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STRENGTHENING THE SUSTAINABILITY OF CARE GROUP VOLUNTEERS

A Guide for Resilience and Food Security Activities

USAID ADVANCING NUTRITION

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About USAID Advancing Nutrition

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Acknowledgments

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Acronyms

BHA	Bureau for Humanitarian Assistance
BRAC	Bangladesh Rural Advancement Committee
CHW	community health worker
CHV	community health volunteer
CLA	Collaborating, Learning, and Adapting
FCHV	female community health volunteer
IP	implementing partner
IYCF	infant and young child feeding
MCH	maternal and child health
MOH	Ministry of Health
NGO	nongovernmental organization
NPDA	Nutrition Program Design Assistant
RFSA	Resilience Food Security Activity
SBC	social and behavior change
USAID	U.S. Agency for International Development
VSLA	village savings and loan association
WHO	World Health Organization

Executive Summary

USAID-funded Resilience Food Security Activities (RFSAs) are multi-sectoral projects designed to address the main drivers of food insecurity by building local capacity, tapping into existing systems, and building long-term sustainability to improve livelihoods, nutrition, and health. Most RFSAs implement their activities through groups, such as village savings and loan associations (VSLAs), farmer groups, peer-to-peer groups, and Care Groups. Care Groups led by Care Group Volunteers are a key social and behavior change (SBC) strategy to achieve improved nutrition and health outcomes. However, there is limited evidence on how to sustain Care Groups in their original form post-award as a means to sustain key health and nutrition outcomes. A significant challenge for sustainability of Care Groups is that the focus of group activities is on the first 1,000 days, which means that activities will no longer be relevant to group participants after their child turns two.

USAID Advancing Nutrition developed this stepwise guide for RFSA implementing partners (IPs) as a reference during project design and implementation (e.g., proposal, Refine and Implement, post-midterm evaluation). The guide aims to assist IPs in thinking critically about whether and how Care Group Volunteers (or similar unpaid peer group volunteers) can be sustained post-project implementation. Evidence shows that after the life of the award, Care Groups and the role of the Care Group Volunteers evolve from supporting optimal health and nutrition to serving as community resources, likely in another form. The volunteers could either be absorbed by the health system or evolve to include (or in some cases, evolve into) an income-generation group such as a VSLA. Currently, there is more evidence for the latter.

Based on what we learned from the literature and key informants, we developed this guide to cover the following suggested four steps:

Step 1: Design an Appropriate Community Nutrition Approach.

- Prioritize Nutrition Behaviors.
- Determine if Care Groups Are Appropriate for the Setting.
- Decide How the Care Groups Will Evolve after the Life of the Award.

Step 2: Develop the Care Group Sustainability and Exit Plan.

- Identify and Strengthen Linkages.
- Strengthen Sources of Resources.
- Define Content and Process for Capacity Strengthening.
- Consider Different Forms of Motivation.
- Set the Vision for Transition.

Step 3: Support Care Group Volunteers throughout Implementation.

- Roll Out Support to Care Group Volunteers.
- Adapt Support to Care Group Volunteers.

Step 4: Transition Support and Disseminate Experiences.

- Transition Support to Groups, Volunteers, or Local Actors.
- Document and Disseminate Experiences within the Nongovernmental Organization (NGO)/Donor Community.

We also presented a decision tree to help IPs navigate these steps.

Photo credit: Romilla Karnati, Save the Children

Introduction

Who is this guide for?

This guide is for USAID Bureau for Humanitarian Assistance (BHA)-funded Resilience Food Security Activity (RFSA) implementing partners (IPs) who plan to implement Care Groups (or similar peer groups) as a part of their program activities.

Why is this guide needed?

USAID-funded RFSA IPs create Care Groups or similar peer groups as a key part of their social and behavior change (SBC) strategy as a means to achieve improved health and nutrition outcomes. However, IPs seldom design activities that consider how to sustain these groups and the volunteers who lead these groups post-award as a means to sustain key health and nutrition outcomes. BHA has placed greater emphasis on sustainability and exit strategies and requires RFSA IPs to plan for post-award sustainability.

From the point of view of sustainability, there are two main concerns with Care Groups. First, it is challenging to motivate Care Group Volunteers and link them to existing systems, where Care Groups are not part of the health system, such that Care Groups activities are sustained beyond the life of the award. Second, the focus of most Care Group nutrition activities center on the first 1,000 days, the period from conception to until a child turns two, because this is a key window of opportunity to prevent and reduce undernutrition. However, these behaviors are by their very nature time limited and transient. Any SBC activities and communication for this age group is only relevant to program participants until their child turns two. Furthermore, experience shows that after the life of the award, Care Groups—and the role of the Care Group Volunteers who lead them—evolve from supporting optimal health and nutrition to serving as community resources, likely in another form. As such, this guide is intended for use by RFSA IPs to assist with planning for the sustainability of Care Groups and Care Group Volunteers from the early stages of program design and implementation.

How was the guide developed?

We conducted a literature search using the Internet database PubMed with key words motivation, incentives, sustainability, Care Groups, peer groups, community health workers (CHWs), and community health volunteers (CHVs) in different combinations during the search. We also used articles, evaluations, and unpublished "gray" literature recommended by key informants and others working with Care Groups to develop this document. Additionally, we conducted semi-structured key informant interviews with 10 individuals who currently or previously have implemented Care Groups, as well as technical experts in sustainability, Care Groups, and/or project implementation and monitoring.

How to use this guide?

RFSA IPs can use this guide as a reference during project design and implementation (e.g., proposal, Refine and Implement, post-midterm evaluation). The guide aims to assist IPs in thinking critically about whether and how Care Group Volunteers (or similar unpaid peer group volunteers) can be sustained post-award. The guide is divided into four steps: 1) Design an appropriate community nutrition approach; 2) Develop the sustainability and exit plan for the Care Group; 3) Support Care Group Volunteers throughout implementation; and 4) Transition support and disseminate experiences.

Background

Resilience Food Security Activities

BHA-funded Resilience Food Security Activities (RFSAs) are multi-sectoral projects designed to address the main drivers of food insecurity and undernutrition by sustainably building local capacity, tapping into existing systems, and improving livelihoods, nutrition, and health. Most RFSAs implement their activities through groups to deliver many resources to communities. The groups can include, but are not limited to, village savings and loan associations (VSLAs), farmer groups, peer-to-peer groups, and Care Groups. In many RFSAs, Care Groups led by Care Group Volunteers are a main approach for promoting optimal nutrition and health behaviors.[1]

Care Groups as a Community Nutrition Approach

Within the constellation of community-level approaches to improving health and nutrition, Care Groups have been widely implemented, covering at least 43 countries (Care Groups, n.d.). Care Groups are groups of peer volunteers who cascade behavior change promotion within a small catchment area of participants. The definition of a Care Group refers to the group of 10 to 15 volunteers who meet regularly (usually monthly) for training and supervision either with a paid nongovernmental organization (NGO) staff member or a CHW, who may be paid or unpaid (see table 1 for definitions) (FSN SBC Task Force 2014; TOPS 2016). Each volunteer, often called a "lead mother," agrees to conduct outreach to 10 to 15 neighbor households who meet certain criteria—for example, usually having a household member who is nutritionally vulnerable due to being pregnant or having a child less than two or less than five years old. Ideally, the households should be near the volunteer's home to share key information and facilitate behavior change at the household level more easily (FSN SBC Task Force 2014; TOPS 2016).

TABLE 1. DEFINITION OF TERMS USED IN CARE GROUPS*

TERM	DESCRIPTION
Care Group	A group of 10 to 15 Care Group Volunteers led by a Promoter.
Care Group Volunteer (often known as Lead Mother)	Volunteers who meet with the Promoter during Care Group meetings and conduct outreach to 10 to 15 Care Group participants living close by.
Care Group participants (often called Neighbor women)	Male or female members of the community who meet with a Care Group Volunteer, usually twice per month. The interaction between the participants and the volunteer can happen individually or as a group.
Promoter (original role for NGO staff)	A community member (or at least someone from the area) who is hired by a project to train and supervise the Care Group Volunteers in their locality.
Promoter (Ministry of Health-embedded model)	A paid or unpaid CHW within the Ministry of Health (MOH) community health system who trains and supervises Care Group Volunteers within a catchment area.
Supervisor (original role for NGO staff)	A project staff member who supervises and supports Promoters.
Supervisor (MOH-embedded model)	An MOH staff who supervises CHWs who train Care Group Volunteers.

**Content adapted from TOPS 2016.*

1 Some RFSAs also support peer-to-peer or support groups similar to Care Groups.

To strengthen the quality of implementation, IPs developed Care Groups: *A Reference Guide for Practitioners and Care Groups: A Training Manual for Program Design and Implementation* (FSN SBC Task Force 2014; TOPS 2016). **Box 1** presents a set of 13 minimum criteria for Care Groups presented in these documents (FSN SBC Task Force 2014). Although Care Group Volunteers do not typically receive any financial compensation, they may receive tangible incentives or job aids (e.g., radios for sharing messages, cell phones for coordination, skirts, hats for identification) or intangible incentives (e.g., training or free travel) (TOPS 2016).

BOX 1. MINIMUM CRITERIA FOR CARE GROUPS

- Care Group participants or village leadership should select the Care Group Volunteers.
- Care Group Volunteers have a limited workload: They are responsible for no more than 15 households.
- The number of Care Group Volunteers in a Care Group is limited to 16.
- Care Group Volunteers interact with mothers at least once a month.
- Care Group Volunteers reach all households at least monthly (or at least 80% of households are reached monthly).
- Care Group Volunteers collect data on pregnancies, birth, and death.
- Actions promoted by Care Groups create behavior change that reduces mortality and undernutrition.
- Care Group Volunteers use visual tools for health promotion at the household level.
- Care Group Volunteers use participatory methods when doing health promotion at the household or small group level.
- Promoters spend no more than two hours per meeting when teaching Care Group Volunteers.
- Supervisors conduct observation of promoters and at least one Care Group Volunteer every month.
- Care Group Volunteers should not have to walk more than 45 minutes to reach households, and they should not have to walk more than 45 minutes to the promoter meeting place.
- Create a sense of respect for mothers and Care Group Volunteers.

Learnings from Implementation of Care Groups

When Care Groups are implemented according to the tested model, they have been found to be a low-cost and effective behavior change methodology associated with impressive improvements in optimal health and nutrition behaviors, leading to lives saved (George et al. 2015; Perry et al. 2023). However, achieving behavior change through Care Groups requires careful analysis of factors that prevent or support the priority health and nutrition behaviors and the context. Care Groups improve knowledge and skills, foster social support, and can create linkages to services. Care Groups are also more likely to be successful when embedded within a set of SBC approaches. This creates a layered and sequenced approach to reinforce learning in Care Groups and address other factors that may be required for change, such as shifting social and gender norms through household visits with family members and community dialogues with influencers, or improving financing for products and services. An adequate level of implementation quality is required to ensure adequate coverage and participation of the people in the targeted age and stage as well as fidelity to the Care Group model.

A synthesis of empirical evidence on Care Groups found that different types of motivation influence the establishment and sustainability of Care Groups (see **annex 1** for summary of evidence). These included resources provided by NGOs setting up the Care Groups but also support among group participants, as well as from volunteers and the wider community (Pieterse et al., n.d.). In Zimbabwe, USAID Advancing Nutrition found that Care Group participants noted unity, visible change (e.g., toilets), peace and respect, and contribution to community development as perceived traits of quality Care Groups *(forthcoming)*. Group participants also shared several

Photo credit: Nena Terrell, USAID Ethiopia

benefits to participating in the groups' activities, such as learning about hygiene and child care; gaining new skills and knowledge; developing hygiene equipment such as pot racks; and developing social connection and support, emotional stress relief, and individual self-fulfillment *(forthcoming)*.

In the context of RFSAs, Care Groups with Care Group Volunteers have predominantly been used to communicate health and nutrition information of relevance to pregnant and lactating women and children under age two. The training modules vary by IPs but can include modules such as vital events registration; essential nutrition and hygiene actions; antenatal care; family planning; immunization; diarrhea and pneumonia; and money management (Care Group Info, n.d.) By design, Care Groups focus on behaviors during the first 1,000 days. These behaviors are practiced only for a short time as relevant to the age and stage of the child or the stage of pregnancy. Therefore, the participants will "age out" of the information provided in Care Groups because the information becomes less relevant as their children get older. Given this, by its very nature, Care Groups will need to evolve during and after the life of the award. Despite this, sustainability considerations are part of the existing Care Group model (FSN SBC Task Force 2014).

There is some evidence that Care Groups (either the group of volunteers or the group of neighbor women) evolve into an income generation-focused group. In Rwanda, on the request of the Care Group Volunteers, Umucyo Child Survival Project helped turn 202 Care Groups (group of volunteers) into formal associations (FSN SBC Task Force 2014). The project trained the group to save contributions from group members and engage in income-generation activities, such as the subsidized sale of insecticide-treated bednets and water purification products. About 11 percent of the groups were functioning six years after the project ended. In Burundi, well-established Care Groups have the opportunity to participate in savings groups (FSN SBC Task Force 2014). In Zimbabwe, the most common new topic Care Group participants wanted and covered during group sessions was skills for income generation. They considered sustainability of the group of Gare Group participants to be a continuation of the same group and noted that in some areas, groups had already morphed into VSLAs or burial societies on their own *(forthcoming)*.

In low-resource settings, income is a significant barrier to achieving optimal health and nutrition and living the lives people want. Therefore, it is not surprising that Care Group participants seek opportunities for income generation both during and at the end of the project. In Ghana, the program Credit with Education successfully combined small loans with health and nutrition education to foster improvements in income and savings, indicators of women's empowerment, food security, health and nutrition behaviors, and child nutritional status (MkNelly and Dunford 1998). In Nepal, the government has mobilized a large cadre of female community health volunteers (FCHVs) to support community-based health and nutrition services since 1988 (Manandhar et al. 2022). FCHVs also facilitate

health mothers groups, composed of women of reproductive age (15–49 years), to discuss and promote optimal health and nutrition behaviors. Many groups also have a savings component, which has been found to facilitate group meeting participation (Manandhar et al. 2022). While FCHVs do not receive a monthly stipend, they have access to a local fund to withdraw small loans (MOH 2014).

Several countries have embraced Care Groups as part of their community health strategies. In Burundi, Malawi, and Zimbabwe, for example, Care Groups were implemented through Ministry of Health (MOH) staff and CHWs, instead of NGO staff (Weiss, Makonnen, and Sula 2015). An evaluation of this approach found that mothers of children 0–23 months who participated in the MOH-led Care Groups had similar levels of knowledge and practices compared with the NGO-led groups (Weiss, Makonnen, and Sula 2015). While this shows that it is possible to implement Care Groups through the MOH system, we need more evidence to show that this is a sustainable model. An implementation guide on how to integrate Care Groups with MOH is currently available (Concern Worldwide 2014). In Zimbabwe, success of the integration of Care Groups with the MOH was attributed to involving MOH early in the implementation of Care Groups (Ncube-Murakwani et al. 2020).

There is some evidence that Care Group Volunteers might continue promoting health and nutrition after the life of the award. In Mozambique, approximately 67 percent of mothers who were part of the original Care Group reported receiving health and nutrition advice from Care Group Volunteers five years after project closeout (Cornish, Tura, and Roberts-Dobie 2020). The Care Group Volunteers did not receive any additional input during this time.

The World Health Organization (WHO) guidelines to optimize CHW programs, principles of practice for NGOs to support national CHW programs, and documentation of what motivates CHWs are valuable resources for IPs who might consider integration with the health system (WHO 2018; Walker et al. 2013; Bhattacharya et al. 2001). Despite integration with the government health system, resources could still be a challenge as governments may not have the funding to adequately support the groups. One way to address this may be for Care Group Volunteers to engage in fee-for-service activities. In Bangladesh, the NGO Bangladesh Rural Advancement Committee (BRAC)'s CHVs offer hygiene products for sale while promoting optimal health and nutrition during home visits (Hodgins, Crigler, and Perry 2018).

USAID's Sustainability and Exit Strategy Study

From 2009 to 2014, USAID supported The Gerald J. and Dorothy R. Friedman School of Nutrition Science and Policy of Tufts University to conduct a multi-country study of 12 legacy Food for Peace-funded food security projects that had been previously implemented in four countries (Rogers and Coates 2015). The projects were implemented in Bolivia, Honduras, India, and Kenya. The goal was to examine the factors associated with the increased sustainability of project activities and outcomes after the life of these projects and provide recommendations to future projects on how to strengthen sustainability. The research considered two main categories of sustainability:

1. continued delivery of services (e.g., whether health promotion activities continued to be provided); and
2. continued use of behaviors promoted by the project.

Quantitative and qualitative research examined activities, outcomes, and impacts in various technical sectors that included maternal and child health (MCH) and nutrition. Three main factors were found to be critical to sustainability (Rogers and Coates 2015):

1. a sustained source of **resources** for each input previously provided by the project. These could come from activities run using a business model, funds from government operating budgets, funds from other organizations, and cash or in-kind contribution from community members.
2. high-quality technical and managerial **capacity** at all stages of the service delivery chain with mechanisms to maintain the capacity
3. continued source of **motivation** for service providers and clients. Financial incentives and in-kind benefits motivated providers the most. In the long run, personal commitment, community service, and prestige were not enough. A tangible and immediate benefit motivated clients to continue to use the services or practice behaviors.

A fourth factor that was important in most cases was **linkages** to other entities, which could be horizontal or vertical. Horizontal linkages were defined as relationships among communities, groups, or individuals, while vertical linkages were defined as relationships between individuals or groups and the government, NGOs, or other entities. The study examined some of the assumptions that projects made about sustainability, such as the idea that volunteers continue to provide services without compensation, presenting questions about interventions that rely primarily on volunteers (Rogers and Coates 2015).

Sustainability strategies. Learnings from the four countries shed light on what approaches have been tried, succeeded, or failed in sustaining CHVs. In each country, the study assessed sustainability and exit strategies of up to three awards implemented by different IPs.

In Honduras, one IP planned to create networks of CHVs, train them on how to write proposals, and secure funding to continue providing services, but these networks were never formed (Rogers, Sanchez, and Fierstein 2016). Another IP attempted to create community health committees to support CHVs. To do this, they trained community health committee members on management and leadership skills, but the committees never took hold. A third IP attempted to link CHVs with agricultural interventions (e.g., inputs to increase production and sale of traditional and non-traditional crops) by ensuring CHVs were participants of the interventions and even encouraging agricultural enterprises (e.g., bakeries, fruit and vegetable canning operations, market unprocessed products to supermarkets) to devote a small percentage of their profits to community-based health services. However, this did not happen because the enterprises had not reached financial security to be able to contribute their profits during the life of the award (Rogers, Sanchez, and Fierstein 2016).

In Kenya, an IP planned to test whether CHVs could charge a fee for their services (Coates et al. 2016). However, CHVs found this unrealistic, given how resource-poor the community was. Similarly, in Bolivia, the IPs did not test a fee-for-service model for CHVs[2] because it was considered unrealistic to charge money for health services (Rogers et al. 2016). Two IPs in Bolivia also attempted to create a network of CHVs, but these were unsuccessful because of a lack of resources to continue. What was successful in some areas of Bolivia was water committees paying CHVs a stipend from water-use fees to continue their services (Rogers et al. 2016).

In all four countries, the plan was to hand over supervision of CHVs to the government. However, these were not always successful because of a lack of resources with the government to adequately support the CHVs (Rogers, Sanchez, and Fierstein 2016). Some CHVs were supported by other NGOs and thus were able to continue providing services (Rogers et al. 2016). Other factors that contributed to the failure included a lack of engagement of the government early in the development of the CHVs and lack of a formal documentation process (e.g., memorandum of understanding) to formalize the handover process (Rogers, Sanchez, and Fierstein 2016).

Exit strategies. Gradual exit aided sustainability, which allowed a project to test its sustainability assumptions during the life of the project while the IP was still available to troubleshoot challenges that arose (Rogers and Coates 2015). For example, in Honduras, two IPs that had a phase-out period of 12 to14 months found CHVs to be working independently with government centers before project closure. However, one IP that had a shorter phase-out period of four months had not tested how the CHVs would function without the IP's support prior to the end of the award (Rogers, Sanchez, and Fierstein 2016).

RFSA Mid-term Evaluation Findings about Sustainability

A review of 16 mid-term evaluations of RFSAs funded from 2015–2020 in Bangladesh; Democratic Republic of Congo; Ethiopia; Guatemala; Haiti; Madagascar; and Malawi offer salient insights to the design of RFSA sustainability strategies and the challenges and opportunities related to sustained sources of motivation, capacity, resources, and linkages for community volunteers (IMPEL 2020a).

2 The study report refers to them as CHWs, but given that they were volunteers we refer to them as CHVs in this guide.

Overarching challenges. The challenge of ensuring sustainability of community volunteers begins with the number and complexity of interventions the project proposes to implement—and that not all interventions could be considered important drivers of food insecurity. A large number of interventions also increases the workload of community volunteers and affects the quality of implementation. Some evaluations noted that the activity had not prioritized behaviors. For example, a mid-term evaluation of a RFSA in Bangladesh found that community health volunteers were spending eight hours per day (a full work day) on project activities including conducting training, home visits, and distribution of food rations. The recommendation to overcome this challenge was to reduce the volunteer workload by focusing on behaviors that were having the highest impact (TANGO International 2018).

Motivation of community volunteers. All RFSAs rely on community volunteers for health and nutrition promotion. However, continued motivation of volunteers during and after project completion was a common issue. Lack of financial or in-kind compensation emerged as a common challenge to motivate volunteers. For example, the mid-term evaluation of the RFSA in Haiti noted concerns from Care Group Volunteers and their supervisors related to expenses incurred while traveling to attend meetings and use of mobile phones to follow up on neighbor women. To address this, the evaluators recommended that the RFSAs provide incentives such as kitchen sets or other gifts per year of service to Care Group Volunteers (Absolute Options 2016). The evaluators further noted that the same gifts should be provided in a program area and that they should be done in coordination with MOH to ensure continuity post-award. Even when RFSAs provided project inputs to Care Group Volunteers, little thought went into ensuring the volunteers understood how to use the inputs for long-term benefit. For example, a RFSA in Madagascar provided one-time support of seeds to Care Group Volunteers to set up kitchen gardens but provided no further instructions on how to save the seeds for subsequent years (ADRA 2017).

Resources for community volunteers. Some evaluations had recommendations on developing fee-for-service models for health and nutrition service delivery. The evaluations also noted that integration of various project activities was weak. For example, while several RFSAs had successfully developed VSLAs, they were not necessarily leveraged to sustain health and nutrition service delivery. The mid-term evaluation of the RFSA in Haiti found VSLAs to be very popular, however, the Care Groups were not necessarily linked with these. Therefore, one of the recommendations for this RFSA was to integrate Care Group membership with VSLA membership to ensure reliable resources for the Care Group Volunteers (Absolute Options 2016). The RFSA implemented this recommendation (Kore Lavi 2017).

Capacity of community volunteers. The mid-term evaluations found variation in the capacity of Care Group Volunteers. For example, in the Democratic Republic of Congo, Care Group Volunteers in certain RFSA-implemented areas were unable to provide accurate information related to health services and problem solve on infant and young child feeding (IYCF) practices. The recommendation was to strengthen supervision of the volunteers and conduct a review of the competencies of in-country technical staff to adequately support the volunteers (IMPEL 2020b). Similarly, the mid-term evaluation in Bangladesh also found that CHVs were simply relaying messages rather than counseling based on the need of the program participants (TANGO International 2018). Even when Care Groups were functioning well, Care Group Volunteers and Care Group participants requested training on additional topics such as health, finance, business management, improved farming, and animal raising practices (Absolute Options 2016). Additionally, rather than acquiring new volunteers at the start of the project, several evaluations recommended RFSAs build the capacity of existing volunteers in the community.

Linkages for community volunteers. There were several recommendations on limiting reliance on public sector outreach services, as they may not be sustainable due to insufficient investment from the government. However, the recommendation for the RFSA in the DRC was to develop a community volunteer association to forge stronger linkages among volunteers, between the volunteers and existing health and nutrition structures (IMPEL 2020b). The structure may include the government health system as well as other NGOs operating in the project area.

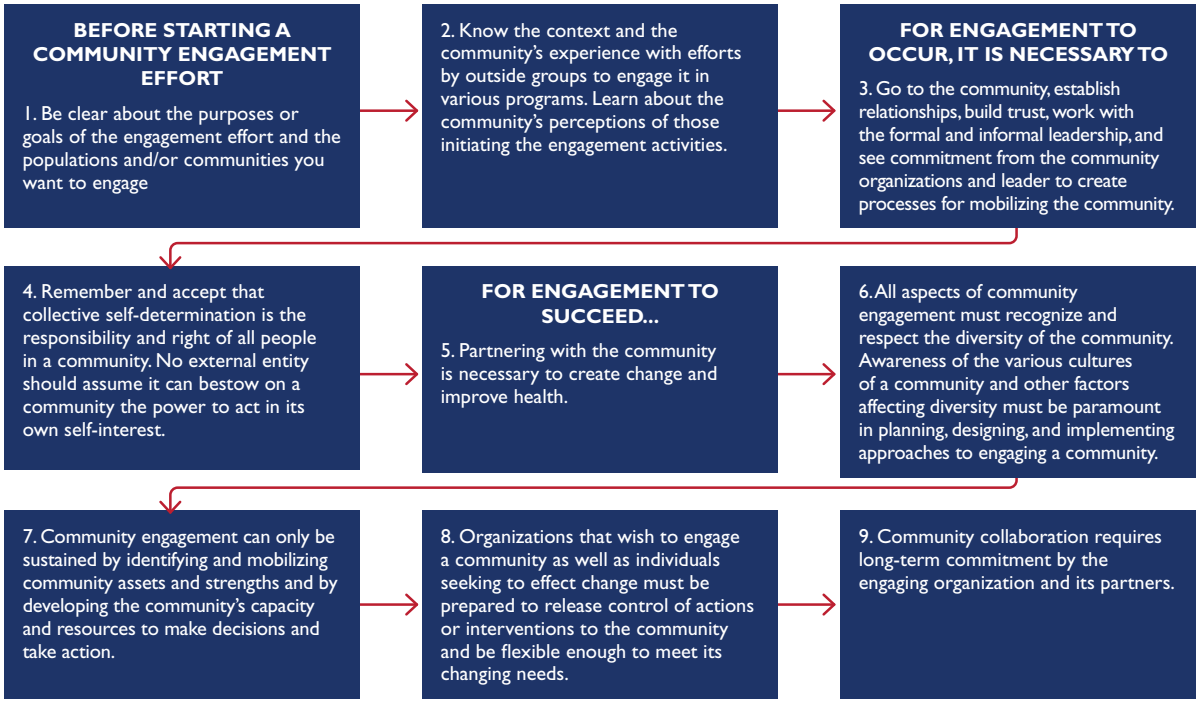
Community Engagement and Social Inclusion for Sustainability

In addition to focusing on reducing food insecurity and malnutrition, RFSAs also aim to promote sustainability, reduce poverty, and strengthen resilience. RFSAs typically use peer group activities (e.g., VSLAs, farmer-to-farmer, and care groups) as a main modality to achieve this. BHA encourages RFSAs to use the Refine and Implement phase of their awards to engage in community visioning, consultation, and engagement. RFSAs are also encouraged to continue this type of engagement over the life of an award. A key motivation for RFSAs to promote community engagement and social inclusion is to assure a sustainable exit on the premise that this will leave communities better off, more empowered, and resilient to future shocks.

Community engagement and social inclusion are also important to support the sustainability of Care Groups, as this can motivate Care Group Volunteers and participants to continue participating in group activities after a RFSA exits. Research shows that social marginalization exacerbates the experience of poverty and that efforts to promote social mobilization, resilience,[3] community engagement, and social inclusion can counteract this by building social trust and cohesion among community groups and providing community group members with intangible benefits that motivate them to stay with a community group long term (Burra, Deshmukh-Ranadive, and Murthy 2005; Dharmadasa et al. 2015). These intangible benefits can include access to resources such as information, financial and health services, and social support from other group members, thereby building trust and social cohesion. Sequencing group activities when forming community groups has also been shown to be important. Starting with steps to build trust and the social cohesion of a group have been shown to contribute to the longevity and sustainability of community groups (Burra, Deshmukh-Ranadive, and Murthy 2005; Dharmadasa et al. 2015).

As shown in **figure 1** that summarizes the principles of community engagement: "Community engagement can only be sustained by identifying and mobilizing community assets and strengths, and by developing the communities' capacity and resources to make decisions and take action" (NIH 2011).

FIGURE 1. NINE PRINCIPLES OF COMMUNITY ENGAGEMENT (ADAPTED FROM NIH 2011)



3 Research on **resilience** identifies bonding, bridging, and linking as key to strengthening resilience (Aldrich 2012). Here, bonding refers to strengthening the bonds between community members within a group; bridging refers to building a bridge between similar groups; and linking refers to building linkages with external groups (such as financial institutions).

These principles can be applied to Care Groups and Care Group Volunteers as well. A review of a Care Group experience in Guatemala found that Care Group implementation benefits from a socially cohesive and stable community with a shared culture and language, while unstable migration patterns and low social cohesion are detrimental (FSN SBC Task Force 2014). However, the authors noted that implementing Care Groups was a valuable tool to rebuild social capital—and therefore resilience—through collective action and connectedness. A key consideration, then, of motivating and sustaining Care Groups and Care Group Volunteers is to use community engagement with potential Care Group participants and leaders to be inclusive and build social cohesion and trust—and identify capacity and resource needs—as a means to build self-reliance and promote sustainability. At the same time, it is important to recognize early in the design and implementation process that the original purpose of Care Groups as a platform for SBC communication on nutrition may change over time, as participants' children turn two. Under these circumstances, Care Groups and the roles of Care Group Volunteers may evolve and should be supported to help volunteers and participants self-determine what they need and what is in their best interest.

Another important concept when considering the sustainability of Care Group Volunteers is gaining "soft skills." Soft skills are defined as skills, behaviors, and qualities that enable an individual to navigate their environment, relate with others, perform a task well, and achieve their goals (Lippman et al. 2015). Youth development literature shows that developing "soft skills" is critical to achieving long-term education, employment, and health (Lippman et al. 2015). Therefore, it is important to consider helping Care Group Volunteers build "soft skills" such that they are able to participate in decision-making processes within their community, advocate for their group, and explore new opportunities for employment. Importantly, many Care Group Volunteers and participants are themselves youth, and applying youth lens can further support the sustainability of Care Groups.

Key Informant Interview Findings

The key informants we spoke to confirmed what we found in the literature and provided additional insights (see **annex II** for interview guide and **annex III** for details of findings). One of the most notable findings is that among the key informants who shared insights on Care Group sustainability, there was no clear consensus on what they expected to be sustained from Care Groups after project closeout. Rather, key informants' expectations generally fell into four main categories for what might happen to the Care Group post-project: original Care Group continues to meet; Care Groups expand to include newly eligible mothers; optimal health and nutrition behaviors are sustained, but there is no active promotion by volunteers; and Care Groups evolve to address priorities beyond health and nutrition. Key informants also offered additional reflections related to the sustainability plan and resources, capacity, motivation, linkages, and gradual exit that could influence the sustainability of the groups and volunteers.

Sustainability plan: Key informants reported that sustainability plans generally lack detail and depth on precise expectations for Care Groups post-project; however, many IPs have developed detailed spreadsheets for internal use. Furthermore, plans often do not specify if new cohorts of women will be recruited in the future. Additionally, many plans lack information on post-award resources that rely on linkages.

Resources: Key informants mentioned that many sustainability plans lack detail on post-award resources for nutrition and health. Resources post-award should be a focus of project monitoring, such as whether people have begun to pay for services that are expected to be sustained. Charging money for nutrition services (especially behavior promotion) is often not acceptable in most contexts, but there are exceptions. Nutrition sustainability strategies often must assume the government linkages will come with resources. However, some IPs are attempting to pair services (e.g., nutrition counseling) with sales that bring resources as a sustainable source of motivation (e.g., selling hygiene supplies at Care Group meetings).

Capacity: Building Care Group capacity to promote behavior change is important, but soft skills (like advocacy, organization, making connections to other resources) will ultimately be critical for the resilience and sustainability of Care Group Volunteers and participants. Investing in health staff's capacity to conduct behavior change is a contribution to a future source of capacity for Care Groups. BHA expects IPs to develop a business plan to provide capacity support based on assessed needs (e.g., technical or financial skills). IPs can provide capacity or link local actors to provide the capacity (e.g., government services, local research institutes, private entities).

Motivation: Key informants' suggestions for how to motivate Care Group Volunteers to function post-project fell into two categories described below:

- **Care Group Volunteers' health promotion activities that paired with a source of financial incentive for volunteers.** Some Care Group Volunteers deliver health promotion (e.g., nutrition counseling) at the same time or place where they provide a service with direct financial value (such as selling hygiene supplies). In addition to "subsidizing" the Care Group Volunteer's role, the continued Care Group meetings provide a setting for ongoing capacity building by government health staff.
- **Care Groups that transition to another purpose, which serves the economic interests of Care Group Volunteers or participants.** New functions could include becoming a VSLA, small business, or burial group. Recognizing that over time women's lives transition from needs related to pregnancy, IYCF, and related behaviors, the Care Group can similarly transition over time to address additional priorities of its members. Stakeholders cited various experiences with USAID-funded projects in which savings groups spontaneously started due to the increased income from project participants that they also used to leverage the experience to start other group initiatives. Stakeholders cited Care Groups in Bolivia and Burkina Faso that formed themselves into small businesses offering services such as making handicrafts. Even when promotion of health and nutrition is not the central purpose of the group, increased financial assets under women's control provide a valuable channel to improved food and nutrition security and household resilience.

Linkages: Key informants considered the MOH to be a vital linkage for Care Groups, given the Care Group model includes a promoter who provides training and supervision to the volunteer who, in turn, reports their activities back to the promoter for accountability purposes. They noted that when working with MOH, it is necessary to make compromises even on the criteria for Care Groups (such as how Care Group Volunteers are selected). They further added that governance, decentralization, and accountability are important for the sustainability of Care Groups, but they are outside of the scope of the project.

Gradual exit: Key informants recognized gradual transfer as a critical sustainability principle that is often neglected. They also noted that project monitoring systems rarely analyze elements of the gradual transition (e.g., how actors are functioning during the transition). They also noted that early transition of support from the IP to local actors (Care Group Volunteers, MOH, community, and NGOs) should commence during the project, which permits the IP to refine and support the process.

Key Considerations for Sustainability

Learnings from our literature review and key informant interviews show that Care Groups are a popular model around the world to promote health and nutrition behaviors in the first 1,000 days. Challenges to sustaining key outcomes include difficulties in ensuring the continuation of the Care Group platform, in part or in its entirety, beyond the life of the award. What we have learned is that it helps to plan early for what aspects need to be sustained in order to perpetuate key nutrition/health outcomes and engage communities in this planning process, begin identifying resources and linkages (including opportunities for handover) early on, focus on building transferable skills as well as technical knowledge of volunteers, and incorporate income-generating components into the group. Below, we present considerations that cover three main phases of project implementation: planning, implementation, and transition. They are based on what we learned in the process of developing this document.

- **Planning**
  - **Be deliberate and plan early** with key stakeholders to improve community ownership and/or government ownership of Care Group Volunteers.
  - **Align with and link to government priorities** and strategies that allow Care Groups to be embraced in the context of a larger, long-term strategy for improved nutrition and health.
  - **Use community visioning and consultation** to engage with potential Care Group Volunteers and participants during the Refine and Implement phase and over the life of the award to understand their needs in terms of training, capacity building, and access to resources and linkages.
  - **Prioritize interventions** that are most likely to be sustainable and address needs of populations at greatest risk (e.g., first 1,000 days) and plan to layer and sequence these within Care Groups.

- **Implementation**
  - **Respect volunteers** by providing adequate basic conditions (e.g., security, supplies, identification badges, workload).
  - **Build on existing groups and structures** to avoid creating parallel structures (e.g., having Care Groups report their activities to the village health committee, involve existing volunteers in Care Groups to build on existing community health capacity).
  - **Sequence and layer activities**
    i. **Start with building trust, social cohesion, and social inclusion** for Care Groups before introducing technical curricula.
    ii. **Connect Care Groups with different approaches, resources, and intra- and inter-community groups** (e.g., community leaders, men, different committees), including with other government and NGO programs.
    iii. **Integrate income-generating activities** such as VSLAs and fee-for-service models into Care Groups.
    iv. **Build transferable soft skills** of Care Group Volunteers (e.g., voice, decision-making, leadership skills) to strengthen the capacity of and access to resources.
  - **Adapt sustainability approaches** at regular intervals to respond to the needs and priorities of the group, community members, and the evolving enabling environment.

- **Transition**
  - Assure a gradual transition so that local actors can "practice sustainability" while implementing partner staff and funding are available to provide support (e.g., encouragement, troubleshooting, management support).

Taking these considerations into account, we developed this guide to cover the following suggested steps. They cover the design, development, implementation, and transition of the Care Groups. In the development step, we present considerations for the four factors that contribute to sustainability (linkages, resources, capacity, and motivation) separately, but we recognize that they are all interconnected. We have also attempted to articulate that development, implementation, and transition are an iterative process. Each step begins with key evidence and recommendations and ends with questions for IPs to consider. We also present a decision tree to help IPs navigate these steps and show the timeline for the steps in the five-year activity cycle (see **figure 2**).

Step 1: Design an Appropriate Community Nutrition Approach.

- Prioritize Nutrition Behaviors.
- Determine if Care Groups Are Appropriate for the Setting.
- Decide How the Care Groups Will Evolve after the Life of the Award.

Step 2: Develop the Care Group Sustainability and Exit Plan.

- Identify and Strengthen Linkages.
- Strengthen Sources of Resources.
- Define Content and Process for Capacity Strengthening.
- Consider Different Forms of Motivation.
- Set the Vision for Transition.

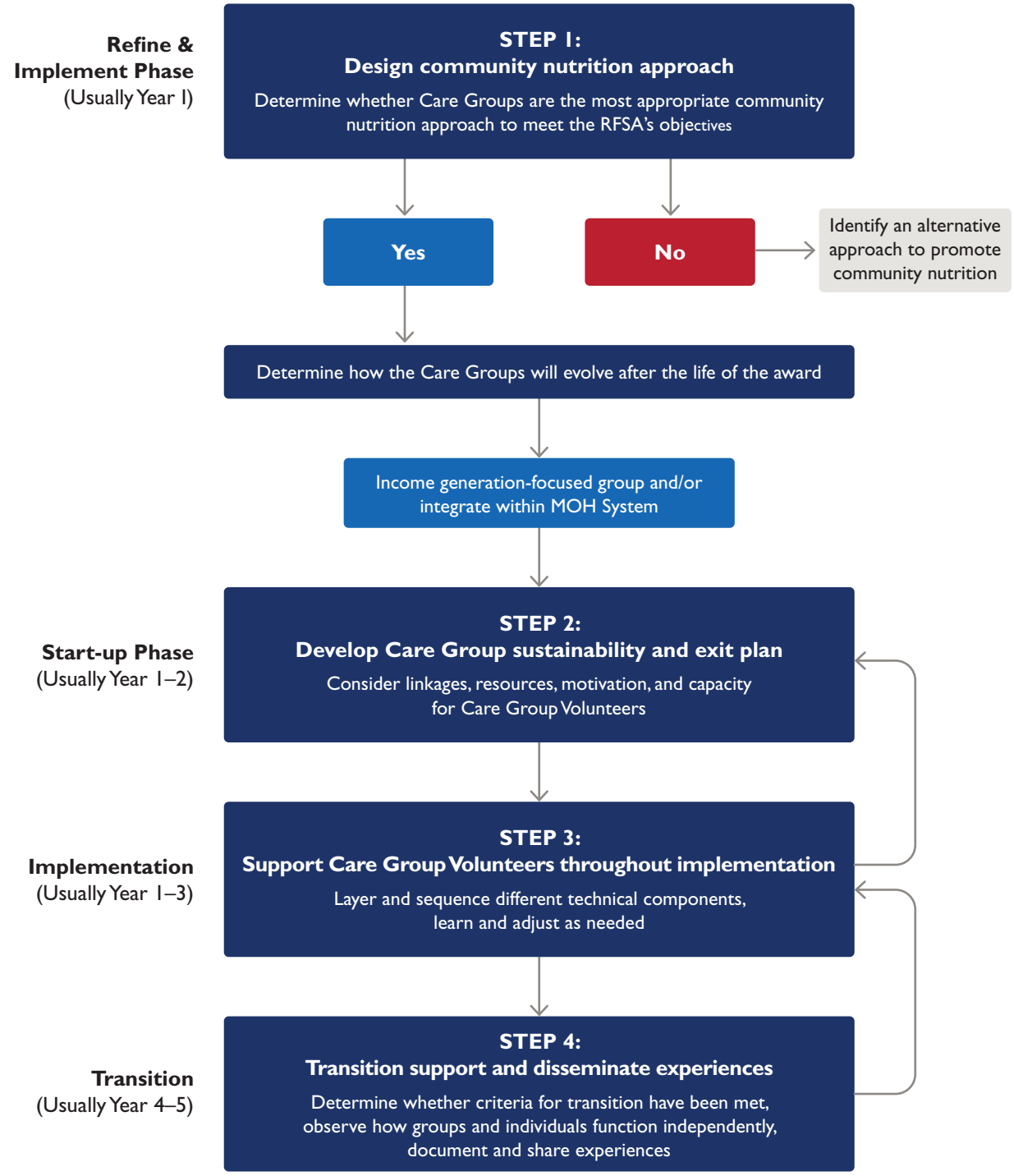
Step 3: Support Care Group Volunteers throughout Implementation.

- Roll Out Support to Care Group Volunteers and Participants.
- Adapt Support to Care Group Volunteers and Participants.

Step 4: Transition Support and Disseminate Experiences.

- Transition Support to Groups, Volunteers, or Local Actors.
- Document and Disseminate Experiences within the NGO/Donor Community.

FIGURE 2. DECISION TREE TO GUIDE IPs THROUGH THE STEPS IN THIS DOCUMENT



Step 1. Design an Appropriate Community Nutrition Approach

KEY EVIDENCE

- The review of 16 RFSA mid-term evaluations found that RFSAs implemented too many interventions and that Care Group Volunteers promoted too many behaviors, both of which increased workloads for the volunteers (IMPEL 2020).
- The key informants we spoke to noted that, based on experience, they did not think the Care Groups, and, in turn, the role of the Care Group Volunteers, would continue nutrition SBC after the project ended. Findings from USAID Advancing Nutrition's research in Zimbabwe showed that sustainability to Care Group participants meant continuation of the same group of participants (forthcoming).
- One of the principles of community engagement is to "release control of actions or interventions to the community and be flexible enough to meet its changing needs" (NIH 2011).

During project design, likely in the Refine and Implement phase (usually year one), IPs need to decide whether Care Groups are an ideal approach to promote community nutrition for their program context. If the groups are selected as part of the RFSA design, then they need to determine how to sustain the Care Groups and their volunteers after the life of the award.

1. PRIORITIZE NUTRITION BEHAVIORS

The first step in designing high-quality nutrition and SBC programs is to prioritize behaviors. To identify priority behaviors, IPs can consider using a tool such as the Nutrition Program Design Assistant (NPDA) to gather and synthesize quantitative and qualitative information on the nutrition situation of their program area (CORE Group Nutrition Working Group, FANTA, and Save the Children 2015). This step will provide an overview of the MCH nutritional status, IYCF practices, micronutrient status, and underlying disease burden as well as their causes, as available. Because RFSAs focus on the first 1,000 days, they may choose to focus on behaviors pertinent to this age group; however, these can be further streamlined. For example, if data show that exclusive breastfeeding rates drop after four months, then groups can focus efforts to ensure mothers have the support to continue breastfeeding up to six months, as per global recommendations. **SBC best practices recommend that projects select three to five behaviors to strengthen per sector** (USAID Advancing Nutrition 2021b). While the RFSA will cover multiple behaviors, they might include multiple activities on the prioritized behaviors.

2. DECIDE IF CARE GROUPS ARE APPROPRIATE FOR THE SETTING

Once IPs have prioritized the behaviors their RFSA will focus on, they can then use the NPDA to map the health and nutrition services at the community level (CORE Group Nutrition Working Group, FANTA, and Save the Children 2015). During this step, they will identify what community platforms and structures exist. They will also examine the type of community workers that exist (e.g., CHWs, community volunteers) as well as the capacity and cultural acceptability of community volunteers. Finally, they will need to make a decision on which approaches to implement and whether Care Groups are the most appropriate in their context. They can engage the community in this step by holding a community consultation, where they present the information they have gathered and solicit feedback from community members on which services or approaches to prioritize. An annex of the NPDA provides examples of different community nutrition approaches, including a section on Care Groups with a description, objectives, target group, criteria for when to use the approach, and elements needed for quality programming.

3. DECIDE HOW CARE GROUPS WILL EVOLVE AFTER THE LIFE OF THE AWARD

Very early in the planning stage, IPs will need to consider how the groups may be sustained after the life of the award. There are two potential ways the groups may be sustained: linkage with a government or NGO structure or evolution into another form or both. To explore the first option, IPs should check whether Care Groups are featured in the government's community health strategy. **Box 2** provides a set of questions that IPs can use to determine if the first option is viable. They should only consider this option if they answer yes to all the questions.

BOX 2. QUESTIONS TO DETERMINE IF INTEGRATION WITH MOH IS VIABLE

- Does the government have a policy in favor of Care Groups?
- If yes, are Care Groups operational in the program area?
- If yes, are the Care Groups currently functional?
- If yes, is the quality of implementation of Care Groups sufficient to revitalize?
- If yes, does the local government agree to absorb and integrate the Care Groups the RFSA plans to revitalize and/or the new ones the RFSA forms?

If Care Groups are not part of the health strategy, it is highly unlikely that MOH policies and strategies will be able to embrace Care Groups during the life of the award and sustain them afterward. To explore the second option, IPs will need to understand whether and how income generation-focused community groups such as VSLAs have been developed in the program area, or the country. This will require mapping NGOs and other associations that IPs may learn from and that the group may ultimately link with. If the IP itself plans to implement income-generation activities as a part of their RFSA, then the IP should consider integrating Care Groups within those activities. While it is critical to make a decision about how the IP thinks the group will evolve to ensure plans are in place early, they must recognize that these plans may change as the groups are formed. Community engagement best practices encourage allowing groups to take the lead in determining what the group will focus on (NIH 2011).

QUESTIONS

Prioritize nutrition behaviors

- Which 3–5 behaviors will the Care Groups hold multiple sessions and activities on?

Determine if Care Groups are appropriate

- Are Care Groups the most appropriate community nutrition approach to meet the RFSA's objectives?

Decide how Care Groups will evolve

- How will the Care Groups evolve after the life of the award?

Step 2. Develop the Sustainability and Exit Plan for the Care Group

KEY EVIDENCE

- The Sustainability and Exit Strategies study showed that resources, motivation, capacity, and linkages (often) were integral for sustainability of service delivery and use, practices, and impact (Rogers and Coates 2015).
- There are several examples linking Care Groups with the MOH. In Burundi, Care Groups were successfully implemented through MOH structures but with significant external support (Weiss 2015). There are more examples, such as in Rwanda, of Care Groups evolving into income-generation groups (e.g., VSLAs) (FSN SBC Task Force 2014).
- To form a group, social inclusion as a result of participating in a peer group is a powerful motivator (Burra 2005). To sustain active service delivery from providers, financial incentives and in-kind benefit were the most successful motivators (Rogers and Coates 2015). Benefits such as prestige alone were insufficient in the long term.
- To build capacity of service providers, youth development literature shows that developing "soft skills" is critical to achieve long-term education, employment, and health (Soares et al. 2017).

Continuing in the Refine and Implement phase and into the Start-up and Implementation phase (years one and two), IPs will need to develop the Care Group model considering factors that will have long-term implications for the group and the Care Group Volunteers. This will include who to form linkages with, how to ensure resources are available, how to keep the group and the volunteers motivated, and what skills are needed to build the capacity of the group and the volunteers. IPs will also need to set their vision for what aspects the group and the volunteers aim to sustain.

1. IDENTIFY AND STRENGTHEN LINKAGES

If the IP's decision to implement Care Groups was based on the potential to link with the MOH or existing NGOs, then they will need to engage with these entities at every step of the planning and implementation phase, including recruitment of the Care Group Volunteers. IPs should consider prioritizing individuals who may be working as volunteers to promote health and nutrition at the time of recruitment or who held such a position in the recent past to build on existing capacity in the community. They can consult *Integrating Care Groups into MOH Systems: A User's Guide for Implementation* if linking directly with MOH systems from the start (Concern Worldwide 2014). Once implementation has begun, they should consider using Collaborating, Learning, and Adapting (CLA) principles to organize pause and reflect sessions at different stages to ensure all entities are engaged, heard, and updated on the progress of the approach (Learning Lab 2018).

Furthermore, IPs need to consider the community as key stakeholders and involve them at every stage as well. Using the *Principles of Community Engagement*, they can allow the community to be in the driving seat of forming the group, selecting participants, and deciding what issues the group should focus on (NIH 2011). The IPs will need to play a facilitating role by considering women's preferences and making the selection criteria transparent to the community. After the group has had a chance to forge a bond, they can then introduce technical content. IPs need to be prepared and comfortable with how the group chooses to conduct itself. They should discuss the topic of sustaining the group with community members early. The *Care Groups: A Training Manual for Program Design and Implementation* offers ways to facilitate a conversation among IP staff on planning for sustainability that could be applied to moderating a similar conversation with other actors (FSN SBC Task Force 2014).

If the IP's decision to implement Care Groups was with the intention that it would evolve into an income generation-focused group such as a VSLA, then they can use tools such as the *VSLA Methodology* or *PROPEL Toolkit* (Dharmadasa et al. 2015; VSL Associates, n.d.). All of the program components may not be relevant or feasible to the implementing partner's RFSA, but this is one way to think about how the livelihood component and the health and nutrition component can be layered and sequenced.

2. STRENGTHEN SOURCES OF RESOURCES

Linkages with the MOH or another NGO may not necessarily come with resources that allow the Care Group Volunteer to continue delivering services. This is because even though some countries have adopted or promoted Care Groups in their MOH strategies, they may not have funding for implementation. Therefore, IPs will need to decide how the Care Group Volunteers will obtain resources to sustain themselves. Charging money for nutrition services, especially SBC, is often not acceptable in many contexts. Innovative approaches to sustainable resources have been attempted, with some success. For example, in Bangladesh, the NGO BRAC's CHVs provide health promotion sessions on nutrition; safe delivery; family planning; immunization; and water, sanitation, and hygiene during monthly home visits (Hodgins, Crigler, and Perry 2018). During this time, they also sell health products such as basic medicine, sanitary napkins, and soap. BRAC gives CHVs small loans to create a revolving fund that they use to purchase the health products and sell them at a small markup (Hodgins, Crigler, and Perry 2018). Evolving into an income-generation group while being linked with the MOH is another way to ensure a sustained source of resources for the volunteers.

There are many forms of income-generation approaches, such as microcredit, peer-to-peer lending, and VSLAs. The IP should ensure that the Care Group participants are able to decide which approach is right for them. This may mean that they are no longer focused on health and nutrition SBC after the life of the award. However, group members and the Care Group Volunteer may naturally share what they learned with others in their family and community, thereby serving as a resource to support adoption of optimal health and nutrition behaviors among those in the vulnerable first 1,000 days. Training activities that focus on voice and leadership can also layer-in a focus on training volunteers and participants to serve as nutrition champions, as advocates, or as resource people for their communities. Resources from the income-generation approach will enable the group members to manage and mitigate potential shocks, build social capital, and become more resilient.

3. DEFINE CONTENT AND PROCESS FOR CAPACITY STRENGTHENING

IPs will need to consider building both technical and soft skills of the Care Groups and the Care Group Volunteers. To build technical skills, IPs can reference the *Community Health Worker Competency List for Nutrition Social and Behavior Change* to identify content of technical skills-building activities (USAID Advancing Nutrition 2021a).

The soft skills will ensure the group functions effectively during the life of the award and that the group members as well as the volunteers have the self-efficacy and agency to engage in current and/or future income-generation opportunities derived directly from the groups or other sources. Given that Care Groups can serve as a channel to develop social capital and transferable skills, IPs should consider supporting Care Group Volunteers and participants to develop overarching skills that build social capital, such as problem-solving, managing groups, possessing leadership, linking to other resources, and advocating for needed resources so that members are part of a wider network that helps them. To do this, IPs can refer to the agriculture and food security sections of the *Global Leadership and Education Advancing Development (LEAD) Toolkit* to design their soft skills-building activities (Elisberg 2021).

To develop technical and soft skills, IPs will also need to consider different capacity building approaches, such as training, mentoring, and supportive supervision. To deliver each of these approaches, IPs should consider whether they can tap into existing capacity. For example, if CHWs train and provide follow-up supportive supervision to Care Group Volunteers on technical content and soft skills, then the CHWs will be available to support the volunteers, as needed, even after the life of the award. Peer-to-peer mentoring can also enable group members to help each other as well as volunteers to help each other, thereby further building social capital.

4. CONSIDER DIFFERENT FORMS OF MOTIVATION

To ensure Care Group Volunteers remain motivated beyond the life of the award, they need to be functional during the award period. To motivate Care Group Volunteers during the award period, IPs can consider different forms of motivation: workload, personal benefits, and financial incentives. As discussed in Step 1, prioritizing behaviors will contribute to a reasonable workload for Care Group Volunteers. Other factors such as minimal distance to travel and less than 15 households for regular follow-up will also keep the workload manageable.

Personal benefits such as in-kind benefits and access to social support and social inclusion can also motivate Care Group Volunteers. Previous projects have used in-kind benefits, such as identification badges, clothing with the project name or an insignia, bags, flashlights, and bicycles, to recognize community volunteers (TOPS 2016). They have also organized public recognition ceremonies or awards and exonerated volunteers from community obligations or fees. A user-friendly data system to publicly document Care Group activities can also foster Care Group Volunteer recognition (Bhattacharya et al. 2001). The prestige of serving as a group leader can motivate volunteers but may not be sufficient for them to continue long term, as noted by the Sustainability and Exit Strategies study (Rogers and Coates 2015). Financial incentives such as stipends, travel subsidies, and phone top-up can also be motivating.

To sustain Care Group Volunteers beyond the life of the award, opportunities for personal development and income generation are key. IPs can invest in personal development activities, such as training on soft skills, literacy, or financial skills, as well as exposure from travel outside of the community, which build long-term skills for the groups and the volunteers. Because peer support groups may evolve into an income-generation group such as a VSLA, it is important for IPs to understand this desire and support the group appropriately.

To understand what forms of motivation to provide Care Group Volunteers, IPs can vet scenarios of benefits and incentives with community members for acceptability and transparency. They can also consult with the MOH and NGOs with similar activities or operating in similar areas to minimize conflict and assure equity.

5. SET THE VISION FOR TRANSITION

Since the ultimate objective is to transition support for the Care Groups to the groups and Care Group Volunteers themselves, or to local actors such as the MOH or other NGOs, IPs should set the vision for what would need to happen in order to sustain the groups, volunteers, or relationships with local actors. It is critical to start with the vision in mind so that they can work toward it and repeatedly assess whether they are on track to achieving that goal during implementation. RFSAs should include handover milestones as part of their monitoring framework to ensure accountability to their exit plan. RFSA IPs will need to develop their own criteria as appropriate to their activity objectives and implementation context. In addition to individual-level measures, they may also choose to set criteria that measure the roles and responsibilities of local actors. RFSAs can also use CLA with regular pause-and-reflect sessions with Care Group volunteers and participants to monitor activities and progress.

QUESTIONS

Linkages

- Who or what will the Care Groups link to (MOH, NGO, income-generation group)?
- What will the RFSA do to reinforce intra- and inter-community linkages?

Resources

- How will Care Group Volunteers have access to resources after the life of the award (selling product, income-generation activity)?

Motivation

- What forms of motivation will RFSAs provide Care Group Volunteers during the project (reasonable workload, in-kind benefits, financial incentives)?
- What forms of motivation will RFSAs provide Care Group Volunteers that will have long-term benefit (financial incentives through income-generation, personal development)?

Capacity

- How will the IP build the capacity of Care Group members and volunteers in technical areas (health and nutrition)?
- How will the IP build the capacity of Care Group members and volunteers for personal development (soft skills)?

Exit

- What is the RFSA's vision for the Care Group and Care Group Volunteers prior to transitioning responsibilities to them?

Step 3. Support Care Group Volunteers throughout Implementation

KEY EVIDENCE

- Credit with Education paired small loans with sequenced delivery of education on health, nutrition, family planning, and small business skills (MkNelly et al 1998).
- CLA principles encourage considering whether the program is collaborating with the right partners, gathering information that is relevant for decision-making, and using the information to make better decisions and adjustments as necessary (Salib, Ziegler, and Hinthorne 2015).

During the Implementation phase (years one through three), IPs will roll out support to Care Groups and the volunteers that lead the groups. We define support as capacity-strengthening actions, inputs (as appropriate), and facilitation to set up an income-generation scheme for sustainability. During rollout, they will need to be mindful of the sequence in which they deliver the different technical components, and they will need to adapt the program design based on regular feedback.

1. ROLL OUT SUPPORT TO CARE GROUP VOLUNTEERS

Based on the Care Group Model designed in Step 2, IPs can roll out support to Care Group Volunteers. During the rollout, IPs will need to be strategic about how they deliver the different components. They can adapt the sequence of delivery from, for example, Credit with Education, to determine the sequence of delivery of different program components. They will want to begin by promoting trust and social cohesion first and then the resources. The components of Credit with Education were securing small loans (less than $300); being educated in health, nutrition, birth timing and spacing; and developing small business skills (MkNelly and Dunford 1998). Participants of the program first form a group that serves as a credit association or village bank. Rural banks provide the loan to participants, which they take to invest in income-generating activities that they are skilled in. They meet weekly to repay the loans and deposit savings. During these meetings, field staff also provide information and facilitate discussions around health and nutrition, microenterprise, and management of the credit association (MkNelly and Dunford 1998). The health and nutrition topics include breastfeeding, IYCF, immunization, diarrhea management and prevention, and family planning.

2. ADAPT SUPPORT TO CARE GROUP VOLUNTEERS

Using CLA principles, IPs can continually interact with the group and the volunteers to gather feedback on delivery sequence, content, and sources of motivation to ensure they are able to adjust the model based on shifting needs and priorities. We recommended that projects seek feedback at least once every quarter. In addition to group members and Care Group Volunteers, IPs may also consider gathering feedback from the wider community and government structures, such as members of the community health system. The feedback will likely be gathered using qualitative methods. To do this, IPs may consider referring to *Qualitative Toolkit: Qualitative Methods for Monitoring Food Security Activities Funded by the USAID Bureau for Humanitarian Assistance* (Fox, Cook, and Peek 2023).

QUESTIONS

Rollout

- In what sequence will the IP deliver different technical components to the Care Groups?

Adaptation

- How and in what frequency will the IP gather feedback from Care Group members, volunteers, and the community about the rollout of support to Care Groups?
- How will the IP use the feedback received to adjust the Care Group model?

Step 4. Transition Support and Disseminate Experiences

KEY EVIDENCE

- There is limited evidence on sustaining Care Groups and the Care Group Volunteers long term (Cornish et al. 2020).

During the Transition phase (years four and five), IPs will prepare for and ultimately hand over support to the Care Groups and Care Group Volunteers or to local actors. To do this, they will need to assess whether the groups and individuals are ready to operate independently or whether local actors are in a position to assume responsibility. And finally, IPs will document their implementation experiences and share with the NGO and donor community.

1. TRANSITION SUPPORT TO GROUPS, VOLUNTEERS, OR LOCAL ACTORS

IPs should consider how they will prepare for the transition of support. At the beginning of year four, they can use criteria established in Step 2 to determine how independently the groups or individuals can function if transitioning into an income-generation group. If groups and individuals need additional support, IPs might consider providing refresher training on technical and non-technical topics as well as formalizing linkages with other groups and NGOs operating in the community. The non-technical topics might also include how to take advantage of opportunities in the community (e.g., future employment with another project).

If handing over responsibilities to local actors, such as the MOH system, IPs will still need to use the criteria set in Step 2 to determine if MOH staff are ready or need additional support. This holds true even if they engaged MOH staff to implement the Care Groups. In both scenarios, IPs will then need to continuously monitor how well the groups and individuals are doing up until the end of the award and step in to troubleshoot challenges as needed. Transitioning support will be an iterative process.

2. DOCUMENT AND DISSEMINATE EXPERIENCES WITHIN THE NGO/DONOR COMMUNITY

Given that data on actions to sustain groups and individuals long term are limited, IPs are encouraged to document their experiences and share them with the wider NGO and donor community. Below are a few suggested platforms where IPs may wish to search for experiences on sustainability of Care Group Volunteers or share their experiences:

- Care Group Info website (www.caregroupinfo.org), which fosters sharing implementation experiences, research, and guides/tools across countries and organizations
- The Core Group (www.coregroup.org) for sharing knowledge, evidence, and best practices through conferences, webinars, working groups, and other approaches for collaboration
- Food Security Network groups
  - CHW Central (www.CHW.org) as a platform for sharing research and resources related to CHWs, both paid and unpaid
  - Platforms among BHA-funded RFSAs
  - National and regional platforms in the implementation country

QUESTIONS

Transition of Support

- Are the groups and volunteers able to operate independently?
- What additional training or connections could groups and individuals benefit from?
- What additional support do MOH staff need to assume full responsibility of the group?

Documentation and dissemination

- How will the IP document their experience designing a community nutrition approach with sustainability in mind from the beginning?
- Through which platforms and in what format can the IP share their experiences?

Photo credit: Andrew Cunningham, JSI

Additional Research

To support IPs in exploring operations research topics relevant for their project and context, we present illustrative topics collected from stakeholders and the literature. These include:

1. Developing models for Care Group sustainability. These questions cover aspects of the Care Group model that might be promising for sustainability.

- **Optimal participant clustering:** Does clustering participants into Care Groups (e.g., by age, pregnancy, newly married) help or hurt sustainability? Does it foster more cohesiveness and easier transition to follow-on activities appropriate for the group's needs? Are there negative implications for behavior change?
- **Traditional structures:** Does leveraging traditional groups and structures foster sustainability?
- **Community ownership:** What are the best practices of IPs that have promoted Care Groups as a community resource rather than a project activity?
- **Community views of sustainability:** What can IPs learn about sustainability from better understanding community perceptions of Care Groups?
- **Support for volunteers:** What is the minimum support required for Care Groups regarding the frequency of promoter support to Care Group Volunteers? Which elements of a Care Group light approach are critical to have for behavior change? And how generalizable is this light model?
- **Integration of new members:** What mechanisms can be effectively used by the community to incorporate newly pregnant women into Care Groups after project closeout?
- **Integration with MOH systems:** How does the Care Group model need to be adapted to be both feasible and effective, while building on existing government models?

2. Design of Care Group Volunteer role. These questions cover how IPs can design or support Care Groups to best facilitate women's voice and leadership long term. This may be a sustainable form of motivation for Care Group Volunteers who are primarily women.

- What are the benefits and drawbacks of different strategies for selecting Care Group Volunteers (e.g., community selection from within the group cohort? self-selection?)?
- How does the Care Group Volunteer selection process impact volunteer retention? What is the profile of the Care Group Volunteer who is effective and stays in the role?
- How can IPs help Care Group Volunteers serve as a long-lasting future resource (e.g., publicize this role, getting involved with other community mechanisms)?
- How can Care Groups support group participants to become new Care Group Volunteers, rather than leave the group?

3. Evolving purpose of the Care Group. These questions cover the impact of Care Groups evolving into groups with another purpose that the group self-determines.

- Can we test models to determine how much the dual purposes of VSLAs and Care Groups could be combined to be supportive on both sides, such as livelihoods/incomes and health/nutrition behaviors?
- How can trained Care Group Volunteers or participants remain a community resource for nutrition/health in a structured way, rather than ad hoc?

4. Sustained behaviors and social norms. These questions cover whether changes in behaviors and social norms achieved when Care Groups are functioning can be sustained.

- What is the threshold of changed behaviors or social norms (related to permanent and transient behaviors) that can be sustained without intentional outreach and promotion?
- What capacity-strengthening strategies facilitate Care Groups' continued influence on norm-shifting, given their potential as agents of change for nutrition?
- Is the peer model for Care Groups sufficient for sustainably influencing participants' changes in behaviors and social norms?

5. Monitoring systems that facilitate sustainability. These questions cover the type of monitoring systems (e.g., methods, tools, indicators) needed to track and assess the transition of support to Care Group Volunteers from IPs to local actors.

- What are the optimal monitoring systems for tracking the transition of Care Groups from IPs to local actors during the final two years of the project?
- What are the optimal monitoring systems for tracking the transition of Care Groups to other activities during the final two years of the project?
- How can IPs track volunteer motivation and further tailor their approaches to align with volunteer priorities?

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Annex I. Summary of Evidence

ANNEX TABLE 1. REVIEW AND SUMMARY ARTICLES THAT PROVIDE INSIGHT ON THE SUSTAINABILITY OF CHWS

REVIEW OBJECTIVE	KEY FINDINGS AND RECOMMENDATIONS
Reviews and Summaries About Sustainability of CHWs, Including CHVs	
Agarwal, S., Sripad, P., Johnson, C. et al. 2019. "A conceptual framework for measuring community health workforce performance within primary health care systems." Human Resources for Health 17, 86. https://doi.org/10.1186/s12960-019-0422-0.	
Propose a common framework for measuring CHW performance, including indicators and measurement considerations.	• Peer-reviewed journal articles, reports, and global data collection tools were reviewed to identify key measurement domains in monitoring CHW performance. Three consultations were convened with global stakeholders, community health implementers, advocates, measurement experts, and MOH representatives. • Twenty-one measurement parameters were identified, including key areas related to sustainability (e.g., measurement of incentives for CHWs, supervision and performance appraisal, data use, data reporting, service delivery, quality of services, CHW absenteeism and attrition, community use of services, experience of services, referral/counter-referral, credibility/trust, programmatic costs). Forty-six indicators were agreed upon to measure the sub-domains. • Quality information about CHW performance, satisfaction, attrition and credibility/trust, costs, etc. would help programs better design sustainable approaches.
Bhattacharyya, K., K. LeBan, M. Tien, and P. Winch. 2001. Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability. Arlington, VA: The Basic Support for Institutionalizing Child Survival Project (BASICS II) for the United States Agency for International Development.	
Examine experience with CHW incentives and which types are needed to motivate and retain volunteers.	• Describes 5 categories of volunteer incentives used to motivate individual CHWs, including 1) monetary; 2) non-monetary; 3) community-level factors; 4) factors that motivate communities to support CHWs; and 5) factors that motivate MOH staff to support and sustain CHWs. • Presents financial incentives as powerful but complicated, as they may influence volunteers to provide services that are easier to quantify (e.g., curative, rather than preventive services, such as nutrition promotion). • Finds that in-kind incentives are highly valued by volunteers (e.g., access to credit, preferential treatment at health facilities). • Links effective training and supervision to volunteer retention, public recognition, and positive community relationships. • Finds that the CHW selection process is at risk of unfair influences (e.g., nepotism), while inclusive selection is associated with retention. • Recommends that projects and national health systems strengthen and legitimize the role of CHWs to improve effectiveness, retention, and satisfaction.

REVIEW OBJECTIVE	KEY FINDINGS AND RECOMMENDATIONS
Crigler L., D. Bjerregaard, R. Furth, and K. Hill. 2011. Community Health Worker Assessment and Improvement Matrix (CHW AIM): A Toolkit for Improving Community Health Worker Programs and Services. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).	
A guided self-assessment that supports a team to assess their own program against 15 programmatic components and 4 levels of functionality. Participants use the results to develop action plans to address weaknesses in performance.	• Includes two key resources: 1) a program functionality matrix with 15 key components to assess an existing CHW program, and 2) a service integration matrix to determine how CHW roles align with program and national guidelines. • Fifteen components cover: CHW recruitment, job functions, initial and continuing training, equipment/supplies, supervision, performance evaluation, incentives, community involvement, referral systems, opportunities for advancement, documentation and information management, linkages to the health system, program performance evaluation, and country ownership. • Recommends that projects map out the specific roles of the CHW in order to assure that training, support, and incentives are appropriate for the exact job functions. • Concludes with a section on evidence for why each recommended program component is important for designing/evaluating a CHW program.
Colvin, C.J., S. Hodgins, and H.B. Perry. 2021. "Community Health Workers at the Dawn of a New Era: 8. Incentives and Remuneration." Health Research Policy and Systems 19 (Suppl 3), 106. https://doi.org/10.1186/s12961-021-00750-w.	
Review the types of incentives provided to CHWs and the factors associated with motivating and demotivating CHWs. Findings are based on a review of detailed case study data about CHW compensation and incentives in 29 national CHW programs.	• There is a false dichotomy of paid CHWs motivated by personal gain and volunteer CHWs motivated by altruism—in fact, it's more complex. A combination of incentives may be most useful to meet program needs over time. • CHWs don't expect that incentives will meet all their needs, but they do expect some benefit. CHWs motivated only by altruism have higher rates of attrition. However, altruism is a central factor for most CHWs, as well as the quality and functionality of relationships among CHWs and with community members and health workers. Motivation is sustained when CHWs feel they are valued. • CHWs' motivation is positively influenced by feeling like a valued part of the health system, with defined roles and responsibilities. • It's essential that CHWs feel their job is "doable" and optimal to have opportunities for personal and professional development. • Findings support WHO's 2018 guidelines on the need for written agreements that define CHWs' role and responsibilities, working conditions, remuneration, and workers' rights as well as financial compensation, when possible.
Closser, S., R. Abesha, G. Backe, S. Fossett, H. Napier, H. Gebremariam, K. Maes, and Y. Tesfaye. 2019. "Does Volunteer Community Health Work Empower Women? Evidence from Ethiopia's Women's Development Army." Health Policy and Planning 34, 298–306.	
Examine the assumption that CHV work is empowering for women. Captures findings from interviews, observations, document reviews, and a survey carried out in rural Amhara, Ethiopia, from 2013 to 2016 to explore experiences of empowerment among unpaid female CHWs in Ethiopia's Women's Development Army.	• About two-thirds of CHVs are female, which links gender and ideas about volunteering. • NGOs often define empowerment as a psychological state, while the anthropological definition of empowerment focuses on increased self-efficacy leading to changes in power or status. • However, the article notes that "CHWs are often disempowered staff at the bottom of health bureaucracies, facing severe restrictions on their ability to advocate for themselves or for the needs of their communities." • Given donor and NGO interest in sustainability, the program goal is often for women to remain in their volunteer roles, but for women to advance, they may need to move into different roles and paid opportunities.

REVIEW OBJECTIVE	KEY FINDINGS AND RECOMMENDATIONS
Pallas, S. W., E. H. Bradley, L. Curry, D. Minhas, R. Pérez-Escamilla, and L. Taylor. 2013. "Community Health Workers in Low- and Middle-Income Countries: What Do We Know about Scaling Up and Sustainability?" American Journal of Public Health 103(7), e74–e82. https://doi.org/10.2105/AJPH.2012.301102.	

Develop criteria for identifying cases of scale-up, sustainability, and success of CHW programs and conduct a systematic review of the determinants of success in scaling up and sustaining CHW programs in low- and middle-income countries.	• Nineteen articles were reviewed from CHW experiences in 16 countries, revealing 23 enabling factors and 15 barriers to scale-up and sustainability.
	• Factors were grouped into 3 categories: 1. program design and management (e.g., recruitment strategies, quality of training, supportive supervision, types of incentives), 2. community fit (e.g., compatibility of CHW program with community norms and perceived value to community members), and 3. integration with the broader environment (e.g., with the health system or entities outside the community).
	• Program design and management:
	  • Enabling factors: consistent management and supervision of CHWs and the CHW program; selection of respected people as CHWs; intensive training with practice periods; incentives; and advancement opportunities
	  • Barriers: insufficient pay or incentives for CHWs relative to other employment opportunities; long distances; weak management; poor training; lack of supplies, stress, and heavy workload
	• Community fit:
	  • Enabling factors: recruitment from the community, agreement with religious/moral norms, adjusting tasks to community need/norms, working with existing community organizations/traditional leaders
	  • Barriers: lack of community support/value placed on CHW role and lack of family support
	• Integration with broader environment:
	  • Enabling factors: CHW integration or cooperation with the broader health system and existing health care providers
	  • Barriers: low CHW respect or poor integration into the health system
	• Conclusions:
	  • CHW programs must be acceptable to the specific communities—start with quick wins or high-profile activities to gain credibility.
	  • Build in mechanisms for morale and incentives (especially social recognition) and tailor workload to needs/expectations/incentives.
	  • Explore funding strategies through national/local and different mechanisms. Interestingly, there is no evidence that foreign donor support enabled sustainability.
	  • Balance integration into the broader health system with local context, as the health system can provide resources, training, coordination, and motivation for CHWs but may weaken community trust in the CHW.
	• A set of key questions related to the above topics is included as a planning resource.

REVIEW OBJECTIVE	KEY FINDINGS AND RECOMMENDATIONS
Perry, H., and L. Crigler, eds. 2013. Developing and Strengthening Community Health Worker Programs at Scale: Guidance for Program Managers and Policy Makers. Washington, D.C.: USAID/MCHI.	
A practical guide to assist in the development or strengthening of a CHW program, drawing lessons from other countries that have implemented CHW programs at scale. • Section 1. Planning, governance, and finance • Section 2 HR (CHW role, recruitment, training, supervision, motivation) • Section 3. Context for community health • Section 4. Operational issues (e.g., scaling up, measurement and data)	• Note: there is a full version and condensed version of this guide. • Guidance is focused on large-scale, public-sector CHW programs but offers useful categories and questions for the creation of CHV programs, such as Care Groups. • Chapter 11 includes topics on CHW motivation and incentives, including the role of financial and non-financial incentives and key decisions that need to be made about defining and financing CHW incentives. • Effective recruitment, training, and supervision of CHWs contribute to satisfaction and retention. • Findings emphasize and promote that the overall objective of CHW programs is to expand the reach and quality of health care services and outcomes (not improve a specific aspect of CHW programming), and therefore, all CHW/CHV activities should contribute to the broader health system.
Rajaa S., and B. Palanisamy. 2022. "Factors Influencing the Sustainability of a Community Health Volunteer Programme—A Scoping Review." Indian J Med Ethics 2022 Oct–Dec; 7(4) NS: 279-286. DOI: 10.20529/IJME.2022.079.	

Identify factors that influence the success and sustainability of a community.	• Socioeconomic factors:
	  • **Sex:** Attrition is higher among female CHVs due to workload/schedule.
	  • **Age:** Attrition is higher among volunteers under age 40.
	  • **Marital status:** Less attrition among married CHVs.
	  • **Education and occupation:** Less attrition among the educated and informal sector.

Health volunteer program based on a scoping review of qualitative and quantitative studies published from January 2000 to May 2022.	• **Program factors:**
	  • Community: Higher attrition if CHVs selected from outside the community.
	  • Incentives: Lack of incentives is associated with higher attrition for CHVs.
	  • Existing volunteers: Selecting CHVs from among existing volunteers aids sustainability.
	  • Family support: If CHVs have family support, it facilitates sustainability.
	• **Sociocultural factors:** Missing family occasions/duties is associated with attrition.
	• **Program factors:** clear job description, appropriate training, supportive supervision, identification and community recognition, security/travel support

REVIEW OBJECTIVE	KEY FINDINGS AND RECOMMENDATIONS
Walker, P., L. Crigler, S. Downey, and K. LeBan. 2013. CHW "Principles of Practice" Guiding Principles for Non-Governmental Organisations and Their Partners for Coordinated National Scale-Up of Community Health Worker Programmes. Washington, D.C.: CORE Group, World Vision International.	
Presents "Principles of Practice" for working with CHWs and asks NGOs to support them as a framework for advocacy, programming, and partnership across organizations. These principles support the sustainability of CHWs and the outcomes of their work.	A "mosaic" of different implementation practices among organizations results in a failure to establish "minimum standards, processes, quality, and coverage." There are inconsistent efforts to use CHW programming to build strong health systems. Therefore, 7 key principles are proposed: 1. Advocate and invest in CHWs within the public health system (i.e., work with existing CHW cadres before considering new ones). 2. Enable and support country leadership (i.e., assure MOH partnership, approval, and oversight of CHW activities). 3. Work with and through existing local health services and mechanisms where possible to strengthen them. 4. Establish standards and methods for the motivation and support of CHWs under a unified country policy. 5. Develop minimum standards of needs- and resource-based training and continuing education of specific cadres of CHWs. 6. Support unified mechanisms for reporting and management of CHW data. 7. Maximize NGO roles in supporting CHW research, developing appropriate low-tech innovations, and judiciously taking to scale evidence-based, cost-effective solutions (e.g., avoiding "boutique" projects).
Reviews and Summaries of Sustainability Specifically Related to Care Group Implementation	
Cornish, D.C., S. Roberts-Dobie, and H. Tura. "Mother-To-Mother: Evaluation of the Sustainability of a Peer Model to Communicate Nutrition Messages in Mozambique." African Journal of Health Sciences Volume 32, Issue No. 5, September–October 2019.	
Examine the sustainability of improvements in MCH and nutrition achieved by a USAID-funded Child Survival Project that used a Care Group Model by conducting a follow-up evaluation 5 years after the program ended with former project participants.	• Results suggest the continuity of capacity among mother leaders as a community resource and that some key activities were still ongoing (e.g., home visits to provide health messages during critical moments postpartum). • Anthropometric gains and health knowledge gains appeared to be sustained (although the analysis would have benefited from a control group for comparison). • The authors recommended efforts to integrate the Care Group approach into government health systems and investigate the inputs necessary for successful integration.
Pieterse, P., E. Chirwa, A. Matthews, and A. Walsh. 2022. "What Are the Mechanisms and Contexts by Which Care Groups Achieve Social and Behavioural Change in Low- and Middle-Income Countries? Group Motivation Findings from a Realist Synthesis." Public Health Nutrition 25(10), 2908-2919. doi:10.1017/S1368980022001367.	

Reviews 42 texts related to the use of Care Groups to examine drivers of volunteer and participant behaviors and provide insights into how CHVs can be motivated and how motivation can be sustained. The review included peer-reviewed journal articles, case studies, program evaluations, and guidance documents.	• Results showed that different types of motivation drive the establishment and the sustainability of peer group interventions.
	• Motivation came from 3 main sources and evolved over time:
	  ◦ Initially, motivation came from resources provided by the NGO establishing the Care Groups (skirts, identification badges, training).
	  ◦ However, during Care Groups implementation, volunteers and participants were motivated by the group dynamics, mutual support, peer recognition and support from the wider community, as well as seeing positive results in their communities.
	  ◦ Finally, volunteers and group members alike became self-motivated by their experience of being involved in group activities.
	• Program designers should take into account that volunteer and participation motivations evolve over time and originate from different sources.

REVIEW OBJECTIVE	KEY FINDINGS AND RECOMMENDATIONS
Weiss, J., R. Makonnen, and D. Sula. 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 15 (Suppl 1), S2. https://doi.org/10.1186/1472-6963-15-S1-S2.	
This study assessed if supervision of Care Group activities by MOH personnel could achieve the same child health outcomes as supervision provided by specialized NGO staff.	• The study used a pre-test/post-test quasi-experimental design implemented to compare 45 MOH-led Care Groups with 478 Care Group Volunteers in the intervention area, with 50 NGO-led Care Groups with 509 Care Group Volunteers in the comparison area. • The MOH-led Care Group Model performed at least as well as the NGO-led model in achieving defined health and nutrition outcomes. • Mothers of children 0–23 months in the intervention and comparison sites reported similar levels of knowledge and practices for nearly all (38 of 40) dependent variables measured. • Process monitoring data confirmed similar implementation fidelity for both the MOH-led and NGO-led Care Groups. • The study provides evidence that MOH community health systems are capable of behavior change results compared to interventions typically implemented by NGOs (with adequate support). Research is needed to fully document the inputs and monetary costs borne by the MOH to implement the model.
2014. "Care Groups: Implications of Current Innovations, Scale-Up and Research." Summary report of a Technical Advisory Group meeting, Washington, D.C., May 28–29.	
Report from 2014 Technical Advisory Group involving 33 organizations whose objectives included: 1. Review the Care Group evidence base. 2. Explore experiences with national adoption and scaling up. 3. Explore the implications of recent innovations and evaluations. 4. Identify recommendations for effective training and quality control to ensure a participatory, peer-learning environment for achieving behavior change. 5. Identify next steps, including a research agenda and channels to share experiences with Care Groups.	• Technical Advisory Group participants recommend that a paid person in the MOH system provide supervision to Care Group activities and that the MOH takes an active role in design and implementation. • Information needed on MOH costs for the Care Group approach. • In terms of research needs, participants identified the need for a rigorous evaluation of Care Groups with a randomized control design and key operations research to pursue (included at end of report), including two sustainability topics: 1. sustainability of both caregiver behavior change and volunteer meetings, and 2. sustainability regarding new cohorts of lead mothers transitioning post-project.

Annex II. Key Informant Interview Guide

Definition and Expectations of Care Group Sustainability

1. Given your experiences working with Care Groups across different contexts, how would you define "sustainability" for Care Groups? What do you expect to happen in communities after closeout?

- Do you think of sustaining behaviors in the cohort of participant mothers?
- Do you think of sustainability as Care Group leaders continuing to visit their group members, or that new Care Group leaders are formed and seek out new pregnant and lactating mothers?
- Changes in social norms that affect nutrition—how would you measure that?
- As many of the key health and nutrition behaviors that Care Groups promote are critically needed during the first 1,000 days and are therefore temporary, how do you understand that in terms of sustaining behavior changes?
- Can you share experiences integrating new members after project closeout?

Examples of Sustainable Care Group Projects

2. Can you share one or more examples of projects that have been successful at fostering the sustainability of Care Group services or outcomes?

- What was sustained?
  - Did the project(s) focus on the continuing provision of Care Group services?
  - Or did the project(s) focus on the sustainability of the outcomes of Care Groups?
  - What factors were important for sustainability?
  - How was sustainability potential assessed?
  - What lessons can future projects draw from these examples?

3. Could you share any experiences of Care Groups that have successfully graduated participating mothers and then have started new groups? What did the model look like?

- Under what conditions do you think it's possible for new groups to be continually started?
- Could you describe any effective models that you have seen (not only for Care Groups) where group members "graduate" due to age or other factors and then hand over their activities to new members of a group?

Experiences with Care Groups Embedded in MOH Systems

4. Regarding NGO-led projects that coordinate with the MOH to embed the Care Group support structure into MOH systems

- What aspects of embedded Care Groups into MOH systems are likely to be sustainable? Given those aspects, how can we enhance their potential?
  - E.g., support Care Groups to transition to become permanent support groups for the members, linking with VSLAs, insurance schemes
- What are the main constraints—and how can these be addressed by a project?
- What questions do you think projects need to ask at the proposal stage and during implementation to best prepare for the reality of sustainability options with the MOH?
- Have you been able to observe the sustainability of Care Groups with the NGO and the MOH-supported model?

Content Needed and Future Use of This Guide

5. What issues do you perceive as critical to be addressed in the stepwise guide focused on sustainability?

- What key elements or activities do you think the guide should contain?
  - Probe also the format, length, example guides, and key reviewers.
- Project cycle: How could this guide be used in the project cycle by NGOs during the design and implementation of food security/nutrition projects?
- What resources should be included or referred to?
- Are there existing tools that guide that thinking?

Guidance on Developing Sustainability and Exit Strategies for CHW/CHV Activities/Outcomes

6. Now, turning to the sustainability and exit strategies for NGO food security projects that include Care Groups…

- Have you seen any examples of sustainability and exit strategies that focus in a comprehensive way on Care Groups?
  - If so, which outcomes do the strategies include for Care Groups?
- Could you mention any sustainability and exit strategies that provide an example of best practices?
- Which aspects of the sustainability and exit strategies generally require improvement? What aspects are strongest (e.g., motivation, capacity, resources, linkages)?

Finally, Related to How NGO Project Experiences Can Contribute to the Evidence Base Related to Care Group Sustainability…

7. Operations research topics: Specifically for food security projects with a health and nutrition component, could you suggest any priority topics for operations research on how project design can further the sustainability of Care Group activities or outcomes?

Information Needed from Donors

8. What information, tools, or support are needed from donors to understand their expectations regarding the sustainability of Care Group activities or the sustainability of the outcomes from their work?

- Key questions and recommendations related to motivation, capacity, resources, and linkages will be distilled from existing literature on the sustainability of volunteer peer group leaders.
  - Any feedback on these resources—especially newer resources?
  - Who else is looking at this topic in academia, research, and donors?
- Follow-up question (time permitting): Given the challenges faced by countries where RFSAs are programmed, the guide will highlight how contextual factors related to a country's health systems, political or economic instability, and other factors require different considerations regarding the sustainability of unpaid peer group volunteers.
  - What different considerations need to be included?
- Follow-up question (time permitting) about the CORE PRINCIPLES FOR SUSTAINABILITY: The guide will present core principles for sustainability (e.g., a text box) and then refer/link to these throughout the guide (e.g., early planning to assess the viability of using Care Groups given the context; link to existing national structures and staff and results; emphasize existing groups/volunteers; avoid new groups/volunteers; implement an iterative process to plan and re-plan as needed; plan an exit and transition early in the project cycle to ensure sustainability).
  - What other key principles could be included?

Annex III. Detailed Key Informant Interview Findings

The key informants we spoke to confirmed what we found in the literature and provided additional insights (see details in **table 2**). One of the most notable findings is that among the stakeholders who shared insights on Care Group sustainability, there was no clear consensus on what they expected to be sustained from Care Groups after project closeout. Rather, stakeholders' expectations generally fell into four main categories:

1. **Original Care Group Model:** Care Groups will continue group meetings and home visits with the original Care Group members.
2. **Care Group expansion:** Care Groups will continue conducting group meetings and home visits AND recruit new members as they enter the life stage where Care Group teachings are relevant (e.g., pregnant women).
3. **Sustained behaviors, not active behavior promotion:** Behaviors and social norms promoted during the project will continue among those who were Care Group participants during the project; however, Care Groups may cease to hold activities to promote new behaviors and social norms.
4. **Care Groups evolve to address priorities beyond health and nutrition:** Care Groups will adopt a new purpose that serves the lead mothers' or Care Group participants' needs (e.g., often related to improving the family's financial situation, like savings groups or livelihood activities).

Key takeaways from key informants' views:

There are doubts that volunteers will sustain Care Group activities as designed. Overall, many key informants were skeptical that volunteers would continue to hold health promotion meetings after the project without remuneration. Most believed that Care Group services could only be sustained through local actors with a clear incentive. One informant believed that although BHA prefers not to rely on volunteerism, it makes an exception for Care Groups due to their value during implementation, even if they cannot be sustained. Key informants referred to the fact that willingness to keep volunteering depends on the cultural context of communitarianism, as well as the individual; for that reason, at least one IP promotes serving others as a core value. Some key informants felt that a challenge to Care Group sustainability is that fidelity to the evidence-based model is often compromised, while other informants believed that the original model is not sustainable and thus requires simplification or streamlining to improve opportunities for sustainability. Key informants thought that most projects had not fully defined the aspects that they expected to continue post-project.

There is the perception among key informants that continuing recruitment of new Care Group participants is unlikely. No key informants reported an example of new participants continuing to be integrated into Care Groups post-project. The majority of key informants thought it would be unrealistic for CHVs to convene Care Group meetings and bring in new members after the support, compensation, or incentive ends. Overall, few key informants actually expected Care Groups to keep recruiting members who become eligible to participate (e.g., pregnancy, new mother). Still, some expressed disappointment that recruitment of new members was unlikely to continue, as they viewed this as a valuable long-term outcome. A few informants believed that Care Groups integrating new participants after project closeout would require a specific role (and probably funding). They distinguished this role of having systems for ongoing recruitment as quite different from whether the lead mother would be willing to keep teaching activities.

There is a belief that there is a lasting legacy for behavior change among Care Group Volunteers and Care Group participants. Several stakeholders acknowledged that while Care Groups might not continue health promotion, they hoped that behavior changes or new social norms achieved during the life of the project would be maintained or expanded. Some key informants thought that sustainable changes in behavior and social norms could achieve a critical mass/tipping point during the life of the project. However, it wasn't clear whether this would involve the whole community, including future families, or focus on sustaining behaviors among those who participated in Care Groups during the project. A few key informants believed that women who were in a formal

Care Group structure during the project will keep reaching out to new mothers post-project so that behaviors are sustained, become the new norm, and are passed to new moms. But other key informants said they do not expect that the organized behavior change communication strategies will continue after the life of a program. Several key informants thought that sustainability should focus on how behavioral goals can be achieved and sustained, rather than how Care Groups (or any specific activity) can continue to be implemented.

Care Groups seem to naturally morph into savings groups. Many stakeholders shared firsthand experiences about Care Groups that spontaneously adopted new activities related to improving participants' economic situations through savings groups or livelihoods activities. Nevertheless, stakeholders expressed disappointment that Care Groups were unlikely to sustainably continue to promote nutrition and health, as that was the original objective of the groups.

There is a perception that projects pursue sustainability as a goal, but may not have mapped out the specific objectives and assumptions. Many projects try to set up the best conditions for sustainability, although the specific aspects to be sustained are not concretely defined. One key informant reflected that over the course of a project, Care Groups may no longer be needed if other resources (e.g., the MOH or other organizations) step up to promote behavior change.

Evidence about sustainability is scarce. Most key informants felt they had limited insights on what happens post-closeout due to lack of resources to monitor activities post-project. Nearly all key informants noted that during years of field experience, they have personally observed only limited examples of Care Groups maintaining activities, as Care Group Volunteers often cease many activities about six months after project closeout, despite their expressed motivation to continue. Some lead mothers say they cannot continue planned activities, but they are willing to remain a resource in the community to provide specific advice as needed. One key informant reported visiting areas where a RFSA had rotated to a new location and had the opportunity to speak with Care Group Volunteers and volunteers in areas where the project had "closed out." In that context, some Care Group Volunteers and participants reported that they continued meeting due to social bonds and their comfort with topics, expressing the most enthusiasm for visible or tangible behaviors, like how to construct a tippy tap or how to hold the baby for breastfeeding.

Rare examples of highly functioning volunteers through government systems were noted, such as in Rwanda, Bangladesh, and Nepal, but continued motivation came from a performance-based financing system (e.g., payment based on the number and quality of home visits, referrals).

Care Groups that "evolve" to adopt a purpose beyond health and nutrition provide promising examples. Many discussions with stakeholders focused on how some Care Groups evolve to embrace an additional source of motivation for Care Group leaders or participants. These fell broadly into two categories:

- **Care Group Volunteers' health promotion activities paired with a source of financial incentive for volunteers.** Some Care Group Volunteers deliver health promotion (e.g., nutrition counseling) at the same time or place where they provide a service with direct financial value (such as selling hygiene supplies). As well as "subsidizing" the Care Group Volunteer's role, the continued Care Group meetings provide a setting for ongoing training by government health staff.
- **Care Groups that transition to another purpose that serves the economic interests of Care Group Volunteers or participants, such as becoming a VSLA, small business, or burial group.** Recognizing that over time women's lives transition from needs related to pregnancy, IYCF, and related behaviors, the Care Group can similarly transition over time to address additional priorities of its members. Stakeholders cited various experiences with USAID-funded projects in which savings groups spontaneously started due to the increased income from project participants, which they also used to leverage the experience to start other group initiatives. Stakeholders cited Care Groups in Bolivia and Burkina Faso that formed themselves into small businesses offering services such as making handicrafts. Even when promotion of health and nutrition is not the central purpose of the group, increased financial assets under women's control provide a valuable channel to improved food and nutrition security and household resilience.

Sustainability principles shared by key informants.

Based on their experiences, key informants shared several sustainability principles that they considered important for planning and implementing sustainability approaches. These included—

- **Early planning** with key stakeholders to improve community ownership and/or government ownership of Care Groups.
- **Having linkages** to government priorities and strategies that allows Care Groups to be embraced in the context of a larger, long-term strategy for improved nutrition and health.
- **Layering, sequencing, and integrating across sectors** so that Care Groups are interrelated with different approaches and community groups (e.g., community leaders, men, different committees), including with other government and NGO programs.
- **Iterating sustainability approaches** to be adapted at regular intervals to respond to the needs and priorities of community members, as well as the evolving enabling environment.
- **Building on existing groups and structures** to avoid creating parallel structures (e.g., having Care Groups report their activities to the village health committee, involving existing volunteers in Care Groups to build on existing community health capacity).
- **Assuring a gradual transition** so that local actors can "practice sustainability" while IP staff and funding are available to provide support (e.g., encouragement, troubleshooting, or management support).
- **Applying market-based approaches** as they are highly effective in some contexts and should be pursued when possible. However, most informants viewed market-based approaches and incentives as more challenging for nutrition and health promotion, given the social norm of not paying for them.

TABLE 2. SUMMARY OF FINDINGS FROM KEY INFORMANT INTERVIEWS

THEME	ILLUSTRATIVE QUOTES
SUSTAINABILITY PLANS	
• Sustainability plans generally lack detail and depth on precise expectations for Care Group post-project; however, many IPs have developed detailed spreadsheets for internal use. • When Care Groups are expected to continue, plans often don't specify if new cohorts of women will be recruited in the future. • Many plans lack information on post-award resources that rely on linkages.	• "One challenge is that (sustainability plans) don't distinctly ask for each of the critical factors of motivation, capacity, and resources, but in fact all three are necessary to achieve sustainability in the child health domain." • "…the plans often end at handover to government or partners, without taking it down to the detail of what is done in the community regarding community exit and transition."
CARE GROUP VOLUNTEER MOTIVATION FOR HEALTH/NUTRITION PROMOTION	
• Most Care Group Volunteers are unpaid but receive incentives that cannot be easily replaced post-project (both tangible and intangible benefits, such as job aids, travel subsidies, skills, and support from staff). • Many Care Group Volunteers express a desire and intent to continue as a volunteer. However, they observed that Care Group Volunteers' activities wane about 6 months post-project. • The diversity of volunteer incentives provided by different NGOs can create confusion and attrition as volunteers rotate roles based on benefits.	• "NGOs bring a level of energy and influence as an external facilitator, and when a project closes, that energy goes away." • "Care Group Volunteers still receive benefits, even material benefits, such as cement or chairs for arranging a meeting space. The flow of benefits stops, and are they going to still convene meetings?" • "Even in the same contiguous areas, different partners have different ways of training, equipping, incentivizing CHWs, causing confusion and distraction as they focus on how things are happening differently around them." • "Skills have to be valuable to volunteers, and once they master some, they want other relevant ones."
MOTIVATION FOR EVOLVING PURPOSE	

• Several stakeholders described the efforts of IPs to facilitate volunteer commitment to the role of lead mother by considering how volunteers could be motivated by market-based incentives.
• Although willingness to pay for nutrition counseling or similar services has worked in specific contexts (e.g., Nepal, Bangladesh), stakeholders did not believe it was feasible across most contexts.
• However, stakeholders shared two models for the evolving purpose of Care Groups that they considered promising:
  ◦ CGVs health promotion activities are paired with a source of financial incentive for volunteers (such as sales of products at meetings).
  ◦ CGs themselves evolve to adopt another purpose which serves the economic interests of CG participants, such as becoming a VSLA, small business, or burial group. (Such groups may or may not involve health education/behavior change promotion).
  ◦ Stakeholders suggested further development and study of these models, as they felt they offered channels for the long-term sustainability of Care Groups.
	• "Although it's a worthy goal to have groups that serve another purpose, the underlying purpose was to get IYCF-type education and training."

THEME	ILLUSTRATIVE QUOTES
RESOURCES	
• Details on post-award resources for nutrition and health are often a gap in RFSA's sustainability plans. • Replacement resources should be a focus on project monitoring, such as whether people have begun to pay for services that are expected to be sustained. • Charging money for nutrition services (especially behavior promotion) is often not acceptable in most contexts. Particular contexts are the exception, not the norm (e.g., Nepal, Bangladesh). • Nutrition sustainability strategies often must assume the government linkages will come with resources. • Some IPs are attempting to pair services (e.g., nutrition counseling) with sales that bring resources as a sustainable source of motivation (e.g., selling hygiene supplies at Care Group meetings).	• "Nutrition is more challenging for market-based approaches." • "The approach of incorporating CG into the government system is positive, but it's most important that the linkages are to a body that has some resources." • "If we are working with very poor people, we need to help them gain access to additional resources so they can pay for services in the future."
CONTINUED SOURCE OF TECHNICAL AND MANAGERIAL CAPACITY	
• Building Care Groups' capacity to promote behavior change is important, but soft skills (like advocacy, organization, making connections to other resources) will ultimately be critical for resilience and sustainability of lead mothers and participants. • Investing in health staff capacity to conduct behavior change is a contribution to a future source of capacity for Care Groups. • BHA expects IPs to develop a business plan to provide capacity support based on assessed needs (e.g., technical or financial skills). IP can provide capacity or link local actors to the capacity (e.g., government services, local research institutes, or private entities).	• Capacity isn't enough to sustain CGs—"Even when groups have the capacity, they don't keep going at the same level of intensity when promoter visits stop." • "Even if CHVs are motivated by their desire to assist others and enjoy the social aspect of volunteering, they still require linkages with some entity in order to keep getting trained."
LINKAGES	
• As the "promoter role" is critical to Care Group sustainability, it is important to work closely with the MOH, which usually controls this role. • Even when the Care Group Model is adopted in MOH policies, it often requires NGO partners to fund and the technical support to implement it. • The evidenced-based Care Group model is very intensive and requires layers of training, supervision, and support to implement it. • Nurses are not well-trained in behavior change, impeding their ability to effectively promote behavior change or train/supervise Care Groups. When MOHs implement Care Groups, often these groups become a different variety of lower-intensity peer groups. • An IP who supported partnerships with MOHs to implement Care Groups in several countries cautioned that it requires years of working with the MOH so that they really understand the concept and the model. • Nutrition is not as urgent a priority as other pressing health topics, distracting MOH support from Care Groups.	• The idea may be that "the local closest health facility is going to conduct that support, but they don't have the conditions to go into the community, to travel into the community, either for lack of time, for lack of vehicle and fuel to go into the communities…this requires realistic planning around what those support structures would look like." • "Often we go right to the CHWs, but actually a scale-up will come from the national-level community health department." • There is a "huge missed opportunity" to strengthen the capacity of nurses to support behavior change. • Although government theoretically assumes certain community health strategies, in reality they lack the needed "capacity strengthening support, the training, the explanation of terms of reference, roles, and responsibilities, what the expectations are, how to conduct these meetings, what the objectives should be, how to problem-solve, how to find resources if resources are needed."

THEME	ILLUSTRATIVE QUOTES
CONTEXT WHERE CARE GROUPS HAVE THE BEST OPPORTUNITY FOR SUSTAINABILITY	
• In locations where CHWs are already strong and capable, it provides a platform for Care Group sustainability. Zimbabwe example: female CHWs, respected, active, sit on Community Health Committee. • A key consideration is CHW workload and how much MOH CHWs would be able to support the Care Groups. Some experiences of NGOs working with MOH promoters all gave those promoters significant support.	• "For this model to work, government would need to have prioritized IYCF and devote personnel, not only have a strong relationship with the project." • MOVE: "the approach of incorporating CG into the government system is positive, but it's most important that the linkages are to a body that has some resources." • Example, MOH embedded: the Community Health Agents who were providing support to the lead mothers during the project have largely been employed and the hope/plan is that they will continue to support and supervise the lead mothers (still in the project implementation stage, but it's the plan).
GRADUAL EXIT	
• Gradual transition is recognized by key informants as a critical sustainability principle, but it's often neglected. • Project monitoring rarely analyzes elements of the gradual transition (e.g., how local actors are functioning during the transition). • Early transition phases should commence during the project, permitting the IP to refine and support the process.	• "Gradual transition allows local actors to gain experience and confidence." • "During the project, it's essential that the project effectively foster the pillars of sustainability, such as building social capital among group members, mentoring, practicing integrating new members or graduating members."

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