Promoters on the Flipchart Lesson, 2) Supervising Promoters in their home and 3) Supervising the Promoters as they teach CG Volunteers.
    B. 1) Training Ministry of Health Staff on the new health materials, 2) Sharing work plans with the Community Leaders and 3) Collecting Registers from Promoters
    C. 1) Training Care Group volunteers on the flipchart Lesson, 2)Observing them teaching others and 3) Collecting the Care Group and Neighbor Group Registers
    D. **1) Planning Supervision Visits with each Promoter, 2) Collecting and Discussing the Promoter Reports and 3)Coaching the Promoters as they practice the new flipchart lesson**

16. **Four of the five statements are TRUE**. Circle the Letter of the statement which i**s FALSE.**

A. The MCHN Manager will lead a one-week training on each new flipchart module (group of lessons) with all supervisors, coordinators and promoters.
B. The MCHN Supervisor with review the current flipchart lesson with all of the CG Promoters every two weeks.
C. **The Care Group Promoters will train the Care Group Volunteers one flipchart lesson every four weeks.**
D. The Care Group volunteers will train the Neighbor Women on flipchart lesson every two weeks in (either in a small group or during a household visit to each neighbor woman's house).
E. Every time a new flipchart lesson is taught to a person responsible for training others (Supervisor, Coordinator, Promoter or Care Group volunteer), he or she will practice the new flipchart lesson in pairs while the Training Facilitator observes and coaches them on their performance.

Supervision Responsibilities and Work plans

17. Three of the four statements are TRUE. Circle the Letter of the statement which is FALSE.
    A. **The MCHN Manager will supervise each MCHN Coordinator with a surprise visit once each month.**
    B. The MCHN Coordinator will use both the QIVC and the Supervision checklist to supervise the MCHN Supervisor.
    C. The MCHN Supervisor will visit the Promoter's home, the Care Group Meeting and the homes of Neighbor women when supervising.
    D. The CG Promoter will supervise at least six different Care Group volunteers every two weeks.

18. Which of the following statements is true about work plans? Choose only ONE answer.
    A. A work plan is used to report to your supervisor on tasks you accomplished in the past.
    B. Only the Care Group Promoters should keep work plans. It is not necessary for Supervisors or Coordinators to plan their activities each month.
    C. Work plans help staff to organize their work responsibilities so that they can work efficiently and complete all of their tasks during normal working hours.
    D. Supervisors will use the Promoter work plans to compile the attendance and vital event information for the monthly reports.

Supervision Checklists

19. How does a MCHN Supervisor review a CG Promoter's monthly report?
    a. Look at a completed report and make sure every box is filled in.
    b. Make sure the CG Promoter has a copy of every monthly report s/he has turned in.

c. Select 2 or 3 pieces of information on the report and ask the CG Promoter to show you how s/he determined the number using her CGV and NW Registers.

d. Look at your copy of the CG Promoter's monthly report and the copy s/he has and make sure all the numbers match.

20. Please fill out the table below with X's, ✓, or *based on the following situation: *The MCHN Supervisor visited the nurse at the nearest health post to the CG Promoter during his 3rd visit of the quarter. He found out that the nurse did not know the CG Promoter's name and no patient had ever made mention of a CG Promoter working in the area. On the 4th visit of the quarter the Promoter went back to the Health Post and found that the nurse knew the CG Promoters name and the CG Promoter had told the nurse about an activity that happened a month ago. The nurse said two patients had mentioned being sent by the CG Promoter in the last two weeks.*

	Visits per Quarter							
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
8. Visit the Health Worker at the nearest Health Facility								
a. Verify the CG Promoter has been coordinating with him/her and discuss ways to improve coordination.			X	✓				
b. Verify that the CG Promoter has been referring patients to the health center for care as needed.			X	✓				

Quality Improvement Verification Checklists (QIVCs)

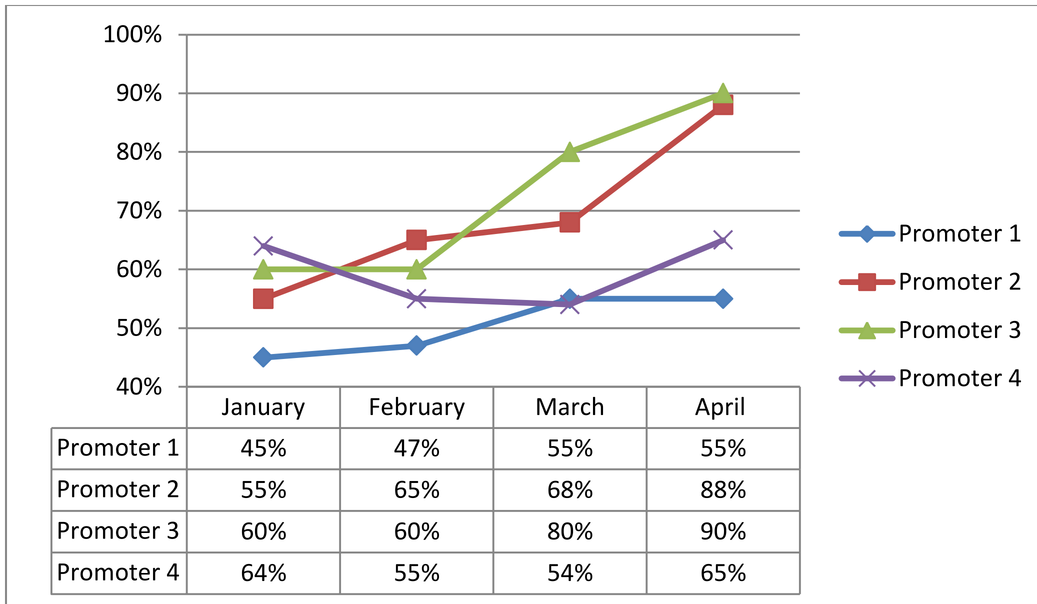
21. The QIVC has 3 purposes. Which of the following is NOT one of the main goals of the QIVC?
    A. Encourage the worker
    B. Evaluate the worker's knowledge or intelligence
    C. Monitor the performance of the worker over a period of time
    D. Improve the workers performance

22. When giving feedback using the QIVC for Educational Methods which of the following should NOT be done:
    A. Ask the person to discuss how *they think* they performed before you begin giving feedback.
    B. Provide more positive feedback than negative feedback to encourage the worker.
    C. Ask the worker how *they think* they could overcome some of the difficulties that they had during the training.
    D. Ask the worker to commit to sharing their QIVC scores with the community leaders.

23. If the Promoter scored 70% on the QIVC for Educational Methods what should the Supervisor do?
    A. Use the QIVC less frequently because the worker scored above the target.
    B. Stop visiting this worker because they have scored above the target.
    C. Continue using the QIV Checklist each time you visit until their score is 80% or above.
    D. Continue using the QIV Checklist each time you visit until their score reaches 100%.

24. Calculate the percentage of scores ≥80% below.
    The percentage of scores ≥ 80% = ___66%___
    Promoter 1: 54%
    Promoter 2: 85%
    Promoter 3: 80%
    Promoter 4: 95%
    Promoter 5: 85%
    Promoter 6: 74%

25. Review the scores below. As the MCHN Supervisor, which of the following recommendations would you suggest? Choose only ONE answer.
    A. Review the questions on the QIVC that Promoter #1 and #4 have missed on the QIVC. Ask each promoter what they should be doing to overcome these problems.
    B. Make sure that both Promoters #1 and #4 are committed to improve. Ask them what has prevented them for making larger improvements.
    C. Talk with the Coordinator about the policy for putting a worker on probation. Plan ahead, giving your workers time to improve before starting a plan for probation if needed.
    D. All of the above.



	January	February	March	April
Promoter 1	45%	47%	55%	55%
Promoter 2	55%	65%	68%	88%
Promoter 3	60%	60%	80%	90%
Promoter 4	64%	55%	54%	65%

Volunteer Motivation

26. When people are given extrinsic rewards (like cash or food) to do something good (donating blood, which of the following are likely to happen. Put an X before the sentences which are the potential negative results. Choose all that apply.

   _X_ They are no longer motivated because their sense of altruism, or doing something of a higher value has been removed.

   ____ Cheating, shortcuts and unethical behavior can be encouraged.

   ____ People become competitive and try to outperform their colleagues

27. When people have autonomy over tasks this means that they are able to decide __________ and __________. (Circle the correct answer)
   A. What and where they will do a task.
   B. Who they will do the task with and understand why they are doing the task.
   C. When they will do it and who they will do it with
   D. Where they will do it and how they will do it.

28. Which is NOT a principle for motivating volunteers? Circle your answer.
   A. Volunteers need to feel like they are making a difference—they need to feel effective.
   B. Volunteers need to feel like they have something to offer the program—that their personal skills and life experiences are valued.
   C. Volunteers need to feel like they are part of a group—they need to feel connected.
   D. Volunteers need to feel like they are doing something that will contribute to the well-being of their family.

Practice Presentations and Community Program Orientation

29. When Care Group Coordinators and/or Supervisors orient the community to the CG program all of the following topics will be covered, except one. Which of the following topics should not be included in the Community Orientation? (Circle the answer that is NOT correct.)
    A. Explain the length of time FH will be in the community running the program and who is the donor.
    B. Discuss that we are partners in the program and we must work together (not wait for a strong man to come) to solve our problems.
    C. Explain the incentives that will be given to the Care Group Volunteers such as vegetables, seeds, cement to build latrines, etc to encourage their participation.
    D. Discuss how the CG project works to prevent malnutrition in children two years of age and younger.

30. If your Care Group projected has budgeted to provide each CG Volunteer and Neighbor Woman household a mosquito net when should you tell the community the project will provide the mosquito nets? (Circle the correct answer.)
    A. At project start up, during the community orientation meetings.
    B. During the census so that women will be interested to register as part of the program.
    C. Before the rainy season starts so that families know they will be receiving a mosquito net and don't buy one of their own.
    D. After you have received the mosquito nets into your offices warehouse and about a week before you have organized to transport the mosquito nets to the community for distribution.

Certificate of Participation

____

Has successfully completed the training

Introduction to care groups
[insert date here]
[insert location here]

____

Signature Date

[insert trainers name, organization and location]

Annexes

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Annex 1: Learning Resource Needs Assessment – Care Groups

One month before your training begins, send the LRNA out to each participant and request their response by email within (more or less) 7 days. Use the responses to adapt and cater your training to meet the needs of the participants. If you find you have an "expert" at the training, be sure to contact them prior to the training to see if they can spend some time sharing their experience.

1. Please describe your previous experience working with Care Groups (a cascade behavior change module that reaches all households through community volunteers)?

2. Please describe training you have already received about Care Groups. (List the name of the training, and the organization who led the training).

3. Please describe your work experience supervising others. Also list tools you have used during supervision.

4. Please describe your work experience organizing community volunteers / working with volunteers.

5. With your current training and experience, how comfortable do you feel training others about the set-up and management of Care Groups? (1 = not comfortable; 10 = extremely comfortable)

6. What are you hoping to receive from this training?

Annex 2: Care Group Criteria Lesson Plan

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Objectives

1. Participants will be able to identify from memory at least 5 of the essential elements (criteria) needed in a Care Group.
2. Participants will understand the rationale for each criteria included in the Care Group Criteria Handout.
3. Participants will be able to determine if a project meets the criteria to be called a Care Group project.
4. Participants will know how to use the Care Group Criteria Minimum Checklist.

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Summary: 2 hours, 15 minutes

- Review Handout – basic steps (70 min)
- Game (40 min)
- Grand Final Care Group Criteria (15 min)
- Care Group Checklist (10 min)
- Alternative activity to review the CG Handout (60-90 min)

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Materials

- ☐ Flipchart and markers
- ☐ Watch with a second hand or a stopwatch.
- ☐ Put the tables together in a way that everyone can see where the people are drawing – also make sure there is room for acting.
- ☐ Prize for winning team members (often use candy and give winners 2X what non-winner receive)
- ☐ Handout Annex 2A : Care Group Criteria (one copy cut into strips and have one copy for each participant)
- ☐ Handout Annex 2B: The Complete Care Group Criteria (one copy per participant)
- ☐ Handout Annex 2C: Care Group Minimum Criteria Reviewer Checklist (one copy per participant)

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Background: The reason this Lesson is included as an Annex and not as part of the formal Care Group Start-Up Training is because this lesson works best to introduce someone to Care Groups who is not familiar with the details of the approach. The Care Group Criteria list key elements of a Care Group project, providing options and choices for program designers. Past experience has taught us that it can be confusing for program staff to learn about Care Group options and it is less confusing to simply present how your Care Group will operate. Lesson 2 and 3 cover all the aspects to setting up and running Care Groups, but provide a framework for the trainer to provide program specific information.

Activity 1: Review Handout – basic steps (70 min)

Instructions:

- Give each participant Handout Annex 2A: Care Group Criteria
- Go through the each of the 13 criteria for Care Groups.
- Offer examples to explain the rationale for each item as below.

- *After the explanation give each participant Handout Annex 2B: The Complete Care Group Criteria*

History

- CG model developed in 1995 by World Relief
- Adopted by FH in 1997
- Since 1995 at least 12 NGOS in more than 14 countries have adopted the model.
- In 2008 CG's were mentioned in UNICEF's State of the World's Children Report
- Using variations of the model and still calling it a Care Group may lead a poor reputation for the model.

The Criteria

- Developed by World Relief and Food for the Hungry staff in 2009 to give practitioners a clear definition of what is a Care Group project and what is not.

2. Care Group volunteers <u>(Leader Mothers) should be **chosen by the mothers**</u>

? Why do you think this is important?

- People will choose someone that they respect – someone that they are willing to "listen to." If an outsider chooses someone – it is more likely that person will not be accepted by the community.
- The community will be somewhat reluctant to listen to their ideas. If it is "one of their own" they are already comfortable and ready to hear.
- Also, using a neighbor has been found through research to be more effective.

A recycling example *(explain recycling).*

- An experiment was designed to find out who could bring about the greatest change in recycling habits.
- Citizens who consistently recycled in their own home were approached and asked to be "recycling neighborhood (block) leaders." Those who agreed were asked to talk with 10 non-recycling neighbors and to give a message to them about recycling - also giving them special recycling bags.
- A second group (of non-recycling households) had bags and the communication left at their door. They did not receive a person message from a neighbor. However, the INFORMATION was left at their door.

Who recycled the most?

- The group with the block leader group. More than those with information and more than those who received nothing.

- We use this same philosophy with Leader Mothers, instructing a Leader Mother and giving her the tools to give persuasive messages to her neighbors.
- The important thing to remember here is that the Leader Mothers have to believe what they are promoting. This is the biggest difference between the Block Leader approach and the Care Group Approach.

? Will the chosen Leader Mothers already be practicing the behaviors that we want them to? (probably not).

? Whose responsibility is it to help Leader Mothers to change their own behavior? (the Promoter!)

- It is important for the promoters to really invest in sharing and encouraging the Leader Mothers to change.

<u>"Peer to peer" promotion. Chosen women are "role models" (early adapters)</u> of the behavior.

- If the Leaders Mothers have made changes in their own lives (as witnessed by their neighbors), they will be much more effective than those who "don't practice what they preach."

Story from Haiti –
• Abstinence promoter who told his Leader Youth that his sex life was "none of their business." • He often wore one of our program t-shirts that said "Abstinence you can do it!" • However, he was unwilling to be honest about his own behavior and struggles in being abstinent. • Do you think this promoter was an effective teacher of Leader Youth?   (Probably not). • It is very important that we work first to in the lives of our leaders and once they are convinced, their "believability" in the community will greatly increase. • It will take time; it won't happen overnight. • We will not force Leader Mothers to commit to our practices, but it does help that each week they share the key messages with others. • The more you talk about changing behavior the more likely YOU will change yourself. (more about this later)

2. Care Group volunteers <u>(Leader Mothers) should visit no more than 15 households</u> (neighbors that they visit).

? Why is this important?

- They are volunteers; they must be able to sustain the activities required by the program. If you ask too much of them, they will not stay in the program.
- The more burden you put on their shoulders, the larger the burden they will put on you for $$$ incentives.

<u>We want Leader Mothers to form strong bonds with those that they meet.</u>

Example
- How many digits are there in your (local) phone number? Why? Because it has been found that the human mind has a natural limit to remembering certain types of information.
- If phone numbers were 8 digits or 9 digits, we would have a much harder time remembering them.
- Seven is the general capacity of our brains to remember numbers.

Example 2
- Psychologist talk about a "sympathy group." This is the group that is made up of our friends and relatives – the ones that we feel closest too.
- Psychologists say that for ALL humans, if we were to list the names of people in their lives whose death would leave you truly devastated… chances are you would come up with about 12 names.
- These names make up the "sympathy group".
- To be someone's close friend requires a certain amount of time and emotional energy. At somewhere between 10 to 15 people we begin to overload. We can't take the emotional strain and energies needed to care for more than 15 people.

? What do you think of this idea? Does it sound true to you?

- In the same manner, we want our Leader Mothers to invest in the people that they meet and have time and energy to get involved in the lives of those she visits.
- Sixteen households (from the research) is too many. The proposal suggests 10-15 households.
- If you go over this number the quality of your Leader Mother interactions greatly reduces. Don't do it. The limit is 15 households.
- And the more households you add, the greater the drop out and the greater the reduction of change.

Personal example:
In our Abstinence and Faithfulness program, I saw this with every organization. They were all trying to add many more households to account for "drop out." Don't do it! The more households you ADD – the greater the drop out!

3. The Care Group (groups of Leader Mothers) should have no more than 16 members.

? Why do you think this is important?

- The larger the group the less time there is to ask questions, to discuss and interact with participants.
- If there are 16 or less people, you can see each of them and talk with each of them in a group. Larger than 16 makes it much more difficult to encourage, discuss address the issues of others, or have good facilitation and participation.
- After 16, a few people begin dominating conversation, and others stop talking.

Group size and participation *Source: Jenny Rogers 1989*

3-6 people:	everyone speaks
7-10 people:	almost everyone speaks Quieter people say less One or two may not speak at all
11-18 people:	5 or 6 people speak a lot 3 or 4 others join in occasionally
19-30 people:	3 or 4 people dominate
30 + people:	little participation is possible

For example:
In one of our HIV programs in Ethiopia, the local partner already had a group of 20 people meeting every week. So he began teaching some of the health messages to large group – 20 up to 50 people at a time.

- Do you think there was a lot of behavior change in these groups? (No. Why not?)
- Because they were too big that people weren't able to interact, ask questions, or relate to the facilitator.
- They couldn't "see changes" in the facilitator's own life (they were not his 10 closest neighbors).

4. Care Group volunteers (Leader Mothers) will visit the neighbor households twice each month

? Why is it important for them to visit their neighbors TWICE each month?

- To build trust and "sympathy" (refer to the sympathy groups above).
- We believe that the better relationship that the LM has with the beneficiary, the greater the behavior change.

? Can you think of an example from your own life where trusted relationships brought about greater influence than other relationships?

- (Perhaps when relationships between parents and children are strong, children are more likely to listen to their parents;
- When relationship between the pastor/priest and parishioners is strong, people are more likely to believe;
- When relationship between the local government is strong – people are more likely to support the person) etc.

- This allows Leader Mother to follow up on previous lessons; allows for greater encouragement and monitoring of activities.

    - Two weeks ago you committed to wash your hands after using the latrine. Have you been able to do this every time you wash your hands?

- Allows for a good relationship over an extended period of time. The more often they meet and develop deep relationships the more sustainable the program. It becomes part of the fabric of the community.

- Builds strong relationships between LM and her neighbors
- Strong relationships increase behavior change as the LM walks them through stages of change.
- Makes meeting and discussing health a habit in the community.
- Helps to build community ownership of the groups after the program is over.

5. At least 80% of all households in the community (with pregnant women and children under 2) will be reached by Care Groups.

? Why is this important?

- In order to create a "new social norm" (not one person changing behavior, but many encouraging each other), we need to reach 80-100% of all households with pregnant mothers and children under two.
- People are more likely to change when others around them are hearing the same message and talking about making their own changes.

    - The Care Group manual says, *"Changed communities: In a participating community, there is at least one Care Group volunteer for every 10-15 households who is leading the way to better health practices. Behavior change becomes more than an individual decision — it becomes a social movement involving the entire community."*
- Create a new social norm; everyone is hearing the message together. The community as a whole can make changes together.
- Community learning helps to increase change.

? Think about changes you have made in your life, is there anything that you changed in your own life because you felt some peer pressure from others – everyone else around you was doing it so you wanted to join in?

? You may ask, "How can we reach 80-100% of all households if Care Group Leaders (Leader Mothers) can only reach 10-15 houses"?

- We need to make sure that we have a sufficient number of Leader Mothers so that we can effectively reach 80-100% of households in our target group.
- Don't overburden your Leader Mothers with too many households. Be sure your budget includes the right number of Leader Mothers to account for the size of your community.

Coverage is monitored
- How is coverage monitored in the PM2A proposal? Attendance of both LM and NW is tracked using registers that Promoters maintain.

6. Care Group volunteers (Leader Mothers) will collect information on pregnancies, births and deaths at each household.

? Why is this important?

- Will help the Leader Mothers to become more "attuned" to epidemics and health behavior in your community as well as how their work affects others.
- Leader Mothers report the information to the promoters; this can be used to help alert local health clinics and communities of areas that need more assistance or interventions.
    - (Care Group Manual says) *In addition, the MOH can rely on Care Groups to help with their community mobilization efforts. For example, MOH staff call on volunteers to rally households in a village for immunization campaigns or weighing sessions. After the MOH communicates to the Care Group leaders, all volunteers spread the news to their assigned households, generating a greater turnout for the event.*

- Working together, the Care Group (with the promoters support) identifies what the volunteer can do to respond to a situation.
- (optional) Leader Mothers may also conduct a verbal autopsy (discussing circumstances around the event and signs of illness) if a child or woman dies. This helps Leader Mothers to determine the probable cause of death.

  - The Care Group needs to be designed so that Leader Mothers are trained by the promoter's example to problem solve and understand the health statistics that they gather in the community.
  - This way when the PM2A program is over, the Leader Mother know exactly how to interpret the information that they receive on their own.

Volunteers:

- During a home visit, ask about family members' health.
- Take note of births, deaths or pregnancies of beneficiaries.
- Ask about circumstances surrounding the event, such as symptoms, the family's response, etc.
- At one Care Group meeting a month, verbally report vital events.
- Illiterate volunteers can easily recall all vital statistics because these events are generally infrequent among their 10 to 15 assigned households.
- A literate volunteer (often the Care Group leader/promoter) records the information.
- The Care Group leader turns in the form to the promoter.

Promoters:

- Immediately discuss the household vital statistics with volunteers as they report the information.
- Ask the reporting volunteer to give a possible reason for the event.
- Invite the other volunteers to share their understanding of the event.
- Discuss with volunteers, learning from their insight and correct any false information, if necessary.
- Help volunteers link health practices or environmental factors to effects on health and disease.
- Identify actions volunteers can take in the future, based on lessons learned from the discussion.

Example of Problem Solving:

- Reminding the Leader Mother: "You remember that your neighbor had a lot of bleeding in her last pregnancy. We will have to watch her."
- Asking the Care Group: "We had two children die and another 22 are sick. What's happening here?"

If Community Development Committee exist in the community:

- Often one or more Care Group leaders become members. She is able to provide updates on vital statistics and health information gathered by her Care Group.
- This data equips CDCs to make well-informed decisions regarding issues affecting community members' health.

7. The majority of what is promoted through the Care Groups creates behaviors that change directed towards reduction of mortality and malnutrition.

- While the cascading or multiplier approach used in Care Groups may be suitable for other purposes, we suggest that a different term be used for those models (e.g. Farmer cascade groups, etc.)

8. Care Group volunteers (Leader Mothers) use visual aids (flipcharts) to promote health and nutrition at each household.

? Why is this important?

- Flipcharts are a guide to make sure that consistent messages are being shared.
- The pictures serve as reminders. The words help the literate to remember the key messages for each picture.
- The visual images attract others and make them curious. It not only aids the Leader Mothers in teaching, but it also encourages the beneficiaries to listen, learn and watch.

I worked in Mali for two years in rural villages. We had a local leader perform on the radio songs and stories about HIV prevention. I used to travel around the village with my tape recorder playing the recorded songs. People loved to listen to the tape recorder. The songs were not the attraction, it was the tape recorder and listening to the box speaking their language.
However, over time, people began to listen to the teachings and learned the messages of HIV prevention as well! The visual aid was attractive, and helped to bring the health messages into the home.

9. Care Group volunteers (Leader Mothers) use participatory methods of teaching (non-formal education) when doing health promoter at each household.

? What is non – formal?

- It means we are not in a school setting or a university. It is not formal training.

? What is participatory learning?

- It is not – giving information only. It is a two way dialogue between the facilitator and the participants. It includes seeing, hearing and doing.
- Helping participants INTERACT with the learning by discussion, drawing, writing, acting or verbally responding is a better teaching method than just telling people what to do. It is more effective than being told information.
- The 20.40.80 rule states that participants remember 20 percent of what they hear, 40% of what they hear and see, and 80% of what they hear see and do.

? What can we do to encourage participants to remember 100%?

Even a well trained staff person will not remember 100% of what they learn at this training or any other educational event. Our hope is that they take small steps – one at a time to reduce malnutrition.

Each practice will reduce risk – we cannot ensure Leader Mothers will recall 100% - we are happy if they recall 80% and do as many of these practices as they can.

10. The Care Group meeting (when promoters come to teach the Leader Mothers) should last no more than two hours.

? Why is this important?

- Shorter meetings improve attendance.
- Long meetings discourage volunteers.
- We need to respect the other responsibilities of the Leader Mothers – they are volunteers and we must not take too much of their time away.

11. Promoters will supervise at least one Leader Mother teaching her neighbors each month.

If they are volunteers why should we supervise them?

- Volunteers sharing inaccurate information can do more harm than good.
- We are responsible to our "donors" to make sure we meet our program goals.
- Promoters will supervise with a QIVC.

In Nigeria in our Abstinence and Faithfulness program – the staff said, "It is not Christian to supervise."

- What do you think of this statement? Would you agree?
- What standard do you think God expects of us?

Colossians 3:23 *Whatever you do, work at it with your heart as working for the Lord, not men.*

12. All of a Leader Mother's beneficiaries should live within a distance that facilitates frequent home visitation and all CG volunteers should live < 1 hour walk from the Promoters meeting place.

- *Make sure that this will work within their current structure.*
- *Again this makes sure we respect the time and workload of the volunteer.*

13. The implementing agency needs to successfully create a project/program culture that conveys respect for the population and volunteers, especially women.

- The WAY in which we do our work has a big impact on the outcome. Have you heard the saying, "Do what I say not what I do?" It is often used in the US b/c many people say they believe something – but do the opposite.
- What is your motivation for working in the SSHiNE program?
- It is important that our staff "buy in" to the objectives and goals of the program. Otherwise their own "agenda" and attitudes may negatively affect the program.

- Example:
- In another of our PM2A programs there is a staff member who sees himself as being "above and better" than the beneficiaries. He doesn't take time to listen and spend time finding out about their needs.
- How do you think this affects his work as a manager?
- How can this negatively impact the beneficiaries?

- During Operations Research conducted near the end of the FH Sofala CG project, CG volunteers ("Leader Mothers") were asked who respected them now that did not respect them before. 86% mentioned other mothers/women, 64% mentioned Community Leaders, 61% mentioned their husbands, 45% mentioned their parents or in-laws, 41% mentioned extended family members, and 25% mentioned health facility staff.

Ask the participants to turn to the complete Care Group Criteria Handout in their notebook.

Answer questions as needed

Ask them to review the "suggested" criteria in the rest of the document for 5 minutes. Discuss and write down any questions that you have.
Clarify differences between your project and the Care Group Criteria

---

Activity 2: Care Group Cranium Game (40 min)

- This will be a time of ACTIVE participation to reinforce what you have learned.
- We will have a contest between two teams.
- Split the group into two teams
    - Option 1: counting off 1/2/1/2/
    - Option 2: putting the "volunteer names" in a hat and drawing them out one at a time for group 1 – all others will be in group 2.

Explain:

- One person in each group will be given a piece of paper with ONE essential element that is needed in a Care Group. That person must try to explain this criteria to your teammates in 1 minute without talking! The underlined text is the most important part. If they are able to guess the underlined text then your team wins 1 point.
- You have two options for helping teammates to guess the "criteria."
    1. Draw pictures. You have 1 minute to draw pictures to explain the criteria. However - no speaking and no words written on the paper.
    2. ACT out the criteria. You have 1 minute to perform the "criteria" for your teammates. No speaking allowed.
- If your team guesses the correct answer – then your team receives 1 point.
    - If your team is NOT able to guess the correct answer, the other team gets one chance to guess. If they guess correctly, then they get one point.
    - If someone speaks, or writes words on their paper, the team loses 1 point.

Ask someone to rephrase what I have said – explaining it to one another.

- Reinforce: no speaking, no writing words on paper.
    - *If there is an odd person, they can serve as the "judge" for both teams to make sure that no one "cheats." Otherwise the facilitator is the judge. (The teams may prefer to have more than 1 judge)
    - Before you start identify an image as a leader mother – for example a woman with a skirt is always the leader mother.

See Handout 2A: Care Group Criteria Cranium Activity (see handout for printing at the end of this lesson)

1. Care Group volunteers (Leader Mothers) should be chosen by the mothers

- Give slip of paper to one member of Team 1. Start the stopwatch (1 minute).
- Give points.

2. Care Group volunteers <u>(Leader Mothers) should have no more than 15 households</u> (neighbors that they visit).
    - *Give slip of paper to one member of Team 2. Start the stopwatch (1 minute).*
    - Give points.

3. The Care Group <u>(groups of Leader Mother Volunteers) should have no more than 15 members.</u>
    - *Give slip of paper to one member of Team 1. Start the stopwatch (1 minute).*
    - Give points.

4. <u>Care Group volunteers (Leader Mothers) will have contact with neighbor households at least twice each month</u>.
    - *Give slip of paper to one member of Team 2. Start the stopwatch (1 minute).*
    - Give points.

5. <u>At least 80% of all households in the community (with pregnant women and children under 2) will be reached</u> by Care Groups.
    - *Give slip of paper to one member of Team 1. Start the stopwatch (1 minute).*
    - *Give points.*

6. <u>Care Group volunteers (Leader Mothers) will collect information on pregnancies, births and deaths</u> at each household.
    - *Give slip of paper to one member of Team 2. Start the stopwatch (1 minute).*
    - *Give points.*

Removed 7,8 and 13 for time as well as ease in drawing and relevance.

9. <u>Care Group volunteers (Leader Mothers) use participatory methods</u> of teaching (non-formal education) when doing health promoter at each household.
    - *Give slip of paper to one member of Team 1. Start the stopwatch (1 minute).*
    - *Give points.*

10. <u>The Care Group meeting</u> (when promoters come to teach the Leader Mothers) <u>should last no more than two hours.</u>
    - *Give slip of paper to one member of Team 2. Start the stopwatch (1 minute).*
    - *Give points.*

11. <u>Promoters will supervise (monitor and use QIVC)</u> at least one Leader Mother teaching her neighbors each month.
    - *Give slip of paper to one member of Team 1. Start the stopwatch (1 minute).*

- *Give points*.

12. Leader Mothers will live within walking distance of all neighbor groups and < 1 hour walk from the Promoter meeting place.
    - *Give slip of paper to one member of Team 2. Start the stopwatch (1 minute).*
    - Give points.

Activity 3: Grand Final Care Group Criteria (15 min)

FINALE – How many criteria can you remember?

Tell the two groups that they will now compete for the finale.
- Ask everyone to put away their notes.
- Put two blank flipchart pages on the tables in front of each group.
- Hold the two markers in your hands.
- Tell them that the first group to write down ALL 10 of the ESSENTIAL CRITERIA wins two points for the game finale.
- Make sure everyone understands.
- Give them the markers and tell them to GO.

Tally the scores
Award a prize

Activity 4: Care Group Criteria Checklist (10 min)
- Ask participants to turn to the Care Group Checklist in the Participants Notebook.
- Review steps that do not apply to our program
- Ask them to go back to this checklist every 6 months and make sure you are following the standards. If you begin to stray off the model, your effectiveness will decrease.

Activity 5: Alternative activity to review the CG Handout (60 - 90 min)

Instructions: Pass out Handout Annex 2D: Care Group Criteria Small Group Questions. Depending on the time available, assign each small group all the question or divide them up among the groups. When small groups have finished answering the questions invite them to share answers in a large group. Pass out Handout Annex 2E: Care Group Criteria Small Group Questions & Answers when the discussion has finished.

Handout Annex 2A: Care Group Criteria

1. Leader Mothers should be chosen by the mothers (neighbor groups)

2. Leader Mothers should meet with no more than 15 neighbors.

3. Promoters should meet with no more than 16 Leader Mothers.

4. Leader Mothers will meet with neighbor groups twice each month.

5. Care groups will cover 80% or more of all households in the community (with pregnant women and children under 2).

6. Leader Mothers will collect information on pregnancies, births and deaths from their neighbor groups.

9. Leader Mothers will use participatory methods (games, activities, demonstrations, group participation) when teaching.

10. The promoters teaching of Leader Mothers will last no more than two hours.

11. Promoters will supervise (monitor and use QIVC) at least one Leader Mother teaching her neighbors each month.

12. Leader Mothers will live within walking distance of all neighbor groups and < 1 hour walk from the Promoter meeting place.

Handout Annex 2B: The Complete Care Group Criteria

Establishing Care Group Criteria

Rationale for this Document:

World Relief (WR) staff developed the Care Group model in Mozambique in 1995. Food for the Hungry (FH) adopted the model in Mozambique in 1997 after discussions with WR project staff, and both organizations have pioneered use of the model since then. A Care Group (CG) is a group of 10-15 volunteer, community-based health educators who regularly meet together with project staff for training and supervision. They are different from typical mother's groups in that each volunteer is responsible for regularly visiting 10-15 of her 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, including promotion of health service utilization. They also provide the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits.

Since 1995, WR, FH, and more than 12 others PVOs in more than 14 countries have "adopted the model," but the degree to which organizations adhere to the original components of the model varies greatly. While there has been increased attention to the model and its effectiveness in lowering child deaths (e.g, mentioned in the UNICEF's 2008 State of the World's Children report), there is a danger that the wide variations in what is called a "Care Group" by various agencies will lead to misunderstandings about the model and the use of less effective strategies that do not fit within the model. These variations, in turn, could lead to fewer opportunities to advocate for the Care Group model and its role in child survival since the term "Care Groups" may come to mean many different things to different people, and will probably develop a very mixed track record. There are already situations in which individuals and organizations are defining Care Groups as "any group where you are teaching mothers" or "any group where you are teaching people to teach other people." Given the excellent and low-cost results seen in the USAID Child Survival and Health Grants Program and Title II food security projects in terms of decreased child mortality and morbidity using Care Groups, we feel that it is important to define official criteria for the Care Group model.

During meetings between World Relief and Food for the Hungry staff members on April 23, 2009, the Care Group criteria in the table below were agreed upon as a draft list. The list is divided into those that we feel should be required to be present when using the term, "Care Group," and other criteria that we feel have been helpful when included in the model, but that should not be considered required. Edits to this list were then made by the two founders of the model, Dr. Pieter Ernst and Dr. Muriel Elmer. During the CORE Group Spring Meeting in April 2010, this list was presented to other community health practitioners and revisions were made based on their input.

Of course there is no way to enforce the use of these criteria – people will use the term how they wish – but by having two organizations that are recognized as having a

history of using and promoting Care Groups extensively (one organization being the original developer), defining formal criteria should provide a stronger basis for recognition of the model and lead to better adherence to the most effective components of the model. We also hope that by informing donors and others about these criteria, they will use the criteria to decide to what degree a proposed implementation strategy is really based on the Care Group model. The **CORE Social & Behavioral Change Working Group** (SBCWG) has helped with the dissemination of this document, and we expect this will further legitimize the list, and will lead to better compliance with the recommended criteria. The table below gives the required and suggested criteria along with a rationale for each.

Criteria for Care Groups	Rationale
***Required*:**	
1. The model is based on peer-to-peer health promotion (mother-to-mother for MCH and nutrition behaviors.) CG volunteers (e.g., "Leader Mothers," "Mother Leaders") should be chosen by the mothers within the group of households that they will serve or by the leadership in the village.	Care Groups are not the same as Mothers Clubs where mothers are simply educated in a group. An essential element is having women serve as role models (early adopters) and to promote adoption of new practices by their neighbors. There is evidence that "block leaders" (like CG volunteers) can be more effective[8] in promoting adoption of behaviors among their neighbors than others who do not know them as well. CG volunteers should be mothers of young children or other respected women from the community. CG volunteers who are chosen by their neighbors (or by a consensus of the full complement of [formal and informal] community leaders) will be the most dedicated to their jobs,[9] and we believe they will be more effective in their communication, trusted by the people they serve, and most willing to serve others with little compensation.
2. The workload of CG volunteers is limited: No more than 15 HH per CG volunteer.	Having one volunteer trained to serve 30+ households (HH) is more in line with the traditional CHW approach, and more regular and sustained financial incentives are required for that model to be effective. In the CG model, the number of households per CG volunteer is kept low so that it fits better with the volunteer's available time and allows for fewer financial incentives to be used. In addition, there is evidence that the ideal size for one's "sympathy group" – the group of people to whom you devote the most time – is 10-15 people.[10]
3. The Care Group size is limited to 16 members and attendance is monitored.	To allow for participatory learning, the number of CG volunteers in the CG should be between 6 and 16 members. As with focus groups, with fewer than six members, dialogue is often not as rich and with more than 16, there is often not enough time for everyone to contribute and participate as fully. A low attendance rate (<70%) at Care Group meetings is often an indication that something is wrong somewhere, either with the teaching methodology or the promoter attitude, and helps the organization to identify problems early in the project. Attendance should be monitored.
4. CG volunteer contact with her assigned beneficiary mothers – and Care Group meeting frequency – is monitored and should be at a minimum once a month, preferably twice monthly.	In order to establish trust and regular rapport with the mothers with which the CG volunteer works, we feel it is necessary to have at least monthly contact with them. Care Groups should meet at least once monthly, as well. We also believe that overall contact time between the CG volunteer and the mother (and other family members) correlates with behavior change. We recommend twice a month contact between CG volunteers and beneficiary mothers, as well as twice a month CG meetings, since the original CG model was based on this meeting frequency (after experimentation to see which meeting frequency aided the most in retention of material).
***Required*:**	

[8] Burn, S.M. (1991). Social psychology and the stimulation of recycling behaviors: The block leader approach. *Journal of Applied Social Psychology*, 21, 611-629.

[9] Operations Research on CGs in Sofala, Mozambique showed that CGVs chosen by the mothers that they serve were 2.7 times more likely to serve for the life of the project (p=0.009).

10 See Gladwell, M. (2002). The Tipping Point, Little, Brown, & Co publishers, pp. 175-181.

Criteria for Care Groups	Rationale
5. The plan is to reach 100% of households in the targeted group on at least a monthly basis, and the project attains at least 80% monthly coverage of households within the target group. Coverage is monitored.	In order to create a supportive social environment for behavior change, it is important that many mothers adopt the new practices being promoted. Behavior change is much more likely to happen when there is regular, direct contact with all mothers of young children (rather than reaching only a small proportion of mothers), and probably more likely when there is contact with all households in a community (but this approach will probably be more costly). There is sometimes a combination of group meetings and individual household contacts with beneficiary mothers, but at least some household visits should be included. For group meetings with beneficiary mothers, any mothers that miss meetings should receive a HH visit. HH visits are helpful in seeing the home situation and in reaching people other than the mother, such as the grandmother, daughter, or mother-in-law.
6. Care Group volunteers collect vital events data on pregnancies, births, and death.	Regular collection of vital events data helps CG volunteers to discover pregnancies and births in a timely way, and to be attentive to deaths happening in their community (and the causes of those deaths). Reporting on vital health events should be done during Care Group meetings, so that the data can be recorded by the CG leader (usually using in a register maintained by her) and discussed by the CG members. The point of discussion should be for CG members to draw connections between their work and the health events in the community (e.g. what can we do to prevent this kind of death in the future?). This should be done on at least a monthly basis, so that the information is not forgotten by volunteers over longer periods of time.
7. The majority of what is promoted through the Care Groups creates behavior change directed towards reduction of mortality and malnutrition (e.g., Essential Nutrition Actions, Essential Hygiene Actions).	This requirement was included mainly for advocacy purposes. We want to establish that the Care Group approach can lead to large reductions in child and maternal mortality, morbidity, and malnutrition so that it is adopted in more and more settings to achieve the health MDGs. While the cascading or multiplier approach used in Care Groups may be suitable for other purposes (e.g., agriculture education), we suggest that a different term be used for those models (e.g., "Cascade Groups based on the CG model").
8. The Care Group volunteers use some sort of visual teaching tool (e.g., flipcharts) to do health promotion at the household level.	We believe the provision of visual teaching tools to CG volunteers helps to guide the health promotion that they do, gives them more credibility in the households and communities that they serve, and helps to keep them "on message" during health promotion. The visual nature of the teaching tool also helps mothers to receive the message by both hearing it and seeing it.
9. Participatory methods of behavior change communication (BCC) are used in the Care Group with the CG volunteers, and by the volunteers when doing health promotion at the household or small-group level.	Principles of adult education should be applied in Care Groups and by CG volunteers since they have been proven to be more effective than lecture and more formal methods when teaching adults.
10. The Care Group instructional time (when a Promoter teaches CG volunteers) is no more than two hours per meeting.	CG members are volunteers, and as such, their time needs to be respected. We have found that limiting the CG meeting time to 1-2 hours helps improve attendance and limits their requests for financial compensation for their time. (This instruction should include interactive and participatory methods.)

Criteria for Care Groups	Rationale
***Required*:**	
11. Supervision of Promoters and at least one of the Care Group Volunteers (e.g., data collection, observation of skills) occurs at least monthly.	For Promoters (who teach CG Volunteers) and CG volunteers to be effective, we believe that regular, supportive supervision and feedback is necessary on a regular basis (monthly or more). For supervision of Care Group volunteers, the usual pattern is for the Promoter to supervise through direct observation at least one volunteer following the CG meeting.
12. All of a CG volunteer's beneficiaries should live within a distance that facilitates frequent home visitation and all CG volunteers should live < 1 hour walk from the Promoter meeting place.	It is preferable that the CG volunteer not have to walk more than 45 minutes to get to the furthest house that she visits so that regular visitation is not hindered. (In many CG projects, the average travel time is much less than this.) This also makes it more likely that she will have a prior relationship with the people that she is serving. Before starting up CGs, the population density of an area should be assessed. A low CG volunteer: Neighbor Women (NWs) and low Promoter:CG ratio should be used when setting up CG in rural, low population density areas. If an area is so sparsely populated that a CG volunteer needs to travel more than 45 minutes to meet with the majority of her beneficiary mothers then the Care Group strategy may not be the most appropriate one to use.
13. The implementing agency needs to successfully create a project/program culture that conveys respect for the population and volunteers, especially women.	During Operations Research conducted near the end of the FH Sofala CG project, CG volunteers ("Leader Mothers") were asked who respected them now that did not respect them before. 86% mentioned other mothers/women, 64% mentioned Community Leaders, 61% mentioned their husbands, 45% mentioned their parents or in-laws, 41% mentioned extended family members, and 25% mentioned health facility staff. We believe that an important part of this model is fostering respect for women, and implementers need to make this an explicit part of the project, encourage these values among project staff, and ideally measure whether CG volunteers are sensing this respect.
Suggested:	
1. Formative research should be conducted, especially on key behaviors promoted.	A review of the most effective projects in terms of behavior change for both exclusive breastfeeding and hand washing with soap (by the CORE Group Social & Behavioral Change Working Group) found that they included formative research (e.g., Barrier Analysis, Doer/NonDoer Analysis) on the behaviors. We believe that more systematic use of formative research on behaviors will lead to the best adoption rates. Formative research also helps assure that the behaviors promoted by project staff are more feasible by community members.
2. The Promoter: Care Group ratio should be no more than 1:9.	For Promoters to know and have the trust of those with which they work, it is best to limit the number of volunteers with which they work to about 150, or nine groups (assuming a CG size of between 6 and 16 members). Some social science research confirms that our maximum "social channel capacity" – the maximum number of people with whom we can have a genuinely social relationship – is about 150 people (and 9 groups x 16 people/group = 144).
3. Measurement of many of the results-level indicators should be conducted annually at a minimum.	We have found that regular measurement of at least some key results-level indicators on an annual (or better) basis is helpful in knowing what is changing and what is not in time to do something about it.

Criteria for Care Groups	Rationale
4. Social/educational differences between the Promoter and CG volunteer should not be too extreme (e.g., having bachelor-degree level staff working with CG volunteers).	We believe that keeping the educational difference between the Promoter and CG volunteers to a modicum is useful in that it makes it more likely that the Promoters will use language/concepts that the CG volunteers can understand. It also helps to keep costs of the model low.

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Latest Revision Date: 11/10/2010

Handout Annex 2C: Care Group Minimum Criteria Reviewer Checklist

Care Group Minimum Criteria Reviewer Checklist

(revised November 23, 2010)

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. Since 1995, World Relief and Food for the Hungry have pioneered the model, and more than 14 others PVOs in more than 14 countries have "adopted the model," but the degree to which organizations adhere to the original components of the model varies greatly. During meetings between the original pioneers of the model (on April 23, 2009), Care Group minimum criteria were agreed upon as a draft list, based on the programs in which the best results had been seen. Edits to this list were then made by the two founders of the model, Dr. Pieter Ernst and Dr. Muriel Elmer. During the CORE Group Spring Meeting in April 2010, this list was presented to other community health practitioners and revisions were made based on their input. Defining formal criteria should provide a stronger basis for recognition of the model and lead to better adherence to the most effective components of the model. The checklist below is based on those minimum criteria, and serve as an aide to reviewers and others who want to see to what degree a proposed "Care Group" project meets these criteria. The full rationale for each criteria can be found at http://www.caregroupinfo.org/blog/criteria.

	Criterion	Yes	No
1.	The project has a strong peer-to-peer health promotion component	❑	❑
2.	CG volunteers will be chosen by the mothers within the group of households that they will serve or by the leadership in the village	❑	❑
3.	CG volunteers will visit no more than 15 households each	❑	❑
4.	The Care Groups will have no more than 16 members	❑	❑
5.	There are plans to monitor Care Group meeting attendance	❑	❑
6.	CG volunteers will contact each of their beneficiary mothers at least once a month	❑	❑
7.	Care Group meeting frequency is planned to be at least once a month	❑	❑
8.	It is planned that 100% of target group households will be reached at least once a month	❑	❑
9.	There is a plan in place to monitor coverage of households (by CG volunteers)	❑	❑
10.	The plan mentions that vital events data on pregnancies, births, and death will be collected via Care Group volunteers	❑	❑
11.	The majority of what is promoted through the Care Groups will create behavior change directed towards reduction of mortality and malnutrition[11]	❑	❑
12.	The plan mentions that Care Group volunteers will use some sort of visual teaching tool (e.g., flipcharts) to do health promotion at the household level	❑	❑
13.	The plan mentions that participatory teaching methods will be used in the Care Groups	❑	❑
14.	The staff plan to have Care Group volunteers use participatory methods at the HH/small-group level	❑	❑
15.	The Care Group instructional time (when a Promoter teaches CG volunteers) will be no more than two hours per meeting	❑	❑
16.	Supervision of Promoters and at least one of the Care Group Volunteers (e.g., data collection, observation of skills) will occur at least monthly	❑	❑
17.	All of a CG volunteer's beneficiaries will live within a distance that facilitates frequent home visitation	❑	❑
18.	The Promoter meeting place will be within one hour walk from the CG volunteers' homes	❑	❑
19.	The implementing agency has plans to create a project/program culture that conveys respect for the population and volunteers, especially women	❑	❑

[11] If it does not meet this criterion, but meets all others, the term Cascade Group should be used rather than Care Group.

Score: ____% (Yes/19)

We recommend that projects scoring < 90% not be considered Care Group projects, and be encouraged to follow more of the criteria. Projects that meet many, but not most, of these criteria should be considered Cascade Groups.

Handout Annex 2D: Care Group Criteria Small Group Questions

Care Group Criteria / Small Group Questions

Directions: Depending on the time available, assign each small group all the question or divide them up among the groups. When small groups have finished answering the questions share answers in a large group.

1. Care Groups are not the same as Mothers Clubs where mothers are simply educated in a group. An essential element is having women serve as role models (early adopters) and to promote adoption of new practices by their neighbors. There is evidence that "block leaders" (like CG volunteers) can be more effective12 in promoting adoption of behaviors among their neighbors than others who do not know them as well. CG Volunteers should be mothers of young children or other respected women from the community. **How should CG Volunteers be selected?**

2. In the CG model, the number of households per CG volunteer is kept low so that it fits better with the volunteer's available time and allows for fewer financial incentives to be used. **What should be the maximum number of households assigned to each CG volunteer to work with?**

3. CG volunteers regularly meet with a Promoter (a paid staff member who shares with them new lessons). Normally a Promoter will work with several groups of CG volunteers or Care Groups. Each group of CG volunteers is called a Care Group. **What should be the maximum number of CG volunteers in each Care Group?**

4. In order to establish trust and regular rapport with the mothers with which the CG volunteer works, it is necessary that she has consistent contact with them. We believe that overall contact time between the CG volunteer and the mother (and other family members) correlates with behavior change. **How often do you recommend that the CG volunteer contact her assigned beneficiary mothers?**

5. In order to create a supportive social environment for behavior change, it is important that many mothers adopt the new practices being promoted. Behavior change is much more likely to happen when there is regular, direct contact with all mothers of young children (rather than reaching only a small proportion of mothers), and probably more likely when there is contact with all households in a community (but this approach will probably be more costly). **What should be the minimum percent of households in the target group that are reached by a Care Group project?**

6. Reporting on vital health events should be done during Care Group meetings, so that the data can be recorded by the CG leader (usually using in a register maintained by her) and discussed by the CG members. The point of discussion should be for CG members to draw connections between their work and the health events in the community (e.g. what can we do to prevent this kind of death in the future?). This should be done on at least a monthly basis, so that the information is not forgotten by volunteers over longer periods of time. **What are the essential vital events that Care Group volunteers should monitor on a monthly basis?** (Hint: some examples of vital events are births, deaths, pregnancies, diseases, disasters, etc…)

[12] Burn, S.M. (1991). Social psychology and the stimulation of recycling behaviors: The block leader approach. *Journal of Applied Social Psychology*, 21, 611-629.

7. **One of the Care Group criteria is** that the majority of what is promoted through the Care Groups is directed towards reduction of mortality and malnutrition (e.g., Essential Nutrition Actions, Essential Hygiene Actions). Why do you think the creators of the CG criteria did not want projects that use cascade teaching to promote agriculture skills, literacy or other sector topics to be called Care Croup projects?

8. One of the Care Group criteria is that volunteers use some sort of visual teaching tool (e.g., flipcharts) to do health promotion at the household level. **What are the benefits to using visual teaching tools to guide health promotion?** (Hint: consider the benefit to the CG volunteer, beneficiary mother and overall project goals.)

9. **What type of teaching methods should be used during Care Group behavior change communication?** Please explain your answer. (Hint: possible teaching methods include didactic, adult, lecture and participatory.)

10. CG members are volunteers, and as such, their time needs to be respected. **What do you think should be the maximum length (in hours) of a Care Group meeting (when a Promoter teaches CG Volunteers)?**

11. For Promoters (who teach CG Volunteers) and CG volunteers to be effective, we believe that regular, supportive supervision and feedback is necessary on a regular basis. **What is the minimum frequency that Promoters should supervise at least one Care Group volunteer?**

Handout Annex 2D: Care Group Criteria Small Group Questions & Answers

Care Group Criteria
Small Group Questions & Answers

Directions: Depending on the time available, assign each small group all the question or divide them up among the groups. When small groups have finished answering the questions share answers in a large group.

12. Care Groups are not the same as Mothers Clubs where mothers are simply educated in a group. An essential element is having women serve as role models (early adopters) and to promote adoption of new practices by their neighbors. There is evidence that "block leaders" (like CG volunteers) can be more effective[13] in promoting adoption of behaviors among their neighbors than others who do not know them as well. CG Volunteers should be mothers of young children or other respected women from the community. **How should CG Volunteers be selected?**

CG Volunteers should be chosen by the mothers within the group of households that they will serve or by the leadership in the village. We believe that CG volunteers who are chosen by their neighbors (or by a consensus of the full complement of [formal and informal] community leaders) will the most dedicated to their jobs, effective in their communication, trusted by the people they serve, and most willing to serve others with little compensation.

13. In the CG model, the number of households per CG volunteer is kept low so that it fits better with the volunteer's available time and allows for fewer financial incentives to be used. **What should be the maximum number of households assigned to each CG volunteer to work with?**

The workload of CG volunteers is limited: No more than 15 HH per CG volunteer. There is evidence that the ideal size for one's "sympathy group" – the group of people to whom you devote the most time – is 10-15 people.[14]

14. CG volunteers regularly meet with a Promoter (a paid staff member who shares with them new lessons). Normally a Promoter will work with several groups of CG volunteers or Care Groups. Each group of CG volunteers is called a Care Group. **What should be the maximum number of CG volunteers in each Care Group?**

The Care Group size is limited to 16 members. To allow for participatory learning, the number of CG volunteers in the CG should be between 6 and 16 members. As with focus group discussions, with fewer than six members, dialogue is often not as rich and with more than 16, there is often not enough time for everyone to contribute and participate as fully.

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[13] Burn, S.M. (1991). Social psychology and the stimulation of recycling behaviors: The block leader approach. *Journal of Applied Social Psychology*, 21, 611-629.

[14] See Gladwell, M. (2002). The Tipping Point, Little, Brown, & Co publishers, pp. 175-181.

15. In order to establish trust and regular rapport with the mothers with which the CG volunteer works, it is necessary that she has consistent contact with them. We believe that overall contact time between the CG volunteer and the mother (and other family members) correlates with behavior change. **How often do you recommend that the CG volunteer contact her assigned beneficiary mothers?**

CG volunteer contact with her assigned beneficiary mothers should be at a minimum once a month, preferably twice monthly.

16. In order to create a supportive social environment for behavior change, it is important that many mothers adopt the new practices being promoted. Behavior change is much more likely to happen when there is regular, direct contact with all mothers of young children (rather than reaching only a small proportion of mothers), and probably more likely when there is contact with all households in a community (but this approach will probably be more costly). **What should be the minimum percent of households in the target group that are reached by a Care Group project?**

The plan is to reach 100% of households in the targeted group on at least a monthly basis, and attainment of at least 80% monthly coverage of households within the target group.

17. Reporting on vital health events should be done during Care Group meetings, so that the data can be recorded by the CG leader (usually using in a register maintained by her) and discussed by the CG members. The point of discussion should be for CG members to draw connections between their work and the health events in the community (e.g. what can we do to prevent this kind of death in the future?). This should be done on at least a monthly basis, so that the information is not forgotten by volunteers over longer periods of time. **What are the essential vital events that Care Group volunteers should monitor on a monthly basis?** (Hint: some examples of vital events are births, deaths, pregnancies, diseases, disasters, etc…)

Care Group Volunteers (e.g., "Leader Mothers," "Mother Leaders") collect vital events data on pregnancies, births, and death. Regular collection of vital events data helps CG volunteers to discover pregnancies and births in a timely way, and to be attentive to deaths happening in their community (and the causes of those deaths).

18. **One of the Care Group criteria** is that the majority of what is promoted through the Care Groups is directed towards reduction of mortality and malnutrition (e.g., Essential Nutrition Actions, Essential Hygiene Actions). Why do you think the creators of the CG criteria did not want projects that use cascade teaching to promote agriculture skills, literacy or other sector topics to be called Care Croup projects?

This requirement was included mainly for advocacy purposes. We want to establish that the Care Group approach can lead to large reductions in child and maternal mortality, morbidity, and

malnutrition so that it is adopted in more and more settings to achieve the health MDGs. While the cascading or multiplier approach used in Care Groups may be suitable for other purposes (e.g., agriculture education), we suggest that a different term be used for those models (e.g., "Cascade Groups based on the Care Group model").

19. One of the Care Group criteria is that volunteers use some sort of visual teaching tool (e.g., flipcharts) to do health promotion at the household level. **What are the benefits to using visual teaching tools to guide health promotion?** (Hint: consider the benefit to the CG volunteer, beneficiary mother and overall project goals.)

We believe the provision of visual teaching tools to CG volunteers helps to guide the health promotion that they do, gives them more credibility in the households and communities that they serve, and helps to keep them "on message" during health promotion. The visual nature of the teaching tool also helps mothers to receive the message by both hearing it and seeing it.

20. **What type of teaching methods should be used during Care Group behavior change communication?** Please explain your answer. (Hint: possible teaching methods include didactic, adult, lecture and participatory.)

Participatory methods of BCC are used in the Care Group with the CG Volunteers, and by the volunteers when doing health promotion at the household or small-group level. Principles of adult education should be used in Care Groups and by CG volunteers since they have been proven to be more effective than lecture and more formal methods when teaching adults.

21. CG members are volunteers, and as such, their time needs to be respected. **What do you think should be the maximum length (in hours) of a Care Group meeting (when a Promoter teaches CG Volunteers)?**

The Care Group instructional time (when a Promoter teaches CG Volunteers) is no more than two hours per meeting. We have found that limiting the CG meeting time to 1-2 hours helps improve attendance and limits their requests for financial compensation for their time. (This instruction should include interactive and participatory methods.)

22. For Promoters (who teach CG Volunteers) and CG volunteers to be effective, we believe that regular, supportive supervision and feedback is necessary on a regular basis. **What is the minimum frequency that Promoters should supervise at least one Care Group volunteer?**

Supervision of Promoters and at least one of the Care Group Volunteers (e.g., data collection, observation of skills) occurs at least monthly. The usual pattern is for the Promoter to supervise through direct observation at least one volunteer following the CG meeting.

Suggested Criteria:

5. Formative research should be conducted, especially on key behaviors promoted.	A review of the most effective projects in terms of behavior change for both exclusive breastfeeding and hand washing with soap (by the CORE Group Social & Behavioral Change Working Group) found that they included formative research (e.g., Barrier Analysis, Doer/NonDoer Analysis) on the behaviors. We believe that more systematic use of formative research on behaviors will lead to the best adoption rates. Formative research also helps assure that the behaviors promoted by project staff are more feasible by community members.
6. The Promoter: Care Group ratio should be no more than 1:9.	For Promoters to know and have the trust of those with which they work, it is best to limit the number of volunteers with which they work to about 150, or nine groups (assuming a CG size of between 6 and 16 members). Some social science research confirms that our maximum "social channel capacity" – the maximum number of people with whom we can have a genuinely social relationship – is about 150 people (and 9 groups x 16 people/group = 144).
7. The average attendance by Care Group Volunteers in CG meetings should be 70% or higher, and should be monitored.	A low attendance rate at Care Group meetings is often an indication that something is wrong somewhere, either with the teaching methodology or the promoter attitude, and helps the organization to identify problems early in the project.
8. Measurement of many of the results-level indicators should be conducted annually at a minimum.	We have found that regular measurement of at least some key results-level indicators on an annual (or better) basis is helpful in knowing what is changing and what is not in time to do something about it.
9. Care Group Volunteers should only be assigned to visiting households that can be reached during regular daily activities.	It's preferable that the Leader Mother not have to walk more than about 30 minutes to get to the furthest house that she visits so that regular visitation is not hindered. (In many CG projects, the travel time is less than this.) This also makes it more likely that she will have a prior relationship with the people that she is serving.
10. Social/educational differences between the Promoter and CG Volunteer should not be too extreme (e.g., having bachelor-degree level staff working with CG volunteers).	We believe that keeping the educational difference between the Promoter and CG volunteers to a modicum is useful in that it makes it more likely that the Promoters will use language/concepts that the CG Volunteers can understand. It also helps to keep costs of the model low.

Annex 3: Care Groups and PM2A

The Preventing Malnutrition in Children Under 2 Approach (PM2A) is a methodology to reduce the prevalence of child malnutrition by targeting a package of health and nutrition interventions, including food distribution, to all pregnant women, mothers of children 0-23 months, and children less than two years of age in food-insecure program areas, regardless of nutritional status. PM2A and the Care Group (CG) Model both target pregnant women and mothers of children 0-23 months; therefore, some MCHN projects include both approaches.

Food for the Hungry recommends that when a project provides direct food assistance and protective household rations to pregnant women and children, the food distribution be conducted separate and independent from the CG activities.

Outlined below is the justification for this recommendation based on lessons learned from CG and PM2A program implementation.

1. **When PM2A and Care Groups are combined using the same lists of beneficiaries, PM2A can limit the number of mothers with children 6-23 months of age who are eligible to participate in Care Groups.** With PM2A, the maximum amount of time a woman and child pair can receive rations is 30 months (6 months of pregnancy + 6 months of EBF + 18 months for the child). But, most PM2A programs limit PM2A initial registration to pregnant women in their 2nd or 3rd trimester only or pregnant women in their 2nd or 3rd trimester + women with children 0-6 months of age. This excludes women with children 6-24 months from being reached initially by Care Groups unless they become pregnant during the period of time when the project is enrolling new mothers.

In the CG Model, all pregnant women (no matter their trimester) and women with children 0-24 months of age are registered in CGs. To widen the target and ensure a broader coverage, some CG programs include women with children 0-59 months of age, newly married women and/or adolescent women. This ensures that the majority of women in a community that are currently (or soon to be) caring for a child less than two years of age receive key MCHN messages prior to when they need the information.

2. **The strict initial registration criteria in PM2A programs can limit Neighbor Women from electing the best suited CG Volunteer.** In a normal CG project, the CGV need only have been a mother (at some point in time). She does not have to have a child in a particular age range. This allows NW to elect an influential women (who is a "hub" in the social network), a women who they respect, and one who may have more time and interest to devote to volunteering. When PM2A and Care Groups are combined using the same groups and registration lists, the women eligible to register have to be pregnant or the mothers of very young children, and therefore the pool of potential CGV candidates is very limited.

3. **PM2A programs may require CG Promoters and/or CGVs to assist with food distribution activities, shifting their focus from behavior change.** If CG Promoters and/or CGVs serve as the gateway for their neighbors to receive food rations, it places them in a position of power over the NW. This can

change the nature of the peer-to-peer relationship and expose CG Promoters and CGVs to possible intimidation. These additional responsibilities can also decrease the time a CG Promoter or CGV has to dedicate to behavior change activities and the development of relationships that promote behavior change. CG Promoters in particular may find a significant portion of their work day spent filling out distribution lists, preparing distribution sites and assisting with the actual distribution. Having a lower Promoter to CGV ratio and CGV to Neighbor Women ratio can help remove some of these disadvantages, but not all of them (e.g., the power differential created).

4. **PM2A links group behavior change participation and attendance (e.g., participation in the Care Group or small groups of Neighbor Women) with an extrinsic benefit.** When the benefit ends, CG participation may stop as well. Since attendance of CG meetings is perceived (or is actually) a condition to receive food rations, it is feared that as soon as the CG Volunteer (CGV) or Neighbor Woman (NW) is no longer eligible to receive food rations, she may stop attending CG sessions. (Research on motivation confirms this tendency.) The Care Group curriculum includes four to eight modules which take 24-48 months to fully teach. To be consistent with adult learning principles and to facilitate high quality teaching by women with limited education, we believe that this length of training is essential. Therefore, for the CGV and NW to receive all the key MCHN messages, she needs to participate in Care Groups or Neighbor Groups for the time it takes for all modules to be taught. For this reason, it's important that Care Group Volunteers and Neighbor Women be encouraged and allowed to participate in group meetings even if their child passes out of the age range. (In some of FH's programs, while Neighbor Women were allowed to continue to meet in small group meetings that the CGVs lead, they no longer received home visits by the CGV in order to not overburden the CGV.)

	Traditional Care Group Project	Burundi PM2A and Care Group Project
Perceived Benefit of CG Attendance	New knowledge, skills	Knowledge, skills, and (++) eligibility to receive a food ration
Length of CG Participation	A CGV or Neighbor Women can participate as long as they desire, although after their child moves out of the target age range their participation is "unofficial." (No home visits, but group attendance okay) New mothers added.	A Care Group Volunteer or Neighbor Woman could participate for 30 months maximum. No home visits, and group participation was discouraged. Note that PM2A technical reference materials do not provide specific instructions about how or for how long BCC should be provided.
Who is Eligible to be elected as a CGV	Any woman who has been a mother	Only women eligible for PM2A participation (had to be pregnant). Note that PM2A technical reference materials do provide specific recommendations about who can provide the BCC, the PM2A project chose to make this a requirement so CGV would be eligible to receive food rations.

Length of time it takes CGV and NW to receive all key messages	This depends on the length of the curricula, but normally is 24 – 48 months	In the Burundi PM2A project the curricula required 24-48 months of participation but the maximum number of months a woman could participate in CGs (and receive the PM2A ration) was 30 months, so some mothers had to leave before receiving all messages.
Focus of Project (Trend)	Behavior Change	Food Distribution and Behavior Change

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Annex 4: CG Workshop Feedback Forms

Daily Feedback Form

________________Date / Daily Feedback Form

Please circle the numbers which best describe your view of the *<u>today's</u>* *workshop activities. Circle one number for each question.*

1. To what degree did you understand today's sessions?

Understood very little - Understood some –Understood most everything

1 2 3 4 5 6 7 8 9 10

If you understood little of one or more sessions, what was the most difficult to understand and why?

2. How useful to you were today's workshop sessions?

Not very useful Somewhat useful Very useful

1 2 3 4 5 6 7 8 9 10

3. How helpful are the materials including handouts that we used today?

Not very helpful Somewhat helpful Very helpful

1 2 3 4 5 6 7 8 9 10

4. Overall, how satisfied are you with the workshop sessions presented today?

Very dissatisfied Somewhat satisfied Very satisfied

1 2 3 4 5 6 7 8 9 10

5. To what extent do you feel that you will be able to apply the ideas and strategies that you have learned today to your work?

Not at all Somewhat Very much

1 2 3 4 5 6 7 8 9 10

6. Please list any comments, criticisms, or recommendations on the back of this form.

End of Workshop Feedback Form

Please provide your comments and offer suggestions for anything related to the workshop content, format, or logistics.

1. What suggestions do you have for any future workshops?

2. How would you rate your satisfaction with the workshop content?

Very dissatisfied			Somewhat satisfied					Very satisfied	
1	2	3	4	5	6	7	8	9	10

3. How would you rate your satisfaction with the workshop trainers?

Very dissatisfied			Somewhat satisfied					Very satisfied	
1	2	3	4	5	6	7	8	9	10

4. What recommendations do you have to help the trainers improve their training methods?

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Annex 5: Monitoring the Impact of Care Group Projects

Access the blank excel file used to prepare this plan – www.caregroupinfo.orgxxxxx

Why Use Mini-KPCs?

Development projects typically measure their impact and result-level indicators at baseline and midterm, when only 40% of the project is left to be completed, allowing little time to adjust strategy and focus on hard-to-change behaviors. Food for the Hungry has used mini-KPCs in Title II, PEPFAR, and Child Survival programs to improve program effectiveness by targeting indicators that are not improving as expected within individual supervision areas.

What Are Mini-KPCs?

Mini-Knowledge, Practice and Coverage (KPCs) are short surveys (12 -20 questions) that are conducted every four to six months. The survey results can be easily analyzed by field offices and the results quickly obtained to inform program decisions. Performance by district can be determined with a small sample (e.g., 19 interviews/district) using the LQAS Survey Methodology.

Table 1: Traditional KPCs vs. Mini-KPCs

	Full KPC	Mini KPC
Number of Questions	Includes around 60 questions	Includes 12-20 questions
Timing	Conducted at baseline, midterm and final	Conducted frequently, every 4-6 months
Sample Size Required	Normally ~300-500 caregivers of children less than 59 months of age	Normally ~100 caregivers of children under 6 months of age and ~100 caregivers of children 6-24 months of age
Who is Surveyed	Population-based sample	Beneficiary-based sample
Staff time required	Requires a large amount of staff time for training, implementation and analysis	Once staff are trained on the methodology, only short refresher and new questionnaire trainings are needed
Staff expertise required	Advanced statistical analysis skills required	Staff with little statistical training can do the analysis and quickly use the results
Type of information provided	Attempts to provide information that allows for a program (or program area) to be completely assessed or evaluated	Attempts to provide frequent feedback about specific aspects of a program

Staffing requirements	Requires large team of staff operating full time for multiple weeks	After a one day training about a new questionnaire, staff can conduct the surveys as part of their normal community work

Implementing Mini-KPCs

- Mini-KPCs should be scheduled every 4-6 months, considering the timing of the baseline, midterm and final evaluations. If a larger evaluation is planned, there is no need to do a Mini-KPC.
- The Mini-KPC should track the indicators listed in the project proposal. If during the length of activity you decide you want to track additional indicators, you will not have baseline data with which to compare your results to.
- Survey questionnaires should be developed to measure specific indicators the program is targeting and hopes to improve.
- Keep in mind that Mini-KPC's are **beneficiary** based surveys and not **population** based surveys. The results of beneficiary based surveys cannot be compared to population based surveys. For example, if your baseline survey was population based and you found that 35% of mothers were exclusively breastfeeding their 0-6 month old children you could not say that EBF had improved if you found that 65% of your beneficiaries were exclusively breastfeeding during your first Mini-KPC. The Mini-KPC results indicate that your beneficiaries are practicing EBF more than the general population of the area, but you have not yet measured program results.

Table 2: Mini-KPC Schedule (Example)

Program Years	Year 1				Year 2				Year 3				Year 4				Year 5			
Quarters	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Survey Type	Baseline KPC		Mini-KPC 1			Mini-KPC 2			Midterm KPC			Mini-KPC 3			Mini-KPC 4			Final KPC		
Indicator 1	x		x						x									x		
Indicator 2	x		x						x			x			x			x		
Indicator 3	x		x						x									x		
Indicator 4	x		x						x						x			x		
Indicator 5	x		x						x						x			x		
Indicator 6	x		x						x			x						x		
Indicator 7	x		x						x									x		
Indicator 8	x		x						x									x		
Indicator 9	x					x			x									x		
Indicator 10	x					x			x						x			x		
Indicator 11	x					x			x			x			x			x		

Indicator 12	x					x			x									x		
Indicator 13	x					x			x									x		
Indicator 14	x					x			x						x			x		
Indicator 15	x					x			x						x			x		
Indicator 16	x					x			x						x			x		
Indicator 17	x								x			x						x		
Indicator 18	x								x			x						x		
Indicator 19	x								x			x						x		
Indicator 20	x								x			x						x		

Benefits of Mini-KPCs

- LQAS is used to determine progress at the supervision area level, allowing each area to focus on its problem indicators.
- Regular monitoring using LQAS and a simple-to-use Excel spreadsheet for data analysis allows field-based monitoring and evaluation staff, with little training, to quickly analyze data and provide survey results to program management.
- Since results are quickly obtained at the project area, they can be immediately used to inform programming decisions.
- Frequent and regular monitoring by supervision area allows program managers to identify slow moving indicators and tailor programming to focus on problem areas, both technically and geographically.

<u>Using LQAS with Care Groups to Select Survey Respondents</u>

Note: This section is not intended to be a primer on LQAS, but how to use LQAS in an area where the population you desire to sample is already organized into Care Groups. For training manuals on LQAS please go to: www.coregroup.org/our-technical-work/working-groups/monitoring-and-evaluation

LQAS is the sampling method used for Mini-KPC's for three reasons:

1. **LQAS allows for a small sample to be taken.** Care Group projects try to keep the cost per beneficiary low, so as many people as possible can be reached with life-saving information. It is important that time and resources are invested into monitoring and evaluation, but the majority of staff time and resources should be focused on creating behavior change. LQAS has a design effect of one. This allows a small sample to provide reasonably specific results with a low investment in time and money.
2. **LQAS provides supervision level information to inform program decisions.** LQAS divides the population to be sampled into supervision areas. A sample of at least 19 is taken from each supervision area and survey results indicate if a region of the project is performing above or below the program average, allowing program management to know where resources and efforts need to be focused in order to reach program goals.

3. **LQAS allows for a point estimate to be calculated to measure project progress toward an indicator.** This allows program management to track indicator progress at the project level.

Criteria for using LQAS in a Care Group Project:

1. The population you wish to sample must be all or some of the Care Group participants. For example if you wish to sample men ages 18-55, you cannot use Care Groups. If you wish to sample all pregnant women you could use Care Group participants. If you wish to sample all women with children 6-23 months of age you could use Care Group participants.
2. Your Care Groups must have been formed including all women in a geographic area who fit the criteria for inclusion in Care Groups.
3. You need to have lists of all your Care Group participants. These lists should be made according to the numbering system described in Lesson 6: Numbering Care Groups.

Decisions to Make before Setting up your Sampling Frame:

1. What is the total sample you want to collect? Normally we aim to collect a total sample of 96. To allow room for error, we usually try and collect about 10% more samples than we need. So a total sample size of 106 will likely result in at least 96 good samples being collected.
2. How many Supervision Areas will you divide your project area into? A sample between 19 and 50 should be collected in each supervision area. So if your total desired sample is 96, then you can have a maximum of five supervision areas and a minimum of 3.

Steps to using LQAS in a Care Group Project:

1. Divide your project area into supervision areas.
2. List all the Care Groups in each district.
3. Divide the total number of Care Groups in a district by the number of interviews scheduled to be done in each district in order to obtain the sampling interval.
4. Select a random number between 1 and the sampling interval. The first Care Group with the corresponding number will be the first selected. Add the sampling interval to the random number to select the 2nd Care Group. Add the sampling interval to the previous CG number until all the Care Groups where interviews should occur have been identified.

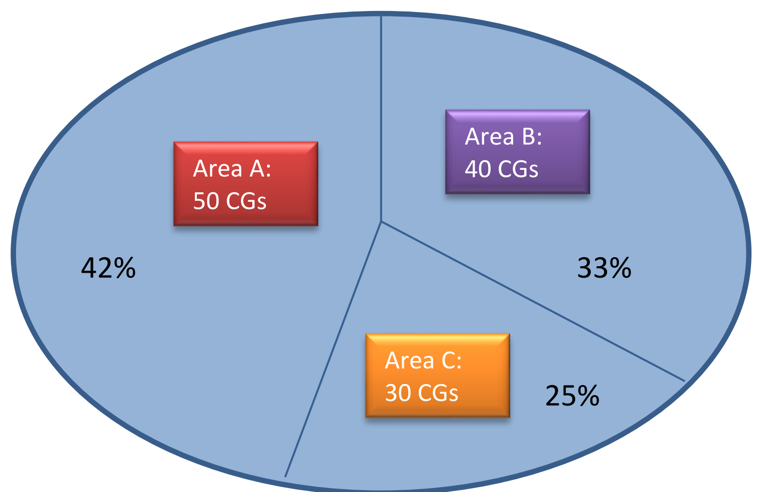

Figure 1: Sample CG Project Area, Total Number of CGs = 120

5. In Table 3, Area A has 50 CGs and 35 Interviews need to be done there. (To determine the number of interviews needed in each area divide total number of samples desired by the number of supervision areas.) The sampling interval is determined by dividing 50 by 36. The random number in this example must be one because the sampling interval is 1.38. Notice that for Area C more than one interview is done is the first, fifth, tenth, etc… CG because the number of interview needed from the area is greater than the # of CGs.

Table 3: Selecting CGs in each Area for interviews.

Area A				Area B				Area C			
Care Groups:		50		Care Groups:		40		Care Groups:		30	
Interviews per Area:		36		Interviews per Area:		36		Interviews per Area:		36	
Sampling Interval:		1.38		Sampling Interval:		1.10		Sampling Interval:		0.83	
Random #:		1		Random #:		1		Random #:		1	
Samples Needed:	Selected Groups (always round down)	Care Group #:	Groups selected for sampling	Samples Needed:	Selected Groups (always round down)	Care Group #:	Groups selected for sampling	Samples Needed:	Selected Groups (always round down)	Care Group #:	Groups selected for sampling
1	1.00	1	x	1	1.00	1	x	1	1.00	1	x,x
2	2.38	2	x	2	2.10	2	x	2	1.83	2	x
3	3.75	3	x	3	3.20	3	x	3	2.65	3	x
4	5.13	4		4	4.30	4	x	4	3.48	4	x
5	6.50	5	x	5	5.40	5	x	5	4.30	5	x,x
6	7.88	6	x	6	6.50	6	x	6	5.13	6	x
7	9.26	7	x	7	7.61	7	x	7	5.95	7	x
8	10.63	8		8	8.71	8	x	8	6.78	8	x
9	12.01	9	x	9	9.81	9	x	9	7.61	9	x
10	13.39	10	x	10	10.91	10	x	10	8.43	10	x,x
11	14.76	11		11	12.01	11		11	9.26	11	x
12	16.14	12	x	12	13.11	12	x	12	10.08	12	x
13	17.51	13	x	13	14.21	13	x	13	10.91	13	x
14	18.89	14	x	14	15.31	14	x	14	11.73	14	x
15	20.27	15		15	16.41	15	x	15	12.56	15	x,x
16	21.64	16	x	16	17.51	16	x	16	13.39	16	x
17	23.02	17	x	17	18.61	17	x	17	14.21	17	x
18	24.39	18	x	18	19.72	18	x	18	15.04	18	x
19	25.77	19		19	20.82	19	x	19	15.86	19	x,x
20	27.15	20	x	20	21.92	20	x	20	16.69	20	x
21	28.52	21	x	21	23.02	21	x	21	17.51	21	x
22	29.90	22		22	24.12	22		22	18.34	22	x
23	31.28	23	x	23	25.22	23	x	23	19.17	23	x
24	32.65	24	x	24	26.32	24	x	24	19.99	24	x,x
25	34.03	25	x	25	27.42	25	x	25	20.82	25	x
26	35.40	26		26	28.52	26	x	26	21.64	26	x
27	36.78	27	x	27	29.62	27	x	27	22.47	27	x
28	38.16	28	x	28	30.72	28	x	28	23.29	28	x
29	39.53	29	x	29	31.83	29	x	29	24.12	29	x

30	40.91	30		30	32.93	30	x	30	24.94	30	x
31	42.28	31	x	31	34.03	31	x	31	25.77		
32	43.66	32	x	32	35.13	32	x	32	26.60		
33	45.04	33		33	36.23	33		33	27.42		
34	46.41	34	x	34	37.33	34	x	34	28.25		
35	47.79	35	x	35	38.43	35	x	35	29.07		
36	49.17	36	x	36	39.53	36	x	36	29.90		
		37				37	x				
		38	x			38	x				
		39	x			39	x				
		40	x			40					
		41									
		42	x								
		43	x								
		44									
		45	x								
		46	x								
		47	x								
		48									
		49	x								
		50									

6. In each selected Care Group, a random number is used to determine which CGV to interview. Then a list of the selected CGVs and all her NW is produced and a random number is used to determine which NW to interview. If the first NW selected had a child 0-5 months of age, then another random number was drawn until a mother with a child 6-23 months of age was selected.

Figure 2: Selecting women to be interviewed from the Care Groups.

Care Group #:	Groups selected for sampling
1	x

Care Group 1 is selected for an interview. All the CGVs are listed. A random number between 1 and 12 is selected. In this example, CGV #3 is selected.

Care Group 1	CG Volunteers	Random Number
	1	
	2	
	3	x
	4	
	5	

The CGV#3 is listed with all her NW. A random number between 1-13 is chosen. In this example, #13 is selected and the CGV is chosen for the interview.

CG Volunteer and Neighbor Women	Random Number
1	
2	
3	
4	
5	

6	
7	
8	
9	
10	
11	
12	

6	
7	
8	
9	
10	
11	
12	
13 (CGV#3)	x

Conducting Interviews

1. A practical way to do this in the field is determine which Care Group and CG Volunteers are selected for interviews in each area. Then, call the CG Volunteers that were selected randomly and use her register select another random number which will determine which NW to interview. (Remember to assign the CGV a random number so that she has equal chance of being selected as her NW.) Then have the CG Volunteer lead you to the randomly selected NW. (Before the survey, set a strategy for the number of times you will return to find CGVs who do not show up or NW who are not in their homes. A selection bias can be introduced if you only interview women from CGV's who come to the central meeting place or only Neighbor Women who are home from 12 to 5pm in the afternoon.)
2. Interviews should be conducted by project personnel who do not directly supervise the work of the CG Promoter, CGV or NW, but do fluently speak the language of the respondents. Enumerators could be hired, but normally FH switches CG project personnel from one project area to another.
3. It is important that the surveys are reviewed by the supervisors before leaving the village where interviews were done. Many errors can be caught and corrected if a review is done in the field.

Weighting Results

1. If your population is evenly distributed you will not need to weight your results. If your population is unevenly distributed you will need to weight the results based on the percentage of your beneficiary population in each supervision area. The example in Figure 4 requires weighting.
2. Determine what percent of the population is in each supervision area. Since Care Groups target all women in a community with certain age or family characteristics and divide them into groups based on geography, the number of Care Groups in a supervision area can tell you what percent of your project population is found in each supervision area. In Figure 1, 42% of the population is in Area A (50 CG/120 CG X 100 = 42%).
3. The table below shows the results for a sample survey question.

a. The percent who answered the question correctly in each Supervision Area is calculated.
b. Then a point estimate is calculated for the combined project area (55/108) = 51%. This is the Unweighted Average Coverage.
c. Next compare the results for each Supervision Area to the Unweighted Average Coverage. If the Supervision Area's results are below the Average Coverage for the combined project area it means that area is below average performance and vice versa.
d. To determine the weighted Average Coverage multiply the area results by the percentage of the beneficiary population in each Supervision Area. Add the results for each Supervision Area to find the Weighted Project Area Average Coverage.

Table 4: Sample Survey Question

	Area A		**Area B**		**Area C**	
Survey Results for a sample survey question	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
	12	36	24	36	19	36
Area Results	33%		67%		53%	
Project Area Average Coverage (unweighted)	51%	The average is found by summing the results for each supervision area and then dividing by the total number of supervision areas. In this case it's (33%+67%+53%)/3 = 51%				
Area above average or below?	**Below** (33% is below the project area average of 51%)		**Above** (67% is above the average)		**Above** (53% is above the average)	
% of beneficiary population in each area	42%		33%		25%	
Weighted Project Area Average Coverage	49%	The weighted project area average is found by multiplying the result for each area by the % of beneficiary population in each area and then summing up the results. In this example the formula is (33%x42%)+(67%x33%)+(53%x25%)=49%				

Annex 6: Care Group Budget Forms

Food for the Hungry Care Group Program Budget Template	Unit	Unit Cost (USD)	Year One			Year Two			Year Three			Year Four			Year Five			Total Cost (USD)
			Qty	Alloc %	Ann. Cost	Qty	Alloc %	Ann. Cost	Qty	Alloc %	Ann. Cost	Qty	Alloc %	Ann. Cost	Qty	Alloc %	Ann. Cost	
I. Personnel Salaries																		
International Staff																		
(Country Director)	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
(Finance Director)	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
(Program Director	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
(BCC Advisor)	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 1	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 2	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
International Staff Subtotal					**$ -**			**$ -**			**$ -**			**$ -**			**$ -**	**$ -**
National Staff																		
Grant Finance Manager	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Accountant	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
M&E Manager	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
M&E Assistant	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
HR Manager	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
HR Assistant	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Logistics/ Procurement Manager	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
MCHN Coordinators	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
MCHN Supervisors	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
CG Promoters	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Administrative Assistants	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Drivers	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Cleaners	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Guards	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 1	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 2	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 3	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 4	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 5	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 6	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 7	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 8	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 9	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 10	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
National Staff Subtotal					**$ -**			**$ -**			**$ -**			**$ -**			**$ -**	**$ -**
I. Personnel Salaries Total					**$ -**			**$ -**			**$ -**			**$ -**			**$ -**	**$ -**
II. Benefits and Fringe																		
International Staff																		
(Country Director)	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
(Finance Director)	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -

(Program Director	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
(BCC Advisor)	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 1	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 2	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
International Staff Subtotal					**$ -**			**$ -**			**$ -**			**$ -**			**$ -**	**$ -**
National Staff																		
Grant Finance Manager	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Accountant	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
M&E Manager	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
M&E Assistant	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
HR Manager	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
HR Assistant	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Logistics/ Procurement Manager	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
MCHN Coordinators	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
MCHN Supervisors	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
CG Promoters	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Administrative Assistants	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Drivers	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Cleaners	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Guards	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 1	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 2	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 3	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 4	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 5	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 6	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 7	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 8	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 9	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
Additional Position 10	Staff	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	0	0%	$ -	$ -
National Staff Subtotal					**$ -**			**$ -**			**$ -**			**$ -**			**$ -**	**$ -**
II. Benefits and Fringe Total					**$ -**			**$ -**			**$ -**			**$ -**			**$ -**	**$ -**
III. Contractual Labor																		
Illustration of CG Materials	Lesson	$ 320	15	100%	####	18	100%	####	12	100%	####	0	100%	$ -	0	100%	$ -	#####
Translation of CG Materials	Page	$ -	64	100%	$ -	78	100%	$ -	53	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Evaluators (Midterm and Final)	Days	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
External Trainers	Days	$ -	0	100%	$ -	3	100%	$ -	1	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
III. Contractual Labor Total					**####**			**####**			**####**			**$ -**			**$ -**	**#####**
IV. Travel and Transport																		
International Travel																		
Regional Office Monitoring Trips- Airfare	Rnd Trp	$ -	4	100%	$ -	2	100%	$ -	2	100%	$ -	2	100%	$ -	2	100%	$ -	$ -
Per Diem & Lodging	Days	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -

Visa & Other Travel	Rnd Trp	$ -	4	100%	$ -	2	100%	$ -	2	100%	$ -	2	100%	$ -	2	100%	$ -	$ -
HQ Monitoring/Training Trips-Airfare	Rnd Trp	$ -	8	100%	$ -	5	100%	$ -	3	100%	$ -	2	100%	$ -	3	100%	$ -	$ -
Per Diem & Lodging	Days	$ -	144	100%	$ -	90	100%	$ -	54	100%	$ -	36	100%	$ -	54	100%	$ -	$ -
Visa & Other Travel	Rnd Trp	$ -	8	100%	$ -	5	100%	$ -	3	100%	$ -	2	100%	$ -	3	100%	$ -	$ -
International Travel Subtotal					$ -			$ -			$ -			$ -			$ -	$ -
Domestic Travel																		
Vehicle- Purchase	Vehicle	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Registration	Vehicle	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Mileage	Km	$ -	#####	100%	#####	#####	100%	#####	#####	100%	#####	#####	100%	#####	#####	100%	#####	#DIV/0!
Insurance	Vehicle	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Repair	Vehicle	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Motorbike- Purchase	Bike	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Mileage	Km	$ -	#####	100%	#####	#####	100%	#####	#####	100%	#####	#####	100%	#####	#####	100%	#####	#DIV/0!
Insurance	Bike	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Repair	Bike	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Safety Equipment	Bike	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Bicycles- Purchase	Bicycle	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Repair	Bicycle	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Domestic Travel Subtotal					#####			#####			#####			#####			#####	#DIV/0!
IV. Travel and Transport Total					#####			#####			#####			#####			#####	#DIV/0!
V. Programmatic Supplies and Materials																		
Office Supplies																		
Country Office- Office Rent	Month	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	$ -
Utilities and Services	Month	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	$ -
Supplies	Month	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	$ -
Program Office- Office Rent	Month	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	$ -
Utilities and Services	Month	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	$ -
Supplies	Month	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	12	0%	$ -	$ -
Mobile phone purchase	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Laptop Computers (Software & Case)	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Desktop Computers and Software	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Printer	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Camera	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Other Program Office Expense 1	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Other Program Office Expense 2	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Other Program Office Expense 3	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Office Supplies Subtotal					$ -			$ -			$ -			$ -			$ -	$ -
Programmatic Supplies and Materials																		
Care Group Start-up Training for Supervisors (TOT)	Day	$ -	14	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Local Determinants of Malnutrition Survey	Day	$ -	6	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -

Orient communities to the CG Program	Day	#DIV/0!	0	100%	#####	0	100%	#####	0	100%	#####	0	100%	#####	0	100%	#####	#DIV/0!
Interview and Hire Promoters	Day	#DIV/0!	0	100%	#####	0	100%	#####	0	100%	#####	0	100%	#####	0	100%	#####	#DIV/0!
Care Group Start-up for Promoters	Day	$ -	14	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Census and Formation of Care Groups	Day	#DIV/0!	0	100%	#####	0	100%	#####	0	100%	#####	0	100%	#####	0	100%	#####	#DIV/0!
Educational Methods & Module 1 TOT for Supervisors	Day	$ -	4	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Educational Methods & Module 1 Training for Promoters	Day	$ -	4	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
TOT for Supervisors, Modules 2-7	Day	$ -	0	100%	$ -	6	100%	$ -	4	100%	$ -	2	100%	$ -	2	100%	$ -	$ -
Training for Promoters, Modules 2-7	Day	$ -	0	100%	$ -	6	100%	$ -	4	100%	$ -	2	100%	$ -	2	100%	$ -	$ -
CG Curriculum Printing: Flipcharts	Lesson	$ -	15	100%	$ -	18	100%	$ -	12	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
CG Curriculum Printing: Lesson Plans	Lesson	$ -	15	100%	$ -	18	100%	$ -	12	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Model Family Posters	Poster	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Pamphlets/Additional Materials	Material	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Bags for CGVs to carry the Flipcharts	Bag	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Annual Health Incentives for CGVs	Incentive	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Other CGV Incentives	Incentive	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
ID Badges for Project Staff	Badge	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Backpacks for Project Staff	Backpk	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Other CG Related Expenses 1	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Other CG Related Expenses 2	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Other CG Related Expenses 3	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 1.1.1	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 1.1.2	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 1.1.3	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 1.2.1	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 1.2.2	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 1.2.3	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 1.3.1	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 1.3.2	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 1.3.3	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 2.1.1	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 2.1.2	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 2.1.3	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 2.2.1	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 2.2.2	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 2.2.3	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 2.3.1	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 2.3.2	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 2.3.3	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 3.1.1	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 3.1.2	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -

Sub-Activity 3.1.3	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 3.2.1	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 3.2.2	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 3.2.3	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 3.3.1	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 3.3.2	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Sub-Activity 3.3.3	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Programmatic Supplies and Materials Subtotal					#####			#####			#####			#####			#####	#DIV/0!
Monitoring and Evaluation																		
Baseline Evaluation	Day	#DIV/0!	1	100%	#####	0	100%	#####	0	100%	#####	0	100%	#####	0	100%	#####	#DIV/0!
Midterm Evaluation	Day	#DIV/0!	0	100%	#####	0	100%	#####	1	100%	#####	0	100%	#####	0	100%	#####	#DIV/0!
Final Evaluation	Day	#DIV/0!	0	100%	#####	0	100%	#####	0	100%	#####	0	100%	#####	1	100%	#####	#DIV/0!
Mini-KPC Trainings and Surveys	Day	#DIV/0!	0	100%	#####	0	100%	#####	0	100%	#####	0	100%	#####	0	100%	#####	#DIV/0!
Care Group Operation Research	Day	#DIV/0!	0	100%	#####	0	100%	#####	0	100%	#####	0	100%	#####	0	100%	#####	#DIV/0!
Additional Operational Research	Day	#DIV/0!	0	100%	#####	0	100%	#####	0	100%	#####	0	100%	#####	0	100%	#####	#DIV/0!
Neighbor Women Registers	Reg	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
CG Volunteer Registers	Reg	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Monitoring Forms	Page	$ -	2	100%	$ -	8	100%	$ -	8	100%	$ -	8	100%	$ -	4	100%	$ -	$ -
Subtotal Monitoring and Evaluation					#####			#####			#####			#####			#####	#DIV/0!
V. Programmatic Supplies and Materials Total					#####			#####			#####			#####			#####	#DIV/0!
VI. Equipment Purchase > $5,000 USD																		
Vehicle Purchase (Including VAT)	Vehicle	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Other equipment >$5,000USD A	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Other equipment >$5,000USD B	Unit	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
VI. Equipment Purchase > $5,000 USD Total					$ -			$ -			$ -			$ -			$ -	$ -
VII. Other																		
USAID Branding & Marketing: Signage	Signs	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
USAID Branding & Marketing: Motorbike Branding	Bikes	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
T-Shirts for Project Staff	Staff	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
Caps for Project Staff	Staff	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	0	100%	$ -	$ -
VII. Other Total					$ -			$ -			$ -			$ -			$ -	$ -
TOTAL DIRECT COSTS					#####			#####			#####			#####			#####	#DIV/0!
INDIRECT COST (NICRA RATE OF 0.1636)					#####			#####			#####			#####			#####	#DIV/0!
TOTAL COSTS					#####			#####			#####			#####			#####	#DIV/0!

Annex 7: Curriculum Development and Overview

Summary: This annex is broken into three parts:

Part 1: Designing new curriculum for your program? Basic guidance to help you develop your own Care Group materials.
Part 2: Care Group Lesson Lists (samples)
Part 3: Considering using another organization's materials for your program? Basic guidance to help you when considering using another organization's materials.

Part 1: Designing new curriculum for your program?

Use the guidance below to help you plan.

The following paragraphs describe the principles of designing quality, new curriculum for your program. The core principles are:

1) Know your audience
2) Study your target audience through formative research
3) Plan for sustained teaching
4) Develop materials that align with the principles of adult learning
5) Pretest the materials
6) Make your materials durable
7) Make your materials the appropriate size

Know your audience (target): Make sure that you narrowly define your target audience before you begin developing materials. Consider their age, social status, language, education level, current behaviors and practices as well as the things that have prevented them from doing the "key practices" in the past. The more you understand the needs of your audience the easier it will be to develop materials for them.

Consider their **reading ability.** Choose the grade level that best represents the majority (95%) of the target audience. It is better to choose a lower level than assume a higher level of reading. Once you begin to develop materials, you should test the reading level of the materials to assess how well you have written to the level of the audience.[15]

Study them (formative research): Once you have narrowly defined the people who will be receiving the messages (your target audience), it is best to study them to test your assumptions. A baseline survey (e.g. standard Knowledge, Practice, and Coverage (KPC)

[15] One option for testing reading level of completed materials is the SMOG test FHI (2002) Developing Materials on HIV/AIDS/STIs for Low-Literate Audiences. Arlington, U.S.A (page 145-146).

surveys) is a great way to gather information about current practices.[16] *Barrier Analysis,* a rapid assessment tool for community health and development projects, can be conducted to identify behavioral determinants associated with a particular behavior.[17]You may also consider in depth focus groups, positive deviant inquiries (such as the Local Determinants of Malnutrition Study[18]), and other formative research methods to gather more information about your target audience and behaviors. Use this research to develop key messages for your audience.

For more information about defining target audience and messages (include guidelines for Barrier Analysis), please see the *Designing for Behavior Change Curriculum.*[19]

Plan for sustained teaching (# of modules): Determine how many lessons will be taught each month (usually about 2 lessons per month) and how long your program will last. Once you know how many lessons will be taught over the life of your program, you will be able to better budget for the development and production of materials.

For example, imagine you are managing a 3 year project and the Care Groups will meet every two weeks for 2 of those years (excluding 12 months for start-up workshops, hiring of staff, and closeout activities). In this example, you could design approximately 50 lessons (26 lessons per year) to sustain two years of teaching. Alternatively, you could choose a smaller number of lessons that are repeated throughout the project. For example you may want to focus on just 25 lessons which are repeated twice during the project.

A sample Care Group Materials list can be found at the end of this document.

Develop materials that align with the principles of adult learning: Don't assume the facilitators know *how* to teach in a participatory way. Include guidance and instructions in the text so that teaching is participatory with discussion questions, small group activities, demonstrations and time to discuss challenges to the new behaviors. For more information about adult learning theory, refer to the Adult Learning Theory trainings conducted by Freedom from Hunger (see website below).

Food for the Hungry uses a standard format for each lesson including games, discussion about current practices, stories, activities, discussion of barriers and time for making commitments.

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[16] For more information about how to conduct and analyze KPC survey, a series of tools and resources are available on Maternal and Child Health Integrated Program (MCHIP)'s website: http://mchipngo.net/controllers/link.cfc?method=tools_mande

[17] For more information about Barrier Analysis, please see the Barrier Analysis Facilitator's Guide by Food for the Hungry (2004) available on: http://www.caregroupinfo.org/docs/Barrier_Analysis_Facilitator_Guide.pdf

[18]An expanded positive deviant inquiry developed by Food for the Hungry, to identify local associations between behaviors and malnutrition. A manual for the Local Determinants of Malnutrition (LDM) is under development.

[19] The 2008 Designing for Behavior Change Curriculum is available on the CORE Group website (http://www.coregroup.org/storage/documents/Workingpapers/dbc_curriculum_final_2008.pdf); the 2011 version will be finalized and distributed by the TOPS program in 2012.

For more about Food for the Hungry's materials, see the website: www.caregroupinfo.org.

Pretesting Materials: Once the first draft of materials is developed it is best to test them with small groups or with individual interviews (the latter work best for low-literacy reviews). Test the materials and images for understanding, acceptance and "inducement to action." The materials should promote particular behaviors or actions - make sure the audience receives the same message which you intended.

Make durable materials: Care Group materials should be built to last so that teaching can continue in the community after a project closes. Ideally, teaching aids/tools (e.g. flipcharts) should printed be on laminated cardstock bound at either the side or the top. This keeps the pages together, helps them resist mildew and deterioration.

Size of Materials: Because the Neighbor Women and CG Volunteers will be meeting in small groups of approximately 12 women, the materials need to be large enough so that each woman in the group can see the pictures (or other visuals) at a distance. We recommend A3 picture pages which are bound into a flipchart or flipbook. Images are large enough for the women to see, but lightweight enough for the Care Group Volunteers to carry when walking in the community.

Resource to guide the development of new materials:

1. FHI (2002) Developing Materials on HIV/AIDS/STIs for Low-Literate Audiences. Arlington, U.S.A Available: http://www.rhrc.org/resources/sti/hivaidsmanual/resources/from-web/lowlitguide2.pdf

Part 2: Care Group Lesson List #1
Sample Care Group Lesson Grouped by Topic

Food for the Hungry prints their Flipcharts (i.e. teaching aids) in a series of Modules. Each Module contains around 6-12 lessons addressing a specific health topic.

Module 1: Essential Nutrition Action (ENAs): Prenatal nutrition & breastfeeding

1. Nutrition for pregnant and lactating mothers – supplements; use of iodized salt; prevention of anemia
2. Antenatal Care, Advantages of Delivery at Health Center and Maternal Danger Signs
3. Preparing for Delivery and Birth
4. Early initiation of breastfeeding
5. Newborn Care
6. Maternal Postpartum Care
7. Exclusive breastfeeding

Module 2: ENAs: Complementary Foods & Micronutrients

1. Complementary feeding 6-8 months:
2. Complementary feeding 9-12 months:
3. Complementary Feeding and Continued Breastfeeding (13-23 months)
4. Positive Deviant foods/practices, use of snacks, and men's responsibility for child nutrition
5. Sanitary Meal Preparation for young children; hygiene
6. Importance of vitamin A foods, vitamin A supplementation
7. Micronutrients: Importance of iron-rich and other nutrient-rich foods
8. Growth monitoring and promotion, nutritional counseling, and referral for growth faltering

Module 3: Essential Hygiene Actions (EHAs)

1. Diarrhea defined, transmission, signs and symptom, including danger signs
2. Hand washing with soap or ash
3. Creation of household hand washing stations / Tippy Tap and Dish Drying Racks
4. Disposal of feces, latrines, and de-worming (of children and pregnant women)
5. Point of use water purification and proper storage of water
6. Proper feeding of sick children: ORS/RHFs, increased breastfeeding, & complementary feeding during & after illness

Module 4: Malaria & Parasites

1. Malaria transmission and effects for children, pregnant women, and food security
2. Prevention using insecticide treated nets (ITN), household spraying, and IPT for pregnant women
3. Early recognition of malaria, care seeking, and ACTs
4. Parasites (intestinal and liver) defined and their effects on food security
5. Parasite transmission and prevention using EHA
6. Promotion of regular treatment of parasites (intestinal and liver)

Module 5: Acute Respiratory Infections

1. ARI defined, transmission, signs and symptoms
2. ARI prevention
3. Prompt treatment of ARI and early recognition of the danger signs of pneumonia
4. Recognizing tuberculosis and promoting prompt and complete treatment

5. Proper feeding of sick children and general danger signs
6. Preparing for graduation and how to maintain your Care Group and your results

Module 6: HIV/AIDS and Preventing Mother-To-Child-Transmission (6 lessons)

1. HIV and AIDS symptoms and transmission
2. HIV prevention
3. HIV stigma effects on food security and decreasing stigma
4. Promotion of HIV testing and treatment
5. Prevention of Mother-to-child Transmission of HIV
6. Proper nutrition for HIV+ children and adults

Module 7: Family Planning

1. Family Planning Introduction (benefits)
2. LAM Method
3. The Two Day Method
4. Cycle Beads
5. Health Facility Options
6. Talking with you Partner about Family Planning (negotiation skills)

Sample Care Group Lesson List #2 (grouped by stage in pregnancy)

Module 1: ENAs/EHAs Actions and Other Important Care during Pregnancy

1. Introduction to Care Groups
2. Teaching Techniques
3. Mother Leader Responsibilities
4. Watching for Change and Monitoring Groups

Module 2: ENAs/EHAs Actions and Other Important Care during Pregnancy

5. Antenatal Care and Health Center Births
6. Materna Nutrition and Anemia Prevention
7. Iodized Salt and Iron-rich Foods
8. Hand Washing with Soap/ash
9. Creation of HH Hand washing Stations
10. Preventing Malaria in Pregnant Women
11. Preparing for Birth and Delivery
12. Immediate Breastfeeding
13. Newborn Care Practices

Module 3: ENAs and EHAs during Early Infancy

1. Importance of Postpartum Care
2. Exclusive Breastfeeding (benefits, on demand, HIV)
3. Exclusive Breastfeeding (overcoming barriers)
4. General Danger Signs during Childhood Illness
5. Breastfeeding Problems and Care of the Breasts
6. Importance of Clinical Services
7. Men’s Involvement in BF and Child Care

8. Child Spacing
9. POU Water Purification
10. Proper Disposal of Feces
11. Malaria Transmission and Prevention
12. When a Child has Malaria: First Response and Home Care

Module 4: ENAs and EHAs during Late Infancy and Childhood

1. Good Complementary Feeding (6-8 months)
2. Good Complementary Feeding (9-11 months)
3. Complementary Feeding (1-2 years)
4. Recipes: Proper Use of Rations
5. Vitamin A rich Foods and Vitamin A Supplementation (children and Postpartum
6. Worms and Deworming
7. Proper Storage/ Sanitary Food Preparation

Module 5: Management of Common Childhood Infections

1. Signs of Dehydration & Why Dehydration is Deadly
2. Prevention of Dehydration with ORT
3. Proper Feeding of Sick Children
4. Deadliest Types of Diarrhea – Dysentery and Persistent Diarrhea
5. Prevention of Pneumonia and Care Seeking
6. Home Vegetable Gardening

Part 3: Considering using another organization's materials for your program?

Ask other non-profit organizations if they can share their materials (e.g. Food for the Hungry Tear Fund, Freedom from Hunger, World Relief, CARE, Save the Children, and Compassion International).

Below are a few online resources where Care Group curriculum is publically posted.

- Care Group Info http://www.caregroupinfo.org (View the curriculum page)
- Freedom From Hunger http://www.ffhtechnical.org/resources/education-modules
- Infant and Young Child Nutrition Project http://www.iycn.org/2011/07/strengthening-community-nutrition-programming-2/
- Media Materials Clearinghouse http://www.m-mc.org/ (search by topic and media type) Materials will have to be adapted to fit the Care Group setting.
- K4Health (Knowledge for Health http://www.k4health.org/

Use the guidance below to guide you to decide whether to use existing materials/resources.

1. Find out if the materials can be reprinted and used (with no cost) for non-profit proposes. Some organizations require that you request PERMISSION. Contact the author of the materials if the copyright information is not clear in the manual.

2. Read the MAIN OBJECTIVES of the curriculum. Look at the objectives for each session. Compare this list with the objectives *your* program (those outlined in the proposal). Identify the proposal objectives that are NOT covered and write them down. Write down a few ideas of how you could overcome this discrepancy if you were to adapt the materials.

3. Review the WORLDVIEW expressed in the materials. Do the materials acknowledge God and Jesus appropriately? Does the subject matter reinforce the truths of God's word, or does it conflict with the truths of God's word? Write down the differences that you see. Write down a few ideas of how you could overcome this discrepancy if you were to adapt the materials.

4. Consider the DESIGN (or theory) of the materials. Write down the differences that you see in the following areas.
    a. How is the subject matter taught? Do they use non-formal teaching techniques or formal teaching techniques? For example, if the proposal says FH will use non-formal educational techniques to teach beneficiaries, but the manual uses lectures and large group presentations

(formal education techniques), this is a difference in theory that you should document.

b. How are the beneficiaries changed by the materials? If the proposal says that FH will use *behavior change theory (behavioral determinants)* to prevent HIV, but the manual uses *information and facts to persuade beneficiaries*, then this is a difference that needs to be documented.

5. Identify FOR WHOM the curriculum was developed (the target group). Compare this with the target group as written in the proposal. If they are NOT the same, make a note of the differences between the two groups. For example, if the manual is designed for couples when our program targets orphans and vulnerable children, this is a difference that should be noted. Write down a few ideas of how you could overcome this discrepancy if you were to adapt the materials.

6. Identify the TIME NEEDED for each lesson and the entire training. Compare this with the time as described on the proposal for these activities. For example, are the sessions 2 hours in length, when FH planned for 30-minute sessions? Is the entire training three weeks, when FH planned for six months of training? Write down the differences that you see. Write down a few ideas of how you could overcome this discrepancy if you were to adapt the materials.

7. Review the READING LEVEL of the materials using the two items below.
   a. Is this written for a small child (easy to understand) or a college professor (with many large words and complicated sentences)? *I*f the reading level is NOT the same as the reading level of the beneficiaries in the program write down an explanation of what needs to be changed so that the reading level can be adapted to the level of the beneficiaries.
   b. Is the format of the manual easy to follow? Based on the literacy level of the teachers in your program, will they be able to follow the formatting in the manual with ease? Write down any problems that you see. Write down a few ideas of how you could overcome the formatting difficulties if you were to adapt the materials.

8. Review the CULTURAL REFERENCES in the materials. Write down the stories, activities or discussions that are not appropriate to the beneficiary culture (using parts A and B below for guidance). Write down a few ideas of how you could adapt the materials to overcome these problems.
   a. Do the people in the pictures look like our beneficiaries? For example, if all of the illustrations are of Nigerians, and FH is using the materials in the Burundi, it would not be appropriate for the local culture.
   b. Are the people, discussions and situations in the manual similar to the people, discussions and situations of beneficiaries in your community? For example, if examples in the manuals include references to upper-

class citizens who struggle purchasing a new car, this example would not be relevant to a Burundian woman who doesn't have money to send her child to school.

Now review the notes that you have taken on the questions above.

- Questions 2, 3 and 4 are the MOST important questions! If you have large differences listed for these questions, you should look for OTHER materials. If the differences are small, you may consider deleting a few activities or adding supplemental sessions and activities so that they MATCH the program needs. However, if worldview and theory are NOT the same (or very similar), this will make it VERY DIFFICULT for you to meet your program objectives and justify the differences between your proposal intent and the materials that you have chosen. Make sure that you seek outside approval (and assistance) before making a decision when questions 2, 3 and 4 have large differences.
- Differences listed for questions 5, 6, 7 and 8 can be resolved with some work on your part. This requires someone who is willing and able (has the time) to work on adapting the materials so that the materials MATCH the intent of your program.
    - *a.* List the MAIN things that NEED to be changed in order to make these materials appropriate for the FH program?
    - *b.* List the NAMES of people on staff who are capable (and available) to do this.
    - c. Confirm that you are you ABLE (copyright information) to adapt the materials for your program? Contact the author if you are not sure. Some authors require that they approve the materials first, which may delay your efforts. Consider making a supplemental booklet to go along with the materials?
    - d. Consider the TIME that it will take to make these changes.
    - e. Decide if you are able to adapt, add supplemental text, or find new materials.

Remember the OBJECTIVES of your program! Don't choose new materials because they seem "fine." Choose the materials that are PROVEN to work, and MATCH the intent of your program. Don't attempt to change the proposal to match your materials; your materials need to MATCH the proposal.

Annex 8: How to Hire Care Group Promoters

The best Care Group Promoters already live in the communities where they will work and only have a secondary school education (or less in some countries)because they are the most likely to be willing to spend their days visiting groups of mothers and/or visiting women in their homes. They speak the local dialect of the women they are working with and are held accountable for their actions and behavior as they go about their daily activities since they are surrounded by their friends and extended family members. The disadvantage to working with such locally-based staff is that they may have to go through a process of changes themselves before they are convinced of the new information and practices they are being paid to promote. However, experience has proven that locally hired Care Group Promoters do try out the new practices they are taught, and as they experience the benefits they become powerful agents of change.

Many rural Care Group Projects make the mistake of announcing Care Group Promoter positions through local newspapers and in city centers. This can lead to a pool of professional candidates who have high expectations regarding salary and the benefits of working for a non-governmental organization. Often these people expect to work in an office and they desire to spend the majority of their time in the city, where they may have a house and their children may attend school. Such candidates may have more knowledge about the MCHN behaviors the Care Group project will promote, but typically they do not make the best Care Group Promoters.

Basic Care Group Promoter Qualifications are:

1. Able to read and write
2. Good reading comprehension in the language that the flipcharts are produced in
3. Basic math skills: addition, subtraction, able to calculate percentages
4. Nominated by the community she or he will serve for the position
5. Fluent in the local dialect and the professional language of the country
6. Be able and willing to be in the community five days a week. Normally, in a rural community this requires living in the community. Physically able to use the transport provided by the project (bicycle or motorcycle) to move around the project area
7. Able to travel to the provincial capital for 1-2 week periods for training
8. Willing to model practices taught in the Care Group curricula (e.g. using a latrine, hand washing station, mosquito net, etc.)
9. Able to speak confidently in front of groups of 12 people and facilitate discussion
10. Respectful and considerate of others

For a complete list of qualifications and the CG Promoter Job Description see Lesson 5.

Should Promoters be Male or Female?

Some Care Group projects only hire female Care Group Promoters. Food for the

Hungry has found that although Care Group Promoters work with groups of women, both men and women can make excellent Care Group Promoters. An advantage to having a male Care Group Promoter is that they: (1) tend to stay longer with the program, (2) can easily leave their families to attend trainings, (3) handle bicycles or motorcycles well, and (4) when conflicts arise in households because of new practices taught by the Care Group Program male Care Group Promoters can advocate with other men on behalf of the women. There is also an advantage to hiring female Care Group Promoters and some of the best Care Group Promoters in Food for the Hungry projects have been women. Female promoters: (1) can model new behaviors specific to women, (2) can more easily speak about sensitive subjects that normally are only discussed among peers of the same gender and (3) encourage CGVs to be leaders by modeling how to be a strong female community leader.

What if no one at the community level has the basic CG Promoter qualifications?
Occasionally, no one at the community level will be qualified to work as a CG Promoter. In this is the case, it is recommended that the grown children or extended family members of community members who have moved to larger cities for education or work be nominated by the community. If hired, such candidates would be expected to move back to the community for their period of employment.

Recommended Steps for Hiring Care Group Promoters:

1. Hire your Care Group Project or Program Manager, Coordinator(s), Supervisors(s) and any other management staff specific to your project.
2. Train them about Care Groups and how to start up a Care Group project using the lessons in this manual.
3. The Care Group Project or Program Manager, Coordinator(s), Supervisors(s) and any other management staff specific to the project orient communities about the program. Once communities understand what Care Groups are and how the project will operate, ask them to nominate 2-3 men and women from their community who they think will make good Care Group Volunteers. Make it very clear to community leaders that the NGO will select the best candidates through interviews and the results of reading and math tests.
4. A team of Care Group project personnel and Human Resource staff should interview candidates.
5. It is very important that candidates' reading comprehension and math skills be tested.
6. Occasionally none of the candidates nominated by the community will meet the qualifications. In this case, return the community and ask for additional nominations.
7. After you have selected all your Care Group Promoters train them on Care Groups and project start-up.

*If possible, we recommend that projects that have 20 or more Care Group Promoters hire one or two Promoter "floaters". These extra Promoters will not be assigned to a

specific community but fill in for 1-3 months when Care Group Promoters with permanent placements go on maternity leave or fall sick.

Sample Math and Reading Comprehension Test for Care Group Promoters

Directions: Encourage test takers to use calculators if they would like.

1. You are working with five (5) groups of women. Each group has ten (10) women in it. How many women in total are you working with?
   Answer: 5X10=50
2. What is the sum of the following ten numbers? 10, 15, 8, 12, 40, 43, 9, 11, 12, 45
   Answer: 205
3. 12 X 12 = ?
   Answer: 144
4. 120 / 30 = ?
   Answer: 4
5. If 25 out of 75 children are malnourished, what percent of children are malnourished?
   Answer: 1/3 or 33%
6. If two out of four households have a latrine. What percent of households have a latrine? **Answer: 2/4 = 1/2 or 50%**
7. Your goal is that at least 80% of women would exclusively breastfeed their 0-6 month old children. You do a survey and find that 60 women out of 80 women sampled do exclusively breastfeed their children. Have you met your goal?
   Answer: No, only 75% of women are exclusively breastfeeding.
8. You have:
   4 Care Groups
   Each Care Group has 12 CG Volunteers in it
   Each of the CG Volunteer reaches out to 10 Neighbor Women.
   How many Neighbor Women are being reached by your four Care Groups?
   Answer 4X12X10=480 women
9. You are told to visit each of your Care Group Volunteers once every three (3) months. You have a total of ninety (90) Care Group volunteers. Each month you have fifteen (15) days available to visit your Care Group volunteers. How many volunteers must you visit each day you have available to do visits to reach your target?
   Answer: 90/(3X15)= 2 visits per day

READING COMPREHENSION

Read the following passage then answer the questions below about what you have read.

Spotted Cats

Several members of the cat family have spotted fur. Do you know the

difference between a leopard, a jaguar, and a cheetah? From a distance they may appear somewhat similar. Examined at closer range, however, they are clearly different cats. They differ in various ways, including where they live, how big they are, how they move and hunt, and how their fur is marked.

Of all the big cats in the wild, the true leopard is found across the largest area. Leopards live in much of Asia and Africa. A leopard grows to be from 3 to 6 feet long, with an added 3 feet of tail. Leopards are skilled climbers that can hunt monkeys in trees. They can also lie in wait and pounce on passing prey. When food sources are scarce, they might eat fruit, field mice, and large insects. Leopard spots are not actually solid spots; they are broken circles.

The jaguar is native to the Americas. Its natural range is from the southern United States to northern Argentina, with the largest concentration of jaguars being in Brazil and Central America. The beauty and power of the jaguar inspired worship among ancient peoples. It measures between 3 and 6 feet long without the tail, which adds another 1 ½ to 2 ½ feet. Possessing a large head and body, the jaguar has legs that are shorter and thicker than a leopard's. Jaguars are excellent climbers and can also swim well. They dine on a variety of land, tree, and water creatures. Their fur can be a vivid yellow color or a rusty shade; their "spots" are called rosettes. Each rosette is large and black, consisting of a middle spot with a circle of spots around it.

Most cheetahs live in the wilds of Africa. There are also some in Iran and northwestern Afghanistan. The cheetah's head is smaller than the leopard's, and its body is longer. This cat is built for speed. Its legs are much longer than the leopard's, allowing it to run at speeds of up to 70 miles per hour! This incredible ability helps the cheetahs catch their dinner, which is usually an unfortunate antelope. A cheetah's spots are simply black spots, not rosettes or circles.

Other spotted cats include the smaller ocelot, mainly of Central and South America, and the lynx or bobcat, mainly of North America. What all of these cats have in common is that they are wild, powerful animals of tremendous grace and beauty.

10. **All of these are ways to tell the difference between spotted cats *except***

A. how big they are
B. what their spots look like
C. where they live
D. how beautiful they are

Answer: D

11. **Which words from the passage are used as persuasion in that they express an attitude of sympathy for animals that are prey to big cats?**

A . . . how they move and hunt . . .
B . . . might eat fruit, field mice, and large insects.
C . . . dinner, which is usually an unfortunate antelope.
D . . . that they are wild, powerful animals.

Answer: C

12. **Which of these is the best summary of this passage?**
    A. All spotted cats are powerful, beautiful, and graceful.
    B. Spotted cats may look similar, but they are different in many ways.
    C. There are many different spotted cats in the world.
    D. Spotted cats in the wild hunt many different kinds of animals.
    Answer: B

Note: This is a reading comprehension test designed for students who have completed grade 6 in the US. You can find tests online for lower grade levels if you think this test is too challenging for the majority of people in your country who have completed 6 grades of schooling.

Annex 9: The Care Group Beneficiary Calculator

The CG Calculator was created to assist CG program designers to quickly estimate the number of staff and CG Volunteers required to implement a CG program in a specific target area. Using national estimates such as the percentage of the population that is pregnant, less than two years of age and fertility rates, this calculator estimates the number of direct and indirect beneficiaries as well as the number of CGVs, CG Promoters and MCHN Supervisors needed.

The CG Beneficiary Calculator can be used in two ways:
Quick and General: To obtain a broad idea of how many staff and volunteers are needed to cover a program area designers need to know how many pregnant women and children less than five or two years of age are present in the area. Using the existing general population breakdowns in this calculator, a user's need only plug in the Care Group ratios and total population to find out how many CG Volunteers, CP Promoters, and MCHN Supervisors they will need to run a CG program.
Precise and Specific: To ensure that the calculations made by the Beneficiary Calculator are specific to the population targeted, the data tables can be adjusted using reference documents specific to the country or area you wish to work.

General Instructions for using the CG Beneficiary Calculator:
The majority of cells are locked to prevent the user from accidently erasing or changing a formula. Only the green cells are unlocked. If you find you need to unlock yellow cells, the password is "cg". To unlock cells using Office 2010 click on "review" on the task bar, then select "unprotect sheet" and enter the password, "cg". After you have made the changes desired, lock the worksheet making sure to keep the same password or record the new password.

Instructions for the "Quick and General" use of the CG Calculator:

1. On the "CG Bene" page, enter information for cells 18B, 19B, 20B, 21B specific to your CG program. Dropdown lists in these cells provide guidance on proper CG ratios.
2. On the same page, enter information for cells A26 –A37 and B26-B37 specific to your project's geographic area.
3. The rest of the page will calculate automatically.
4. See rows 43-54 to determine the number of beneficiaries, CGVs and project staff needed.

Number of Mother Beneficiaries (MB) per Care Group Volunteer (CGV)	10
Number of CGV in each Care Group	12
Number of Care Groups per Promoter	6
Number of Promoters per Supervisor	5

Instructions for the Precise and Specific use of the CG Calculator:

1. On the “Children per Woman” worksheet, use the first table to enter the information specific to your country or area. Write the name of your country in cell B3.
2. Refer to the last DHS done for your country. Look for the number of people included in the DHS survey and fill in cell D4. You may wish to put the page number where you found this information in cell E4 so you can easily reference it in the future.
3. Determine if the DHS indicates what number or percent of the people interviewed had children less than five and two years of age. If so, use this information to fill in cells B8 and B9 on the “CG Bene” page. If the DHS does not indicate the percentage less than two years of age, you can estimate it by assuming that the age distribution of all children less than five years of age is equal; meaning that approximately 40% of the children less than five years of age will be less than two years of age. If the DHS does not provide information about the percentage of children less than five you can also often find this information using the population pyramids at the US Census Bureau website. http://www.census.gov/ipc/www/idb/informationGateway.php
4. Fill in cell D7 and E7 on the “Children per Woman” page using information from the DHS or another reliable source.
5. Normally the DHS will provide the number of woman who gave birth in the last five years in the Antenatal Care Section of the report. The tables in the DHS report percentages, but they also provide the total numbers that when divided with the total number surveyed (cell D4) can estimate the percentage of the population.
6. The DHS should also indicate the percentage of women who gave birth less than 24 months since preceding birth and those who gave birth less than 60 months since the preceding birth. Fill in cell C14 on and C15 on the “Children per Woman” page with those percentages and note the page number where that information is located.
7. On the “CG Bene” page, fill in cell B6 and B7 using information from the DHS or the US Census Bureau.
8. Unlock the “CG Bene” page and make sure that cells B12, B13, B14 and B15 are drawing information from the table you completed specific to your program context. Lock the “CG Bene” page.
9. Lock the “Children per Woman” page.
10. On the “CG Bene” page, enter information for cells 18B, 19B, 20B, 21B specific to your CG program.
11. Also on the “CG Bene” page, enter information for cells A26 –A37 and B26-B37 specific to your projects geographic area.
12. The rest of the sheet will calculate automatically. See rows 43-54 to determine the number of beneficiaries, CGVs and project staff needed.

Additional Notes:

If your country has high fertility rates it is possible the CG Calculator will calculate more Total Indirect Beneficiaries (“CG Bene” page, cell L38) than the total number of people

who live in the area (“CG Bene” page, cell B38). If this is the case, reduce the Total Indirect Beneficiaries so they are at least five percent below the total population.

If your program is not working with children less than five years of age, then you will need to adjust the formulas in the table “CG Direct and Indirect Beneficiaries” to reflect this.

Five Year DIP

Program Year	Year 1												Year 2				Year 3				Year 4				Year 5			
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep																
Program Quarter	Q1			Q2			Q3			Q4			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Financial Year	2014												2015				2016				2017				2018			
Financial Quarter	Q1			Q2			Q3			Q4			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ACTIVITIES																												
Hire Coordinator and Supervisors																												
Formative Research																												
Care Group Start-up Training for Supervisors (TOT)																												
Orient communities to the CG Program																												
Interview and Hire Promoters																												
Care Group Start-up for Promoters																												
Census and Formation of Care Groups																												
Write/Adapt CG Module Content (M1)																												
Adapt materials to local context and translate (M2)																												
Identify local artist																												
Work with artist to illistrate modules (M3-M4)																												
Print Modules (M5- SHOULD BE COMPLETED BEFORE MODULE TRAINING)																												
Create & Print Model Family Posters or other materials																												
Education Methods & Module 1 TOT for Coordinators, Supervisors & Promoters																												
Module 1 Community Teaching (Promoter to CGVs, CGVs to NW)																												
Module 2 TOT for Coordinators, Supervisors & Promoters																												
Module 2 Community Teaching (Promoter to CGVs, CGVs to NW)																												
Module 3 TOT for Coordinators, Supervisors and Promoters																												
Module 3 Community Teaching (Promoter to CGVs, CGVs to NW)																												
Module 4 TOT for Coordinators, Supervisors and Promoters																												

Activity
Module 4 TOT for Coordinators, Supervisors and Promoters
Module 4 Community Teaching (Promoter to CGVs, CGVs to NW)
Module 5 TOT for Coordinators, Supervisors and Promoters
Module 5 Community Teaching (Promoter to CGVs, CGVs to NW)
Module 6 TOT for Coordinators, Supervisors and Promoters
Module 6 Community Teaching (Promoter to CGVs, CGVs to NW)
Module 7 TOT for Coordinators, Supervisors and Promoters
Module 7 Community Teaching (Promoter to CGVs, CGVs to NW)
Mini-KPC Training & 1st Mini-KPC Survey
Mini-KPC Questionarie Trainings and Surveys
Mini-KPC Trainings and Surveys with Anthropometric Measurements (1/Year)
Baseline Evaluation
Midterm Evaluation
Final Evaluation
Designing for Behavior Change and Barrier Analysis TOT for Management and Supervisors
Care Group Operation Research
Additional Operational Research
Bi-Monthly CGV & Neighbor Group Supervision (Promoters to CGVs)
Bi-Monthly Training and Reporting Meetings (Supervisor to Promoter)
Supervision of the Promoters by Supervisors (2/Month/Promoter)
Supervision of the Supervisors by the Coordinators
Regional Trimester Mtgs (Coordinator to Supervisor)
Mgmt Trimestral Mtgs (Manager to Coordinator)
Trimester Mgmt Planning Mtgs
HQ Monitoring Trips

Care Group Beneficiary Calculator Spreadsheet

Directions: In the DHS Table: Children's Living Arrangements and Orphanhood, there are the numbers of children under 2 years and under 5 years. Divide them by the total number of household members from the Table: Household population. That gives the proportion of children. From the DHS Table: there is the number of women with a birth in the last 5 years. Divide this number into the number of children under five years to get the average number of children under five per mother of children under five. (However, because of under-five mortality this average will be a little high.) If the equivalent number of women with a birth in the last 2 years is not provided, a quick tabulation would get you this average.

ETHIOPIA	Proportion	Number
Total Population 10,000		67556
Children <2	7.36%	4972
Children <5	15.80%	10674
Total number of HH members		5.00
# of HH members who are children <2	7.36%	4972
# of HH members who are children <5	15.80%	10674
Number of women with a birth in the last 5 years	10.82%	7307
Number of women with a birth in the last 2 years	7.21%	4871
Average number of children under five per mother of children under five		**1.46**
Average number of children under two per mother of children under two		**1.02**
% of women who gave birth less than 24 months since preceding birth	21.30%	
% of women who gave birth less than 60 months since preceding birth	91.00%	

MOZAMBIQUE	Proportion	Number
Total Population 10,000		57147
Children <2	6.96%	3977
Children <5	17.40%	9944
Total number of HH members		4.90
# of HH members who are children <2	6.96%	3977
# of HH members who are children <5	17.40%	9944
Number of women with a birth in the last 5 years	12.56%	7179
Number of women with a birth in the last 2 years	8.37%	4786
Average number of children under five per mother of children under five		**1.39**
Average number of children under two per mother of children under two		**0.83**
% of women who gave birth less than 24 months since preceding birth	16.40%	
% of women who gave birth less than 48 months since preceding birth	77.00%	

DRC	Proportion	Number
Total Population 10,000		47228
Children <2	7.52%	3552
Children <5	18.80%	8879
Total number of HH members		5.40
# of HH members who are children <2	7.52%	3552
# of HH members who are children <5	18.80%	8879
Number of women with a birth in the last 5 years	11.59%	5473
Number of women with a birth in the last 2 years	7.73%	3649
Average number of children under five per mother of children under five		**1.62**
Average number of children under two per mother of children under two		**1.00**
% of women who gave birth less than 24 months since preceding birth	26.00%	
% of women who gave birth less than 48 months since preceding birth	92.40%	

ALL COUNTRIES	
Average number of children under five per mother of children under five	1.49
Average number of children under two per mother of children under two	0.95

HIGHTEST RATE TO ENSURE MAXIMUM NUMBER OF MOTHERS (preventing under-budgeting	
Average number of children under five per mother of children under five	1.62
Average number of children under two per mother of children under two	1.02

Average % of women who gave birth less than 24 months since preceding birth	21.23%
Average % of women who gave birth less than 60 months since preceding birth	91.70%

DHS 2005	Table Name
pg.13	Household population by age, sex, and residence
calculate	
pg13	Household population by age, sex, and residence
p.14	Household composition
calculate	
calculate	
p.113	Antenatal Care
calculate	
calculate	
calculate	
pg.53	Birth intervals
pg.53	Birth intervals

DHS 2003	Table Name
p.21	População dos domicílios, por idade, residência e sexo
p.21	População dos domicílios, por idade, residência e sexo
p.22	Composição dos agregados familiares
p.144	Cuidados de saúde reprodutiva por estatuto da mulher
p.59	Intervalo entre os nascimentos
p.59	Intervalo entre os nascimentos

DHS 2003	Table Name
pg11	Population des ménages par âge, sexe et milieu de résidence
calculate	
p.11	Population des ménages par âge, sexe et milieu de résidence
p.13	Composition des ménages
calculate	
calculate	
p. 115	Soins prénatals
p.50	Intervalle intergénésique
p.51	Intervalle intergénésique

Project Area (District)	Total Population	WRA	Children <5	Children <2	Children 2-5 yrs	Housholds with Children < 2	Households with Pregnant Women (who do not have a child under 2)	Households with Pregnant Women (who do not have a child under 5)	Household with Mothers of Children < 5	Total Direct Beneficiaries	Total Indirect
Area A	10,000	2,168	1,840	736	1,104	721	303	172	1,136	2,865	10,058
Area B	5,000	1,084	920	368	552	361	152	86	568	1,432	5,029
Area C	30,000	6,505	5,520	2,208	3,312	2,163	910	515	3,407	8,594	30,175
		0	0	0	0	0	0	0	0	0	0
Totals	**45,000**	**9,757**	**8,280**	**3,312**	**4,968**	**3,245**	**1,366**	**773**	**5,111**	**12,890**	**45,263**

Care Group Neighbor Women and Mother Leaders

Project Area (District)	Women reached by CGVs	# of beneficiary mother groupings	# of CG Volunteers	# of Care Groups	# of Promoters needed (rounded up)	# of Supervisors needed (combine areas if poss.)	# of Supervisors needed (rounded up, no sharing)
Area A	1,025	93	93	8	2.00	0.40	1.00
Area B	512	47	47	4	1.00	0.20	1.00
Area C	3,074	279	279	23	4.00	0.80	1.00
	0	0	0	0	0.00	0.00	0.00
Totals	**4,610**	**419**	**419**	**35**	**7**	**1**	**3**

Male and Female Direct and Indirect Beneficiaries

Project Area (District)	Male Beneficiaries	Female Beneficiaries	Indirect Male Beneficiarie	Indirect Female Beneficiarie
Area A	920	1,945	5,029	5,029
Area B	460	972	2,515	2,515
Area C	2,760	5,834	15,088	15,088
	0	0	0	0
Totals	**4,140**	**8,750**	**22,632**	**22,632**

Care Group Beneficiary Worksheet **** Note this sheet assumes your Care Groups include preg. women and women with children < 2 years of age and that children < 5 years of age will benefit from other services (e.g., GMP, EPI, and/or Deworming)***

	% or #	Source & Calculation Notes
WRA	21.68%	US Census Bureau - Determine total population of females 15 and 49 years of age then divide by total population. (DHS can also provide this number using % of population, not actual numbers) http://www.census.gov/ipc/www/idb/informationGateway.php
% of population that is female	50.78%	US Census Bureau or DHS taking total # of females divided by total popualation. (Use 50% if you cannot find that information.)
Children <5 yrs	18.40%	DHS Table "Household population by age, sex, and residence" or the US Census Bureau 2010. (This is often ~18%.)
Children <2 yrs	7.36%	Multiply the % of children < 5 years by 40% (if age distribution is equal then 2 years/ 5 years means that ~40% of the children < 5 will be < 2). (This is often ~7%.)
Pregnant Women	3.80%	UNICEF Country Statistics: Take the total population and divide by # of births in a year to get an estimated % of pregnant women. (This is often ~4%.) http://www.unicef.org/infobycountry/
Average Household Size	5	Get this from the DHS Table, "Household Composition"
Mothers per child 0-24m	1.02	Calculated based on highest ratio in a review of data from three countries. See the worksheet "children per woman" to see how to calculate this specific for your country, or accept this figure if you want a reasonable estimate.
Mothers per child 0-59m	1.62	Calculated based on highest ratio in a review of data from three countries. See the worksheet "children per woman" to see how to calculate this specific for your country., or accept this figure if you want a reasonable estimate.
% of women who gave birth less than 24 months since preceding birth	21.23%	Calculated based on average from three countries. See the worksheet "children per woman" to see how to calculate this specific for your country.
% of women who gave birth less than 60 months since preceding birth	91.70%	Calculated based on average from two countries. See the worksheet "children per woman" to see how to calculate this specific for your country.
Total Direct Beneficiaries	Definition	Mothers of children < 5 years + Pregnant Women who are not mothers of children < 5 years + Children < 5 years (this depends on who your program targets)
Total Indirect Beneficiaries	Definition	((Households with Children < 5 years/mothers per child 0-59m) + (Pregnant women who don't have children < 5 years of age)) * Average Household Size
Number of Neighbor Women (NW) per Care Group Volunteer (CGV)	10	http://www.caregroupinfo.org/blog/criteria

Number of CGV in each Care Group	12
Number of Care Groups per Promoter	6
Number of Promoters per Supervisor	5