Family Health Approach (FHA) Implementation Guidelines

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Family Health Approach for Empowering Mothers to Adopt Positive Maternal and Childcare Household Behaviors.

An Implementation Guide for Social and Behavior Change Communication Officers and Community Development Workers

Disclaimer

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Statement on Acknowledgement

The present document aims to provide public access to the Family Health Approach Implementation Guide for other organisations who wish to implement the FHA approach as part of their MNCH programmes. We ask that GOAL Ethiopia be explicitly and visibly credited in any use of the material or the approach.

This is a working document. Any comments or correction to this version may be sent to: Helina Tufa helinat@et.goal.ie.

Acknowledgments

Development of the FHA approach draws heavily on GOAL Ethiopia experience over the last ten years of implementing the Care Group approach and nutritional response programmes for maternal and child health and nutrition programmes, especially in including men as household decisions makers in these programmes. The Approach also draws heavily on PCI experience of including grandmothers and Care Groups: A Training Manual for Program Design and Implementation developed by Food Security and Nutrition Network Social and Behavioral Change Task Force 2014.

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I. About the implementation Guide

Who is this guide for

This implementation guide was developed to support GOAL's Ethiopia Social and Behavior Change Communication Officers and Community Development Workers (CDWs) to operationalize the Family Health Approach (FHA). The Family Health Approach is GOAL's Ethiopia Social and Behavior Change approach that brings together three different peer groups, pregnant and lactating woman, and mothers of children under the age of five years, men, and grandmothers to create mutual understanding on family health.

How to use this guide

This resource is intended as a guide for the SBCC senior managers and officers and CDWs, supporting them to implement the FHA approach. It provides the team with necessary guidance to understand the structure of the FHA approach, how to establish peer groups, how to mentor the peer groups through using participatory facilitation skills to empower mothers and others in the community towards change.

Family Health Approach

The FHA is based on GOAL's SBC approach of building the aptitude of mothers by increasing their knowledge (functional aptitude), skills (interactive aptitude) and empowering them to be able to make powerful choices on their household maternal and childcare behaviors. Using lessons learned and both GOAL and PCIs experience, the Family Health Approach targets three different peer groups, pregnant and lactating woman, and mothers of children under the age of five years, men and grandmothers to create mutual understanding on family health.

Studies show that, in rural societies men continue to have the sole control over household resources and in most of the cases husbands can approve or disapprove if their wives can seek health care[1]. Men are influential and have the power to either support or undermine the efforts of the community in adopting positive health and nutrition behaviors and from practicing it. Considering this, since 2014 GE has successfully established MHG in its Rural Development Programme to allow husbands/fathers influential leaders support their wives/mothers to adopt the practices and support the day-to-day activities of Care Group Mothers. In collaboration with the Technical and Operational Performance Support (TOPS) GOAL

[1] Michael Nnachebe Onah, Susan Horton, Male-female differences in households' resource allocation and decision to seek healthcare in south-eastern Nigeria: Results from a mixed methods study, Social Science & Medicine, Volume 204,2018,Pages 84-91,

conducted research on this approach[2] which showed that there was an increase in the number of husbands encouraging spouses and children to eat nutritious food. The priority to consume nutritional food shifted from men to pregnant women and children. Also, mothers started to prepare nutritious complementary food for children using the readily available foods at home including milk and eggs. These were previously marketed to raise additional incomes to buy non-food items for the households.

Grandmother Group (GMG) is the new peer group added to the approach which GOAL adopted from PCIs care group trio model. Grandmothers play a central role as advisors to younger women and as caregivers of both women and children on nutrition and health issues. Grandmother social networks exercise collective influence on maternal and child nutrition-related practices, specifically regarding pregnancy, feeding and care of infants, young children, and sick children[3]. Project Concern International's (PCI) care group trio model assessment[4], which was conducted by external consultant showed improvement in the relationships between mothers and grandmothers, in a way that grandmothers began helping their daughters-in-law at the house more often and actively supported early initiation of breastfeeding, exclusive breastfeeding, and appropriate complementary feeding.

II. Family Health Approach for RIPA

For the RIPA project the FHA model will target the following maternal and childcare practices.

Key Nutrition Topics	***Key hygiene Topics***
· *Early initiation of breastfeeding and exclusive breastfeeding*	· *Hand washing practice*
· *Child Meal Frequency*	· *Access to clean latrine*
· *Child dietary diversity*	· *Safe storage of water*
· *Women dietary diversity*	***Health***
	· *Antenatal care*

In each community pregnant and lactating woman (PLW) and mothers of children under five form neighborhood Care Group (NCG) of 8-15 households. Each group then elects a volunteer mother to represent them twice a month in participatory facilitated discussion with the Health Extension Workers (HEWs) who is supported by the Community Development Worker on key nutrition and hygiene

[2] Small Grants Big Impact A Retrospective of the TOPS Small Grants Program 2010-2015 November 2015.pdf (fsnnetwork.org)

[3] J. Aubel, The role and influence of grandmothers on child nutrition: Culturally designated advisors and caregivers, Maternal and child nutrition (2012), 8, pp. 19–35

[4] https://www.pciglobal.org/wp-content/uploads/2015/10/Bangladesh_Fact_Sheet_PCI_FY15.pdf

messages using the Ethiopia Family Health Card as guide. After the twice month session, these mothers then meet with their NCG once a month to discuss the information and skills and possible determinants and barriers that may prevent them adopting those behaviors. Volunteer men and grandmother meet in their own peer groups on a monthly basis with the key messages tailored to the specific role they play in child rearing allowing them to support the NCG to adopt the new behaviors. Once a quarter all these peer groups come together as a community to discuss the messages, the barriers to change and solutions that will support families to adopt prioritized health and nutritional behaviors. This is coupled with multi-media messaging and information sessions (radio, health visits information session, and community events and for vulnerable households tailored counselling and skills building sessions).

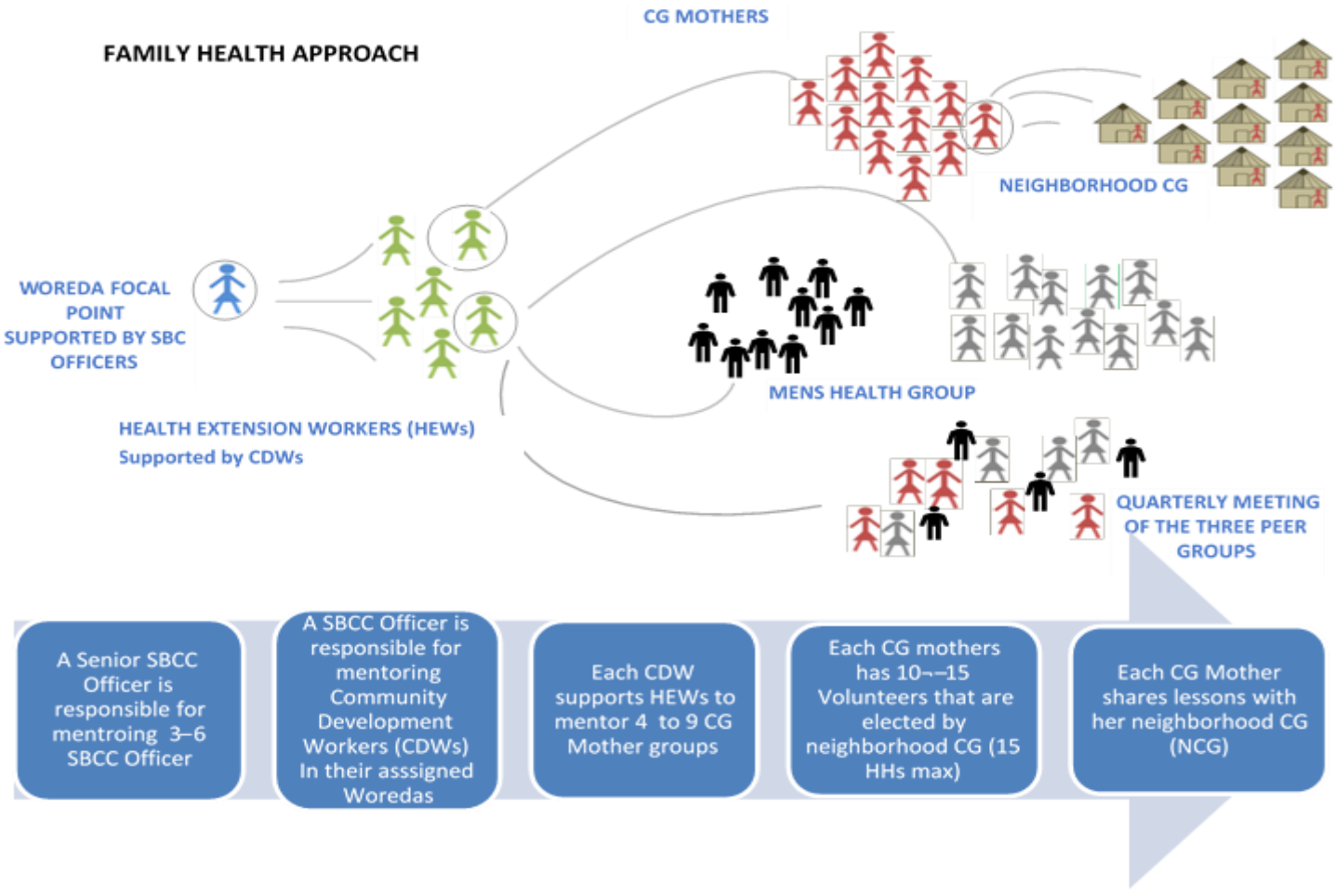

Figure 1 Family Health Approach Diagram

III. Implementation of the FHA approach.

The FHA approach has 8 steps as described below.

Step 1: Sensitization of the community: Sensitization is conducted at the village level in collaboration with Health Extension Workers (HEWs) and Health Development armies (HDAs) as well as with the local leaders to sensitize the community on the objectives, and the outcomes of the FHA approach. At the sensitization session the challenges and expectation are discussed and dealt with. This is a very important aspect of the approach as it allows the community to start owning the approach rather than it being something GOAL wants to happen.

Step 2: Household mapping: Once sensitization is done, mapping of all households with pregnant and lactating woman and mothers of children under the age of five years is conducted and mapped into Neighborhood Care Groups (NCGs)

Step 3: Care Group Mothers (CGMs)

From each NCG a volunteer mother is selected to represent the group at a twice a month participatory facilitated discussion with the Community Development Workers (CDW) and Health Extension Workers (HEWs) on key nutrition and hygiene messages using the Ethiopia Family Health Card as guide. The volunteer mothers who are chosen by their neighbors should be empowered to deliver quality information, and she should be a model in promoting positive behaviors. It should be emphasized that the mother must be an individual who is willing and able to attend the facilitated education sessions and who will be a role model for the behaviors that communities need to take up. The volunteer mothers meet with her NCG once a month to discuss what she has learned and create dialogue on overcoming the determinants and barriers to households adopting positive maternal and child-care practices.

Step 4 Men's Health Group (MHG)

MHG is a group of 8 -15 people, who meet in monthly bases with the HEWs for awareness and mentoring sessions. From the households, men can volunteer to attend the monthly education sessions. The MHGs should include influential leaders such as religious leaders, Kebele Chairman, elders (35%), Husband of CGM (35%), and new expectant fathers (30%). Men health group are expected to primarily influence behavior changes within their own family, and then in their community. These groups of local leaders are important links among CGMs, grandmother groups, the community at large and the health care provider. Support from the various influential community leaders in a community is very important in gaining community acceptance for care groups as well as promotion of positive health behaviors.

Step 5 Grandmothers Group (GMG)

The GMGs is a group of 8 -15 people, who meet in monthly bases with the HEWs for awareness and mentoring sessions. The GMGs should include mothers and mother in laws of pregnant women and lactating mothers, former traditional birth attendants and other influential women of the community. Traditional birth attendants (TBAs) are equally important as they are highly respected by the communities. If adequately trained TBAs can become catalysts to overcome cultural barriers to access skilled delivery services as major decision makers on referrals.

Step 7 Quarterly meeting of the all the peer groups

All three peer groups will meet on a quarterly basis to discuss on the implications of the proposed behavioral changes on the families and community, common barriers which ban them from practicing the given behavior and what actions families need to take as result of the information received at the education sessions.

Step 8: Supportive Households Visits: Households will develop appropriate behaviors and change practices at different times so there is no set timescale on when people will change. However, it will be clear to the within the neighborhood care groups which households are challenged to uptake new behaviors. These households may require extra visits by the HEW/CDW to provide individual tailored counselling and skills building sessions.

IV. Roles And Responsibilities of FHA Groups

Care Group Mothers

The objective of the CGM is to that working together, the mothers be empowered to adopt positive maternal and childcare behaviors. The group will support each other to overcome determinants and barriers by finding solutions that work within their context. This is led by the volunteer mother who obtains participatory facilitation skills so that she guides and led the neighborhood care groups. The care group mother is responsible for the following key actions.

1. Attend the twice monthly CGM sessions with the CDW/HEWs
2. Organize to meet with the neighborhood group and provide feedback on the CGM session and facilitate discussion on the barriers of the given behavior and possible action points.
3. Collect from the NCG the vital statistics on births, deaths, and severe illness among pregnant and lactating woman and mothers of children under the age of five years and brings this information to the twice monthly CGM sessions.

4. Mobilizes NCG to participate in community activities that will benefit their families, such as immunization campaigns, latrine construction …etc.
5. Report problems that cannot be solved at the household level to local leadership, and request support and collaboration from the HEW and the referral facility.
6. Models the health, nutrition, and hygiene behaviors she discusses with NDGs.
7. Organizes to meet with the other peer groups on a quarterly basis to discuss determinants and barriers and solutions

Men Health Group

The objective of the MHG is that the men have the information and skills to be able to provide the social support to mothers, particularly mobilize pregnant women to attend ANC, improve health seeking behavior at HH level, help improve nutritional status of women and children, good hygiene practice at household level and prevent absenteeism by CGMs from their fortnightly discussion session. Hence, as influential bodies and early adopters of positive health behaviors in their community, the MHGs should perform the following key activities in their support to the CGMs, grandmother groups and other community-based volunteers.

- They should select their own chairman/leader and secretary and meet at least once monthly. Their meeting should follow the CGMs' meeting so that they will build on the successes of the CGMs' as well support the Volunteer Women to solve their challenges.
- They should discuss nutrition, health, and hygiene issues (progresses and challenges) on monthly basis and provide solutions for problems the CGMs and other community-based volunteers encountered during their monthly activity. This includes understanding and appreciating care groups' impact on the health and nutritional status of women and children in their community as well they should discuss on Vital statistic reported by CGMs and the key nutrition and hygiene messages discussed during the month as well.
- Effective MHGs take initiative in the community through their words and actions, such as lead development and implementation of local laws related to health, support resistant households to adopt positive maternal and child care behaviors and support and lead attempts to stop negative health practices/behaviors, keeping sick child at home for local and ineffective treatments, as well as harmful traditional practices.
- Sensitize community for meetings whenever there is community-based meetings or discussions,
- Mobilize Communities to practice positive nutrition and hygiene behaviors as well as gather husbands to discuss and solve challenges reported by CGMs as well as on the key nutrition and hygiene messages.

Grandmother groups

Empowering care group mothers; enhancing communication between grandmothers, younger women, and men; and strengthening the role of grandmother groups can contribute to strengthening understanding and social cohesion within families and communities.

The objective of the GMG is working towards improved and sustained nutritional status of mothers and children. Generally, the GMG should provide social support to mothers, particularly mobilize pregnant women to attend ANC, improve access to skilled delivery, help improve nutritional status of women and children and good hygiene practice at household level. GMGs work closely with care group mothers and Men health groups for cross learning and bring about the intended behavioral change.

The GMGs are expected to perform the following key activities:

- They should select their own chairman/leader and secretary and meet at least once a month.
- They should discuss nutrition, health, and hygiene issues (progresses and challenges) on monthly basis and provide solutions.
- They should build strong relationships with CGMs and MHGs for cross learning and achieving their goal. Grandmother leaders are expected to hold regular quarterly meetings with CGMs and MHGs.
- Target resistant households to adopt positive health behavior and practices advocated by volunteers and conduct home visit with the CGMs or MHGs.
- Support and lead attempts to stop negative health practices/behaviors, keeping sick child at home for local and ineffective treatments, as well as harmful traditional practices,
- Mobilize Communities to practice positive nutrition and hygiene behaviors and support their daughters and daughter in laws in improving maternal nutrition and child caring practice.
- Identify/Map pregnant mothers and refer to health facilities for ANC and institutional delivery. Advise pregnant women and young mothers after birth.
- Advise male family members on issues regarding the well-being of children and women.
- Provide support to women and children within both the immediate family and neighborhood.
- Share the mother's workload so that the mother get time to care for herself and her children.

Neighbor Group Dialogue

- Within 2-3 days following the last CGM dialogue with CDW/HEWs the volunteer mother should contact every member of her neighborhood care group and organize for them to meet. This should happen on monthly bases. Any neighbor mother that misses a group dialogue

should receive a household visit from the volunteer mother to see why they missed it and if they can make it to the next one.

- The MHGs and GMGs will not have their own neighborhood group but will exercise what they have learnt through informally reaching to their neighbors and friends through nutrition and hygiene message and also support the care group mothers whenever needed to bring the intended change.

Quarterly FHA Meetings

- Care group mothers, men health group and the grandmothers group meet in quarterly bases to discuss on major issues and barriers raised during each FHA meetings. The CDW/HEW facilitating the dialogue should engage everyone in identifying ways to overcome the barriers mentioned. Brainstorming solutions is a group responsibility and will help empower the mothers to become effective problem solvers. This step should always be carried out, as it can be a very important dialogue to have for certain behaviors where influencers have a big role in determining whether the behavior is practiced or not.

V. How To Keep FHA Groups Motivated

i. Care group mothers

Ways to Feel Connected/ Uniquely Valued/Valuable

- Celebrate group achievements, such as recognizing when all CGM are present at three meetings in a row.
- Invite special guests to Care Group (CG) meetings that can speak on how the program has impacted them personally, such as testimonies from community members that have seen malnutrition decrease in their homes.
- Identify a "Care Group Mother" to be recognized at a monthly meeting. Specify the reasons that volunteers received the award.
- Rotate special roles (e.g., committee secretary) so that more people have the opportunity to hold unique positions.
- Express concern for the individual needs of volunteers.
- Spend time discussing the positive things Promoters have seen in the lives of the volunteers.
- Provide a special celebration annually.
- Give annual certificates or awards that highlight volunteers' special qualities (e.g., most inspirational).
- Learn each volunteer's name, address her by name, and thank her regularly.

- Provide time at CG meetings so that volunteer mothers have the opportunity to voice their individual experiences, challenges and concerns.
- Share life events, such as weddings or funerals, together. Foster an environment where CGVs can support each other through these life events.

ii. Men Health Group

Men Health Group do provide volunteer services, i.e., they devote their time and energy freely and receive no monetary allowances. Hence, some sort of non-financial incentives should be considered through the following means to keep them motivated. Recognition by the community and empowerment should be encouraged. This is because recognition and praise from their community will raise volunteers' self-esteem and commitments. This can help convince them that their work is important. Being catalysts for community-wide action makes them feel connected to a movement larger than themselves.

Hence, RIPA will work with local health authority and community on recognition of best performing MHGs, and this will be held during the annual ceremonies. The community through their CGMs and GMGs will be supported to select their best performing MHGs. There will be no material benefits; but recognition of MHG's achievement by their own community will be encouraged. It is important for MHG, GMGs and CGMs to celebrate together when it reaches a goal.

iii. Grandmother Group

For grandmothers to be motivated to participate in FHA, the following must occur:

- Recognize and actively affirm the role of senior women in the community.
- Other community members must openly acknowledge the importance of grandmothers' contribution to family and community life. It is particularly important that younger women be included in activities to increase respect for grandmothers.
- In community sessions openly acknowledge the importance of their role in society.
- Arrange meetings at times of day that fit with their schedules.
- Provide opportunities for them to lead discussions and to summaries results.
- Allow them to speak without interrupting them.
- Praise grandmothers during FHA ceremonies and other community events by mentioning their contribution to the improvement of maternal and child health and nutrition.

VI. FHA Group Dialogue Format

The CDW/HEW organizes for CGM to meet every 2 weeks and MHGs and GMGs to meet monthly to discuss a particular topic. Any dialogue session should last no more than two hours: all the peers are volunteers and, as such, their time needs to be respected. Limiting the dialogue time to one to two hours helps improve attendance and limits requests for financial compensation. For how to frame the dialogue see the step-by-step instructions below.

Step by step instructions for facilitating a Group Dialogue.

Each dialogue will follow a similar structure, whether it's between the HEW/CDW leading a dialogue between FHA groups or a CGM leading a neighbor group dialogue. The specific sequence may vary, but each of the following steps should be included:

1. **Wash Hands:** At the start of each dialogue all the participants should wash their hands with what is available. (e.g., tippy tap, ash, or soap)
2. **Dialogue Objectives:** Each dialogue should focus on one or two similar doable behaviors. These are the behaviors that the project expects the participants to practice based on the key messages.
3. **Game, Role Play or Song:** Each dialogue should start with a game, role play or song. This helps the participants feel relaxed and builds a sense of safety. When women feel safe, they are more likely to share their experiences, talk openly about their struggles, and consider trying new practices at home.
4. **Attendance and Trouble-Shooting:** The person leading the dialogue records attendance and any vital events that occurred in the last 2 weeks (birth, deaths, or new pregnancies. There should be a discussion on how the last dialogue went and if they were all able to try out the behaviors, they learnt themselves. This is an important opportunity to address any barriers that come up in practicing a new behavior.
5. **Session (for technical messages and activity instructions per session):**
    a. **Dialogue points:** The Facilitator should use dialogue points to find out the current knowledge and practices by the community in the group and identify what are the misconceptions and current positive and negative practices.
    b. **Activity (if possible):** People usually do not change their behavior just by being told to do so! Behavior change will be much more likely if women are able to try out the behavior in a safe environment. For example, If the behavior is on dietary diversity, a simple cooking demonstration could be arranged. The Facilitator is responsible for organizing materials

for each lesson's activity. Materials may be brought by the group members from their own homes to create a 'real life' situation. An activity may not be possible for all behaviors.

6. **Discuss Potential Barriers and Solutions**: When the participants discuss potential barriers to the behavior they have to really imagine doing the behavior within their household context. Once all of the barriers are discussed, the person facilitating the dialogue should engage everyone in identifying ways to overcome the barriers mentioned. Brainstorming solutions is a group responsibility and will help empower the mothers to become effective problem solvers. This step should always be carried out, as it can be a very important dialogue to have for certain behaviors where influencers have a big role in determining whether the behavior is practiced or not.
7. **Practice and Coach**: Each FHA participant should practice discussing the behavior with neighbors and friends through creating songs, telling stories, or carrying out role plays.
8. **Reflection:** There should be an open dialogue on what their own families and their neighbor families would look like if they changed their behaviors. And what would be the cost of not changing this behavior?

VII. RIPA Nutrition And Hygiene SBCC Schedule For Family Health Approach (FHA) Groups

There are 5 modules relevant for RIPA project and each module has two sessions in a month accordingly, and the CGM graduate when they have completed all five modules. The behavioral modules start from session two, with session one providing a dialogue on the CG process, participatory skills and organizing the neighborhood care groups (NCG) and session seven is the graduation ceremony.

The modules guide below are for both the facilitators and CGM Each states the objective and a brief description of the group dialogue, the activity and key dialogue points.

The Men Health Group (MHG) and Grandmother Groups (GMGs) sessions will be facilitated by HEWs and supported by CDW. The session happens in monthly bases and all the key messages under the below modules are covered accordingly. In MHG and GMG dialog sessions, its advisable to focus more on the challenges raised during care group dialog so that they can discuss among themselves and cam-up with their own solution. Both groups will be graduated once they have finished all the sessions.

Session 1: Start-up Meeting and Communication Skills

Objective: Facilitators & CGM know how to facilitate group dialogue, ask open ended questions and practice active listening, strategic questioning and how to use participatory learning in action tools to overcome barriers. During this session the group will set norms, develop team dynamics, orientation on FHA approach.

Dialogue Point	Key Messages for the facilitator & participants of the group dialogue
Group Dialogue facilitation	• Good facilitation skills improve group dialogue & problem solving. • Sit in a circle and make sure everyone can hear each other and is comfortable. • The group should agree on the aims, length of dialogue & rules, develop team dynamics …etc • Thank all participants at the end for their time & contribution
Active Listening	• It is more than just listening, it is showing understanding, • Use body language to show interest and understanding, • Ask questions to show the person you want to understand, Summarise/ rephrase to check you understand what the person said
Asking open ended questions	• Use 5 key 'helper' questions (What? When? Where? Who and How?) • Ask probing questions by following up answers with further questions. • Asks clarifying questions to ensure understanding. • Ask Q's about personal points of view by asking how people feel, what they have learned, or what they have observed; not just about what they know.
Value local knowledge & experience	• This shows the group how much they already know, which is motivating. • For actions on Healthy behaviour to work they need to be tailored for the specific needs of the specific people in that village and also address the barriers to woman being able to adopt these behaviours-such as dealing with people who influence them daily, the social norms of the community etc.
Group analysis & learning	• Debate & dialogue on the challenges they face increases the groups motivation to take action to address the challenges
Use mixture of verbal, visual & practical learning in	We remember 20% of what we hear, we remember 40% of what we hear & see, we remember 80% of what we hear, see & do and we take action and adopt a practices or behaviour when we see value for ourselves. Therefore, need to use as many different interactive techniques as possible

action tools techniques	
Actively involve the unheard voice	Often the most vulnerable members of the group say the least e.g. single mothers, women who became pregnant from rape, women who can't breastfeed etc. Those facilitating group dialogues should actively try to find out who wants to participate but are being excluded, and then try to include them.

Activity: Divide into small groups and have all participants practicing the communication skills on each other. In the same group they should practice creating and using the visual aids which they can then use in the group dialogues they will facilitate. This step should be exercised in all FHA groups.

Session 2: Antenatal and Delivery Care

Objective: Provide an opportunity for the FHA groups understand the importance of antenatal care (ANC), delivery by skilled birth attendant, postnatal care and family planning.

Dialogue Point	Key Messages for the facilitator & participants of the group dialogue	Tools
What are the benefits of ANC, delivery, and postnatal care	• Benefits of attending at least 4 antenatal care (ANC) visits at the nearest health facility. • Health services provided at health facilities during ANC visit • Benefits of attending delivery at health facility • Benefits of accessing postnatal care services after the baby is born • Sleeping under a mosquito net (Long Lasting Insecticide-Treated Net) • Taking anti-malarial prescribed during ANC	SBCC strategy and Family health card
Danger signs during pregnancy	• Discuss on danger signs during pregnancy based on the family health card • Measures to be taken when danger signs are observed during pregnancy	
What are the common	• Discuss thoroughly with the group on the major challenges and facilitate the	

challenges to attend reproductive health services	discussion to come up with their own solution.	
Preparation for Delivery	• Prepare to deliver at a health facility by a skilled birth attendant to ensure your health and the health of your new baby. • Make financial planning and budgeting for transportation to a health facility for delivery service.	

The FHA groups are provided an opportunity to hear, discuss and converse about the importance of ANC, delivery by skilled birth attendant, postnatal care and family planning. Also discuss the barriers to seek these services in the health facilities.

Session 3: Maternal nutrition

Objective: Participants understand the importance of maternal nutrition & care of mothers during pregnancy and lactation.

Dialogue Point	Key Messages for the facilitator & participants of the group dialogue	Tools
Why is maternal nutrition important?	• Good maternal nutrition prevents child malnutrition by preventing the cycle of low birth weight: low weight of infants plus poor care practices leads to underweight children, underweight adolescents and in turn underweight mothers (explain intergenerational cycle of malnutrition) • Explain the need for diversified and extra meal during pregnancy and lactation	
Why is extra nutrition during pregnancy and	Talk about the eating habits of the women when they are pregnant & breastfeeding and identify barriers to	

lactation important?	women getting the food they need and how they could address them e.g. they eat last	
What are the common challenges to practice maternal dietary diversity?	• Identify FHA group members who practice maternal nutrition as recommended and ask them to share their experiences. • Facilitate conversation so that the FHA group brainstorm barriers and facilitators to the given behaviour. • Discuss on maternal dietary diversity,	

Activity: Cooking demonstration

Demonstrate how to prepare diversified food using locally available food. During cooking demonstration it's advisable for the care group mother to bring what is available at home.

Session 4: Breast feeding

Objective: Participants understand the benefits of breastfeeding, the importance of exclusive breastfeeding, and are able to dispel common myths

Dialogue Point	Key Messages for the facilitator & participants of the group dialogue	Tools
Why is breastfeeding important?	• Ask the group members the importance of breast feeding. • Then explain its importance (grow healthy and strong, protection against diseases, Convenient, hygienic, cheap, and readily available, contraceptive effect, bonding with mother …etc) • Discuss on the importance of breast feeding up to two years and beyond	
What are the common	• Identify breastfeeding mothers and ask them to share their experiences if it's the	

breastfeeding practices of the group?	care group mothers meeting or ask MHGs & GMGs the breast-feeding practice in their HHs. • The group should understand early initiation of breastfeeding & exclusive breastfeeding. • Discuss on importance of feeding a child colostrum (the first thick yellow milk)	SBCC strategy and family health card
What challenges does the group experience with breastfeeding?	• Identify challenges with breastfeeding and discuss solutions. e.g. not enough milk / incorrect latching/ sore nipples etc. • Identify myths & misconceptions to breastfeeding in the group e.g. the heat makes my milk go bad / I am stressed so my milk is bad / I didn't eat enough food so my milk won't be enough etc.	
When should food or other liquids be introduced to infants?	• Explain to the group that no food should be introduced before six months other than breast milk, • Food should be introduced at six months, NO EARLIER • Infants from 6 months need extra energy for growth, at this time breast milk alone cannot meet all the child's needs	

Activity: Breastfeeding demonstration

If there is a breastfeeding mother in the group, ask if she is happy to participate in a breastfeeding demo. During the feed the facilitator can show her:

Different ways of correct positioning so the mother and baby are comfortable

Check if latching of baby to nipple is correct. If it is explain how you can tell - the baby's face is close up to the breast and the baby's **chin is touching the breast.** The baby's **mouth is wide open** and the baby's lower lip is curled outwards. You can see the baby taking slow and deep sucks. If the baby is not latching correctly then show the mother as described above how to do it properly.

Session 5: Complementary feeding

Objective: Participants understand complementary feeding, the importance of nutrition during the first 2 years of an infant life. Also practice preparing suitable complementary food using locally available food groups.

Dialogue Point	Key Messages	Tools
Why is nutrition important for children?	• Discuss on the importance of nutrition for children	- SBCC Strategy and family health card - Songs and role play
When should food or other liquids be introduced to infants?	• Should be introduced at six months, NOT EARLIER • Infants from 6 months need extra energy for growth, at this time breast milk alone cannot meet all the nutrition requirements of the child and needs to be complemented	
What types of food should be given?	• Identify what the group feeds their children and point out the ones with highest nutritional content. • Continue to breastfeed up to 2 years of age	
How often should a child be fed?	• Talk about when participants feed their children, identify challenges e.g. working all day so can only give one meal in evening • Children have small stomachs so they need small meals and more frequently	
How do you make a nutrient rich meal?	In each meal try to include: Body building foods (proteins) add 1 of beans/peas/groundnuts/ meat/fish/dairy/egg Energy-giving foods (carbohydrates) add 1 cereal or root/tuber	

	Protective foods (vitamins and minerals) add 1-2 fruit or vegetable Extra energy giving (fats, oils and sugar) add 1 teaspoon/meal	
What good hygiene practices can you do when cooking food?	• Wash hands before & after preparing food • Wash all foods before cooking • Use clean utensils and equipment • Wash fruits and vegetables (and hands) before eating • Food hygiene, focusing more on animal source food, such as feeding children boiled milk ..etc • Discuss safe storage methods (closed containers with lids to prevent contamination, store out of sun, etc.)	

Activity: Building recipes for Complementary feeding

The purpose of the cooking demonstrations is to promote diet diversity and ensure participants are empowered to use their own produce. This activity is timed to coincide with the harvest of vegetables if possible. The cooking demonstration will include lessons on hygienic food preparation, and recipes for meals focusing on low-input and high-nutrient meals. Items necessary for the cooking demonstrations will be sourced from the CGM and Neighbour Women as much as possible. This includes, but is not limited to: cooking utensils, pots, plates, cooking fuel, clean water, soap, and necessary food ingredients, from the garden as well as from the market where necessary. If all items cannot be provided voluntarily by the community, critical items can be provided by GOAL/ RIPA.

Session 6: Hygiene and Sanitation

Objective: Participants understand the importance of appropriate personal and household hygiene and sanitation and will learn how to practice optimal behaviors i.e., hand washing, using latrines, safe storage of water and disposing of waste materials appropriately.

Dialogue Point	Key Messages for the facilitator & participants of the group dialogue	Tools

What do you think is good hygiene?	Identify what are the good practises they are aware of and what they practice Identify why they don't do some of the good practices they are aware of	
What are the benefits to good hygiene?	– Identify why they practise the hygiene practises they have just identified – General benefits: reduces risk of illness and malnutrition, improves health and reduces the time and money you would have to spend attending health services	
What are the impacts of poor hygiene?	– Identify what are the problems they experience from poor hygiene – Identify any misconceptions and discuss why they are not true – Examples of negative impacts: diarrhoea/ vomiting / skin problems/ infections/ eye diseases/ Typhoid/ communicable diseases/ tooth decay and gum diseases/ stunting	
When should you wash your hands?	Identify when they wash their hands and do they use soap or ash. Encourage handwashing: Before/after meals After defecating/assisting a child who defecated Before food/after food preparation What are the challenges to washing your hands at this time – How could you and other mothers overcome those challenges?	
What good hygiene practices can you do when defecating?	– Identify where participants defecate. Open defecation? Or do they have a private or shared latrine? – Use of sanitary disposal of human waste: benefits of HH latrines, how to construct them using locally available materials, how to use them – What are the challenges to adopting these practices and how could you and the community overcome these challenges?	

What can you do to safely store your water and utilize?	Discuss on locally available water containers, how safe it is from contamination, sources of water…etc, and facilitate the discussion so that the group identifies their common problem and come up with their own solution – Ensure your drinking water is not contaminated, get your water from a clean source, and store it in a clean container with a narrow neck and a cover. – If you are getting your water from an unclean source, make sure to boil the water before you drink.	
Separate animal and family shelter	Avoid keeping animals in family house, as it is the main source of communicable disease which can be transmitted from Animals to human	

Activity: Installing Tippy Tap and handwashing demonstration

Demonstrate how to build a tippy/sprinkle tap (if HHs do not have hand-washing facilities), then how to use them with soap and/or ash. The tippy tap should be built from locally available resources. Every meeting will commence with a handwashing demonstration to highlight their functionality and to promote handwashing. The Tippy-Tap consists of a large container (around 5 litres) hanging on a horizontal stick. The container can be tipped by pushing a foot down on a stick balancing on the ground which is attached by a thin rope or piece of cord to the cap of the container. As only the soap is touched during hand washing, the device is very hygienic.

Session 7: Reflection and Graduation Celebration

Objective: Reflect on what they have learnt, the improvements to their homes and the behaviors they have changed. Reflect on if these changes have had positive or negative effects on their lives and the health of themselves and their families & communities.

Activity: Graduation Ceremony with certificates

VIII. Role of Community Development Workers (CDWs)

The CDWs will have the following roles, and these roles will be in collaboration with HEWs:

- Respect the culture and tradition of the community and build on the existing positive behavior.
- Lead the sensitization of the community for the FHA activity, its objectives, the target households and the types of activities involved.
- Support the HEW and the community to develop the FHA group in the community and the neighbor groups to select the volunteer mothers
- In collaboration with HEWs, the CDW should facilitate FHA group meetings, which will discuss on key nutrition and hygiene behavior and vital statistic and challenges reported by FHA groups.
- With the HEW the CDW should also record, and document issues discussed during FHA group meetings. Report progresses, challenges, and lessons/feedback to the woreda supervisor.
- Support the HEWs ensure access and function of health facility service for ANC, Institutional delivery, postnatal care, family planning, immunization, treatment of sick child …etc. are in place as per the government HEP (Health Extension Programme) and communicate gaps to the woreda supervisor.
- Should support FHA groups in taking their own monthly meeting minute (through their secretary) and develop action plan for the coming months meeting as required.
- Ensure the link among all FHA groups and Kebele development committee is stable, and their output contribute for improved nutritional status of women and children.
- Coordinates local-level activities and maintains cooperation with other community-level institutions, such as the village council, churches, and schools.

Models the health, nutrition and sanitation behaviors he/she teaches FHA groups in his/her own homes

IX. Mentoring

Mentoring of Care Group Mothers

The CDW/HEW should have the capacity to support and mentor the CGM to be able to openly discuss the different behaviors and the determinants and barriers that prevent the mothers adopting the behaviors. The CDW with the HEW should visit neighborhood care group session at least once a quarter.

During the visit, the Facilitator should:

- Observe the CGM facilitating a Neighbour Group meeting and mentor them to use the participatory skills taught in session 1

- Visit the home of the Volunteer Mother to see if the CGM is following the practices that she is promoting. The Volunteers Mothers are the 'model' mothers in their community. If they are unable to adopt the behaviors that they are promoting then the CDW must discuss and support her to overcome the barriers.
- Review the CGM register for completeness and accuracy.
- Ask about any problems the CGM are facing and trouble-shoot; accordingly, support and encourage the Lead & Assistant Lead Mothers, and thank them for their important work.

Supervision of CDW by SBCC Officer (Senior SBCC Officer)

The ability of the facilitator/CDW to facilitate FHA activities is the linchpin of the FHA. Facilitators require supportive supervision by project staff supervisors to ensure they are implementing the approach with high levels of quality.

Ideally, each facilitator/CDW should receive a supervision visit once per month. Almost all the facilitator's/CDW work is done in the community, so supervision must take place in the community. Simply meeting with facilitator /CDW during trainings and reviewing reports is not considered supervision.

During the supervision visit, the supervisor should:

- Observe the Facilitator/CDW facilitating a FHA meeting
- Talk to three to five CGMs to assess their participation level and interest in the project, and the quality and consistency of the Facilitators' work.
- If possible, talk to some of the Neighbour Women to assess their participation level, their interest in the project, and the quality and consistency of the Facilitators'/CDW work.
- Review the Facilitator's/CDW reports for completeness and accuracy.
- Assess whether the Facilitator's/CDW materials (registers, teaching materials) are kept in a safe, clean place
- Ask about any problems the Facilitator/CDW is facing and trouble-shoot accordingly; support and encourage the Facilitator, and thank them for their important work.

X. Monitoring & Evaluation:

There will be different monitoring and evaluation tools used for the CG approach. These include household registers, Care Group Mothers bimonthly meetings attendance monitoring sheet, care Group Monthly reporting Form, Care Group sessions plan. Indicators to be considered includes:

i. Process indicator:

- Number of FHA groups established.
- Number of FHA meeting held in a month.
- Number of neighborhood discussion held.
- Proportion of kebeles with active FHA groups.
- Number of HHs reached through neighborhood discussion.

ii. Output indicator

- Maternal, new-born and child health and nutrition knowledge, practices, and behavior in the target community; including

✓ Percent of households that adopt 3 identified key nutrition behaviors such as, early initiation of breastfeeding and exclusive breastfeeding, child minimum acceptable diet (meal frequency and dietary diversity), woman dietary diversity.

✓ Percent of households that adopt 3 identified key hygiene behaviors such as, access to clean latrine, safe storage of water, handwashing.

Number of children under five (0-59 months) reached with nutrition-specific interventions through USG supported programs.

iii. Outcome indicators:

- Percent of children 6-23 months receiving a minimum acceptable diet.
- Prevalence of exclusive breastfeeding of children under six months of age
- Percent of women of reproductive age consuming a diet of minimum diversity.
- Percent of households with soap and water at handwashing stations on premises
- Percent of female participants of USG nutrition-sensitive agricultural activities consuming a diet of minimum diversity.

XI. Annexes

Annes 1: FHA course outline

Annex 2: Neighborhood care group mothers education session attendance monitoring sheet

Annex 3: Home visit checklist

Annex 4: Pre and post retention tests

Annex 5: Monthly FHA activity reporting format