Care Group Model Guidelines for Zimbabwe

2021

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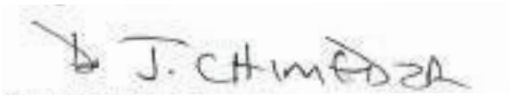
FOREWORD

The Government of Zimbabwe is committed to the survival of children and women in the country and in this regard has made great strides to address child and maternal health issues in the context of international and regional agreements aimed at improving maternal and child health. Despite the concerted effort, Zimbabwe is among the countries with a high burden of neonatal and under-5 mortality. Zimbabwe has also made tremendous progress in reducing maternal mortality. The MMR reduced from 651 per 100 000 live births (ZDHS 2015) to 462 deaths per 100,000 live births (MICS 2019). However, the maternal mortality rate is still unacceptably high.

Malnutrition, in the form of under-nutrition, contributes to nearly half of all child deaths globally. Due to the intergenerational consequences of malnutrition, undernourished children who survive often suffer throughout their life. Infant and young child feeding (IYCF) is a critical component of the first 1000 days of a child. WHO recommends initiation of breastfeeding within the first hour of birth, exclusive breastfeeding for the first six months of life, and timely and appropriate complementary feeding, with continued breastfeeding up to two years or beyond. Exclusive breastfeeding reduces infant morbidity and mortality from common infections, such as diarrhoea or pneumonia. Almost 3 in 5 new-born babies were put to the breast within the first hour of birth while only two in five infants under the age of six months were exclusively breastfed. Beyond 6 months, only 17% of children 6 to 23 months were consuming foods from the recommended number of food groups per day and only 1 in 10 children received the minimum acceptable diet. These indicators show that a lot is still needed to improve infant and young child feeding practices.

Implementation of the care group approach as a behaviour change strategy has proved to have high impact results in the pilot projects implemented by partners in some districts in Zimbabwe. Each development partner adopted a different care group approach where lessons have been drawn. The Care groups have been used to help in behaviour change in communities. The Ministry of Health and Child Care had to come up with hybrid care group model guidelines from the experiences gained from these pilot projects. The goal of the guide is to provide an adaptable model for enhancing nutrition, health, growth and development of women, infants and young children at individual and community level.

We would like to call for support from other sectors: Ministry of Lands, Agriculture, Fisheries, Water and Rural Development, Public service Labour and social welfare, Ministry of Women Affairs, Community small and medium Enterprises, Local government, Ministry of Primary and Education and Development partners during the implementation of these guidelines.



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ACKNOWLEDGEMENTS

Developing National Care Group guidelines is a complex endeavour that requires the input, collaboration, and support from a multi –sectoral stakeholders from the district, provincial to national level.

The Ministry of Health and Child Care is grateful to the integrated team for the stewardship provided during the development process of the Care Group Resource Package with the support from development partners; UNICEF, DFID, USAID, BMZ, FAO, WHO, WFP, Community Technology Development Organisation CTDO, Nutrition Action Zimbabwe, Welthungerhilfe-WHH, World Vision, Practical Action, International Medical Corps, Amalima Loko, LFSP, MANA for their valuable technical input throughout the development of this booklet.

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We also want to extend our gratitude to other line ministries such as the Ministry of Local Government, Ministry of Lands, Agriculture, Fisheries, Water and Rural Development, Ministry of Women Affairs, Community, Small and Medium Enterprises Development, Ministry of Higher and Tertiary Education, Ministry of Labour and Social Welfare and University of Zimbabwe among others.

LIST OF ABBREVIATIONS

AEW	Agricultural Extension Worker
AGRITEX	Agriculture Technical and Extension Services
ANC	Antenatal Care
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
CCW	Community Case Care Worker
CDC	Community Development Coordinator
CGLs	Care Group Leaders
CGM	Care Group Model
CTDO	Community Technical Development Organisation
DAEO	District Agriculture and Extension Officer
DCP	Dialogue Counselling Process
DDC	District Development Coordinator
DDO	District Development Officer
DEHO	District Environmental Health Officer
DFNSC	District Food and Nutrition Security Committee
DHPO	District Health Promotion Officer
DN	District Nutritionist
DNO	District Nursing Officer
DRT	District Remedial Tutor
DSWO	District Social Welfare Officer
ECD	Early Childhood Development
EHT	Environmental Health Technician
EMTCT	Elimination of Mother To Child Transmission
EPI	Expanded Program for Immunisation
FAO	Food and Agriculture Organisation
FH	Food for the Hungry
FNSCs	Food and Nutrition Security Committees
FSN	Food Security and Nutrition Network
GBV	Gender Based Violence
HCC	Health Centre Committee
HDDS	Household Dietary Diversity Score
HH	Household Handbook
HIV	Human Immuno-deficiency Virus
HPV	Human Papilloma Virus Vaccine
IEC	Information Education Communication
IMAM	Integrated Management for Acute Malnutrition
IMC	International Medical Corps
IMNCI	Integrated Management of Neonatal and Childhood Illness
ISAL	Internal Savings and Lending groups
IYCF	Infant and Young Child Feeding
LFSP	Livelihoods and Food Security Programme
LIST	Lives Saved Tools
LLINs	Long Lasting Insecticidal Nets

LIST OF ABBREVIATIONS

LM	Lead Mother
LMICs	Low Medium Income Countries
MANA	Multi-sectoral Approach Towards Nutrition Adaptation
MDD	Minimum Dietary Diversity
MICS	Multiple Indicator Cluster Survey
MIYCN	Maternal Infant and Young Child Nutrition
MNCAHN	Maternal New-born Child Adolescent Health and Nutrition
MNCH	Maternal Neonatal Child Health
MOHCC	Ministry of Health and Child Care
MUAC	Mid Upper Arm Circumference
NGO	Non-Governmental Organisation
NSBCC	Nutrition Social and Behaviour Change Communication
OVC	Orphans and Vulnerable Children
PDC	Provincial Development Coordinator
PFNSC	Provincial Food and Nutrition Security Committee
PHE	Provincial Health Executive
PNC	Postnatal Care
POTRAZ	Postal and Telecommunications Regulatory Authority of Zimbabwe
PPPs	Private Public Partnerships
PS	Permanent Secretary
QIVC	Quality Improvement Verification Checklist
SBCC	Social and Behaviour Change Communication
SMS	Short Message Services
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VFNSC	Village Food and Nutrition Security Committee
VIDCO	Village Development Committee
WADCO	Ward Development Committee
WASH	Water and Sanitation Hygiene
WFNSC	Ward Food and Nutrition Security Committee
WFP	World Food Program
WHO	World Health Organisation
WHH	Welthungerhilfe
WNC	Ward Nutrition Coordinator
WR	World Relief
YDO	Youth and Development Officer
YO	Youth Officer
ZDHS	Zimbabwe Demographic Health Survey
ZIMVAC	Zimbabwe Vulnerability Assessment Committee
ZMNS	Zimbabwe Micronutrient Survey
ZNNS	Zimbabwe National Nutrition Survey

SECTION 1 INTRODUCTION

1.1 Background

1.1.1 Maternal, Neonatal and Child Health (MNCH) Situation

Globally significant progress has been made in maternal, new-born, and child health (MNCH) in recent decades. Between 1990 and 2015, the global mortality rate for children under the age of five years dropped by 53 percent, from 90.6 deaths per 1,000 live births in 1990 to 42.5 in 2015 (Liu et al, 2016). Despite this progress, maternal, neonatal and under-five mortality remain high in many low- and middle-income countries (LMICs). Globally, an estimated 5.9 million children under the age of five years die each year, including 2.7 million within the first month of life (Liu et al, 2016).Health indicators differ across countries, regions, and socioeconomic levels with children living in low-income countries being three times more likely to die before the age of five years than their counterparts in high-income countries (Lozano et al, 2011 and Black et al, 2016).

In Zimbabwe, approximately 32 new-born deaths per 1000 live births, account for approximately 42% of all under-five child deaths (MICS, 2019). A closer analysis of this data shows that complications due to prematurity are the leading cause of death. According to WHO global data, Zimbabwe ranks 4th in the world in terms of rates of preterm births, at 16.6 pre-term births per 100 live births. Around 14,000 neonates die every year, mainly from preventable causes (MICS, 2019). The rate of decline of these key indicators leaves the country off-track to meet many of the targets set by the Sustainable Development Goals (SDGs) by 2030.

Good maternal health and nutrition are important contributors to child survival. Undernourished women give birth to smaller infants than those nourished adequately. Low-birth infants, in turn, are at a higher risk of death due to infections and asphyxia. Further, undernutrition increases the likelihood that children will be stunted when they reach adulthood. As adults, those children tend to have lower educational attainment and hence lower economic status. On the other hand, maternal survival is also affected by the women's nutritional status. Specifically, maternal short stature and iron deficiency are associated with a higher risk of death of the mother at delivery and account for at least 20 per cent of maternal deaths. Addressing the issues of undernutrition through high coverage of proved interventions greatly increases the impact of all other services across the continuum and accelerates the achievement of goals for both maternal and child survival (International Federation of Red Cross and Red Crescent Societies, Geneva, 2013)

1.2 Malnutrition

Globally, more than 820 million individuals were chronically malnourished (FAO et al, 2018). This highlights that the SDG 2 target 2.2 to end all forms of malnutrition by 2030 is off track. Forty percent of the world's population is micronutrient deficient and this has a negative effect on the growth and development of young children (Tucker, 2003; Development initiative, 2018). The prevalence of undernutrition in Africa stands at 20.4 %. Though Southern Africa (8.4%) is the second least affected region, it has shown a steady rise in prevalence over the years (FAO et al, 2018).

Malnutrition remains a cause for concern in Zimbabwe with national reports showing consistently high prevalence of stunting (24%) and micronutrient deficiencies (Vitamin A deficiency 21%, Iron deficiency 72% and Anaemia 37%) over the years (MICS, 2019; ZMNS, 2012). The trends of nutritional status of children from 1988 to 2019 are shown in Figure1 below.

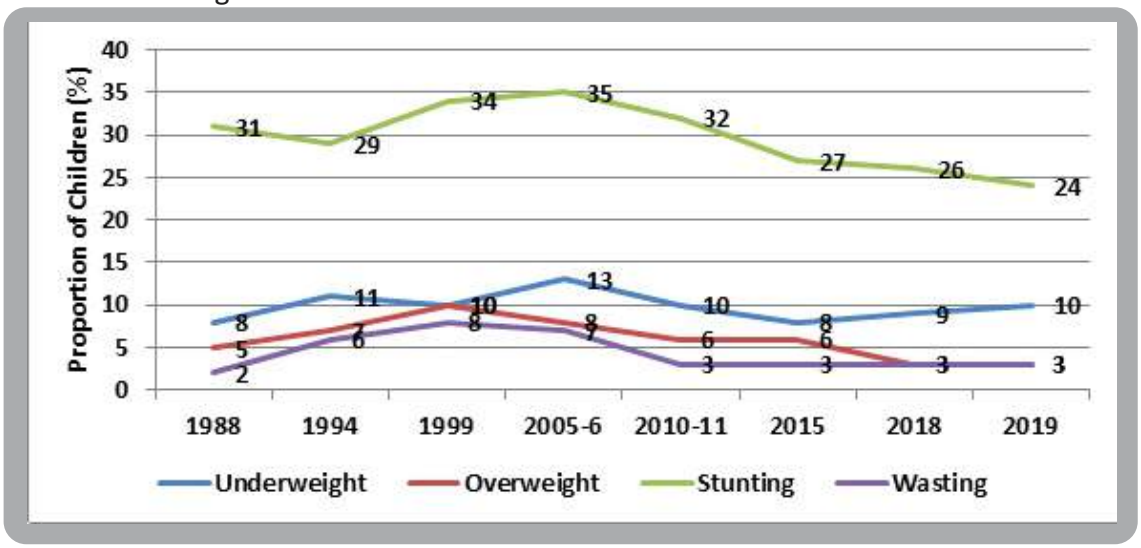

Figure 1: Trends of nutritional status of children from 1988 to 2019 (*ZDHS 1988-2015; NNS 2018 and MICS 2019)*

1.2.1 Causes of Malnutrition

The causes of malnutrition are complex and multi-sectorial; this is amply reflected by the United Nations Children's Fund (UNICEF) conceptual framework on causes of malnutrition which recognizes them as multi-sectorial encompassing food, health and caring practices (UNICEF, 2013). In the same vein the interventions need to be pluralistic and innovative.

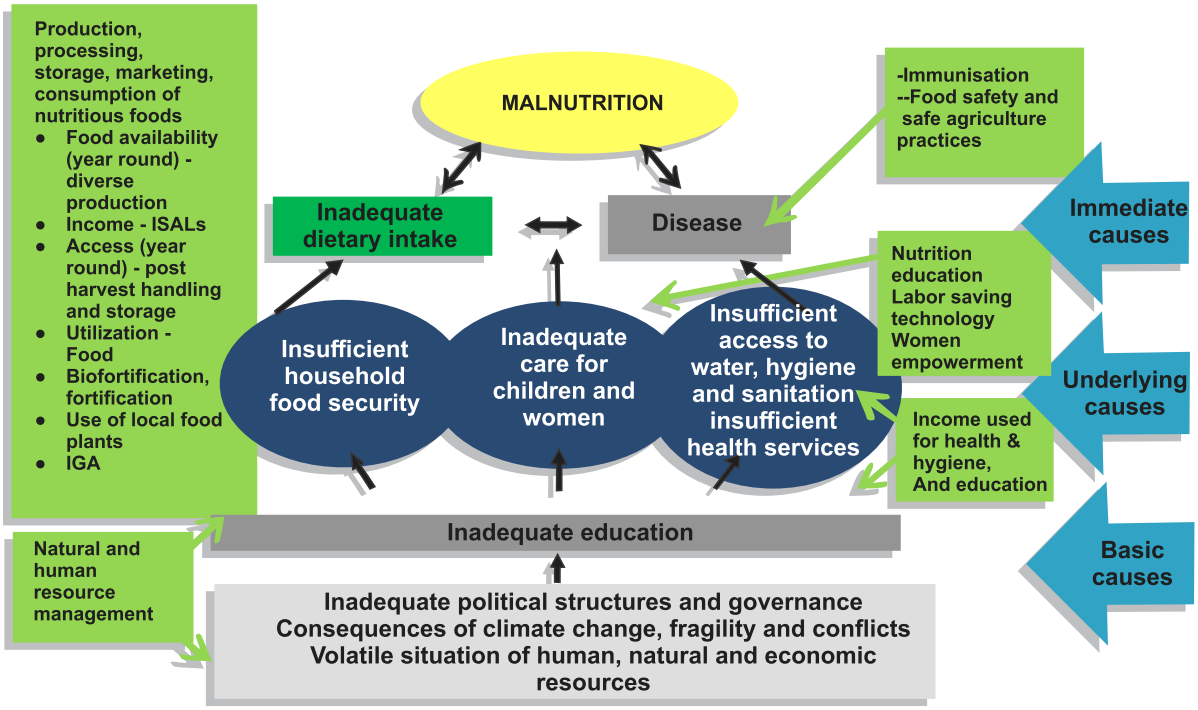

Figure 2: Conceptual framework of causes of childhood under-nutrition (UNICEF, 2013)

Caring practices such as breastfeeding, appropriate complementary feeding, as well as hygiene and health seeking behaviours support good nutrition. Optimal maternal, infant and young child feeding practices are critical for the survival, growth and development of infants and young children particularly in the first 1000 days (WHO, 2018). Zimbabwe has made strides in improving breastfeeding rates with 59% of infants are breastfed within the first hour of birth (MICS, 2019).While more than 95% of children were ever breastfed, the proportion of children who continued breastfeeding up to 2 years of life remained at less than 15%. Exclusive breastfeeding rates were at 42% which is below the global target of 50% (MICS, 2019).

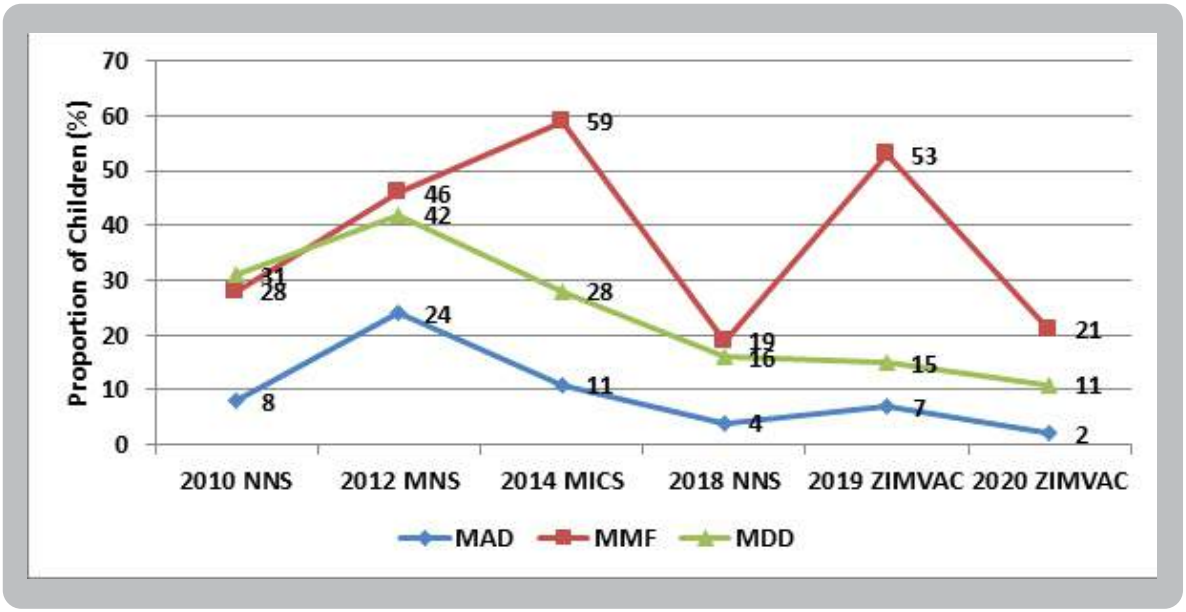

Figure 3: Performance of Complementary Feeding Indicators 2010-2020

1.3 Interventions

1.3.1 Maternal Infant and Young Child Nutrition (MIYCN) Interventions

Programs aimed at improving infant and young child feeding amongst children under the age of 2 years are being implemented at both community and health facility level. At health facility level, several platforms are used to deliver infant and young child feeding interventions. These take place at mother–health worker contact during ante-natal care (ANC), delivery, post-natal care (PNC), routine vaccination and growth monitoring. Services are also provided at any contact with the health facility and during in-patient admissions. In addition, the WHO/UNICEF Baby Friendly Hospital Initiative (BFHI) is being implemented at institutions that offer delivery services to promote, protect and support breastfeeding (MOHCC, 2018). At community level, Infant and Young Child Feeding (IYCF) interventions are largely being done by Village Health Workers (VHWs) mainly through counselling of pregnant and lactating women on infant and young child feeding. VHWs have been trained on IYCF counselling but there has been no structured guideline for the implementation of IYCF.

There is not enough evidence to show achievement of high level population coverage for key maternal and child health interventions and mortality impact from facility-based services alone in resource-constrained settings.

Expanding coverage of key interventions and achieving documented reduction in maternal, neonatal and child mortality will require approaches that are not only low-cost and effective on a short-term in small populations but also low-cost, effective, and feasible at large scale over the longer term period. This requires, among other things, approaches that engage the community as government; empower women and communities and reach a high proportion of households with health education that encourages healthy behaviours and appropriate use of health facilities.This necessitated the piloting of the care group approach by Ministry of Health and Child Care and its partners.

1.4 The Care Group approach

The Care Group approach is a delivery strategy for expanding coverage of maternal and child health intervention (Perry et al, 2015). The main goal of this community-based strategy was to improve behaviour change in a large population while maintaining low cost and sustainability. (Peace Corps Benin, 2010). This approach is based on the socio-ecological model which takes into consideration the individual and their affiliations to people, organizations and their community at large to be effective. It calls for government and its partners to pool resources and ideas together in order to improve community health. The Social Ecological Model has proven, in many differing situations, that in order to get the best results out of people at risk, it is best to approach the situation while addressing all levels of the framework while employing a multi-faceted approach,(Montano et al, 2015).

Evidence has shown that implementation of high impact but affordable priority interventions at a high scale can prevent 63 percent of current mortality in young children, especially when the interventions are implemented at home and in the community (Ceschia et al, Lancet 2016). George et al conducted a study on evaluation of the effectiveness of Care Groups in expanding population coverage of key child survival interventions and reducing under-5 mortality. When the improvements in coverage of key child survival interventions were compared, Care Group projects had significantly greater increases in coverage for all key interventions, where data was available. Care Groups have since been implemented and adapted in 27 countries by various international development organizations. (USAID, 2015).

1.5 Rationale

An appropriate mix of interventions can significantly reduce the burden of maternal and child mortality and morbidity. However, these interventions often do not reach those who need them most. An integrated approach that includes community-based care as an essential component has the potential to substantially improve maternal, new-born, and child health outcomes(Requejo et al, 2014).

Lives Saved Tool (LiST) Analysis of Care Group versus Non-Care Group Child Survival Projects looked at the care group models in 5 African countries (Kenya, Malawi, Mozambique, Rwanda) and 1 Asian country (Cambodia) (George et al, 2014). The study aimed to assess whether Care Group projects achieve greater improvement in

high-impact child survival coverage indicators than non-Care Group projects and whether they achieve greater reductions in the under-five mortality rate than non-Care Group projects. Fifteen high-impact coverage indicators were modelled in list. The meta-analysis showed that care groups were associated with 37% reduction maternal mortality and 23% reduction in neonatal mortality. The intervention was cost effective by WHO standards and could save an estimated 283000 new-born infants and 41 100 mothers per year if implemented in rural areas of 74 Countdown countries, (Prost et al, Lancet 2013). For all 15 high-impact indicators for which change in coverage was calculated for Care Group and non-Care Group projects, the mean change in coverage was greater in the Care Group projects.

Figure 4 below summarizes these findings.

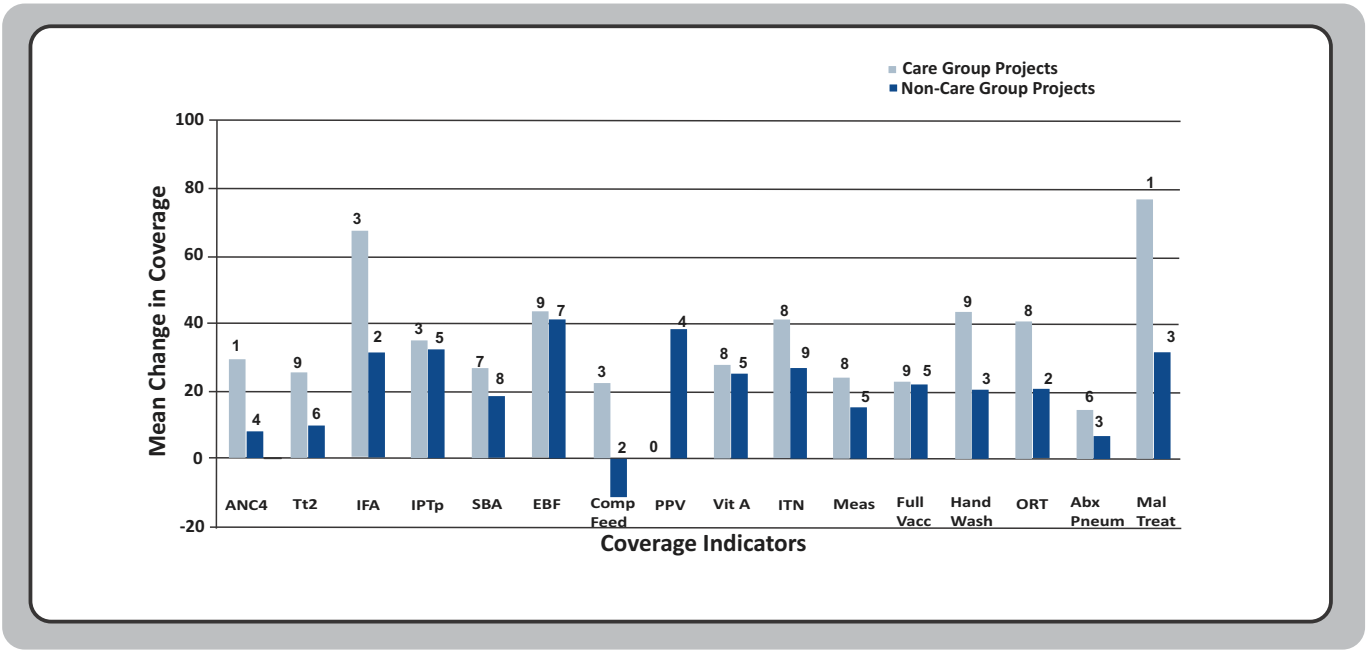

Figure 4: High Impact Child Survival Indicator Coverage Changes

To date since 2011, the care group model has been implemented at varying degrees in 24 out of 64 districts within 6 of the 10 provinces, in Zimbabwe. The following programmes and organisations have implemented the CG approach namely Amalima 2011, ENSURE 2014, CARE 2018, LFSP-ENTERPRISE 2014, LFSP-INSIRE 2018, LFSP-EXTRA 2018, NAZ 2018 and CARITAS 2019. The CG programme has been implemented in Manicaland- Mutasa, Mutare, Makoni, Buhera, Chipinge, Chimanimani; Mashonaland Central- Mt Darwin, Guruve, Bindura; Masvingo-Chivi, Bikita, Zaka, Chiredzi, Mwenezi; Matebeleland North-Tsholotsho; Matebeleland South-Bulilima, Gwanda, Mangwe; Midlands- Kwekwe, Gokwe South, Gokwe North and Shurugwi district.

The LFSP APN programme implemented care groups in 12 districts since 2018. A rapid nutrition assessment showed that these districts had higher complementary feeding outcomes compared to the national averages. MDD and HDDS was at 45.3% and 44.1% for LSFP project district compared to the national averages of 15.2% and 23.8% respectively. Children of mothers and primary care givers participating in Care Groups were more

likely to be consuming a minimum acceptable diet (53.4%) than their nonparticipating counterparts (35.8%) The Amalima programme showed improvements in consumption of the three non-staple groups in the "four star diet" promoted by the Care Groups namely vegetables and fruits, legumes and animal source foods. Results showed that children whose caregivers were members of Care Groups had a higher consumption of pulses and legumes (29%), fruits and vegetables (33%) and animal source foods (59%) compared to children whose caregivers were not Care Group members (Murakwani-Ncube et al, 2020).

An evaluation of the effectiveness of the Care Group Approach in addressing key drivers of stunting within the first 1000days also revealed improvements in complementary feeding indicators as compared to the national average. Within the project districts MAD was at 26.4% compared to national average of 6.9% while MDD was 33.3% compared to national average of 15.2% and MMF was 70.3% compared to national average of 52.8% (NAZ, 2020).It is against this background that the Ministry of Health and Child Care seeks to establish an effective model that stimulates demand and supply for MNC services at community level, at a large scale population.

1.6 Objectives

The aim of this guideline is to provide a sustainable, adaptable model for enhancing nutrition, health, growth and development of women, infants and young children at community level. It also intends to strengthen care and support for infants and young children's parents/caretakers to achieve optimal maternal, infant and young child nutrition.

The specific objectives of the guideline are to:

- Provide a standardised and adaptable implementation framework for CGs.
- Promote linkages, multi sectorial and integrated approach to address maternal, neonatal, child and adolescent health outcomes
- Specify roles and responsibilities of key stakeholders in promoting appropriate MIYCN practices.
- To strengthen capacity of PFNSCs, DFNSCs, DHEs, coordinators, supervisors, stakeholders in planning, implementation and monitoring of CGs
- Provide a monitoring, evaluation, accountability and learning (MEAL) framework for CGs

1.7 Target Audience for the CG guidelines

- Policy makers
- Government ministries
- Donors and NGOs
- FNSCs
- Health workers and extension workers

2.1 Defining the Care Group Approach

The Care Group Model is a community-based strategy for promoting behaviour change. This approach has been pioneered and documented by Food for the Hungry (FH) and World Relief (WR) during the past decade (FSN Network, 2014). A Care Group is a group of 10 -15 community-based volunteers who regularly meet together with the VHW for training and supervision. The Care Groups are different from typical mother's groups in that each volunteer is responsible for regularly visiting 10-15 women in her neighborhood to share what she has learned and facilitate behavior change at the household level. Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication messages, improving coverage and accelerating behaviour change by creating a large network of volunteer women. They also provide the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits.

Apart from the neighbor women groups, there are other key groups of people who can be either enablers or a hindrance to adoption of promoted behavior. In light of that, the care group approach in Zimbabwe will also include these influential groups such as the men's fora, youth groups and elderly women. These three groups will complement the activities of the neighbor women groups in promoting the adoption of new behaviour in addition to creating enabling home environment.

2.2 The Care Group Structure

The care group structure is made up of key stakeholders who are responsible for the coordination and implementation of the care group model. The structure includes coordinators, supervisors, promoters, care groups, influencing groups (adolescent, male advocates and elderly) and the care group clients as shown in figure 5 below.

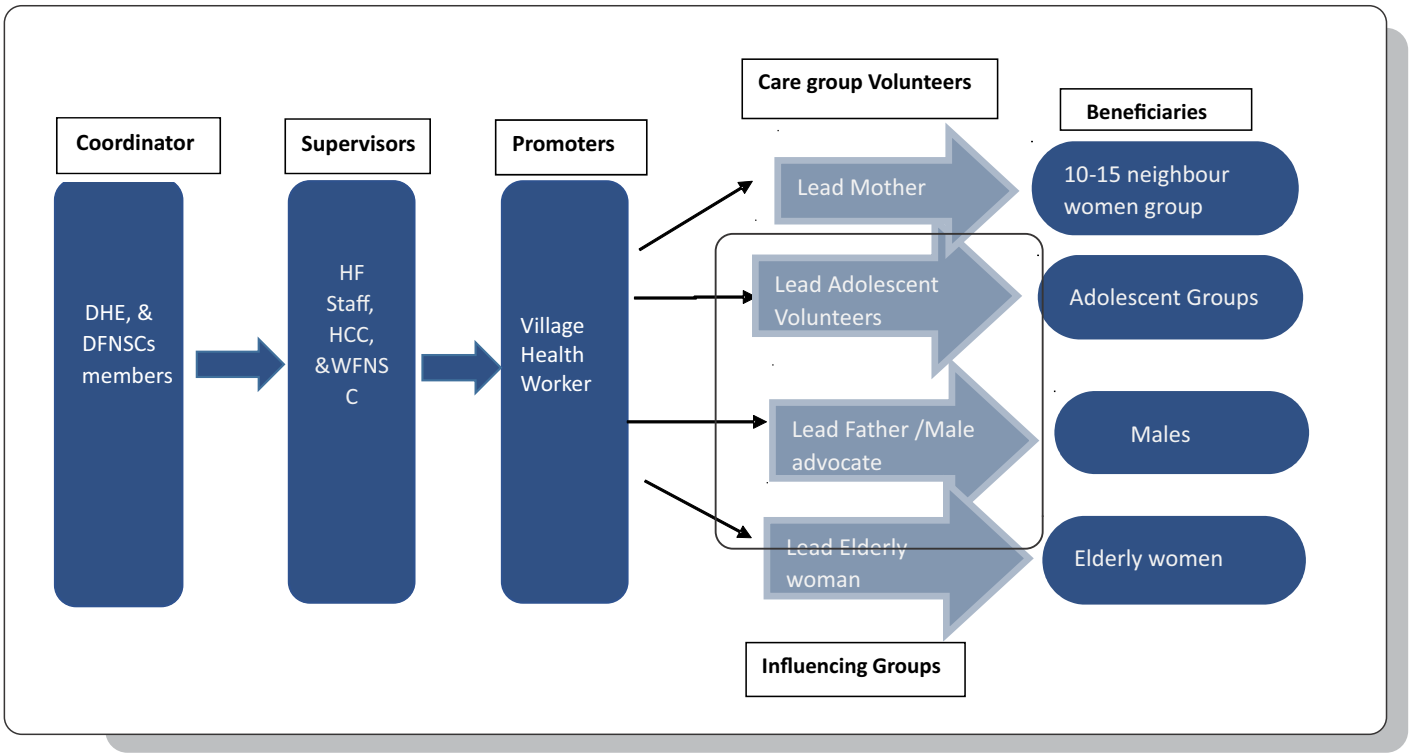

Figure 5: The Care Group Model Structure

Note: In hard to reach areas or areas with spatial geographic population distribution, care group can consist of 6-12 lead mothers and neighbour women 5-10 participants for maximum participation
Elderly men are encompassed in the male fora.
In the ideal situation, the district focal person should be the leading person (Nutritionist, Nutrition Assistant), however, in the absence of the district nutrition focal person the following will lead, DEHO, DNO and HPO.

At health facility level, the hierarchy will follow the Ministry of Health Policy.The extension officer (EHT) will be responsible for the supervision of Caregroups while the Nurse in Charge will be responsible for the facility
Partners such as NGOs who will be supporting the ministry will fall under the DFNSC as supporting members
The Promoter will work in tandem with the Village head in sustaining the work of Care Groups
Each promoter will lead a maximum of 2 care groups (20 lead mothers) beyond this figure he or she should in conjunction with the village head identify a pseudo promoter(volunteer who is chosen basically on voluntary basis for the purposes of rolling out the care group model) in leading the remaining lead mothers. Ideally 10 to 15 lead mothers form 1 care group.

Each lead mother should lead a group of 10 to 15 neighbour women beyond this figure the promoter in conjunction with the village head should choose another lead mother to take care of the reminder women
All activities conducted by Lead father/Male advocate, Lead Adolescent and Lead Elderly woman will be conducted around supporting women of child bearing age to uptake and adopt the promoted health and nutrition behaviours.

2.3 Establishing Care Groups

Establishment of care groups involve various steps, that should be taken at all levels from national to grass root level. Every stakeholder should be involved from the onset of the programme. The following steps should be followed when establishing a care group model:

- Sensitisation of key stakeholders from national to community level
- Baseline survey/needs assessment/barrier analysis
- Development of key behaviours and tools
- Training of key stakeholders from provincial and district level
- Training of supervisors (Health facility staff, HCC, WFNSC)
- Care group mapping
- Formation and registration of Care groups

The steps to be followed are highlighted and explained below.

Sensitisation of key stakeholders from national to district level

The National Care group focal person will sensitisekey stakeholders at national and provincial level.
Provincial level staff to sensitise district level stakeholders.
A one day sensitization of district level stakeholders on the care group approach/model, their goals, objectives

and expected outcomes should be done before cascading trainings to ward level cadres.
District level staff to sensitise ward level stakeholders who will sensitise the community leaders and general community.
Prior to establishment of care group, there is need for a one day sensitization meeting of Community Leaders, faith leaders, HCC members and VHWs on the goals, objectives, expectations and outcomes of the care group approach. Their roles and responsibilities should be clearly defined during this meeting and action plans for the establishment of care groups should be an output of this sensitization meeting.

Baseline survey/needs assessment/barrier analysis
Coordinators (DFNSC) and supervisors to conduct the baseline survey
Needs Assessment is to be conducted by both the coordinators and supervisors. The Precede-proceed model which is a comprehensive structure for assessing health needs for designing, implementing and evaluating health promotion and other public health programmes to meet those needs is to be adopted.
Barrier analysis may be conducted funds permitting.It is a survey that focuses on identifying what is preventing the priority group from adopting the behavior, as well as enablers of the behavior. It helps prioritise barriers and enablers so that resources can be channeled towards the most influential ones.
Development of key behaviours and tools
District team (DFNSC) to reconvene and analyse data from baseline survey/needs assessment/barrier analysis.
Using results from the Baseline survey/needs assessment/barrier analysis each district is to identify, develop and print the relevant key messages to be used in Caregroups

Training of key stakeholders from provincial and district level
This is followed by conducting a Trainer of trainers training on the care group model targeting key technical district staff. List of people to be trained includes District Nutritionist, DNO, DEHO, DHPO, DSWO, DCLPO, DRT, DDO and YDO. The training duration should be three to four days.
Ministry to identify cadres from the ministry or outsource trainers of the Caregroup model to train the district and selected provincial stakeholders

The provincial stakeholders are trained to have an appreciation of the model while the district level stakeholders are to cascade down the training to ward level.

Training of supervisors (Health facility staff, HCC, WFNSC)
A three to four dayToT targeting technical ward level cadres on care group approach/model, their goals, objectives, implementation modalities and expected outcomes should be conducted by district level staff. List of people to be trained includes EHT, Nurse, WNC, AEW, CCW, WDC and YO. The trained cadres would then be expected to sensitize ward stakeholder including the WFNSC and cascade trainings to VHWS and care group volunteers.
After the training the district stakeholders will train the supervisors (Health facility staff, HCC, WFNSC) on caregroup model and develop key messages.

Care group mapping

Soon after training of supervisors mapping is to be conducted. Mapping is done to provide the deserved information on the intended beneficiaries, to give eagle view so as to assist in planning. The community mapping assists in identification of beneficiary households with at least one pregnant or lactating woman or a mother/caregiver of children under two years of age (Care Group projects may also include mothers of children under five; or even all women of child bearing age). Community mapping allows identification the geophysical of the area to enable appreciation of distribution of mothers of child bearing age. It will also enable the identification of hard to reach communities such as the apostolic sects.

*Data collected to be tabulated using the register from group 5

2.4 Formation and registration of Care groups

The following two key tenants must be followed when forming Care Groups:

- Care Groups are an equitable approach and aim to have 80-100% of all beneficiaries (women who are pregnant, lactating, or mothers of young children) included in Care Group activities.
- Each Lead Mother's assigned beneficiary households should be as close together as possible so that regular visitation is not hindered. This also makes it more likely that the Lead Mother will have prior relationships with the people they serve, enhancing acceptance which will help to foster behavior change.

Soon after the community mapping exercise, guided by the above tenants, supervisors will facilitate the formation of the caregroups through the village health worker (promoter) and community leaders. The promoters facilitate a community meeting in which all the identified beneficiaries participate. Depending on the total number of beneficiary households identified in the village, neighbor women groups of 10 to 15 should be formed. Neighbour women comprising of pregnant mothers, lactating mothers and caregivers of under 5, should be residing close to each other. This will lessen walking burden to the meeting point.

Once the neighbor women groups have been formed based on their geographic proximity, the VHWs supported by the community leaders gather the neighbor women together to select their Leader. The process involves discussing the lead mother selection criteria before they select their leader.

At minimum, a Lead Mother must possess the following qualities:

- Be willing to work as a volunteer.
- resident of that neighbourhood
- should be relational with an impeccable character
- Respected in the community
- At least 18 years of age
- Be supported by their household members
- Positive attitude and have a desire to serve her neighbors.
- Be willing to adopt and models behaviors being promoted in terms of maternal and child care practises
- Able to read and write.

Once the Neighbor women group leader is selected, place a check mark next to the mother's name on the village beneficiary household listing.
After the selection of lead mothers, the lead mothers will then register their neighbour women. Registration of Care groups is done for accountability purposes. Each lead mother registers all her neighbour women according to the criteria in the table below

Standardised Care Group Mapping Form is used to identify all the beneficiary households in a village, a list of all beneficiary households should be generated, See Annex :
Note: Lead mothers keep registers for their neighbour women while the promoters keep registers for caregroups for the whole village

Selection and formation of influencer groups

Influencer groups comprise of elderly woman, youth and male advocates. Formation and recruitment of participants into these groups follow an almost similar process as for the neighbor women groups however, there might be slight differences in certain situations. In order to lead these influencer groups one should possess the following attributes:

- Be willing to work as a volunteer.
- Respected in the community
- At least 50 years of age for elderly women
- Be 12 to 17 years of age for adolescents
- Be supported by their household members
- Positive attitude and have a desire to serve her neighbors.
- Be willing to adopt and models behaviors being promoted
- Able to read and write.

Training of promoters, lead mothers and leaders of influential groups

After the formation of care groups; a five days training on the care group approach/model should be conducted.The trained supervisors will train the promoters, lead mothers and leaders from influential groups with support from the coordinators (DFNSC).

The promoter, lead mothers and leaders of influencing groups will be trained mainly on key health and nutrition behaviours, caregroup tools and key selected topics from the caregroup manual. The trainers will share and agree with the promoters, lead mothers and leaders of influential groups on all reporting modalities.Key tools to be used should be clearly highlighted to the participants at the training. Job descriptions of the promoters, lead mothers and leaders of influential groups to the clarified to ensure the smooth integration of activities and roll out of the programme. The trained cadres will be then expected to cascade the information gained.

Roll out and monitoring of care groups

When the modalities have been put in place, resources mobilised and organised the care group roll out should kick start. The district coordinators agree and arrange the behaviours to be promoted according to their

priorities and seasons, then develop an Activity and message calendar .The activity calendar is shared with the supervisors either through formal physical meetings or virtual meetings (whatsapp groups). The supervisors will then share the program with the promoters who will intern share with the lead mothers and leaders of the influential groups. To reinforce learning and adoption of behaviours each district will promote and report 1 behaviour per month. The district coordinator, supervisors and promoters will use developed checklists to monitor the effectiveness of the implementation process. The sharing of health and nutrition behaviours will take a top down approach while the reporting will use a bottom up approach. At village level the Lead mothers and Leaders of the influential groups will cascade the behaviours to their groups and peers, report the coverage, lessons learnt and success stories on monthly, quarterly and annual bases through the promoters. First consolidation of report from the Lead mothers and leaders of influential groups will be done by promoters at village level then forward their reports to supervisors who will then compile for the whole catchment area and then to the district coordinator who will then compile for the district. Initial visits by Supervisor to all Promoters and or Lead Mother should be done Regular / Periodic spot checks will be done by the district coordinators, supervisors and promoters. The initial visits should ensure that all Promoters and/or lead mothers are visited within the first two months. QIVC forms are used on the visits and a score of 80% or above means the promoter/LM is conducting the sessions well and might not require much supervision. The promoters will be responsible for day to day management of lead mothers and the leaders of the influential groups. They will also identify risks, manage and resolve conflicts and liaison with the village heads were necessary.

2.5 Roles and Responsibilities of Care group stakeholders

Successful implementation of the Care Group Model will depend on the collaborative efforts and interactions of all the stakeholders and actors through creation of effective partnerships. Key actors at different levels should play their roles to effectively plan, coordinate, implement, monitor, and evaluate activities.

The Lead Mother

- Meets with her neighbor women at least twice per month to promote behavior change
- Visits at least two neighbor woman and extended family members at home per month (according to the need and the relevance of the behavior) to negotiate behavior change
- Monitors and reports vital events that have occurred within the group, such as births, deaths, and severe illness
- Mobilizes neighbor women to participate in community activities that will benefit their families, such as integrated health campaigns, income generation initiatives, food production initiatives, food distribution, or WASH interventions e.t.c.
- Attends Care Group meetings facilitated by the Promoters and share reports.
- Reports problems that cannot be solved at the household level to local leadership, and requests support and collaboration from the Promoter
- Models behaviours being promoted

Male Advocate/Elderly Woman/Adolescent Volunteer

- Registers Participants into their influencer groups
- Meets with group members at least once a month to promote behaviour change
- Mobilize group members to participate in community activities that will benefit their families, such as integrated health campaigns, income generation initiatives, food production initiatives, food distribution, or WASH interventions etc.
- Attends Care Group meetings facilitated by the Promoter and share reports.
- Reports problems that cannot be solved at the household level to local leadership, and requests support and collaboration from the Promoter
- Models behaviours that are being promoted

Community/Faith Leaders

- Mobilizes the community to join and participate in care group activities
- Updates household village register quarterly
- Monitors participation of community members in the care group
- Provides support that enables Promoters and care group volunteers (male advocate, lead mother and elderly woman) to continue conducting care group activities e.g during community gatherings including funerals
- Models behaviours that are being promoted

The Promoter:

- Facilitates Care Group meetings with his/her care group volunteers (lead mothers, male advocate, elderly woman) at least once a month following the lesson plans in the educational materials provided
- Apart from day to day monitoring of Care groups, Promoter supervises each Care Group Volunteer at least quarterly by accompanying them on home visits and/or observing them leading group meetings
- Promoter to conduct at least 4 visits per month to Lead Mothers
- Completes monthly reports based on the Care Group Volunteer's (Lead Mothers, Male Advocate, elderly women) registers
- Coordinates and streamline care group activities into other community initiatives and maintains cooperation with other community-level institutions, such as the village assemble, churches, and schools
- Models behaviours being promoted
- Ensure that all care groups have adequate tools to conduct care group activities

Neighbour Women

- Attend meetings facilitated by the LMs
- Participate in group activities
- Engage their family members in adopting behaviors being promoted
- Mobilize each other to attend group meetings

Health Centre Committee

- Provides support that enables Promoters and care group volunteers (male advocate, lead mother and elderly woman) to continue conducting care group activities within the health facility catchment area.
- Models behaviours that are being promoted
- Mobilizes the community to join and participate in care group activities

Health Facility Staff - EHTs/Nurses/ NWCs

- Organizing and facilitating PROMOTER training on care group model
- Support the PROMOTERs in assigned tasks and mentor them to ensure achievement of desired outputs and outcomes
- Establishing, coordinating, and supervising Care Groups
- Collating information gathered by the PROMOTERs to display summaries at strategic sites to provide relevant feedback as well as material for dialogue at household and community levels
- Compiling reports from PROMOTERs and sharing with WFNSC and DHE
- Receiving feedback from the DHE and passing it to the Care Groups and PROMOTERs through dialogue and planning that leads to actions to improve identified issues
- Organize monthly and quarterly review meetings for PROMOTERs
- Advocate for Care group community awareness at community level
- Provide refresher trainings and updates to PROMOTERs

WFNSC

- Coordinate care group activities in the ward e.g. community dialogues
- Convene food and nutrition stakeholders at ward level and get feedback on the care group activities
- Participate in the training of care groups
- Monitor and evaluate care group activities
- Provides support that enables village health workers and care group volunteers (male advocate, lead mother and elderly woman) to continue conducting care group activities within their ward.

District Health Executive/ DFNSC:

- Mobilizes resources and liaise with other partners for support
- Facilitating ward level cadre trainings on care group model
- Provide technical support to ward level staff on care group Implementation modalities
- Co-ordinate care group activities at district level
- Plan, coordinate and facilitate inter-ward exchange visit
- Write monthly district care group report
- Conduct mentorship and supportive visits to ward level cadres
- Advocacy and social mobilization at district level

Developing and Implementing Partners

- Provide technical and financial support for the implementation of the care group

2.6 Mode of Operation

The Care Group primarily consists of monthly meetings and home visits. These activities more or less follow the same process and the aim of both is to influence behaviour change at household level.

Group Meetings

- Promoter monthly meetings at health facilities
- Promoter to meet Lead mothers (Care group) at least once a month
- Lead mother to have at least two group meetings with neighbor women
- Home visits by Lead mothers to at least two neighbor women a month
- Male advocates and elderly women Leader to meet with Promoter and/ or project staff once a month
- Men's fora and elderly women to meet once a month
- WFNSC meetings to be held monthly
- Participation of the Promoters and Lead Mothers during the Village Assembly Meetings when necessary

Each month at least three (3) group meetings are conducted, first at the Health facility where Promoter are trained on the behaviour of the month by the health facility staff and / other WFNSC members. Secondly, each Promoter conducts a training meeting with all his/her care group volunteers, to pass on the message of the month and make sure they are equipped with the necessary skills and materials to support the community to adopt the behaviour. Lastly, the lead mothers meet their neighbour women group to find out the current practices, identify barriers, enablers and then agree on small doable actions with the women with regards to the behaviour of that month. Similarly, male advocate and elderly women conduct meetings with their respective groups to promote identified behaviours for the month.

Home Visits

The LM conducts home visits to at least two neighbour woman once a month. During the home visit the LM ensure that other adult household members are part of the discussion. The discussion at household level is also aimed at determining the current practice, barriers, enablers and agreeing with the household on small doable action regarding the behaviour of the month. Furthermore, the LM checks whether the household is practicing the behaviours previously promoted. Any neighbour women that miss a group meeting should receive a household visit from the Lead Mother.

Home visits and group meetings should follow the same general structure as those in the Care Group meeting, with the following adaptations:

1. **Lesson Objectives:** Inform the neighbor woman and her household members the behaviour to be promoted. Each lesson should focus on one or two doable behaviours.
2. **Game or song:** If conducting a group meeting, the Care Group Volunteer may facilitate a game or song. This helps neighbor women to 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. At home

visits, creating a safe and comfortable atmosphere with a little relaxed conversation and greeting everyone in the family might be more beneficial.

3. **Reporting and Trouble shooting:** The Lead Mother notes the neighbour women present at the meeting, records attendance and date of the visit or meeting, and inquiries about any vital events in the previous month (birth, deaths, or new pregnancies). The Care Group Volunteer asks the neighbor woman if she could try out the behaviors committed to in the previous meeting. This is an important opportunity to address any barriers that come up in practicing a new behavior.

4. **Behavior Change Promotion through Pictures and Stories**: The Care Group Volunteer should then use pictures or stories. Stories told should include a positive and negative story so that benefits of adopting the behavior and dangers of not adopting the new behaviour are highlighted. In a group setting, discussion questions should be used to find out the current practices by the mothers in the group. If at a household visit, the Care Group Volunteer should try to involve other family members present (such as a husband, mother-in-law, etc.) in the lesson.

5. **ASK ABOUT CURRENT PRACTICES:**
   Discuss current practices with the women using the household handbook as a guide. Ask the women about a current practice, starting with the first one on the page. Circle the smiling icon under the image of any behavior as the woman shares a positive current practice. Praise her for each behavior she is already practicing. If in a group meeting, the facilitator would ask the participants what they are seeing in their communities and work with those. If conducting a home visit, the Lead Mother would directly pose the question to the mother.

6. **IDENTIFY BARRIERS:** For any behaviour a mother is not already practicing, the facilitator should circle the frown face icon and probe to understand the barrier. Ask what might be one obstacle that prevents the mother from practicing the behaviour. Ask questions to get to the root causes of the obstacles. For example, ask the mother questions like, What makes this difficult?" and "Why do you think that is the case?" Once the facilitator has identified a root cause, or a level of 'doable action', she should note it in the box and move on to identifying enablers.

7. **IDENTIFY ENABLERS:** Once After discussing barriers, seek to help the mother think of enablers by asking, "What do you think would make it easier for you to do this?" and "How do you think we can make this happen?" or "Is there anything that might help with this problem?" Allow the mother to come up with ideas first, then offer suggestions afterward.

8. **NEGOTIATE ACTIONS:** Once the facilitator has discovered a viable solution, she should ask the mother to make a Commitment to Action to apply the solution. She may say, "Can we agree that you will try…" If the mother agrees, she should sign in the box as a show of her commitment. The facilitator should explain that the frown face does not mean that the mother has done anything wrong, but that it will remind them both of what they have agreed to do. When

the care group volunteer returns on the next visit, she can refer to the HH and ask the mother about her level of success.

9. **Activity (if possible):** Activities are “hands-on” exercises to help the participants understand and apply what they have learned. People usually do not change their behaviour just by being told to do so! Behaviour change will be much more likely if women are able to try out the behaviour in a safe environment. For example if the behaviour is on dietary diversity, a simple cooking demonstration could be arranged. The care group volunteer is responsible for organizing materials for each lesson's activity. Materials may be brought by neighbor women from their own homes to create a 'real life' situation. An activity may not be possible for all behaviours.

10. **Discuss Potential Barriers and Solutions:** When neighbour women discuss barriers during each lesson; they have to really imagine doing the behaviour within their household context. Once all of the barriers are discussed, the care group volunteer should engage all participants in identifying ways to overcome the barriers mentioned. It is not the responsibility of the Lead Mother to offer solutions. Brainstorming solutions is a group responsibility and will help empower neighbor women to become effective problem solvers.

11. **Practice and Coach the Dialogue counselling process:** Each Community Nutrition Support Group Client should practice teaching the lesson to another Client. The Clients should observe and give advice when needed. This helps the neighbour women become familiar and comfortable with the behaviour messages.

12. **Request a Commitment to Try the New Behaviour:** Studies have shown that when someone promises to do something they are much more likely to do it. The Promoter should ask each neighbor woman to commit to trying out the new behaviour herself, before leaving the meeting and telling others about it.
    At the end of this session refer to the monthly meeting and organize the participants into groups so that they can practice role plays for the monthly meeting.

Table1: Summary of the Care Group Meetings and the Home Visit activities

LM TRAINING MEETING	Neighbor women Training Meeting	HOME VISIT
Objectives	Objectives	Greeting
game or song	game or song	Ask others to join
attendance and troubleshooting	attendance and troubleshooting	Objectives
Storytelling	storytelling	Storytelling
ask about current practices	ask about current practices	ask about current practices
discuss barriers and enablers	discuss barriers and enablers	discuss barriers and enablers
negotiate behaviors	negotiate behaviors	negotiate behaviors
secure a commitment (as a LM)	secure a commitment (as a LM)	secure commitments (mother and family)
Activity	Activity	Activity
practice coaching of the dialogue counseling process		
secure a commitment (personal or as LM)	share individual commitment	
		give technical information when needed
		thank the family and offer praise, remind them when you will come back set a follow up visit

What happens during Care Group meetings?

- Short walk to the meeting site: 30 minutes or less
- Reporting of vital events (births, deaths) and progress in health promotion
- Demonstration with pictures or story telling of 2-3 key messages
- Group reflection on the messages then practice in pairs (Checking understanding).
  Meetings are 1.5 – 2 hours once a month.

Table 2: Other Activities which can be conducted during Group Meetings

Activity	Summary
Cooking Demonstrations	• To be done using locally available foods using ingredients from household participants. • Development of recipes for complementary feeds for children 6-23 months. • Recipes developed by the groups should be documented for sharing with other groups and also for production of local recipe booklets.
Internal Savings and Lending Groups	• Groups to be capacitated on ISALs • Trainings on constitution development for ISALS to be conducted • ISALs also become incorporated during their monthly group meetings
Fuel Efficient Stoves	• Trainings on fuel efficient stoves construction (jengetahuni, tsotso stoves, hot box cooker and ground oven) to Lead mothers, Male advocates, elderly women and adolescent advocates. • Cascading of this can be done during their respective group meetings
Clay pot fridge	• Trainings on clay pot fridge construction to Lead mothers, Male advocates, elderly women and adolescent advocates. • Cascading of this can be done during their respective group meetings and time set aside for the
Tippy tap	• Trainings on tippy tap construction to Lead mothers, Male advocates, elderly women and adolescent advocates. • Cascading of this can be done during their respective group meetings

Solar drier	• Trainings on solar drier construction to Lead mothers, Male advocates, elderly women and adolescent advocates. • Cascading of this can be done during their respective group meetings
Keyhole garden	• Trainings on Key Hole garden construction to Lead mothers, Male advocates, elderly women and adolescent advocates. • Cascading of this can be done during their respective group meetings
Two level pot rack	• Trainings on two level pot rack construction to Lead mothers, Male advocates, elderly women and adolescent advocates. • Cascading of this can be done during their respective group meetings
Mother Led MUAC	• Neighbor women groups to measure the children MUAC during their meetings • The measurements will be given to the Lead Mother for submission to the PROMOTER • Children with oedema, yellow and red MUAC are to be referred to the nearest health facility.
Crop and small livestock production	• Livestock Pass On projects e.g. goat , chicken • Crop production to improve household dietary diversity. • Construction of keyhole gardens
Income Generating Activities	• Groups to be capacitated to embark into a variety of income generating activities of their choice using locally available resources. • These activities include crop & small livestock production, sewing clubs, bread making etc.

2.7 Sustainability

Sustainability is a process that improves conditions that enable individuals, communities and local organizations to improve their functionality, develop mutual relationships of support and accountability, and decrease dependency on insecure (institutional, technical and financial) resources(FSN Network, 2014). Sustainability enables these local stakeholders to play their respective roles effectively, thus maintaining gains in health and development beyond the project period. The individuals, communities, health services and local organizations constitute a local system interacting with and embedded in a larger environment. The efforts and interactions of these actors in the local system are what lead to lasting health impact. Their efforts will be based on their own understanding of their community's health and development.

The goal here is to sustain the structures, activities, benefits and outcomes of the programme. This goes along with the following pillars:

- Motivation
- Linkages
- Capacity
- Resources
- Community Ownership

i) Motivation

Care group volunteers maybe motivated through a wide range of activities. These may include the following

- Provision with promotional materials-(Zambia, hats, T-shirts)
- Provision with hygienic enablers (soap, sanitizers)
- Conducting exchange visits
- Providing constant support by supervisors and other stakeholders which promotes the care group to continue meeting
- Issuing certificates
- Provision of tools of trade
- Celebrate the Care group volunteers (Lead Mothers, Male advocates, elderly women and adolescent advocates.
- Conduct Cooking demonstrations, sports days
- Constant feedback about each volunteer's performance

ii) Linkages

Sustainability of care groups is much based on the integration into existing additional components in the communities (Gomorra et al, 2019). Creating linkages with other community initiatives will ensure cementing of the care groups. Care groups can be linked to:

- Income Generating Activities e.g. ISALS
- Crop and livestock production activities
- Nutrition gardens
- Cooking Demonstrations and Competition

- Seed and Food Fairs
- Child Protection Committees
- Charity Groups
- Community Based Organization

iii) Capacity

All stakeholders at all levels should be capacitated on the CARE group approach. The stakeholders' continual support to the communities will also improve the capacity of the communities in adopting new behaviors hence ensuring sustainability. Capacity involves all the aspects that enables the group to conduct all the other complementary activities that are also cement the care group. Refresher trainings should also be planned from the onset and be offered periodically. Areas that care group volunteers should be capacitated in include:

- Maternal, child and adolescent issues
- Food security initiatives
- Cross cutting issues e.g. gender, HIV
- Constitution development for example if they want to engage in Income generating activities like ISALs
- Social protection issues

iv) Resources

Tools for the trade are key for volunteers. Community Volunteers want identification and feel so elevated when the community uniquely identifies them. Provision of adequate reference materials, teaching aids and reporting tools is key for the care group volunteer to remain committed to tasks assigned. Furthermore, use of locally available resources in aiding the adoption of behaviour being promoted also enhance sustainability. For example during cooking demonstrations use of locally available foods to come with recipes and nutritious dishes is essential as this is cost effective since the foods are found locally. The following tools of trade of the trade are necessary for the Care group volunteer;

- Counselling cards
- Recipe books
- Quick Reference guide
- Pamphlets
- Registers
- Reporting tools
- Planning guides
- MUAC tapes

v) Community Ownership

Community leadership involvement from the onset have a positive effect on the functionality of the CARE groups and will lead to the sustainability of these CARE groups. Sensitization of community leaders on the CARE group approach during the inception and also clearly highlighting their roles and responsibilities will ensure sustainability of the CARE groups and maintenance of the behaviors being promoted. It is very crucial that

community leaders are involved during formation and during the implementation of CARE groups. Community leaders may also play a role of enforcement of some of the behaviors which are being promoted hence ensuring sustainability.

2.8 Functionality of Care groups

Although the Care Group approach has been proven to be very effective as a behaviour change strategy, if not executed with a high level of quality, it will not yield the desired results. Hence there is need to monitor implementation focusing on quantity (number of meetings held and how many people attended) and quality of meetings and outcomes of the care groups. Therefore, functionality of care groups can be measured through constant monitoring and supportive supervision.

2.9 Supportive Supervision

Supportive supervision is an on-going process designed to mentor and coach a worker so that they gain the independence, self-confidence, and skills needed to effectively accomplish the tasks. Supportive supervision is important in Care Group implementation as a source of support to Care Group volunteers and ensures the approach is implemented as planned.

Therefore, Supportive supervision of Care Group activities occurs on at least two levels:

i) the supervision of Care Group Volunteers by PROMOTERs
ii) and the supervision of Promoters by the Health facility staff

Supportive Supervision of Care Group Volunteers by Promoters

The Promoter should conduct home visits to at least four Lead Mothers &/or Leaders of Influential Groups from each of their Care Groups on a monthly basis. During the home visit, the Promoter should:

- Observe the Lead Mothers &/or Leaders of Influential Groups facilitating a home visit or neighbour group meeting. A monitoring tool called a Quality Improvement Verification Checklist (QIVC) must be used which includes the key steps of the Care Group meeting against which the Promoter can assess to what extent each step was completed.

- After the session the Promoter must return to the Lead Mothers &/or Leaders of Influential Groups home to give feedback.

- The Promoter needs to assess the Lead Mothers &/or Leaders of Influential Groups home and practices to see whether the Lead Mothers &/or Leaders of Influential Groups is following the practices that s/he is promoting. The Lead Mothers &/or Leaders of Influential Groups is the 'model' mother in her community. If she is not following the practices she is teaching, the Promoter should help the Care Group Volunteer overcome any barriers.

- In addition, the Promoter must review the Lead Mothers &/or Leaders of Influential Groups register for completeness and accuracy.

- It is important also for the Promoter to ask about any problems the Care Group Volunteer is facing and trouble-shoot accordingly;

- Offer support and encourage the Care Group Volunteer, and thank her for important work.

Supportive Supervision of PROMOTERs by Health Facility Staff

The ability of the PROMOTER to facilitate Care Group activities is the backbone of the Care Group approach. PROMOTERs require routine supportive supervision by their supervisors to ensure they are implementing the approach with high levels of quality and fidelity to the model.

The PROMOTER should receive supportive supervision visit once per month. Since the PROMOTER work is community based the supportive supervision should take place at community level. During the supportive supervision visit, the supervisor should:

- Observe the PROMOTER facilitating a Care Group meeting, preferably using a QIVC

- Talk to three to five Care Group Volunteers to assess their participation level and interest in the program, and the quality and consistency of the PROMOTERs' work.

- Talk to some of the neighbor women to assess their participation level, their interest in the program, and the quality and consistency of the PROMOTERs' work.

- Review the PROMOTER's reports for completeness and accuracy

- Assess whether the PROMOTER's materials (registers, teaching materials) are kept in a safe, clean place

- Inquire any problems being faced by the PROMOTER and trouble-shoot accordingly;

- Offer support and encourage the PROMOTER, and thank them for their important work.

3.1 Introduction

The roots of poor nutrition lie in human behaviour. Improvements in nutrition are not possible without broad, widespread changes in the everyday behaviours of people and organizations around the world. Virtually all the immediate and underlying causes of malnutrition are behavioural influenced by the behaviours of individuals and their household members. Nutrition is also influenced, however, by the behaviours of many other actors. These range from health care providers and schoolteachers to farmers and other agricultural agents, from religious and community leaders to private sector companies and policymakers, who collectively directly or indirectly influence care and feeding practices, household food security, the household environment, and health care services". (USAID, 2017)

This section provides guidance on the Nutrition behaviour change strategy to be implemented in the roll out of the Care group model. The guideline defines **Social and Behaviour Change (SBC)** as an approach to programming that applies insight about why people behave the way they do, and how behaviours change within wider social and economic systems, to affect positive outcomes for and by specific groups of people. The guideline further defines **Nutrition social and Behaviour Change Communication (SBCC)** as a set of interventions that combines elements of interpersonal communication, social change and community mobilization activities, mass media, and advocacy to support individuals, families, communities, institutions, and countries to adopt and maintain high-impact nutrition-related practices. For effective nutrition SBCC the approaches defined in this guideline aim to increase the factors that encourage these behaviours while reducing the barriers to change (USAID 2017).

Behaviour change for the care group model will be guided by the health belief model which suggests that a person's belief in a personal threat of an illness or disease together with a person's belief in the effectiveness of the recommended health behavior or action will predict the likelihood the person will adopt the behavior.[1] Bahaviour change activities as detailed in this section will through practical, context specific and interactive approaches deliver critical information to communities as well as trigger adoption of recommended practices at all levels.

The Vehicle for Behaviour Change should Support the Stages of Behaviour Change as described in the Figure 6:

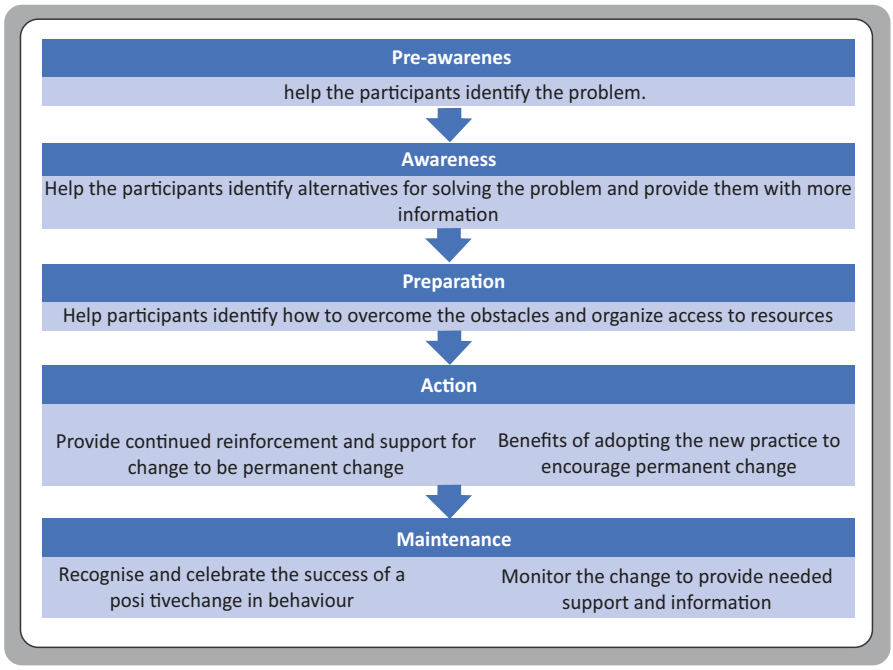

Figure 6: Stages of behaviour change

[1] https://sphweb.bumc.bu.edu/otlt/mph-modules/sb/behavioralchangetheories/behavioralchangetheories2.html

3.2 List of behaviours

A list of behaviours has been drawn from gaps identified by studies in the country and previous behaviour change implementation in the country. These behaviours will guide implementation in varied operational areas addressing issues in communities that hinder optimal nutrition under the following focus areas or thematic areas. The list of behaviours will not be exhaustive but will be further informed by additional studies in targeted areas (see Annex 1).

3.3 Steps in Selection of Behaviour and Tools Development

The selection of behaviours and development of tools, will be guided by the Precede and Proceed model of behaviour change which is a comprehensive structure for assessing health needs for designing, implementing, and evaluating health promotion and other public health programs to meet those needs. The model's ability to provide a framework on which different health behaviour change theories can be applied, will guide the selection of behaviours in the targeted regions and subsequently guide in the development of tools as well roll out of the behaviour change activities. The steps detailed below will guide the process as follows;

Table 3: Steps in selection of behaviours

	Step	Description
1	Identify poor performing indicators in targeted area.	This will be done using national level studies and assessments as well as other representative studies on food and nutrition. District level data will be critical for the selection process. Where ward level is available it may also be consulted for more specific behaviour selection. e.g ZIMVAC, NNS, MICS etc
2	Select from the list of behaviors, which behaviors will address the poor performing indicators.	The guideline provides a list of behaviours within thematic areas in Maternal health, IYCF, WASH, Nutrition sensitive agriculture, production, Gender, Food consumption etc. From that list the identified behaviours that resonate with the poor performing indicators will be selected.
3	Conduct formative study on the selected behaviours to inform reasons why the behaviours are not being practiced.	A barrier analysis survey will be conducted on the selected behaviours[2]. The barrier analysis will be a doer non-doer assessment that aims to identify barriers and enablers for adoption of recommended behaviours.
		After the study, identify significant perceptions that determine adoption of the behaviour.
4	Develop materials, tools and activities for Care group meetings based on the Significant perceptions in the community (as informed by the study).	The significant perceptions will provide information on why behaviours are not being adopted. This will inform the specific activities that will be conducted in the Care groups as well other community engagement activities. Stories for the group meetings and household visits for Care group members, will be developed as guided by the findings of the study. Specific districts will have different perceptions on adoption of behaviours.

[2] Kittle, Bonnie. 2013. A Practical Guide to Conducting a **Barrier Analysis**. New York, NY: Helen Keller International.

Table 4: Description of tools to be developed

Tool	Description
Counselling cards	Will contain technical information in pictures to guide the counselling process when technical information is needed. This can be done during the monthly training session for Lead mothers or when Village health workers are supported.
Story books	Stories will be developed based on the findings of the formative studies. The stories will depict a positive story and a negative story to allow trigger mothers practicing the positive behaviour.
Monthly meeting guide	Will provide a guideline for the PROMOTERs and LMs to conduct monthly meetings. Sections of the guidance will cover topics as described in the section on what is done during a monthly meeting.
Household handbooks	Will be used by the mother to record behaviours that they would have adopted as well as challenges to conduct the behaviours.

Table 5: Roles of Care Group actors and materials used

#	CG Actors	SBCC Role	SBCC Materials
1	**Neighbour Women**	Implement behaviours	HH Hand book, Recipe Books
2	**Lead Mothers (LM)**	Groups Sessions/ meetings Conduct Home Visit	Story Books, Recipe Books Counselling Cards
3	**Male Advocates (MA)**	Men's Fora/Group Sessions	Session Guides
4	**Village Health Workers (PROMOTER)**	Lead Mothers training Session Mas training Sessions Community Dialogues Monitoring & supportive visits	Story Books Counselling Cards Recipe Books
5	**Health Workers**	PROMOTER training PROMOTER monthly behaviour discussion	Story Books Counselling Cards Recipe Books Participant Manuals

Delivery platforms

Behaviour change activities will be conducted at different levels, over multiple platforms in a bid to trigger adoption of behaviours by the communities. The care group approach will be the primary platform for interaction with mothers and care givers of children below 5 years and other community members. Through the model, activities will be implemented key points of engagement to enhance adoption of behaviours. Behaviour change activities in care groups will primarily be conducted during monthly meetings and home visits. These activities more less follow the same process, and aim to influence behaviour change at household level. The steps highlighted in section 2 indicate the activities that will be conducted as the group meeting, household visit and training meeting is conducted.

3.4 Dialogue Counselling Process (DCP)

The DCP uses stories that can be shared with the entire family to outline the connection between negative behaviours and outcomes and positive behaviours and outcomes. Stories which engage audiences are easier to remember than a list of facts, and therefore they prove to be more powerful tools in the behaviour change toolkit. The DCP includes the following processes;

i. storytelling
ii. ask about current practices
iii. discuss barriers and enablers
iv. negotiate doable action
v. secure a commitment

The DCP is the key to behaviour change and CGL should be equipped with the skills required to assists the family in identify barriers and enablers, undertake a negotiation process, and finally obtain a commitment to try the new practice.

Behaviour change communication platforms

COMMUNICATION APPROACHES

The communication strategy for CGM will be based on three key mutually reinforcing communication approaches which are advocacy, social mobilisation and social behaviour change communication. Advocacy will focus on influencing decision makers and opinion leaders to support nutrition messaging as well as creating an enabling operating environment.

Social mobilisation will involve enlisting the participation of institutions, community networks and social and religious groups to use their membership and other resources to raise awareness of optimum nutrition practices. Social and behaviour change communication will focus on interpersonal dialogue with individuals and groups to inform, motivate, problem-solve or plan, with the objective of promoting optimal nutrition related behaviour change. The social ecological model below will inform the communication approaches:

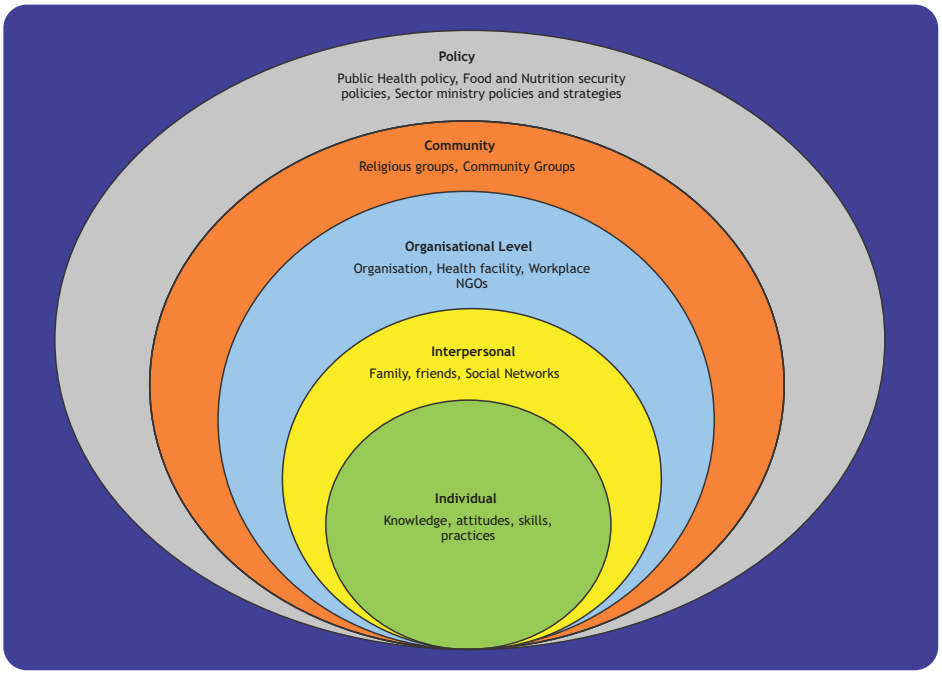

Figure 7: SBCC social ecological model

Table 6: Communication Approaches

Socio Ecological Level	COMMUNICATION APPROACH	FOCUS	TARGET	Communication Platforms
Tertiary targets National Policy and local by-laws	**Advocacy** (Influencing policy/decision makers to support objectives of the CGM	Creating an enabling environment for adoption and sustenance of optimal nutrition behaviours	Parliamentarians, Religious Leaders Traditional/Community Leaders, Media Research Institutions, NGOs, Private Sector	Parliamentary Portfolio committee meetings Policy briefs Media briefs
Secondary targets Interpersonal and Community	**Social Mobilisation** (Enlisting the participation of institutions, community networks and social and religious groups to use their membership and other resources to strengthen participation in care group activities at the grass roots level)	Utilising social networks and structures to introduce, reinforce or sustain optimal nutrition behaviours	eligious groups, Community Groups, Schools, NGOs, Health facilities	Meetings Workshops
Primary targets Individuals	**Behaviour Change Communication** (Interpersonal dialogue with individuals and groups to inform, motivate, problem-solve or plan, with the objective to promote nutrition related behaviour change)	To equip individuals with the knowledge and skills necessary for adoption of optimal nutrition behaviours	Mothers, Mothers in law, Husbands, Adolescents, Women of childbearing age	**Small Media** ▪ IEC Material (Fliers, Pamphlets, Posters), Billboards ▪ Newsletter/Bulletin **Mid Media** • Interpersonal communication • Community Dialogues/meetings (targeting different audiences) • Testimonies • Documentaries **Mass Media** • Community Radio Stations • TV • Social media • Newspapers SMSs

COMMUNICATION CHANNELS

Analysis of available evidence on nutrition communication shows that there are multiple communication channels which can be used. Barrier analyses (2014) conducted as part of the strategy development further showed that different audiences preferred different communication channels for different messages. The communication matrix will provide proposed communication channels for different messages but the overall determining factor will be the potential to deliver the message effectively and at the lowest possible cost. The communication channels are outlined below and the broader messages they are likely to be used to convey:

Mass media (Television, Radio, Public Announcement System): Although evidence shows limited access to the mass media, participants during consultations for the barrier analyses cited them as key communication channels especially for messages aimed at creating an enabling environment and reinforcing attitudes. The mass media was further suggested for advocacy messages and all messages that do not require adaptation based on the micro-context.

The Internet (social media): The internet and in particular social media was further cited as potential channels of communicating nutrition information. This would however require firstly determining levels of access for a specific group being targeted. Use of social media platforms have generally improved especially among young people through use of mobile phones to access the internet. About 22 percent of women and 31 percent of men aged 15-24 years were reported to have used the internet in the 12 months preceding the MICS survey (MICS, 2014). In Zimbabwe the internet penetration rate is currently estimated at 44% according to the Postal and Telecommunications sector performance report (POTRAZ, 2015).

Mobile Phones (bulk SMS): The high level of mobile phone penetration in Zimbabwe means that this is a potential communication channel to be utilised. Key approaches include sending bulk messages on nutrition especially for messages aimed at the entire population. Private-Public Partnerships (PPP) can be formed with telecommunication companies and have targeted messages for various population groups or certain geographic locations. The mobile penetration rate of active subscribers is increasing currently estimated at 91% (POTRAZ, 2015) and this highlights the potential of utilizing mobile phones for communication.

Inter Personal Communication Consultations and available evidence cited interpersonal communication as the key way through which people are receiving nutrition related information. Target audiences include health workers, friends, siblings, colleagues, parents, mothers-in-law, community and religious leaders. Interpersonal communication was the most preferred for messages that targeted behaviour change at the individual level for example encouraging exclusive breastfeeding, promoting uptake of and adherence to iron and folate supplementation as well as promoting consumption of nutritious foods.

Posters and Pamphlets: These were cited as potential communication channels and use of simple language easy to understand was emphasized. Posters were proposed for use within institutions where the targeted population often visits like the clinics where lactating mothers visit. In addition, pamphlets were proposed in circumstances where the health workers will be too busy to explain nutrition information.

Platforms and Activities

Activities within the Care Group

- Home visits
- Meetings
- Cooking demos
- Edutainment

4.1 Introduction

The determinants of malnutrition are multi-sectoral (World Bank, 2013). The Food and Nutrition Security Policy (2012) supports the preceding notion by stating that food and nutrition security is an important national and strategic issue that requires multi-sectoral interventions and coordination at all levels. The more direct nutrition-specific interventions implemented primarily by the health sector need to be complemented by the indirect nutrition sensitive interventions implemented through sectors such as agriculture and food security, social protection, and water and sanitation (UNICEF, 1990). All sectors will need to plan and implement investments to maximize the nutrition benefits for women and young children and minimize harmful, often unintended consequences.

Hence there is need to have a comprehensive and holistic approach to address the 4 systems which include Food Systems, Health Systems, Wash Systems and Social Protection Systems, (Food and Nutrition policy, (2012).
According to the UNICEF Malnutrition Conceptual Framework (1990), the immediate causes are related to food and nutrient intake and health. The underlying causes are embedded in the household and community level context in which under nutrition occurs. These causes are further impacted by issues such as agricultural practices and climate change, lack of access to and availability of clean water and sanitation, health services, girls' education and gender issues, social protection, and social safety nets. The basic causes of under nutrition are rooted in institutional, political, and economic issues such as poverty reduction and economic growth, governance and stewardship capacities, environmental safeguards and trade and patents issues, including the role of the private sector (UNICEF, 1990).

4.2 Defining integration

Integration can be defined as the extent of adoption and eventual assimilation of interventions, functions and responsibilities from various systems into one system to achieve a common agenda, (www.mscprogram.org, (2019). According to Webb, P. (2011) there are several approaches to integration. As such, programs can promote a menu of inputs and services framed by a cross-sectoral conceptual framework, seeking outcomes across a range of sectors (e.g., health, nutrition, education). This approach allows for flexibility across a menu of inputs and allows for potential synergies to emerge where multiple innovations are adopted in one location. The comprehensive nature of the approach depends on the local context and what already exists that can be built on, the priority domains that need to be addressed, what can be effectively tackled through multisectoral programming, and the existing points of service delivery and service providers. Furthermore, clarity on how integration is defined and understood by the multiple stakeholders involved is critical, (Webb, P. (2011).

The systems approach is effective in nutrition programs where key organisations have important roles as they implement nutrition sensitive community based projects. In Zimbabwe, these key organisations include the Ministry of Lands Agriculture Water and Rural Resources, Ministry of Public Service Labour and Social Welfare, Ministry of Women Affairs Community Small and Medium Enterprise Development, Ministry of Local Government and Housing, Ministry of Youth Arts Sports and Culture, NGO's and the private sector (UNICEF,2020). There is a growing body of practice-based evidence in Zimbabwe that suggests integrated health-nutrition-development programs produce positive health outcomes for everyone. The reports from different development implementors of community based projects acknowledge the interlinkages and inter-dependence of these projects and successful achievement of health outcomes.

Furthermore, integrated programming also provides several advantages from a programmatic and advocacy perspective.

Strategic Actions for the Systems Approach

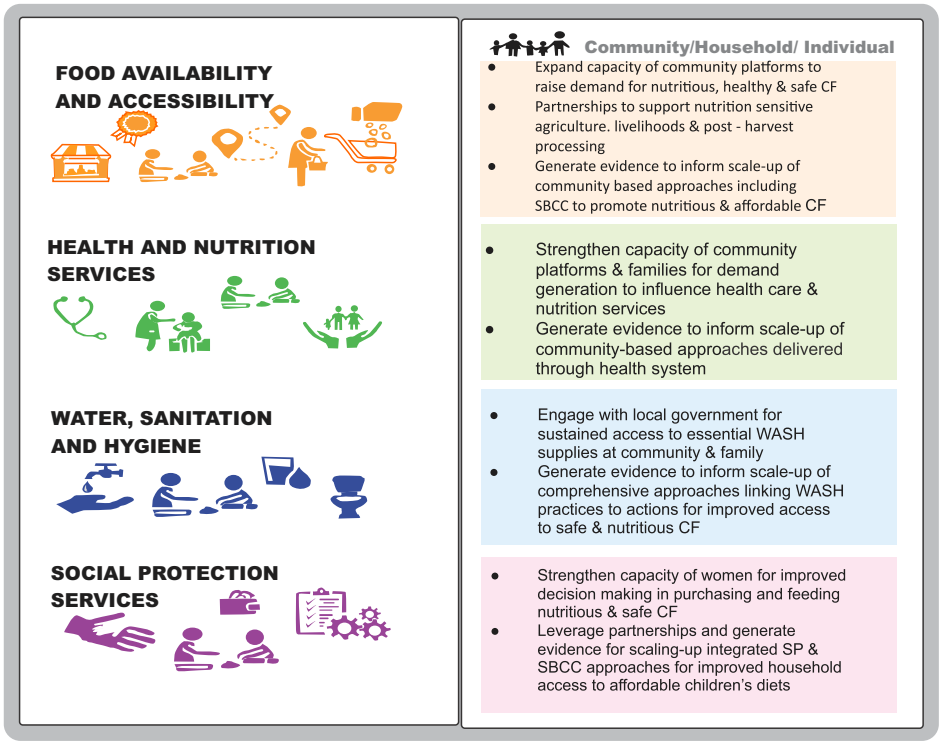

Figure 8: Strategic Actions for the Systems Approach

4.3 Benefits of integration

Integration has multiple benefits which include:

- *Cost effective* - the colocation of services means a family can access the multi disciplinary services in a one-stop shop therefore reducing cost such as traveling to multiple service delivery venues. Also there is sharing of resources among sectors hence implementation becomes less costly.
- *Standardisation* – uniformity in information dissemination
- *Sustainability* – there is continuity in activities being implemented
- *Wide coverage* - increase the geographical coverage and efficiency many groups will be working hand in hand therefore more work will be covered
- *Complementarity* – organisation efforts complement each other
- *Cross learning* – knowledge transfer
- *Creates an awareness* – of multi disciplinary issues as messages are re-enforced through different platforms.

4.4 Key challenges

Apart from the advantages integration, there are disadvantages that exist which include:

- Multiple responsibilities may be added to community staff without being cognizant of their current workload and without any training in prioritization or problem solving.
- Integration may lead to diluted messages and services, poorer quality of the intervention received, and potential community staff fatigue and poor retention.
- There is risk of families receiving too much information at one time, not knowing how to prioritize or digest all of the information received.

4.5 CARE GROUP INTEGRATION CONCEPTUAL FRAMEWORK

The multiplier effect of the care group model is of critical importance in reaching out to the communities with health, nutrition, agriculture, cross-cutting themes (gender, disability, etc.) and WASH interventions. The care group model is a multi-purpose structure that can assist the community to access multiple information good for their health, nutrition, livelihoods and generally well being.

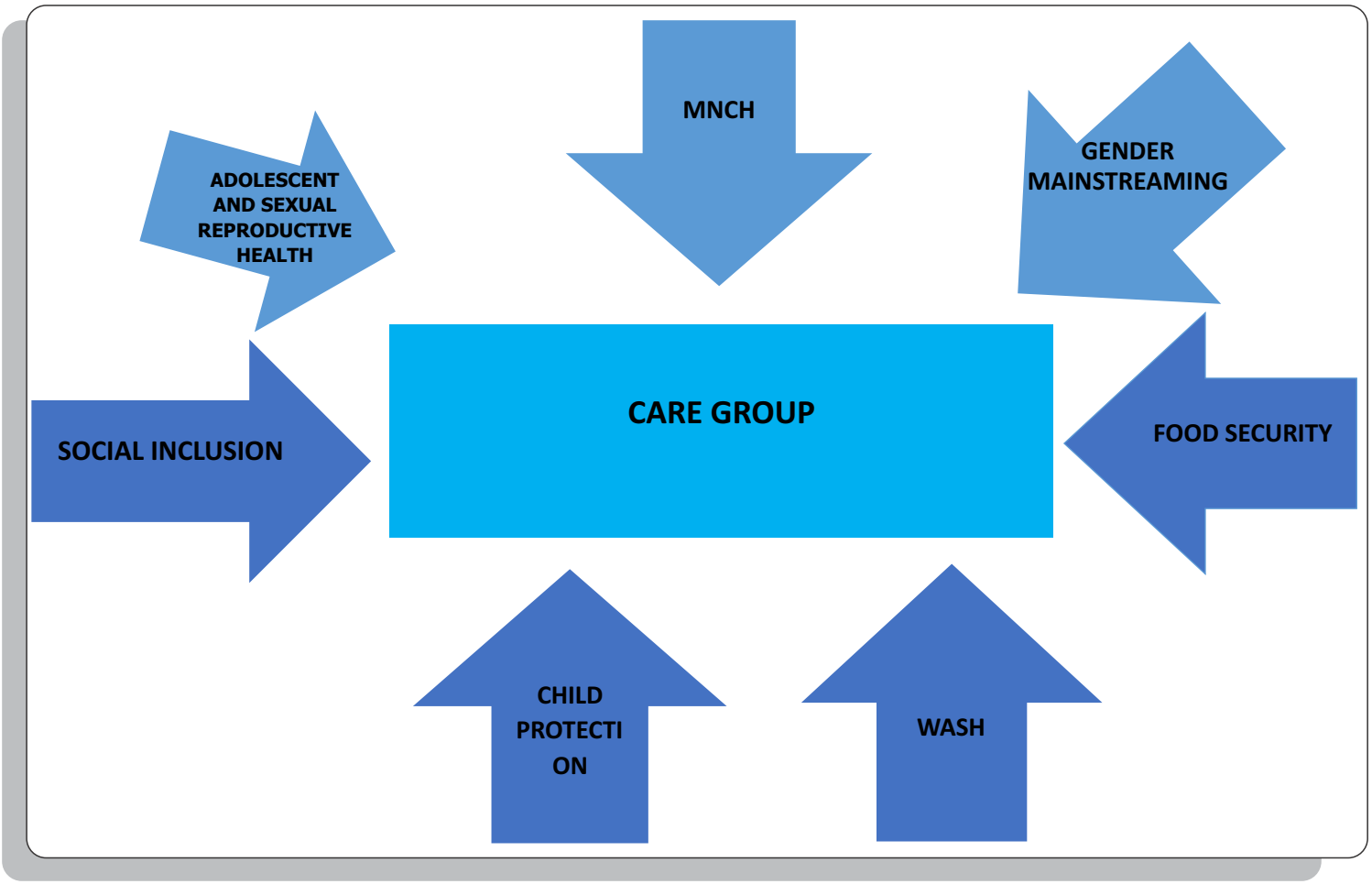

Figure 9: Integration Linkages *(Source: Authors' own initiatives)*

4.6 Integration Entry points

Table 7: Integration of programmes and their entry points in Care Group Approach

Sector	Program	Entry Point	How
Ministry of Health and Child Care	• EPI • My village My home • ANC\PMC • IMNCI • IMAM • Rehab • Growth monitoring • Mental health • BFCI • IYCF • WASH • Micronutrient supplementation • ASRH • HIV/OI/PMTCT	• Checking for children due and overdue for immunization and referring to clinic (PROMOTER). • Pregnancy test screening • Early bookings before 14 weeks • Test and treat \PMTCT • Distribution of ITNs • Identification and referral of the sick infant to the PROMOTER • Identification of abnormalities and referral to village health worker and clinic • Disease surveillance for notifiable diseases • Peer to peer education at care group level • Reinforcement of behaviours through practical activities and troubleshooting at Care Group level • Information sharing • Advocating for HIV, self-testing and encouraging use of CARGS	• Screening for malnutrition and referring malnutrition patients for treatment. • Screening for other childhood illnesses and referring patients for treatment. • IYCF counselling • Checking for micronutrient supplementation status and supplementing those who are due

Ministry of Lands Agriculture Water and Rural Resettlement (AGRITEX)	• demonstration plots • Promotion of climate smart agriculture (Pfumvudza) • Promotion of small and traditional neglected crops • Biofortification • Small livestock • Seed and Food Fairs • Nutrition gardens • Income generating projects • Healthy Harvest	• Capacity building and promotion of production, consumption and marketing of diversified food and biofortification foods (Nutrition Sensitive Agriculture) • Sensitization and mobilization of participants • Identification of eligible beneficiaries • Awareness raising and promotion of healthy complementary food options • Awareness raising to promote joint management of family farms, gender equity and women empowerment	• Monitoring crop condition, crop and livestock diversity, post-harvest management issues, food processing, food safety • Encouraging consumption of biofortified and industrial fortified foods • Encouraging consumption of foods they produce e.g crops and livestock • Advocating for farmers to grow, eat and sell with a nutrition lense (Nutrition Sensitive Value Chains)
Social Welfare	• Food Deficit Mitigation Strategy	• Identification of eligible beneficiary households	• Advocate for eligible beneficiary households
	Child protection	• Identification, report and referal of child protection issues • Awareness raising and other social protection issues	• Raise awareness on child protection issues (child immunisation, treatment of child illness, early marriages, abuse, treatment of malnutrition, education etc) through youth, elderly, male advocate and lead mothers
	Social protection	• Identification of cross cutting themes (disabled, GBV, early marriage) and social safety nets (OVC) available to the community	• Enlighten identified households on the rights of disabled individuals • Linking the disabled individuals/ care givers to service providers • Linking the vulnerable (OVC, elderly, street kids, PLWHIV) to village and ward social safety nets and psychosocial support services. • Mainstream cross cutting themes along all programs

Ministry of Primary and Secondary Education	• In-Schools feeding program • ECD programming • School feeding program • WASH • School health program	• Awareness raising on feeding patterns, HPV for the girl, micronutrient, EPI, WASH and school health program • Identify children eligible for immunization, active screening for malnutrition, HPV vaccination, micronutrient supplementation • Identifying eligible out of school children	• Awareness raising at a household level through home visits and meetings • Use of registers for identifying eligible children for programs • Use the results of formative research to identifying eligible children for programs
Women Affairs	Gender mainstreaming	• Capacitate care group members to mainstream gender issues in all village developmental activities.	• Advocating for access to resources (land, finance, services, marketing etc) in all communal initiatives
	Women Empowerment	• Identifying beneficiaries for income generating projects and capacitate on financial literacy	• Mobilise eligible women of child bearing age (pregnant, lactating and care givers of the under five children) to join care / neighbour women groups. • Mobilise men to support women in care groups to uptake and adopt health and nutrition behaviours • Advocate for empowerment through income generating projects (ISALS, Women Development Fund, Community Development Fund, Micro-finance Banks (Women's Bank) and

			capacitate them on financial literacy. • Empowering women in decision on the management of financial resources

4.7 Integration channels

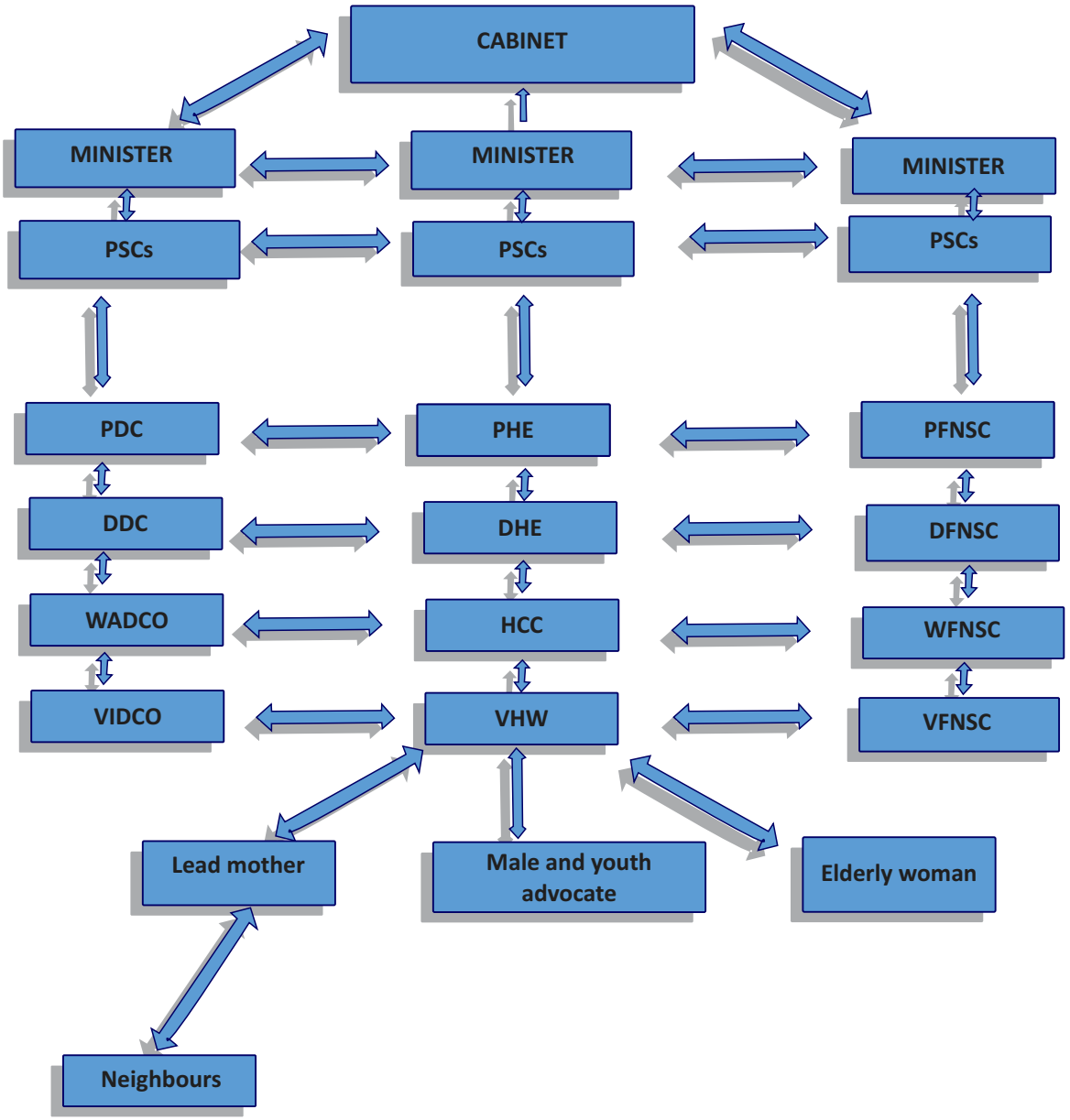

Figure 10: Channels of reporting *(Source: Authors' own initiatives)*

At the centre of the Care group model there is a PROMOTER who supervises the lead mothers, male and youth advocates and elderly woman who have contact with the neighbour households. At the village level, the PROMOTERs will be managing and coordinating activities of the care group where there is both vertical and horizontal coordination. The PROMOTERS coordinates with the VIDCO and the VFNSC horizontally were different sectors share information pertaining to nutrition specific and sensitive interventions. Through the VFNSC different sectors that include lead farmers, case care workers, local leadership religious leadership interact and share information which feeds into the Food and nutrition committees, information pertaining to village development through the VIDCO. The VFNSC reports upwards through the multi -sectoral committees of the Food and Nutrition committee while VIDCOs reporting to the Development committees channel of the local Government. Vertically the PROMOTERs report to the HCC and the information reports vertically through the Health coordination committees. The different integrating sectors also report vertically through their respective channels. Information is also cascaded from upwards to the neighbour households using the same vertical and horizontal coordination channels.

Combined interventions are more efficient than separate interventions, because they are intended for the same population and make use of the same facilities, transportation, and client contacts. In addition, for families, particularly for those most at risk, combined interventions can also lead to increased access to services. However, in order for integrated systems to be achieved successfully in a Care Group Model as noted, a variety of challenges must be addressed, including workload of staff and supervisors, communication and coordination among different ministries and among staff in different sectors, and an acknowledgement at the national and community levels that comprehensive integrated care addressing both the physical and developmental needs of the child is key to promoting optimal health, food and nutrition security and development of children, adolescents and women.

5.1 Introduction

The purpose of monitoring, evaluation and learning practices is to apply knowledge gained from evidence and analysis to improve development outcomes and ensure accountability for the resources used to achieve them (ADS 201.3.5). Before we plan our activities, we need to know what we are trying to do and what we need to learn to ensure that the data we collect will help us make decisions.

It is important to remember that monitoring, evaluation, and CLA are not the end goal, but rather the means by which we achieve our development outcomes more effectively. If the knowledge we are generating through monitoring or evaluation is not yet contributing to real-time decision-making about design and implementation, we may need to take a deeper look at our M&E systems. We can also assess other aspects such as the enabling conditions and decision-making process that may hinder the effective use of analysis of monitoring data and evaluations.

The M&E in the care group programme will encompass a participatory process to develop a performance monitoring framework (PMF) and a performance-monitoring plan (PMP) that embraces two major dimensions of monitoring: tracking progress and performance for accountability (to address the reporting requirements of the programme) and process and outcomes monitoring (for programme learning). This framework will ensure that the programme will rigorously measure progress against set targets through routine monitoring, as well as enable a continuous learning loop to improve the quality of implementation. This process will entail strengthening the M&E systems for the care group approach. A short list of key indicators will be adopted (ensuring process indicators are included) for monitoring progress and assessing performance and agreed to by all implementing partners. Practical and strategic guidance to programme implementation will be developed through analysis of the data and information collected by M&E. The PMF and PMP will support programme management in effective decision making and to improve responsiveness to stakeholders by collecting, processing, and providing reliable and timely information.

Performance monitoring and operations studies will provide data that will guide ongoing management decisions, while periodic evaluations conducted at baseline, midline and final evaluation will help set benchmarks for and measure relevance, performance, efficiency, effectiveness, and impact of the program. This M&E Plan recognizes that specific elements of the implementation program may require adjustment to respond to evolving internal or external conditions, as well as helping to solidify activities upon startup of the programme should the situation on the ground have changed since proposal development. The plan will serve as a management tool for systematically reviewing programme progress, troubleshooting and identifying issues during programme implementation, and assessing areas where programme activities may need to be refocused to ensure plans, schedules, and assignments remain current.

MoHCC, as the lead ministry, will be responsible coordination of data generation to meet various information needs of stakeholders, including participants, partners, donor, and provincial governments. Specifically, the plan will aid in planning for and implementing data collection on key performance indicators, assessing progress toward achieving results, and communicating the outputs and outcomes to various stakeholders.

5.2 Monitoring

The Organization for European Cooperation and Development (OECD) (2000) define monitoring as the continuous function that uses the systematic collection of data on specified indicators to provide management and main stakeholders of an ongoing development intervention with indications of the extent of progress and achievement of objectives and progress in the use of allocated funds. FAO (2011) also sees monitoring as an observation system verifying whether programme activities are happening according to plan and whether resources are used in a correct and efficient manner.

5.3 Evaluation

Evaluation is systematically and objectively assessing the relevance, performance and success, or lack thereof, of ongoing and completed programmes and programme. This is done by comparing available data, monitoring implementation and conducting planned periodic evaluations (World Vision, 2020)[3].

5.4 Accountability

Demonstrating responsibility to provide evidence to all partners that a programme has been carried out according to the agreed design (World Vision, 2020)[4].

5.5 Planning

Identifying and scheduling adequate resources for activities that logically lead to outputs, outcomes and goals; working with management to link programme plans to national and regional strategies(Ruel and Alderman, 2013).

5.6 Learning

Learning is the process of acquiring new understanding, knowledge, behaviors, skills, values, attitudes, and preferences.

"Learning is the relatively permanent change in a person's knowledge or behavior due to experience. This definition has three components: 1) the duration of the change is long-term rather than short-term; 2) the locus of the change is the content and structure of knowledge in memory or the behavior of the learner; 3) the cause of the change is the learner's experience in the environment rather than fatigue, motivation, drugs, physical condition or physiologic intervention."

–From Learning in Encyclopedia of Educational Research, Richard E. Mayer
(http://theelearningcoach.com/learning/10-definitions-learning/)

5.7 Reporting

The successful implementation of Care Groups relies on effective and timely reporting of Care Group activities. This reporting enables the model to monitor attendance at Care Group meetings and coverage of household visits and neighbour group meetings, which are the two most important aspects of the Care Group approach. If Care LMs are not attending the Care Group meetings, and are not visiting their neighbour women, the model will not be successful.
In addition to monitoring Care Group activities, data is also reported on vital events for all members of Neighbour Groups and Care Groups, allowing the programme to track maternal, child, and infant mortality (data that would otherwise be expensive and time intensive to collect).

[3] https://www.wvi.org/health/nurturing-care-groups#:~:text=The%20Nurturing%20Care%20Group%20(NCG,Nutrition)%3B%20poor%20early%20child

[4] https://www.wvi.org/health/nurturing-care-groups#:~:text=The%20Nurturing%20Care%20Group%20(NCG,Nutrition)%3B%20poor%20early%20child

5.8 Data Collection Tools

- Neighbour women Group register
- Neighbour Women Monthly Attendance Register
- PROMOTER report template/ form
- Health facility report template
- National and District monthly report template
- A monitoring check list (Care group volunteer, PROMOTER, clinics, districts)
- Rapid assessment forms
- Focus group discussion guide
- KAP survey questionnaires
- Activity tracker for media monitoring
- Monthly indicator tracking tools

Assessment Tools

- Questionnaire
- Focus Group Discussions
- Key Informant Interviews
- Child Health Card
- ANC Card

5.9 Care Group Management Information System

To ensure timely and accurate reporting, registers should be utilized to capture and share key data. The main registers are:

- Neighbour Group register (maintained by the LM)
- Care Group register (maintained by the PROMOTER)

These registers should be similar to one another. The registers are used to collect four types of information from the Neighbour Groups and Care Groups:

- Date when the members joined (registration information)
- Attendance at group meetings or home visits
- Vital events of group members (such as maternal deaths, deaths of children under 2 years of age and child births)
- Lessons in the Care Group curriculum that have been covered

Reporting will be done at every monthly meeting for each Care Group so that the PROMOTERs may submit their summary reports to their supervisors (health facility staff) at the end of each month.

Baseline Indicators

- Proportion of infants initiated on breast milk within the first hour.
- Proportion of children who were exclusively breastfed in the first six months.
- Proportion of women booked within 12 weeks of pregnancy
- Proportion of women receiving iron and folate supplementation up to six weeks post delivery
- Proportion of babies born with low birth weight (<2500g)
- Percentage of women giving birth at home
- Proportion of children who have reached the primary course complete
- Proportion of children with up to date growth monitoring
- Proportion of children 6-23months receiving Vitamin A
- Proportion of children 6-23 months receiving micronutrient powders

- Proportion of children 6-23 months who received food from four or more food groups
- Proportion of breastfed and non-breast fed children 6-23months of age who received solid, semi-solid or soft food
- Proportion of children 6-23months of age who received a minimum acceptable diet
- Proportion of children 6-23months with continued breastfeeding
- Proportion of children 0-23months stunted
- Proportion of children 0-23months wasted
- Proportion of children 0-23months underweight
- Proportion of households with BVIPs and handwashing facilities
- Proportion of households with access to safe drinking water
- Minimum Dietary Diversity for women aged 15-49 years (MDD-W)
- Household Dietary Diversity Score (HDDS)

Table 8: The Logic Model for monitoring the care group model

Narrative	Objectively verifiable indicators	Means of verification	Risks
Goal: Contribute to improved Maternal, Neonatal, Child and Adolescent health and well being	• Malnutrition rates • Reduced mortality • Low birth weights rates	• ZimVAC Surveys • Nutrition Surveys • Zimbabwe Demographic health survey (DHS) • District Health information system (DHIS)	• Food security • household vulnerability • Political instability • Disasters and epidemics • Siloed interventions
Outcomes • Improved IYCF practices, • Reduced morbidity • Improved WASH practices • Reduced teenage pregnancies • Reduced unwanted pregnancies • Decreased gender based violence cases • Reduced child marriages • Reduced cases of child abuse • Increased early ANC booking • Increased number of ANC visit • Decreased home deliveries • Improved household food security • Improved household dietary diversity • Improved home-grown school feeding program • Youth clubs established	• Minimum Adequate diet • Continued breastfeeding up to 2 years • Exclusive breastfeeding • Child morbidity rates • Open defecation rates • Proposition of households with hand washing facilities • Proportion of women booking in the first trimester • Proportion of women attending at least 4 ANC visits • Prevalence of diarrhoea • Keyhole gardens established • Nutrition gardens established	• ZimVAC surveys • ZDHS • DHIS • MICS • Nutrition surveys • Health centre, District reports • Programme reports (monthly, quarterly, and annually	• Poor integration with other programmes • Overburdening community health workers • Competing programs • Poor social-economic status
Outputs • Trainings conducted • Cooking demonstrations conducted • IEC materials such as, Pamphlets, fact sheets, booklets and counselling cards distributed • Media Coverage	• Number of completed trainings • Proportion of cooking demonstrations • Quantity of pamphlets, key message booklets and counselling cards distributed	• PROMOTER, Health centre, District reports • Programme reports • Management books • Activity Tracker • Group information giving registers • Advocacy handbook	• Competing programmes • Quality trainings • Uptake of programme by community • Inadequate programme funds

Outputs • Established care groups • Established mother support groups • Malnutrition cases identified • Screened children • Care givers counselled • Support and supervisory visits accomplished • Mentorship visits done • Home visits done • Health education sessions completed • Community advocacy and sensitisation campaigns done • Community dialogues conduced	• Quantity of care groups established • Number of mother support and care groups established • Proportion of cases identified • Proportion of children screened • Proportion of care givers counselled • Proportion of accomplished support visits • Percentage of complete mentorship visits • Number of home visits done • Number of health education sessions completed • Community advocacy and sensitisation campaigns • Number of media programmes conducted	• Group maturity index (GMI)	• Unavailability of medicines and therapeutic products
Activities • Training of health care workers • Training of PROMOTER • Training of lead mothers • Carrying out cooking demonstration • Distribution of recipe books • Establishing care groups • Establishing support groups	• Number of health workers trained • Number of PROMOTER trained • Number of lead mothers trained • Number cooking demonstrations • Number of recipe books distributed • Number of care groups established	• staff development register • VHW, Health centre, District reports	• Competing programmes • Poor quality oftrainings • poor uptake of programme by community • Poor integration with other programmes

Activities • Conducting active screening of undernutrition • Referring acute malnutrition cases • Counselling of mothers and care givers • Distribution of key message pamphlets and counselling cards • Supporting PROMOTER, heath workers • Conducting home visits • Mentoring health workers • Mass Media communication • Training of mothers and care givers on active screening • Conducting health education on Infant and Young Child Feeding and Water Sanitation and Hygiene • Conducting community advocacy • IEC materials distribution	• Number of mother support groups established • Number of active screening sessions conducted • Proportion of cases referred • Number of caregivers counselled • Number of flyers and counselling cards distributed • Number PROMOTER and health worker support visits • Number of home visits conducted • Number of mentorship visits • Number of care givers trained • Number of health education sessions conducted • Number of community advocacy sessions conducted • Number of people reached through mass media • Number of IEC materials distributed		• Parallel programming • inadequate programme funds • Unavailability of medicines and therapeutic products

5.10 Evaluation of Care Groups

While the Care Group reporting data will provide information on Care Group functionality, the uptake of specific healthy practices promoted by the programme is the ultimate indication of the programme's success. To assess the coverage of these practices, a prospective household level evaluation with participating mothers as well as Lot Quality Assurance Sampling (LQAS) at baseline (formative stage) should be conducted or indicators may be obtained from previous local surveys. The evaluation should involve interviewing intervention participants, their families, community leaders, VHWs, extension workers, healthcare workers and HCC members. The evaluation is aimed to determine their knowledge and perceptions about the programme, achievements, implementation challenges, and suggestions on possible measures to improve the intervention.

Mid-term and End Line Evaluation

- Mentorship with VHWs and LMs (Checklists, Focus Group Discussions, Key Informant Interviews)
- Data Analysis

5.11 Data collection and management

Routine monitoring data will be collected using simple tracking templates for activities and indicators that will be developed by program stakeholders.

Consultative processes will start with a workshop for programme stakeholders to review the logical framework and jointly develop practical data collection tools for process-output level indicators. In addition, this workshop will form a platform for conducting a capacity assessment of M & E skills of stakeholders. Baseline data will be followed by the collection of quantitative and qualitative data at three month intervals. Monitoring will help to track and correct deviations in the course of implementing planned activities and will be carried out by district field staff and as well as A, M & E staff. Data collected in these areas would focus on measuring output level indicators, as well as to detect changes that might call for adjustments of objectives, plans or procedures.

Quarterly monitoring will be conducted through household surveys, focus group discussions and key informant interviews. Tracking forms will be developed. These will, among others, help collect data on a monthly basis on farmers' participation in training sessions, demos and group formation.

The Group Maturity Index (GMI) will be used to assess and determine the degree of maturity of the farmer associations/groups. The Group Maturity Index aims at ensuring that community groups are sustainable by going through the four group maturity index levels/stages. It will give an insight into the current situation of the groups' implementation processes, and how they should pursue the desirable situation (i.e. a higher maturity level). The Group Maturity Index will be used for measuring the number of farmer associations with successful implementation of group plans (collective buying and selling, written constitution and record keeping). Data will be collected once every quarter from the same farmer groups to measure their progression. The GMI tool measures aspects of group governance, resources, objectives, functionality, systems and impact.

In addition, human interest stories will be collected as a qualitative method of assessing the intended and unintended impacts, positive and negative of the interventions at the household and community levels, based on perceived changes in status and self-esteem, social networks and support, and village cohesion.

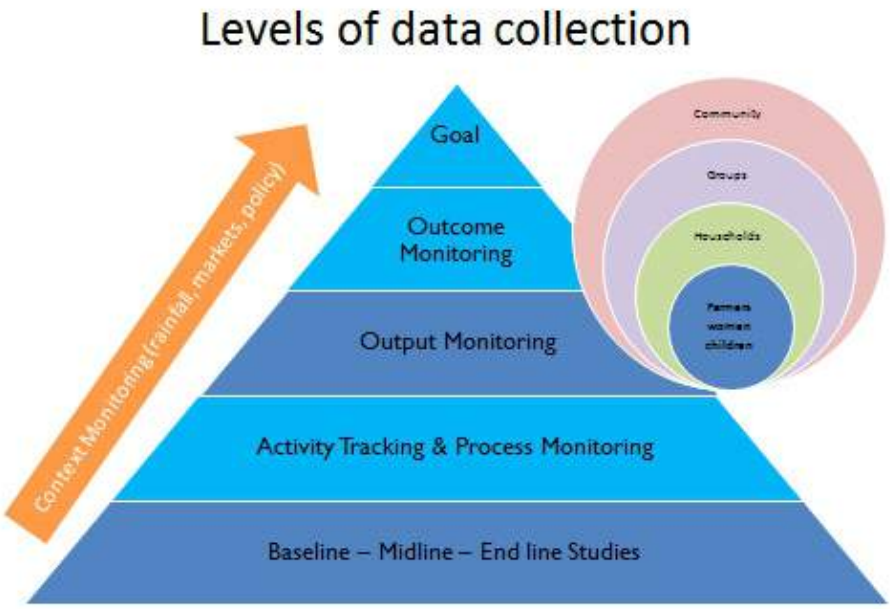

Fig 11: Levels of data collection

To ensure data of the highest possible quality that meets international data quality standards, a data flow map will be developed detailing data verification responsibilities and procedures at every stage of data collection and reporting. This will ensure that errors and inconsistences will be caught early, traced back to the source, and further means of verification will be pursued as required, such as cross-checking alternative data sources. Data collected will be disaggregated by district, gender and ability. For health and nutrition indicators, data will also be disaggregated by age to ensure collection and analysis for promised results.

Data quality control measures will be planned for and implemented for each indicator.Data will be entered and analysed using the appropriate software packages (C-SPro, Excel and SPSS) and a database of all the data sets will be created and managed by the MoHCC.

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Annex 1: List of behaviours

Behavior	Key Messages
Good health and nutrition for women of child bearing age	• It is important that women have a healthy diet throughout their child-bearing years, including before they get pregnant as this leads to healthy outcomes. • Eat at least three balanced meals per day – 4-star diet. • Eat foods high in iron such as organ meat, beans, dark green leafy vegetables, traditional grains such as rapoko, millet and sorghum. • Eat foods high in vitamin A such as orange coloured fruits and vegetables, green leafy vegetables, animal source foods such as liver, milk, eggs, chicken and fish • Drink plenty of safe water, and other healthy fluids such as fruit juices, herbal tea and non-alcoholic beverages. • Eat unrefined and wholesome foods such as straight run mealie meal, brown rice etc. • Use fats, oils, salt and sugar sparingly. • Avoid smoking. • Exercise or do physical activity regularly • Don't suffer in silence; get support for your mental health
Hand washing at the five critical times for all household members	**Wash hands at the five critical times** 1. after using the latrine 2. after changing/cleaning a baby who has defecated 3. before cooking 4. before feeding a baby 5. before eating
	* Clean hands save lives! * Handwashing with soap consistently at critical moments prevents the spread of diseases like diarrhoea, cholera and flu. * Having hand washing facilities at strategic points can help remind family members the need to wash hands. * Tippy taps should be constructed around the home - outside the toilet, near the cooking hut, and at the household entrance
Exclusive Breastfeeding for children from birth to 6 months.	• **Initiate breastfeeding within the first hour of birth** • **Exclusively breastfeed (no other food, water or drink) from 0 up to 6 months** • **Breastfeed frequently day and night** • **The more you breastfeed, the more milk is produced.** • **Breastfeed on demand every time the baby wants to breastfeed** • **Let the infant finish one breast and come off by him/herself before switching to the other breast** • **Attach the baby to the breast appropriately– *1. Ensure baby's mouth is wide open, 2. Baby's lower lip is turned out, 3. Baby's chin is touch the breast and 4. More areola showing above than below the nipple.*** • **Position the baby well when breastfeeding – 1. Baby's body should be straight, 2. Baby should be facing the breast, 3. Baby should be close to the mother, 4. Mother should support the baby's whole body with her hand and fore-arm, not just the neck and shoulders.** • **Continue breast-feeding when the baby or mother is ill.** • **A mother can express breastmilk to be fed to her baby when she is away. Expressed breastmilk can be stored in a clean covered container kept in a cool place for 6 to 8 hours.** • **Avoid the use of feeding bottles, teats and pacifiers. Feed baby mother's milk using a clean cup with a smooth edge and without a fold**

Complementary feeding from 6 months up to 2yrs and beyond.	• Continue breastfeeding your baby on demand both day and night. This will maintain his or her health and strength as breast mil k continues to be the most important part of your baby's diet. • Breast milk continues to be the most important part of your baby's diet. • Breastfeed first before giving other foods. • Feed your baby o 2 -3 times per day for infants 6 –8 months o 3 – 4 times per da y for children 9 –23 months o and continue breast feeding up to 2 years or beyond • When giving complementary foods to your baby, think: Amount, Frequency, Adequacy, Thickness, Variety, Responsiveness and Hygiene
Promoting growth monitoring, immunization and micronutrient supplementation for children under 5 years.	• Attend regular growth monitoring and promotion sessions (GMP) to make sure your baby is growing well. • A healthy child who is growing well should gain weight every month. If your child is not gaining weight or is losing weight, there is a problem. • During growth monitoring and promotion sessions, you can ask questions about your child's growth, health and nutrition. • You should also ask about your baby's immunization schedule. Immunizat ions protect babies against several diseases • A diet of foods with too few micronutrients will harm the health and development of young children from 6 up to 24 months of age. • MNPs are vitamin and mineral powders that can be added directly to soft or mushy semi solid or solid cooked foods prepared in the home to improve the nutritional quality of foods for young children. • The single serving sachets allow families to fortify a young child's food at an appropriate and safe level • Vitamin A supplementation for children 6 to 59 months improves children's eyesight and strengthens children's immune system.
Community management of childhood illnesses.	• Childhood illnesses include malaria, diarrhoea, acute malnutrition, pneumonia and measles • Caregivers should take their sick children to village health workers for assistance. VHWs are equipped with skills and tools to help them manage childhood illnesses at community level
Promote good health and nutrition for adolescents	Avoid drug abuse and sex • All young people are encouraged to abstain and in case of failure to abstain: use condoms as contraception • All young people have the right to education and information, including comprehensive gender sensitive and rights-based sexuality education. • Safer sex is pleasurable sex. It reduces the risk of sexually transmitted infections and unintended pregnancy. • Every young person has the right to choose when, if, how and with whom to marry. • All young people have the right to life, liberty and to be free from harm, which includes the right to express one's sexuality and gender free from coercion or violence. • Avoid drug and alcohol use Food variety for adolescents and good exercise • Eat at least three balanced meals per day – 4-star diet. • Use fats, oils, salt and sugar sparingly • Exercise or do physical activity regularly

Promoting good health and nutrition for pregnant and lactating women	• During your pregnancy, eat an extra meal or "snack" (extra food between meals) each day to provide energy and nutrition for you and your growing baby. • During breastfeeding, eat two extra meals or "snacks" each day to provide energy and nutrition for you and your growing baby. • You need to eat the best foods available, including milk, fresh fruit and vegetables, meat, fish, eggs, grains , peas and beans. • Drink plenty of safe water, and other healthy fluids such as fruit juices, herbal tea and non-alcoholic beverages. • Taking tea or coffee with meals can interfere with your body's use of the foods. Limit the amount of coffee you drink during pregnancy • During pregnancy and breastfeeding, special nutrients will help your baby grow well and be healthy. • Take iron and folic acid tablets to prevent anaemia during pregnancy and for at least 3 months after your baby's birth. • Use iodised salt to help your baby's brain and body develop well. • Attend antenatal care at least 8 times during pregnancy. These check-ups are important for you to learn about your health and how your baby is growing. • To prevent malaria, use malaria prevention methods. • Know your HIV status, attend all the clinic appointments and take your medicines as advised by your health provider. • Adolescent mothers: you need extra care, more food and more rest than an older mother. You need to nourish your own body, which is still growing, as well as your growing baby's
Household production, collection and consumption of diverse nutritious foods including neglected underutilized foods, iron rich and vitamin A rich foods all year-round	Good agriculture practices (GAP) such as conservation agriculture (pfumvudza), low input sustainable agriculture (LISA) help families have access to safe and nutritious foods all year round. • Food is necessary for our bodies to function properly and for us to have good health (GO, GROW, GLOW) • A balanced diet (four-star diet)contains the right proportions of foods from the different food groups and variety within the same food group. The food groups to include in the four-star diet are carbohydrates, proteins, legumes and fruits and vegetables • Eating a wide variety of foods ensures that you meet your nutritional requirements. • Not one food contains all the nutrients required by the body in their rightful amounts - except for breastmilk for children less than 6 months. • Eat different colored fruits and vegetables - the rainbow plate. Different colours reflect different nutrients. Animal source foods are very important in the diet too.
Production and consumption of biofortified crops	• Biofortified crop varieties are a cheap way of preventing and reversing hidden hunger and should be grown and consumed by the whole family everyday. • Vitamin A maize VAM (Orange maize) and orange fleshed sweet potatoes (OFSP) are high in vitamin A which is needed by the body for: good eyesight, healthy immune system, promote healthy skin, for good growth of children and reproductive health. • High Iron beans such as NUA45 is rich in iron and zinc and helps with formation of blood, brain development, good child growth and development, healthy immune system • VAM, OFSP and High iron beans should be eaten as a component of a healthy balanced diet for maximum benefits.

Safe household handling, processing, preparation, preservation, and storage of food	• Food handling • When handling food, consider the 5 keys to safer food • Keep clean • Separate raw and cooked food • Cook thoroughly • Keep food at safe temperatures • Use safe water and raw materials • Food preservation • Practice good hygiene in the preservation of food. • Use only ripe, good quality fruits and vegetables that are not rotten, damaged, or diseased • Blanch all vegetables in hot water before drying. Tear them, rather than fine cutting. • Avoid drying in direct sunlight to prevent nutrient loss. Use solar driers when available • Food processing and storage • When processing food, take note of the following: • Minimize loss of nutrients. • Practice good hygiene. • Select food that is appropriate for example when processing groundnuts ensure they do not have aflatoxins. • Food storage • Sort food before storage to remove damaged and spoiled produce • Store food in clean and dry containers. Place these containers in safe, cool, dark, dry, and well-ventilated places protected from rats, mice and insects • Ensure that food is dried to the recommended moisture levels before storage • Food preparation • **When preparing food:** • Cook all meat until well cooked. Cooked meat should not be pink or red • Cook vegetables for a very short time. Steam and stir-fry vegetables and ensure they retain colour • Cook cereals and legumes until well cooked. A hot box cooker can be used to reduce cooking time • Use salt, sugar, and cooking oil sparingly. Avoid deep fat frying • Practice good hygiene at all times • Make use of fuel-efficient stoves e.g tsotso and jengetahuni.
Drinking safe water and use of improved sanitary facilities	• Drink water from safe sources such as boreholes, protected well etc. • If using surface water or unprotected sources, purify the water before drinking by boiling, chlorinating at home or using aqua-tabs. Adhere to instructions on use of water tablets, chlorinating agents such as water guard. • All family members should use improved sanitary facilities and children's faeces should be deposited in the sanitary facility. Avoid open defecation. • All family members should wash their hands properly after using the toilet, cleaning nappies or looking after a sick person, as well as before and after preparing food and eating meals.

Community and household use of hygiene enabling facilities	• It is important to practice good household and personal hygiene to prevent illness and malnutrition. • All household rubbish should be safely disposed in rubbish pits. • Organic waste, livestock and animal manure should be cleared up regularly and made into compost. • Domestic animals should be kept away from food. • Food should be stored off the ground and away from agricultural and other chemicals
Discouraging Gender based violence	• Spouses should love, support, and respect each other and their families. • Spouses should practice emotional intelligence management. • Mother and father should plan together the welfare of the family. • Avoid verbal, physical, emotional, and economic abuse to your loved ones. • Gender based violence causes spouse neglect, stress, economic deprivation which contributes to malnutrition

Discouraging Early child marriages	• Early child marriages negatively impacts female teenagers emotionally, economically, physically, psychologically and socially. • Early child marriage increases the risk of viral infections, cervical cancer, unplanned or unwanted pregnancies, poor fertility, malnutrition, and poor health among mothers, maternal death during childbirth, miscarriages, stillborn and abortions. • Early marriage is human rights violation that denies a girl of her childhood, disrupts her education, limits her opportunities, increase her risk of violence and abuse, and jeopardizes her health and trapping them in the vicious cycle of poverty. • Delaying first pregnancy until a girl is at least 18 years of age helps to ensure safer pregnancy and childbirth. It reduces the risk of her baby being born prematurely and/or underweight. • Women who marry before the age of 18 are more likely to experience psychological trauma and mental health problems. • Early marriage exposes female adolescents to Obstetric fistula. Obstetric fistula disproportionately affects child brides whose bodies are not yet ready for childbirth

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