Integrated Community Based Nutrition Intervention using the Care Group Model

I-LIFE PROGRAM
Catholic Relief Services (CRS) Malawi
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i-life

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Acknowledgment

Many thanks to the I-LIFE partner PVO staff and PMU staff who dedicated their time and energy working to improve the health and nutrition situation of the rural communities in Malawi.

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Acronyms

ACSGD	Accelerated Child Survival Growth and Development
AIDS	Acquired Immune Deficiency Syndrome
BCC	Behavior Change and Communication
CHW	Community Health Workers
CI	Chronically Ill
COOPI	Cooperazione Internazionale
CRS	Catholic Relief Services
CTC	Community Therapeutic Center
DAP	Development Assistance Program
DHMT	District Health Management Team
EI	Emmanuel International
ENA	Essential Nutrition Action
FAO	Food Assistance Organization
FGD	Focus Group Discussion
GVH	Group Village Heads
HBC	Home Based care
HIV	Human Immune deficiency Virus
HSA	Health Surveillance Assistance
IGA	Income Generating Activities
I-LIFE	Improving Livelihood through Increased Food security
ITN	Insecticide Treated Nets
IYCF	Infant and Young Child Feeding
GM	Growth Monitoring
GOM	Government of Malawi
GTZ	German Technical Cooperation
LM	Lead Mothers
LQAS	Lots Quality Assurance Sampling
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
OVC	Orphans and Vulnerable Children
NGO	Non-Governmental Organization
NRU	Nutrition Rehabilitation Unit
PD/HEARTH	Positive Deviance and Hearth
PVO	Private Voluntary Organization
PLHIV	People Living with HIV
PMU	Program Management Unit
USAID	United States Agency for International Development
VHC	Village Health Committee
VCT	Voluntary and Counseling and Testing
VSL	Village Saving and Loan

Contents

Executive Summary

The proposed study aims to document the achievements and lessons learnt by I-LIFE in implementing the Care Group model[1]. The results of this study will be instrumental in further improving the quality of I-LIFE's health and nutrition interventions as well as in facilitating the replication of best-practices within and outside the consortium. Since the adoption of the Care Group model by I-LIFE in May 2007, the program coverage has increased from 12,000 to over 65,000 households and the quality of service has improved through active community participation, integration of Nutrition interventions with other I-LIFE program components and coordination with stakeholders. The household survey showed that 75% of children under six months of age in I-LIFE program participating households are breastfed within the first 30 minutes after birth and the rate of exclusive breastfeeding among these children is 69%. These results are much higher than the national average rates; 58%[2] and 57% respectively From the various FGDs, the Care Groups approach has been acknowledged for building stakeholders' capacities to contribute actively in health and nutrition development initiatives, promoting local ownership and empowerment. It is noted as the best strategy to share new information and transfer skills at a large scale and act as a central point to integrate various complementary interventions. In general, the Care Groups approach has decentralized a key aspect of health service provision to the grassroots level, by equipping the common mother/father with crucial competencies to positively impact on his/her community's health status. It has created ownership of services delivered at a community level and empowered communities to organize themselves for action and to request services from the government.

The study is carried out from June 1 – July 31 2008. Qualitative data was gathered through Focus Group Discussions (FGD's) and in-depth interviews with field staff, volunteers, beneficiary households and stakeholders involved in the program. Quantitative data was collected using a standardized household questionnaire. Four out of the seven I-LIFE implementing partners participated in the study. The four districts for each of the four partners are selected based on their geographic representation and the length of time Care Groups have become functional.

[1] The Care Groups model is World Relief's innovation for community based health and Nutrition interventions to ensure high program coverage and to enhance community participation for sustainable high program impact using a network of community volunteers.

[2] MICS 2006 survey – on average 58% of children under six months in Malawi are breastfed within the recommended one hour after birth.

Introduction

Development programs aimed at helping the poor from the cycle of Poverty, poor health conditions and other basic services have put a lot of effort for decades on strategies that can create effective, efficient and sustainable programs that meet the needs of the people in the poverty trap and enable them to stand out for them selves to over come the day to day problems they are facing. Studies have proved that active community participation in development programs is vital for the success of any development intervention to bring about long lasting solution that can have an impact on the lives of the people to be served.

To facilitate communities' participation in development programs and provide basic services to the closest possible service delivery point, Government's and Humanitarian organizations used trained community members as changing/ mobilizing agents. The grassroots development workers are not only the bridge between the program expert and the communities to be served but experts by their own stand who could provide invaluable advice and information to the program. In many community based development programs, they are the front line service providers, the faces and the hands of the program whose contribution matters most for the success of interventions.

Since the start of the i-life program late in 2004, efforts have been made to train volunteers on growth monitoring, PD/HERATH and various other health and nutrition skills that are meant to contribute to activities identified in the health and nutrition program. However, a preliminary analysis of volunteer's service in I-LIFE using FGD and an in-depth interview to volunteers conducted in July 2007 showed that PVOs are facing a high drop out rate among volunteers at a rate of 30% to 50% every year. Five major factors identified for drop out include insufficient training and lack of equipment (such as teaching aid, scales), low community support, lack of incentives, lack of transport and length of time required by the volunteer to provide service. This has instigated the need to look for ways of minimizing their workloads while at the same time strengthening their roles in efficient, effective and sustainable service delivery in the I-LIFE health and nutrition program

Following the mid-term review in April 2007, the I-LIFE consortium health and nutrition program through the Care Group model has trained over 600 volunteers and 80 health promoters actively working in promoting child feeding, caring and health seeking behaviors using Essential Nutrition action and PD/HEARTH approaches. They are involved in promoting the cultivation, processing and preservation of high nutrient value crops, a program integrated to irrigation schemes and Agriculture extension services. They encourage and mobilize target households to actively participate in Village Saving and Loan schemes.

The purpose of this study is therefore to document on successes in the I-LIFE health and nutrition program following the adoption of the Care Group model in to an integrated Food security program and apply lessons learned from the current program to subsequent similar interventions in Malawi and elsewhere.

Background and justifications

General information - Malawi

Malawi is among 20 countries in the world seriously ravaged by high deaths of under-five children. According to the MICS 2006, 45.9% of children under 59 months of age are stunted (<-2SD), 3.3% are wasted (<-2SD) and 19.4% are underweight (<-2SD). The prevalence of under nutrition didn't show any significant change since the 1990s[1]. Among adults, 7 percent of women of childbearing age are undernourished (low body mass index); 57 percent have sub-clinical vitamin A deficiency while 27 percent are anemic. Prevalence of anemia among pregnant women is very high, ranging from 54 to 94 percent (MOHP, 1998). Prevalence of under nutrition is further worsened by the HIV/AIDS pandemic.

Evidence showed that implementation of high impact but affordable priority interventions at a high scale can prevent 63 percent of current mortality in young children, especially when the interventions are implemented at home and in the community[4].

The Government of Malawi in its National Nutrition policy and strategic plan for 2007-2011 identified three key focus areas for effective delivery of services, all referring the importance of communities participation at all levels and the need for a community based structures that facilitates their involvement in Nutrition interventions. The three main focus areas include:

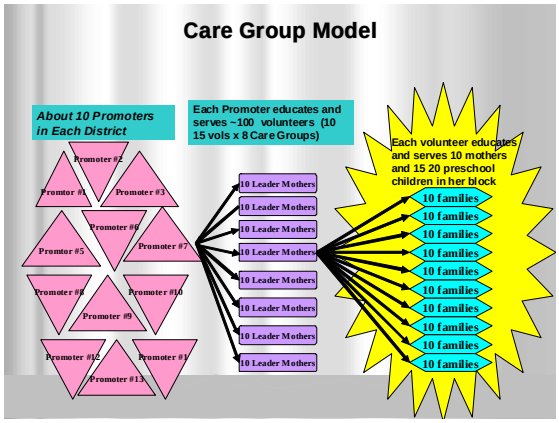
1. Prevention and control of various forms of nutrition disorders
2. Promotion for access and quality of nutrition and related services for effective management of nutrition disorders and
3. Creation of an enabling environment that adequately provides for delivery of nutrition services and implementation of the nutrition programmes, projects and interventions

In support of the GoM's effort, NGOs are actively involved in implementing various sound and evidence based nutrition interventions. A number of CTC programs, NRU services and community level interventions such as Nutrition education, PD/HERATH community based rehabilitation, horticulture and permiculture programs in the community and at Schools are supported by NGOs. For a number of years, World Vision Malawi through its MICAH program has been providing successful community based nutrition interventions that promote cultivation and consumption of micronutrient rich vegetables, raring of small animals (rabbits, Guinea foul, Goats etc). GTZ promotes horticulture and permiculture interventions through school health and nutrition programs. Others such COPPI Maleza and Goal Malawi use community volunteers and the MOH structure mainly Health Surveillance Assistances to reach out communities and households for Nutrition interventions.

Program summary: Improving Livelihood through increased Food Security (I-LIFE)

I-LIFE program is a five year (2004-2009) development assistance program (DAP), funded by USAID with a goal to reduce food insecurity among vulnerable households and communities in rural Malawi. It is implemented in seven districts of Malawi by seven US based PVOs: CRS, CARE, Africare, Emmanuel International, Save the Children, The Salvation Army and World Vision. CRS is the grant holder and in charge of providing technical guidance and support for Health and Nutrition interventions to the consortium members. The I-LIFE food security program has three major components: Economic development, Maternal and Child Health & HIV and Community capacity building. The Economic development program is designed to decrease the number of months of household food insecurity of the target population by increasing the household agricultural production and incomes through extension support, linkages to markets, village savings and loan, and small-scale irrigation schemes. The health and nutrition component aims at improving and enhancing the nutritional status of vulnerable groups through improved food utilization and increased adoption of nutrition and complementary health behavior practices. I-LIFE also strengthens the capacity of community based organizations e.g. village health committees to support and ensure the sustainability of the program.

The 2007 I-LIFE mid-term review recommended the need to increase in the coverage and quality of the health and nutrition interventions along with an improvement in food utilization by fostering integration with other I-LIFE program components. In accordance with this recommendation, I-LIFE adopted the Care Group model[3] in May 2007.



A Care Group model (adopted from FH)

In the Care Group methodology, an initial census is done to divide households with children under five years of age and pregnant/lactating women into groups of 12 - 14. Each 12 or 14 household group elects a Lead Mother (LM) or Lead Father (LF) under the guidance of a Promoter. A Care Group is formed by each group of 12-14 Lead Mothers/Fathers. Each Promoter oversees ten Care Groups, and meets with the (12-14) Lead Mothers/Fathers in each Care Group every two weeks for two hours.

This model has been successful, within eight months, in increasing I-LIFE's coverage and quality of health services and empowering local communities to easily access and deliver the services within their villages. The model is keenly observed by the Government of Malawi while some NGOs have adopted it, based on I-LIFE's positive experience. Having seen its benefit in scaling-up intervention such as PD/HEARTH, the Office of the President Cabinet, Secretary for Nutrition, HIV& AIDS office has chosen I-LIFE to facilitate the documentation of lessons learned on the adoption of the PD/HEARTH approach in Malawi for Nation wide use.

Key current health and nutrition activities in I-LIFE following the adoption of the Care Groups model are:

1. Health and nutrition education using ENA resources adopted by the GoM. ENA includes lessons in Infant and Young child feeding (Breastfeeding and complementary feeding), maternal nutrition and micronutrients.
2. PD/Hearth sessions (modified) aimed at rehabilitation of mild to moderate malnourished children, while teaching skills on child feeding and caring practices to care givers.
3. Promote the cultivation of high nutrition value crops (through vegetable gardening, cultivation of Orange-fleshed sweet potato, Amaranths, fruits, soy, graound nuts etc) through household gardens, irrigation sites and communal farm, in addition to facilitating skills training in food processing, preservation and preparation techniques through food demonstrations, PD/HEARTH sessions etc
4. Facilitate integration of Care Groups into micro-enterprise activities through the Village Saving and Loan scheme.
5. Promote active participation of communities in MOH services at the district level, i.e.:
    - Mobilizing mothers for Immunization, Growth Monitoring (GM), Vit A capsule distribution, and deworming campaigns
    - Linking PD/ Hearth sessions with CTC/ NRU services where ever these services are available (setting up referral and follow-up mechanisms)
6. Capacity building of government health workers (HSAs) and community Health Committees.

Currently, the I-LIFE partners reach out over 60,000 households with children under 5 years of age (with more emphasis on children <2 years), more than 10,000 Pregnant and lactating mothers and about 10,000 Chronically ill and OVC hosting families with a comprehensive community based health and nutrition interventions through 81 promoters, 600 Care Groups having 6000 Care Group volunteers (Lead Mothers and Fathers).

I-LIFE Care Groups structure by PVO and District (as of sep 20 2007)

Category	Africare	CADECOM	CARE	EI	SC	TSA	WV	TOTAL
TA	3	2	4	2	3	2	4	20
GVHA	12	7	20	18	50	6	11	124
Target Households	10600	8968	6000	7748	8200	9250	12217	62983
Care Groups	110	61	40	85	78	85	138	
CG Volunteer	1084	637	600	850	788	850	1727	6536
Promoters	16	9	13	13	10	9	13	81
Supervisors	4	3	6	5	2	2	10	38
Coordinator	1	1	2	2	1	1	1	9

Community participation and the care group model

Based on the lessons learned globally in the implementation of effective child survival programs, five key elements have been suggested for programs to be effective and efficient in their service delivery[5]. These include: sound planning using relevant data, selection of interventions to be implemented at the community level that proved effective and feasible in achieving high, sustained and equitable coverage, exploring alternative delivery strategies, develop activities tailored to meet demand and respond to the needs of the community and strengthening the national system to sustain child health interventions.

Successful community based health and nutrition interventions ensure that participating communities are provided with the necessary knowledge and skills to prevent malnutrition while at the same time seek therapeutic solutions for those who are already suffering from under nutrition[6].

In its in-depth assessment and analysis of nine programs from three regions, FAO (Food and Agriculture Organization) found out that community involvement, participation, ownership and empowerment are strongly related to effective community based food and nutrition programs. The study identified that a community-based program should engage communities in decision-making and the selection of activities to answer their felt needs with a high level of involvement from passive participation in existing programs and services to self-mobilization for decision making[7].

Evidence has shown that Group-based programs for microfinance, livestock development, tree nurseries, and other activities build upon neighborhood and family networks are successful. These programs not only offer efficient ways of reaching women, but also strengthen women's social capital, enabling them to undertake other activities.

The concept of the Care Group approach emanates from the need to create conducive enabling environment that will give opportunity to participating communities to fully utilize their potentials and resources for the common goods of their community. A number of World Relief and Food for the Hungry child Survival and MCH- Food security programs have proved this fact.

The model has demonstrated considerable success in malaria control by building health system capacity to deliver effective treatment and community capacity to effectively address behavior change at the local level. Using the Care Group Model, World Relief "Vurhonga" Child Survival Program (1999–2003) has increased the use of ITNs by pregnant women and children under 2 years of age from 1% to 85%, improved community access to health facility and essential drug treatment from 65% to 99% and Improved care-seeking practices: Percent of children under 2 years seen at a health facility within 24 hours of malaria symptoms increased from 28% to 90%[8].

Further more mortality study through John Hopkins School of Public Health using modified DHS on the impact of community partnership through the Care Groups approach in World Relief child survival program implemented in Chokwe district of Gaza province, Mozambique showed a reductions of 49% in infant mortality and 42% under-five mortality through high coverage for bed net use (80%), oral rehydration therapy for children with diarrhea (94%) and prompt care-seeking from trained providers for children with danger signs[9].

Similarly, Food for the Hungry in four districts of the Sofala province, Mozambique recorded a dramatic rapid change in Knowledge and Practice such as the use of ORT and optimal Breastfeeding practices, a marked increase in coverage for Vitamin A capsule distribution, Immunization and deworming, and a marked reduction in disease prevalence such as diarrheal disease from 48% to 28%, decrease in moderate and severe stunting by 40% (from 50.4% to 30.3%), severe stunting among children 6-23 months reduction by 48% (from 25% to 13%)[10].

Objectives of the study

General Objectives: To document lessons learned in the use of the Care Groups model in the I-LIFE health and Nutrition program during the last one year.

Specific Objectives

1. To document lessons learned in establishing and managing Care Groups for community based Health/ Nutrition interventions in a Food Security program.
2. To verify and record successes achieved in I-LIFE health/ nutrition intervention through the use of Care Groups and
3. To apply lessons learned from the current program to similar interventions in Malawi and elsewhere.

Methodology

The study was carried out from June 1 – July 31 2008. Due to financial and time constraints a decision is made to select four out of seven I-LIFE current Health and Nutrition project implementation districts. The selection take into account geographic representation of the districts by region and the length of time PVOs started applying the Care Groups model in the program. The study applied both quantitative and qualitative survey methodologies.

Qualitative Survey

Qualitative data was gathered through FGD's and in-depth interviews with field staff, volunteers, beneficiary households and stakeholders involved in the program. Four groups of facilitators from among I-LIFE staff were selected and given orientation on the study objectives and protocols, identification of FGD group members, facilitation techniques and on FGD questions. All the four groups were given SANYO tape recorders to record discussion sessions (See Annex III FGD Guideline for facilitators). Notes taken during the FGD were compared with the transcript for verification. A summary of responses for each of the FGD questions are discussed below.

Focus Group discussions were conducted to a total of 28 Groups each having 8-15 participants (See Annex I for details).

The groups participated in the FGD are:

1. Care Givers of children under 5 years old participating in the I-LIFE health and Nutrition program. a group of 10-12 care givers from each GVH participated in the FGD, i.e. A total of 8 groups from the 8 GVHs selected in 4 PVOs),
2. Care Group Volunteers (Mother and Father Leads): a group of 10-12 Care Groups from each GVH were identified, i.e. 8 FGD Care Groups from 8 GVH in 4 PVOs participated in the study.
3. Health and Nutrition Program Promoters – Community level extension health workers hired by PVOs to implement health/ nutrition and HIV/AIDS programs in the community. Each Promoter covers 8-10 Care Groups. For each of the 4 PVOs 9-13 Promoters participated in the FGD
4. Health Surveillance Assistances of the MoH. In each of the four districts FGD were carried out with Health Surveillance Assistance (HSA) working in I-LIFE project sites.
5. Village Health Committee members responsible for health and Nutrition program activities in their village. A FGD was conducted to each VHC in the 8 Group Village Head (GVH) selected for the study

In depth interview with officials at the District Health Management Team (DHMT) were carried out to verify the participation of the District Health System in the I-LIFE health and nutrition program and explore further how the Care Groups approach contributed to the District Health Service community based programs.

The findings from the FGDs were further used to facilitate a SWOT analysis at a meeting with the district health Coordinator and Supervisors of the Health and Nutrition program to identify strengths, limitations, opportunities and threats in using the Care Groups approach for community based intervention.

Quantitative Survey

The quantitative data was collected using standardized household questionnaire to determine efficiency of the health and nutrition education service delivered on Breastfeeding through the Care Groups. I-life Health and nutrition programs and Monitoring and Evaluation (M&E) Technical Leads facilitated the study. PVO and Health and Nutrition program coordinators and PMU Project officers also took part in the data collection, entry and analysis process.

For both qualitative and quantitative studies data was collected from the same GVHs in four out of seven districts where I-LIFE has a health and nutrition intervention using the Care Groups' model. The four districts (two from central and other two from the south) were selected randomly taking into consideration their geographic representation. Two-stage cluster sampling method combined with LQAS was applied for the selection of two GVHs per PVO. (See details in sample design and list of GVHA's selected in Annex II)

RESULTS

Key Results on FGDs

- All the participants agree that undernutrition among young children is a major challenge in their community for a long time, though the number of cases has reduced markedly in recent years. They attribute the reduction in malnutrition to the various I-LIFE program activities; most notably to PD/HERATH, Growth monitoring and nutrition education sessions.

- Participating households, Care Group lead parents, MOH Health Surveillance Assistances (HSA) and Health committee members reported participating in the program at various levels. Project targeted participating households and Care Group lead parents reported participating in PD/ Hearth sessions, cooking demonstrations and food processing health and nutrition education sessions, in communal and kitchen garden activities and construction of sanitation facilitates such as dish racks, toilets and tipi-taps that the project promotes. MOH Health Surveillance Assistances (HSA) are involved as service providers distributing Vitamin A and Albendazole tablets to children participating in PD/ HERATH and facilitating health education at PD/HEARTH sessions in collaboration with the I-LIFE health and nutrition promoters and supervisors. Village Health committee participate in monitoring activities, as a role model to the rest of the community by adopting healthy practices first and as advisors and community mobilizes for health interventions

> *"As a lead mother we participate in PD/Hearth sessions, Cooking demonstrations, Soya processing, Communal and Kitchen gardens, sanitation program and in education. We also educate fellow mothers how to prepare nutritious food to their under five children." A Care Group Volunteer Mother from Dedza district*
>
> *"This is the most reasonable thing for us to do because we are learning new skills". A Care Group volunteer from Netchu*

- Study participants testified learning new information and skills in optimal breastfeeding practices, hygiene and Sanitation, infant feeding options for HIV positive mothers, the importance of VCT, preparation (cooking) and preservation techniques through the Care Group health and nutrition education and PD/HEARTH sessions. Trainings are reported having an effect in changing

care givers and mothers practice in child feeding, caring and health seeking behaviors. Trainees appreciated the use of teaching aids (flip charts), the practical nature of the training and the benefits of follow-up home visits by the Care Group Lead parents.

- Supervisory & consultative visits within the care group structure are highly appreciated by all, as this keeps volunteers and promoters motivated to continue serving their communities and help to resolve some of the challenges they are facing on time.

"Promoters should be visiting us more frequently (more than once in two weeks), because we get encouraged when we are visited by either the Promoter or Supervisor and they will also help us to solve the challenges we face during our meeting with other mothers" a Care Group Volunteer from Dedza.

- All participants pointed out that the Care Group approach has facilitated easily access to information (health education) and other services to target groups, helped in getting people together for joint action as Care Group Leads and Care Group members participating in communal gardens and PD/ HEARTH sessions enabling mothers and care givers to learn new skills in child feeding and caring practices, food processing and preparation as well as sanitation and hygiene practices. It is acknowledged that the Care Group approach has brought more service to the community such as follow-up of growth monitoring, promotion of kitchen / communal gardens and Village Saving and Loan Scheme and enhanced integration of various programs within I-LIFE contributing to the success of the program.

- HAS's, Village Health Committee and promoters reported seeing adaptation of key healthy practices such as proper household hygiene and sanitation practices, use of diversified diet by households, exclusive breastfeeding for children under six months, initiation of complementary feeding at six months of age and a reduction in malnutrition among children in communities practicing PD/HEARTH sessions.

"There is a huge improvement in the community because now they are able to use their locally available resources properly. The Care Group approach has brought unity in the community. It is a good system for health and nutrition education, because when people meet they share experiences.
(HSA from Dedza)

- The Care Group approach is different from other service strategies because it provides better access to services, enhances community participation building accountability and trust between participating targeted households and their Care Group Leads. It promotes continuous engagement between service providers (promoters and Care Groups) and target households for follow-up, one-on-one and group counseling and communities' participation through the Care Group. Care Groups have a much easier structure to integrate different activities and programs (Agriculture, VSL, HIV/AIDS etc) at a community level that complement each other.

"Adaption rate for new healthy practices is somehow, because Care group messages are simple and correct. The frequency of delivering messages has increased, because HSAs deliver Health education at growth monitoring centers once a month and not all mothers were attending the growth monitoring sessions. Care group activities are hot! Hot!" A Village health committee from Mchinji)

- When asked their suggestion on what the community should do for the CG activities to continue after the project phases out, all participants expressed their commitment to continue with the Care Group approach linked with the MOH. However, they suggested more trainings, and continuous supply of teaching materials and getting support from promoters or HSAs. HSAs are willing to continue supervising Promoters when the program phased out. The HAS's suggested intensive Community sensitization for community ownership, and to let the communities know that the activities will continue through ministry of health and community structures such as VHCs. They also emphasized the need for proper hand over with MOH both at community and district level during the time of phasing out.

"When the project phases out we will continue conducting meetings with lead mothers to follow up care group activities; we will be doing joint implementation and supervision of activities with lead mothers and VHCs"
HSA from Phalombe.

- Following the discussion with the various stakeholders and community members a preliminary analysis of the findings with project coordinators and supervisors to identify strengths and limitations of the Care Group strategy and its potential use for future programming was carried out. During the discussion the following key elements are found to be the strengths of the Care Group strategy.

1. High level of Knowledge retention and practice by the households on the nutrition education sessions they got trained. (Phalombe/ TSA)
2. The CARE group model and its implementation approach have beefed up program coverage in PD HEARTH, GM, cooking demonstrations and nutrient crop cultivation (Netchu/ Africare)
3. It has created opportunities for learning and experience sharing between communities groups i.e. HBCs, PLWHAs. (Netchu/ Africare)
4. The Care Groups approach has helped to create strong collaboration with stakeholders (MOH – HSA's) in implementing activities. (Mchinji/ CADECOM)

5. It helped to improve program quality because it involves close supervision along the Care Group structure and enhances accountability. (Dedza/ Save the Children)
6. The consistent use of checklists for activities in the care groups has enabled supervisors to effectively monitor progress. (Dedza/ Save the Children)
7. The use of detailed action plans by promoters facilitates the timely implementation of activities ensuring that they stay focused. . (Dedza/ Save the Children)
8. There is steady support and encouragement from the local leadership to CARE group activities through provision of land for nutrient crop cultivation by CARE group mothers (Netchu/ Africare).
9. Enhance staff capacity through on the job training to develop relevant skills for implementation and monitoring activities.
10. Require assigning adequate number of staffs for Health and Nutrition program that are able to implement H/N activities effectively (Africare/ Netchu and Mchunji/ CADECOM)
11. It is a foundation for holistic approach because beneficiaries are in groups as such entry point for different activities is easy.(SCUS, CADECOM, Africare)
12. Staff members and Promoter are community based thus good interaction with community.(SCUS, CADECOM, Africare)
13. Committed communities, Lead Mother carrying on voluntary work despite lack of incentives this maximize program ownership.(SCUS, CADECOM)
14. Care groups good avenues for message delivery.(TSA, SCUS)

The following are limitations of the Care Group approach as identified by the project coordinators and field supervisors:

1. The approach requires availability of adequate resources such as transportation facilities (bicycles), fuel for motor bicycles etc for the promoters and supervisors. .(SCUS, TSA, Africare and CADECOM).
2. Early preparation of teaching materials and aids save project time. In the I-LIFE Program, delays in developing and printing teaching materials interrupted project activity for long.
3. A need to provide incentives to volunteers to boost the morale. Though there is a plan to provide T-shirts and Kitenge's with Nutrition messages as a health promotion material to volunteers, it has taken long for I-LIFE to make these materials available.

Key Results on the Quantitative Survey

A total of 152 mothers/ care givers of children under six months old children from 8 randomly selected GVHs in the four districts were interviewed using a standardized household questionnaire. 85% (129) of the respondents are participating Care Group mothers while 15% (23) are lead mothers for their respective Care Groups.

Characteristics of households

Of all the 152 children included in the study, 50.7% (77) are under or equal to three months old (17% (26) are 0 months, 17% (26) are one month and 15.1% (23) are 3 months). The ratio of boys to girls is 1:1. Among the respondents, 94.1% (143) are biological mothers, 21.1% (32) had no any formal education while 7.9% (12) reported having secondary school level education. Regarding their marital status, 88.8% (135) are currently married, 2.6% (4) divorced, 5.3% (8) never married, 1.3% (2) separated and 0.7% (1) are widow.

All the respondents reported participating in one or more I-LIFE health and nutrition program activities. Majority of them, 93.4% (142) reported participating in health education, 82.9% (126) in Growth monitoring and 61.2% (93) in PD/HEARTH sessions. Other activities mentioned by care givers include Communal/ Kitchen gardening by 59.2% (90), Food demonstration sessions by 56.6% (86), Vitamin A and Deworming campaigns by 46.7%(71), and Village Saving and Loan scheme by 32.2%(49) of the respondents.

Breastfeeding Practice

All the children in the study are currently on breast milk. Three-fourths (114) of these children started breastfeeding within 30 minutes of birth, 96.7% (147) are given colostrum and are exclusively breastfed for 3 days after birth. However, continuous exclusive breastfeeding after 3 days is practiced only in 69.1% (105) of the care givers. 88.8% (135) of the respondents reported that the child had breastfeeding 8 or more times during the day and night prior to the date of the data collection.

Knowledge on optimal breastfeeding practices

All mothers practicing exclusive breastfeeding (69%) were able to spontaneously identify/ mention exclusive breastfeeding for children under six months as one of the critical optimal breastfeeding practice. Only 53% (81) and 15% (23) of mothers/ care givers were able to mention initiation of breastfeeding within 30 minutes after birth and frequency of breastfeeding (8-12 times in a day) as critical optimal breastfeeding practices.

Over 40% (61) of the care givers and mothers know 3 or more and 64% (97) know two or more critical optimal breastfeeding practices out of the five practices selected for this study. 85% (129) of mothers and care givers were able to spontaneously mention one or more benefits of breastfeeding to the infant and 66% (100) mentioned its benefit to the mother. About two-third of the respondents know two or more advantages of early initiation of breastfeeding and 77.0% (117) advantages of exclusive breastfeeding. 86% (131) know babies correct positions and attachment during breastfeeding. Over half of the respondents (54%) know factors that increase the risk of HIV transmission from HIV positive mother to child through breastfeeding. Majority of the mothers/ care givers (67.8%) know advantages of complementary feeding for children from 6 months onwards.

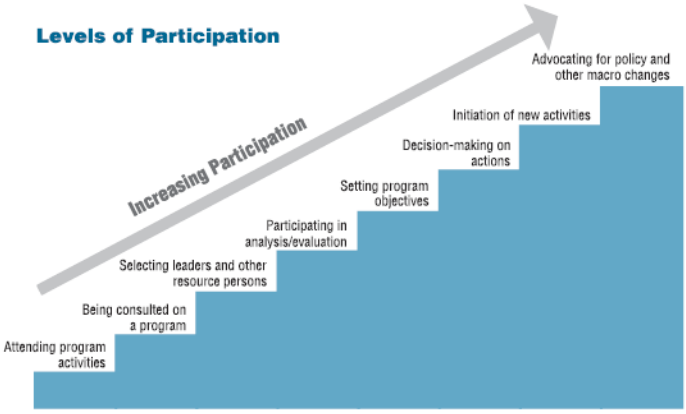
Review of the Care Group approach using qualitative Information

The prevalence of malnutrition in Malawi varies from district to district. Based on the 2006 MICS, the four districts included in this study are among the districts with more than the average malnutrition rate in stunting (ranging from 46% to 57%) and wasting (ranging from 3% in Mchinji to 4.6% in Dedza). From the FGD it is clear that there is a general awareness about the causes of malnutrition and its consequences among community members and service providers. They also acknowledged that child malnutrition is a major challenge in their communities.

All the FGD participants reported participating in the I-LIFE Health and nutrition program at different levels which clearly demonstrates the potential of the Care Group approach in creating conducive environment for stakeholders to contribute actively in health and nutrition development initiatives. Community Participation or involvement ranges from the lowest passive form of service utilization to the highest level of decision making and advocating for policy and other macro changes.

Experience has shows that effective community based nutrition programs requires active community participation that promote local ownership, and empowerment. As it has been clearly demonstrated in the FGD, the level of participation of the various stakeholders range from the lowest level of participation of target households involved in Care Group activities such as learning sessions, PD/HEARTH rehabilitation and training programs and gardening activities to a higher from of participation where volunteer Mother/ Father leaders of Care Groups themselves are facilitating trainings to households they represent and the Village heath committee members involved in monitoring the Care Group activities.

The Care Groups approach has also helped HSA's participating in the program area to mobilize households for the various health campaigns, to participate in growth monitoring services and to disseminate easily key health messages.



Participation guide: involving those directly affected in health and development communication programs, USAID, Health Communication Partnership, 2007

Participants also appreciated the knowledge and skills transferred through the Care Groups in their respective communities. Target Households had the opportunity to access new information on Breastfeeding, hygiene and sanitation, infant feeding options and learned new skills in food processing and preparation techniques. The Care Group leaders also mentioned how these lessons have motivated them to change some of their traditional practices. As leaders, they recognize their responsibility to be a model for the households they are representing, which is a motivation factor for leaders to practice healthy behaviors they are sharing to others. The HSA's and promoters appreciated the practical nature of trainings and the use of teaching aids that

are made available for Care Group leaders. Similar community based health programs demonstrated that community health workers and target groups appreciate the value of Flip charts and other communication tools. Health workers and volunteers find them useful giving them confidence to facilitate discussions on a certain health topic or in conveying particular information. For example, HEALTHCOM's evaluation of flip charts in a child survival program in Indonesia showed that Community health workers valued the use of Flip charts as their best tool for teaching mothers signs of dehydration and how to prepare ORS. Mothers participating in the program also appreciated the realistic drawings with features that they can identify and that it helped them feel comfortable in participating in group discussions[11]. It is therefore commendable to provide HSA's, Health promoters and Care Group lead parents with simple to learn but technically sound, culturally acceptable, easy to carry around and durable teaching aids (flip charts, counseling cards and posters) to facilitate community based behavioral Change and communication interventions.

The mere fact that these trainings are facilitated by promoters and lead mothers/ fathers from the same village that are part of the traditional/ cultural, and socio-economic dynamics of the same community gives power to the message they are sharing and induce a positive response for action by the Households.

It is recognized from the HSA's and Promoters response how the Care Group approach has helped to reach out more households with health and nutrition interventions that can bring behavioral change through practical learning sessions, motivates group dynamics and ensures accountability among the Care Group members unlike the traditional mass education session which don't have a system to follow-up on individual household practices. HSA's and promoters acknowledged that the large coverage of households through the Care Groups has initiated mass movement in the community for a positive transformation and action. So far, Care Groups are successful in reaching out over 65,000 households through 6000 lead mothers/fathers promoting the adoption of good health behaviors that can bring sustainable behavioral change.

The community appreciates the Care Groups function in mobilizing communities for health interventions. This has been demonstrated by target households and Care Group volunteers request for an increase in the frequency of Care Group leaders and promoters' supervisory visits to their households. Participating households also recognize Care Groups as the best structure to get health/ nutrition services to their families and as a mechanism to contribute their share to the health and well being of their children. These include Care Groups benefit in facilitating easy access to health and nutrition information and other services such as VSL, follow-up on Growth Monitoring, the opportunity Care Groups have created in getting people together for joint actions such as the communal gardens, skills learning sessions in food processing, preparation and preservation techniques etc.

Service providers; Promoters, HSA's and the Village Health committee members looks at the Care Groups approach as an efficient strategy to scale up health and nutrition interventions such as PD/ HEARTH that otherwise would have been difficult to scale for community wide intervention.

A dish rack constructed by the household

The Care Groups approach has also been acknowledged for being a central point to integrate various interventions that complement each other to achieve the goal of food security. The Care Group model in the I-LIFE program has been successful in building the capacity of 6000 lead mothers/fathers to promote the adoption of good health behaviors, through a simplified delivery system, to their targeted households in a manner that can bring sustainable behavioral change. The introduction of VSL, HIV/AIDS and Agriculture activities into the Care Groups is appreciated by participating households.

Participating targeted households and mother/ father leaders reported confidence and commitment to continue working as Care Groups as the project phases out. A similar study by World Relief in Southern Mozambique Child Survival program showed that Care Groups were able to continue their regular fortnight meetings and home visits to target households two years after the project phases out in the project area[12]. The Care Groups also expressed the value of their participation in VSL in sustaining the group together and providing access to financial support for activities such as PD/HERATH. This demonstrates that Care Groups backed by other interventions such as IGAs and VSL are in a better position to have the motivation to continue working as a group.

Several studies have shown the benefits of multiple incentive such as material and financial incentives, community recognition and respect, personal growth and development through trainings to reduce attrition rates among volunteer community health workers[13]. HSA's and VHC's would like to see the Care Group volunteers to continue providing service with support and guidance from the MOH. It is therefore important for programs using the Care Groups model to set up community support mechanisms and linkage with MOH system from the start. The current working relationship between the promoter, Care Group leaders and the HSA's is highly commended by all. Experience showed that community based interventions integrated with Government system are more likely to be sustainable than those interventions that do work in isolation.

In general the Care Groups approach has decentralized a key aspect of health service provision to the grassroots level, by equipping the common mother/father with crucial competencies to positively impact on his/her community's health status. It has created ownership of services delivered at a community level and empowered communities to organize themselves for action and to request services from the government.

Review of the Care Group approach using Quantitative Survey

Breastfeeding is generally a common practice among mothers in I-LIFE project sites, though the time of initiation of breastfeeding and the practice of exclusive breastfeeding varies across districts. The 2006 Malawi MICS study showed that on average 58% of children under six months in Malawi are breastfed within the recommended one hour after birth. It ranges from 37% in Dedza to 62% in Netchu among the districts selected for this study. In I-life operation villages 75% of children are breastfed with in the first 30 minutes. Similarly, the rate of exclusive breastfeeding in this study is as high as 69% which is much higher than the national average exclusive breastfeeding rate recorded as 57%. Frequency of breastfeeding is another critical determinant factor in optimal breastfeeding practice where i-life project sites have a high record rate of 89%.

Breastfeeding Practice	National Figure (MISC)	I-LIFE Study GVH (Dedza, Mchinji, Netchu and Phalombe)
Initiation of breastfeeding	58%	75%
Exclusive Breastfeeding	57%	69%
Frequency of breastfeeding	-	89%

The increased level of knowledge that mother/ care givers have attained through the Care Group health and nutrition education sessions has also been demonstrated in this study. Most mothers/ care givers are now aware of the advantages of optimal breastfeeding including the time of initiation of breastfeeding, benefits of giving colostrum to a child and exclusive breastfeeding for a child under six months. This has also been translated to mothers/ care givers appropriate breastfeeding practices as shown in the table.

Conclusion and Lessons learned

Both the qualitative and quantitative surveys have established once again the benefits of using the Care Group model in Community based health and nutrition interventions for a rapid and high coverage result through active community participation. This has been clearly demonstrated with the drastic increase in the I-LIFE program coverage from 12,000 to over 65,000 households after the introduction of Care Groups.

The marked difference observed with optimal breastfeeding practice after the promotion of breastfeeding through the Care Groups is attributed to relentless support provided by the PVO staff, promoters and Care Group Volunteers to pregnant and lactating mothers.

The model has proved efficient in building the capacity of lead mothers/fathers to promote the adoption of good health behaviors, a simplified and well structured delivery system, to their targeted households in a manner that can bring sustainable behavioral change.

The Care Group model has decentralized a key aspect of health service provision to the grassroots level, empowered communities and enhanced community participation by equipping the common mother/father with crucial competencies to positively impact on his/her community's health status that leads to sustainability. Care Group participating households are role models. They cultivate high nutrient value crops such as yellow flesh sweet potato, Soy beans ground nuts and various indigenous vegetables and fruits in their individual plots, kitchen gardens and communal gardens. The involvement of Care Groups in village savings and loan schemes has boosted mothers' active participation in health and nutrition interventions, with some baking nutritious snacks for sale during PD/Hearth sessions. Experience from PD/Hearth sessions have also shown an improvement in dietary intake at household level

Care Groups have become a focal point for integrated health and nutrition interventions: for Essential Nutrition Actions; growth monitoring sessions; addressing malnutrition through PD/Heath and a referral points to recuperation programs; and for the promotion of cultivation of high nutrient crops through communal farms and vegetable gardens. It has also provided opportunity for integration of health and nutrition interventions to other economic development programs (Agricultural extension and Village Saving and Loan schemes) and HIV/AIDS prevention, care and support interventions.

Key features of a successful community Nutrition program[14] are properly addressed through the Care Groups approach. Interventions through Care Groups involve people from the community, ensure equity adapts to community needs and builds on existing community resources with better coverage and significant impact at household and community level. Care Groups are ideal structures to integrate other sectors in development programs and strengthen links between the community and the health system. It is a strategy with remarkable outcomes that lead to sustainability through community empowerment. At the heart of all this effort is the Promotion and support of a set of key health and nutrition behaviors to improve child health and development.

Key lessons learned

Based on the quantitative and qualitative surveys findings, discussion with project staff and lessons leaned brainstorming session with the Health and Nutrition Technical Working Group that include all the health and nutrition program coordinators of the seven I-LIFE partner PVOs, the I-LIFE Project Management Unit Project Officers and the technical Lead, the following key lessons and major challenges have been pinpointed.

1. Using a Care Groups approach has helped the I-LIFE program to reach out a wider geographic area and there by increasing service coverage for health and nutrition interventions. The Care Group approach helped to facilitate integration of activities within the health and nutrition program to provide a holistic nutrition intervention as well as

"Health and nutrition messages through lead mothers are reaching more households and follow up on practices is also easy. This is so because lead mothers/fathers stay in the same communities with the beneficiary households as such communication with the households is easy since they use the same language."
A health promoter from Phalombe

complementing Nutrition interventions with Agriculture, VSL/ IGA and HIV program activities. Food security programs similar to I-LIFE can effectively implement integrated Agriculture, Maternal and Child Health/ Nutrition and HIV/AIDS programs with high coverage, and impact through active community participation using the Care Groups model.

2. The Positive Deviance and HEARTH program can easily be scaled up using the Care Group structure to recuperate mild to moderate malnourished children within their community set-up using food resources locally cultivated through communal farms, gardens etc or purchased with money from the Care Groups VS&L scheme.

3. High quality ENA and PD/HEARTH are effectively delivered through the Care Groups because it involves close supervision of service providers along the Care Group structure and enhances accountability. The consistent use of checklists for programs enables supervisors to effectively monitor the progress of activities. The use of detailed work plans by promoters facilitates the timely implementation of activities making certain that they stay focused. The task of program coordination and monitoring is easier due to the well defined structure of Care Groups.

4. It increases efficacy in delivering health messages through a network of Care Group Volunteer lead mothers and fathers who lead by example which improves uptake.

5. The use of appropriate teaching aids such as flip charts and facilitating community level training sessions by trained community members (such as Care Group Leaders and Promoters, village health committee) builds accountability and confidence to service providers and promotes community ownership. The use of stories in training modules is also an effective way of sharing health information from mother leaders to beneficiary mothers. It is essential that materials developed for this purpose are backed by a barrier analysis and other formative researches.

6. It has the potential to enhance community participation at all levels and promotes program coordination and collaboration with the MOH, to create self-sustaining structures at the community levels, and ties among community leaders, health facilities, and VHCs and the community. Through the Care Groups the I-LIFE program enhanced coordination of community-based health and nutrition services provided by PVOs with the MOH Primary Health Care programs such as Growth monitoring, Vitamin A and Deworming Campaigns and Immunization. This can further be strengthened by linking the I-LIFE community based intervention with available CTC/ NRU services through community mobilization, referral and feedback, and health surveillance.

Major challenges

1. The start-up phase for Care Groups take substantial amount of the project time since it involved community orientations sessions, sensitization of stakeholders, registration and establishment of Care Groups in the project area and training health and nutrition promoters.

2. The Care Groups approach was introduced mid-way to the life of the I-LIFE project following the mid term evaluation and as such the effort was to build on existing structures and approaches that worked well while phasing over from those that didn't add value to the project. By the time the Care Group strategy was introduced, the I-LIFE program has left with 2 years.

It is therefore difficult for the current project to fully roll out all key health and Nutrition practices within the ENA package and to establish sustainability strategies in place.

3. As much as flipcharts and other education materials are important for the success of health and nutrition education sessions, it took a long time for the I-LIFE program to develop and print out these materials on time. Allocating adequate time for the development and/or adoption of education materials that already exist before starting the Care Groups function will minimize unwanted interruptions and delays in implementation.

Annexes

Annex 1: FGD Participants by district

District	*FGD participants*	*GVHA Mtemwende*	*GVHA Chamangwmana*	*Number of participants*
Dedza	Target Households	12	11	22
	Care Group Volunteers	14	12	26
	Promoters	4	5	9
	HSA's	4	5	9
	Village Health Committee	9		9
Phalombe	*FGD participants*	*Chabuka*	*Mtemanyme*	*Total*
	Target Households	12	9	21
	Care Group Volunteers	11	11	22
	Promoters			9
	HSA's			5
	Village Health Committee			9
Mchinji	*FGD participants*	*Dambe*	*Kanda*	*Total*
	Target Households	10	7	17
	Care Group Volunteers	11	13	23
	Promoters			7
	HSA			8
	Village Health Committee	12	8	15
Netchu	*FGD participants*	*Gongolo*	*Kamphulusa*	*Total*
	Target Households	15	12	
	Care Group Volunteers	8	12	20
	Promoters			6
	HSA			5
	Village Health Committee	7	8	15

Note: 2 FGDs for Target houholds, Care Group Volunteers per district = 2x2x4= 16
1 FGD for HSAs, Promoters and VHC per district – 3 x 4 = 12
Total FGDs = 28

Annex II: Sample design for Quantitative survey

Data is collected from four districts where four of the I-LIFE PVOs (SCUS, CADECOM, AFRICARE and TSA) are implementing health and nutrition interventions using the Care Group model.

The selection of 19 Care Group mothers with a child below 6 months (0 to 5 months) from each GVH. Sample is self-weighted at PVO level, but weighted at consortium level. Total sample size at consortium level is 4 X 2 X 19 = 152; this sample should be sufficient to provide estimates for exclusive breastfeeding practice and critical knowledge of breastfeeding benefits indicators at 90% confidence. The LQAS design allows making comparison between PVOs in terms of testing if they meet indicators' thresholds.

Expected outputs: The study explores the value added in using a Care Group model in Title II nutrition programs and the factors contributing to the strength and limitations of the Care Group strategy in community based health and nutrition interventions in general.

Select the two sample GVHs using Systematic Probability Proportional to Size (SPPS), as per the steps listed below:

CG beneficiary mothers' with child < 6 months selection at selected GVH level

Select 19 CG beneficiary and/or lead mothers with child < 6 months using random sampling technique.
Step1: List CG program villages as per geographical order within the selected GVH;
Step2: Select a random start village by selecting a Random Number (RN) between 1 and total no. of villages in the GVH,.
Step3: Go to the center of the selected village, and choose a direction to start the survey by spinning a bottle, and knock each CG beneficiary mother household in the direction selected to identify and interview a CG beneficiary/lead mothers.
Step4: Subsequent mothers were selected by moving to the nearest household to the right.
Step5: If you interviewed a total of 19 sample mothers in the village/s, stop the survey in the GVH, otherwise go to the next village in the list and repeat steps3 to step5.

Note: If a household has more than one CG beneficiary/lead mother with a child < 6 months randomly select and interview only one mother per HH.

SAMPLE GVHs IN SELECTED DISTRICTS AND SAMPLE SIZE

District	GVH	Sample size
Mchinji	Matuwamba	19
	Mphanda	19
Dedza	Chamangwana	19
	Mikoche	19
Ntcheu	Gongolo	19
	Kamphulusa	19
Phalambe	Chabuka	19
	Ntemanya	19

Annex III: FGD Guiding Questions

1. To Beneficiary Households

1. How serious is the problem of child malnutrition in your community?
2. Do you participate in any health and nutrition program activities? If yes, How? If not, why not?
3. What do you know about i-life's (or name of the PVO running the program) Care Groups work in the area of Health and Nutrition in your community?
4. How are you involved in i-life Care Groups health and nutrition program to address the problem of malnutrition in your community? If you are not involved, why?
5. How many of the beneficiary households participating in the FGD are trained by i-life PVO on a subject related to Nutrition and health? Ask each of the participants to give you a full account of the trainings they had with the PVO. What have they learned form the training? How helpful were the trainings for you as a mother/ father and to the community as a whole?
    a. On Breastfeeding
    b. On Sanitation
    c. On PD/Hearth, On Growth Monitoring
    d. Others: Diversification of food (the six food groups), HIV, ETC
6. Can you tell us the action you took in promoting breastfeeding and other nutrition and health initiatives in your household or community during the last one year after receiving training from the PVO?
7. How frequently does the PVO field staff (Promoter/ supervisor) or a CG Volunteer communicated to you in helping you apply the knowledge you gained in the training? (Follow-up)
8. What is their view (assessment) of the Care Groups Model's contribution in the health and nutrition program at their community? What was good about Care Groups (Which activity was most useful)? What went wrong during the last 6-8 months? In your view, what needs to be changed in CGs and what needs to be strengthened?
9. In your view, how can the care group model help in building the capacity of beneficiary households to adopt key healthy practices? What is your assessment regarding adoption of key practices by households benefiting from Care Groups compared to HHs receiving service by HSAs alone?
10. When the project phases out, what do you suggest that the community should do for the CG activities to continue?
11. Do you have any question, comments or suggestions for us?

2. FGD for Care Group Volunteers and VHC

1. How serious is the problem of child malnutrition in your community? (Ice breaker)
2. What do you do to change the situation of malnutrition in your community? Do you participate in any health and nutrition program? If yes, how? If not, why not?
3. What do you know about the I-LIFE's (PVOs) work in health and nutrition program in your community?

4. As a CG volunteer, how are you involved in the I-LIFE's (PVOs) health & nutrition program addressing the problem of malnutrition in your community? If you are not, why not?
5. How many of the participating households had training on health and nutrition related topic by I-LIFE (PVO)? Ask participants to give you a full account about the training: Objective of the training, lessons learnt during the training, the importance of the training for the household?
6. Can you tell us your major contribution as a volunteer (or LM/ LF for your groups) in the I-life (PVO) Health and Nutrition program during the last 6-8 months following the training your received by the I-LIFE (PVOs) ?
7. How frequently does I-LIFE's (PVOs) staff meet/ communicate with you in order to help you apply the knowledge you gained from the training?
8. What is your view of the Care Group model's contribution in helping your community to prevent malnutrition? What is good about care groups? Which activity of the care groups do you like most? Why? Which activity is less interesting to you? Why? In your view, what needs to be changed in the project to make it more effective in the prevention of malnutrition? What needs to be strengthened?
9. What would help the care groups to continue their activity after the I-life project phases out?
10. Do you have any questions, comments or suggestions for us?

3. FGD for Promoters

1. How serious is the problem of child malnutrition in your community? (Ice breaker)
2. As a Promoter, tell us how you are participating in the health and nutrition program?
3. Ask how many of the participants are given training by the PVO and ask them to give you a full account of the trainings they had. Objectives of the training, lessons learnt, how useful was the training etc?
4. As a Promoter, Can you tell us your main contribution in the I-life health and nutrition project during the last one year following the training you received from the PVO?
5. How frequently do your supervisor and coordinator communicate/ meet with you in order to help you apply the knowledge you gained from the training?
6. What is your view (assessment) of the care groups' model contribution in improving the nutritional status of children? What is the most interesting (useful) part of the care group approach? Why? What is the least interesting (useful) part with the care groups approach? Why? In your view, what needs to be changed and what needs to be strengthened in the use of the care group model in the coming years.
7. What is your view of the Lead mothers/ fathers role as a changing agent in health and nutrition interventions? Can you give examples how CG have become changing agents to their community?
8. What is your view of the care groups approach in integrating various i-life programs? What makes the CG approach different from other Health and nutrition programs in delivering key health and nutrition messages and practices to the community?
9. How does the care group approach contribute to sustainability? How do we sustain services provided to the community by the care groups when the project phases out?

10. Do you have any questions, suggestions or comments for us?

4. FGD HSAs

1. How serious is the problem of child malnutrition in your community? (Ice breaker)
2. As a HSA, tell us your roles and responsibilities in promoting key health and nutrition practices in your operation area? How many GVHAs do you cover? On average how many Households do you serve?
3. As a HSA, tell us how you are participating in the I-life health and nutrition program?
4. Ask how many of the HSAs are given training by the PVO and ask them to give you a full account of the trainings they had. Objectives of the training, lessons learnt, how useful was the training etc?
5. Can you tell us your main contribution in the I-life project during the last 6-8 months following the training you received from the PVO?
6. How frequently does the PVO staff (promoter, supervisor or coordinator) communicate/ meet with you in order to support you to apply the knowledge you gained from the training?
7. What is your view (assessment) of I-LIFE's health and nutrition programs contribution in improving the nutritional status of children? What is the most interesting (useful) activity in this project? Why? What is the least interesting (useful) activity in the project? Why? In your view, what needs to be changed and what needs to be strengthened in the project for the coming years.
8. What is your view of the care groups approach in integrating MOH community based health and nutrition programs? What makes the CG approach different from other Health and nutrition programs in delivering key health and nutrition messages and practices to the community?

9. What do you suggest to us to do to sustain services provided to the community by the project when the project phases out? How do you continue supporting the care groups when i-life phases out? Have you made any plan or do you have something in your mind that you would like to share with us that would help you to continue your support for the care groups when the project phases out?
10. Do you have any questions, comments or suggestions for us?

Annex IV: The Care Group Model in I-LIFE

In the Care Group methodology, an initial census is done to divide households with children under five years of age and pregnant/lactating women into groups of 12 - 14. Each 12 or 14 household group elects a Lead Mother (LM) or Lead Father (LF) under the guidance of a Promoter. A Care Group is formed by each group of 12-14 Lead Mothers/Fathers. Each Promoter oversees ten Care Groups, and meets with the (12-14) Lead Mothers/Fathers in each Care Group every two weeks for two hours. (See diagram below.)

During the Care Group meetings, the Promoter teaches the LM/LFs the health and nutrition messages for the week, using small flipcharts and other educational materials and methods. The health and nutrition topics that will be covered using the C-IMCI strategic approach include:

a. Nutrition to a young child using Essential Nutrition Action (ENA[3]) resource materials,
b. Prevention and management of Diarrhea diseases, Malaria, Acute Respiratory Infections (ARIs), and
c. Sanitation and hygiene.

Each of the health and nutrition education training topics take approximately 3 months, as they are divided into lesson plans to fit to the Care Group structure and their frequency of meeting. Related flipcharts and teaching aids will be used when facilitating trainings to the LM/LFs.

Skills transfer trainings will also include cultivation of nutritionally rich crops, food processing, preparation and preservation techniques as well as child feeding, caring and health seeking practices. A modified form of PD/hearth will be undertaken to facilitate the skills transfer. Each of the Care Groups will conduct PD/Hearth sessions twice a year: during the harvest season and the lean months (December to March). PDI (Positive Deviance Inquire studies) will be carried out twice a year by trained health and nutrition coordinators in selected geographically and culturally representative sites, within the project coverage area. Apart from the bi-annual planned PD/ Hearth sessions, Care Group Lead Mothers/Fathers are also encouraged to initiate a rehabilitation session using the PD/ Hearth process, depending on the number of moderately malnourished children in their communities. Care Group Mothers/Fathers will bring locally available foods, from the six recommended food groups, and be taught how to prepare a nutritious meal from the ingredients.

Care Groups are also encouraged to establish communal gardens and kitchen gardens to grow high nutrient value crops such as yellow-flesh sweet potato, Soya beans, ground nuts, vegetables and fruits that can be used for PD/hearth sessions and for follow-up care and support to rehabilitated children. Agriculture extension agents and promoters provide technical support to the Care Groups in growing, harvesting, processing, preparation and preservation techniques. Unlike the common PD/Hearth program which mainly focuses on households with malnourished children, the modified form of PD/Hearth is open to all mothers who are interested to learn skills in food processing, preparation and preservation during the 12 days session. The Promoter and Lead Mothers/Fathers will follow-up on the trained mothers and rehabilitated children to support them in adopting the promoted practices and to ensure that children are receiving the required care and support for appropriate growth and

[3] ENA stands for essential nutrition actions proved to work in improving nutrition in infants and young children and in pregnant and lactating women in various resource poor countries. These include: Improving women nutrition, optimal breastfeeding, optimal complementary feeding, feeding a sick child, control of iodine, vitamin A and Iron deficiencies. ENA resource materials are adopted by the MOH Malawi.

development. All trainings emphasize on the nutrition and health issues related to children under 2 years and pregnant and lactating women.

LMs/LFs discuss the health lesson, report on illnesses of children in the households they serve, discuss problem cases (e.g., in terms of behavior change), and report on vital events. LMs/LFs practice their health promotion on the lesson that they just learned (in pairs), supervised and coached by the Promoter. During the two weeks between meetings, each LM/LF does health promotion through home visits to each of the fourteen women/mothers that she/he serves (i.e., all of the households with pregnant women or children under two). This pattern of work allows the Promoter to spend an entire day in each Care Group catchment area, spending the morning in the Care Group meeting where the week's lessons are taught, and the afternoon to work with several Lead Mothers/Fathers in skills based training, conducting PD/ Hearth session and home visits.

Each of I-LIFE's 7 consortium PVOs has a Health and Nutrition Coordinator, who oversees the implementation of the health/nutrition activities through the Care Group model. The Coordinators supervise at total of 23 Supervisors, who manage a total of 80 Promoters. The 80 Promoters in turn oversee 629 Care Groups, through the supervision of 6,708 Lead Mothers/Fathers. In total, I-LIFE currently reaches more than 67,000 households through the model.

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