Learning with Care Groups through Human-Centered Design in Zimbabwe

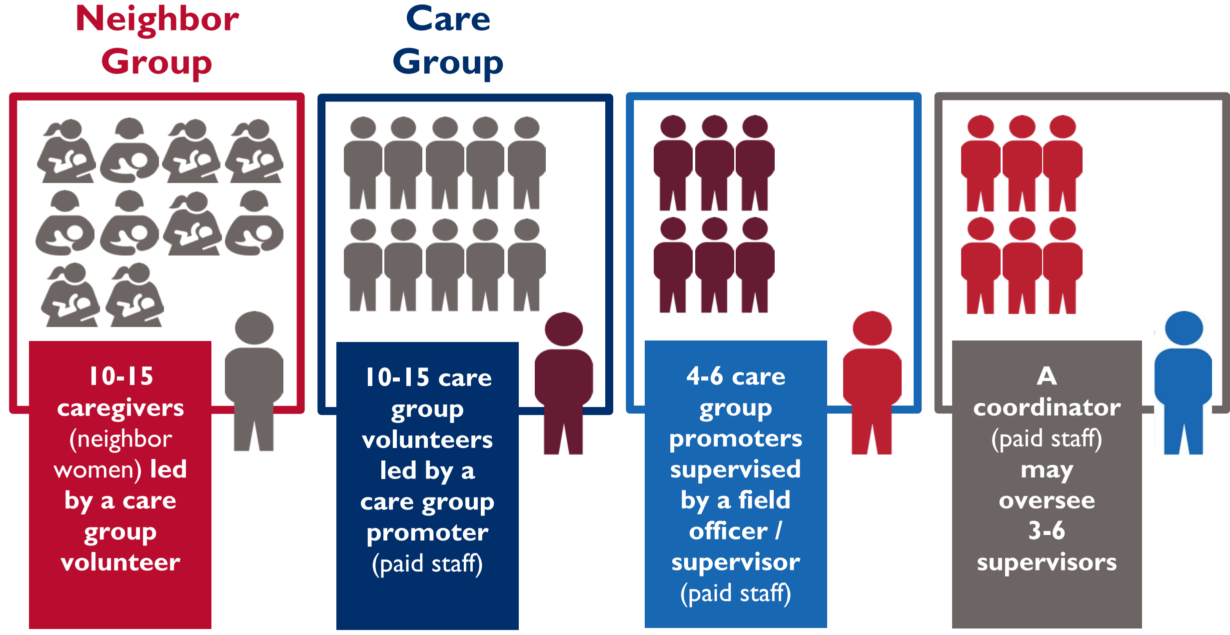
Overview

Peer support groups are a common community program platform to support multiple development outcomes including health and nutrition. As programs and studies generate evidence on quality standards, learning from the group participants themselves is critical to ensure high quality design and implementation in local contexts. To contribute to this learning, USAID Advancing Nutrition partnered with Amalima Loko, a USAID Bureau for Humanitarian Assistance (BHA)-funded Resilience Food Security Activity (RFSA), to facilitate a participatory design process and to test transferable solutions to improve the quality of peer support groups using human-centered design (HCD). **This brief shares prototypes and lessons learned from the process with Amalima Loko participants that may be useful to adapt to other contexts by implementers aiming to strengthen their own groups.**

Care Groups

Care groups are one type of peer to peer support group model used in health and nutrition programs. The Care Group Model has been implemented in 43 countries (caregroupinfo.org). The model uses an amplifying effect such that a program needs a limited number of paid staff to achieve high coverage within communities. Typically a care group consists of 10-15 volunteers led by a promoter who is supervised by staff. Each volunteer meets regularly with 10-15 women who are pregnant or have a young child in her neighborhood (figure 1).

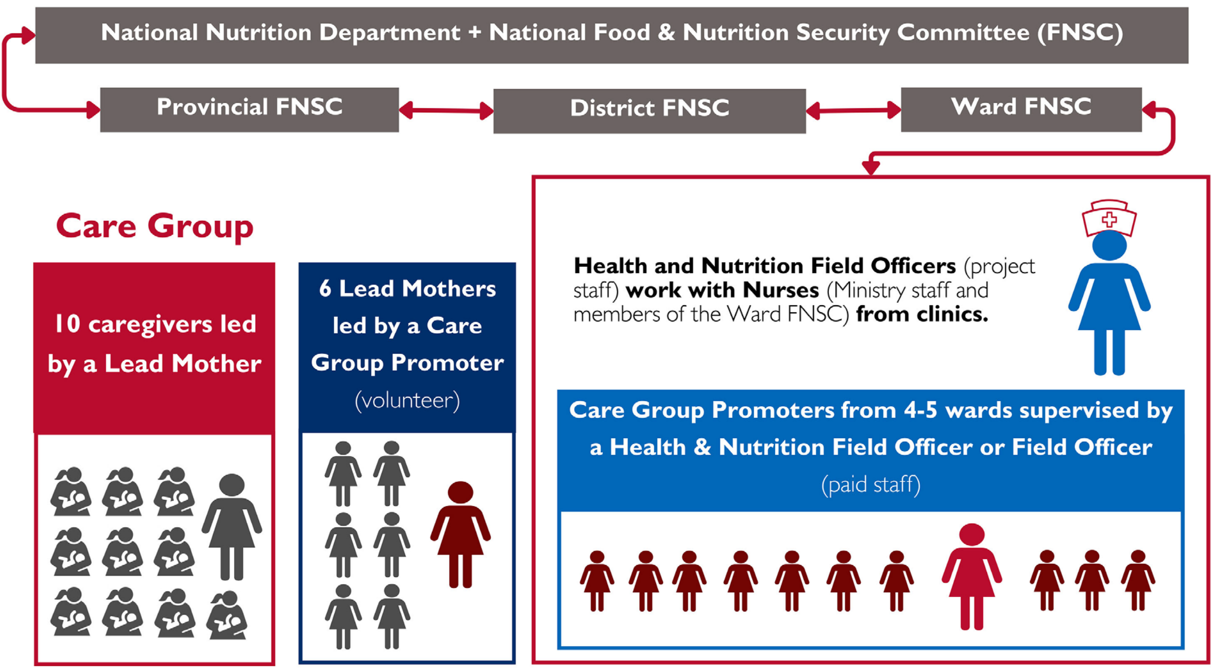
Figure 1. The Care Group Model



Source: TOPS 2016

Amalima Loko aims to improve food security in five districts of Zimbabwe's Matabeleland North region (Binga, Hwange, Lupane, Nkayi, and Tsholotsho) through increased food access and sustainable watershed management. Under Amalima Loko, care groups consist, on average, of groups of up to 10 caregivers of children under five led by a volunteer lead mother (Cultivating New Frontiers in Agriculture 2022). This group meets regularly—typically twice a month—and receives household-level counseling from a lead mother.

Figure 2. Amalima Loko Care Group Cascade



Source: Ncube-Murakwami et al. 2021, adapted by USAID Advancing Nutrition

Research Objective

This study facilitated a participatory process to design and test transferrable solutions to improve the quality of peer groups with the Amalima Loko RFSA. This brief focuses on sharing findings from two key research questions—

1. What are the challenges to the quality of peer groups as defined by peer group leaders, members, and other key stakeholders?
2. What are feasible ways to improve the quality of peer groups defined by peer group leaders and members including, but not limited to, the care group model?

Overview of the Research Method

This study used a participatory HCD approach to implementation research. HCD is increasingly applied to global health challenges (LaFond and Chenery 2021) to help program or service providers think differently about problems and collaboratively generate solutions with intended users or program participants. HCD can be useful for programmatic learning and improving design and delivery of social and behavior change (SBC) programming due its three core tenants (Lafond and Cherney, 2021)—

- engages diverse stakeholders to frame challenges and co-create solutions

- puts program participant needs, desires, and contexts in the center of solutions
- uses cycles of creative and iterative solution development, testing, and monitoring.

Messages

- Amalima Loko, an RFSA in Zimbabwe, used human-centered design to co-design local solutions to quality care groups with stakeholders and program participants.
- Care group participants defined a quality group as one that is united, peaceful, and contributes to relevant, visible changes in their homes and communities. Participants identified challenges to participation, facilitation and learning, recognition in communities, and sustainability of groups.
- Care group participants identified and tested four solutions to improve quality from their perspectives, by strengthening dialogic facilitation and community recognition through the inclusion of reflection and interactive, fun activities, and increasing social support for participation through commitments.
- These four solutions are ready for local adaptation and use by programs that aim to strengthen care groups or other peer to peer support groups through dialogic facilitation and social support leading to improved participation and adoption of key practices.

In phase 1 of the research, we conducted individual interviews with neighbor mothers, lead mothers, and care group promoters in Binga, Lupane, and Tsholotsho districts as well as Amalima Loko national- and district-level staff. The purpose was to understand and document the range of experiences and perspectives. The research team used Atlas.ti to thematically analyze the data. The team then synthesized key findings using HCD tools as a framework. With these findings, the research team shared back HCD tools and an experiential quality matrix with care group participants in semi-structured focus group discussions (FGDs) at the district level.

In phase 2 of the research, care groups tested and refined prototypes twice. For each round of testing, the research team observed and conducted FGDs. Data from observations and FGDs were thematically analyzed.

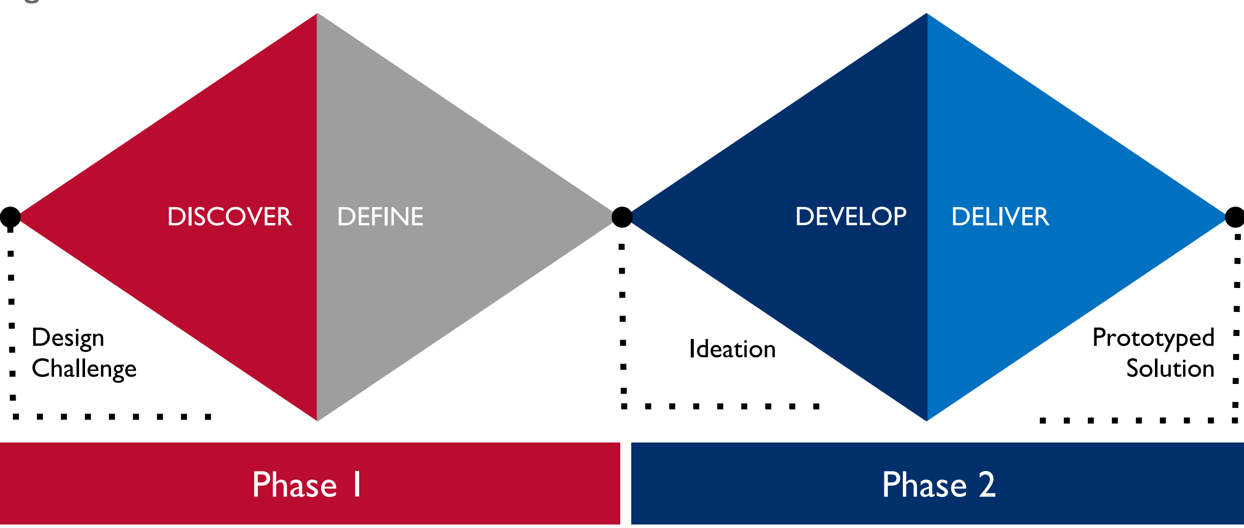
Details of the process and findings are described below in parallel because findings of each phase informed the development and process of subsequent phases.

This research was constrained by two key limitations. First, the small sample size of qualitative research means that the findings may not be representative of all participants and are not statistically significant. This challenge was addressed by conducting the research in multiple districts and communities using a similar design and question guides. Second, time and resource limitations restricted the feasibility of frequent and close engagement with the implementing partner for routine decision-making, and restricted the number of iterations possible during prototype testing.

Findings

The research followed the double-diamond design framework (Design Council 2019) (figure 3). In the first phase of research, we explored the experiences of care group members', care group leaders (called "lead mothers") and care group volunteers ("care group promoters") to "discover" and "define" the design challenge. In the second phase, we collaborated with key care group stakeholders to design ("develop") and iteratively test ("deliver") feasible and sustainable solutions to prioritized challenges to care group quality.

Figure 3. Double Diamond



Source: Adapted from Design Council 2019

Discover

Between September and November 2022, individual interviews were conducted with Neighbor Mothers (n=64), lead mothers (n=30), care group promoters (n=15) in Binga, Lupane, and Tsholotsho districts as well as Amalima Loko national- and district-level staff (n=5) to understand and document the range of experiences and challenges related to peer group quality. The research team used Atlas.ti to thematically analyze the data, and synthesized key findings using HCD tools as a framework.

The research team conducted in-depth interviews with care group participants, promoters, and Amalima Loko staff between September and November 2022. The research team used a set of HCD tools to synthesize preliminary findings for validation with participants during Define. The HCD tools included a journey map and empathy map (figure 1). The journey map outlined four stages: 1) starting a care group; 2) joining; 3) attending; and 4) sustaining. The empathy map captured what participants hear, see, think, feel, say, and do related to care groups with a particular focus on challenges and opportunities to address those challenges (figure 4). Participants also validated findings on their perceptions of quality groups (table 1).

Figure 4. Empathy and Journey Map Frameworks

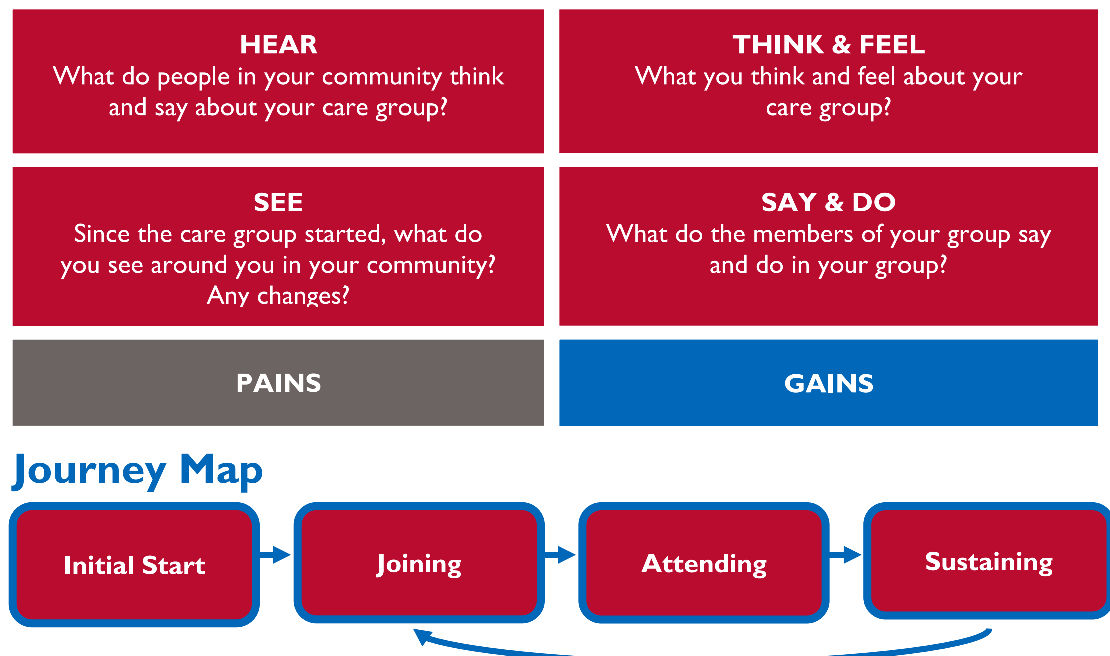


Table 1. Summary of Care Group Participant Perspectives on Quality Care Groups

	Neighbor Mothers	Lead Mothers
Definition of quality from the perspective of care group participants	• united group • peaceful, open, and willing to learn • tangible success/visible change • contribute to community development	• participation of neighbor mothers • behavior change (neighbor mothers practice what they learn)
Challenges to quality from the perspective of care group participants	• some members come late, resulting in long wait time/conflict with family • same topics; not always relevant to them • want more interactive activities/exercises	• want more participation of neighbor mothers • want more behavior change (neighbor mothers practice what they learn)

Opportunities identified to address the challenges—

- **Participation**—encourage more family support so that members can participate and so that others do not have to wait long periods to join
- **Facilitation**—expand dialogic facilitation tailored to the age and stage of the member, with fun activities and peer-to-peer learning
- **Sustainability**—provide support to groups to establish ways to bring in new members as participants age in or out

Define

In January 2023, the HCD tools and experiential quality matrix were shared back to care group participants in semi-structured FGDs (N=48) at the district level. The FGDs aimed to validate and expand on the findings from the individual interviews and collaboratively identify priority challenges and opportunities. The research team framed findings as six design questions:

1. How might we engage family members to support care group participation?
2. How might we incorporate adult learning principles to facilitate behavior change in neighbor mothers?
3. How might we tailor discussions to group members' needs and current situations?
4. How might we build social support for action (behavior change) in the group?
5. How might we help lead mothers become trusted (credible) messengers within the communities?
6. How might we support lead mothers to accommodate an evolving structure of care groups where everyone feels welcome?

Develop

Ideation In February 2023, the research team (n=5) and Amalima Loko staff (n=12) convened a one-day "ideation" workshop to review the findings from the first phase (i.e., care group participant definition of a "quality group" and recommendations for and challenges to achieving quality), and identify possible solutions to the six design questions.

The team prioritized five possible solutions and shared these with care group promoters and lead mothers (N=37) during district-level FGDs in May 2023. The team advanced the top three highest-ranked solutions in each district. In total, four of the original five solutions were "prototyped" (e.g., were developed into a tangible model, guidance and/or tool for participants to interact with; see bolded titles below) with input from care group participants.

1. **Simple Job Aid for Reflection Session**
2. **Drama Development Guide**
3. **Look-and-Learn**
4. **Commitment Card**
5. **Buddy System**

Prototype Testing: Care groups tested and refined prototypes twice, starting in July 2023 (see table 2). During testing, the research team paired prototypes with care groups based on the ranking by the lead mother and invited care groups to use the prototype during a group session. The research team conducted detailed observations of care groups using the prototypes during a group session and FGDs after a group session.

Table 2. Solutions Tested with Care Groups

Solution	*Binga*	*Lupane*	*Tsholotsho*	*Total*
Simple Job Aid for Reflection Session		2	2	4 care groups
Drama Development Guide	2	2		4 care groups
Look-and-Learn	2	2	2	6 care groups
Commitment Card	2			2 care groups

The research team used the findings to refine prototypes for a second round of testing in August and September 2023. Two groups tested each revision: one care group that used the earlier version and one group that had not but which had prioritized the solution.

Deliver

The research team, with Amalima Loko staff, used the findings to finalize prototypes. These prototypes aimed to encourage increased social cohesion and support, strengthen creative and didactic facilitation skills of lead mothers, aid commitment and family support for trying promoted behaviors, and strengthen soft skills of lead mothers and caregivers. Amalima Loko care groups will be able to use the solutions across the project.

Simple Job Aid for Reflection Session provides an adaptable template for facilitating a care group meeting to reflect on behaviors tried or discussed in the previous module or meeting. The template includes welcome exercises, illustrative discussion prompts, and facilitation tips. It was designed to be used by lead mothers.

Drama Development Guide provides two adaptable templates for facilitating the development and optional performance of an original drama based on care group member experiences and priorities. The guide was designed to be used by lead mothers.

Look-and-Learn Guide shares tips for preparing lead mothers and facilitating a look-and-learn. During these care group meetings, a hosting lead mother and promoter invite visiting lead mothers to observe a care group session. After the meeting, the lead mothers and promoter debrief to share recommendations and reflections on the session. The guide was designed to be used by a hosting lead mother and/or a promoter.

Commitment Card includes guidance for using a commitment card in care group meetings and home visits, an adaptable template for creating a commitment card, and an illustrative commitment card and lead mother monitoring form developed around the Amalima Loko program. The aim of the prototype is to support family engagement and support for recommended behaviors. The process involves inviting

a member of a caregiver's household to serve as their commitment partner. The guide was designed for use by lead mothers and the illustrative card was designed to be used by caregivers.

Key Takeaways

Care groups should have fun! Care group members value group unity and cohesion as key elements of a quality care group. The solutions drafted build on these insights, including at least one element intended to increase interactions among members during a care group meeting. These included welcome activities, new games, and song and dance. After testing these new activities, participants reported feeling more comfortable and a higher willingness to engage during and after "fun" activities. Such activities represented an opportunity to strengthen the dialog from member-to-member and member-to-lead mother.

> *"Yes, today I adopted a welcome exercise in the guide and the neighbor mothers really enjoyed that, especially the 'draw your neighbor' [exercise]. It's something that we don't use in our lessons [currently]. It really helped them to relax and enjoy the lesson."*
>
> --Lead mother, Tsholotsho, speaking about the Simple Job Aid for Reflection sessions

> *"This session was good as it helped us to get to know each other and made us laugh through drawing each other which made us laugh and have fun [throughout] the entire process without any fear."*
>
> --Neighbor mother, Lupane, speaking about the Simple Job Aid for Reflection sessions

> *"This will promote friendship within the care group and, when the shy are paired with someone, they can laugh and engage more as they will be looking at each other. This will help them to talk and have fun with each other."*
>
> --Neighbor mother, Binga, speaking about the Drama Development Guide

Care groups can learn from and be accountability mechanisms for each other. Care group participants expressed interest in learning from one another and co-developed a mechanism, called "look-and-learn," to facilitate peer-to-peer learning between lead mothers. During the testing of the prototype, participants across the cascade appreciated the look-and-learn as a way to introduce new and strengthen existing skills among lead mothers, assess fidelity of care group content delivery, strengthen the rapport of lead mothers as credible teachers among neighbor mothers, and develop an opportunity to strengthen social connections between lead mothers through observation and peer-to-peer exchange.

> *"I want to keep using this approach as it will help us to have the truth that what they [lead mothers] are reporting to us on a monthly basis is true. This is because we will be visiting them to check how they are teaching and in doing so this will make them have their groups and sessions at the same time. They will also help to teach each other through peer-to-peer engagement after the sessions."*
>
> --Care group promoter, Tsholotsho, speaking about the Look-and-Learn

"I wanted to be part of these sessions as these sessions will help me to give assurance to my neighbor mothers that this thing is not mine only, there are other lead mothers from other villages who are doing the same thing we are doing."

--Visiting lead mother, Lupane, speaking about the Look-and-Learn

"The hosting lead mother and the visiting lead mother understood the approach because the hosting lead mother was able to take all the critiques at the debrief without being so defensive or personal. The visiting lead mothers were able to get some insights from the hosting lead mother's session through the way she facilitated and the way she was free with her neighbor mothers. They were coming to me to tell me that we should start our own look-and-learn without the involvement of Amalima Loko staff, this will help [with] capacitating each other."

--Care group promoter, Lupane, speaking about the Look-and-Learn

The study team noted enthusiasm for the look-and-learn solution as a means for self-directed capacity building and a potential means to sustain care groups between periods of partner implementation. During iteration, we also learned that care groups in Tsholotsho decided to move forward with one of the proposed prototypes without support from the research team. The groups developed and implemented their own buddy system to support participation and accountability within their care groups. For solution concepts that have low resource requirements, care groups can use the design process to generate and implement solutions without additional support from implementing partners.

Family support is a key factor for care group participation. Care group participants emphasized that family support was both a key facilitator and a key barrier to participation from care group members and lead mothers. Implementing partners could consider exploring family support as a factor and using a co-creation design process such as HCD to determine the design and to implement an approach to strengthen family support.

"The challenge can be their husbands who do not understand the purpose and benefits of care groups."

--Lead mother, Lupane

To respond to family support as a barrier to participation, care groups in Binga co-developed a commitment card that pairs a neighbor caregiver with a member of their household. Commitment cards were designed to be integrated into Amalima Loko's programming, and were enthusiastically received by commitment partners, care group members, and lead mothers. Participants appreciated the cards as a reminder of their commitments. The cards were easy-to-understand accountability mechanisms for attending sessions, an opportunity to highlight non-behavioral factors, and a way to elevate household commitment and awareness of recommended behaviors.

"The benefits of using this approach is that now we are involving the family members into the whole issue of commitments where they have been left out in all these past years. But with this approach they are being involved in all the things that are done in the commitments exercise. Such commitments will help to increase the attendance of the neighbor mothers to the sessions because the commitment partners will be reminding them and encouraging them to attend."

--Lead mother, Binga, speaking about the Commitment Card

“Yes I want to keep using the commitment method because this method will help my household to know what I have chosen to commit myself to and help them in doing so. Doing it alone will not help me in any way.”

--Neighbor mother, Binga, speaking about the Commitment Card

"[The commitment card] has given me information and helped me to get the support that I need from my mother-in-law and the household. It has brought us to work together rather than having a one-sided commitment that is not known at home."

--Neighbor mother, Binga, speaking about the Commitment Card

Community ownership is critical. We found that community ownership was a key factor in community support for participation in care groups as well as key to all conceptualizations of sustainability (see related recommendation below). Care group members and leaders said that village leaders were critical to the formation of the care groups as well as supportive to ongoing implementation of care groups, even contributing to conflict resolution and problem-solving within individual groups.

“Nothing happens without the knowledge of the community leadership.”

--Promoter, Tsholotsho

“Community leaders are aware of what we are doing as they support us by joining us in our group meetings. And when a group member has a problem our village head helps us somehow.”

--Neighbor mother, Lupane

Engagement between village leaders and individual care groups increases the likelihood that care groups can be sustained between periods of program implementation and can have greater impact on their communities. Care group members and leaders noted that engagement with village leaders provided opportunities for the care group to perform publicly and/or contribute to community development.

“There is need to continue with such sessions in the future because this will help us to be prepared to act at any occasion. This is because we are always called to act dramas at events and community functions so having these dramas will help us to be always prepared. These will help to reach to the high multitude of people. Furthermore, these sessions would help lead mothers to have experience working with community leadership as they mobilized and prepared for meetings.”

--Lead mother, Lupane, speaking about the Drama Development Guide

Implementing partners may consider sustained engagement with community leaders around care groups throughout the program cycle.

Adapting Solutions for Other Care Groups

The collection of prototypes generated aimed to strengthen care group participant-defined quality by addressing the range of challenges they described. While individual prototypes have a specific focus or intended purpose, each prototype addresses a range of crosscutting challenges such that the prototypes could be used individually and still provide an overall value to groups. Programs with care groups experiencing the following focused challenges, could consider testing and adapting these prototypes to local needs (table 3).

Table 3. Care Group Quality Domain by Prototype

Challenge	Prototype(s)
Participation and Family Engagement	**Commitment Card** **Drama Development Guide**
Facilitation Capacity Building	**Look-and-Learn Guide** **Simple Job Aid for Reflection sessions**
Tailored Content for Groups of Diverse Age and Stage	**Drama Development Guide**
Social Support for Action	**Simple Job Aid for Reflection sessions**
Ownership of Monitoring and Accountability	**Commitment Card** **Look-and-Learn Guide**
Community Linkages and Recognition of Groups	**Look-and-learn Guide** **Drama Development Guide**

Other Useful Resources

Acumen Academy. n.d. "Acumen Human-Centered Design 201: Prototyping." https://acumenacademy.org/course/human-centered-design-prototyping/

Blynn, E., E. Harris,, M. Wendland, C. Chang, D. Kasungami, M. Ashok, and M. Ayenekulu. 2021. "Integrating Human-Centered Design to Advance Global Health: Lessons From 3 Programs." *Glob Health Sci Pract* 9(2):S261-S273. https://doi.org/10.9745/GHSP-D-21-00279

Breakthrough ACTION and United States Agency for International Development. 2020. *Leveraging Human-Centered Design for Family Planning: Lessons and Considerations*. Arlington, VA: United States Agency for International Development. https://breakthroughactionandresearch.org/wp-content/uploads/2021/02/Leveraging-HCD-for-FP.pdf

USAID Advancing Nutrition. 2023. Design Innovations Resource Collection: Bringing Emotional Intelligence to Nutrition Social and Behavior Change. Washington, DC: USAID Advancing Nutrition.

References

Cultivating New Frontiers in Agriculture (CNFA). 2022. *Amalima Loko Training Module: Introduction to the Care Group Model.* Washington, DC: United States Agency for International Development.

Design Council. 2019. "The Double Diamond." https://www.designcouncil.org.uk/our-resources/the-double-diamond/

LaFond, A. and M. Cherney. 2021. "A Theory of Change for Guiding the Integration of Human-Centered Design Into Global Health Programming." *Glob Health Sci Pract* 9(2):S209-S216.

Ncube-Murakwani, P. 2021. "A qualitative investigation of adolescent participation in Care Groups for improved maternal and child nutrition: Experiences from rural Zimbabwe." *World Nutrition* 12(2):32-47. https://doi.org/10.26596/wn.202112232-47

TOPS (Technical and Operational Performance Support) Program. 2016. *Care Groups: A Reference Guide for Practitioners.* Washington, DC: The Technical and Operational Performance Support Program.

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