

CDSC FOR ECD CASE STUDY

MALILIMA: The Rules Nobody Wrote

How 75 care groups drove malnutrition to zero, and started writing their own child protection rules along the way.

Case Snapshot

CBO Malilima CBO	COUNTRY Malawi
DISTRICT Mulanje	COMMUNITY 15 villages across Malilima's catchment area
ECD ISSUE High child malnutrition, affecting roughly 7 of every 100 children, more than double the national action threshold	CDSC FOCUS A three-tier Care Group model, promoters, home visitors and lead parents, rolled out simultaneously across all 15 villages
KEY ROOT CAUSES Caregivers lacked consistent knowledge of nutritious food preparation; malnutrition was managed reactively by a small number of overstretched actors rather than prevented through routine household support	MAIN SOLUTION 75 Care Groups of 10 to 15 parents each, taught by trained volunteer promoters and monitored through regular home visits
KEY STAKEHOLDERS Malilima CBO, Health Surveillance Assistants, promoters, home visitors, lead parents, traditional leaders, World Vision and the Social Welfare Office	MOST IMPORTANT OUTCOME Health workers now report zero confirmed malnutrition cases in Malilima's catchment area
QUANTIFIED RESULT Caregivers able to give at least two examples of applying health professional advice rose from 42.4% to 66.7%	SUSTAINABILITY SIGNAL Communities invented two new rules Malilima never introduced, including a chief-enforced by-law on child injury caused by parental negligence

THE CASE IN ONE LESSON

The clearest sign that a community has taken ownership of a model is not that they follow it well. It is that they add rules to it the CBO never wrote.

The Problem

Brief background

Malilima CBO works across 15 villages in Mulanje district in southern Malawi. Before this case, a baseline study conducted with Health Surveillance Assistants found that roughly 7 out of every 100 children in the catchment area were suffering from malnutrition. Malawi's health system treats a rate above 3 per 100 as a harsh condition requiring intensive care, so Malilima's baseline was more than double that threshold.

At the time, malnutrition cases were managed reactively, mainly by Health Surveillance Assistants, chiefs, and ad hoc community committees, once a case had already become severe. There was no routine, household-level system for catching problems earlier.

The problem

The presenting problem

A baseline survey found child malnutrition affecting roughly 7 of every 100 children in Malilima's catchment area, more than double the national threshold requiring intensive attention.

The underlying problem

Malnutrition was being managed reactively by a small number of overstretched actors once cases became severe, rather than prevented through routine, household-level nutrition support.

The root causes

- Caregivers lacked consistent knowledge of how to prepare a nutritious diet and how to recognise early warning signs of malnutrition.
- There was no systematic mechanism for checking on household nutrition practices between clinic visits.
- Response to malnutrition was concentrated in Health Surveillance Assistants and chiefs, rather than distributed across the community itself.

The systems involved

Household system → Nutrition system → Health system → Community governance system

The root cause sat in the gap between the household and the formal health system: caregivers needed routine, nearby support translating clinical nutrition guidance into daily practice, which neither the clinic nor the household alone could reliably provide.

"In the past, as parents, we were also not taking our children to the hospital when they were sick. Instead, we would put things around their necks, believing they would protect them from illness. These practices have now stopped."

— Focus group discussion, Malilima males

CDSC in Action

Malilima's case shows an unusually precise, quantified problem identification process and strong evidence of communities extending the model with rules of their own.

CDSC stage	What happened	Evidence strength
1. Problem identification and prioritisation	<p>The problem was identified through a Health Surveillance Assistant led baseline study, giving it an unusually precise starting point: roughly 7 malnourished children per 100, against a national threshold of 3 per 100 requiring intensive care.</p> <p>This quantified baseline gave Malilima and the community a clear, shared threshold for both prioritising the problem and later confirming whether it had genuinely been resolved.</p>	Strong
2. Root cause analysis	<p>A separate, structured root cause exercise is not clearly documented, but the shift from a reactive, HSA and chief led response model to a routine, household level monitoring model implies a working diagnosis that the previous response system caught problems too late.</p>	Moderate
3. Solution identification	<p>The Care Group model and its training curriculum were adapted from an existing Care for Child Development guide provided jointly by World Vision and the Social Welfare Office, rather than designed from scratch.</p> <p>Malilima's own contribution was the three-tier volunteer structure, promoters, home visitors and lead parents, and the decision to launch all 75 care groups simultaneously across all 15 villages, rather than piloting in one location first, a genuinely ambitious, high coverage launch.</p>	Strong
4. Action planning and implementation	<p>Roles were clearly divided: home visitors check households and escalate concerns to promoters, promoters teach quarterly using a standard guide adapted to local conditions, and lead parents represent their peers within each care group.</p> <p>Training participation was rotated deliberately, so that once a participant had been selected for a given training, they would not be selected again until others had a turn.</p> <p>Care groups deliberately broadened their scope over time: an initial narrow focus on nutrition expanded to include child protection and responsive caregiving once malnutrition itself began to fall, a genuine, evidence based expansion rather than a fixed original design.</p>	Strong
5. Monitoring, evaluation and learning	<p>Monitoring is built directly into the care group structure itself, through weekly contact between Malilima, promoters, home visitors and lead parents, which Malilima describes as making monitoring not a main challenge.</p> <p>Communities extended this system on their own initiative. Two new rules emerged that Malilima never introduced: treating care group absence as a possible early sign of malnutrition risk, and a chief-enforced by-law requiring parents to appear before traditional leaders when a child is injured through parental negligence.</p>	Strong

Action and System Change

What actually happened

HSA baseline finds 7% malnutrition → 75 care groups formed at once → Promoters teach, home visitors monitor → Scope expands to protection & caregiving → Communities add their own new rules

Key actions and who was responsible

- Community: formed and staffed 75 care groups, elected promoters, home visitors and lead parents, and generated new rules and by-laws Malilima never introduced.
- Malilima CBO: coordinated the overall roll-out, adapted training curriculum to local conditions, and connected care groups to Health Surveillance Assistants and district health staff.
- Health Surveillance Assistants: co-led the original baseline study, jointly assess and refer identified malnutrition cases, and continue to visit care groups directly.
- World Vision and the Social Welfare Office: supplied the Care for Child Development training guide that underpins promoters' teaching content.
- Traditional leaders: encourage household participation, mobilise resources such as food items for cooking demonstrations, and enforce the community's own new child protection by-law.

Systems influenced

- Health system: District Health Office staff now visit Malilima's care groups directly, and Health Surveillance Assistants are embedded as ongoing, routine partners rather than occasional visitors.
- Community governance: two entirely new rules, treating care group absence as a malnutrition warning sign and a chief-enforced child injury by-law, emerged from the community itself, extending the model beyond what Malilima designed.
- Peer replication: neighbouring communities across a nearby river boundary have approached Malilima's office directly seeking the same child protection and nutrition guidance, without being formally recruited.

Implementation adaptation

The clearest adaptation was the deliberate broadening of care group content over time. Malilima describes starting narrowly on nutrition, then adding child protection and responsive caregiving once the original malnutrition problem began to improve, using the same trusted structure to take on new value rather than starting an entirely separate initiative.

Outcomes

The clearest outcome is the fall in confirmed malnutrition cases. Health workers report zero confirmed cases of malnutrition in Malilima's catchment area at the time of this case study, down from a baseline of roughly 7 per 100 children. A specific, documented case illustrates the mechanism: a family with a malnourished child, recently arrived from Mozambique, was identified and supported collectively by neighbours who pooled resources and shared feeding practices before formally reporting the case to Malilima and health services.

Community testimony describes real behaviour change beyond the clinical measure. Harmful traditional practices, such as tying charms or strings around a child's neck or waist to ward off illness, are reported to have stopped, replaced by prompt hospital visits when a child is unwell. Parents describe reading books, making homemade play materials, and fathers actively playing with their children, with one account describing children no longer being afraid when their father returns from the farm.

However, the quantitative household indicator for children receiving a nutritious, well balanced daily diet barely moved, and slightly declined, from 80.5% to 77.1%. This is a genuine tension worth reporting honestly rather than resolving in favour of the more encouraging clinical result: the case-based fall in confirmed malnutrition is dramatic, but the broader, self-reported measure of daily balanced diet did not show a corresponding population-wide gain, which may mean the strongest gains are concentrated among the specific households that were identified and supported directly.

A similar gap appears around gender norms. Qualitative accounts describe fathers actively playing with and reading to their children, yet the quantitative indicator for caregivers reporting that men are responsible and involved in child care showed no measured change at all, remaining flat at 20.9% in both the baseline and endline surveys. Both results are reported here, since resolving the gap in either direction would overstate what the evidence actually shows.

Indicators linked to Malilima's malnutrition pathway

The indicators below are drawn from the Malawi CDSC4ECD endline evaluation's CBO specific results tables. They are limited to indicators directly connected to Malilima's malnutrition and caregiving issue.

Relevant indicator (Malilima)	Baseline	Endline	Change	What the result suggests
Caregivers giving at least two examples of applying health professional advice	42.4%	66.7%	+24.3 pp	Consistent with the Care Group model's core purpose of translating clinical guidance into household practice.



A MALILIMA CARE GROUP MEETING ON COOKING DEMONSTRATION

A Malilima care group meeting, where nutrition, protection and caregiving practices are taught side by side.

Relevant indicator (Malilima)	Baseline	Endline	Change	What the result suggests
Caregivers citing at least two or three pieces of information from a health professional	67.4%	97.9%	+30.5 pp	A large gain in nutrition knowledge, reflecting the promoters' quarterly teaching cycle.
Caregivers reporting access to books and play materials at home	34.6%	70.8%	+36.2 pp	The largest gain in Malilima's data, consistent with care groups broadening into responsive caregiving content over time.
Children receiving nutritious foods and a well balanced diet daily	80.5%	77.1%	-3.4 pp	Essentially flat, despite confirmed malnutrition cases falling to zero. A genuine tension worth investigating.
Caregivers reporting that men are responsible and involved in caring for children	20.9%	20.9%	0.0 pp	No measured change, despite qualitative accounts of increased father involvement in play and caregiving.

Changes across four areas

A. Children and families

- Health workers report zero confirmed malnutrition cases in Malilima's catchment area, down from a baseline rate more than double the national action threshold.
- Harmful traditional protective practices have stopped, replaced by prompt hospital visits when a child is unwell.

B. Community practices

- Every care group operates its own linked village savings and loan group, which some households use to fund agricultural inputs supporting household food security.
- Communities generated two entirely new rules Malilima never introduced, including a chief-enforced by-law on child injury caused by parental negligence.

C. Systems

- District Health Office staff visit Malilima's care groups directly, and Health Surveillance Assistants function as embedded, ongoing partners rather than occasional visitors.
- Neighbouring communities across a nearby river boundary have approached Malilima directly seeking the same guidance, without formal recruitment.

D. CBO capacity

- Malilima's three-tier volunteer structure, selected against explicit education criteria and rotated deliberately for equity, is credited in the wider Malawi evaluation as clear evidence of genuine, operationally real community ownership.

What Changed, and Why?

Quantitative, qualitative and implementation evidence converge clearly on nutrition knowledge and case-based recovery, while two genuine gaps, diet and gender norms, are reported honestly rather than smoothed over.

Quantitative evidence

Large gains in applying and citing health professional advice, and in access to books and play materials at home, are concentrated exactly where the Care Group model's teaching function was designed to have an effect.

Qualitative evidence

Community members describe a specific, documented recovery case, the end of harmful traditional protective practices, and visible changes in caregiving behaviour including reading, play and father involvement.

Implementation evidence

The three-tier care group structure, HSA co-leadership, and two entirely new community-generated rules confirm the model is genuinely functioning as a distributed system, not simply a reporting exercise.

Taken together

Quantitative results, community testimony and implementation records converge clearly on improved nutrition knowledge and case-based malnutrition recovery. The evidence supports a plausible contribution pathway from routine, distributed household support to a measurable fall in confirmed malnutrition cases, though the flat daily-diet and male-involvement indicators show the pathway did not move every related measure equally.

What did not change, or changed less

- Children receiving a nutritious, well balanced daily diet was essentially flat, from 80.5% to 77.1%, despite confirmed malnutrition cases falling to zero.
- Caregivers reporting that men are responsible and involved in child care showed no measured change, remaining flat at 20.9%, despite qualitative accounts of increased father involvement.
- CBCC-based school feeding programmes in Malilima's area are fragile and resource dependent. A Primary School Advisor described feeding programmes collapsing once external financial support ended, causing learner absenteeism, and a community self-funding attempt lasting only three to four months before, in the advisor's own words, starvation came in.
- 13 of the 15 CBCCs in Malilima's catchment area still lack any permanent shelter at all, since Malilima's approach relied on renovating existing structures rather than new construction.
- Resource constraints limit both household contribution to shared activities like kitchen gardens, particularly on poor quality soil, and Malilima's own ability to expand the care group model beyond its current 75 groups.

Lessons and Recommendations

Lessons learned

- Anchoring problem identification in a specific, quantified baseline measure, rather than a general community impression, gives a CBO and community a clear, shared threshold for both prioritising a problem and later confirming whether it has genuinely been resolved.
- A three-tier volunteer structure, in which home visitors surface problems, promoters diagnose and teach, and lead parents represent their peers, distributes both monitoring and teaching responsibility widely enough that the CBO does not become the single point of failure for either function.
- Deliberately broadening a care group's scope over time, from nutrition to child protection and responsive caregiving once the original problem began to improve, allows a single, trusted community structure to take on new value rather than requiring an entirely new initiative for each new priority.
- When communities begin generating their own rules and informal monitoring heuristics that the CBO never introduced, this is a strong signal of genuine ownership, and CBOs should watch for and document these community-originated additions rather than only tracking their own planned activities.
- A clinical or case-based improvement in a health outcome should not be assumed to mean the same thing as a corresponding rise in the broader, self-reported behaviours meant to sustain that outcome. Both should be tracked and reported, even when they appear to tell different stories.

Recommendations

Recommendation	Responsible actor	CDSC stage	Evidence and rationale	Priority
Investigate the gap between the fall in confirmed malnutrition cases and the largely unchanged daily balanced diet indicator, to determine whether gains are concentrated among previously identified at-risk households.	Malilima; Firelight	Monitoring, evaluation and learning	Confirmed malnutrition cases fell to zero while the daily balanced diet indicator moved only marginally, from 80.5% to 77.1%.	High
Develop a feeding programme sustainability plan that does not rely solely on external funding or ad hoc household grain contributions.	Malilima; District Education and Social Welfare offices	Sustainability	A Primary School Advisor described feeding programme collapse leading to learner absenteeism, with a community self-funding attempt lasting only three to four months.	High
Prioritise permanent shelter construction or renovation for the 13 of 15 CBCCs in Malilima's catchment area that currently lack any permanent structure.	Malilima; Firelight; District Social Welfare Office	Action planning; infrastructure investment	The wider Malawi evaluation documents that 13 of 15 CBCCs in Malilima's area lack any permanent shelter.	High

Recommendation	Responsible actor	CDSC stage	Evidence and rationale	Priority
Investigate the disconnect between qualitative accounts of increased father involvement and the unchanged quantitative indicator for men's caregiving responsibility.	Malilima; Firelight	Monitoring, evaluation and learning	Caregivers reporting men as responsible and involved in child care remained flat at 20.9%, despite qualitative accounts of fathers playing with and reading to their children.	Medium

WHAT THIS CASE TEACHES US ABOUT CDSC

A community that only follows a CBO's plan has been organised. A community that starts enforcing rules the CBO never wrote, such as treating care group absence as a warning sign, has taken ownership. Malilima's case shows that this kind of unplanned extension is some of the strongest evidence CDSC can produce, even when other indicators tell a more mixed story.