Food and Nutrition Enhanced Resilience Project.

Care Group Facilitation Guide

July 2021

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LIST OF ABBREVIATIONS

BCC	-	Behaviour Change Communication
CG	-	Care Group
CGV	-	Community Group Volunteer
CHA	-	Community Health Assistant
CL	-	Community Leader
CRS	-	Catholic Relief Services
CU2	-	Children Under 2 years
CSH	-	communication Support for Health
DHD	-	District Health Director
NO	-	Nutrition Officer
DNCC	-	District Nutrition Coordinating Committee
DRG	-	Discussion Report Guide
EHT	-	Environmental Health Technologist
FANSER	-	Food and Nutrition Security Enhanced Resilience
IYCF	-	Infant and Young Child Feeding
LRNA	-	Learning Resources and Needs Assessment
MAIYCN		Maternal Adolescent Infant and Young Child Nutrition
MCDSS	-	Ministry of Community Development and Social Services
MEAL	-	Monitoring Evaluation Accountability and Learning
MoA	-	Ministry of Agriculture
MoH	-	Ministry of Health
MoFL	-	Ministry of Fisheries and Livestock
MWDSEP	-	Ministry of Water Development Sanitation and Environmental Protection
NG	-	Neighbour Group
NGO	-	Non-Governmental Organization
NHC	-	Neighborhood Health Committee
NHH	-	Neighbour Households
CG	-	Care Group
HP	-	Health Promoter
FS	-	Field Supervisor
NV	-	Nutrition Volunteer
QIVC		Quality Improvement Checklist
NW	-	Neighbour women
PLW	-	Pregnant and lactating women
QIVC	-	Quality Improvement Verification Checklist
UNICEF	-	United Nations Children's Fund
USAID	-	United States Agency for International Development
WNCC	-	Ward Nutrition Coordinating Committee
ZNCC	-	Zonal Nutrition Coordinating Committee

Glossary

Behaviour change: The practice of changing people's behaviour through methods that can influence the way people act. They are often based on communications and awareness-raising. https://behaviourchange.org.uk/what-are-we

Care Groups: A group of about 10 community-based Nutrition volunteers who regularly meet together with Health/Sanitation Promoters for training and supervision under the care group model

Community events: Events held at community level and mainly coordinated and/or organized by the Health/Sanitation Promoter, i.e., cooking demonstration, group demonstration to construct wash facility, gardening demonstration, etc.

Coordinator: Refers to the Nutrition Officer

Care Group Supervisor (Health and Nutrition Field Supervisors): Refers to the staff at Ward Nutrition Coordinating Committee level who supervises promoters.

Mentoring: The processes designed to coach a volunteer to gain the independence, self-confidence and skills needed to effectively accomplish the work.

Health/Sanitation Promoters: Refers to volunteers at the Zonal Nutrition Coordinating Committee level who train and supervises 50 volunteers.

Nutrition Volunteers: Refers to volunteers at the community/village level who offers counselling to 10-12 beneficiary households.

Care Group: This is a group of 10-15 Nutrition Volunteers who meet regularly for training and reporting purposes.

CONTENTS

HOW TO USE THE MANUAL

This manual was developed as a training resource to be used in the training of trainers for the Care Group front line workers. The manual is to be used hand in hand with the Care Group Course Director's guide, the Care Group annex, and the Behaviour Change Communication (BCC) materials.

The Pre-training preparation should include master's materials list, room set up, facilitator trainee ratio, mini and max participants per training.

- The list of materials which will be required are listed in the course director's guide. However, additional guidance for materials needed for each session is given at the beginning of each session.
- For the room set up, it is recommended that participants seat in small round tables or in one semi-circle, depending on the number of participants.
- It is recommended that the number of training participants for a master trainer training is 20. It is further recommended that the trainer to trainee ratio is at 1:6. For the ToT, participants can be 30 and the same trainer to trainee ratio can be maintained. This allows for better communication, intensive interaction between trainee and trainer and, allows for better crowd management.

TRAINING PARTICIPANTS AND OBJECTIVES

Training participants: The participants targeted for Trainer of Trainers in the Care Groups are the Environmental Health Technologists, Community Health Assistants, Field Supervisors and District Nutrition Officers.
Duration: 7 days

Training objectives

- To develop understanding of the Care Group Model and its use for the converging of multisectoral services
- To develop an understanding of the multisectoral approach to reduce stunting.
- To provide additional practice and guidance on use of CG reporting forms
- To refine understanding of Field Supervisors' role under National Food and Nutrition Strategic plan

TABLE 1: LIST OF SESSIONS

Session 1	Training Overview and pre-test
Session 2	Overview of The FANSER Project
Session 3	Care Groups and why the Care Groups
Session 4	Care Group Characteristics
Session 5	Organizing Communities into Care Groups
Session 6	Job descriptions, the role of Nutrition Volunteers, Health Promoters, Field Supervisors and Nutrition Officer
Session 7	Training Process
Session 8	Negotiating Behavior Change
Session 9	Supervising Health/Sanitation Promoters
Session 10	Supervision Responsibilities and Work Plans
Session 11	Monitoring and Improving Facilitation
Session 12	Principles of Giving Positive Feedback
Session 13	Volunteer Motivation and Incentives
Session 14	Kitchen Garden
Session 15	Behavior Change Communication (BCC) Materials
Session 16	Practice Presentations and Community Program Orientation Lesson
Session 17	Care Group Monitoring and Evaluation System: Reports (Nutrition Volunteer hardcovers, Promoter and Supervisor reports)
Session 18	Post-test and Workshop Closing

ORIENTATION SCHEDULE

Day	Morning			Mid-Morning			Afternoon			
1	**(08:00-09: 30) Session 1**: Training Overview and pre-test	**(09:30-10: 35) Session 2:** Overview of the FANSER approach to addressing Stunting	BREAK	**(11:00-13:00) Session 3**: Care Groups and Why Care Groups		LUNCH	**(14:00-14:30) Session 3 cont.':** Care Groups and Why Care Groups	**(14:20-16:45) Session 4:** Care Group Characteristics		**(16:45-17:00)** End of Day Evaluation, afternoon tea and close
2	**(08:00-08:20)** Morning Check-in and recap	**(08:20-10:35) Session 5:** Organizing communities into Care Groups		**(11:00-13:00) Session 6**: Job Descriptions (NV, HP & SP, FS, NO)			**(14:00-16:00) Session 7**: Training Process	**(16:00-16:45) Session 8:** Introduction to Negotiating Behavior Change		**(16:45-17:00)** End of Day Evaluation, afternoon tea and close
3	**(08:00-08:20)** Morning Check-in and recap	**(08:20-10:35) Session 8:** cont.' Negotiating Behavior Change		**(11:00-12:00) Session 8**: cont.' Negotiating Behavior Change	**(12:00-13:00) Session 9:** Supervision Health Promoters		**(14:00-14:45) Session 9 cont.'**: Supervision Health Promoters	**(14:45-16:45) Session 10:** Supervision Responsibilities and Workplans		**(16:45-17:00)** End of Day Evaluation, afternoon tea and close
4	**(08:00-08:20)** Morning Check-in and recap	**(08:20-10:00) Session 11:** Monitoring and Improving facilitation		**(10:30-12:00) Session 12**: Principles of positive feedback	**(12:00-13:00) Session 13:** Volunteer Incentives		**(14:00-14:40) Session 13 cont.'**: Volunteer Incentives	**(14:40-16:15) Session 14:** Kitchen Garden	**(16:15-16:45) Session 14:** Introduction to BCC material	**(16:45-17:00)** End of Day Evaluation, afternoon tea and close

5	**(08:00-08:20)** Morning Check-in and recap	**(08:20-10:00) Session 15:** Introduction to BCC c'ontd		**(10:20-12:00) Session 15:** Introduction to BCC c'ontd	**(10:30-12:10) Session 16**: Practice presentations and community program Orientation		**(14:00-15:35) Session 17** Care Group Monitoring and Evaluation System	**(15:30-16:00) Session 17:** Care Group Monitoring and Evaluation System	**(16:00-16:45) Session 18:** Post-test	**(16:45-17:00)** End of Day Evaluation, afternoon tea and close
6	**(08:00-08:20)** Morning Check-in and recap	**(08:20-10:30)** overview to lessons and practice		**(10:30-13:00)** Introduction to lessons and practice			**(14:00-16:45)** Introduction to lessons and practice			**(16:45-17:00)** End of Day Evaluation, afternoon tea and close
7	**(08:00-08:20)** Morning Check-in and recap	**(08:20-10:30)** Introduction to lessons and practice		**(10:30-13:00)** Introduction to lessons and practice			**(14:00-16:00)** Introduction to lessons and practice			**(16:00-17:00)** End of workshop evaluation, presentation of certificates and closing

SESSION 1: TRAINING OVERVIEW AND PRE-TEST]

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. To establish participants' knowledge and understanding of the care group model (pre-test)

Summary: 1 hr. 45 min	**Materials:**
• Introductions and Training Expectations (30 min) • Activity 1: Getting to know one another (15 min) • Training Objectives (10 min) • Review the Agenda (10 min) • Training Rules or Guidelines (10 min) • Pre-Test (30 min)	☐ Attendance sheet ☐ Name tags for each participant or cardstock for table tents ☐ Agenda ☐ Flipchart and markers ☐ LRNA (Handout 1A from facilitators toolkit) ☐ Pre-test (handout 1B from facilitators toolkit)

Introduction and Training Expectations (30 min)

Go around the room and have each participant introduce themselves and give their expectations for the training. List each one on the flipchart.

Activity 1: Getting to know one another (15 min)

Play a game that allows the group to learn something about other members from the group.

Stand up if: In this game, the facilitator asks participants to stand up if participants meet a specific criterion (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 Facilitator: *A higher energy variation could be used, called That is Me! – Have participants stand, throw both hands up overhead, and shout "That's Me!"*

Sample criteria

- Have children
- Likes watching Chipolopolo
- 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?
- *Have each person suggest a criterion*

Note: be sure to include at least one question that most of the group can say yes to.

Training Objectives (10 min)

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 min)

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 min)

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.

Pre-Test (30 min)

Tell participants that everyone will take a pre and post-test so that the trainers can gauge if all the training objectives have been met. Remind participants that the pretest will be difficult since they are new to the material. Be sure to let them know that the aggregated test scores will only be shared with their managers, to reduce test-anxiety among the group.
Facilitators should review how to fill out the question paper:

- Remind participants to enter their name at the top of page one.
- Circle the best answer.
- 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 20 min have passed.

SESSION 2: OVERVIEW OF The FANSER Project

Objectives:	
1. Participants will be able to state how the Care Group (CG) methodology contributes to the nutrition strategic objectives and/or results. 2. Participants will be able to understand about the structure of CG approach (e.g., number of staff, supervision levels, training, and training process). 3. Participants will be able to identify their position on a CG chart.	
Summary: 1hr.35 min	**Materials:**
• Presentation: Overview of program Information (1 hr.) • Activity 1: Matching Objectives and Activities (20 min)	☐ Power point presentation from Staff Orientation ☐ Handout 2A: FANSER Objectives on strips of paper

Presentation: Overview of FANSER Project (1 hr.)

Provide orientation on the program, including information on strategies, responsibilities, actual activities, and CG structure. The overview to include Activity 1 to gain a better understanding of the program goal, objectives, results, and activities. The presentation can highlight the program overview of FANSER project and how intervention link to First 1000 Most Critical Days Program Phase II (30 min)

Activity 1: Matching Goal, Objectives, Results and Activities (20 min)

Give the strips of paper that contain the goal and strategic objectives of the Food and Nutrition Security Enhanced Resiliency, strategic objectives (SOs) document, intermediate results mixed – to the participants. In a small group, ask participants to identify the program goal from the strips of paper, as well as the strategic objectives, intermediate results for each SO and priority interventions or project activities. Then, participants must match the activities to the results and the results to the objectives. After 15 min, the facilitators will check to see if they are correct and go through the overall flow.

Notes to the facilitator: Refer to the annex on the FANSER results framework

SESSION 3: CARE GROUPS AND WHY THE CARE GROUP

Objectives:

1. Participants will be able to list three characteristics of Care Groups and identify key differences to 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 peer to peer support groups are effective.
4. Participants will be able to state why the primary target of Care Groups are pregnant or lactating women and children under two years of age.
5. Participants will be able to state why Care Groups focus on household behavior change.

Summary: 2 hr. 20 min

- Activity 1: What are Care Groups (with emphasis on behavior change communication)? (20 min)
- Activity 2: How Effective Are Care Groups? (20 min)
- Activity 3: Diagramming Care Groups (20 min)
- Activity 4: Frequently Asked Questions (30 min)
- Activity 5: Why do CGs focus on pregnant and lactating women? (15 min)
- Activity 6: Why do CGs focus on HH behavior change? (15 min)
- Activity 7: Completing the CG Reference Table (20 min)

Materials

- ☐ Projector and laptop (if possible)
- ☐ Handout 3A: Care Group Diagrams [Print one per participant unless noted]
- ☐ Handout 3B: Causes of Death in Children less than Five Years of Age, Lancet
- ☐ Handout 3C: Results from operations research
- ☐ Print Handout 3D: CG Reference Table (blank) – one per participant
- ☐ Print Handout 3E of completed CG Reference Table for facilitators
- ☐ Power point Presentation Session 3
- ☐ Flipchart paper
- ☐ Bolstic
- ☐ Markers

Activity 1: What are Care Groups (with emphasis on BCC? (20 min)

? Ask participants: "Has any of you heard about Care Groups?"

Identify participants who indicated 'YES' to share one or two things they have heard (Ask for a volunteer to summarize participants' thoughts on flip chart paper). Encourage people with experience of 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 related to **health and nutrition practices.**

- A Care Group is a group of 8-12 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 8-12 of her/his neighbors. Sharing what s/he learned and facilitating behaviour change at the household level.
- Care Groups create a multiplying effect to equitably reaching every beneficiary household with interpersonal behaviour change communication and negotiation. (Write this statement on a flipchart and ask the group to discuss the meaning especially looking at underlined words and thinking about how behavior change occurs.)

Activity 2: How Effective Are Care Groups? (20 min)

- Use power point presentation Session 3: *Introduction to Care Groups* – use Tables 1 and 2 to show proof of the effectiveness of Care Groups.
- Look at **Table One:**
  - **Main point:** USAID CSHGP projects that used a Care Group Model had a greater impact on health/nutrition-specific indicators, such as exclusive breastfeeding, birth spacing, underweight, using insecticide-treated bed nets, and several other indicators, compared to CSHGP projects that did not use the CG Model.
  - 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 outperformed the average child survival project in terms of indicator gap closure on all indicators 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.
  - **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.
    - Acronyms used in the table 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 bed net last night; Danger Signs = maternal knowledge of child danger signs; AIDS Know = maternal knowledge of HIV risk reduction; HWWS = Handwashing washing with soap.

- Now look at **Table Two:**
  - In case you might think that these results are atypical, here is 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 (Nutrition Volunteers) – coached and trained by paid CHWs (Promoters) – mak e 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.

Introduction to Care Group

***Note to facilitator**: Facilitator to 'set the scene' ahead of this session using the following key notes for participants BEFORE you start the activities*

- In this session we do draw specific evidence from the World Relief/Food for Hungry tried and tested 'Care Group Model' as a basis for reaching FANSER households with a package of SBC messages for improved nutrition
  - Care Groups have historically sat within donor funded projects, whereas FANSER Care Groups in Zambia will be implemented within the MOH structures. This is to allow for increased sustainability
  - Improved integration and convergence of both nutrition-specific and nutrition sensitive activates being layered to target HHs.
- Care groups originated in Maternal & Child Survival programs, and as such some evidence and therefore examples used do lean towards 'health examples'
  - PLEASE REMEMBER: Whilst Care Groups aim to improve a nutrition outcome 'stunting reduction' several sectors play a major role in improving the basic and underlying causes of malnutrition for this to happen, therefore CG are multi-sectorial by design.

Activity 3: Diagramming Care Groups (20 min)

Pass out Handout 3A: Care Group Diagrams. Give participants 10 min in small groups to look over the handouts. Ask them to try to estimate how many mothers they could reach with 30 total Health Promoters (HPs) in a program, 6 Care Groups per Promoter, 10 Nutrition Volunteers (NVs) per 'Care Group', and 10 households per CG 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 CG model in **one village**, using 5 Health Promoters, 6 Care Groups per Promoter, 10 NVs per Group, and 10 Neighbour Households per NV. Ask participants to diagram this in a different way than what is shown in Handout 3A.

Alternate option: On a flipchart, draw one or both diagrams from Handout 3A Ask a volunteer to explain the diagram to the group.

Activity 4: Frequently Asked Questions (30 min)

Ask participants "What questions do you have about CGs and the CG 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, if so, let participants know that is coming up. If you do not know the answer, it is better to say so, and 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 have not already been asked).

FAQS:

- How do Nutrition volunteers find time to work as volunteers?
    - Generally, Nutrition Volunteers are expected to attend a 2hour Care Group meeting with the Health Promoters once a month and meet 1-2 times a month with the beneficiaries who are the neighbors they serve, through home visits.
        - The Volunteers are men or women who are usually nominated for the position by other households in their neighbor Group. If more than one person is nominated, the group should vote to select their most preferred person. The elected or chosen person should be given the choice to become an NV. Some may decline because they are too busy.
- Why do People become NVs?
    - They become NVs 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?
  - Previous care group experience shows giving Volunteers "tools for the job" such as flipcharts and other messaging materials. Some Care Group program have 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 NVs and HHs. If only NV receive incentives, it can create jealousy between the HH and the NVs who aim to serve them.
- How are NVs motivated without the use of incentives? (Refer to Handout 3C: Results from Operational Research.)
  - There is consistently **high attendance and low turnover** of NVs in most countries which could indicate high motivation.
  - NVs have reported **decreases in domestic violence**, and receiving **more respect from their spouses, parents, community leaders and in-laws.**
  - **NVs want to help others and be useful** in their communities. (***Purpose***)
  - **NVs learn new things. (*Mastery*)**
  - **Community Leaders' public recognition and praise** of the NVs during community meetings.
  - **Feelings of pride** in the fact that the community recognizes their work, trust them, and seeks advice from them.
  - **NVs 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: Why do Care Groups (and our Care Groups) focus on pregnant women and children under two, or the first 1000 days? (15 min)

Tell participants, 'Most Care Groups have focused on pregnant women and mothers of children under two, also known as the 'first 1,000 most critical days. Why do you think it's important that we focus on this age group?' Have participants discuss this question as a group and then 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.
- Mention cycle: children under two who do not grow well and become stunted are more likely to have low birthweight/undernourished children.
- Mention 1,000 Most Critical Days Initiative under the Government of the Republic of Zambia. It aims to improve health/nutrition of pregnant women and children under two.

Activity 6: Why do Care Groups (and our Care Groups) focus on household behaviors? (15 min)

NB: this is an EXAMPLE that is health focused but the key concept is the same across sectors,
Pass out Handout 3B: Causes of Death in Children less than Five Years of Age, Lancet.
Ask participants to spend 10 min looking at the diagram and to discuss, as a table, what the diagram means. After 10 min, 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/CG focus on the first one thousand days and household behavior change.

Thank the group for their comments and say that in future sections we will continue to learn more about Care Groups (adapted from the Care Group model)

Activity 7: Completing the CG Reference Table (20 min)

Before starting this activity, go through the program structure for FANSER to review number of Field supervisors, Promoters, Nutrition Volunteers, etc.

Preparation: Complete table in Handout 3E: CG Reference Table. Save it as a separate file.

Give participants Handout 3D: 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.

SESSION 4: CARE GROUP CHARACTERISTICS

Objectives:	
1. Participants will be able to explain why each Care Group (CG) characteristic is important. 2. Participants will be able to explain how to phase out beneficiaries from Care Groups	
Summary: 2 hr. 20 min • Activity 1: Characteristics for Your Care group Program (2 hr.) • Activity 2: Beneficiary graduation process (20 min)	**Materials:** ☐ Flipchart, markers and bolstic ☐ Handout 4A: Care Group Program Characteristics – Blank (With Column C left blank) ☐ Handout 4B: Care Group Program Characteristics – Completed (With Column C information included)

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

- Give each participant Handout 4A care group Program Characteristics – *Blank*
- Divide participants into groups of 4 -5; assign each group 7-8 characteristics to review.
- Ask each group to fill in Column C: 'Why is this important?' for their assigned characteristics. In their groups, the participants should spend time discussing how their characteristic makes their Care group Program more effective and other reasons the characteristic might be important. They should note their response in Column C. Give each table/group 10 min per characteristic to complete this.
- Once everyone has completed their group work, discuss each characteristic one by one as a full group. Have each pair 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 these characteristics allow their program to fit the 'Care Group Criteria' which was developed between Food for the Hungry (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 that everyone has a full, completed table for reference.

Note to facilitator: *CG Characteristics were adopted from the care group model*

1. The target group should be pregnant women and mothers with children under two

? Why do you think this is important?

During pregnancy, lactation, and infant growth there is an increased demand for nutrients by the body. Inadequate dietary intake and disease lead to under nutrition.

- Targeting women and children under two is a 'window of opportunity' where pregnant and lactating women and young children are most vulnerable to disease and death, and where nutrition specific and nutrition sensitive interventions can have the greatest impact.

2. At least 90% of all households in the community (with pregnant and lactating women and children under two) will be reached by CG.

? Why is this important?

- To create a "new social norm" (not one person changing behavior, but many encouraging each other), we need to reach 90-100% 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 Nutrition Volunteer for every 10-12 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 90-100% of target households if each Nutrition Volunteer (NV) can only reach 10-12 individual homes"?

- We need to make sure that we have enough NVs so that we can effectively reach 90-100% of households in our target group.

- Do not overburden your NVs with too many households. Be sure your structure includes the right number of NVs to account for the size of your community.

3. Nutrition Volunteers (NVs) should visit not more than 12 households (neighbours 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.
- If you over burden volunteers, the larger the cost on the program in terms of quality-of-service delivery.

  We want Nutrition Volunteers to form strong bonds with those that they meet.

Note to Facilitator: *Each NV should have between 10-12 households. In some cases, it may not be possible to have this number of households. The lowest number of households per NV is 8. This decision should be arrived at in consultation with the supervisor and the Nutrition Officer.*

Example 1

- How many digits are there in your (local) phone number after the prefix (here the prefix numbers are the first 4 digits common to all or most numbers i.e., 0977, 0966,0955,0777, 0978 etc.? 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

- Psychologists 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 12 people we begin to overload. We cannot take the emotional strain and energies needed to care for more than 12 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 they visit.
- Sixteen households (from the research) are too many. We suggest 10-12 households.
- If you exceed this number, then the quality of your CG Volunteer interactions greatly reduces. Do not do it. The minimum limit is 6 and the maximum is 12 households.
- And the more households you add, the greater the drop out and the greater the reduction of behaviour change.

4. The Care Group (groups of NVs) should have approximately 10 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 7-10 people, you can see each of them and talk with each of them in a group. Larger than 10 and especially larger than 12 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

Source: Jenny Rogers 1989

For example: In one of Food for the Hungry 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 behaviour change in these groups? (No. Why not?)

- Because they were too big that people were not able to interact, ask questions, or relate to the facilitator.
- They could not "see changes" in the facilitator's own life (they were not his 10 closest neighbors).

Note: *Each CG should have between 10-12 volunteers. The least number of volunteers in a Care Group should be 6. Any lower number the program becomes less effective. The decision to go as low as 6 volunteers per CG should be arrived at in consultation with the supervisor and the Nutrition Officer.*

5. Nutrition Volunteers (NVs) 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 neighbour has been found through research to be more effective.
- The important thing to remember here is that the NVs must believe what they are promoting. This is the biggest difference between the Block Leader approach and the CG Approach.

? Will the chosen NVs already be practicing the behaviour that we want them to? (Probably not).

? Whose responsibility is it to help NVs 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. The CG model is anchored on promotion of "Peer to peer" support. Chosen women or men are "role models" (early adapters) of the behavior change.
- If the NVs 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

- An 'Abstinence promoter' 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 behaviour and struggles in being abstinent.
- Do you think this promoter was an effective teacher or Leader Youth? (Probably not).

- It is very important that we work first to gain buy-in from our leaders and once they are convinced, their "believability" in the community will greatly increase.
- It will take time; it will not happen overnight.

- We will not force NVs 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 behaviour the more likely YOU will change yourself. (More about this later)

6. All beneficiaries for an NV should live within a distance that facilitates frequent home visitation, and all NVs should live less than one hr. 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 between 5-6 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 60, or six groups (assuming a CG size of between 6 and 12 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). For the FANSER Program, the maximum number of CGs per promoter is 6 and the maximum number of volunteers per CG is 12.

8. Promoters will supervise at least one NV from each CG teaching her neighbours 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 beneficiaries to make sure we meet our program goals.
- Promoters will supervise with a Quality Improvement and Verification Checklist -QIVC. (This will be looked at in detail in the supervision session).

9. **Nutrition Volunteers (NVs) will visit the neighbour households at least once each month**

? Why is it important for them to visit their neighbors at least once each month?

- To build trust and "sympathy" (refer to the sympathy groups above).
- We believe that the better relationship that the NV has with the beneficiary, the greater the behaviour 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 NV 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 wash your hands every time you use the latrine?
- Allows for a good relationship over an extended period. 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 an NV and their neighbours
- Strong relationships increase behaviour change as the NV 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.

10. The Care Group meeting (when promoters come to teach the NVs) 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 NVs – they are volunteers, and we must not take too much of their time away.

11. Nutrition Volunteers (NVs) 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 NVs in teaching, but it also encourages the beneficiaries to listen, learn and watch.

12. Nutrition Volunteers (NVs) use participatory methods of teaching (non-formal education) when doing health promotion 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.

13. Nutrition Volunteers (NVs) will collect information on attendance, referrals and linking members to other services, tracking successes and challenges at each household.

? Why is this important?

- Will help the NVs to become more "attuned" to health behaviour in your community as well as how their work affects others.

- NVs report the information to the promoters; this can be used to help alert other local service providers (such as health clinics, farmers group and savings groups) and communities of areas that need more assistance or interventions.
- In addition, the Ministry of Health (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.
- Other household members can also be linked to community services that can contribute to positive nutrition outcomes for our primary target. For example, a pregnant woman who is part of the CG whose husband wants to diversify his food crop production to provide more diverse food for the family could be linked to the lead farmer.
- Working together, the CG (with the promoter's support) identifies what the volunteer can do to respond to a situation.
- The CG needs to be designed so that NVs are trained by the promoters to be able to solve problems and understand the information that they gather in the community. They especially need to know when it is necessary to refer the HH members to the needed available services, e.g., a child to the clinic for SAM treatment, SILC, Agriculture
- This way when the program is over, the NVs know exactly how to interpret the information that they receive on their own.
- Nutrition Volunteers report referrals made to their promoter. This is important for knowing when to schedule a practical session, and for following up with households referred to a health facility to see if they went to the facility, if not – why not, and what additional support they may need from their volunteer.
- A low attendance rate (<70%) at CG meetings is often an indication that something is wrong somewhere, either with the teaching methodology or the promoter attitude, and helps the supervisors to identify problems early in the process.
- Documenting and discussing program successes and challenges is important for improving the quality of program activities and ensuring activities are effective in changing household behaviour.

Care Group Volunteers

- At the CG meeting each month, verbally report referrals made to health facilities and any other service providers.
- Illiterate volunteers can easily recall all referrals because these events are generally infrequent among their 10 assigned households.
- A literate volunteer (often the CG leader/promoter) records the information.
- The CG leader turns in the form to the promoter.

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

Formative research also helps assure that the behaviours' promoted by project staff are more feasible by community members. Through the multisectoral coordination structures and National Food and Nutrition commission, periodic research is carried out. It is such research which informs the program on specific barriers which communities face in changing behaviours of interest.

Activity 2: Beneficiary Graduation process (20 min)

- Ask participants to share what they think should determine the Care Group beneficiary to be graduated from the neighbour group.
- Allow a discussion and capture feedback on a flipchart

The FANSER technical working group on the Care Groups proposed one criterion as follows:

1. Any enrolled household will be graduated once it has undergone the whole lesson package. This is regardless of the age at which the child is, for those enrolled with children under the age of two.
2. Linking the graduated households to other project or government services such as SILC, Cooperatives, FSIP.

SESSION 5: ORGANIZING COMMUNITIES INTO CARE GROUPS

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 Neighbour Groups and Care Groups through a census, community list or community gathering.

Summary: 2 hrs.	**Materials:**
• Priorities when Organizing CGs (15 min) • Two Approaches to Forming CGs (30 min) • Activity 1: Creating a Community Map (45 min) • Activity 2: Forming CGs Role Play (30 min)	☐ Flipchart paper, markers, pens for participants ☐ Handout 5A: HH House-hold registration form ☐ Handout 5B: Creating a Community Map [Print one copy for every 4 participants] ☐ Handout 5C: Community Census ☐ Handout 5D: List from Census of HHs in a Sample Community [Print one copy for every 4 participants]

Priorities when Organizing Care Groups and Neighbour Groups (15 min)

Now we are going to learn about how you form CGs. One of the most important things to keep in mind when forming CGs is to make sure that the NVs live close to the HHs they visit.

? Why is this important? Why do we need NVs and HHs to live close to each other?

It is preferable that the CG Volunteer does not have to walk more than 45 min to get to the furthest house that they visit so that regular visitation is not hindered. 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 behaviour change. It is also important that NVs do not have to walk over 1 hr. to get to the CG Meeting. Whatever way you decide to form CGs, it is a high priority to ensure that the method you use groups women by geographic proximity.

? If after attempting to form CG, you find that women are walking more than one hr to attend CG meetings. What should you do?

If NVs are walking more than 1 hr to attend CG meetings, the problem should be brought to program management. They can review the coverage strategy and adjust it to allow for smaller CG's.

Another important factor in forming CGs is to make sure that all (or nearly all) of our target beneficiaries (household with WRA- PLW and children under 2) are in CGs.

? Why is this important? Why do we need to ensure that nearly all our target beneficiaries are

a part of a Care group Program?

To create a supportive social environment for behaviour change, it is important that many mothers adopt the new practices being promoted. Behaviour change is much more likely to happen when there is regular, direct contact with <u>all</u> 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 neighbour, in groups of two, and brainstorm for two mins)

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

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

Two approaches to forming Care Groups (30 min)

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 personnel on the ground, that can identify all the PLW/women with children under 2 years in the program area?
2. When was the last census conducted in the program area?
3. Is there a list of every household in the program area?
4. Is there another active program(s) in the program area that works with PLW/women with children under 2 years?
5. If a community leader called all the PLW/women with children under 2 years to meet on a specific day and time, how many would be willing and able to show up?

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

Using information from the household registration kept by the village, we can create a list of all households in each community that have a PLW or CU2. If registration need updating, see handout 5A. We will use this as the basis for forming Neighbour Groups, in addition to some of the other tools described below.

If there are already active programs in your geographic areas that work with PLWs/women with children under 2 years, 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 and 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**.

Option 1: Forming Care Groups based on lists

1. If community leaders do not feel it is necessary to use a map to group women into Neighbour 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 and ensure that any women missing are added on.
3. It is more difficult to tell how close the NVs and HHs are to each other using this method.

Option 2: 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 min)

1. Split the participants into groups of four. Assign two participants as Community Leaders (CL) and two as census takers.
2. Sub-Divide the community

a. Pass out the blank outline of a Community (Handout 5B: 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 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 neighbourhoods, 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.)

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

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

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

8. Pass out Handout 5C: Community Census and have the groups fill out the census for one group of 10 HHs (Neighbor Group) plus the one NV.
9. Fill in the household number (HH #) that corresponds the houses in your Neighbour Group.
10. 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 J
11. For the household where the elected NV lives, assign a letter between A-F and place that letter next to the corresponding house on the map.
12. Then, give your Neighbour Group (including the NV who is leading them) a temporary number (1-11).

Activity 2: Forming Care Groups scenarios (30 min)

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 min to discuss).
3. Request feedback from the remaining participants.

? Would they have done something different?

Scenario 1:

You are a Health/sanitation Promoter, and you were just assigned by the Field supervisor 3 weeks ago. You have attended your CG Training and are now ready to form CG. You know you will be responsible to oversee 5-6 CGs, so 60 Nutrition Volunteers in total. This means you will have around 600 PLW in your area!

You have 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 helped count people.

? How will you organize the community into CGs?
? 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 2:

You are also a Health Promoter, and you were just assigned by the Field supervisor 3 weeks ago. You have attended your CG Training and are now ready to form CGs. You know you will be responsible to oversee 5-6 CGs, so 60 Nutrition Volunteers in total. This means you will have around 600 PLW in your area!

You are excited about this role because it allows you to execute work that can save the lives of the children in your work area. In several of your villages, you know that an NGO is working on breastfeeding and complementary feeding. However, in recent years, their trainings have been infrequent, and they do not seem to have a big presence in your community.

? How will you organize the community into CG?
? 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 3

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 Neighbour Groups with ten HHs plus one woman who will be elected to be the NV.

? Around how many Neighbour 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.

Frequently Asked Questions

? What if a locality does not have enough women eligible to participate in the FANSER Program to form a nutrition group with at least 6-12 women? (6 is recommended for communities which are sparsely populated)

If there are not enough women to form a Neighbour Group and elect an NV, then the Health Promoter should report this problem to his/her supervisor. It could be that another Health Promoter has too many eligible women in his or her area (requiring that he/she forms groups larger than the targeted number). In that case, the Health Promoter coverage may need to be adjusted. The minimum number of volunteers in a CG should be 6. Any lower, the program becomes less effective.

? 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.

? Who supervises the CG in a ward where there are more than one health facilities?

? If the health facility catchment area covers two wards, who manages the CG in the other ward (as is the case for health facility one in Handout 5E)?

Lead a discussion and get responses from participants and list them on a flip chart. To conclude the discussion, use handout 5E and explain by adding the following:

1. In the first question, where a ward has more than one health facility, each health facility will have a CG supervisor to cover their catchment area.
2. In the second question, a health facility will be responsible for its entire catchment area irrespective of the ward. Additionally, when reporting, the supervisor should indicate in which ward, a particular CG falls.

? What should be done when a health facility shares a boundary with another none-FANSER District and provides health services to some households in that district?

Lead a discussion and get responses from participants and list them on a flip chart. To conclude the discussion, use Handout 5E "Ward Map" and explain by adding the following:

1. The health facility can extend their services, including the CG model to these areas provided they still fall within the country boundary (Zambia).

? Where are the promoters selected from?

Refer to Handout 3A "CG Structure". *Lead a discussion and get responses from participants and list them on a flip chart. To conclude the discussion by adding the following:*

1. Health Promoters are selected from the pool of Nutrition volunteers. Additionally, they must meet the criteria to be discussed in session 6.

Note to facilitator: *Participants decisions on how they would like to form Care Groups*

SESSION 6: JOB DESCRIPTIONS, THE ROLE OF NUTRITION VOLUNTEERS, HEALTH PROMOTERS, NUTRITION FIELD SUPERVISORS AND NUTRITION OFFICER

Objectives:

1. Participants will be able to differentiate between the essential responsibilities for Nutrition Volunteers, Health Promoters, Care Group Supervisors, and Nutrition Officer.
2. Participants will be able to list essential characteristics of Nutrition Volunteers for this project.

Summary: 2 hr.	**Materials:**
• The Responsibilities of the Care Group Team (30 min) • Activity 1: CG Team Responsibilities (45 min) • Activity 2: Characteristics of Nutrition Volunteers (25 min) • Activity 3: Creating a Final List of CG Volunteer Characteristics (20 min)	☐ Scissors, markers, tape, and butcher/flipchart paper. ☐ Handout 3A: Care Group diagram [Already printed in Care Group Introduction Lesson] ☐ Handout 6A: Care Group Team Essential Responsibilities Jumble (cut into strips) [Print one set] ☐ Handout 6B: Care Group Team Essential Responsibilities [Print one for each participant] ☐ Handout 6C: Characteristics of Nutrition Volunteers (cut into strips) [Print one set per group]

The Responsibilities of the Care Group Team (30 min)

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

? What do you think are the major activities the Nutrition 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. Write participants responses on a flip chart. Compare responses listed and complete using the list below.

Nutrition Volunteer Essential Responsibilities

1. Visit 10 Neighbour households at least once a month to promote behaviour change using the counselling cards, action cards and lesson booklet.
2. Meet once every month or two with the neighbor group to conduct group cooking sessions, kitchen garden demonstrations, or other group activities.
3. Report to the Health Promoters on a monthly basis the number of Neighbor households

they have visited or who attended the group activities.

4. Refer WRA, PLW or Cu2 to the health facility or other services, as necessary.
5. Support practical sessions within Care Groups.
6. Mobilize Neighbour households to participate in community activities that will benefit their families such as Immunization Campaigns, food production, and/or latrine construction.
7. Attend Care Group meetings (the monthly trainings) provided by the Health Promoters.
8. Report problems that cannot be solved at the household level to the local leadership and request support and collaboration from the Health Promoters.
9. Model the health, nutrition, and sanitation behaviours' they are teaching Neighbour households.

? What do you think are the major activities the Health Promoters will do?

Lead a discussion focusing on the Health Promoters essential responsibilities listed below. Ask questions to help participants think through what responsibilities might be. Write participants responses on a flip chart. Compare responses listed and complete using the list below.

Health Promoter Essential Responsibilities

1. Coordinate activities at the ward/Zone level and maintain cooperation with other structures involved in community action at community level such as the ZNCC, NHC (and/or the village council, churches, and schools).
2. Need to work together with other sectors in the ZNCC, NHC for multi-sectoral response within CG
3. Report's progress of CG to the Field Supervisor.
4. Facilitate organized, participatory learning sessions with each of their Care Group (made up of 10 Nutrition Volunteers) every month, following the lesson plans in the educational materials provided.
5. Collect and analyze household data from Nutrition Volunteers and write program reports.
6. Attend monthly Training and Reporting Meetings provided by the Field Supervisor. From these trainings, Health Promoters should be able to accurately replicate trainings received with Nutrition Volunteers, sharing correct information, and demonstrating skills learned.
7. Model the health, nutrition, and sanitation behaviours they are teaching to Nutrition Volunteers in their own homes, located in the community.
8. Visit and monitor each Nutrition Volunteer. Supervise the work of Nutrition Volunteers by accompanying them on home visits to Neighbour households.
9. Assist with other program activities such as: National Vaccination Days, distribution of Vitamin A and deworming medicine, weighing of children <5years of age, or other community health events.

10. Help coordinate with other intermediaries (FA, /PSP/SLF) and conduct nutrition related activities.

? What do you think are the major activities the Field Supervisor will do?

Lead a discussion focusing on the Field Supervisor *essential responsibilities listed below. Ask questions to help participants think through what responsibilities might be. Write participants responses on a flip chart. Compare responses listed and complete using the list below.*

Field Supervisor Essential Responsibilities

1. Coordinates with program partners, staff, and other stakeholders regarding upcoming activities and needs at the community and ward levels.
2. Need to work together with other sectors in the WNCC, for multi-sectoral response within CG e.g. Agriculture extension officer, community development assistant, fisheries officer etc.
3. Provides updates to WNCC on FANSER Program
4. Responsible for the performance and professional development of the Promoters who report to him/her.
5. Receive monthly lesson from Nutrition Officer in preparation to share with Promoters
6. Review Flipchart Lesson Plans with Promoters every month and assure they understand the information well and can teach back the information in a participatory manner.
7. Coordinate with existing community groups leaders to promote relevant nutrition specific and sensitive practices
8. Collect Promoters reports monthly, review the reports, and assure the information presented is reasonable and complete.
9. Prepare a monthly report using the information provided by Promoters.
10. Ensure program quality among Promoters.
11. Maintain a filing system so that copies of Promoters Reports and Field Supervisor Reports are easily accessible.
12. Responsible to supervise each Promoters who reports to him or her in the field at least twice a month, using the Promoters Supervision Checklist in the annex Handout 10A.
13. Responsible to liaison with the appropriate people in a timely and professional manner to ensure the logistical issues required to implement project activities.

Requirements for Field Supervisor/GRZ focal point person

1. Salaried GRZ and Project Partner staff, Project staff to be attached to the Health Facility reporting Technically to the Nutritionists (Project and MOH) the Health Facility in-charge will still provide oversight to this person, if they themselves are not the focal point person

2. Personnel from health facility structure (Community Health Assistant (CHA), Environmental Health Technologist (EHT), Nurse, Nutritionist etc.)
3. Able to consolidate and submit timely Promoters reports
4. Preferably trained in MAIYCN

? What do you think are the major activities the Nutrition Officer will do?

Lead a discussion focusing on the Nutrition Officer essential responsibilities listed below. Ask questions to help participants think through what responsibilities might be. write participants responses on a flip chart. Compare responses listed and complete using the list below.
Lead a discussion focusing on the Nutrition Officer *essential responsibilities listed below.*

Nutrition Officer Essential Responsibilities

1. Provide technical leadership, guidance and support and oversight of Care group Model in the district
2. Train Field Supervisors in Care Group approach, behavior change methodologies and technical lessons.
3. Works with other sectors in the DNCC, for multi-sectoral response within CG Model
4. Stay abreast with relevant evidence and guidelines, review available technical materials, develop, or adapt materials as necessary, share with Field Supervisors and assist partners to adopt best practices.
5. Support quality assurance through regular technical reviews and technical input on monitoring and evaluation indicators.
6. Assess staff capacities and coordinate initial or ongoing trainings based on need and program goals.
7. Prepare a monthly report using the information provided by Field Supervisors.
8. Provide updates to DNCC on Care Group Model
9. Participate in supervisory visits, together with the Provincial and district coordinators, to provide technical guidance and support to Field Supervisors.
10. Ensure that the program is well represented in regular district/provincial level meetings and forums.
11. Identify learning needs of Field Supervisors and provide mentorship to meet those needs.

Requirements for Nutrition Officer/District Nutritionist

1. Salaried Project staff/ MoH/GRZ staff,
2. Representative of FANSER and MoH in DNCC

3. Project staff supervised by the Regional Program Manager and MoH staff report to Principal nutritionist.
4. Ability to guide planning, budgeting, and contextual revisions of CG activities

Ensure 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: Care Group Team Responsibilities (45 min)

1. Using the Handout 6A: Care Group Team Essential Responsibilities Jumble, cut the paper into strips with one responsibility on each strip and mix them up.
2. Facilitator draws one slip and reads the responsibility. The participant to identify which position that responsibility falls under first wins that slip of paper.
3. Continue drawing slips until they are gone.
4. The participant with the most slips at the end wins.
5. When finished, distribute Handout 6B: Care Group Team Essential Responsibilities for participants' reference.
6. Ask if there are any questions regarding what each member of the Care Group team will be doing and respond to them.

Below are two examples of a previously used criteria for selecting volunteers as used in the Care Group Programs.

Example 1: Key Criteria for selecting Volunteers developed by the CRS Mawa Project-Eastern province, Zambia

1. Preferably female.
2. Mothers of healthy children (even if children are grown).
3. Old enough to be respected by beneficiary households.
4. Interested in health issues.
5. Positive attitude and the desire to serve neighbours.
6. Volunteers should possess good facilitation skills.
7. CG volunteers do not need to be very literate to be effective; but should be of the same literate level or slightly above that of the mothers in her group. Most of the reporting will be verbal. Basic reading and math would be an advantage.

Example 2: Criteria for selecting Nutrition Volunteers developed by a Care Group Project in Burundi

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 relationship 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	

Note to facilitator: *The success of each CG Model rests on committed volunteers who are truly interested in improving the wellbeing of their community.*
Each program should develop their own list of Nutrition Volunteer traits which they will use as their guide when recruiting Nutrition Volunteers, orienting community leadership, and when discussing the Program with stakeholders/ government officers.
There are a few traits that are essential and should be on every list of Nutrition Volunteer trait. 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 FANSER Project Principles.

Activity 2: Characteristics of Nutrition Volunteers (20 min)

1. Using the Handout 6C: Characteristics of Nutrition Volunteers, cut the paper into strips with one characteristic on each strip and mix them up. [Print a set for each group attending the training.
2. Divide participants into groups.
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 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. Provide blank strips to add any characteristics that may not be listed but that the participants think are important.

Activity 3: Creating a Final List of Nutrition Volunteer Characteristics (20 min)

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 Nutrition Volunteer Characteristics based on the work during this lesson.

For further discussion, ask participants:

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

Below is the list of recommended traits for Volunteers in a FANSER Program. Share handout 6D: Traits for Nutrition Volunteers

Traits for Nutrition Volunteers

Required (Must Have)	Desired (Good to Have)	Not Necessary
Must be **selected** from and **accepted** by the beneficiary Neighbour households Able to read and write in local language	Models FANSER promoted Behaviour e.g., good hygiene,	Mid-wife or traditional healer *Has bicycle*

	sanitation, and nutrition practices	
Respected by the neighbour households, trusted and honest	Ability to mobilize neighbor HH's for community events	Has a child in good health
Must be a resident within the CG locality		
Must be willing to work as a volunteer	Not addicted to alcohol	
Positive Attitude and desire to serve their community		
For initial recruitment this should be a person from a HH with a target group (WRA/PLW/primary caregiver of CU2)		
Must be confident to speak, listen and take action with peers		
Should have sufficient time to fulfil their responsibilities (12 hours per month) as a volunteer	/	

Traits for Health/sanitation Promoters

Candidates to fill the role of the Promoters must fulfil the traits in the table below and undergo a mini-interview to assess his or her basic mathematics, reading and writing skills.

Required (Must Have)	Desired (Good to Have)	Not Necessary
Must be a member of the Care Group (**selected** from the pool of volunteers in the Care Group)	Models FANSER promoted behaviors e.g., good hygiene, sanitation, and nutrition practices	Has children in good health
Respected by the neighbour households, trusted and honest	Ability to mobilize neighbor HH's for community events	
Must be a resident within the CG locality	Not addicted to alcohol	
Must be willing to work as a volunteer		
Positive Attitude and desire to serve their community		
Must be able to use a phone		

Must be confident to speak, listen and take action with peers		
Should have sufficient time to fulfil their responsibilities (12 hours per month) as a volunteer		
Attain a minimum of 7th grade education		
Able to read and write		
Must undergo and pass the Promoters interview		

Using handout 6D, go through the interview questions for the promoter with participants.

Particular attention must be given to the following traits in the Care Group *Criteria:*

REQUIRED: The model is based on peer-to-peer health promotion (mother-to-mother for MCH and nutrition behaviors.) NVs should be chosen by the mothers within the group of households that they will serve or by the leadership in the village.	Care Group 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 NVs) can be more effective in promoting adoption of behaviors among their neighbors than others who do not know them as well. NVs should be mothers of young children or other respected women from the community. NVs 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 an NV's beneficiaries (Neighbour households) should live within a distance that facilitates frequent home visitation and all NVs should live < 1 hr. walk from the Promoters meeting place.	It is preferable that the NV does not have to walk more than 45 min to get to the furthest house that she visits so that regular visitation is not hindered. (In many Care Group projects from which CG model is adapted, 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 Care Groups, the population density of an area should be assessed. A low NV: Mother Beneficiaries (Neighbour household) and low HP: Care Group ratio should be used when setting up Care Group in rural, low population density areas. If an area is so sparsely populated that an NV needs to travel more than 45 minutes to meet with most 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 NV should not be too extreme (e.g., having bachelor-degree level staff working with NVs).	We believe that keeping the educational difference between the Health Promoters and NVs to a minimum is useful in that it makes it more likely that the Promoters will use language/concepts that the NVs can understand. It also helps to keep costs of the model low.

SESSION 7: TRAINING PROCESS

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 Monthly Training Meeting and the purpose of these activities. 3. Participants are able to develop or review a lesson calendar	
Summary: 2 hr. Telephone Game (20 min) Training Race (20 min) Training Discussion (20 min) Agenda Assembly Activity (20 min) Agenda Discussion (20 min) Review of lesson calendar (20 min)	**Materials needed:** Flipchart or whiteboard with markers Masking tape (a strip for each team) Handout 7A: Training Table [Print one copy for every 2 participants] Handout 7B: Training Table Answer Key [Print one group of papers cut into strips for every 2 participants] Handout 7C: Agenda Assembly Game [Print 1 for every 3-4 participants; cut into squares] Handout 7D: Agenda Overview Answers Rocks to hold down papers (or tin cans or baskets to hold the slips of paper for each team). Handout 7E: Sample of a lesson calendar (one for each pair) Prizes for winning teams (small gifts like sweets)

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

Telephone Game (20 min)

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.

Discuss the following 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 if 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 cannot 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, 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 min)

Note to facilitators: *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 pairs 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 Field Supervisor be longer or shorter (in hour) than a training given by a CG Volunteer?

  Answer: Those with more responsibilities will give very detailed trainings that are more intense and longer than the trainings for those who have less responsibilities. Volunteers also have less time devoted to the program, 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 pairs.
2. At the far side of the room, place one blank Training Handout (Handout 7A) 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

1. 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 hour). The next column lists the frequency (how often the training occurs) and the last column lists what materials are used for this training.

2. 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 the pieces together.
3. 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.
4. The team that finishes CORRECTLY first will win a prize.
5. 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.
6. 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).
7. 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.
8. Only one person can look at the handout at a time.
9. 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 7B and review the corrected table.

Training overview / Discussion (20 min)

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
Nutrition Officer	Field Supervisors	½ day	Monthly	New Flipchart and detailed Lesson Plan

- The Nutrition Officer conducts a 1/2-day training for the Field Supervisors on each new session before it is distributed to the community. This training happens monthly.

- Depending on the level of expertise the Nutrition Officer has 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 session, training on the use of the lesson plan and coaching and practicing of the lesson by each Field Supervisor.

Lead Trainer	People receiving the training	Length of the Training	Frequency	Materials
Field Supervisors	Health/sanitation Promoters	2 hours	Monthly	Review of the lesson in flipchart and lesson plan

- The Field Supervisors review this current lesson with the Health/sanitation Promoters once a month and spend time coaching them, so they are ready to replicate the lesson with the Nutrition Volunteers.

Lead Trainer	People receiving the training	Length of the Training	Frequency	Materials
Health/sanitation Promoters	Nutrition Volunteers	1-2 hours	Monthly	Flipchart and brief Lesson Plan

- The Health/sanitation Promoters will teach a new lesson to the Nutrition Volunteers once a month, during the Care Group meeting, 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; they will repeat with the Nutrition Volunteers.
- The materials needed are a flipchart and a lesson plan.
- 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
Nutrition Volunteers	Beneficiary HHs	1 hr.	Monthly	Flipchart and Talking Points

- The Nutrition Volunteers teach a new lesson to their beneficiary households once a month. This includes discussion, games, activities, and a time for discussing barriers and making commitments.

- Most Nutrition Volunteers are not literate, so their only tool is the counselling cards or action cards. However, they will model everything they saw and heard the promoter say – so it is important that the Promoters model the correct behavior during each training.

  Answer Questions.

Monthly Training Meeting (20 min)

Let us review in detail a possible plan for the Training that takes place every month between the Field Supervisor and the Health/sanitation 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 pairs.
2. Give each group a cut-out stack of the different sections on the agenda (Handout 7C).
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 min 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 min)

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

Lead a discussion of the following:

- ? What did your group have in common with the other groups?
- ? What did your 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 7D; the 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.

Review of the lesson Calendar (30 min)

1. Put participants into small groups (4-5).
2. On a flip chart, let each group draw a calendar as follows:
   Top row: Month-Indicate all the months in a year Jan-Dec
   Second row: Season-indicate the agriculture season the month falls in
   Third row: lesson-indicate the lesson to be delivered in each month
   Fourth row: Why lesson in that month-Indicate if there is any reason/rationale for having that lesson in that month.

Lesson calendar

	month1	month2	month 3
Month			
Season			
Lesson			
Why lesson in that month			

3. Ask each group to discuss and complete the table (15 min)
4. Each group selects a presenter to share the group work. (10 min)
5. Facilitator concludes by sharing a sample of a calendar (handout 8E) (5 min)

Note to facilitator: *Kindly ensure that the lessons are reflective of the different themes from all the sectors showing messages that need to be channeled through the CGs.*

SESSION 8: NEGOTIATING BEHAVIOR CHANGE

Objectives:

1. Participants will understand broad theory and determinants of behavior change
2. Participants will be able to explain and demonstrate the seven steps of behavior change negotiation
3. Participants will strengthen negotiation skills to be able to model and teach Health/sanitation Promoters

Summary: 3 hr. 45 min	**Materials:**
• Why is Behavior Change Important? (10 min) • How Does Behavior Change? (45 min) • Determinants of Behavior Change (20 min) • Introduction to with ASPIRE (30 min) • Activity 1: Practicing ASPIRE (1 hr. 30 min)	☐ Flip chart paper ☐ Markers ☐ Handout 8A: Stages of Behavior Change Cards ☐ Handout 8B: Stages of Behavior Change ☐ Lesson Handouts 8C-8G: From Facilitators Toolkit (One handout per participant) ☐ Handout 8F: Aspire Skills for Promoters and Volunteers

Why is Behaviour Change Important? (10 min)

As we mentioned at the beginning of this training, the approach to improving the health and nutrition of WRA, PLW and CU2 focuses on Behaviour change and behavior change negotiation.

? Why do you think behavior change is important? *List responses on flip chart paper.*

Development in all sectors – whether health, agriculture, microfinance, or another sector – requires that people do something new or different. The importance of Behaviour change is not particular only to the health sector. If a program is responding to a problem such as poor health and nutrition among a population, it means that if people continue as normal, they will continue to have poor health and nutrition and to suffer from its effects: more illness and death, lower productivity in the fields and at home, and less likely to succeed in school. However, if people are willing and able to make changes in their Behaviour to improve their health and nutrition, they will have less illness and death in their community, they will be more productive at home and in their fields, and they will be more likely to succeed in school. Knowledge alone is not enough to change Behaviour – one must turn that knowledge into action, changing the Behaviour, and that Behaviour change must be maintained.

How Does Behaviour Change? (45 min)

Transtheoretical Model of Behaviour Change (Stages of Change)

There are many theories about how Behaviour changes. A simple model of behavior change that is often used in health is the Stages of Change model.

Arranging cards: *Provide participants with a set of cards (Handout 8A), with one step of the model written on each card. Ask the participants to work together to put the cards in order – what is the first stage of behavior change? And the second? Etc. Ask the participants to explain why they put the cards in that order.*

Simple stages of change model:

1. Knowledge/pre-contemplation/pre-awareness
2. Approval/contemplation/awareness
3. Interest /preparation/intention
4. Practice/action/trials - assessment
5. Advocacy/maintenance/maintenance - relapse

Use Handout 8B[1] to explain the different stages of behavior change and to provide examples of interventions that can occur to address behavior change at each stage within the model. Below is the definition of the stages[2]

Pre-Awareness/pre-contemplation: In this stage, people do not intend to take action in the foreseeable future (defined as within the next 6 months). People are often unaware that their behavior is problematic or produces negative consequences. People in this stage often underestimate the pros of changing behavior and place too much emphasis on the cons of changing behavior.

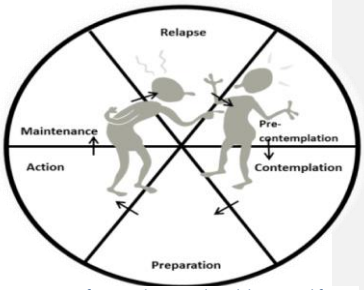


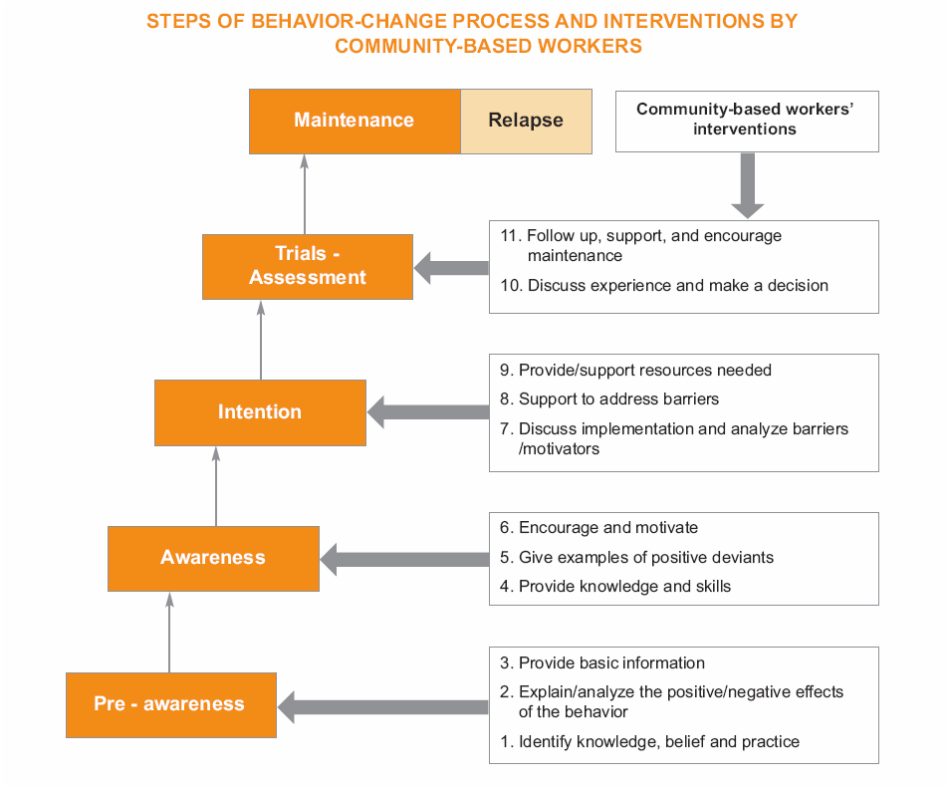
Figure 1: Image of Trans-Theoretical Model Accessed from Dr. Dally Lecture notes January 2017

1. **Awareness/Contemplation:** In this stage, people are intending to start the healthy behavior in the foreseeable future (defined as within the next 6 months). People recognize that their behavior may be problematic, and a more thoughtful and practical consideration of the pros and cons of changing the behavior takes place, with equal emphasis placed on both. Even with this recognition, people may still feel ambivalent toward changing their behaviour.

[1] Alive and Thrive. Behavior Change Communication on Infant and Young Child Feeding in the Community. Trainer Manual Three. July 2011. Available at: http://dev-aliveandthrive.org/resources/training-manuals.

[2] Theory at a Glance: A Guide to health Promotion Practice. National Cancer Institute Pub. No. 05-3896 September 2005

2. **Intention/Preparation**: In this stage, people are ready to take action within the next 30 days. People start to take small steps toward the behavior change, and they believe changing their behavior can lead to a healthier life.
3. **Trials-Assessment/Action:** In this stage, people have recently changed their behavior (defined as within the last 6 months) and intend to keep moving toward with that behavior change. People may exhibit this by modifying their problem behavior or acquiring new healthy behaviors.
4. **Maintenance-relapse:** In this stage, people have sustained their behavior (defined as withing the last 6 months) and intend to maintain the behavior change going forward. People in this stage work to prevent relapse to earlier stages but others may fail to maintain their acquired health behavior and go back to their old behavior.



Take Ms. Phiri's story as an Example

Note to Facilitator: *Read out the Stories of Ms. Phiri and after each step in the story, pause and ask the participants at what stage of change is she in that step of the story and what actions can be done? Only after the participants have responded, you read out the stage and action to be taken.*

Step 1

Ms. Phiri does not know that 88% of breastmilk is water so she often gives her baby water, especially when it is hot. At what stage of behavior change is Ms. Phiri?

Answer: Pre-awareness. Action in this case: *the community-based worker should tell her that there is a lot of water in breastmilk (88%). Therefore, the baby will not get thirsty.*

Step 2

Ms. Phiri knows that breastmilk has enough water, but she still gives her baby some spoons of water after each breastfeed to clean the baby's mouth. At what stage of behavior change is Ms. Phiri?

Answer: Awareness. Action in this case: *The community-based worker needs to ask the mother why she does this and provide her with information. "Breastmilk contains a lot of anti-bodies so the baby does not need to clean his/her mouth and the infant does not have teeth so the mother should not be afraid that sediments will harm the baby's teeth, etc.*

Step 3

Ms. Phiri knows that the baby does not need to drink water for any reason and wants to change her behavior, but her husband and mother-in-law do not agree and always force her to *"clean the baby's mouth"* after each breastfeed and to give water to the baby when it is hot, etc. At what stage of behavior change is Ms. Phiri?

Answer: Intention. Action in this case: *The community-based worker clearly has to ask and encourage Ms. Phiri as well as meet her family to explain and encourage them to support Ms. Phiri to practice behavior that is good for the baby.*

Step 4

With the support from her family, Ms. Phiri has tried not to give her baby water after each breastfeed and breastfeeds her baby more when it is hot, etc. The whole family sees that there is no problem, and the baby grows well. At what stage of behavior change is Ms. Phiri?

Answer: Trials-Assessment

Step 5

Normally, any difficulty arising during the practice of new Behaviour will lead to a "relapse". For example, after a few days of not giving water to her baby, one of Ms. Phiri's relatives visits her and says that she should give the child fruit juice to supplement vitamins. Ms. Phiri wonders if she should follow this advice. At what stage of behavior change is Ms. Phiri?
Answer: Maintenance/Relapse: *The community-based worker must always follow up and identify difficulties in time and talk to Ms. Phiri and her family so that they understand that breastmilk contains sufficient nutrients, including vitamins. On the other hand, the baby's stomach is very small so if s/he drinks fruit juice, s/he will suckle less. This both affects mother's milk secretion and is dangerous for the baby because s/he can easily get diarrhea.*

? Why is understanding stages of change important when implementing the CG model? Allow the participant to give their views and then add the point below.

Trainer concludes: From Ms. Phiri's story, we can see that in BCC, for timely support in maintaining new Behaviour, the community-based workers need to know the steps that the mother is currently doing, to identify the mother's *"motivators"* and *"barriers"* as well as to be able to negotiate change with the mother.

***Note to the Facilitator**: Whether individuals use self-management methods or take part in professional programs, they go through the same stages of change. Nonetheless, the way they pass through these stages may vary, depending on the type of behavior change. For example, a person who is trying to give up smoking may experience the stages differently than someone who is seeking to improve their dietary habits by eating more fruits and vegetables.*

Determinants of Behaviour Change-Health Belief Model (20 min)

The determinants of Behaviour change are factors that commonly influence whether a person is likely to change their Behaviour and can help you to identify a caregiver's motivators and barriers to adopting a new practice. Factors that determine behaviors can be internal or external. In other words, factors that influence a current or new (changed) Behaviour can come from within a person (internal) or from that person's environment (external). A person who perceives that latrine use is essential for her family's health will be more likely to use a latrine. Her feelings are an internal determinant. Another person may consistently dispose of her young children's feces in the latrine because her husband told her to do so and the local community health worker showed her how, or perhaps because all the other mothers in her community do so. The health worker's lesson or the fact that the other mothers carry out this action are considered external determinants. Of the many different factors that influence behavior change – internal and external - three determinants in particular – the Three Most Powerful

Determinants – should always be explored when trying to identify why people are not adopting specific behaviors. These Three Most Powerful Determinants are:

1. **Perceived self-efficacy/skills (control beliefs):** Individual's belief that s/he can do a particular behavior given their current knowledge and skills. Includes what makes it easier and what makes it more difficult to do the Behaviour. (Internal)

   Example activity to address self-efficacy: Have breastfeeding support groups where mothers help each other overcome breastfeeding difficulties.

2. **Perceived social norms:** Perception that people important to an individual think that s/he should do the Behaviour. Includes who approves/disapproves. Who matters the most to the person on a particular issue, and what does s/he perceive those people think s/he should do? (Internal)

   Example activity to address perceived social norms: If grandmothers are respected leaders within the family, especially on childcare and nutrition, a project might recruit grandmothers to become advocates for essential nutrition actions and infant and young child feeding practices.

3. **Perceived positive or negative consequences:** What a person thinks will happen, either positive or negative, as a result of performing a behavior. Includes advantages/disadvantages of the behavior. (Internal)

   Example activity to address perceived positive or negative consequences: Make examples of exclusively breastfed infants in communities to show that no harm comes, and infants indeed have less illness and better weight gain. Also, cooking demonstrations with specific ingredients, such as eggs – to show mothers that children 6-11 months can digest animal-source foods contrary to local beliefs.

It is important to understand how these determinants affect Behaviours in the communities in which we work to be able to design a project to be as effective as possible. ENSUSRE, you collaborate with the DNCC and other institutions carrying out Behaviour change research to know what data is available before adapting any messages for your program areas.

Other determinants of Behaviour change

1. **Access:** Are the needed products or services required to adopt a give behavior available? For example, insecticide-treated bed nets or growth monitoring services. (External)

2. **Cues for action/reminders:** Are reminders present that will help a person remember to do a particular Behaviour or remember the steps involved in doing the behavior. For example, a radio announcement reminding people about an immunization clinic or to attend ANC. (External)

3. **Perceived barriers:** What makes it more difficult to perform a given Behaviour? For example, distance to a health center can be a barrier to delivery at the health facility. (Internal)

4. **Perceived enablers:** What makes it easier to perform a given Behaviour? For example, an abundance of wild fruit trees can make it easier to incorporate fruits into a child's diet. (Internal)

5. **Perceived risk/susceptibility:** How vulnerable does the person feel to the problem? For example, a married person may feel like it is not possible for him/her to get HIV/AIDS. (Internal)

6. **Perceived severity:** How serious does the person think the problem (that the Behaviour would prevent) is? For example, a caregiver may be more likely to take her child for immunizations if she believes measles, is a serious disease. (Internal)

7. **Cultural norms:** What are the cultural beliefs and values surrounding the behavior? For example, in some cultures it is believed that pregnant women should not eat eggs. (External)

8. **Policy:** What policies are in place that may influence the Behaviour? For example, local law may require that all children under five must attend under-five clinics. (External)

Introduction to ASPIRE (30 min)

***Note to the facilitator**: On a flip chart paper, write out ASPIRE and what each letter stands for. Explain that we will use behaviour change negotiation to help people move through the stages of change. We never tell people what to do; rather, our approach is about discussions, identifying barriers or problems and potential solutions – through discussion – and negotiating with caregivers to adapt a solution that they think can work well for them.*

The steps we follow for behavior change negotiation are abbreviated as ASPIRE – each representing a step during negotiation. These steps are incorporated into our monthly lessons.

1. "**A**" stands for **Ask**: This step seeks to find out caregiver's current practices related to the lesson. This section is meant for discussion, and not for teaching; everyone should have a chance to participate.
2. "**S**" stands for **Show and explain**: Using visual aids including the IYCF counselling cards and Child Health Reminder Card, shares the content of the lesson. Encourages caregivers to interpret images before Nutrition Volunteers add new information.
3. "**P**" stands for **Probe**: The CG volunteer asks the caregiver about obstacles that may prevent them from trying the new practices.
4. "**I**" stands for **Inform**: The CG volunteer discusses with the caregiver possible solutions to the identified obstacles and how the caregiver might overcome the problem.
5. "**R**" stands for **Request**: The CG volunteer requests a commitment for action from the caregiver, to try a new practice related to the lesson that is feasible and realistic for that household. The caregiver is asked to give a verbal commitment, and it is their decision what they can commit to do.
6. "**E**" stands for **Examine**: The nutrition volunteer follows up with the household about their commitment from the previous month, encouraging them to continue the practice or helping them identifying solutions to challenges that may be preventing them from trying the new practice.

Note to facilitator: *Using Handout 8F, go through the ASPIRE skills required for Health Promoters and volunteers during the negotiation of behavior change or lesson delivery to the CG or to the household*

A replica session using negotiation steps in ASPIRE using a case study as an example. Facilitators demonstrate ASPIRE steps using one of the case studies below and an appropriate lesson. The demonstration should depict a nutrition volunteer counselling a household using an appropriate lesson and ensuring that the demonstration depicts the ASPIRE steps correctly.

The volunteer:

1. Greets the client(s) and establishes rapport.
2. Asks: Encourage discussion by asking the questions in the lesson
3. Show and Explain: The BCC material indicated in the lesson handout and ask question the accompanying questions
4. Probe: Ask the questions in the lesson handout to help identify barriers and motivators to practicing the behavior.
5. Inform: Provide key messages in form of suggestions and not commands as indicated in the lesson handout.

6. Request: Ask for a commitment from the client/s in form of a doable action to address the identified barrier or obstacle
7. Examine: Review the previous doable action the client/s committed to and follow instructions in the lesson handout
8. Practice and coaching: Participants in pairs take turns delivering the lesson to the other.

Activity 1: Practicing ASPIRE (1 hr. 40 min)

Pair participants and have them take turns practicing their behavior change negotiation skills by acting out the case studies below. For each case study, have one person act as the Nutrition Volunteer and one as the mother/caregiver. In each case, let the mother/caregiver provide feedback on the use of ASPIRE. Pairs should switch roles after 30 min so that everyone has a chance to act as the nutrition Volunteer and the mother/caregiver, and to provide feedback. When all pairs have had a chance to practice, select 2 pairs to demonstrate to the whole group. Allow participants to provide feedback and facilitators compliment and correct any errors.

Case Study 1:

Hannah is a 22-year-old woman who is married and has a one-year-old child. She just took her child to the under-five clinic and the child has not gained sufficient weight since last month.

Procedure:

1. Using ASPIRE, ask, and listen to the current practice and identify problems and causes for the problems. In this case, the main problem is that Hannah is not feeding her child a variety of foods.
2. Use the lesson "Feeding a child 6-23 months (FADDAUH)" to counsel the client (Handout 8C from facilitators toolkit).

Case Study 2

You visit Maria who has a four (4) month old baby. Maria's baby has a fever and is refusing to eat. Maria has not taken the baby to the clinic as she hopes this will pass.

Procedure:

5. Using ASPIRE, ask, and listen to the current practice and identify problems and causes for the problem. In this case the main problem is that Maria has not taken the child to the clinic.
6. Use the lesson "Catching Child Health Problems Early" to counsel the client (Handout 8D from facilitators toolkit).

Case Study 3

You visit Betty and you find that she has a lot of pumpkin leaves, blackjack, bean leaves and Rosella sour in her field. Betty shares that she plans to weed them out because they are

interfering with the growth of her maize. You recall that 3 months ago in the month of October when you visited Betty, she complained of not having vegetables to use for her family.

Procedure

1. Using ASPIRE ask and listen to the current practice and identify problems and causes for the problems. In this case Betty does not practice vegetable processing or preservation.
2. Use the lesson "Food Processing and preservation" to counsel Betty (Handout 8E from facilitators toolkit).

Case study 4

You visit Yvonne's home, and they offer you lunch. They give you water in a dish without soap for washing your hands. You observe that everyone washed their hands without soap and without following the steps for washing hand properly.

Procedure

1. Using ASPIRE ask and listen to the current practice and identify problems and causes for the problems. In this case Yvonne's household does not practice proper handwashing.
2. Use the lesson "Hand washing" to counsel Yvonne (Handout 8F from facilitators toolkit).

Case study 5

Mable is 22 years old and has 2 children. She is breastfeeding her youngest child who is 2 months old. Mable is concerned that her milk supply is not giving the baby enough food and is thinking about adding porridge to the baby's diet. What themes will you try to negotiate with Mable?

Procedure:

1. Using ASPIRE ask and listen to the current practice and identify problems and causes for the problems. In this case Mable is considering introducing complementary foods because she is worried that her breastmilk is not enough for her child. Praise Mable for breastfeeding and reassure her that breastmilk provides all the nutrients that her baby needs.
2. Use the lesson "Better Breastfeeding" to counsel Mable (Handout 8G from facilitators toolkit).

SESSION 9: SUPERVISING HEALTH/SANITATION PROMOTERS

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.

Summary: 1 hr. 45 min	**Materials:**
• Introduction to Supervision (15 min) • Review of Supervision Checklists (45 min) • Activity: Supervision Actions Game (45 min)	☐ Butcher/flipchart paper, markers, pens for participants ☐ Handout 9A: CG Supervisor's Checklist for Supervising a Health Promoters [Print one per participant] ☐ Handout 9B: Supervision Actions Game [Print one copy]

Introduction to Supervision - 15 min

? How would you define supervision?

Turn to the person next to you and write a short definition… (2-3 min)
Listen to definitions given, write them on a flipchart. Summarize the definitions given – then ask them to consider this definition:

<u>Supervision is 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 is 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: to change others – we must 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 min)

? 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 visit?

Pass out Handout 9A: Field Supervisor's Checklist for Supervising a Health Promoters

On this checklist for supervision, there are eight categories that we suggest the Field Supervisor reviews while conducting a supervision visit to a Health/sanitation Promoters.

1. Observe Health/Sanitation Promoters Teaching Nutrition Volunteers
2. Review the Health/Sanitation promoters' Monthly Reports
3. Observe the Health/Sanitation promoters' Equipment
4. Visit Nutrition Volunteers
5. Visit Neighbor Households
6. Visit Community Leaders or participate in a Community Leadership Meeting
7. Visit the Health Worker at the nearest Health Facility
8. Visit the Health Promoters' house

? How do these actions compare to the Health/Sanitation Promoters' essential responsibilities?

These categories should be reflective of the duties presented in Lesson 5, Job Descriptions. Refer 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 Field Supervisor should:

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

? Why is the observation of the Health/Sanitation Promoters' household important?

If we do not practice what we are teaching, no one will listen to us.
Someone may say, well that is a lot to ask the Health/Sanitation Promoters. If it is a lot to ask of the Promoters, then it is a lot to ask the mother in the community. To be effective facilitators and leaders in the FANSER Project the 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?

Personal Stories (Adjust as appropriate):

When I visit our program 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 Nutrition 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 in (or have not tried) they will not be effective. In fact, it is a waste of time.

Read the introduction at the top of Handout 9A: Field Supervisor's Checklist for Supervising a Health/Sanitation Promoters.

Field Supervisor's Checklist for Supervising a Health/Sanitation 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 Health/Sanitation Promoters 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.

Activity: Supervision Actions Game (45 min)

1. Using Handout 9B: Supervision Charades, cut the sections into strips, fold them, and place them in a bowl.
2. The group of supervisors may select a strip that they would like to act out.
3. The presenting team will have one minute to create a plan. They will then have 3 min to use words and actions to perform all the correct supervision activities listed on the paper they selected.
4. If a word appears in the supervision category (such as "Observe the Health Promoters Teaching Nutrition 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.

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

SESSION 10: SUPERVISION RESPONSIBILITIES AND WORK PLANS

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

Summary: 2 hr.	**Materials needed:**
• Supervision Race (30 min) • Small Group Work Plan Activity & Discussion (60 min) • Group discussion per district/ward (30 min)	☐ Flipchart or whiteboard with markers ☐ Handout 10A: Supervision Table and Slips [Print one copy for every 4-6 participants] ☐ Handout 10B: Supervision Answer Key ☐ Handout 10C: 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)

Supervision Race (30 min)

Now that we have reviewed all 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 pairs.
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 (Handout 10B) 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.

1. 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.
2. 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 the pieces together.
3. 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.
4. The team that finishes CORRECTLY first will win a prize.
5. 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.
6. 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).
7. 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.
8. Only one person can look at the handout at a time.
9. 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 10 B and review the corrected table using the information below.

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

Nutrition Officer	Each Field Supervisor	Office, Monthly Meeting; Field Visits	Once each month (every third visit is a surprise visit)	Supervision Checklist

- The Nutrition Officer will visit the Supervisor once each month. Every third visit is a surprise.

? What is the purpose of surprise visits?

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

The working environment of a community worker is unstructured and depends a lot on personal discipline and motivation. Even the best volunteer may have a rough week and feel tempted to do personal tasks when s/he should be meeting with Care Group or visiting a Health 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 supervisory team will observe the monthly meetings done by the supervisor.
- They will visit the promoter's homes and talk with them about the program.
- They will observe the household counselling and the Care Group meetings.
- EVERY time they visit the Supervisor, they will use the appropriate Supervision Checklist.

One Supervising	Person Receiving the Observation	Location/ Meetings	Frequency	Supervision Tools
Field Supervisor	Each Nutrition Promoter	Promoter's home, Care Group Meeting Field visits with NV	Twice each month; one scheduled visit and one surprise visit	Supervision Checklist

- Almost all 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/her home for that section of the Supervision Checklist.
- S/He will visit them during Care Group meetings, to observe how they teach the Nutrition Volunteers.
- S/He will visit and observe the neighbor group activities or household visits with a Nutrition Volunteer.
- EVERY time s/he visits the Promoter, he will use the appropriate Supervision Checklist.

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
Health Promoter	Each Nutrition Volunteer	Home visits and/or group activities	Once every three months	NA

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

? What will s/he be looking for?

  - Remember this is your "model" caregiver/mother in the community.
  - You should be able to see her by her home and observe her practices to assess if 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 for a volunteer to model desired behaviors when they are first selected as volunteers. But as a promoter, you will have to help your Nutrition Volunteers to try the new behaviors and "practice what they teach."

- You will also supervise the Nutrition Volunteer as she teaches her neighbors during home visits.
- After the observation return to her home to give feedback. 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 Nutrition Volunteer more often than once every 6 months, but because you will have up to 50-60 Nutrition Volunteers that you are supervising, it is not possible. For FANSER project we recommend supervising one NV per care group per month.

Answer questions.

Small Group Work Plan Activity (60 min)

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 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 10C: Blank Work plan and handout 10 D samples of monthly workplans for volunteers, promoters, and supervisors

Instructions:

Field Supervisors will work as a group to create a work plan for the month of July, and a typical month once Care Groups are formed.
Ask the participants to copy the schedule onto a blank flipchart.
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.
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.
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.

If there is additional time, ask participants to think about what a work plan would look like for the Health Promoters and Nutrition Volunteers.

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 Nutrition Volunteers. (If the participants are having trouble, work through the Nutrition Volunteer schedule together at the front of the class).

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

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 Monthly Workplan for Nutrition Volunteers

(Reminder – volunteers do not work an 8-hour. day! Never plan a meeting longer than 2 hours with volunteers)

Week	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1	Attend Care Group meeting		Visit Neighbor HH #1	Visit Neighbor HH #2	
Week 2		Support Community Health Event/ GMP session			
Week 3	Visit Neighbor HH #3	Visit Neighbor HH #4	Visit Neighbor HH #5	Visit Neighbor HH #6	Visit Neighbor HH #7
Week 4	Visit Neighbor HH #8 & #9	Visit Neighbor HH #10		Hold kitchen garden demonstration with HHs	

Sample Monthly Workplan for Promoters

Week	Monday	Tuesday	Wednesday	Thursday	Friday

Week 1	Meet with CG#1	Meet with CG #2	Meet with CG #3	Meet with CG #4	
Week 2	Meet with CG#5	Meet with CG #6		Prepare Reports for Monthly Meeting	Monthly Meeting with FS
Week 3	Supervise two NVs		Host Community Health Event / support practical	Supervise two NVs	Community Meeting
Week 4		Supervise two NVs		Host Community Health Event / Support practical	

Sample Monthly Workplan for Supervisors

Week	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1	Supervise Promoter #1	Supervise Promoter #2	Supervise Promoter #3	Supervise Promoter #4	Coordination meeting with Community Group Supervisors
Week 2	Supervise Promoter #5	Support Community Health Events	Supervise Promoter #1	Prepare for Monthly Training	Monthly Meeting & Reporting with HPs
Week 3	Supervise Promoter #2	Supervise Promoter #3	Supervise Promoter #4	Supervise Promoter #5	Coordination meeting with Community Group Supervisors Report Writing
Week 4	Report Writing	Monthly Meeting with Nutrition Officer, Fieldsupervisors	Monthly Meeting with Nutrition Officer, Field supervisors	Monthly Meeting with Nutrition Officer, Field supervisors	Monthly Meeting with Nutrition Officer, Field supervisors

Activity: Group Work Action planning

1. Divide participants according to their district, ward, or zone

2. Use the following questions to guide the discussion

3. Document the following using the template provided.

- Chronological list of activities to be undertaken
- location
- Output from each activity
- Person/s responsible for each activity
- Timeline

Make sure the participants have the two copies of the action plans. **Please use template below for action planning**

FANSER PROJECT Roll out Workplan for……

WORK PLAN

ACTIVITY	PERSONS RESPONSIBLE	LOCATION	WEEKS/DATES
Community Mobilization			
Identification and registration Households			
Training Promoters			

SESSION 11: MONITORING AND IMPROVING FACILITATION

One to two days in advance:

- *Choose a volunteer to give a short educational message using instructions laid out on the **Skit for a volunteer (Handout 11B)**. Give them a copy of the volunteer lesson Handout, Handout 8C and a blank **Educational Session QIVC (Handout 11A)** to review. Review the instructions on how they should act during the presentation from Handout 11B. This skit depicts a scene for a Promoters training a CG. 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 11 B.** 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 describe how the QIVC is used after watching a three-part skit.

Summary: 1 hr. 30 min

- Introducing QIVCs (30 min)
- Skit Parts I and II (30 min)
- Skit Part III (30 min)

Materials needed:

- ☐ Flipchart or whiteboard with markers
- ☐ One Volunteer for skit
- ☐ Handout 11A: QIVC for Educational Sessions [Print one per participant]
- ☐ Handout 11B: Skit Volunteer [Print one per participant]

Introducing the Quality Improvement and Verification Checklist (QIVC) (30 min)

***Instructions:** Lead a discussion that covers the following points.*

Food for the Hungry developed a tool to help monitor and improve educators teaching methods. The tool is called the Quality Improvement and Verification Checklist (QIVC).

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 the following people have a teaching role in this program:

- Nutrition Officer
- Field Supervisors
- Health Promoters
- Nutrition 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 Promoters' performance improved by 38% in 7 months while using QIVCs.3
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 us say your Nutrition Volunteers encourage mothers to come to vaccination posts. Your Nutrition Volunteers reach 24,000 mothers every six months.
If this process created a 10% improvement (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. program

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

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

QIVCs are ONLY useful for tasks that can be observed and have multiple steps.

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

- Teaching Care Groups lessons to Beneficiaries HHs
- Teaching Care Groups lessons to Care Groups
- Teaching Care Groups lessons to Health/Sanitation Promoters
- Teaching Care Groups lessons to Field Supervisors

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 11A: 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 not only; or use both).

Additional Information for the Trainer:

QIVCs should be adapted to fit the culture and design of each Care Groups program. After using the QIVC checklist for 3-4 months, ask staff and volunteers to meet 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 us learn more about what happens from this skit.

Skit Parts I and II (30 min)

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 will not forget things that you should comment on.

- However, I suggest you complete the form after the presentation is complete.

Begin the skit (Handout 11B) – (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.
   - Do not 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 11A: 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 number of yes responses.
    b. Divide the number of yes responses by the total number of answered questions (questions answered with a yes or no response).
    c. Remind them to SKIP (do not 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 min)

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 dealt 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?

- *Do not 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 is 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 is 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.

SESSION 12: PRINCIPLES OF GIVING POSITIVE FEEDBACK

Objectives:

1. Participants will be able to explain the effects of positive feedback on volunteers and promoter'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 hr.30 min	**Materials needed:**
• Coin Toss Activity (30 min) • Steps for Giving Feedback (1 hr.)	☐ 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 ☐ Handout 12A: Steps for Giving Positive Feedback [Print one for each participant] ☐ Handout 12B: QIVC for Positive Feedback

Preparations for the Coin Toss (30 min)

- 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 and write on a small piece of paper. The scores should be transferred to the table above on a flip chart when all volunteers have tossed their stones or coins.
- 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 cannot throw at all – that was a mile away.*
- *You are never going to make it.*
- *You are way off; you did not even get close to the bowl.*

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

Note to facilitator: *In pairs, ask participant to practice giving positive feedback to each other to ensure they know what to do! Giving POSITIVE feedback is often a challenge for workers. 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 "supervisors" 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!

? **Optional:** **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.)**

Commented [CU1]: addition

Add:

- To use a new skill, a person must have self-confidence, which is usually nurtured by other people.
- Self-confidence is key to behavior change in mothers, health workers, and us. 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 is 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 facilitator:

*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 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 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 help them learn new skills and improves their performance in mastering new tasks.

Steps for Giving Feedback to Workers (45 min)

Let us now review exactly how feedback is given to the 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 12A: Steps for Giving Positive Feedback and read through with participants.

This is a handout that was made to help Nutrition Officers and Supervisors remember the key actions to take when giving feedback.

Pass out handout 12B and 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 number 7, go over each question – making it into a statement and reinforcing what the one supervising should say and do when giving feedback.

1. Give feedback in private

2. 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 Nutrition 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."

3. 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.

4. 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.

5. 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.

6. Do not use mixed comments.

- Give all positive comments without adding negative things on the end.
- Do not say," I like your introduction except you talked too quietly."
- Mention ALL the positive things together, not mentioning any of the things they need to improve (that will come later).

7. 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.

8. 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.

9. 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).

10. 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.

11. 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, if 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.

12. 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 are not 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.

13. 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 cannot come up with ideas on their own.

14. 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 need to focus on what is correct, appropriate, complete, and specific.

- Often, we need someone watching us to tell us if we are off task.
- Therefore, 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?

15. Ask the person to give a summary of the things that they will improve.

16. If they have forgotten areas, add those.

17. Ask them to make a commitment to improve these issues.

18. Ask the person to give a summary of the things they did well.

19. 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?

Providing positive feedback is a skill that needs to be built in all workers. Using the QIVC, a worker can be mentored on how to effectively give feedback to whoever they are supervising.

Note to Facilitator: Briefly look at the first two sections of the QIVC Handout 12B.

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 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 (Handout 12 B)

? 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 Nutrition Volunteer.
- As a manager supervising the CG 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!*

SESSION 13: VOLUNTEER MOTIVATION AND INCENTIVES

Objectives:	
1. Participants will be able to state when extrinsic and Intrinsic rewards produce better performance 2. Participants will be able to list intrinsic motivators of good performance. 3. Participants will be name at least three ways to keep volunteer motivation high. 4. Participants will have discussed the action steps they will take to fulfill the three "motivators" for volunteers.	
Summary: 1 hr. 40 min • What are motivators-Video? (10 min) • The three motivators for volunteers (15 Min) • **Activity 1:** Presentation about Volunteer Value and Motivation (30 min) • **Activity 2:** Group work and presentations (45 min)	**Materials:** ☐ Laptop ☐ Internet connection or downloaded video for motivation ☐ Projector ☐ 3 pieces of flip chart paper and 3 markers

? What are motivators? 10 min

Show the following video if possible: Video before session: http://www.youtube.com/watch?

The Three "motivators" for volunteers 15 min

There are 3 Levels of Motivations:

1. Biological Motivation
2. Extrinsic Motivation
3. Intrinsic Motivation

Biological Motivation

Biological motivators are ones which do not usually require a lot of cognitive thought. They drive us to act. It is not something we learn to do, but something that is part of our design or make up. Examples of Level 1 **Biological** Motivations are hunger, thirst, and sex.

Extrinsic Motivation

Extrinsic (or external) motivation is motivation that prompts us to act 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 act.

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.

1. 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

2. 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.

Explain

Now let us talk about intrinsic motivation. 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 is not the volunteers helping the managers to meet project targets. It is 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 contribute 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."

Activity 1: Presentation about Volunteer Value and Motivation (20 min)

Explain to particpants:

Nutrition Volunteers (NVs) are the strength of a Care Group 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 Nutrition Volunteers. When the NV leaves (or stops working for the program), the organization loses all of the NV'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 NV stops attending.

2. **Financial investment.** When NVs 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 Nutrition 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 NVs lack the same trust, time and relationship with the program making it harder to reach program goals.
4. **Reaching our program goals of reducing malnutrition /stunting and 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 NV 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 NV and the Health Promoters
2) The relationship between NV and her HHs and
3) The relationship shared between NVs.

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, Health 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 Care Group program use to help personnel 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 2: Group work and presentations (45 min)

Instructions

Divide participants into 3 groups and give each group a marker and butcher paper. Assign each group to brainstorm **ACTIONS to help NVs and beneficiary HHs 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 20 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 (Nutrition Volunteers and / or Beneficiary HHs)?

Some possible activities to promote CONNECTEDNESS include:

- Celebrating group achievements (no NV 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
- Personnel 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 (Nutrition Volunteers and / or NeighborHHs)?
   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 (Nutrition Volunteers and / or Neighbor HHs)?
   Possible answers include:

- Have NV or Neighbor HHs 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 NV training of recent evaluations, field visits, or surveys.
- Have discussions where NV 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.

Session 14: Kitchen Garden

Objectives:	
1. Participants will understand the importance of a home garden. 2. Participants will be able to choose nutritious, diverse crops for their home garden. 3. Participants will understand the importance of involving the entire household in garden planning.	
Summary: 1 hour, 35 min • Discussion: Importance of Home Gardens (15 min) • Discussion: Considering Nutrition When Planning (15 min) • Activity: Planning a Home Garden (30 min) • Gender Discussion (15 min) • Discussion: Overview of Kitchen Garden lessons (20 min)	**Materials:** Flipchart paper, markers Handout 14: Companion planting guide

Discussion: Importance of Home Gardens (15 min)

As mentioned during the monthly lesson, now is the time (when water levels are still high and other local leafy green vegetables are no longer fresh) to re-emphasize the importance of home gardens with beneficiary households and encourage them to plant a home garden again this year. Let's review

Ask participants to give reasons why home gardens are important. Give participants 10 minutes to discuss. Add any of the points below that were not mentioned.

- The home garden contributes significantly to household food security.

- Home garden foods supplement staple crops and add variety and nutritional value to the diet through providing foods rich in protein and other nutrients, which are very important for children and pregnant and lactating women in order to grow healthy. During the lean season, when staple foods have been depleted and before the new harvest is ready, home gardens can help provide the household food supply.
- Home gardens can be cultivated, and vegetables harvested for family consumption all year round, as long as water is available.
- Animals consume the waste from vegetables harvested and return nutrients to the soil through their manure.
- Gardens can provide income from the sale of produce.
- Home garden trees and shrubs provide shade and act as natural windbreaks and barriers to scavenging animals. They can also provide fencing, building materials, fruit and fuel wood.
- It is important for women to have access to good quality land for the home garden.

Discussion: Considering Nutrition when Planning for the Home Garden (15 min)

Review the information below with participants.

Everyone should eat a variety of foods every day, so the body gets enough energy and everything it needs to be active, to grow and to be protected against illness.

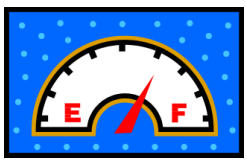
A healthy diet is important because it:

- Keeps the body and mind healthy
- Gives the body energy to be active and function well
- Helps the body to grow and repair itself
- Helps the body to fight infections and illness
- Helps children grow well
- Helps pregnant women produce health babies

Most foods have more than one function. All foods provide *energy* but some provide more than others. Most foods help the body to *grow and repair* and *protect the body* against illness.

Staple foods such as grains, roots and tubers mainly provide fuel and energy for the body. Grains also help with body growth and repair.



Vitamin-rich foods such as vegetables and fruits mainly protect the body against illness.




Protein-rich foods such as legumes, nuts and seeds are the body's building blocks and mainly help the body to grow and repair. They also help to protect the body against illness. Nuts also provide extra energy, too. Animal foods (e.g. milk, eggs, meat and fish) mainly help the body to grow and repair. They also provide energy and protect against illness.




When planning a home garden, it is important to consider what foods are needed in the household to provide a balanced diet. In addition, the more colors of vegetables in the garden the better. Different colored vegetables and fruits provide different types of vitamins and minerals. For example, carrots and mangoes are high in Vitamin A.

ASK: If a family does not have access to meat or eggs, what would you recommend that they plant in a home garden?

- ✓ Although meats and eggs are the best source of protein for building the body, many legumes and vegetables are high in protein. The family could plant soybeans, beans, peas or spinach.

ASK: If a family runs short of mealie-meal during lean season, what could they plant to supplement their diet while waiting for their maize to mature?

- ✓ They could plant maize in the garden before the rains start to harvest green maize during the time when the household is most likely to run short of mealie-meal. They could also try growing other grains like millet or starchy root crops like cassava and sweet potatoes.

A home garden can be kept year-round if water is available near-by, and the household can grow different types of vegetables or fruits at different times of the year depending on their needs.

Activity: Planning a Home Garden (30 min)

Instruction to facilitator: Divide the participants into pairs. Ask them to use one page from their hardcover; explain that the hardcover page represents the area of their garden. They must plan which 8 fruits or vegetables they will grow in their garden. The pair should first discuss how they will arrange the crops on the page in the areas where they will be grown. The pair should draw in the crops in the area they have decided to plant.

Share information from the companion planting guide for crops commonly grown in Zambia. Explain that some crops benefit each other when grown in the same area, while others might inhibit the growth of certain plants. The companion planting guide shows which crops grow well together and which crops to avoid growing together. They should consider companion planting when planning their home garden.

Table 2.1 Companion Planting Guide for Zambian Garden Crops

Crop	Grows well with…	Does not grow well with…
Amaranth	Maize, onion, potato	
Beans	Carrot, Chinese cabbage, maize, impwa/eggplant, peas, potato, pumpkin, rape, sunflower, Swiss chard, tomato	Onion, garlic
Cabbage	Onion, Irish potato	Tomato, sweet pepper, impwa/eggplant, pole beans
Carrots	Onion, tomato	
Chinese Cabbage	Garlic, onion, Irish potato	Tomato, sweet pepper, impwa/eggplant
Garlic	Carrot, tomato	Beans, cabbage, peas
Impwa/Eggplant	Amaranth, beans, peas	Cabbage, Chinese cabbage, rape
Irish Potato	Bush bean, cabbage, Chinese cabbage, carrot, peas, rape, onion	Pumpkin/squash, sunflower, tomato
Maize	Amaranth, beans, peas, Irish potato, pumpkin/squash, sunflower	Tomato

Okra	Impwa/eggplant, sweet peppers	
Onion	Cabbage, carrot, Chinese cabbage, rape, tomato	Peas
Peas	Beans, carrots, impwa/eggplant, maize, sweet pepper, tomato	Garlic, onion
Pumpkin/Squash	Maize, pumpkin/squash	
Rape	Garlic, onion, potato	
Soybeans	Everything	
Sunflower	Maize	
Sweet Pepper	Carrot, onion, okra, tomato	Beans, cabbage
Sweet Potato	Bush beans, Irish potato	Pumpkin/squash
Swiss Chard	Beans, cabbage, Chinese cabbage, onion, rape, tomato	Maize, watermelon
Tomato	Beans, carrot, garlic, onion, peas, sweet pepper	Cabbage, maize, Irish potato
Watermelon	Maize, peas, sunflower, pumpkin/squash	Swiss chard

Give participants 15 minutes to plan their garden and arrange their crops. Once finished, discuss as a larger group. Ask participants why they chose their crops and why they decided to arrange them as they did. Give time for the other participants to ask questions, seek clarification or provide feedback.

GENDER DISCUSSION (15 min): Remind participants that planning for a garden should be a household discussion. Discuss the following questions in regard to gender concerns.

- Do men or women usually choose which crops to grow?
- Do women have access to good quality land to grow crops or plant a home garden?
- Are women able to access this land at all times of the year? If not, why?
- What could be done to address women's lack of access to land or to encourage husbands to consult their wives in regard to gardens or crop choice?

Discussion: Overview of Kitchen Garden Lessons (20 minutes)

Last year, we included lessons focused on kitchen gardens during the regular monthly lessons. The first lesson was the one we just reviewed – discussing the importance of planting a kitchen garden and considering nutrition when planning for what to plant.

The second lesson focused on building skills to plant a garden, including a demonstration of how to prepare different types of beds. (**Planning and preparing for a Kitchen Garden**, two parts)

The next lesson discussed methods for **maintaining and improving soil fertility**. It included a demonstration of how to make compost manure, using locally available resources.

Because we are promoting kitchen gardens during the dry season, when water levels are still high but there are no longer rains, one lesson focused on **watering plants, and water-saving techniques**, such as catching the water used from handwashing and using it to water your garden. It also included a demonstration of how to mulch, which helps reduce water loss through evaporation.

The final kitchen garden lesson discussed different types of pests that might harm the produce in your garden and reduce your garden's productivity. The lesson explains good agricultural practices that can help **prevent and control pests** (such as crop rotation, timely planting, maintaining good soil fertility and using good quality seed) and includes a demonstration of how to make natural insecticides using locally available materials.

Each of these lessons included a demonstration, which NVs conducted in their demonstration gardens. NVs should be strongly encouraged to continue the practice of having a home garden and continue conducting these demonstrations (together with the lessons) for their neighbor group members. Each of these kitchen garden lessons was shared during a regular monthly household visit last year (May – August, or so), and should be reinforced over the coming months. We need to encourage households to ask their NV to review any specific lessons if they cannot remember, or as they are going through the process of planting and growing a garden.

SESSION 15: BEHAVIOR CHANGE COMMUNICATION (BCC) MATERIALS

Objectives:

1. Participants will understand different ways to use the BCC materials (action cards, menu games, play mat, food groups, feeding reminder card, nutrition play cards) to maximize their impact on changing the nutrition-related behavior of beneficiaries
2. Participants will plan for the roll-out and use of the BCC materials.
4. Participants will be able to explain how to play the menu games and nutrition play cards.

Summary: 3 hr. 30 min

- What are BCC materials?
- What are action cards? (5 min)
- Activity 1: Using action cards to emphasize key nutrition messages and behaviors (15 min)
- How do you use Action cards (15 min)
- Activity 2: Becoming familiar with action card messages (15 min)
- Activity 3: Role Play on using action cards to support the Child Health and Nutrition Reminder Cards (20 min)
- Activity 4: Using action cards to promote key themes in monthly lessons for Care Groups (30 min)
- Activity 6: CSH Menu Planning Game, food group chart and Feeding Bowl (45 min)

Materials:

- ☐ Flipchart paper, markers
- ☐ Child Health and Nutrition Reminder Cards
- ☐ Action cards set
- ☐ Menu planning game
- ☐ Place mat
- ☐ Food groups chart
- ☐ Nutrition play cards
- ☐ Feeding Bowl

• Activity 7: CSH Child Feeding Mat (20 min) • Discussion: Incorporating BCC materials in monthly lessons (40 min) • Activity 8: Discussion on Nutrition Game Cards (20 min)	

Introduction

The FANSER Project uses BCC materials to enhance behavioural change among the beneficiary households. The BCC materials covered in this session are menu game, place mat, food groups chart and nutrition play cards.

Introduction to Action cards:

The action cards were developed to complement the NFNC IYCF flipcharts and CSH/NFNC *Child Health and Nutrition Reminder Card,* highlighting the food preparation and feeding practices identified as important by the MAWA Positive Deviance Inquiry conducted in 2013. Following their successful use in the MAWA project, these cards have also been used in CRS' FANSER project.

What are the action cards? (5 min)

Description

Action cards are behavior change communication materials. Each action card has one illustration and there is no text. Each card is numbered in the upper left corner. The illustrations show various behaviors that the program is promoting to lead to healthier pregnant women and children under 2 years old.

The action cards focus on small practical actions that most people can do. One example is feeding the child more orange colored food such as sweet potatoes and carrots or mashing these foods and mixing them into the child's porridge to improve nutrition. Another example is feeding the younger children more frequently and increasing the quantity and different types of food.

Activity 1: Using action cards to emphasize key nutrition messages and behaviors (15 min)

Distribute a complete set of 35 action cards to each Health Promoter/Nutrition Volunteer for their review. (Each action card illustrates different types of behaviors and key messages).
Give the participants 5 min to review all the action cards in their set of 35.
The Facilitator should demonstrate how action cards can be used in a Care Group or during a HH visit:

- Show a specific behavior or message in the flip chart or child health card.
- Show how the illustration in the action card reflects that same behavior or message.

- Hold an action card up to show the group. Ask them what they think is the key message or behavior illustrated in the card.
- The group should discuss the card's key message or behavior and how the Health Promoters will discuss it during their Care Groups or the Nutrition Volunteers during their home visits with women.

The list below are illustrations and key messages in various action cards. Ask participants if they can identify the cards related to each category. The facilitator should complement the responses using the list below.

Nutrition

- Exclusive breastfeeding. card 5
- Mother feeding the child with different types of foods, several times a day. Cards 6 to 10
- Mother mashing different types of foods (leafy green vegetable, insects, peanuts) to add to her child's porridge to increase the nutritional value.
- Pregnant woman eating healthy food several times a day. Card 10
- *Noted missing: growth monitoring and promotion card*

Gender

- Man and woman working together in the field. Card 15
- Man cooking a meal and carrying the child. Card 12
- Man feeding his child. Card 13
- Man involved in nutrition education session (Care Group). Card 2

Finance

- Saving money and planning for agricultural needs. Card 16 & 17

Agricultural

- Using a ripper plough Card 31
- Cross- cultivating crops Card 24
- Caring for kitchen gardens Card 4
- Protecting the health of animals (chickens). Card 30

How Do You Use the Action Cards? (20 min)

Each Health/Sanitation Promoter and Nutrition Volunteer will have a complete set of 35 action cards. They will use these cards to help promote improved nutrition behaviors and to complement nutrition

sessions they provide using the Zambian IYCF (Child Health) flipchart and the *Child Health and Nutrition Reminder Card*.

Health/Sanitation Promoters and Nutrition Volunteers should give action cards to mothers because during the early stages of the program, it is useful to take the action cards home to share with their husbands and mothers-in-law. It would support their desire to change their behavior, and the importance of their husbands and mothers-in-law also changing their behavior.

Health/Sanitation Promoters' and Nutrition Volunteers' use of action cards vary by the responsibilities required of their different positions:

Health/Sanitation Promoters

Health/Sanitation Promoters will use the action cards to introduce and illustrate key behaviors that they discuss as they lead the monthly Care Group lessons to train the Nutrition Volunteers.

Nutrition Volunteers

Originally Nutrition Volunteers used the IYCF flipcharts in one-on-one conversations during home visits. Recently some Nutrition Volunteers have started hosting Household Groups with mothers using the flip chart and following up those lessons with individual visits to households. The Nutrition Volunteers will use the action cards during these same interventions.

After conducting nutrition counseling using the flipchart during the household sessions, the Nutrition Volunteers will ask mothers to identify one nutrition behavior or action they want to change. After identifying the behavior, a relevant action card will be given to each mother to place at a central place in their home as a cue or reminder. The Nutrition Volunteer will ask the mothers to commit to discussing this action card with their husbands/mothers-in-law and perform the specific behavior on the action card during the next month. The mother must choose an action card to be shown to the father and grandmother/mother-in-law to ensure they are informed and supportive of this new food or practice.

During the follow-up home visit, the mother and Nutrition Volunteer will discuss whether the action card supported behavior change successfully and make plans for how to continue or adjust that behavior. A new behavior will be introduced in each month's lesson.

There are several uses for action cards. Action cards can be used to:

1. *Stimulate discussion*

The most important use of action cards is to STIMULATE DISCUSSION of new behaviors during the Nutrition individual home visits with mothers. Health/Sanitation Promoters can use them when training Nutrition Volunteers during Care Groups and in community events i.e., GMP, cooking demos, etc.

Because many of the cards promote behaviors that are unusual or not traditional, the stimulated discussions should focus on how the new behavior differs from tradition and whether, despite it being unusual, it might offer benefits by improving the health of the young child or pregnant woman.

Some mothers may be ready to include new nutrition information in their daily food preparation; the stimulation discussions may encourage and support that change. Others may be ready to adopt new ways of feeding their children under 2, but unsure how to do it in a way that gets positive results.

For some women there are barriers to accepting new feeding behaviors – their husband, mother-in-law or mother may block such change. In those cases, it is very helpful for the older women to be involved in the women's household sessions in which action cards introduce new methods/behavior.

Activity 2: *Becoming familiar with action card messages* (15 min)

- Ask each Health/Sanitation Promoter or Nutrition Volunteer to choose 1 action card that they particularly like. (1 minute)
- Ask 2 or 3 participants to share with the rest of the Health/Sanitation Promoters or Nutrition Volunteers in the group their opinion about the behavior illustrated in the action card, and why they support it. (1 minute each)
- After 2 or 3 Health/Sanitation Promoters or Nutrition Volunteers share their opinions about the behavior in their action card, hold a general discussion about the behaviors: why others like or dislike them, whether they feel they will improve the health of children under 2, pregnant women, etc. What is the advantage of adopting these new behaviors? What are the disadvantages or barriers to adopting these new behaviors? (10 min)
- Thank the group and end the exercise.

2. Support the key messages in the Child Health and Nutrition Reminder Card

In addition to stimulating new discussions, the action cards can be used to support key messages and small, doable actions shown in the flip chart or *Child Health and Nutrition Reminder Card*. Example: feed children under 2 years old more frequently and increase the quantity of food. It is useful if the Nutrition Volunteer reviews all the action cards, carefully chooses which action cards reinforce messages and images in the flip chart and/or *Child Health and Nutrition Reminder Card* and uses all three when holding a household counselling.

Activity 3: Role Play 3 *Using action cards to support Child Health and Nutrition Reminder Cards* (20 min)

Objective:

Participants will be able to use action cards to support the *Child Health and Nutrition Reminder Cards.*

- Give a *Child Health and Nutrition Reminder Card* to each Nutrition Volunteer. Give them 3 action cards that show a woman feeding her child different amounts of food at different times in the day.
- Ask them to compare the action cards to the *Child Health and Nutrition Reminder Card. (2 min)*
- Ask how the action cards can stimulate discussion with mothers about the health issues in the *Child Health and Nutrition Reminder Card*.
- Ask two Nutrition Volunteers to demonstrate/role play (5 min each) how they would use the action cards to support the messages of the *Child Health and Nutrition Reminder Card* during one of their Household Groups with mothers.
- After the role-plays are completed, ask for feedback from the group (3 min). How will the action cards be useful in promoting the key messages in the *Child Health and Nutrition Reminder Cards*? What are some of the problems with the images? How would you improve them?
- Thank the group and end the exercise.

3. Action cards will support the monthly written nutrition lessons that use the Zambian IYCF (Child Health) flipchart

Nutrition Volunteers will use action cards to complement the monthly nutrition lessons and the Zambian IYCF (Child Health) flipchart during individual household visits or community events.

After nutrition counseling with the flipchart, each mother will be asked to identify one nutrition or feeding behavior they want to change. After identifying the behavior, one action card each will be given to mothers to take home to stimulate discussion about the behavior change with her husband, mother, or mother-in-law; the action card will promote joint decision-making in families. This is a powerful method to promote behavior change in the household because by influencing the family norms, behavior change is easier to initiate and continue.

Some themes for joint decision-making might include the importance of regularly eating different types of foods while pregnant or the importance of giving a child under 2 different types of foods and frequent feedings to prevent malnutrition.

Activity 4: Discussion-Using action cards to promote the major themes in monthly lessons for household groups (15 min)

Objective:

Participants will be able to use action cards to stimulate discussions that promote the themes in the monthly lessons.

- Ask the Nutrition Volunteers how they would use the action cards to stimulate discussion within their monthly household counselling.
- Randomly distribute copies of the monthly nutrition lessons (they receive these written lessons during their participation in monthly Care Groups) to participants; each participant gets 1 nutrition lesson.

- Ask the participants to choose 1 action card from their set that illustrates a point in their monthly nutrition lesson.
- Ask for 1 or 2 participants to tell the group which part of the nutrition lesson corresponds to their action card message. Then ask them to hold up the action card and use it to stimulate discussion to promote a key theme in the monthly nutrition lesson. Each volunteer has 3 min.

NOTE: Key questions that can be used to help stimulate discussion:

1) What do you see in this picture?
2) Do you think you can do this?
3) What are the barriers to practicing the behavior?
4) What are advantages/disadvantages of practicing the behavior?
5) Who approves/supports behavior?
6) Who disapproves of behavior?
7) What do you like about behavior?
8) What don't you like about behavior?

- Finish the exercise by summarizing how the action cards can be useful in stimulating discussion about the major themes in the monthly nutrition lessons.

4. Use the action cards in a "choice exercise" and as an individual talking point

The Health/Sanitation Promoter leading the Care Group or the Nutrition Volunteer leading the Household Group of mothers should show 5 different action cards, each showing a woman feeding a child food from a bowl, with an image of a food inset (circle with food). The participants should be asked to identify: 1) what the woman is doing, and 2) what the food is. Then ask which of the 5 foods they think they could try adding to their children's porridge the next day. Practice doing this with participants.

5. Use the action cards in a "story telling exercise".

Tape 5-7 different action cards to the wall so that the participants can easily see them. Ask the participants to tell a story using some or all the images. Emphasize the new behaviors that are being tried.

6. Use the action cards to play the Concentration game

Provide participants with a set of 15-20 pairs of cards. Shuffle them, turn them image side down and play "concentration" in which players turn two cards face-up at a time, attempting to find pairs. This familiarizes participants with behaviors illustrated on the action cards, helping to make them feel like more "normal" behaviors.

- Remind participants that the action cards can be a very useful tool to promote the key nutrition themes that they are discussing in their Care Groups and/or neighbour Groups with mothers and during home visits.
- Ask if they have any questions or concerns.
- Thank them for their participation.

Activity 5: CSH Menu Planning Game, Food group chart and Feeding Bowl (45 min)

The game is a fun way to get caregivers talking about what to feed their children every day and how to plan meals and snacks to be nutritious, while the food group charts help remind the caregiver the types/groups of food a child can be given and plan the meals.

The board shows all possible meals for one day. This is the board:

he game includes 43 card pieces as specified below:

2 Star Cards: **animal source foods!** For example, fish, Kapenta, beef, liver, chicken, mabisi, egg, caterpillar

1 Star Cards: **nutrient-dense foods!** For example, green leaves, pawpaw, mango, orange, avocado, guava, carrot, orange pumpkin, sweet potato, kidney beans, cowpeas, pounded ground nuts

Cards with no Stars: These foods are basics and not high nutrient foods. **Eat these foods with Star foods**

Cards with a 0: for example, soda, candy, jiggies

TIP: The cards cab be used to talk about STAR foods. Use them as discussion Starters

Answers for children's examples

There are many correct answers. There should be one 2 Star food every day and at least one 1 Star food at every meal, or in every big bowl. The bowl indicates the amount of food to feed the child according to age. Use the child growth reminder card for help. Use the food group chart to determine how many food groups a child eats in the day as indicated on the menu planning game.

James- a 7-month-old boy

- ✓ 2 meals, or big bowls, a day
- ✓ 1to 2 Star food card a day
- ✓ 1 Star food card in each bowl
- ✓ the mother will continue breastfeeding 8 to 10 times a day

Patricia- a 20-month-old girl

all the foods that the family eats

- ✓ 3 meals, or big bowls and 2 snacks or small bowls 1 2 Star food card a day
- ✓ 1 Star food card in each big bowl
- ✓ The mother will continue breastfeeding 4 to 6 times a day

Mutinta- a 13-month-old girl

- ✓ all the foods that the family eats
- ✓ 3 meals, or big bowls and 2 snacks or small bowls 1 2 Star food card a day
- ✓ 1 Star food card in each bowl
- ✓ The mother will continue breastfeeding 4 to 6 times a day

Samuel-a 9-month-old boy

- ✓ 3 meals, or big bowls, and 1 snack, or small bowl
- ✓ 1 2 Star food card a day
- ✓ 1 Star food card in each big bowl
- ✓ the mother will continue breastfeeding 6 to 8 times a day

Beauty- a 17-month-old girl

- ✓ all the foods that the family eats
- ✓ 3 meals, or big bowls and 2 snacks or small bowls 1 2 Star food card a day
- ✓ 1 Star food card in each big bowl
- ✓ The mother will continue breastfeeding 4 to 6 times a day

Jonas- an 11-month-old boy

- ✓ 3 meals, or big bowls, and 1 snack, or small bowl
- ✓ 1 2 Star food card a day
- ✓ 1 Star food card in each big bowl
- ✓ the mother will continue breastfeeding 6 to 8 times a day

Activity 6: Discussion CSH child feeding mat and Food group chart (20 min)

The Child Feeding Mat is a way for caregiver's to give their children a safe and clean area to eat meals and snacks, The information on the mat is also a reminder for caregivers to give one 1 Star food at every meal and one 2 Star food every day.

How to use

The mat and chart should be placed under the child's bowl during meals and snacks. After every use, it is important to wash the mat and chart with soap and water.

? The Project has received some feeding mats and food groups charts. How do you suggest we share these placemats and food group charts with households?

Record ideas on flipchart paper and agree on a final plan for distributing the limited number of placemats and food group charts to households.

Activity 7: Discussion: Incorporating BCC materials into monthly lessons (40 min)

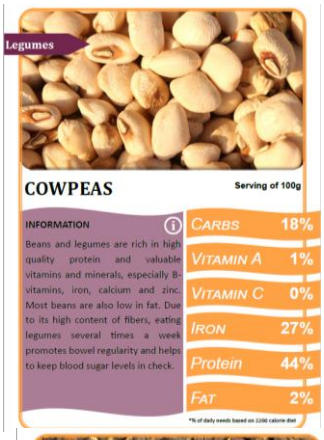
Demonstrate how the action cards will be incorporated into this month's lesson. Give participants time to practice giving the lesson to each other, using the action cards. Review other ways that the cards may be incorporated into future lessons.

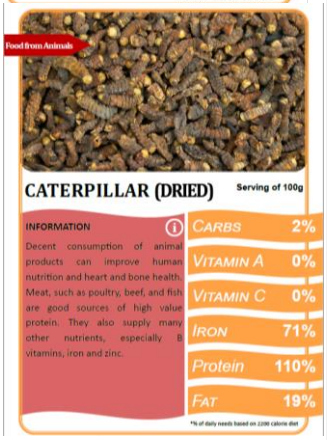
? How can the menu planning game be used with our CG and Neighbor HHs?

Explain how many copies of the game we have and discuss how they can be distributed amongst Health/Sanitation Promoters, for use with Care Groups and Neighbor Groups.

Activity 8: Discussion on Nutrition Game Cards (20 min)

Find the space outside the conference facilities where the participants will play the game in groups.
Divide participants in groups of five
Give a set of game cards to each group





Let each group play the game as follows:

Shuffle and deal all the cards one by one face down until all the cards are handed out.

- Each player holds their cards so that they can see the top card only.
- The player who sits on the left side of the player who dealt the cards starts by reading out a self-selected nutrient category from the top card, eg. Vitamin C, value 38
- The other player(s) then read out the same category from their cards.
- The one with the highest value, wins, and collects all the top cards from other players and moves them to the bottom of their own pile.
- It is then his/her turn again to choose a category from the next card. In general, it is always the player who won the previous round who selects the next nutrient category.
- If two or more cards share the top value, then all the cards are placed in the middle. The same player chooses again from the next card, and the winner of this round takes the cards in the middle as well.
- The person who holds all the cards at the end wins the game.

At the end of the game session ask the following questions to the participants:
What did you learn from this game?

How can this game help to reinforce the behaviours we are promoting on dietary diversity?
Write the responses from Participants on a flip chart
Add on the following (Possible responses):
The game helps to know nutrient contents found in different foods
The game helps balancing meals for the families
Guide on types of foods they should produce

SESSION 16: PRACTICE PRESENTATIONS AND COMMUNITY PROGRAM ORIENTATION LESSON PLAN

Objectives

1. Participants will be able to present key program 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 Care Group and in reducing stunting and 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.

Summary: 1 hr.40 min	**Materials:**
• Activity One: Participants Brainstorm Important messages to share with the Community (20 min) • Activity Two: Small & Large Group Presentation Practice (1hr.20 min)	Option 1: ☐ "KEY TALKING POINT" Handout 15A that includes the Crossing the River Skit. (One for each participant.) Option 2: ☐ Flipchart, markers and bolstik to take notes during discussion. ☐ Handouts for each participant. Both options require: ☐ A watch or timer for at least ½ of the participants.

Activity 1: Participants Brainstorm Important messages to share with the Community and How to Share Messages (30 min)

***Note to the Facilitator**: 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 presentation in session 2).*

Tell participants:

1. Take a minute to think about what the community needs to know to understand the Care Group.
2. Think about possible problems that could occur in the Care Group. What information could be provided at program 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 program?
   - What has worked well in past development program?
   - How should we orient the community to program 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 15A:

Program Goals and Methodology

1. The FANSER project goal is to improve nutritional situation of people living in food-insecure households in Eastern and Luapula provinces, especially of women of reproductive age and children under the age of two years.

. Project strategic objectives are:

i. Diversification of dietary intake through reliable access to safe and nutritious foods.
ii. Scaling of recommended feeding practices for children under 2 and nutrition of women of reproductive age.
iii. Improved nutrition-sensitive hygiene practices among women of reproductive age and children under 2

The Project uses the Care Group model to implement activities that contribute to the prevention of malnutrition in children under two. The project is focusing on the following areas:

- Promotion and support of Saving and Internal Lending Communities (SILC) groups formation.
- Inclusion of men in activities that help improve joint decision-making and enhance women's access to and control over resources.
- Social Behavior Change through the Care group and CLTN model
- Promotion of improved Infant Young Child Feeding and Caring Practices
- *Promotion of Maternal and Adolescent Nutrition*
- *Dietary Diversification through Nutrition Sensitive Agriculture*
- *Promotion of Safe Water, Hygiene and Sanitation*

2. 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.[4] If families do not make these changes, if program activities are slowed, things will go back to how they were before it started.

l. Right now, nearly half of all children in this community suffer from chronic malnutrition. To change this situation, families must change household practices.

3. To change these behaviors the Care Group will train community volunteers so they can train all the families in the community. To do this we need your help.

[4] 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.

4. The Care Group Program 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.

5. These volunteers will not be the Government or 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 are not willing to learn or if the families will not listen to the volunteers or adopt the behaviors, then malnutrition will not decrease during the life of the program.

6. The Care Group approach is a development program, not an emergency and relief project. The goal of this Care Group approach is to change behavior to improve the community's ability and resilience to preventing child malnutrition and associated negative consequences, including death.

Note: It is best not to tell communities what material goods the program plans to provide, even if you are confident the program will provide the inputs. Mentioning incentives at the start of a program can cause the following problems to arise:

- *The* Care Group *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 incentives, 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 does not 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 Zambezi River (10 min)

Required: 4 actors – they should all be around the same age and gender. The strong young man should be strong in appearance and the thin 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 is not an easy task, but the young man manages and reassures the two friends as he carries them across that they do not have to worry he is 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 cannot 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 riverbank 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 cannot 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 is 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 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 excited. They exclaim we did it, we crossed the river! They say, that was not easy, but it was not as hard as I thought it would be. They thank the young man for teaching them how to do it.

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?

Share FANSER Project Details

(Refer to session 2: Program Overview)

- Donor
- Goal and how it relates to MCDPII
- Objectives
- Intermediate results
- Activities (interventions)

Activity 2: Small & Large Group Presentation Practice (50 min)

1. Divide the participants into three groups. Ask them to practice explaining to each other key elements of the Care Group program (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 20 min. 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 min. Let participants know that they will be asked later to share what they practice in front of the group and will be required to stand before the group and talk for 10 min.

2. Come back as a group and ask groups to present the key Care Group program information in 10 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.

SESSION 17: CARE GROUP MONITORING AND EVALUATION SYSTEM: REPORTS (NUTRITION VOLUNTEER (NV) HARDCOVERS, PROMOTER AND SUPERVISOR REPORTS)

Objectives:

1. Participants will be able to state the purpose of the *Care Group* monitoring and evaluation system.
2. Participants will be able to accurately fill out forms and reports.
3. Participants will be able to read and interpret all forms and reports.
4. Participants will be able to teach others how to use forms and reports.

Summary: 2 hr. 15 min

- Monitoring Overview (15 min)
- Review of Forms and Reports (20 min)
- Activity 1: Practice using Forms and Reports (40 min)
- Activity 2: Health Promoters (HP) – Nutrition Field Supervisor (NFS) Meeting Role-Play (30 min)
- Activity 3: Practice Writing a Report (30 min)

Materials

- ☐ Flip chart paper, markers, sticky tac
- ☐ Complete set of monitoring forms/reports for each participant
- ☐ Handout 17A: NV Form, (one copy per participant)
- ☐ Handout 17B: Health Promoters Form (one copy per participant)
- ☐ Handout 17C: Nutrition Field Supervisor Form (one copy per participant)
- ☐ Handout 17: NV Out put form(one form per participant)

Monitoring and Evaluation Overview (15 min)

Explain

It is important to collect certain information about our project and activities so that we can inform our partners about what exactly we are doing and the impact it is having in the communities in which we work. It is also important to understand progress being made by Care Groups and make changes if necessary, during the implementation process. The information is also important to guide planning activities of Care Groups particularly when developing annual plans.

To provide this information, the Care Group Monitoring and Evaluation system is based on three basic information sources: 1) Nutrition Volunteer form; 2) Health/sanitation Promoter form; and 3) Field Supervisor form. These forms and reports are very similar to one another and collect three types of information: 1) Registration information (when the members of the group

joined): 2) attendance at group meetings or home visits; and 3) curriculum (the progress groups have made through the Care Group Curriculum).

Write on a Flip Chart

Three types of information in Care Group monitoring and evaluation

1) **Registration** (to know **who** is registered in the group)
2) **Attendance** (to know **how often** women are receiving the lessons! If no one is attending meetings, then no one is receiving messages and behaviors will not be changed.)
3) **Curriculum** (to know which lesson/modules are/were being taught to mothers. This allows program staff to know how far their groups are progressing in the curriculum.)

Note to facilitator: *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 indicators for the Care Group Programs: household visits and attendance at Care Group meetings. If women are not attending these meetings or visits are not happening, we know our program will not be successful.

Distribute copies of the Monitoring forms and reports. Describe the overall flow of information for the monitoring and evaluation system, using the nutrition strategies list. Describe that all our information will come from the Nutrition Volunteer Hardcover, and Health Promoters Report. This information will be compiled as it is passed up the chain of command and eventually given to the Nutrition Officer.

Explain that in this session, we will teach you how to use/fill in forms and reports and teach you how to create Supervisor reports from these forms.

Review of Forms and Reports (20 min)

Review the information collected in each form/report: The Nutrition Volunteer Hardcover, Health/Sanitation Promoters Reporting Form, Field Supervisor Reporting Form, and Nutrition Officer Monthly Reports. Describe how the information flows from one report to the next.

Additional Information for the facilitator:
Adding new women to Neighbor Groups: *If other women in the community become pregnant, they should be invited to join the group if the group size does not exceed 12 (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 women) so there is enough room in the groups for new women to join during the project.*

Replacing Care Group Volunteers: *If a* ***Care Group*** *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* ***Care Group*** *Volunteer's name should be crossed off the* ***Care Group*** *Register, and the newly elected* ***Care Group*** *Volunteer's name should be added in an empty row. In the Neighbor Group Register, the previous* ***Care Group*** *Volunteer's name should be crossed off and replaced with the new* ***Care Group*** *Volunteer.*

Activity 1: Practice Using Forms and Reports (40 min)

1. Provide one completed example of the NV Hardcover (Handout 16A). Provide three completed Health Promoters reporting forms, with specific errors (Handout 16B). Point out how the information flows from the NV Hardcover to the HP report.
2. In pairs, participants discuss what is good and what is bad about the sample HP reports. Where do you need more clarification/detail? Where would you go back to your HP to ask more questions?
3. Come back to discuss as a larger group.

Activity 2: Health/Sanitation Promoters – Nutrition Field Supervisor Meeting Role-Play (30 min)

Participants role-play what a meeting between Health/Sanitation Promoters and Nutrition Field Supervisor would look like. In the group of five, select four people to represent the four Health/Sanitation Promoters and one person to be the Nutrition Field Supervisor; demonstrate what the meeting might look like, based on the sample reports provided. Again, what questions does the NFS ask during the meeting to clarify information in the report? How do HPs/SPs respond/clarify?

Activity 3: Practice Writing a Report (30 min)

After the role play, each participant should practice writing their Field Supervisor report (Handout 12C), based on the sample HP/SP reports and the additional information provided in the role play.

In pairs, have participants compare and critique their completed reports. What did they do differently? What do they like about each other's reports? How could their reports be improved?

SESSION 18: POST-TEST AND WORKSHOP CLOSING

Objectives:

1. Participants will complete the post-test
2. Participants will receive certificates.
3. Participants will give feedback to the facilitator for adaptation of future workshops.

Summary: 1 hr. 40 min	**Materials:**
• Activity 1: Post-test (30 min) • Activity 2: Review of Expectations (20 min) • Activity 3: Workshop Evaluation (30 min) • Activity 4: Certificates (20 min)	☐ Handout 1B: Post Test (Course Director Guide ☐ Handout 17A: End of Training Evaluation ☐ Handout 17B: Certificates ☐ Preparation: Organize the expectations cards from session 1 into common themes.

Activity 1: Post-Test (30 min)

Tell participants that everyone will take a post-test so we, the trainers, can gauge if we have met all our objectives. 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 guide how to fill out the form:

- Remind participants to enter their name at the top of page one.
- Circle POST-TEST.
- 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 20 min have passed

***Note to facilitator**: If the training incorporates the overview of lessons, then the next step should be the overview of lessons followed by practice sessions by*

participants as scheduled in the training agenda. The review of participants expectations, workshop summary and presentation of certificates should come at the end.

Activity 2 :Review of Participants' Expectations (20 min)

The facilitator will go through the expectations with participants to get their view as to wether they have been met or not. During this time, the co-facilitator/s will be marking the post test in readiness for sharing of the overall results.

1. Go through the individual expectations by theme asking participants what their impression is with regards to understanding of the sessions related to the expectation.
2. Be explicit about expectations which could not be met during the workshop.
3. Provide a way forward for unresolved issues where applicable

Activity 3 :Workshop Summary (30 min)

1. *Hand out the End of Training Evaluation (Handout 17A). 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 min 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:
3. *What is something new that you learned during this training?*
4. *Which activity was the most meaningful for you?*
5. *How could I as a trainer better adapt the training for future workshops?*
6. On a scale of 1 to 10, how equipped do you feel to set up Care Groups in your communities?

Activity 3: Certificates of Participation (20 min)

Give closing remarks encouraging the participants in their work. Hand out the certificates and call each participant by name.