



Discussion paper: Implementing Care Groups for Improved Maternal and Child Nutrition: Critical Factors for Success from the Amalima Program in Rural Zimbabwe

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Abstract

Over the last 30 years, Zimbabwe has made noteworthy progress in reducing both underweight and wasting in children under the age of five years, however one in four children in Zimbabwe is stunted. The rate in the decline of the number of children stunted still falls short of meeting the World Health Assembly target, and it goes without saying that effective, innovative community based strategies are required by the government and development partners to accelerate the rate of stunting reduction. This paper presents experiences from using the care group approach for promoting improved infant and young child feeding and care based on lessons from the Amalima program, a seven-year United States Agency for International Development (USAID) Office of Food for Peace intervention. The Amalima program has been promoting care groups as a community and family centered approach to improve maternal and child nutrition in Zimbabwe. The Care Groups are an innovative community-based strategy that has been rolled out as part of the Amalima program activities in four food and nutrition insecure districts in Zimbabwe. We present the key 'secret' ingredients for effective care group implementation, we highlight the modifications that we made in Care Group implementation to ensure a context appropriate approach, and discuss how Care Groups can be integrated into the Ministry of Health and Child Care structure. Most importantly, this discussion paper presents the critical factors for successful care group implementation. The critical factors have been grouped into five broad categories: Conduct a Formative Research; ensure Context Specific Approaches & Adaptive Management; Leverage on Social Capital and Cohesion; Invest in Human Capital; Prioritise Quality Assurance & Reviews.

Background

Adequate nutrition during the period from conception to when a child is two years of age is critical for a child's optimal growth, health and development. Vast literature and evidence exists that highlights that adequate nutrition during the period from birth to two years of age is critical for a child's optimal growth, health and development and that childhood stunting is one of the most significant impediments to human development. The first 1000 days¹ between conception and a child's second birthday has been identified as the most crucial window of opportunity for interventions to reduce stunting (Cusick & Georgieff, 2019). Evidence suggests that stunting is largely irreversible after the first 1000 days, leading to an intergenerational cycle of poor growth and development, in which women who were stunted in childhood remain stunted as adults and tend to have stunted offspring (Georgiadis & Penny, 2017). Stunting was endorsed as a key indicator for monitoring maternal, infant and young child nutrition by the World Health Assembly (WHA) in 2012; and UNICEF, 2015).

Stunting rates in Zimbabwe

Whilst Zimbabwe has made commendable progress in reducing malnutrition in children under the age of five years, one in four children in Zimbabwe is stunted. (National Nutrition Survey, 2018). The 2018 National Nutrition survey indicates a national stunting prevalence rate of 26.2%, which is considered high according to global standards (de Onis et al, 2019). The Government of Zimbabwe has aligned its

¹ The first 1,000 days of life - the time spanning roughly between conception and one's second birthday - is a unique period of opportunity when the foundations of optimum health, growth, and neurodevelopment across the lifespan are established, information available at <https://www.unicef-irc.org/article/958-the-first-1000-days-of-life-the-brains-window-of-opportunity.html>. The 1,000 days between a woman's pregnancy and her child's 2nd birthday offer a unique window of opportunity to shape healthier and more prosperous futures. The right nutrition during this 1,000 day window can have a profound impact on a child's ability to grow, learn, and rise out of poverty. It can also shape a society's long-term health, stability and prosperity

commitment to the World Health Assembly (WHA) target of a 40% reduction in stunting by 2025, however the latest projections anticipate that Zimbabwe will not meet the WHA target² by 2025 (which also represents the government's target) (WHO, 2019). Therefore additional efforts are required by the government and development partners to accelerate the rate of stunting reduction.

The Zimbabwe National Nutrition Strategy³ promotes appropriate infant and young child feeding practices that contribute to improvements in early childhood nutrition, reduce under-nutrition, and also contribute to improved health outcomes in children (Food and Nutrition Council, 2014). Whilst, several strides have been made to implement stunting reduction strategies including through multi-sectoral approaches which recognise nutrition specific and nutrition sensitive activities⁴, much still needs to be done in reaching mothers and caregivers, and their families (influencers) with key messages for enhanced coverage, and strengthening the adoption of key behaviours to promote recommended infant and young child feeding practices (Ruel et al, 2013). In view of the fact that Zimbabwe will not meet the SDG 2⁵ and the World Health Assembly (WHA) target⁶ by 2025, impactful innovative, low cost community based strategies are urgently needed to accelerate stunting reduction (ZNVN, 2017; WHO, 2019). One of the important reasons for lack of progress has been the low population coverage of interventions. Perry et al (2015) cites that expanding coverage of key interventions and achieving documented reductions in maternal, neonatal, and child mortality will require approaches that are low-cost, effective, and feasible at scale over the longer term. The authors of this article recognise Care Groups as one example of the growing importance of participatory women's groups in improving maternal and child health and nutrition and share their experience with implementing care groups in Zimbabwe. This discussion paper presents some of our key learning about care groups for improved IYCF based on lessons from the Amalima program in rural Zimbabwe (15). We leverage on our experience of implementing care groups over 6 years on the USAID Food For Peace funded Amalima program which has rolled out care groups across 4 food and nutrition insecure districts from 2014 to 2020. We describe the key 'secret' ingredients for effective care group implementation, the modifications that we made in Care Group implementation, and how Care Groups can be integrated into the Ministry of Health and Child Care structure. Evidence shows that Care Groups may provide a promising approach to significantly increase key child survival interventions and increase reductions in under five mortality rate (George et al, 2015). Companion articles looking at adolescent participation in care groups, and comparing diet quality amongst care group and non-care group participants have also been documented to contribute to the evidence on the effectiveness of the Care Group approach.

Tackling the Stunting challenge in Zimbabwe: The AMALIMA program Care Groups

Care groups are peer to peer support groups made up of pregnant or lactating women and caregivers of young children. The members are led by a trained facilitator, and meet on a regular basis. The objective of the group sessions is imparting knowledge, practices and skills for the adoption of key behaviours. The care group approach or model has the advantage of being able to reach a large number of caregivers using trained community health workers or volunteers.

² https://www.who.int/nutrition/topics/globaltargets_stunting_policybrief.pdf

³ Zimbabwe National Nutrition strategy, 2014-2018. Available at <https://extranet.who.int/nutrition/gina/sites/default/files/ZWE%202014%20National%20Nutrition%20Strategy.pdf>

⁴ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60843-0/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60843-0/fulltext)

⁵ ZVNR (2017)

⁶ https://www.who.int/nutrition/topics/globaltargets_stunting_policybrief.pdf

Amalima Care Groups: a concise summary

- The approach promotes optimal maternal and infant and young child nutrition and care practices in the first 1,000 days for prevention of chronic malnutrition
- A care group consists of upto 10 mothers or caregivers meeting once a month, and led by a trained Volunteer
- Sessions are led by trained community volunteers. Amalima has 425 Care Group Volunteers (CGV), and 1,713 Lead Mothers (LM)
- Care groups leverage on the multiplier effect to reach large numbers of mothers and caregivers with key messages each month
- CGVs and LMs use context and culturally appropriate materials in the local language – Amalima developed flipcharts and counselling cards informed by the UNICEF IYCF materials and a Formative Research
- Mothers join care groups from pregnancy until the child is two years of age
- Meetings last up to two hours and are held in a central place that is easily accessible by foot for all.
- LMs share key messages through a participatory, interactive session with a behavior-centred approach
- Session activities include community cooking demonstrations which promote dietary diversity utilising locally available foods
- LMs conduct a follow up home visit to the care group members to offer one on one tailored support, reach other family members with key messages and strengthen adoption of practices
- Some sessions are 'opened' up to men, mother in laws, grandmothers and other family members
- Ministry of Health Village Health Workers (VHW) were adopted as CGVs to avoid creating a parallel volunteer structure.

The Amalima program has been implementing care groups in Tsholotsho district in Matabeleland North and Gwanda, Bulilima and Mangwe districts in Matabeleland South. The four districts are in areas which are prone to low rainfall, drought and food insecurity. The goal of the Amalima program is to improve household food and nutrition security. The baseline study for the program was conducted in 2014 and the stunting rate was found to be at 31.7%. The exclusive breastfeeding rate was at 44.9%⁷ (ICF, 2015). The care groups have been the vehicle used by the program to promote improved IYCF practices. The findings from the Endline survey conducted in 2019, show a decline in stunting rate to 24.5%⁸.

In 2014, the USAID Food for Peace funded Amalima and ENSURE programs⁹ joined the growing list of Non-governmental organizations implementing care groups world-wide (17). In Zimbabwe, this was the first time that care groups were implemented to scale to promote the adoption of recommended IYCF practices at community level. A Care Group is a group of

10–15 volunteers, community-based health educators who regularly meet together with project staff for training and supervision. They are different from typical mother's groups in that each volunteer is responsible for regularly visiting 10–15 of her neighbors, sharing what she has learned and facilitating behavior change at the household level. Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication¹⁰. (18)

From program onset, the care group activities have been implemented collaboratively with the Ministry of Health and Child Care (MoHCC) structures. Firstly, at program onset the Ministry of Health (MoH) was sensitised and engaged at National, Provincial and District level. Following this initial engagement, key MoHCC District level cadres¹¹ were trained on the approach and engaged on how

⁷<https://www.usaid.gov/sites/default/files/documents/1866/Zimbabwe%20Baseline%20Study%20Report%2C%20June%202015.pdf>

⁸ USAID Food for Peace preliminary endline findings for the Amalima Development Food Security Activity (2019)

⁹ The Amalima program is led by CNFA. Other partners include International Medical Corps, Manoff Group, Africare, Dabane Trust and ORAP. The ENSURE program is led by World Vision.

¹⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4570011/>

¹¹ District Nutritionist, District Nursing Officer, and Community Nursing Sister

the care group activities could be best tailored for the context. Based on recommendations from discussions with MoHCC it was proposed to implement the activities through utilisation of the Village Health Workers (VHW)¹² as Care Group Volunteers. The MoHCC nurses from clinics/health centres received training on the care group approach and were engaged on how they could support the VHWs in rolling out the activities. The Care Groups create a multiplier effect, reaching all households in a community at low cost (Perry et al 2015). On the Amalima program, over 2,000 Volunteers have been trained, with the same volunteers reaching 80,000 men and women in rural areas using care groups to achieve the high coverage¹³ (22).

Nutrition social and behavior change communication (SBCC) is 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. Effective nutrition SBCC seeks to increase the factors that encourage these behaviors while reducing the barriers to change. Amalima’s care group approach has been centered on nutrition social and behavior change communication. Through a Formative research, Amalima identified key IYCF behaviours to be promoted for the program. Conducting a formative research on key behaviours to be promoted was in line with other researchers such as Perry et al (2015) suggested in order to maximize on behaviour change. The table below shows some of the key behaviours identified through the Formative research that are being promoted through the Care Groups.

Table 1: Examples of behaviours identified by Formative research and being promoted through the Care Groups

Infants 6-11 months	
<ul style="list-style-type: none"> • Mothers increase number of meals up to 3 times per day • Mothers/caregivers give 1 nutrition snack per day from available food 	<ul style="list-style-type: none"> • Mothers/caregivers feed animal source foods at least 2 times each week • Mothers/caregivers enrich porridge with nuts, legumes and veg

Care group trainings focused on promoting key behavior’s to achieve optimal infant and young child feeding during the 1000 day window of opportunity period¹⁴.

¹² Village Health Workers are community health volunteers under the Ministry of Health, who conduct community health activities with support from nurses from the local clinics/health centres.

¹³ Amalima program results for the period 2014 to 2020

¹⁴ The 1,000 days between a woman’s pregnancy and her child’s 2nd birthday offer a unique window of opportunity to shape healthier and more prosperous futures. The right nutrition during this 1,000 day window can have a profound impact on a child’s ability to grow, learn, and rise out of poverty. It can also shape a society’s long-term health, stability and prosperity.

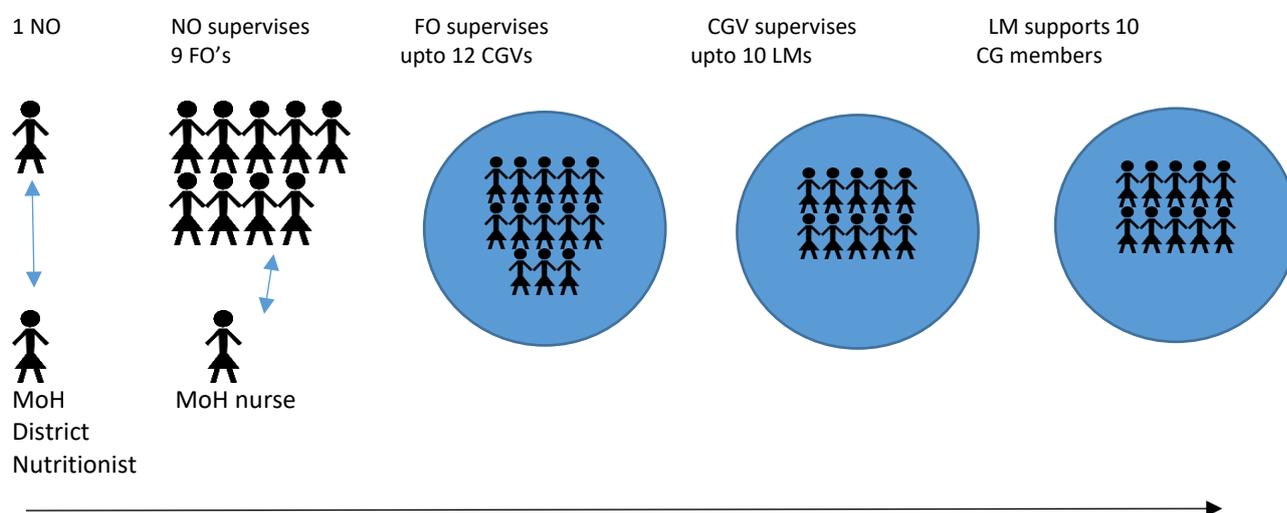
KEY AMALIMA ACHIEVEMENTS

- Over 80,000 men and women have participated in the care groups
- Exclusive Breastfeeding rate increased from 44.9 to 75.3%
- Stunting reduced from 31.7 to 24.5% from 2014 to 2019; underweight reduced from 14.6 to 6.5% over the same period

The diagram below summarises the structure of the Amalima program care group model. Within the Amalima care group approach, Supervisors/ Nutrition Officers (NOs) who are paid program staff meet with, teach and support Promoters/Field Officers (FOs) who are also paid program staff, they in turn meet with, teach and support Care Group Volunteers (Ministry of Health Village Health Workers). Monthly, each Promoter is

responsible for training and supportive supervision to a group of 5 to 12 Care Group Volunteers. The Care Group Volunteers (CGV) mentor and support Lead Mothers (LM), who are a lower-level cadre of community volunteers to work with groups of up to 10 mothers and caregivers (who are referred to as the Care Group).

Amalima Care Group model – district structure



Through the multiplier effect of care groups, 1 CGV can potentially support 10 LM's who can go on to support up to 100 care group members and their families.

The reduction in stunting levels from 31.7% (baseline) to 24.5% (endline) is suggestive of the fact that mothers and caregivers were adopting the recommended IYCF practices promoted through the care groups. Based on the seven years of care group implementation, the following are the **suggested factors for successful care group implementation**, which fall into the following five broad categories:

1. Formative Research

- Conduct a Formative Research at inception as this is critical, the research helps the program identify the key behaviours to promote, and ensure that the recommended behaviours or practices are context appropriate.
- As necessary, include other key topics as part of the curricular to be covered during the care group sessions. The Amalima program mainstreamed key hygiene messages (5 critical times for handwashing, the fecal-oral route, and promotion of handwashing stations such as the 'tippy tap') as part of the curricular. In addition, another message promoted the use of anti-retroviral treatment for HIV positive mothers and babies.

2. Context Specific Approaches & Adaptive Management

- The program had to look at limiting the workload for the volunteers to prevent volunteer fatigue. The program implementation areas are sparsely populated, and it was important to tailor the approach so as to reduce the burden of work on the CGVs and LMs. The program reduced the volunteer burden of work through the following ways:
 - Care group meetings take place once a month and not twice monthly, as is the case with other care group models.
 - Limit the number of neighbour women per LM, this helps reduce the burden of work on the LM. The Amalima program LM could only have upto 10 neighbour women per LM.
 - Ensure that sessions do not take more than 2 hours at the most. On average sessions should last 1 to 2 hours as neighbour women and their LM's have a lot of other shores that they do at home, and it is prudent to be mindful of this.
- Be open to the views from the community. In a few wards in one of the project districts (Gwanda), the communities opted to have men taking up the role of 'Lead Mothers' as these communities were able to identify motivated men within their communities, who had a keen interest in infant and young child nutrition. These Lead fathers were as committed, and dedicated as they worked exceptionally hard surpassing expectations and adapting to their duties of conducting care group trainings and home visits.
- Invest in developing or adapting and modifying quality context appropriate materials in the local language. Visual teaching tools and participatory behaviour change materials are essential. The Amalima program translated flipcharts and counselling cards into isiNdebele (the pre-dominant local language in the region). The materials were rigorously pre-tested to ensure acceptability and accuracy of terms used. This contributes hugely to the degree to which volunteers will 'own' the materials and use them.
- Focus on learning for improved programming (adaptive management¹⁵) as you implement as this will help you to make the necessary tweaks to ensure your approaches are context specific or appropriate. In addition, this will help address real gaps and challenges and improve program performance.
- It is important to mainstream gender sensitive approaches in the program. All Amalima program staff were trained on gender sensitive approaches, more importantly as the program

The key tweaks to the Amalima care group approach

The program 'opened' up a key care group lesson on child feeding to include men, mother in laws, grandmothers, aunts and other family members. Other family members can have an influence over resources in the home, and adopted practices. Including them in the care group session strengthened their understanding and appreciation of the care group sessions and enhanced social cohesion at household level.

During the first year of the program, it was clear that young adolescent mothers were not keen on attending care groups. The program conducted discussions with some of the young mothers and tweaked care groups to include (netball, and cooking demonstrations) as part of the group sessions to make them fun, and appealing for the young mothers. Annual events – such as cooking and sporting competitions where one care group competed against another were introduced resulting in a marginal increase the participation of young mothers in care groups.

¹⁵ See Box 2 which outlines how the project has modified its activities

was implemented in very patriarchal communities. In addition, CGVs and LM's were sensitised on key gender issues¹⁶ to strengthen gender sensitive programming.

- Analyse as you implement, and don't be afraid to be innovative. During the program design stage, there was no plan of developing a recipe book. However, during implementation it was recognized that mothers were shunning locally available foods, opting for more 'affluent' type of processed foods such as salty or sugary snacks which are unhealthy for young children. The team Together with mothers, the team developed a recipe book that was to be used for the complementary feeding of children aged 6 to 23 months. The Trials of improved practices (TIPS) methodology was utilized with groups of mothers from within the districts of operation. Recipes created were enhanced (had their nutrient content modified) through the use of Nutri-Survey software. The selected recipes were translated into the local language of isiNdebele and compiled along with pictures (taken during the recipe creation) into a recipe book. The program distributed the recipe book to all care group members.

3. Social Capital and Cohesion

- The Amalima care group approach recognises and epitomises the value of reaching the 'Sphere of influence around the mother', that is other family members (grandmothers, husbands, mother in laws etc) - they are reached through a tailored care group session that is open for them to attend. They are also reached through the monthly home visit. This contributes hugely to ensuring an enabling environment around the mother – which may be an

Home visits

Home visits should be a critical part of the care groups' structure. The home visit provides a unique opportunity for the LM to interface with the mother on a one to one basis. From the Amalima program experience, the home visit present an opportune platform to:

- Tailor key messages specifically for the mother. Through the home visit, the LM is able to support the mother/caregiver and address any challenges
- Make observations in terms of the home environment for example by observing hygiene conditions in the home in order to make the necessary recommendations. Reach influential family members with key messages (mothers in law, grandmothers, husbands, aunts etc) as oftentimes the mother is not the key decision maker on how resources are used in the home, or what the child eats.

important precursor for adoption of promoted practices. Evidence shows that that people can change their behaviors to improve nutrition outcomes, especially when the environment in which they live and work supports those changes¹⁷ (Spring, 2017) – and this is a key strength of the care groups. Lead Mothers carry out monthly home visits to each care group member. Monthly contact between LM's and the mothers/caregivers is essential. This is promoted not only through the care group meetings, but also during the monthly home visit sessions which encourage strong interpersonal interface between the mother and the LM. The LM becomes an important part of the social support system for the neighbor women. USAID's Technical Guidance Brief for Effective At-Scale Nutrition Social and Behavior Change Communication, highlights that "virtually all the immediate and underlying causes of malnutrition are

¹⁶ As informed by the Amalima program's Gender Analysis

¹⁷ https://www.spring-nutrition.org/sites/default/files/publications/briefs/spring_sbc_learning_brief.pdf

behavioral—influenced by the behaviors of individuals and their household members¹⁸.” In the Zimbabwean culture, it is not surprising to have family set-ups with a lot of ‘other’ family members living together as one household. These family members include grandmothers, grandfathers, aunts and uncles. Hence when these family members are present, they are invited to attend the home visit (Perry et al, 2015a/b). As acknowledged by Aubele, (2006), grandmothers are gatekeepers of indigenous knowledge and as such should be treated as the knowledge ‘hard drives’ they are. On the other hand, fathers/husbands are typically the household heads providing both financial and material resources for the upkeep of their families. Against this background, and also the realization that when all family members are provided with the correct information by LMs, they (family members) can better support the mother during the period of infant and young child feeding. This is a critical way of enriching the mother’s social capital and contributing to social cohesion at household and community level.

- The use of Edutainment makes the care group sessions fun, interesting and engaging for the neighbor women. Participatory learning with the use of role plays, songs and skits is important to key convey messages in a fun way that helps strengthen group cohesion. The Amalima program built in edutainment into the materials and made this an essential and mandatory component for care group session delivery. Peer to peer health and nutrition promotion (between neighbor women in the same care group) is key, through social cohesion mothers will naturally form relationships as they share experiences. The care group became a platform for mothers and caregivers to share their personal experiences, develop friendships, enrich their social capital through having a support network of other women to reach out to and give them a sense of empowerment. The sense of psychological safety is seen as central to the success of groups including those promoting improved health and nutrition behavior change (Taylor and Mupeyiwa, 2019). Psychological safety creates a context where individuals feel psychologically safe to engage, learn, and develop

4. Human Capital

- Resources are of paramount importance, to ensure success and quality of activities. A key resource for effective implementation of care groups is to ensure a project has adequate, trained human resources or staffing to ensure a robust structure is in place. The human resources include Supervisors, Promoters (the program used program staff¹⁹ as promoters), Care Group Volunteers and Lead Mothers. In addition resources for effective implementation of the care group program include financial resources to support quality program trainings.

¹⁸ <https://www.usaid.gov/sites/default/files/documents/1864/at-scale-nutritionSBCC-technical-guidance-brief-edit-508.pdf>

¹⁹ Program Field Officers

- Recognise that the volunteer is the backbone of the approach, and is a key resource. The motivation of volunteers can make or break the success of the project. On the Amalima program, from program onset extrinsic motivation was critical to motivate the Care Group Volunteers in carrying out the program activities. The program used job-aide related incentives²⁰ to motivate the Care Group Volunteers and Lead Mothers. Whilst extrinsic incentivisation has been critical in motivating the Care Group Volunteers, intrinsic motivation has played a key role for sustained motivation of the volunteers. After the first year of program implementation, supervision and monitoring data showed that retaining Lead Mothers was considerably more difficult than retaining Care Group Volunteers. This was to be expected given that the Lead Mothers were a new structure that was introduced by the program, and in some cases pre-conceived expectations for monetary incentives were not forthcoming. Amalima adjusted its approach for volunteer motivation by strengthening the intrinsic motivation of volunteers. For example, we worked to ensure that Care Group Volunteers and Lead Mothers are recognised and appreciated by community leadership (traditional leaders include Councillors, Kraal Heads and Village Heads) and stakeholders. Amalima also placed a lot of value in sensitising community leadership on the value of the important work that CGVs and Lead Mothers were doing in their community such as promoting key health and nutrition practices for the prevention of malnutrition. This resulted in heightened community recognition of the volunteers. Interestingly, the Care Group Volunteers and Lead Mothers place a lot of value in being recognised for the position that they hold, and being given a platform at community meetings to share key health and nutrition messages. Overtime, the program implementers gradually reduced the extrinsic motivation by giving less and less of the job-aides whilst promoting increased intrinsic motivation of the volunteers as a way of building towards sustainability beyond the project.

Integrating care groups into the MoH system

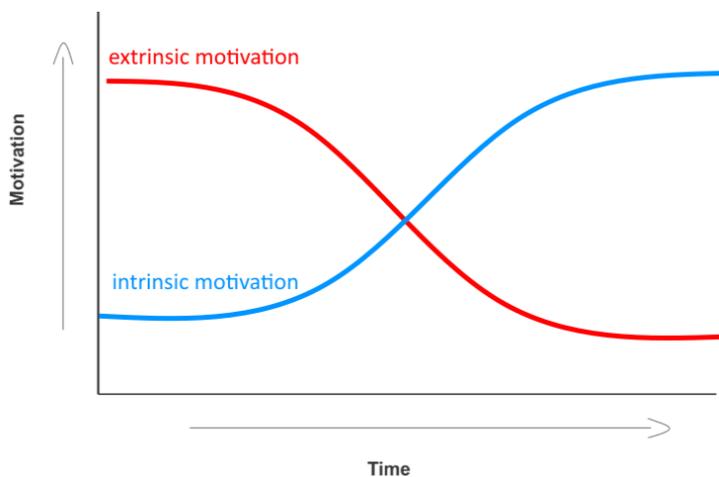
From program onset, it is important to **integrate care groups into the Ministry of Health system to help sustain the approach**. The Amalima program did this in the following ways:

- Engaged MOHCC at all levels from project onset – discussions were held with national level, Provincial level and District level MOHCC prior to implementation
- Shared the Formative Research findings with MOHCC, and involved MOHCC in developing and pre-testing care group materials
- MOHCC Village Health Workers were adopted as Care Group Volunteers as the project did not want to create a parallel volunteer structure
- MOHCC Nurses and Ward Nutrition Coordinators were engaged in a co- Promoter role as they worked alongside program Field Officers in training and supporting Care Group Volunteers in rolling out the care groups. Towards the last two years of the program, the nurses and Ward Nutrition Officers took on a stronger/lead facilitation role whilst the Field Officers took on a reduced facilitation role.
 - Conducted supportive monitoring and supervision / mentorship visits together with key MOHCC cadres¹. This enhanced MOHCC appreciation of the care group approach, recognising that strong linkages are a key factor for sustainability.

By working hand in glove with MOHCC, the Amalima program Nutritionists received requests from MOHCC Provincial and District Nutritionists to scale up the activities to three other non-program districts.

²⁰ Bicycles to facilitate travel to support LMs, T-shirts with key messages, bags to carry training materials, hats, canvas shoes

- Invest in Capacity building on the key topics/messages to be delivered by the volunteers. The program trainings are carried out on a quarterly basis, where at the first instance project Nutrition Officers (Supervisors) train Field Officers (Promoters) on a set number of modules or sessions. The trained Field Officers then go on to train Care Group Volunteers, who in turn train Lead Mothers. Once the Lead Mothers are trained, they deliver the training to mothers and caregivers (Neighbour women). The trainings have the advantage of reaching a large number of mothers and caregivers due to the cascade nature of the care group approach. Essentially, with the model, through one trained Field Officer the training can be cascaded to up to 1,000 mothers or caregivers on a monthly basis.
- Care Group lessons need to be delivered in a participatory, and not a didactic approach. This centres on ensuring that CGVs and LMs are trained on participatory, engaging adult training techniques. Amalima invested a lot of time in training the CGVs and LMs on adult learning techniques. The training cannot be a once-off training, it needs to be delivered on a pre-determined schedule (such as built into quarterly trainings for the CGVs and LMs) as part of their training on the key messages to be delivered
- Behaviour change is a process that takes time, and capacity building on counselling and negotiation skills cannot be overemphasised. The emphasis on behavior change remains key throughout the care group training curricular, with use of behavior change concepts informing care group session delivery.
- Strong collaboration with MOH from project onset, and throughout implementation is critical. This includes investing in capacity building for key MOH cadres. The Amalima program trained nurses and Ward Nutrition Coordinators on the key nutrition topics. The training was conducted in collaboration with MOH, and co-facilitated by the MOH District Nutritionists.



Graphical presentation: extrinsic versus intrinsic motivation

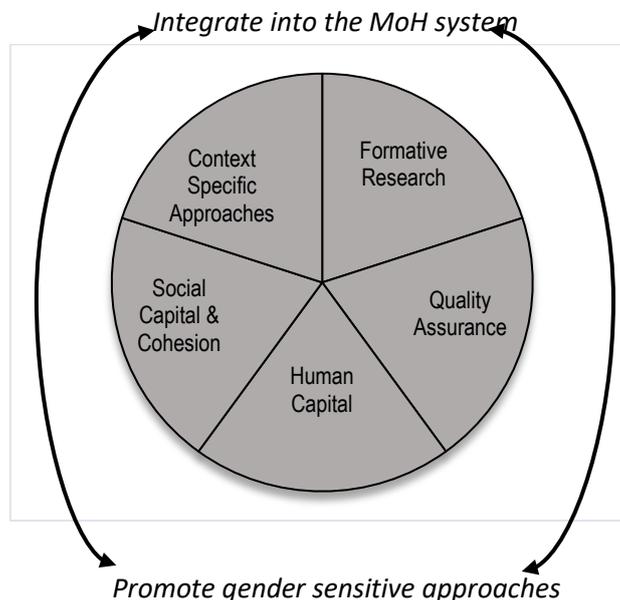
5. Quality Assurance & Reviews

- Put in place an effective supportive monitoring system to ensure quality programming. The Amalima program conducted quarterly quality improvement verification checks to identify capacity gaps through monitoring of care group sessions using a modified quality

improvement verification checklist (QIVC)²¹. One aspect of the care group model is the likely dilution of messaging from one volunteer level to another- as CGVs train/capacitate LMs and these in-turn capacitate neighbor women. Having the QIVC in place is one of the essential criteria in applying the care group approach to ensure regular supervision of volunteers. Supportive supervision has also been identified by Hill *et al* (2014) as being key in the implementation of community health worker programs. For the Amalima programme, CGVs and LMs through supportive supervision have reported feeling supported and this in-turn has contributed to their intrinsic motivation to some extent.

- Provide platforms for learning, and sharing. Quarterly review meetings which bring the volunteers together for capacity building on gaps identified through the QIVC. The Quarterly review meetings are facilitated by MOHCC nurses, Ward Nutrition Coordinators in collaboration with Promoters (Field Officers). This is in line with Amalima’s sustainability strategy which sees MOH cadres supporting the trained volunteers after the project ends. The quarterly review meetings give the volunteers a platform to learn from each other, and share experiences. In addition, it gives them an enhanced the volunteers appreciation of the vastness of the stunting problem, giving them heightened appreciation for the program objective to reduce malnutrition in their communities. Overall, the platform presented an opportunity for both groups of volunteers to receive the same type of training and messages, solve problems and plan for routine activities (Vernon *et al*, 1994).

Amalima Care Group: ingredients for successful care group implementation



²¹ The Amalima program developed a QIVC checklist in the local language, isiNdebele adapted from the QIVC in the TOPS care group toolkit

Conclusion:

There is a substantial body of literature documenting experiences on implementing care groups, this discussion article adds to experiences on operationalising the approach in a rural setting in Zimbabwe. The Amalima care group interventions contributed to a reduction in stunting by 7 percentage points in rural Zimbabwe. Based on the Amalima program experience, the care group approach presents a promising alternative to current strategies for delivering key nutrition messages geared for behaviour change in rural Zimbabwean communities. It is encouraging that the MOH in Zimbabwe has endorsed care groups as the vehicle of choice for promoting appropriate infant and young child feeding and care practices that contribute to improvements in early childhood nutrition, reduce under-nutrition, and also contribute to improved health outcomes in children. At national Care Group Model Seminar held in the country, there was consensus to enhance the adoption of the Care Group Model in Food and Nutrition Security Programming²². This discussion paper contributes to the best practices in promoting care groups in Zimbabwe given the urgency for promising strategies that reach large populations in an effort to accelerate stunting reduction and to address the slow progress being made against the WHA targets. Even though the costs of implementing care group model may seem large in the beginning of implementation, its very success lies in understanding the communities and thus adapting the approach as necessary and ensuring context appropriateness, capacity building of volunteers and motivation (intrinsic and extrinsic), strengthening care group cohesion, promoting good quality assurance systems and incorporating care groups into the MOH system to help make them sustainable.

²² Communique on Care Group Model for delivery of Community Nutrition Interventions, Declarations on the National Nutrition ENSURE Care Group Model Seminar held at Cresta Lodge, Harare, Zimbabwe from 27 - 28 August 2018

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