Care Groups and Improved Nutrition Outcomes

What does the evidence show us?

TOMAK Learning & Development Platform

Think Piece 3, January 2019

Key Messages

The Care Group (CG) model is an internationally recognised strategy and set of social and behaviour change interventions designed to reduce undernutrition and child mortality. First created by World Relief in 1995[1], there is now significant evidence supporting the efficacy of this model, which has led to the development of global standards for its utilisation. In practice, the CG model is often adapted to fit the context as well as specific social and behaviour change objectives. Since 2003 this has been the case in Timor-Leste, with the Ministry of Health (MoH) and a range of development partners each having advanced variations of the traditional CG model. Variations should however be based on the pool of evidence available in Timor-Leste and globally, so as not to replicate past mistakes or encourage practices which are known to be ineffective. To help guide effective adaptation, 13 key criteria have been established to guide implementation of the CG model.[2] In addition to these criteria, this Think Piece explores a number of lessons learned which may help guide stakeholders that are considering applying the CG model in Timor-Leste including sustainability, value for money, dynamism, male engagement, and managing incentives.

Introduction to the Care Group Model

A review of available evidence suggests that using the CG model to promote nutrition-related behaviour change shows promise in terms of impact, scalability and reach[3] - particularly with poor populations through demand creation and

1 CORE Group, Food for the Hungry & World Relief. *Care Group Info*. http://caregroupinfo.org
2 Davis et al. 2010. *Establishing Care Group Criteria*. World Relief and Food for the Hungry.
3 George et al. 2015. 'Evaluation of the effectiveness of Care Groups in expanding population coverage of key child survival interventions and reducing under-5 mortality: a comparative analysis using the lives saved tool (LiST).' *BMC Public Health*; See also Perry et al. 2015a. 'Care Groups I: An Innovative Community-Based Strategy for Improving Maternal, Neonatal, and Child Health in Resource-Constrained Settings'. *Global Health: Science and Practice*, Volume 3: Number 3.

household service delivery[4]. Since its creation, the model has been successfully used in more than 20 countries and is globally recognised as best practice for reducing mortality and improving nutritional status of children under 5 years of age (CU5).

The CG model consists of a group of community-based, volunteer health educators (Care Group Volunteers or CGVs), led by a Promoter (usually a paid project staff member). The CGVs use interpersonal communication techniques as a means of prompting or influencing social and behaviour change at community level. These techniques take the form of frequent one-on-one and small group meetings with mothers using content designed to influence behaviours that can improve child survival and nutrition. Each volunteer is responsible for regularly visiting (weekly or monthly) Neighbour Groups, sharing what they have learned and facilitating behaviour change at the household level. CGVs create a multiplying effect to equitably reach every beneficiary household with interpersonal behaviour change communication.[5] The Promoters are in charge of training and supporting CGVs and are led by a Program Supervisor[6] (See Figure 1).

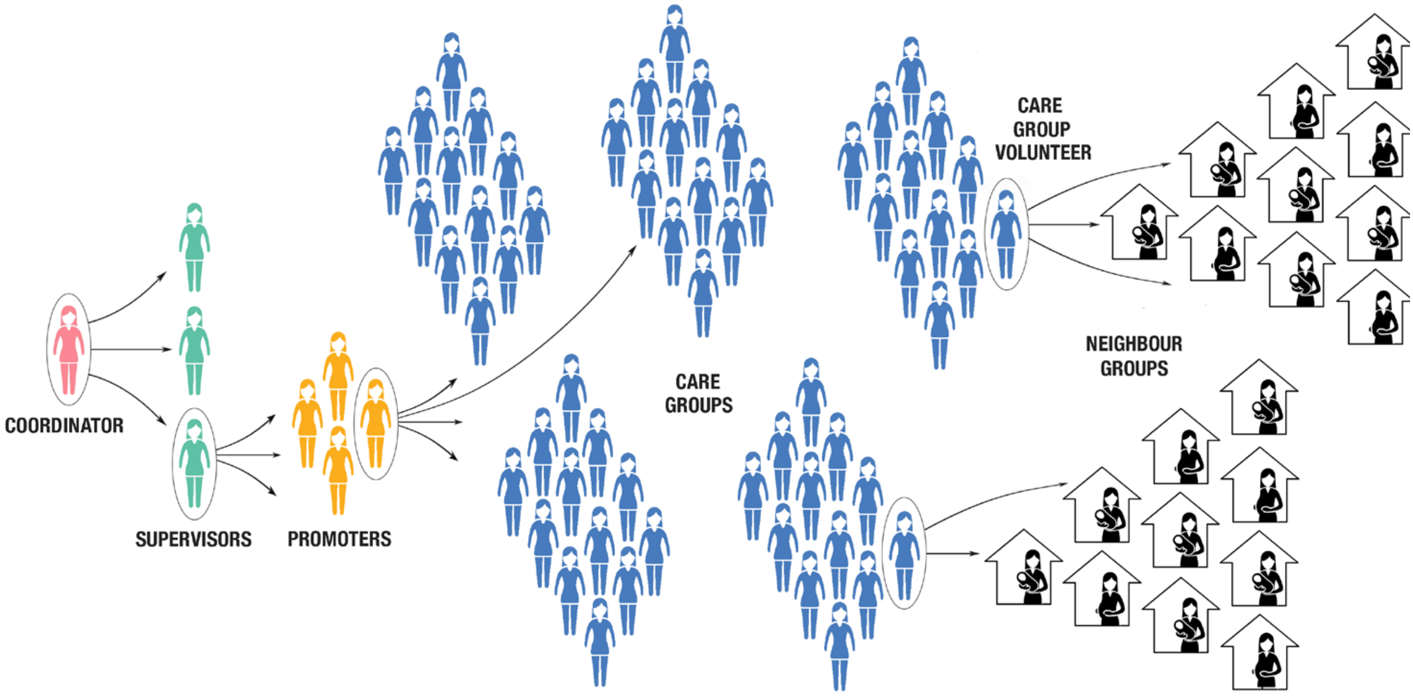

Figure 1. The traditional CG model of cascading behaviour change sessions

Key Criteria and Rationale for Care Groups

While adapting the CG model is critical to ensure local appropriateness, variations must be based on both global and local evidence to avoid repeating past mistakes or promoting ineffective practice. To aid in adapting CGs to the local context, increase the potential of CGs to improve health and nutrition outcomes, and improve group sustainability, the CG community of practice identified 13 minimum criteria that need to be met in order for an intervention to qualify as a care group, with details listed below.[7]

1. **Use a peer to peer learning approach.** The CG model is based on peer-to-peer (mother-to-mother) health and nutrition promotion. Women volunteers serve as role models and promote adoption of new practices by their neighbours. Volunteers should be chosen by the women/households they support, and they should be mothers of young children or other respected women from the community.

2. **The workload of CG volunteers is limited to no more than 15 households per volunteer.** This number is kept low so that it fits better with the volunteer's available time and reduces the need for incentives.

3. **The size of the CGV Group should be 6-15 members.** CGVs learn a lot from each other and rely on their CGV group for sustained motivation. With fewer than 6 CGVs in a group the dialogue is often considered not rich enough, while more than 16 volunteers means insufficient time for everyone to fully contribute and participate. Attendance must be monitored.

4 Bhutta et al. 2013. *Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost?* The Lancet Nutrition Interventions Review Group, and the Maternal and Child Nutrition Study Group.
5 CORE Group, Food for the Hungry & World Relief. Care Group Info. http://caregroupinfo.org
6 Perry et al. 2015a. 'Care Groups I: An Innovative Community-Based Strategy for Improving Maternal, Neonatal, and Child Health in Resource-Constrained Settings.'
7 Davis et al. 2010. *Establishing Care Group Criteria*. Accessible here.

4. **CGVs meet households at least once per month.** Monthly contact is necessary in order to establish trust and rapport. The overall contact time and frequency of contact between the CGV and the mother (and other family members) is directly related to the adoption of promoted practices. Frequency of contact is monitored.
5. **100% coverage of target households.** In order to create sustained behaviour change, the program must plan to reach 100% of households in the targeted group on at least a monthly basis, and the project should attain at least 80% monthly coverage of households within the target group. Coverage is monitored.
6. **Vital events data on pregnancies, births, and deaths are collected and monitored.** This helps CGVs discover pregnancies and births in a timely way, and to be attentive to causes of deaths happening in their community. CGVs collect data and reflect on vital events in meetings with promoters.
7. **Groups are organised around the goal of reduced malnutrition and mortality.** The CG model can lead to large reductions in child and maternal mortality, morbidity, and malnutrition. While the cascading or multiplier effect used in CGs may be suitable for other purposes, it is suggested to use a different term for those models.
8. **Use visual tools for health promotion.** CGVs use visual tools to guide the health promotion lessons. These tools give the CGV more credibility, while also helping mothers to interact with the message by both hearing and seeing it.
9. **Use participatory teaching methods.** Group lessons are designed to be participatory, requiring active learning and interactive elements.
10. **CG instructional time (when a Promoter teaches CGVs) will be no more than two hours per meeting.** CGVs are volunteers, and as such, their time needs to be respected. Limiting the CG meeting time to 1-2 hours improves attendance to trainings and limits CGVs' requests for financial compensation for their time.
11. **Supervision of promoters and at least one of the CGVs occurs at least monthly.** For CGVs to be effective, supportive supervision and feedback is necessary on a regular basis.
12. **Meeting places should be within one hour's walking distance.** Neighbours should live within 1 hour of the meeting place to meet their CGV. Similarly, all CGVs should live <1 hour walk from the Promoter meeting place. CGVs need to visit their beneficiary households frequently. Ideally the CGV will live in the same community as the households they serve.
13. **Gender and cultural sensitivity.** The implementing agency needs to successfully create a project/program culture that conveys respect for the population and volunteers, especially women.

History of the Care Group Model in Timor-Leste

Timor-Leste has the highest rate of child malnutrition in Asia with almost half of children under five stunted (low height for age). Research shows that rates of exclusive breastfeeding vary widely across the country (28-75%) and there is a lack of dietary diversity with only 13% of children under two years consuming a minimum acceptable diet.[8]

The CG model was first piloted in Timor-Leste in 2003 by Alola Foundation, the Ministry of Health (MoH) and UNICEF. At the time, the primary aim was to support women to initiate and continue breastfeeding.[9] This variation of the CG model was called Mother Support Groups (MSGs). In 2004, the objectives of MSGs were expanded to include: supporting mothers during and beyond the breastfeeding period; involving mothers in the formation and ongoing activities of the MSG; and strengthening community support systems to access the healthcare system. In 2006, MoH adopted this expanded version of the earlier MSG model as their official MSG program. By 2013, 120 villages in 11 districts around the country had MSGs (30% coverage at village level).[10] Further expansion of the MSG program was prioritised in the government's National Nutrition Strategy 2014-2019[11] with an objective to "establish partnerships with community based organisations/non-governmental organisations/church-based organisations to scale up MSG coverage to 280 (70%) additional villages". In 2017, MoH standardised its National Guidelines for establishing and working with MSGs, for use by MoH Primary Health Care staff and all implementing partners in Timor-Leste. These guidelines describe the overall objective of MSGs as "to improve the health of mothers, infants and young children in communities by: 1) Enabling access to services (linking mothers to services and assisting referral); and, 2) Providing peer counselling to mothers".[12]

8 General Directorate of Statistics (GDS), 2017. Ministry of Health and ICF 2018.*Timor-Leste Demographic and Health Survey 2016*. Ministry of Finance, Planning and Ministry of Health, ICF.

9 Ministry of Health Timor-Leste, 2017. *Guideline for establishment and operation of mother support groups. Nutrition and Maternal Newborn and Child Health Practices in the Context of Primary Health Care*. MoH TL and UNICEF.

10 Ibid.

11 Ibid.

12 Ibid.

Ministry of Health MSGs now operate at village level in all municipalities of Timor-Leste.[13] MSG volunteers are appointed by village councils, with a focus on finding motivated men, women, traditional birth attendants, wives of village chiefs, and community health volunteers (locally called *Promotor Saude Familiar* or PSFs), as well as other local leaders that live permanently in the village.[14] Per guidelines, MSGs are established, mentored and monitored by Primary Health Care staff. Each MSG volunteer is expected to be responsible for at least 5 households of their choosing. Their main roles are to: liaise with health facilities to carry out MSG related activities; provide counselling services to mothers; identify mothers and children in danger/risk; refer cases to health workers; and record health information. They are trained once and subsequently implement three month workplans, with supervision throughout implementation. The MSG meets after every three months to review progress, and receive yearly refresher trainings. The MSG model might not then be considered a Care Group model. On one hand, it has the potential for deeper integration with the health system, while on the other, the start up process, level of coverage of target group, methods and frequency of contact are divergent from the CG model's evidence-based structure.

Scale up of MSGs at community level has been limited because implementation has not been mainstreamed into the function of the MoH Primary Health Care network (i.e. as part of health provider job descriptions and MoH official targets). As a consequence, development partner support for MSGs at community level has not been sustained.[15] A further challenge is that the MoH MSG model is being implemented at village (*suku*) level instead of at sub-village (*aldeia*) level, making it difficult, if not impossible, to reach full coverage of targeted households. Given the larger geographic area and population of many villages, the creation of one MSG per village would be insufficient to reach even 50% of pregnant and lactating women (PLW) and mothers of CU5.

Several donor agencies (USAID, Australian Aid, EU, World Bank, JICA, UNDP) and development organisations (Health Alliance International, World Vision, CRS, Mercy Corps, Child Fund, CARE, Oxfam, Plan) have implemented other variations of the CG model in Timor-Leste. These projects have faced similar challenges to the MSG program in terms of sustainability and needing to mainstream CG implementation into the function of MoH Primary Health Care Network. Other challenges include difficulty enforcing MSG national guidelines among implementing partners to reach community level, and evaluating the effectiveness of such groups in changing key maternal and child health practices.[16]

Women in Baucau, Timor-Leste read MoH materials promoting improved nutrition practices (Photo: TOMAK/World Vision)

13 Government of Timor-Leste (GoTL), 2017. *The National Action Plan for Children (NAPC) in Timor-Leste (2016-2020)*, UNICEF and the Government of Norway.

14 Ministry of Health Timor-Leste, 2017. *Guideline for establishment and operation of mother support groups.*

15 Ibid.

16 Ibid.

Variations of the Care Group Model in Timor-Leste

The table below summarises variations of the CG model that have been advanced by MoH and TOMAK's lead INGO partners (Mercy Corps, World Vision and CRS), and compares them to the internationally recognised criteria for Care Groups.[17] It is important to note that no program in Timor-Leste achieves all the criteria, and many programs were not designed to be CGs, so intentionally diverge for a variety of reasons including past experience in implementation, budget restrictions, etc.

	Criteria	Global standard CG model	MoH MSG	Mercy Corps (modified MSGs)	World Vision (parents' club)*	CRS (mothers' group)*
1.	Peer-to-peer health promotion component and peer election of CGVs	Peer approach. Volunteer elected by peers	Peer approach. Volunteers appointed by local officials.	Peer approach. Volunteer elected by peers	Peer approach. Volunteer appointed by local officials.	Non-peer approach. Trainer is partner staff.
2.	CGVs visit a maximum of 15 households each	No more than 15	Minimum 5 households	5-10 households	15-20 households	12-15 households
3.	CGs have between 6 and 16 members	6-16 members	12-15 members per village (*suku*)	6-12 trainers per MSG	NGO staff trainers	NGO staff trainers
4.	CGVs will meet their beneficiary mothers at least once a month	Monthly	Undefined	Monthly	Weekly	1x per 2 months
5.	CGVs plan to reach 100% coverage of households. Coverage is monitored.	100% local coverage.	> 5 households per community	100% coverage	100% coverage	100% coverage
6.	CGVs collect events data on pregnancies, births, and deaths	yes	yes	no	yes	yes
7.	Main goal of the CG is to reduce malnutrition and mortality	yes	Improve health and health service uptake	yes	yes	yes
8.	Use of visual teaching tools	yes	yes	yes	yes	yes
9.	Use of participatory teaching methods in CG	yes	yes	yes	yes	yes
10.	CG instructional time (when a Promoter teaches CGVs) does not exceed 2 hours per meeting	< 2hrs	Less frequent, longer meetings	< 2hrs	< 2hrs	<2 hrs
11.	Promoters supervise at least one CGV monthly	monthly	Primary Health Care staff	monthly	monthly	bi-monthly
12.	CGV and beneficiaries live within max 1 hour walking distance to facilitate meetings and home visitation	yes	no	yes	yes	yes
13.	Project/program culture conveys respect for the population and volunteers, especially women	yes	yes	yes	yes	yes

*Intentionally not based on Care Group Model

Evidence of Nutritional Efficacy of the Care Group Model

Global evidence regarding the efficacy of the CG model in improving nutritional outcomes is summarised below under five categories, with evidence from Timor-Leste presented where available.

1. Nutritional status of children under 2 years of age (CU2)

CGs can have a positive effect on nutritional status of CU2 and on key nutrition behaviours and associated indicators (breastfeeding, underweight, complementary feeding practices).[18] The body of literature on the effectiveness of social

17 World Relief and Food for the Hungry, 2012. *Care Group Minimum Criteria Reviewer Checklist*. USAID, Food Security and Nutrition Network (FSNN) and Promoting Excellence in Food Security Programing (TOPS).

18 Perry et al., 2015a. 'Care Groups I: An Innovative Community-Based Strategy for Improving Maternal, Neonatal, and Child Health in Resource-Constrained Settings.'

and behaviour change communication (SBCC) approaches for improving exclusive breastfeeding (EBF) practices is strong and supports the claim that they can and do succeed in improving uptake of the behaviours promoted.[19]

In Kenya, an evaluation of the effectiveness of a government-run CG intervention[20] showed that the mean height and weight status of CU2 in households served by CGs was significantly better than those who did not receive services. Cases of severe acute malnutrition were also less prevalent in children whose mothers were reached by CGs.[21] A separate CG intervention in Sofala province, Mozambique, achieved 78% increase in EBF[22] and a 37% reduction in children classified as underweight. The average annual rate of decline in undernutrition in intervention areas was 2.2% compared to 0.4-0.6% nationwide.[23] In Kenya, local health workers in the village of Laisamis reported that mothers' compliance with the treatment for malnourished children was better in CGs than in the non-support groups.[24]

In Timor-Leste, MoH MSGs have not been significantly associated with increasing EBF for children aged 0-5 months or the minimum acceptable diet for children aged 6-23 months.[25] However, a recent evaluation of the CD-NIP project implemented by CRS[26] demonstrated positive impacts on breastfeeding within those reached by CRS peer-to-peer intervention. From baseline to endline, there was an 18% increase in the proportion of newborns put on the breast within the first hour after birth, and a 29% increase in the proportion of children aged between 6-23 months being breastfed among beneficiaries.[27] In the same program, the proportion of children (aged 6-23 months) who received the minimum dietary diversity increased from 3.9% to 23%.[28]

A recent CRS peer-to-peer intervention in Timor-Leste demonstrated positive impacts on breastfeeding (Photo: TOMAK/CRS)

19 Bhutta et al. 2013. *Evidence-based interventions for improvement of maternal and child nutrition*; and Lamstein et al, 2014. *Evidence of Effective Approaches to Social and Behavior Change Communication for Preventing, Reducing Stunting, and Anemia*: USAID and SPRING Project; See also Mercy Corps, 2017. *Final Report Evaluation of the Northern Karamoja Growth, Health and Governance Project in Karamoja Region, Uganda*. USAID

20 Undlien M., Viervoll H-A and Rostad B., 2016. 'Effect of mother support groups on nutritional status in children under two years of age in Laisamis village, Kenya, *African Health Sciences*, 2016, Vol. 16.

21 Ibid.

22 CORE Group, Food for the Hungry & World Relief. *Care Group Info*. http://caregroupinfo.org

23 Bhutta et al. 2013. *Evidence-based interventions for improvement of maternal and child nutrition.*

24 Undlien M, Viervoll H-A, Rostad B. 2016. 'Effect of mother support groups on nutritional status in children under two years of age in Laisamis village, Kenya'.

25 Ministry of Health Timor-Leste, 2015. *Timor-Leste Food and Nutrition Survey 2013*. Australian Aid and UNICEF.

26 Catholic Relief Services (CRS) and Knowledge for Development (K4Dev), 2018. *Community-Driven Nutrition Improvement Project (CDNIP) 2014-2018. Evaluation Report*, Japanese Social Development Fund and World Bank.

27 Ibid.

28 Ibid.

In a comparison of CG and non-CG projects in six countries (Cambodia, Kenya, Mozambique, Rwanda, and Malawi), the behaviour change documented in CG projects was almost double that of non-CG interventions.[29] An example of this can be seen in complementary feeding which increased by an average of 22% across CG projects versus an increase of 12% in non-CG projects.[30]

Adapting the CG model to target fathers has also shown promise. The final evaluation of a CG program in Ethiopia found that behaviour change targeting men can also have a positive effect on maternal dietary intake and diversity, household hygiene and sanitation practices, all practices linked to child nutritional status. Men in the program were encouraged to support their partners and be actively involved in supporting the nutrition of PLW and children.[31]

2. Child mortality reduction

Two peer-reviewed publications have documented the effectiveness of the CG model in increasing coverage of child survival interventions and reducing CU5 mortality.[32] Among these programs, a CG program implemented in Sofala Province, Mozambique, achieved a 29% decrease in CU5 mortality.

In Uttar Pradesh, India, an evaluation of the effects of CGs found that peer group-based counselling was effective in reducing infant/child mortality by improving infant and young child feeding practices at community level, and that these changes could be sustained.[33]

3. Women's nutrition outcomes

There is evidence that MSGs in Timor-Leste may have been effective in promoting some maternal, newborn and child health outcomes. The Timor-Leste Food and Nutrition Survey (2013) reported that maternal thinness was 26% lower in MSG villages and maternal anaemia was 35% lower.[34]

The final evaluation of the CD-NIP project[35] showed increased dietary diversity for both mothers and children when mothers attended CG meetings. In the same project, the proportion of mothers eating iron-rich foods more than doubled from 15% to 37%. Improvements in diversification of household food production were also significant with 92% of participants having introduced a new crop during the lifetime of the project, compared to only 4% of households who did not participate in the project.[36]

4. Nutritional status of adolescent girls

To break the intergenerational cycle of malnutrition, it is critical to not only improve the nutritional status of children but also of malnourished adolescent girls prior to and during pregnancy. CGs can be used to influence household behaviours that improve the nutritional status of adolescent girls and also the age of marriage and first birth. In Nigeria's North West State of Sokoto, where there is a high rate of teen pregnancy, the children of adolescent mothers had low bodyweight and were malnourished, and the care practices of children were found to be very poor. The CG model provided an opportunity to appropriately target adolescents to achieve improved maternal and child health and nutrition. This case found positive effects from providing adolescent girls with useful knowledge and information on practices to 1) prevent malnutrition by maintaining a healthy nutritional status for themselves and their families, 2) prevent illness in their households, and 3) seek health services and facilities when necessary. However, it was necessary to overcome several cultural and social barriers in order to reach and involve adolescent girls in CGs.[37]

Care groups face several limitations as a platform for reaching adolescents. Adolescent mothers or first time mothers have very specific needs and may need extra and specialised support in the areas of self-efficacy, social standing, or skills (social or otherwise) to adopt a behaviour. One limitation of CGs is that volunteers are often older adult women, whereas adolescent mothers have specific needs that may be better addressed by their peers, i.e. other adolescents. Young or first time mothers are not always considered when a CG is initially formed and may be overlooked by CG volunteers, limiting the chance for them to have a 'peer' supporting them through the CG approach.

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29 George et al. 2015. 'Evaluation of the effectiveness of Care Groups in expanding population coverage of key child survival interventions and reducing under-5 mortality.'

30 Ibid.

31 GOAL, 2015. *Final Evaluation: For the project "Building on community strengths: identifying and addressing the social and cultural aspects of maternal, infant and young child nutrition" West Hararghe Zone of Oromiya Region, Ethiopia*. USAID - Technical and Operational Performance Support (TOPS)

32 George et al. 2015. 'Evaluation of the effectiveness of Care Groups in expanding population coverage of key child survival interventions and reducing under-5 mortality.'

33 Kushwaha et al. 2014. 'Effect of Peer Counseling by Mother Support Groups on Infant and Young Child Feeding Practices: The Lalitpur Experience.' *PLOS ONE,* 2014 November, Vol. 9.

34 Ministry of Health Timor-Leste, 2015. *Timor-Leste Food and Nutrition Survey 2013*. Australian Aid and UNICEF.

35 CRS and K4Dev, 2018. *Community-Driven Nutrition Improvement Project (CDNIP) 2014-2018. Evaluation Report.*

36 Ibid.

37 Perera, S. 2015. *Case Study on Adolescent Inclusion in the Care Group Approach- the Nigeria Experience*. USAID Technical and Operational Performance Support (TOPS) Program.

Lessons Learned: Care Group Model for Behaviour Change

Evidence suggests that sustained behaviour change requires more than simply increasing knowledge and awareness of good nutrition practices. Beyond knowledge-transfer, social behaviour change communication strategies see change as a process that takes place over time, not through a single event. Internal processes and environmental influences on behaviour accelerate or discourage the change process at different times. *"A person may change their behaviour but later return to old practices. They may go around the cycle several times before finally incorporating the change into their lives"*.[38] Below are some key lessons learned around implementing the CG model to change health behaviours:

- **Sustainability.** The sustainability of CG programs can be evaluated according to the following criteria: 1) ownership of project achievements by target communities; 2) government readiness to take over the project; 3) capacity of the institution taking over the CG project; and 4) financial sustainability of a CG project.[39] Levels of sustained behaviour change have been shown in post-program assessments, indicating that for at least some behaviours, they can be a lasting pathway to sustained behaviour change.[40] CGs have also been successfully integrated into health systems in several countries.[41] Integration with government health services requires CG formation, training, and ongoing support to be integrated into formal job descriptions and health ministries' official targets, in addition to dedicated material resources.[42] Recent experiences in Burundi, Rwanda and Mozambique indicate that integrating the CG model into government rural health delivery systems is more effective than NGOs implementing the CG model alone, and results in greater use of health facilities. In Mozambique, health system integration of CGs helped to assure continued data surveillance and incorporation of health and nutrition data into the Ministry of Health's information system.

- **Value for money.** Expanding coverage and achieving impact requires approaches that are not only low cost and effective for small populations in the short-term, but are also low cost, effective and feasible at scale over the longer term.[43] The CG model has been recognised as one of the most efficient interventions for effectively engaging many people within a short period as well as being highly cost effective.[44]

- **Dynamic structure and processes allow for integrated activities.** There are several examples of the CG model being adapted to integrate additional activities (i.e. male engagement, financial inclusion, livelihoods).

  Male Engagement. One of the key lessons of CG implementation in Uganda[45] and Timor-Leste[46] has been that engaging men is critical for changing social norms and attitudes over the long-term. Focusing on women alone was shown to have less success compared to a more holistic approach that involved men. Behaviour shifts were more evident where both husband and wife were engaged in CG supportive platforms.

  Financial Inclusion. Introducing a savings group approach allows mothers with a nutrition goal to accumulate savings, which in turn, is often reinvested in areas that are nutrition-sensitive, such as vegetable production or more nutritious food purchase. Evidence indicates this can then improve household food insecurity.[47]

  Livelihoods. Malnutrition is multifactoral. The most effective behaviour change strategies assess various factors in the societal and physical environment that enable or constrain people's motivation and ability to make changes, and then seek to overcome or harness them respectively. Household decision-making dynamics and households' livelihood portfolios are therefore key to promoting behaviour change, including with CGs[48].

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38 Hubley J, *Communicating Health: An Action Guide to Health Education and Health Promotion*, 2nd ed. London, TALC. In CRS and K4Dev. 2018. *Community-Driven Nutrition Improvement Project (CDNIP) 2014-2018. Evaluation Report*.

39 GOAL 2015. *Final Evaluation for the project "Building on community strengths: identifying and addressing the social and cultural aspects of maternal, infant and young child nutrition" West Hararghe Zone of Oromiya Region, Ethiopia*.

40 CORE Group, 2014. 'Care Groups: Implications of Current Innovations, Scale-up and Research'. *Summary Report of a Technical Advisory Group meeting*, May 28-29 2014, CORE Group: Washington D.C.

41 Perry et al. 2015a. 'Care Groups I: An Innovative Community-Based Strategy for Improving Maternal, Neonatal, and Child Health in Resource-Constrained Settings.'; See also Weiss et al, 2015. 'Shifting management of a community volunteer system for improved child health outcomes: results from an operations research study in Burundi.' *BMC Health Services Research*, 2015, Vol. 15.

42 Perry et al, 2015a. 'Care Groups I: An Innovative Community-Based Strategy for Improving Maternal, Neonatal, and Child Health in Resource-Constrained Settings.'

43 Ibid.

44 Ibid.

45 Wasilkowska K, 2017. Growth, Health and Governance (GHG) *Gender and Behavior Change Impact Assessment Report*. USAID – Mercy Corps; See also Mercy Corps, 2017. *Final Report Evaluation of the Northern Karamoja Growth, Health and Governance Project in Karamoja Region, Uganda. USAID.*

46 CRS and K4Dev, 2018. *Community-Driven Nutrition Improvement Project (CDNIP) 2014-2018. Evaluation Report.*

47 Mercy Corps, 2017. *Final Report Evaluation of the Northern Karamoja Growth, Health and Governance Project*; See also TOMAK, Mercy Corps 2018 'The impact of Savings Groups on Food Security and Nutrition: What does the evidence show us?', Australian Aid.

48 Ibid.

- **Managing incentives.** Comparisons of paid versus volunteer delivery of the CG model have shown that non-monetary incentives for CG leaders (CGVs) can be successful.[49] Incentives should therefore be carefully managed whether financial support, medical treatment provision[50] or any other in-kind gift (i.e. seeds, tools, saving boxes, etc.).
- **Trusted sources.** Continued engagement by a trusted source is more likely to enable behaviour change around complex behaviours. Having mothers choose their group leaders results in a higher likelihood of behaviour change. Trusted facilitators who participants identify with are more successful.
- **Reducing the number of behaviours targeted and increasing the quality of interaction.** The timely and targeted promotion of behaviours as well as dosage (frequency) of messaging are key determinants of behaviour change adoption. CG curricula of five countries (Mozambique, Burundi, Ethiopia, the DRC, and Timor-Leste) all focus on a large number of health topics – maternal, infant and young child nutrition (essential nutrition and hygiene actions) including specific disease topics according to the context (tuberculosis, malaria, Ebola, HIV). Implementers must balance desire to create behaviour change across a range of topics with increased focus over a smaller number of topics. According to the CD-NIP evaluation in Timor-Leste, when the number of promoted practices was reduced, interactivity increased among group leaders and mothers.[51] As such, it's recommended that CG curricula focus on a targeted set of practices to promote, use shorter and more frequent training sessions, and develop visual materials which have few messages (i.e. focus on the promotion of one specific behaviour per training). Evidence from CD-NIP also suggests that interactive learning events like cooking demonstrations were more successful in improving knowledge retention and converting knowledge into practice, while more routine mothers' groups and didactic training sessions did not attract the same level of attendance.[52]

Evidence suggests that behaviour change is more likely when women are engaged by a trusted source who they identify with and respect (Photo: Mercy Corps)

49 Ibid; See also Perry et al, 2015b. 'Care Groups II: A Summary of the Child Survival Outcomes Achieved Using Volunteer Community Health Workers in Resource-Constrained Settings', *Global Health: Science and Practice*, 2015, Vol. 3.

50 GOAL, 2015. *Final Evaluation for the project "Building on community strengths: identifying and addressing the social and cultural aspects of maternal, infant and young child nutrition".*

51 CRS and K4Dev, 2018. *Community-Driven Nutrition Improvement Project (CDNIP) 2014-2018. Evaluation Report.*

52 Ibid.

Questions for Government, Development Partners and Other Stakeholders

Learnings from global evidence and locally implemented adaptations of the CG model in Timor-Leste open up a range of questions for government, development partners, and other stakeholders. To help guide future discussions, some of these key questions are outlined below:

- **Sustainability:** What different roles should government, NGOs and the private sector play for CGs to be sustainable? Can we generate a shared vision of sustainability and an advocacy action plan for Timor-Leste?
- **Link to the health system:** What are the most/least appropriate and effective ways to link CGs with the MoH (MSGs and primary care services)? What level of involvement of village-based health services (doctors, nurses, midwives, etc.) has worked best? What links are could or should be made with the agricultural extension service?
- **Integrating interventions:** What are appropriate non-nutrition interventions that can be integrated into CGs (links to savings groups, agriculture groups)? What are inappropriate interventions to integrate?
- **Curricula:** What are the features of the current CG curricula being used? What are principles we can agree on as best practice for CG curricula? Are we appealing to the interests of women and other key influencers (which may not always correspond with program objectives)?
- **Focus:** How do we keep the focus on a targeted set of practices in order to increase the chance of changing behaviours?
- **Measurement:** There is evidence that involvement in CGs including MSGs and other peer-to-peer mother groups in Timor-Leste can have positive impacts on maternal nutrition, but there is a lack of evidence on a broader scale. How can we best direct monitoring, evaluation and learning efforts across MoH and partner activities? How are teams measuring?
- **Sharing with and learning from other peer organisations:** How can collaborative learning be encouraged among all organisations implementing the CG model in Timor-Leste?

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Mothers and other family members including fathers and grandmothers attend a parents club meeting in Baucau, Timor-Leste (Photo: TOMAK/World Vision)

About TOMAK

TOMAK (*To'os ba Moris Di'ak*, or Farming for Prosperity), a 5-10 year agricultural livelihoods program supported by the Australian Government in Timor-Leste.

TOMAK works with and through government, NGO and private sector partners to help farmers grow more and better food, improve family nutrition, and increase household income. Working together to improve the systems which support farmers to do this has the potential to enhance livelihoods and bring long-term change.

The target area for the first phase of TOMAK is 66 suku (villages) located in the inland, irrigable zones in Timor-Leste. These suku are located in 3 municipalities - Bobonaro, Baucau and Viqueque.

About the Learning & Development Platform

To consolidate learnings in the sector, TOMAK has established a dedicated Learning and Development Platform (L&DP). The platform aims to facilitate cross-program learning by capturing and sharing lessons related to nutrition-sensitive agriculture (NSA) and social behaviour change (SBC), and by highlighting appropriate international examples.

The TOMAK L&DP has developed a number of think pieces – a series of articles that analyse a range of evidence around key trends, best practices and lessons in NSA and SBC relevant for Timor-Leste. This evidence comes from Timor-Leste as well as the larger global discourse. These think pieces aim to move beyond data and recommendations in order to stimulate new ideas, discussion and innovation. Partners are encouraged to use the information or ideas presented here to further their individual and agencies' own ideas, trials, and practices.

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