

Recommendations for Using Care Groups in Emergency Settings



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ABBREVIATIONS AND ACRONYMS

BCC	Behavior Change Communication
CG	Care Group
CGV	Care Group Volunteer
IDPs	Internally Displaced Persons
IYCF	Infant and Young Child Feeding
MoH	Ministry of Health
MUAC	Mid-Upper Arm Circumference
PLW	Pregnant and Lactating Women
U2	Children under 2
U5	Children under 5
WASH	Water, Sanitation and Hygiene



Background

This guide is based on findings from the International Medical Corps *Care Groups in Emergencies: Evidence on the Use of Care Groups and Peer Support Groups in Emergency Settings* project, which reviewed evidence on the use of the Care Group model and other types of peer support groups in emergency settings. The insights presented are based on experiences with the use of Care Groups in emergencies to date and the guide is intended as a working document to be updated as the body of evidence and experiences around the use of the model in emergencies expand. The Care Group community is therefore encouraged to share experiences and insights on the use of the Care Group model in emergencies. For more details on the findings from the project, please refer to the *Care Groups in Emergencies: Evidence on the Use of Care Groups and Peer Support Groups in Emergency Settings*¹ report.

Definitions

CARE GROUPS

A Care Group is a group of 10-15 volunteer, community-based health educators who regularly meet together with project staff for training and supervision. They are different from typical mother's groups in that each volunteer is responsible for regularly visiting 10-15 of her neighbors, sharing what she has learned and facilitating behavior change at the household level. Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication. They also provide the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits (www.caregroups.info).

The circumstances of emergency settings, however, may require adaptations to the model to allow it to be implemented while retaining its benefits, such as its large, rapid, and cost-effective reach of target populations with key messages.

EMERGENCIES

For the purposes of this project, emergency contexts have been classified across three dimensions: emergency type, stage, and setting. These categories reflect the most commonly found characteristics of the emergency contexts in which peer support group models, including Care Groups have been implemented.

The **emergency type** is dependent on the source causing the emergency state. Examples of types of emergencies are: natural disasters - such as typhoons, tsunamis, earthquakes, or droughts; epidemics - such as Ebola or cholera; or

conflicts - civil, religious, ethnic, or international.

Emergency stage refers to the nature of an emergency's onset and its current phase in relation to its onset. The three main stages identified in this project were: acute, protracted, and transitional.

An **acute** emergency stage is the one immediately following the onset of a catastrophic event. An example of the acute stage would be the situation brought on by a natural disaster such as a typhoon, earthquake, or tsunami. A **protracted** emergency, on the other hand, is one resulting from an emergency state that has developed over time, whether because the situation following a catastrophic event has not been resolved, or because the onset of the emergency occurred gradually. Common examples of protracted emergencies are droughts or long-standing civil, religious, or ethnic conflicts. Finally, an emergency is in a **transitional** stage when it is moving from a development setting to an emergency setting or vice-versa. From a programming standpoint, this can occur when a development program has been in place in a development setting and a sudden emergency situation develops. In this case, the programming may shift from development into emergency response. This has been the case, for example, for the 2014 Ebola outbreak in West Africa, where certain established development programs transitioned to respond to the needs that emerged from the epidemic. On the other end, programs that were established as emergency response, may transition into development programming when the emergency begins to stabilize.

Emergency setting refers to the location of the population affected by the emergency. The main distinction for the implementation of peer support groups is between **camp settings**, usually occupied by refugees or internally displaced people (IDPs), and **community** settings, where the target population is people residing in the area, permanently or temporarily.

Benefits of Using Care Groups in Emergency Settings

Listed below are those benefits identified by stakeholders as most relevant to the Care Group model in emergency settings.

- **Documented Effectiveness:** One of the rationales cited for choosing to implement Care Groups in the specified emergency setting was that the model had been used previously by the organizations and found to be effective for behavior change.
- **Large Coverage:** A key advantage of Care Groups in emergency settings is that they allow programs to cover a high percentage of the target population through its cascading mechanism.
- **Cost Effectiveness:** Through the use of Care Group Volunteers programs can cover a large area with a minimal number of paid staff.

¹ Serino A, Stokes H, Wilcox S. Care Groups in Emergencies: Evidence on the Use of Care Groups and Peer Support Groups in Emergency Settings. Washington, DC: International Medical Corps. May 2015.

- **Rapid Dissemination of Information:** The cascading and multiplying flow of information from staff down to Care Group Volunteers and beneficiaries also allows messages to be disseminated rapidly to a large number of people. This is particularly advantageous in emergency settings, where there is a need to reach people quickly with key life-saving messages.
- **Rapid Behavior Change:** Community behavior change can occur much more rapidly in emergency relief settings than would occur in development settings. People are upended from their usual support systems and trying to survive, so they are much more open to making changes in their behavior that will foster survival.
- **Peer Support:** In both development and emergency settings Care Group structure encourages bonding among participants and peer support where social cohesion plays an important role in personal and community recovery.
- **Trusted Channel of Communication:** The Care Group system provides a community structure that can be leveraged for additional purposes during both acute and protracted emergencies, such as using Care Group Volunteers to spread information regarding food distribution.
- **System for Monitoring, Screening and Referrals:** The Care Group model can provide an effective and wide reaching system for data collection, screening and referrals for communities especially during an emergency when health workers may not be available to fulfill these functions.
- **Sustainability:** Because of its community integration and the broad coverage, the model is highly sustainable and behaviors continue being practiced after programs end.

Challenges of Using Care Groups in Emergency Setting

Stakeholders identified a number of challenges in the set-up and implementation of CGs in emergency contexts.

- **Initial Set-up of Care Groups:** The requirements for setting up a CG are time-consuming and labor-intensive and may pull relief staff away from other immediate needs. Relief funding tends to be short-term and can end before significant behavior change can be accomplished. When organizing CGs one needs to consider the length of the funding cycle, the stage of the emergency and staff capacity.
- **Development of Program Materials:** Development of program materials can be a challenge in both acute and protracted emergencies due to time constraints, cost of printing, and the need for context-specific information.
- **Community Sensitization:** During the acute stage of an emergency, it can be difficult to devote time to community sensitization for CGs with community leaders due to other competing priorities.
- **Finding Qualified Program Staff and Volunteers:** It is

often difficult to recruit qualified Promoters and Care Group Volunteers, especially women, due to cultural barriers, language, literacy levels, traditional beliefs or lack of incentives.

- **Knowledge of Care Group Methodology:** Staff running Care Group programs often have inadequate knowledge/experience with the Care Group methodology. In relief settings, there is often a high turnover of staff, which impacts program direction.
- **Incentives:** Because Care Group Volunteers are traditionally not given monetary incentives, it can be difficult to recruit volunteers when other organizations are providing paid positions for similar work. In protracted emergencies, there is volunteer fatigue and the need to motivate CGVs over the long-term, with a focus on non-monetary, value based incentives.
- **Insecurity:** In emergency settings, insecurity due to violence can interrupt programs and limit staff's ability to train CGVs or CGVs ability to hold meetings and conduct household visits.
- **Population Mobility:** Mobile populations due to seasonal migration, epidemics or natural disasters can also interrupt programming and make it difficult to hold regular trainings and meetings.
- **Program Continuity:** Care Groups operating over long periods, such as protracted emergencies, may grow in size and as the beneficiaries become increasingly diverse it can be difficult to target behavior change messages. Additionally, it is unclear what next steps are after a Care Group has completed all behavior modules.

Lessons Learned and Recommendations²

The table below summarizes lessons learned and recommendations regarding the use of the Care Group model in emergency settings. The information is based on the experiences of eleven international NGOs implementing CGs in emergencies across fourteen countries³. This document should be updated as new evidence and discussion around the use of the model emerge. It may be used in conjunction to the Care Group Manual⁴ by implementers considering the use of CGs in emergencies.

2 These recommendations are provided by the International Medical Corps team that conducted this study and prepared this report based on literature reviews, interviews, field visits, and food security community feedback. These recommendations were not created by the USAID Office of Food for Peace or The TOPS Program and should not be understood as guidelines issued by either entity.

3 For details see: Serino A, Stokes H, Wilcox S. Care Groups in Emergencies: Evidence on the Use of Care Groups and Peer Support Groups in Emergency Settings. Washington, DC: International Medical Corps. May 2015.

4 Hanold M, Wetzel C, Davis T, et al. Care Groups: A Training Manual for Program Design and Implementation. Washington, DC: Technical and Operational Performance Support Program. 2014. http://fsnnetwork.org/sites/default/files/resource_uploads/tops_care_group_training_manual_2014.pdf

Element	Lessons Learned	Recommendations
Initial Set-up of CGs	Successful setup of CGs in an acute emergency is dependent on funding cycle, phase of the emergency and staff capacity.	<ul style="list-style-type: none"> a. Begin CGs after the acute phase of the emergency has “stabilized”. b. Assign development staff to set up CGs in acute emergencies.
Development of Program Materials	<p>It takes time and resources to adapt appropriate visual tools, which can affect implementation in an acute emergency</p> <p>Materials adapted from NGO or government development programs may not reflect the resources available during an emergency. Nutritious foods or WASH materials may not be available in the relief setting.</p>	<ul style="list-style-type: none"> a. Ensure that sufficient funding is included in the emergency response budget for production of material including designing, translating, printing and pre-testing. b. Prepare in advance generic emergency visual tools and basic modules, such as WASH, that are appropriate to the countries you work in and have them ready for emergency use. c. Pre-test visual tools and products to ensure that they represent resources and materials available to the target population. d. When using existing materials from another program during an emergency, train Promoters on how to adapt messages and select context-appropriate pictures for training/educating CGVs. e. Train Promoters on behavior change activities that utilize participatory methods such as songs and skits rather than rely on visual tools.
Topics Covered	The topics covered in CGs in emergency settings must reflect priority behavior change actions relevant to the specific emergency.	<ul style="list-style-type: none"> a. Use rapid assessment tools, formative research and available data to identify topics relevant to the target population and emergency context. b. Adapt instruction to address relevant health behaviors during the emergency. For acute emergencies, curriculum should focus on immediate and life-saving benefits of promoted behavior - such as hand washing or exclusive breastfeeding. For protracted emergencies, curriculum can focus on longer-term benefits of promoted behavior such as optimal child growth. c. Train volunteers on how to protect their own health while conducting household visits during an epidemic.
Target Population	In acute emergency settings, there is a need to address the entire affected population through CGs with life-saving BCC messages.	<ul style="list-style-type: none"> a. In acute emergencies, expand target population beyond caregivers, PLWs and U2 and U5 to affected population. b. Adapt BCC messages to address appropriate health behaviors for the target population during the emergency.
Care Group Volunteer (CGV) Selection	The aftermath of an acute emergency may be too chaotic to organize elections of CGVs by neighborhood groups.	When lack of stability in an emergency does not allow for election of CGVs by neighborhood groups, use community leaders or program staff to select interim CGVs based on CG criteria. Once stabilized, evaluate the situation and encourage beneficiaries to conduct elections.
Meeting Length	In emergencies, it may be necessary for meetings with beneficiaries to last more than two hours, as the trauma suffered during the emergency may slow down learning and require more psychosocial support.	Keep meeting length flexible depending on needs, spending longer time if is beneficial for psychosocial support and getting messages across effectively.

Element	Lessons Learned	Recommendations
Monitoring and Evaluation	<p>Data collection may not be a priority concern in emergency programming.</p> <p>CGVs' literacy levels may be a challenge for data collection.</p>	<ol style="list-style-type: none"> Collect monitoring data that is relevant to the emergency circumstances such as child growth measurements (e.g. MUAC), household needs and disease burden. Provide training and monitoring tools that are appropriate for literacy levels of the CGVs.
Formative Research	<p>Formative research, such as barrier analysis, is instrumental for determining curriculum topics and ensuring that the approach to BCC is appropriate to the context.</p> <p>At the beginning of an acute emergency, time constraints and funding may limit the ability to conduct formal analyses for formative research.</p>	<ol style="list-style-type: none"> Conduct barrier analysis to identify obstacles to behavior change once an emergency situation has stabilized. If relief staff is engaged in other activities during the acute emergency stage, ask development staff to conduct the research. Ensure formative research is conducted by considering less formal methods than barrier analysis i.e. focus groups, windshield surveys or mixed methods. Review of secondary literature and greater collaboration with other organizations working in the response.
Ministry of Health	<p>Involvement of the MoH with CG programming is optimal to ensure consistency of messaging and for program sustainability after the program has ended.</p>	<ol style="list-style-type: none"> When government is disrupted or disabled due to an emergency, begin program implementation and coordinate with government once it is functional again. Coordinate materials and health messages with MoH administration and providers to ensure consistency of messages. Coordinate trainings with MoH staff to facilitate sustainability and transitioning at the end of the program.
System for Monitoring, Screening and Referrals	<p>The CG model can provide an effective and wide reaching system for data collection, screening and referrals through CGVs. This is especially important during an emergency, when health workers and other systems may not be available.</p>	<ol style="list-style-type: none"> Train CGVs to collect vital statistics, and to screen and provide referrals for common conditions if appropriate in the given context. During an epidemic, train CGVs to teach beneficiary mothers how to screen their own children for malnutrition and suspected disease.
Community Sensitization	<p>It is essential to have buy-in of household, community, and religious leaders for program success.</p> <p>During the acute stage of an emergency, community sensitization can be challenging due to other competing priorities.</p>	<ol style="list-style-type: none"> Plan and budget for community sensitization activities to get buy-in of decision makers. Include community sensitization activities in CG implementation timeline/ work plan. Train CGVs on how to include family members (men, grandmothers, etc.) in BCC during household visits.
Finding Qualified Program Staff & Volunteers	<p>It can be difficult to recruit qualified Promoters and CGVs due to literacy, language, and cultural barriers.</p> <p>In protracted emergencies, there is often a high turnover of staff.</p>	<ol style="list-style-type: none"> Adapt monitoring and visual tools for low literacy of Promoters. Provide training to Promoters on how to encourage women to take leadership roles and how to work with more reserved women.
Knowledge of CG Methodology	<p>Staff running CG programs often have inadequate knowledge/experience with the CG methodology.</p> <p>In emergency settings, there is often a high turnover of staff.</p>	<ol style="list-style-type: none"> Ensure that higher-level staff, such as Supervisors and Coordinators are trained in CG methodology. Develop a rapid CG training program for staff and/or have staff attend a CG training program provided by the organization. In protracted emergencies, offer annual refresher CG training for all staff and CGVs.

Element	Lessons Learned	Recommendations
Incentives	Use of incentives needs to be evaluated in terms of program length, funding cycles and long versus short-term objectives.	<ul style="list-style-type: none"> a. CGVs should not be given incentives or selected for livelihood schemes that undermine CG group cohesion. b. Instead of paying CGVs incentives, use the funds for projects/ activities that benefit the entire community. c. Provide non-monetary tools for the job, such as signs, ID badges, refreshments, certificates, skirts with behavior change images, boots, umbrellas, coats, hats, bags, notebooks etc. d. Train program staff and CGVs about the importance and intrinsic value of volunteerism. e. Be transparent at the outset of acute emergency if short-term incentives are provided, explaining that incentives will be withdrawn as emergency stabilizes.
Insecurity	<p>Insecurity due to emergency circumstances can interrupt trainings and/or regular group meetings.</p> <p>It is still possible to hold meetings in insecure settings if a safe location can be identified.</p>	<ul style="list-style-type: none"> a. Allow flexible training times/intervals to work around security concerns. b. Hold meetings in a secure location, such as a health post, if community-based/outdoor spaces are unsafe.
Population Mobility	Population mobility is a concern in emergencies where movement or interruptions are unpredictable and can affect consistency of CG participation and uptake of BCC messaging.	<ul style="list-style-type: none"> a. In settings where populations have predictable patterns of movement (ex. seasonal migration), teach short modules with a small number of topics and few key messages appropriate to the context. b. Using the CG model with temporarily displaced populations or mobile groups with no predictable pattern of migration is not recommended.
Program Continuity	<p>Care Groups can become large and unwieldy as new members join the group.</p> <p>In protracted emergencies, it is unclear how programs should proceed after completing the initial modules in the curriculum.</p> <p>To promote sustainability, cooperation with MoH can ensure continued delivery of BCC messages to the community.</p>	<ul style="list-style-type: none"> a. When Care Group beneficiary groups grow large: 1) split them into two groups and have an experienced mother lead as CGV of the second group; or 2) experienced mothers can continue attending group meetings but will no longer receive household visits or qualify for supplementary food. b. Once all the modules are complete, repeat lessons or modules where the behavior change level is not meeting targets. c. Develop new modules as needed based on formative research that captures new issues arising in the emergency. d. Integrate program with MoH: training, materials and Promoters to facilitate sustainability.