Care Groups in Emergencies:

Evidence on the Use of Care Groups and Peer Support Groups in Emergency Settings
APRIL 2015

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Photo: International Medical Corps, Ethiopia

Photo: International Medical Corps, Ethiopia

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ABBREVIATIONS AND ACRONYMS

ACF Action Against Hunger
ANC Antenatal care
BCC Behavior Change Communication
CAR Central African Republic
CG Care Group
CGV Care Group Volunteer
CHW Community Health Worker
CRS Catholic Relief Services
EBF Exclusive breastfeeding
EVD Ebola Virus Disease
FH Food for the Hungry
FSN Food Security and Nutrition
IDP Internally Displaced Person
IYCF Infant and Young Child Feeding
LBW Low Birth Weight
LM Lead Mothers
MAM Moderate Acute Malnutrition
MoH Ministry of Health
MUAC Middle upper arm circumference
MtMSG Mother-to-Mother Support Groups
NGO Non Government Organization
PCI Project Concern International
PLW Pregnant and Lactating Women
PNC Postnatal Care
SAM Severe Acute Malnutrition
SBC Social and Behavior Change
STC Save the Children
TOPS Technical and Operational Performance Support
WASH Water, Sanitation & Hygiene
WR World Relief
WVI World Vision International

EXECUTIVE SUMMARY

INTRODUCTION AND BACKGROUND

The Care Group (CG) approach, a specific type of peer support group model, has proven instrumental in addressing issues of food insecurity and nutrition within many development contexts. International Medical Corps along with other implementing partners, including members of the CORE Social and Behavior Change (SBC) working group, have modified the model for use in emergency contexts, finding that variations of the CG approach could lead to successful behavior change.

The Objectives of this project were to gather evidence about the use of Care Groups (CGs) and other types of peer support groups in emergency settings in order to analyze the use of CGs in emergencies and develop recommendations to ensure their effective use in these contexts.

The Objectives were:

1. Conduct a review of peer support group models used in emergency contexts for behavior change.

2. Use these findings to develop recommendations on adapting the CG model for emergencies.[1]

3. Disseminate findings within the programming community.

The report discusses experiences with implementing Care Groups, Cascade Groups and Mother-to-Mother Support Groups (MtMSG) in emergency settings. It also defines emergencies in terms of type (natural disaster, epidemics, conflict), stage (acute, transitional, protracted), and setting (camps, host communities).

FINDINGS

The majority of findings relevant to CGs in emergency contexts can be classified as 1) adaptations to the CG model, 2) benefits of the model and 3) challenges of the model in an emergency context.

ADAPTATIONS TO THE CARE GROUP MODEL IN EMERGENCY SETTINGS

This section identifies the criteria for the traditional Care Group model used in development settings compared with findings from individual programs in emergency settings that adapted certain elements of Care Groups adaptations used by stakeholders in emergency settings.

- **Care Group and Beneficiary Group Size:** Under CG adaptations it was found that the CG and beneficiary group size depended on several variables that were accentuated by the circumstances of the emergency including incentives, funding, population dispersion,

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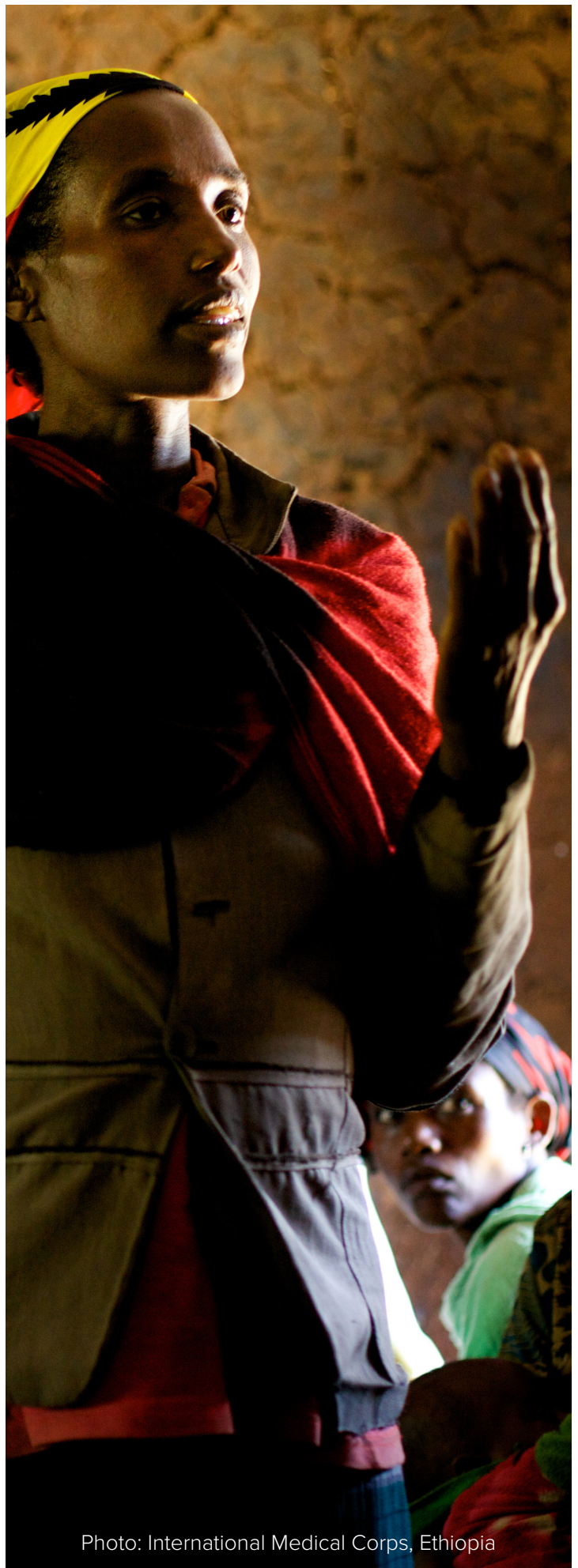
Photo: International Medical Corps, Ethiopia

Care Group Elements	Care Group Model	Emergency Adaptations
Care Group and Beneficiary Size	Up to 16	Smaller groups
Target Population	PLW, WRA, U2, U5	Entire community
Volunteer Selection	Elected by the community	Selected by staff or community leaders
Group Meeting Length	Up to 2 hours	More than 2 hours
Topics covered	Nutrition, hygiene, Acute respiratory infection Gender-based Violence Family Planning	Nutrition, hygiene Acute respiratory infection Gender-based Violence Family Planning Psychosocial support
Monitoring and Evaluation	Vital events data	Often only attendance
Formative Research	Barrier Analysis	Rarely conducted
Ministry of Health	Integrated CG model	Coordination levels varied

and literacy levels. However, in general, the groups tended to be on the smaller end of the CG size criteria (2-10).

- **Target Population:** Target groups are usually pregnant and lactating women (PLW)/women of reproductive age (WRA) and women with children under 2 or 5. In emergencies, however, the target group expanded to include whole communities to accommodate emergency circumstances such as disease outbreaks.
- **Care Group Volunteer (CGV) Selection:** While in most programs the CGVs were elected by their neighborhood beneficiary groups, in some cases this was not possible due to the chaos in the aftermath of an acute emergency, which required program staff to focus on other relief priorities. In these instances, program staff, community leaders or political entities selected the CGVs.
- **Meeting Length:** Generally, CG meetings with beneficiaries last less than 2 hours. However, there are examples when more time was spent during the visit to socialize or provide psychosocial support to the mother and family for trauma suffered during the emergency.
- **Topics Covered:** Most topics covered in the CG curricula were related to basic health priorities, such as nutrition and hygiene. However, the programs were flexible in including other topics related to emergency priorities of interest to beneficiaries.
- **Monitoring and Evaluation:** Most CG programs collected meeting attendance and home visit data that was reported up through the Promoters to the Supervisor and recorded in donor reports. In protracted emergency settings, some collected additional vital events data and used it as a screening and referral mechanism for local health clinics.
- **Formative Research:** Although the majority of programs did not do formative research due to lack

of time, resources, and other relief priorities, a few did. The information was found useful for informing the educational messages and determining topics for upcoming modules.

- **Ministry of Health:** Although coordinating with the Ministry of Health can be important for sustainability of improving health behaviors, programs in emergencies had varying levels of coordination ranging from no involvement to conducting trainings and sharing resources with Ministry staff.

Benefits of Using Care Groups in Emergency Settings

Listed below are those benefits identified by stakeholders as a contributing factor to selecting Care Groups as a methodology or from the experience of implementing the CG model in emergency settings.

- **Large Coverage:** One key advantage of the CG model is that it allows programs to cover a high percentage of the target population through its cascading mechanism.
- **Cost Effectiveness:** Through the use of CGVs, programs can cover a large area with a minimal number of paid staff.
- **Rapid Dissemination of Information:** The cascading and multiplying flow of information from staff down to CGVs and beneficiaries allows messages to be disseminated rapidly to a large number of people. This is advantageous in emergency settings, where there is a need to reach people quickly with key life-saving messages.
- **Rapid Behavior Change:** Community behavior change occurs much more rapidly in emergency relief settings

than would occur in development settings.[2] In a context where people are upended from their usual support systems and struggling to survive, they are more open to making behavior changes that will foster survival.

- **Peer Support:** In both development and emergency settings, the CG structure encourages bonding among participants and peer support, thus strengthening trust and social cohesion.
- **Trusted Channel for Communication:** The CG system provides a community structure that can be leveraged for additional purposes during both acute and protracted emergencies, such as using CGVs to spread information regarding food distribution.
- **System for Monitoring, Screening and Referrals:** The CG model can provide an effective and wide-reaching system for data collection, screening and referrals for communities, especially during an emergency when CHWs may not be available to fulfill these functions.
- **Sustainability:** Because of its community integration and the broad coverage, the model is highly sustainable and behaviors continue being practiced after programs end.
- **Documented Effectiveness:** One of the rationales cited for choosing to implement CGs in the specified emergency setting was that the model had been used previously by the organizations and found to be effective for behavior change.

Challenges of Using Care Groups in Emergency Settings

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

- **Initial Set-up of CGs:** The requirements for setting up a CG are time-consuming, labor-intensive, and pull relief staff away from other immediate needs. Relief funding tends to be short-term and can end before significant behavior change can be accomplished. When organizing CGs, the length of the funding cycle, the stage of the emergency and staff capacity must be considered.
- **Development of Program Materials:** Development of program materials can be challenging in both acute and protracted emergencies due to time, cost of printing and the need for context-specific information.
- **Community Sensitization:** During the acute stage of an emergency, it can be difficult to devote time to community buy-in for CGs from community leaders due to other competing priorities.
- **Finding Qualified Program Staff and Volunteers:** It is often difficult to recruit qualified CGV candidates, especially women, due to culture, literacy, language, traditional beliefs or lack of incentives.

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

Recommendations

Recommendations were based on the available evidence gathered during this study from current or past programs implementing peer support groups in emergency settings and stakeholder input. Two sets of recommendations emerged from this evidence; one set is overall recommendations based on the stage of emergency: acute, transitional (moving from development context to emergency or vice versa) and protracted. The second is specific recommendations based on the adaptations, challenges and benefits of using Care Groups in emergency settings. These specific recommendations are documented as Recommendations for Using Care Groups in Emergency Settings and can be found on the TOPS FSN Resource Library. Lastly, the stakeholder workshop produced more ideas on how to adapt Care Groups to emergency settings. These ideas have been captured in a section on recommendations for further research to continue to add to the evidence base of applying the Care Group methodology in emergency settings.

2 Bagrow, James P, Wang Dashun, Barabasi Albert Laszlo. "Collective Response of Human Populations to Large-Scale Emergencies." DOI: 10.1371/journal.pone.0017680. March 30, 2011.

Type	Recommendations from this study	Rationale
Acute Emergencies	Not recommended (for less than 6 months expected funding) unless previously set up	Time constraints: staff capacity; Initial CG set-up; Short funding cycle
Transitional: Emergency ←→ Development	Recommended	**Development to Emergency:** CG structure already in place **Emergency to Development:** Behavior change continues as emergency stabilizes
Protracted Emergencies	Recommended	Complements health infrastructure
Mobile Populations	Recommended (conditional)	When the mobile population moves in predictable patterns

I. INTRODUCTION AND BACKGROUND

During an emergency, the need to reach the affected population with life-saving behavior change messages and activities, especially on infant and young child feeding (IYCF) and hygiene, is critical. The CG approach[3], a specific peer support group model and behavior change promotion approach, has proven instrumental in addressing issues of food insecurity and nutrition within many development contexts. However, emergencies are complex situations with multiple variables that present challenges to implementing the CG approach, including mobility within the target population, lack of local resources, infrastructure, and time necessary to set up CGs. Although CGs have traditionally been used for nutrition and hygiene education, they are expanding into other sectors.

Despite these challenges, International Medical Corps and other implementing partners have modified the model for use in emergency contexts. Although no formal evaluation or review of these programs had been conducted, preliminary findings indicated that variations of the CG approach could lead to successful behavior change in emergencies. [4]Furthermore, using this approach in emergencies appeared to provide additional benefits including increasing social cohesion and providing psychosocial support in the midst of traumatic situations.[5] These findings indicated that the

success seen in using the CG approach may translate, if appropriately adapted, to emergency contexts.

A. Aims and Objectives

The overarching aim of this project was to gather evidence on the use of CGs and peer support groups in emergency settings in order to contribute to identifying evidence-based practices addressing malnutrition and food insecurity in emergencies.

International Medical Corps set out to achieve this aim through the following Objectives:

1. Conduct an analysis of peer support group models used in emergency contexts for behavior change.

2. Use these findings to develop recommendations on adapting the CG model for emergencies.[6]

3. Disseminate findings within the programming community.

Information on peer support group models used in emergencies was gathered by using a combination of methods including desk-based literature reviews, surveys, and field-based interviews, to gather best practices and lessons learned associated with the use of CGs in emergency settings. The focus of the reviews and evaluations was on:

1) identifying emergency contexts that best support the use

of the CG approach; and

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3 Laughlin M. The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Health Educators (2nd Edition). Baltimore, MD: World Relief and the Child Survival Collaborations and Resources (CORE) Group; 2010

4 Rutishauser-Perera, Alexandra. "Cascade groups Sierra Leone: IYCF Social behavior change integrated in CMAM research program". Care Group Forward Interest Group Meeting, Feb 2014.

5 Davis, Tom. "SBC in Emergencies: Food for the Hungry's Experience". Core Group Fall Meeting. Washington, DC. October 2013.

2) identifying components of the CG approach that can be adapted for emergency contexts.

Recommendations for adapting the CG approach for emergency settings was then developed based on the findings from the analysis of current use of CGs and peer support groups in emergencies (objective 1). The recommendations, developed by the research team, are intended for all parties who are supporting peer support group models in emergencies or plan to establish them in the future, including donors, implementing organizations, government ministries and local partners.

The findings were shared with the programming community through a stakeholder workshop and a presentation at the CORE Group Spring 2015 Global Health Practitioner Conference in Alexandria, VA, and feedback from the conference was incorporated into the final reports. The recommendations from this study and final report will be disseminated through mailing lists and the FSN Network and the CORE Group, and can also be requested individually from International Medical Corps.

B. Definitions

Provided below are the working definitions for each peer support group model and emergencies included in this research.

CARE GROUPS, CASCADE GROUPS, MOTHER-TO-MOTHER SUPPORT GROUPS

Care Groups: CGs are a model of peer support group programming pioneered by World Relief (WR) and Food for the Hungry (FH) in the 1990s. In this project, the definition, criteria, and terminology set out by WR and FH are used when referring to CGs. The approach is defined as follows:

> *A Care Group is a group of 10-15 volunteer, community-based health educators who regularly meet together with project staff for training and supervision. They are different from typical mother's groups in that each volunteer is responsible for regularly visiting 10-15 of her neighbors, sharing what she has learned and facilitating behavior change at the household level. Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication. They also provide the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits.[7]*

The CG model has proven to be extremely effective and cost-efficient in reducing child mortality and morbidity in

food security programming[8]. For this reason, it is important that a program adhere to certain essential criteria for it to be considered a CG, though there is no way of enforcing the use of these criteria. The criteria have been outlined by World Relief and Food for the Hungry[9] (see below). The "required" criteria refer to the characteristics that differentiate this model from other types of peer support groups and are outlined below:

CARE GROUP CRITERIA (DEVELOPMENT MODEL)**:**

1. **Care Group Volunteer Selection:** CGVs should be elected by mothers within the group of households they will serve or by the leadership in the village, rather than appointed by program staff.
2. **Care Group Volunteer Workload:** The workload of each CGV is limited to no more than 15 households, as opposed to the 30+ found in traditional CHW approaches, in order to fit in with CGVs' available time and to require the use of fewer financial incentives.
3. **Care Group Size:** The size of CGs, in which CGVs are trained, is between 6 and 16 CGVs to allow for participatory learning. Attendance is monitored, as low attendance rates at CG meetings is a sign that something is wrong and the organization should identify potential problems.
4. **Frequency of Contact:** CGV contact with assigned beneficiary mothers and CG meeting frequency is at least once a month (preferably twice a month) and is monitored, in order to establish trust and rapport.

Photo: International Medical Corps, Ethiopia

Meeting frequency also correlates with behavior change.

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7   Care Groups Info. Definition and Criteria. http://caregroups.info/?page_id=35.

8   Care Groups Info. http://caregroups.info.
9   Davis TP, Wetzel C. Establishing Care Group Criteria. Washington, DC. 30 May 2009.

5. **Coverage:** Coverage is monitored. The plan is to reach 100% of households in the targeted group at least once monthly and the project achieves a minimum of 80% monthly coverage of targeted households. This is important as behavior change is more likely when contact is regular and when many mothers adopt the promoted practices.

6. **Vital Data:** CGVs collect data on pregnancies, births, and deaths during meetings with beneficiary mothers, so that CG beneficiaries can discuss the data and draw connections between the CG project and events in the community.

7. **Target Behaviors:** The majority of what is promoted through CGs is directed towards reduction of mortality and malnutrition – this criterion was established for advocacy purposes, in order to establish the effectiveness of CGs in reducing child and maternal mortality, morbidity and malnutrition. The structure of CGs can then be adapted for other settings and topics with a different name.

8. **Teaching Tools:** CGVs use visual teaching tools, such as flipcharts, when conducting health promotion at the Care Groups Info. http://caregroups.info. Household level.

9. **Participatory Methods of Social Behavior Change (SBC):** These are used with CGVs and by CGVs in community, as they are proven to be more effective than more formal methods when teaching adults.

10. **Instructional Time:** CG meeting time is limited to 1-2 hours, to respect CGVs' time and to limit requests for financial compensation.

11. **Supervision:** Supervision of Promoters and at least one CGV (data collection, observation of skills) occurs at least monthly, to receive feedback and support.

12. **Distance:** All beneficiaries live within a distance that facilitates frequent home visitation by their CGV. This is to facilitate household visits and to increase the likelihood that the CGV has a prior relationship with the people she is serving. All CGVs should also live less than an hour walk from the location of CG training meetings with the Promoter.

13. **Program Culture:** The program culture should convey respect for the beneficiaries and CGVs, especially women, as an important part of the model is fostering the empowerment of women.

Other suggested criteria are 1) the use of formative research, especially on the behaviors promoted; 2) regular measurement of result-level indicators, to determine what is changing and what is not; 3) a Promoter to CG ratio of no more than 1 to 9; and 4) that the social and educational differences between Promoters and CGVs not be too extreme.[10]

The structure of the CG model involves various roles and a cascading flow of messaging on targeted behaviors from top to bottom, as illustrated in the figure below

(Care Groups, A Training Manual for Program Design and Implementation[11]):

Figure 1. Care Group Structure (from "Care Groups, A Training Manual for Program Design and Implementation"[12])

Care Group Structure
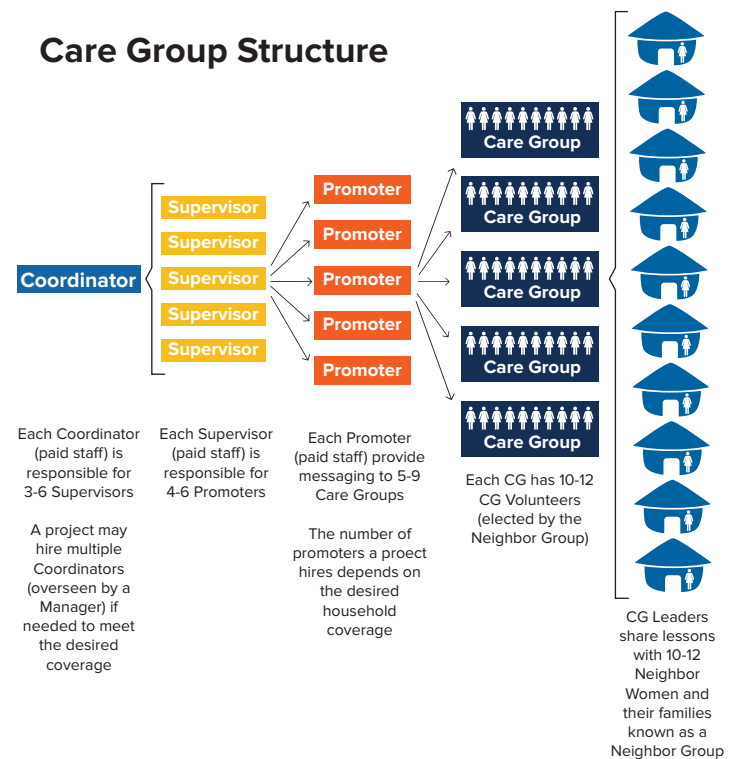
Coordinators are usually NGO staff, who train Supervisors, who are also paid staff. On a bi-monthly basis, Promoters are trained by Supervisors on targeted behaviors and are usually given some form of remuneration. During the same two-week period, Promoters teach the lesson to CGVs in their respective CGs, and CGVs disseminate the information to their Neighbor Group of women through household visits and group meetings.

The structure works in the opposite direction for data collection, where CGVs report group attendance, coverage of households and vital data to Promoters, who in turn report to Supervisors.

The target population, or beneficiaries, of CGs are usually women of reproductive age and mothers/caregivers with children under five years of age.

Cascade Groups: The structure of the CG model is also used for behavior change related to topics beyond nutrition and hygiene, including other health, or non-health related subject, such as agriculture. Where the cascading and multiplying structure of the CGs model is used for purposes

10   Davis TP, Wetzel C. Establishing Care Group Criteria. Washington, DC. 30 May 2009.

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

12   Hanold M, Wetzel C, Davis T, et al. Care Groups: A Training Manual for Program Design and Implementation. Washington, DC: Technical and Operational Performance Support Program. 2014. http://www.fsnnetwork.org/care-groups-training-manual-program-design-and-implementation

other than reducing maternal and child mortality, morbidity and malnutrition, the term "Cascade Groups" is used to distinguish the model from CGs[13].

Mother-to-Mother Support Groups: Other types of peer support groups reviewed in this project were mother-to-mother support groups (MtMSGs). These models involved meetings amongst mothers to receive support and discuss topics such as exclusive breastfeeding, but did not include the cascading and multiplying structure of CGs, or the use the essential CG criteria. The Infant and Young Child Nutrition (IYCN) Project defines MtMSGs as follows:

> Mother-to-mother support groups are groups of women, of any age, who come together to learn about and discuss issues of infant and young child nutrition. These women also support each other as they care for children ages 0–5 years. One member of each group will be trained on IYCN, as well as on basic group facilitation techniques. This person will be responsible for engaging group members in discussion about IYCN and providing basic health education in an interactive, participatory manner[14].

EMERGENCIES

The term "emergency" used in this project refers to a humanitarian emergency. Emergencies are diverse in nature and complex in their characteristics. For the purposes of this project, emergency contexts have been classified across three dimensions: emergency type, stage, and setting. It is recognized that the framework used in this report is not comprehensive of all emergency contexts and characteristics. Rather, it reflects the ones most commonly found in the implementation of peer support group models.

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

Emergency stage is an important distinguishing factor amongst the contexts examined in this project. It refers to the nature of an emergency's onset and its current phase in relation to its onset. Three main stages have been identified in this project: acute, protracted, and transitional. An **acute** emergency stage is the one immediately following the onset of a catastrophic event. An example of the acute stage would be the situation brought on by a natural

disaster[15] such as a typhoon, earthquake, or tsunami[16]. A **protracted** emergency, on the other hand, is one resulting from an emergency state that has developed over time, whether because the situation following a catastrophic event has not been resolved, or because the onset of the emergency occurred gradually. Common examples of protracted emergencies are droughts or long-standing civil, religious, or ethnic conflicts. Finally, an emergency is in a **transitional** stage when it is moving from a development setting to an emergency setting or vice-versa. From a programming standpoint, this can occur, for example, when a development program has been in place and a sudden emergency situation develops. In this case, the programming may shift from development into emergency response. This has been the case, for example, for the 2014 Ebola outbreak in West Africa, where certain established development programs transitioned to respond to the needs that emerged from the epidemic. On the other end, programs that were established as emergency response, may transition into development programming when the emergency begins to stabilize.

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

II. METHODS

A. LITERATURE REVIEW

Sixty documents were found and reviewed overall (Annex D, Bibliography). Initially, Google Scholar, PubMed, and Medline were searched for articles relevant to the use of CGs and peer support groups in emergency settings. The search terms used were: "Care Groups" OR "peer support groups" OR "mother to mother support groups" AND "humanitarian emergency" OR "emergency" OR "emergencies" OR "relief". No relevant peer-reviewed articles were found. The search was then extended to other Internet search engines, such as Google, and relevant websites, such as Caregroup.info. The majority of the material yielded by the search was grey literature, such as organization documents and reports.

Thirty documents on the use of CGs and peer support groups in emergencies across 8 countries were found and reviewed (Annex D) both through searches and by contacting relevant staff in the NGO community. The

13   Care Groups Info. http://caregroups.info
14   PCI Global, USAID, PATH, IYCN. Mother-to-Mother Support Groups: Trainer's Manual. http://www.pciglobal.org/downloads/M2MSupportGroupManual.pdf

15   OCHA. Occasional Policy Briefing Series, Brief No. 6: OCHA and slow-onset emergencies. April 2011. http://reliefweb.int/sites/reliefweb.int/files/resources/report_36.pdf
16   World Health Organization. SAGE Working Group on Vaccination in Humanitarian Emergencies: Vaccination in Acute Humanitarian Emergencies: a Framework for Decision-Making. Geneva: 23 October 2013. http://apps.who.int/iris/bitstream/10665/92462/1/WHO_IVB_13.07_eng.pdf?ua=1

majority of the documents were program proposals, reports, or monitoring data, from organizations implementing the CG approach in emergency settings. Although documents relating to the use of CGs in development settings were reviewed and used as background information, they were excluded for use in the findings.

The program documents reviewed that related to the use of CGs and peer support groups in emergency settings, however, did not provide the details on methodology and specific components of the CG approach sought by the researchers. The information in the literature was thus used as background and the researchers followed-up by conducting interviews with staff from the reviewed programs to obtain more detailed information. The interviews were conducted via Skype and followed the format used for the rest of the stakeholder interviews (see Interviews section).

B. INTERVIEWS

Interviews were conducted with stakeholders who had knowledge or experience with the use of the CG or peer support group model in an emergency setting. This included implementers, donors and consultants (see Annex E for list of contacts and organizations). A semi-structured interview guide (Annex A) was created and used to facilitate discussion with respondents. The survey tool was used for three types of interviews: 1) Follow-ups to the literature search to fill information gaps in the reviewed reports; 2) Interviews conducted over Skype independent of the literature search; 3) The same interview guide uploaded to Survey Monkey.

The contact list for conducting the interviews was initially created based on contacts from the Caregroup.info (or Care Group Info) website as well as an attendance list from a 2014 CORE Group Care Group meeting[17]. Additionally, a request for information was posted to relevant working groups such as: Care Groups Forward from the Food Security & Nutrition (FSN) Network and the CORE Social and Behavior Change (SBC) Working Group. From there, people were contacted and introduced to the research project. Based on their experience they agreed to be interviewed or referred a colleague who they believed had experience working with CGs in emergency settings, creating a snowball sampling effect. A total of 73 people were contacted for interviews or referrals resulting in 24 interviews via Skype or SM. These interviews spanned 14 countries representing 11 different international NGOs (Annex E).

C. FIELD VISITS

Field visits were conducted to carry out in-depth interviews not only with CG implementers but also with CGVs and beneficiaries. A separate interview guide (Annex B) was created in order to survey CGVs and beneficiaries.

Ethiopia: The consultant traveled to Ethiopia between January 19 and 31, 2015. She visited the International Medical Corps office in Addis Ababa and met with two nutrition staff members and the Monitoring and Evaluation Coordinator, who were overseeing the CG-related nutrition activities in Dollo Ado. The consultant also met with health staff responsible for Food for the Hungry's (FH) CG program in central Ethiopia and with Save the Children's (STC) Health Officer who oversees an MtMSG program in the Bolkolomayo camp in Dollo Ado, Ethiopia.

The consultant spent the majority of her time in Dollo Ado interviewing International Medical Corps staff and CG participants at the Melkadida and Kobe camps. She conducted key informant interviews with: the Dollo Ado International Medical Corps Nutrition Director and Assistant Director and focus groups with: 6 Promoters from the Melkadida camp and 7 from the Kobe camp, 2 Care Group Volunteers from Melkadida and 3 from Kobe, 30 beneficiaries from Melkadida and 15 from Kobe. The consultant was also able to meet with health staff from STC's Bolkolomayo project in Dollo Ado.

Photo: Food for the Hungry – Philippines, Sandra Wilcox

Philippines: The consultant traveled to the Philippines between February 19 and 28, 2015 to visit the CGs operated by FH on Samar Island after Typhoon Haiyan. She met with the Director and the Food for Peace Officer at the International Medical Corps office in Tacloban to learn about a nutrition program that used the CG methodology, which ended in December 2014.

She spent most of the time interviewing staff and CG beneficiaries in the FH program on Samar Island, which was

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

set up in early 2014 after Typhoon Haiyan. She interviewed the Regional Health Officer, the Health Coordinator, 7 Promoters, 12 CGVs and 19 beneficiaries from Basay and Marabut. The interviews with Promoters, CGVs and beneficiaries were conducted in separate focus groups at each location. In Manila, the consultant was also able to interview the FH Relief Director and the Health/Nutrition Program Officer who had originally set up the program in Tacloban/Samar Island. The results of the field visits are discussed in the Findings section of the report along with the data from interviews and literature searches.

D. DATA ANALYSIS

Each interview conducted, including those from the field, was entered into a data table (Annex C). The table collected pertinent project and respondent information, details about the structure of the CG or peer support group, and program lessons such as advantages and challenges of using the model in an emergency setting. The research team utilized the data tables as summaries of the findings and as a tool for analysis by comparing the same information across programs.

E. STAKEHOLDER WORKSHOP

Findings including CG adaptations, benefits and challenges to using the model in emergency settings were presented in a stakeholder workshop in April 2015. Overall recommendations for the type of emergency context most conducive to the use of CGs were also presented. There were 21 in-person participants and 8 online participants involved in breakout groups on topics that required discussion and input from stakeholders after the initial data collection. These topics included: Monitoring & Evaluation; Formative Research; Incentives; Population Mobility; Sustainability and Acute Emergencies. The online community also discussed what it meant for an acute emergency to "stabilize" and how to recognize when the situation is no longer considered an acute emergency. The input from the workshop was then incorporated into the final document. The workshop was recorded and sent to workshop participants and invitees (approximately 130 people).

F. LIMITATIONS

As mentioned in the background, designating a model as a CG versus another peer support model proved difficult, as did defining emergencies. While introducing the research project to potential interviewees, the interviewers explained that the request for information included the traditional CG definition as well as peer support group models using cascade training to meet program objectives. While this strategy allowed for cross-comparison among similar programs, some respondents called their models CGs when they did not fit the cascade training or other criteria.

Similarly, there was some hesitancy among potential interviewees to discuss their use of CGs because it was not in a traditional emergency setting. This often meant that while their program was facing challenges associated with protracted emergencies, such as drought, conflict, etc., they were using development funding (such as a five year child survival grant) and therefore did not consider the CGs to be conducted in an emergency setting. Because of this, there were some missed opportunities to capture development programs facing emergency challenges.

Due to time constraints on the part of the researchers and stakeholders, written surveys were also completed as an alternative to voice Skype interviews. With limited opportunity for follow-up, those who completed online surveys versus a Skype interview often provided less information. Online survey respondents were also more likely to skip questions compared to those who were interviewed by a research team member. While this method reached additional stakeholders, it was not as in-depth as the interviews conducted over Skype. Skype interviews allowed for follow-up questions and clarifications and tended to yield richer details.

Similarly, the written project reports found in the literature review were limited because they were focused on program outcomes rather than the specific effect of the CG model. Since not all reports yielded a follow-up interview, the result was an incomplete picture of how CGs were used in emergency contexts.

III. FINDINGS, LESSONS LEARNED, RECOMMENDATIONS[18]

A. ADAPTATIONS TO THE CARE GROUP MODEL IN EMERGENCY SETTINGS

In the review of CG programs, it was found that some adaptations had been made to CGs to accommodate emergency circumstances. This section discusses the adaptations found during the analysis.

1. CARE GROUP AND BENEFICIARY GROUP SIZE
The recommended CG size is 6-16 CGVs to allow for participatory learning. However, the numbers of CGVs in a CG varied in emergency settings depending on the program size, context and resources. The number of beneficiaries per CGV also tended to differ.

A PCI CG program in Liberia during the Ebola outbreak in

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

2014 was able to continue operating despite a government ban on large meetings, because the CGs were limited to 8-10 CGVs. Conversely, an International Medical Corps CG program in a region affected by a long-term drought in Somalia only had 2 CGVs per Promoter. This was due to population dispersion and the low literacy of the CGVs, who required more individualized attention to understand and practice the behavior change messaging and activities. CG size may also vary due to donor or government requirements. For example, in an International Medical Corps South Sudan program, the CGs consisted of 50 volunteers due to a UNHCR requirement and each CGV was responsible for 50-150 households. In Ethiopia, all organizations with CGs are moving towards the government mandated Health Development Army (HAD) configuration, which requires neighborhood groups of six individuals, one of which is selected to be the leader.

In emergencies, it is also common to have fewer beneficiaries to each CGV. In Dollo Ado camps in Ethiopia, CGVs held group meetings with approximately five beneficiaries rather than conduct individual household visits. Because the CGVs are unpaid, staff felt that it was better not to overload them with household visits. There were also insufficient numbers of mothers in the camps to assign CGVs large numbers of beneficiaries.

Other considerations affecting the ratio of CGVs to beneficiaries included literacy levels. Several respondents pointed out that if literacy levels are low, it is useful for CGVs to spend more time explaining and repeating messages to a smaller number of beneficiaries.

Programs that included beneficiary group meetings found that groups had good retention and often grew with time as new mothers joined. One explanation for this is that in emergency settings, groups become important support networks, particularly in camps, where there is regular influx of new families. In camps, where few people work, group meetings are a welcomed opportunity for social interaction, support, and bonding (International Medical Corps and STC, Dollo Ado, Ethiopia; CARE, Dadaab, Kenya).

2. TARGET POPULATION

The target population (beneficiaries) in the reviewed CG programs usually consisted of PLW and mothers of U2 or U5, depending on context. However, the target population category did expand to serve the particular emergency circumstances. Curamericas program in Liberia targeted the whole community for prevention messages due to the Ebola outbreak. FH's post-earthquake CG programming in Haiti, targeted "affected households", regardless of whether they had children, for WASH SBC. In the Philippines, FH targeted single women and fathers, as they were often caregivers.

Programs also included family members of beneficiary women to adopt new health and nutrition practices. Some CG programs have had success in working with husbands

Photo: International Medical Corps, Ethiopia

and grandmothers and gaining their support. For example, a World Vision International (WVI) program in Uganda established a parallel men's group that taught the same topics as the CGs. GOAL Ethiopia, which has a long-term protracted emergency program, set up complementary men's groups consisting mainly of the CGVs' husbands, to encourage understanding and support of the new behaviors. Adolescent girls were also included as part of the target population (International Medical Corps, Dollo Ado, Ethiopia) in emergency settings where they are vulnerable to pregnancy because of not attending school, rape, or marrying at a young age. In these situations, adolescent girls also often become heads of households and have to care for younger siblings because families are split up. As a result it is important to include them in CGs as primary care takers.

Lessons Learned:
In acute emergency settings, there is a need to address the entire affected population through CGs with life-saving SBC messages.
Recommendations:

a. In acute emergencies, expand target population entire affected population.

b. Adapt SBC messages to address appropriate health behaviors for the target population during the emergency.

3. CARE GROUP VOLUNTEER SELECTION
According to the traditional CG model, CGVs are elected by the beneficiary mothers in the areas where they live (Neighborhood Group). However, due to emergency circumstances, program staff or community leaders sometimes appoint CGVs. In the FH Philippines program, due to the chaos following Typhoon Haiyan, the implementing team did not have the resources to organize neighborhood elections. Instead, Promoters worked with the local community leaders and MoH officials to select CGVs. As a result, most of the CGVs selected were nurses from the government health service. After the emergency situation had stabilized, it was discovered that many of the CGVs did not have time for the volunteer tasks due to their full-time MoH jobs. In addition, some of the neighborhood beneficiary mothers were not happy with the women who had been appointed as CGVs. To remedy the situation, the project decided to "graduate" the appointed CGVs and hold elections in their neighborhood groups for their replacements. In Ugandan refugee camps, program staff was not able to identify enough candidates that modeled correct IYCF behaviors to become CGVs. Therefore, community health workers (CHWs) served as Promoters and educated beneficiary mothers until uptake of behaviors was strong enough that some of the beneficiaries were eligible to become CGVs (WVI, Uganda). In other programs, CGVs were selected by religious or community leaders as was culturally appropriate to ensure the buy-in of the community (International Medical Corps, Nigeria).
In Ethiopia, the Health Development Army, the new community organization structure being implemented by the government, is replacing the current CG model. CGs are used by many organizations in Ethiopia (International Medical Corps, FH, GOAL, STC), particularly in camps. These organizations are discussing how to organize CGs in line with the new HDA structure. One of the areas of concern is how CGVs are selected, as in some areas the HDA leader is male and is appointed by the government.

Lessons Learned:
The aftermath of an acute emergency may be too chaotic to organize elections of CGVs by neighborhood groups.
Recommendations:
When lack of stability in an emergency does not allow for election of CGVs by neighborhood groups, use community leaders or program staff to select interim CGVs based on CG criteria. Once stabilized, evaluate the situation and encourage beneficiaries to conduct elections.

4. MEETING LENGTH
Care Group criteria recommend that group meetings with CGVs last no longer than 2 hours. The meeting limit of 2 hours was a challenge for CRS Sudan, as the Program Manager indicated: " We tried to stick as closely as possible to the concept that each [CG] meeting should only be 2 hours long…. That's not possible".

Meeting length for engaging beneficiaries is not specified in the CG criteria. According to the site visits and most interviews, household visits by CGVs usually lasted between 30 minutes to two hours. Programs did not want to overtax either CGVs or beneficiaries and their families. However, it was indicated that because the visits were with neighbors and people often wanted to socialize as well as impart and receive information, many times the visits lasted longer. Sometimes CGVs spent more time explaining the lessons because of low literacy.

The FH Training Coordinator in the Philippines CG program and Program Officer for FH CG program set-up after the Haiti Earthquake, noted that in the period right after an acute emergency, it is usually necessary to spend more time in household visits to provide emotional support for the psychological trauma suffered by families during the disaster.

Lessons Learned:
In emergencies, it may be necessary for meetings with beneficiaries to last more than two hours, as the trauma suffered during the emergency may slow down learning and require psychosocial support.
Recommendations:
Keep meeting length flexible depending on needs, spending longer time if it is beneficial for psychosocial support and getting messages across effectively.

5. TOPICS COVERED
In emergencies, there is limited time to write new curricula and programs tended to follow modules presented in flip

charts that were previously developed by the organization or government.

Topics traditionally covered in the CG development curricula include essential nutrition actions (ENA), such as exclusive breastfeeding and complementary feeding, as well as essential hygiene actions, such as hand washing.

In the Philippines, an Acute Respiratory Infections module was added after a review of vital statistics showed it to be a major cause of child morbidity and mortality. In DRC, topics included gender-based-violence and psychosocial support (DRC, WVI). A family planning module was also added in the FH Philippines project after conducting a Barrier Analysis to determine the most appropriate way to introduce it. In Haiti, a module on values was tested, a theme that was seen as beneficial in the post-earthquake chaos, where people were dealing with loss of structure and livelihood (FH). The module received very positive feedback from participants, who stated that everyone in the country should have had this discussion about values such as honesty. In Liberia, CGVs were trained on how to protect their health while continuing their household visits during the Ebola outbreak including proper hand washing and strictly adhering to a "no touch" policy (PCI). In addition to ENA and WASH, interviewees reported sessions addressing the following topics:

- Community Integrated Management of Childhood Illness
- Pneumonia
- Reproductive health
- Early childhood development
- Gender Based Violence
- Psychosocial support

Lessons Learned:

The topics covered in CGs in emergency settings must reflect priority behavior change actions relevant to the specific emergency.

Recommendations:

a. Use rapid assessment tools, formative research and available data to identify additional topics relevant to the target population and emergency context.

b. Adapt instruction to address relevant health behaviors during the emergency. For acute emergencies, curriculum should focus on immediate and life-saving benefits of promoted behavior - such as hand washing or exclusive breastfeeding. For protracted emergencies, curriculum can focus on longer-term benefits of promoted behavior such as optimal child growth.

c. Train volunteers on how to protect their own health while conducting household visits during an epidemic.

6. MONITORING AND EVALUATION

Care Group criteria recommend collection of CG attendance as well as vital events data such as births, deaths and pregnancies. When asked about data collection, some respondents indicated that due to instability and short-term funding during an emergency, it is difficult to set up monitoring systems. Additionally, most emergency donors do not require this information.

The majority of the programs interviewed indicated that they only collected attendance data at the CG sessions and recorded the number of home visits made each period. This information was passed from the CGVs to the Promoters and entered in the Supervisor's monthly reports.

International Medical Corps Ethiopia, South Sudan, Yemen, Nigeria, and FH Philippines, recorded additional vital events. In some protracted emergencies where the situation is more stable, it was possible for the CGVs to conduct nutrition monitoring such as MUAC (middle upper arm circumference) screening (International Medical Corps, Nigeria and CAR), children receiving Vitamin A and de-wormers (International Medical Corps, South Sudan) and referrals to local health clinics. Monitoring data was usually checked on a recording form, which in some cases was adapted for literacy through pictorial symbols (International Medical Corps, South Sudan). However, some CGVs did report details to the Promoters orally. In Liberia, CGVs were the first to report growth faltering and a resurgence of malaria among their assigned households due to the upheaval of the health system during the Ebola outbreak (PCI, Liberia).

Lessons Learned:

1. Data collection may not be a priority concern in emergency programming.

2. CGVs' literacy levels may be a challenge for data collection.

Recommendations:

a. Collect monitoring data that is relevant to the emergency circumstances such as child growth measurements (e.g. MUAC), household needs and disease burden.

b. Provide training and monitoring tools that are appropriate for literacy levels of the CGVs.

7. FORMATIVE RESEARCH
Formative research on key behaviors is a recommended Care Group criterion. However, many of the projects examined did not conduct formative research. They indicated that because of emergency circumstances they did not have time or funding to do research and instead made decisions based on previous emergency experience about what information beneficiaries needed immediately, usually WASH and/or nutrition.

The programs that did conduct research were usually

ones that had been in place for several months and some, such as FH Philippines, aimed to transition to development status. These programs often conducted Barrier Analysis to better understand the obstacles to changing behaviors and inform future modules. Interviewees believed that conducting research with the separate doer/non-doer aspect of the Barrier Analysis was more useful than just having focus groups with both audiences combined.

The FH program in Haiti conducted a Barrier Analysis seven months post-earthquake and at the time of the cholera

Photo: International Medical Corps, Ethiopia

outbreak to understand obstacles to hand washing with soap and purifying water. Several other programs including GOAL Sudan, FH Philippines, CRS Sudan and GOAL Ethiopia conducted barrier analyses to address obstacles to behavior change and guide messaging. Most of these were conducted in protracted emergency settings.

When Barrier Analysis was conducted in emergency settings where the population is mobile, such as in Somalia, the program claimed to not be able to do much with the results due to lack of funding.

Although formative research does improve programming and guide topics, it is often difficult to do during an emergency, given immediate relief priorities, short-term funding, movement of people, and general crisis conditions, where staff are more concerned about beneficiary survival than contributing to research. Most of the programs cited waited until the emergency had stabilized and the CGs had been in place for several months before trying to do formative research. In the FH Haiti case mentioned above, FH development staff took on this task seven months post-earthquake.

Lessons Learned:

1. Formative research, such as Barrier Analysis, is instrumental for determining curriculum topics and ensuring that the approach to SBC is appropriate to the context.

2. At the beginning of an acute emergency, time constraints and funding may limit the ability to conduct formal analyses for formative research.

Recommendations:

a. Conduct Barrier Analysis to identify obstacles to behavior change once an emergency situation has stabilized. If relief staff is engaged in other activities during the acute emergency stage, ask development staff to conduct the research.

b. Ensure formative research is conducted by considering less formal methods than Barrier Analysis i.e. focus groups, windshield surveys or mixed methods. Review of secondary literature and greater collaboration with other organizations working in the response.

8. MINISTRY OF HEALTH
While Care Group criteria do not include collaboration with the MoH, there is an adaptation in the development model called the "integrated Care Group" model, which uses MoH staff as Promoters. Programs in Ethiopia and Liberia used this adaptation and the MoH provided training for CGVs and Promoters. MoH had varying levels of involvement with CG programming in the programs reviewed. In the DRC, Liberia, and Uganda, the MoH facilitated training for program staff. In Somalia, the MoH took part in the sensitization sessions and were involved in organizing and facilitating training of the CGVs (International Medical Corps, Somalia). Sometimes the MoH provided materials that were duplicated and then used by the CG programs. This allowed for health/ nutrition messaging to be consistent among CG beneficiaries who also received MoH services. "Having a unified message between IYCF and health providers is very important" (Program Manager, STC Jordan). In addition, the MoH used the CG structure in South Sudan and Liberia to quickly disseminate information regarding cholera, vaccination campaigns, and Ebola.

Other programs, however, were not able to rely on government support due to the disruptions caused by emergencies. The International Medical Corps program in CAR stated that government presence was non-existent because of security problems. Furthermore, governments may not have the capacity to be immediately involved in CG activities during an acute emergency, as they must focus on other activities, such as restoring facilities. Because of the chaos created by the emergency "you have to move forward without them [government] and then start coordinating with them once they get back on track." (Program Officer, FH Haiti)

Lessons Learned:

Involvement of the MoH with CG programming is important to ensure consistency of messaging and for program sustainability after the program has ended.

Recommendations:

a. When government is disrupted or disabled due to an emergency, begin program implementation and coordinate with government once it is functional again.

b. Coordinate materials and health messages with MoH administration and providers to ensure consistency of messages.

c. Coordinate trainings with MoH staff to facilitate sustainability and transitioning at the end of the program.

B. BENEFITS OF USING CARE GROUPS IN EMERGENCY SETTINGS

When used in emergency settings, the Care Group model offered the same benefits documented in development settings as well as some additional benefits specific to the emergency context. These benefits emerged from interviews and workshops with stakeholders.

1. DOCUMENTED EFFECTIVENESS
One of the rationales cited by the organizations interviewed for choosing to implement CGs in the specified emergency setting was that the model had been used previously by the organizations and found to be effective for behavior change.

Project Concern International used Care Groups already in place in Liberia to address the Ebola crisis. Similarly, Curamericas enlisted the help of previous Care Group Volunteers from a successful program closed out in 2013 to once again implement Care Groups in Sierra Leone to aid the Ebola-affected communities.

2. LARGE COVERAGE
While the Care Group model program costs are low, it also permits broad coverage of beneficiaries by messaging through its extensive cascade structure. In emergencies, this benefit was found to be particularly apparent in camp settings, where the population is dense and living in close proximity. One of the respondents, a Nutrition Manager running the CG program in a camp in South Sudan, expressed that the CG model provided the largest coverage of beneficiaries he had ever seen as a nutritionist, where 100% of the target households were being reached with messages and screened for nutritional status by CGVs monthly. The nutritionists at the International Medical Corps camp in Dollo Ado made similar comments. Respondents who had worked with an MtMSG program in the Dadaab refugee camps in Kenya also felt that the expansion of the support groups was organic in this setting because of the population density and the mothers desire for support and companionship with other mothers (CARE).

3. COST EFFECTIVENESS
Cost effectiveness is a Care Group model benefit in all settings including emergencies. The model permits wide coverage of target populations at low cost. The only staff costs to the program are for the program management and the Promoters/ Supervisors. Usually the CGVs are unpaid or given small incentives. Many of the interviewees quoted cost effectiveness as an advantage of this model compared to others.

4. RAPID DISSEMINATION OF INFORMATION
The cascading and multiplying flow of information from staff down to Care Group Volunteers and beneficiaries also allows messages to be disseminated rapidly to a large number of people. This is particularly advantageous in emergency settings, where there is a need to reach people quickly with key life-saving messages. In Sierra Leone, CGs proved far more efficient in spreading health messages about Ebola than neighboring communities that did not have the Care Groups. As a Team Leader expressed: "In some other districts that do not have the CG, they have hard time to mobilize the communities and get the message about the screening out but for us its just passing it on to the Lead Mother and within a week or two it will reach to all households we want to reach" (International Medical Corps, Sierra Leone). Similarly, in Haiti, there was anecdotal evidence that very few people died from cholera in the communities targeted with CGs compared to neighboring communities. (Food for the Hungry)

5. RAPID BEHAVIOR CHANGE
Care Groups can bring about rapid behavior change in emergency settings where the targeted behaviors are easy to adopt and show immediate life-saving effects. Community behavior change occurs more rapidly in emergency relief settings than would occur in development settings[19]. People are upended from their usual support systems and trying to survive, so they are much more open to making changes in their behavior that will foster survival. People are also more likely to be influenced by what others are doing when making their own decisions[20]. CGs provide an excellent structure and support system to help individuals manage the crisis. In post-earthquake Haiti, significant improvements in hand washing with soap, households drinking uncontaminated water, and children suffering from diarrhea were reported after only nine months of program implementation (FH, Haiti). It was also observed that there were fewer deaths from cholera in the area targeted by the program, although no formal data was collected on this factor. CGVs working in Liberia during the Ebola outbreak were trained on hand washing and "no touch" policies so they could continue household visits during the outbreak. Although Ebola cases had been confirmed in the same counties, anecdotal evidence found that none of the CGVs had been infected despite the fact that they were continuing to make household visits (PCI, Liberia).

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19   Bagrow, James P, Wang Dashun, Barabasi Albert Laszlo. "Collective Response of Human Populations to Large-Scale Emergencies". DOI: 10.1371/journal.pone.0017680. March 30, 2011.
20   Bagrow, James P, Wang Dashun, Barabasi Albert Laszlo. "Collective Response of Human Populations to Large-Scale Emergencies". DOI: 10.1371/journal.pone.0017680. March 30, 2011.

6. PEER SUPPORT

The peer-to-peer aspect of messaging in the Care Group model is a benefit in any setting, as learning from neighbors is shown to be more effective in promoting adoption of behaviors than leaning from strangers[21]. Several interviewees reflected on this:

> "It is very convincing for mothers to learn from peers in their own context" (Program Manager, GOAL Ethiopia).
> "Behavior change is always best if the target feels that they are doing something that has been tried by others and has proven to work well" (Nutritionist, ACF Sudan).

The disruptions to social bonds caused by emergencies make this benefit even more important. One respondent cited evidence[22] that "social capital is the most important factor in the speed and level of recovery of communities and households after a disaster" (Program Officer, FH Haiti) and that the CG model promoted social bonding and cohesion in acute emergencies. Neighbors visit existing neighbors but there is also an opportunity for new bonds to form in contexts where people have been displaced. In camp settings, the CGs help bring together women from different ethnic, religious and country backgrounds and fosters community and bonding. One respondent felt that the presence of MtMSGs reduced isolation and helped form a social structure. It brought women together that were sharing the same living space but were still isolated because they lacked immediate family members or because they were from different ethnic or religious backgrounds (CARE, Dadaab, Kenya; International Medical Corps, Dollo Ado, Ethiopia). Another respondent from International Medical Corps CAR noted that in emergencies, when mothers are under stress, CGVs are the ones providing counseling in the community. Peer support groups provide a space where participants can share experiences, information and support each other.

7. TRUSTED CHANNEL OF COMMUNICATION

The Care Group system provides a community structure that can be leveraged for additional purposes during both acute and protracted emergencies. For example, in acute emergency settings such as the earthquake in Haiti, the CG network was used to spread news and messages about the availability of services, to announce opportunities, to mobilize the community for collective work, or to identify people in need (FH, Haiti). In the International Medical Corps CAR program, during a protracted emergency, the CG structure was used in periods of severe food shortages, as program staff left food stocks with CGVs, who were trained and trusted by the communities. In other instances, the CGs were used to spread information about vaccination campaigns, cholera prevention and Ebola control activities (International Medical Corps South Sudan/Sierra Leone).

21 Burns, S.M. (1991). Social Psychology and the Stimulation of Recycling Behaviors: The Block Leader Approach. Journal of Applied Social Psychology, 21, 611-629.
22 Aldrich, Daniel. Findings. http://www.youtube.com/watch?v=tx4Ii5tueDo.

8. SYSTEM FOR MONITORING, SCREENING AND REFERRALS

The Care Group model can provide an effective and wide reaching system for data collection, screening and referrals for communities. The traditional CG model supports the regular collection and reporting of vital events data on pregnancies, births, and deaths in the community by CGVs. Some of the CG programs reviewed also trained CGVs to screen for malnutrition, illness, and to make referrals to clinics and antenatal programs. Because of the broad coverage permitted by the CG model, data collection, screening, and referrals can be conducted efficiently and at low cost. In emergencies, this may be the only system for data collection and screening available, as other methods may be interrupted. In Liberia, CGVs proved to be essential for general health screening during the Ebola outbreak as they discovered that malaria control and growth monitoring were lagging behind (PCI, Liberia). Health issues had fallen under the radar during the epidemic: "[W]e started to see and hear from our Lead Mothers there's more malaria, the kids are growth faltering the women are not going to ANC visits. We were able to use our Lead Mothers to establish linkages between the health system and the community" (Program Officer, PCI Liberia).

Lessons Learned:

The Care Group model can provide an effective and wide-reaching system for data collection, screening and referrals through CGVs. This is especially important during an emergency, when health workers and other systems may not be available.

Recommendations:

During an epidemic, train volunteers to teach beneficiary mothers how to monitor their own children for malnutrition and suspected disease.

9. SUSTAINABILITY

Several respondents identified sustainability as the rationale for choosing the Care Group model. This may have resulted from their own experience or the documentation that behaviors continued after the program ended. A Program Officer for PCI Liberia expressed this: "[W]e see it [Care Groups] as having the most sustainable lasting change and because you're building this cadre of community leaders that are knowledgeable we find that they stay with the Care Group well after the program leaves or after they would no longer be eligible" (Program Officer, PCI, Liberia).

The CG structure was also considered sustainable because CGVs remain points of reference for the community long after relief programming and staff have moved on (International Medical Corps, CAR). In refugee camps in Jordan, staff found that over time volunteers became more knowledgeable and become role models for the rest of the community: "After 3-4 years you'll find there will be many mothers who are trained on this and can provide support on [nutrition and hygiene messages]" (Program Manager,

STC, Jordan).

CGs that are set up in acute emergency settings also have the potential for continuing as communities transition out of emergency and into longer-term programming. The CG model was chosen by FH in the Philippines after typhoon Haiyan because the organization planned to continue working in the emergency area as it transitioned back to development status. FH believed the CG model would be useful as a transition mechanism.

C. CHALLENGES OF USING CARE GROUPS IN EMERGENCY SETTINGS

Below is a discussion of the major challenges that were found in reviewing Care Groups implemented during emergency situations.

1. INITIAL SET-UP OF CARE GROUPS
The initial Care Group setup is an important consideration when determining feasibility of the model in an emergency. There are three factors that can influence this set-up: 1) length of funding cycle and program 2) phase of the emergency and 3) staff capacity.

In acute emergencies, emergency donors usually provide program funding for short-term interventions, ranging from 3 months to one year in length. CGs are a development model that is designed to be in place over a substantial period of time (usually 5 years), to allow participants to internalize and adopt new behaviors. The time constraint of short emergency funding cycles presents challenges to the set-up of a CG program, which involves organizing communities into Neighborhood Groups, holding neighborhood elections of CGVs, developing appropriate educational materials, such as flip charts, and training Promoters and CGVs. In Haiti, FH's development staff set up the CG program over 2 months and achieved behavior changes in hygiene and sanitation practices within 9 months. The CG program set up in the Philippines after Typhoon Haiyan, however, faced challenges, as emergency funding targets expected the program to be set-up within three months. In reality, it took the organization 6 months to get CGs set up. Given that CGs typically take anywhere from two to nine months to set up, the CG model may not be an ideal fit for acute emergency contexts, unless a CG structure was previously in place. Unless there is a plan for continued programming and funding, it is unlikely that the CGs will have enough time to become established and accomplish significant behavior change in the short cycles of emergency funding.

The phase of the emergency is another factor to be considered in the set-up of CGs. The immediate aftermath of acute emergencies, such as natural disasters, is chaotic and conditions are not amenable to the immediate set-up of CGs. Part of the challenge faced by FH in the set-up of CGs in the Philippines was the fact that it competed with other pressing relief priorities, which may have contributed

to falling short of targets of having modules rolled out within 3 months. In contrast to this, in the acute emergency in Haiti, CGs were not set up until several months after the earthquake, in a phase where emergency conditions were more "stabilized".

Lastly, staff capacity can affect the set-up of CGs. During an acute emergency, beneficiaries and relief staff are generally focused on basic needs, such as food, water, and shelter. Setting up CGs is labor intensive and requires significant staff time. In the Philippines, relief staff was tasked with organizing the community into CGs in addition to addressing other immediate needs. In contrast, development staff set up CGs in post-earthquake Haiti, thus allowing relief staff to focus on other immediate priorities.

Lesson Learned:

Successful set-up of CGs in an acute emergency is dependent on funding cycle, phase of the emergency and staff capacity.

Recommendations:

a. Begin CGs after the acute phase of the emergency has "stabilized". (See *Recommendation for Further Research: Stabilized Emergency below*)

b. Assign development staff to set up CGs in acute emergencies.

2. DEVELOPMENT OF PROGRAM MATERIALS
Development of program materials can be a challenge in both acute and protracted emergencies. During an emergency, considerable short-term funding is available and organizations may make rapid plans for program development and implementation. However, without the necessary considerations, this can lead to development of tools and materials that are not appropriate or do not match the needs of the target population.

Most programs interviewed used flip charts as visual tools for educating CGVs and beneficiaries. Some organizations also used counseling cards. Flip charts were either adapted from another country or organization or provided by the MoH. In an emergency, it can be difficult to procure materials quickly. Even organizations that have developed materials ahead of time still must develop budgets, adapt (design changes, pre-test materials, messages) and print materials in a short period of time to address the emergency. During the Ebola outbreak, several INGOs created a task force to develop appropriate messaging for an Ebola CG curriculum (Program Officer, PCI, Liberia).

According to field visits and interviews, the respondents indicated that simple or no language and large pictures made the most useful flip charts. This was because of the low literacy levels and different languages or dialects spoken by the CGVs and beneficiaries, particularly in camps. Often because of the emergency context, programs had to use

pre-existing materials and did not have time to adapt them. In this case, the best design included large pictures on the front side of the flip-chart with simple messages on the back. Promoters, who usually have higher literacy levels and speak local languages, with this could train CGVs using the messages on the flip-chart and adapt them to the local context and/or skip or change irrelevant information. CGVs could then relay the messages to beneficiaries by studying the pictures. Several projects (International Medical Corps Ethiopia, STC Ethiopia, FH Philippines) noted that the CGVs often relied on their children to read the key messages and practiced them at home before giving their sessions.

Despite the limited resources and time constraints of an emergency, it is important to provide tools appropriate to the context to ensure the validity of materials. This was an issue with several of the programs interviewed. In the International Medical Corps and STC's programs in the Dollo Ado camps in Ethiopia, because of the emergency and the urgent need for materials, the project used flip-charts in local language, which had been developed by government nutrition programs but had not been field tested in camps. The flip charts showed fruits, vegetables and meats as weaning foods, which were not readily available to mothers in camps. In interviews with mothers, when asked what they had learned from the sessions they never mentioned weaning foods or young child feeding for this reason, even though these topics had been taught. This was also true in Somalia, where foods depicted in flip charts were not available due to drought conditions and crop failures (International Medical Corps, Somalia). In the Philippines, the promotion of tippy taps was hindered by the limited available of the necessary materials. (Food for the Hungry)

Lessons Learned:

1. It takes time and resources to adapt appropriate visual tools, which can affect implementation in an acute emergency.

2. Materials adapted from NGO or government development programs may not reflect the resources available during an emergency. Nutritious foods or WASH materials may not be available in the relief setting.

Recommendations:

a. Ensure that sufficient funding is included in the emergency response budget for production of material including designing, translating, printing and pre-testing.

b. Prepare in advance generic emergency visual tools and basic modules, such as WASH, that are appropriate to the countries you work in and have them ready for emergency use.

c. Pre-test visual tools and products to ensure that they represent resources and materials available to the target population.

d. When using existing materials from another program during an emergency, train Promoters on how to adapt messages and select context-appropriate pictures for training/educating CGVs.

e. Train Promoters on behavior change activities that utilize participatory methods such as songs and skits rather than rely on visual tools.

3. Community Sensitization

Many of the programs interviewed found that traditional beliefs and attitudes of husbands, mothers-in-law or community leaders could be a barrier to the success of Care Group programming if they were not supportive of the activities. For this reason, community buy-in, especially from decision makers within the family and community, was found to be essential to successful implementation. This challenge was most commonly mentioned in protracted emergency settings, where women, rather than community members generally, were the target population of CGs.
In the camp settings in Ethiopia, it was found that people entering the camps often held traditional beliefs that conflicted with the Care Group SBC messages. The program addressed these issues by having CGVs meet with the whole family during household visits and they were usually able to convince families to adopt new behaviors. Project staff thought this was because people were more open to adopting new behaviors in a camp setting. (International Medical Corps and STC, Ethiopia). Such willingness to adopt new behaviors in an emergency context were also documented in post-earthquake Haiti. (Food for the Hungry)

Lessons Learned:

1. It is essential to have buy-in of household, community, and religious leaders for program success.

2. During the acute stage of an emergency, community sensitization can be challenging due to other competing priorities.

Recommendations:

a. Plan and budget for community sensitization activities to get buy-in of decision makers.

b. Include community sensitization activities in CG implementation timeline/ work plan.

c. Train CGVs on how to include family members (men, grandmothers, etc.) in SBC during household visits.

4. FINDING QUALIFIED PROGRAM STAFF AND VOLUNTEERS
In protracted emergencies, many respondents reported difficulty in finding qualified and appropriate Promoters and CGVs especially women, due to literacy, language or lack of incentives.

Low literacy among women in many target populations can prove challenging for recruiting Promoters. For example, in Sudan, program staff planned to have 80-100% women as Promoters. However, because the majority of women could not read, men were mostly employed to fill the position. Additionally, low literacy of CGVs can prove to be a challenge in collecting monitoring data. "Our record keeping is something we all acknowledge will be quite difficult with the literacy rates" (Program Manager, CRS Sudan).

Having mostly male Promoters is a lost opportunity for women's empowerment, one of the criteria for CGs[23], and can also affect their ability to discuss sensitive topics. As staff in Ethiopia pointed out, it is often easier for women to facilitate discussion with other women regarding certain topics such as breastfeeding (GOAL Ethiopia).

In camp settings, where many languages are spoken, finding Promoters that speak the local and national language can be challenging. In the refugee camps in Ethiopia, this was cited as one of the reasons more men were selected to fill this role (International Medical Corps, Dollo Ado, Ethiopia).

Lastly, several programs cited difficulty in finding sufficient numbers of volunteers. In Uganda, WVI staff found it difficult to find enough mothers modeling healthy behaviors and instead used community health workers until beneficiaries began behavior uptake. Other programs found it difficult to recruit volunteers due to expectation of incentives. Insufficient volunteers affects the ability of the program to provide 100% coverage of the target population, which is one of the major advantages of CGs.

Lessons Learned:

It is often difficult to recruit qualified Promoters and CGVs due to literacy, language, and lack of incentives.

Recommendations:

a.   Adapt monitoring and visual tools for low literacy of Promoters.

b.   Provide training to Promoters on how to encourage women to take leadership roles and how to work with more reserved women.

5. KNOWLEDGE OF CARE GROUP METHODOLOGY

Another staffing challenge is ensuring senior level program staff is thoroughly trained in the CG methodology. While most programs interviewed did provide some kind of regular refresher training for CGVs and Promoters, this was not the case for senior program managers. One staff member in CAR stated that it would be useful to do a complete training on the CG model for 2-3 staff members in each country team and then cascade it down to make implementation easier (International Medical Corps, CAR).

23   Davis TP, Wetzel C. Establishing Care Group Criteria. Washington, DC. 30 May 2009.

Photo: International Medical Corps, Burundi

In the International Medical Corps camp in Dollo Ado Ethiopia, the senior nutritionist had not had the CG training and indicated it was an issue for managing the program, as he did not understand all the requirements. In acute emergencies, there may not be time to train staff before implementing the program. In protracted emergencies where program cycles may be five years, staff turnover can result in senior management who have not had CG training.

Lessons Learned:

1.   Staff running CG programs often have inadequate knowledge/experience with the CG methodology.

2.   In protracted emergencies, there is often a high turnover of staff.

Recommendations:

a.   Ensure that higher-level staff, such as Supervisors and Coordinators are trained in CG methodology.

b.   Develop a rapid CG training program for staff and/or have staff attend a CG training program provided by the organization.

c.   In protracted emergencies, offer annual refresher CG training for all staff and CGVs.

6. INCENTIVES

The question of incentives for CGVs varied widely in most emergency programs reviewed for this research. Considerations for using them include sustainability, motivation and setting. One factor is that CGs are a development programming model. Relief and development programs tend to follow different strategies regarding incentives and payment for community volunteers. For example, in an effort to get people back on their feet, some relief programs offer small stipends to volunteers because there are few opportunities for employment. This was noted in several programs such as the STC's MtMSG program in Jordan and the FH Philippines program. Additionally, the unpaid volunteer driven CG model often operates alongside other relief programs that are paying their "volunteers". This presents a challenge for the program to recruit and retain CGVs.

In contrast, development programs take a longer-term view and plan for sustainability. In order to do this, they usually try to make the programs voluntary with no or limited non-monetary incentives so that when the program ends, the volunteers will continue in their roles. Several of the program staff interviewed indicated that either they gave the CGVs incentives or in protracted settings, such as the Dollo Ado camps in Ethiopia, had started with incentives when the emergency began but as time went on and the budgets shrank, they stopped the incentives. This resulted in fewer women willing to volunteer. The staff tried to address this by having CGVs work with fewer beneficiaries and shortening their terms to one year. In Uganda, refugees in the WVI program dropped out due to lack of incentives. In Sierra Leone, International Medical Corps began with food aid as incentives for CGVs but had to phase it out as funding was reduced. In Somalia, where willingness to volunteer was an issue, the SBCC Coordinator for International Medical Corps suggested that lack of incentives had a direct effect on CGVs' motivation. Staff found that when CGVs were then given incentives they doubled their work and commitment. In other settings, if the CGV was given an incentive, it impacted group cohesion, as beneficiaries questioned why the leader was being privileged.

Photo: International Medical Corps, Burundi

The view on incentives may also differ between acute and protracted emergency settings. Several NGOs, including FH in Haiti, found it easy to recruit volunteers during an acute emergency. People want to help and have the time to provide service to their communities. However, there is usually funding available for cash-for-work programs and incentives to pay other "volunteers". There is pressure for donors and organizations to inject money into the communities. In addition, paying women for their work is empowering and helps them support their families. To address this, some programs have given CGVs supplies (soap, utensils etc.) to sell to their CG beneficiaries in order to obtain some income. In some cases, this is linked to cash voucher schemes and livelihood programs. However, giving income opportunities to the CGVs can also weaken her bond with the beneficiary group, who question why she is selected for that benefit. During the Ebola outbreak in Sierra Leone, FH staff found that the credibility of the CGVs was questioned when the program started paying incentives to volunteers.

Ultimately, this is a question of balancing a sustainable cost-efficient group education activity that relies on unpaid community volunteers against the conditions of an emergency where individuals have immediate needs for paid work to survive and rebuild their lives.

Lessons Learned:

CGs rely on volunteer spirit to build social cohesion and trust. Use of incentives needs to be evaluated in terms of program length, funding cycles and long versus short-term objectives.

Recommendations:

a. CGVs should not be given incentives or selected for livelihood schemes that undermine CG group cohesion.

b. Instead of paying CGVs incentives, use the funds for projects/ activities that benefit the entire community.

c. Provide non-monetary tools, such as signs, ID badges, refreshments, certificates, skirts, boots, umbrellas, coats, hats, bags, notebooks etc.

d. Train program staff and CGVs about the importance and intrinsic value of volunteerism.

e. Be transparent at the outset of acute emergency if short-term incentives are provided, explaining that incentives will be withdrawn as emergency stabilizes.

7. INSECURITY

Insecurity due to conflict in protracted emergencies, proved challenging for implementing CGs. Several of the programs operating in insecure zones such as Somalia, Sudan, or the Daadab camp in Kenya, experienced interrupted programming due to insecurity which can affect behavior uptake.

In one area affected by conflict in Somalia, CGVs held meetings at the local health posts instead of their respective neighborhoods, because they were the only secure location. The International Medical Corps/ Ethiopia staff noted that these instances of interrupted programming usually meant that these women are not part of the group for long enough periods to adopt the new behaviors. While some benefited from the groups and even transmitted the information to their families, others did not have sufficient time to absorb the new messages and behaviors.

Lessons Learned:

1. Insecurity due to emergency circumstances can interrupt trainings and/or regular group meetings.
2. It is still possible to hold meetings in insecure settings if a safe location can be identified.

Recommendations:

a. Allow flexible training times/intervals to work around security concerns.
b. Hold meetings in a secure location, such as a health post, if community-based/outdoor spaces are unsafe.

8. POPULATION MOBILITY
Population mobility proved to be challenging in both acute and protracted emergencies. Programs struggled to keep track of Care Group Volunteers and beneficiaries due to a variety of circumstances.

A couple of months after Typhoon Haiyan in the Philippines, FH program staff tried to set up CGs. The target population, however, was very transient, moving from homes to temporary shelter or vice versa, staying with relatives, or leaving the island altogether, so it was difficult to maintain cohesive groups. CGVs had to travel further distances to reach the mothers assigned to them. The Health and Nutrition Coordinator expressed the challenges they faced: "If you're in a highly transient area where people are all over the place and back and forth and you can't keep track of them you might want to wait until things stabilize" (FH Philippines).

In Sierra Leone, program staff had difficulty tracking CG beneficiaries during the Ebola outbreak (International Medical Corps). It was difficult to ascertain who was infected, who had moved, and who had died. In Somalia, the population targeted in CG programming was pastoral and due to drought moved periodically, making it difficult for program staff to track their movements, follow-up, and hold regular trainings (International Medical Corps). In Sudan, the target population are seasonal returnees who live part of the year in a refugee camp and part of the year (harvest time) in their homes where CG staff are located (CRS). This was also the case for refugees in the Dollo Ado camps in Ethiopia who traveled back to Somalia during harvest season.

Lessons Learned:

Population mobility is a concern in emergencies where movement or interruptions are unpredictable and can affect consistency of CG participation and uptake of SBC messaging.

Recommendations:

a. In settings where populations have predictable patterns of movement (ex. seasonal migration), teach short modules with a small number of topics and few key messages appropriate to the context.
b. Using the CG model with temporarily displaced populations or mobile groups with no predictable pattern of migration is not recommended.

9. PROGRAM CONTINUITY
Some challenges related to sustainability of Care Group programming were mentioned during interviews. These included growing group size, limited curriculum modules, and incentives.

In protracted emergency settings, such as the Dollo Ado camps where groups have been meeting over a long period of time, there is a tendency for the groups to continue growing as more mothers join. Often mothers whose children are older than 2, prefer to remain in the group for reasons of peer support and social cohesion. Also it was observed that the experienced mothers were used in programs to give "guided testimonials" to new mothers regarding how CGs had helped them. The question was raised about whether to "graduate" the mothers of older children or just allow the groups to grow since one benefit of the CGs is social support. The growing group size may impact resources if it becomes too large.

Another issue to be addressed in the longer-term emergency settings was what to do once the basic modules in the CG curriculum have been taught. Some programs believed that repetition is an important technique for sustaining learning and that CGVs had an opportunity to better learn the modules if they were repeated (International Medical Corps and STC, Dollo Ado, Ethiopia). Other programs identified areas that needed to be added to the CG curriculum as it was appropriate for their emergency circumstances, such as Ebola self-care during the epidemic in West Africa, or acute respiratory infections in FH Philippines project (see 5. Topics Covered section in Adaptations to the Care Group Model in Emergency Settings).

Lessons Learned:

CGs can become large and unwieldy if mothers do not graduate when their children age out.

In protracted emergencies, it is unclear how programs

should proceed after completing the initial modules in the curriculum.

To promote sustainability, cooperation with MoH can ensure continued delivery of SBC messages to the community. Recommendations:

a. When CG beneficiary groups grow large and unfocused: 1) split them into two groups and have an experienced mother lead as CGV of the second group; or 2) experienced mothers can continue attending group meetings but will no longer receive household visits.

b. Once all the modules are complete, repeat lessons or modules where the behavior change level is not meeting targets.

c. Develop new modules as needed based on formative research that captures new issues arising in the emergency.

d. Integrate program with MoH: training, materials and Promoters to facilitate sustainability.

IV. RECOMMENDATIONS FOR FURTHER RESEARCH

A. PRE-CARE GROUPS
It is not recommended that Care Groups be established in acute emergencies where: 1) the situation is too unstable to set up groups, 2) where it is unlikely that the program will continue after the emergency "stabilizes", 3) if the beneficiaries are IDPs or groups who will leave the area. However, if it is likely that the program will continue when conditions stabilize after the acute phase of the emergency, development staff may begin organizing for CGs, or "Pre-Care Groups" (PCG). PCG activities could include informally starting to organize people in neighborhoods and talking about pressing concerns, as well as beginning to speak with community leaders about how the program could benefit the community. In this way Pre-Care Groups can also be used to promote social cohesion prior to SBC. This idea emerged in the stakeholder workshop and has not been tested. It is recommended that further research be conducted on how and under what conditions CGs or Pre-Care Groups can be introduced in acute emergencies.

B. MOBILE POPULATIONS
As noted in the above section on challenges, starting Care Groups when populations are mobile is not recommended. Generally, population movements do not allow for the basic two-week training to take place and if Promoters are inadequately trained, they will not provide reliable information to CGVs. In addition, when programs are interrupted and individuals are not visited regularly, significant behavior change in the target population cannot be seen and it is difficult to monitor CGV activities. Workshop participants did believe that it was possible to plan programs around routines of pastoral populations,

seasonal migration or others with predictable patterns of movement. However, there are questions about whether programs with migrating populations would require too many adaptations to qualify as CGs. Given that the numbers of mobile populations in the world are increasing, it is recommended that further research be conducted on development of behavior change promotion models that are appropriate for these groups.

C. FORMATIVE RESEARCH
Although formative research is recommended when developing topics and approaches for Care Group instruction, it is sometimes difficult to carry out in emergency settings. Relief staff are occupied with emergency tasks and are unlikely to have time for research. However, stakeholder participants noted that there are certain informal methods that might be used. For example, even if it is not feasible to do a formal Barrier Analysis, it might be possible to organize rapid informal focus groups using questions from a Barrier Analysis, or use observational methods such as a windshield survey. Therefore, it is recommended that further research be conducted on appropriate methods for rapidly gathering information about target group needs during emergencies. The results could then be discussed and approved by SBC working groups and presented as alternative methods for formative research in acute emergency settings.

D. STABILIZED EMERGENCY
One of the tasks assigned to the groups during the stakeholder workshop was to come up with indicators for "stabilized" emergencies. There were several suggestions such as: low influx of new beneficiaries, systems start to be in place, reorganization of communities, increased availability of products in the market, basic health / WASH services in place, people moving back to homes, assessment of cash for work attendance. There was also discussion of a WHO mortality rate threshold that indicated when an emergency situation had stabilized. However, there was no definitive conclusion regarding what the key indicators should be and how to prioritize them. Because the stabilization of an emergency is important for deciding when to establish CGs, it is recommended that the CG community work to define when an acute emergency has "stabilized".

E. RECEPTIVENESS TO BEHAVIOR CHANGE DURING EMERGENCIES
Another area for further research is to explore the effects that Care Groups have in helping build social cohesion and psychological support during emergencies and how that impacts receptiveness of behavior change messages among participants who are in states of confusion and mental distress following an emergency.

V. OVERALL RECOMMENDATIONS

Acute Emergency Stage: Generally, it is not recommended

to initiate the CG model during an acute emergency. This is due mainly to time constraints during this phase. This applies to short-term programming that lasts less than a year with no plans for continued development programming. However, in contexts where CGs already exist and can be used for emergency messaging, they may prove to be a useful structure during the acute stage.

Transitional Emergency Stage: CGs are recommended and have successfully been used during the transition from development to emergency settings as well as from emergency to development. CGs already established in West Africa proved vital to responding to the Ebola outbreak. Conversely, CGs implemented in post-earthquake Haiti were initially used to address short-term concerns such as cholera and then transitioned to a more traditional CG in development program.

Protracted Emergency Stage: CGs are recommended for those operating in protracted emergencies, such as drought or conflict. Protracted emergencies typically have longer-term funding which provides the time and planning necessary for successful CG implementation. CGs in protracted emergencies help complement the health infrastructure through monitoring, screening and referrals.

Mobile Populations: CGs are only recommended for mobile populations when the target population has predictable patterns of movement, such as pastoralists or seasonal returnees. Other types of mobile populations with unpredictable patterns of movement, such as temporarily displaced people, make it difficult to monitor beneficiaries, train volunteers and see behavior change due to interrupted programming.

VI. CONCLUSION

Care Groups have played an important role in addressing health and malnutrition in development contexts. With the occurrence of more frequent humanitarian emergencies it is important to test how this model can be adapted to different emergency contexts. This report is the result of guided discussions with the SBC and Nutrition communities implementing CGs. The intention is that this will be a starting point for further exploration and discussion on the topics of CGs and peer support groups in emergency contexts.

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Kristin	Heltz	CARE Kenya / Am Red Cross
Mary	Hennigan	Catholic Relief Services
Whitney	Hostetter	Catholic Relief Services, Sudan
Rachel	Hower	World Relief
Joan	Jennings	Save the Children
Lindsey	Jones	ACDI/VOCA
Erin	Jones	World Vision
Melissa	Joy	FFP/USAID
Adugna	Kebede	World Vision
Philippa	Keys	Food for the Hungry
Alice	Kiplangat	International Medical Corps
Bonnie	Kittle	CORE Group
Regine	Kopplow	Concern Worldwide
Carolyn	Kruger	Project Concern International
Geraldine	Le Cuziat	Save the Children UK
Sisay	Legesse	International Medical Corps
Louise	Logre	ACF International
Amie	Lompri Karama	Freetown WASH Consortium/Sierra Leone
Mary S	Lung'aho	Cornell University/CARE USA
Raphael	Makonnen	USAID
Jessi	Mann	Save the Children
Yetayish	Maru	Save the Children
Hamed	Maryoud	International Medical Corps
Corinne	Mazzeo	ChildFund International
Sam	Mbuto	International Medical Corps
Megan	McGrath	World Vision
Gillian	McKay	GOAL
Suha	Mhanna	International Medical Corps
Peter	Morris	OFDA/USAID
Melanie	Morrow	ICF International
Phil	Moses	Feed the Children
Melody	Muchimwe	ACF International
Richard	Muhumuza	World Vision
Altrena	Mukuria	Partners of the Americas
Mueni	Mutunga	UNICEF
Doris	Mwenda	ACF International

First Name	Last Name	Organization
Thomas	Ndambu	International Medical Corps
Rose	Ndolo	CARE Kenya /Save the Children
Debra	Olson	ADRA
Shiromi	Perera	International Medical Corps
Antony	Peter	World Vision
Cindy	Pfitzenmaier	Project Concern International
Ketty	Philogene	AME-SADA
Silke	Pietzsch	ACF International
Mathias	Pollock	Mercy Corps
Fabienne	Ray	Medair
Amelia	Reese-Masterson	International Medical Corps
Yves-Laurent	Regis	Partners of the Americas
Kathryn	Reider	World Vision
Mercy	Riungu	GOAL Sudan
Paul	Robinson	International Medical Corps
Mikey	Rosato	Women and Children First UK
Alexandra	Rutishauser-Perera	International Medical Corps
John	Rynne	GOAL Ethiopia
Emma	Sacks	ICF International
Sarah	Sahlaney	ACDI/VOCA
Lilly	Schofield	Save the Children
Arianna	Serino	International Medical Corps
Hormazd N.	Sethna	Project Concern International
Linda	Shaker-Berbari	International Orthodox Christian Charities
Mark	Smith, C.	World Vision
Patricia	Souza	UNICEF C4D Unit
Harley	Stokes	International Medical Corps
Maryanne	Stone-Jimenez	Consultant
Sisay	Tadesse	International Medical Corps
Daniel	Takea	International Medical Corps
Seife	Temere	International Medical Corps
Casie	Tesfai	International Rescue Committee
Sharon	Tobing	ADRA
Cindy	Uttley	Samaritan's Purse
Sonia	Walia	OFDA/USAID
Fitih	Wedajeneh	TOPS
Jennifer	Weiss	Concern Worldwide
Alanna	White	Bureau of Global Health/USAID
Sandy	Wilcox	International Medical Corps
Caroline	Wilkinson	UNHCR
Naqeebullah	Yaad	International Medical Corps
Hana	Yemane Wodogo	International Medical Corps
Mailing Lists:		Care Group Forwards
		CORE group Nutrition WG
		CORE Group SBC WG
		FSN general newsletter
		FSN Nutrition WG
		FSN SBC WG