A Qualitative Investigation of Adolescent Participation in Care Groups: The Zimbabwe Experience

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Abstract

The Amalima program in Matabeleland North and South provinces of Zimbabwe, a United States Agency for International Development (USAID) Office of Food for Peace intervention, has been promoting the Care Group approach since 2014. Care Groups are community peer- to- peer support groups that provide a platform for promoting optimal nutrition and health for pregnant and lactating women, as well as children 6-23 months through trainings to promote recommended infant and young child feeding and care practices. Generally, the participation of adolescent mothers in Care Groups has been low, therefore a qualitative study was conducted in two districts (Gwanda and Tsholotsho) to describe the experience of adolescent mother[1] inclusion and participation in Care Groups, highlighting key barriers and facilitators for participation. Qualitative methods were used, specifically 28 in-depth interviews were conducted with adolescents in Care Groups, as well as adolescents not participating in Care Groups. In addition, focus group discussions were held with family members of adolescent Care Group participants, family members of adolescent non-participants, as well as Care Group Volunteers and Lead Mothers. The study findings indicate that key motivators for Care Group participation by adolescent mothers include: learning or gaining knowledge on how to take care of their child, fun and exciting sessions, such as cooking demonstrations and having the opportunity to interact with, and learn from other mothers. Key barriers to participation were highlighted as follows: Care Group attendees form 'peer cliques' leaving adolescent mothers feeling left out; adolescents are not free to express themselves during the sessions due to shyness; and workload/chores at home prevented adolescents from finding time to attend Care Group activities. Key recommendations include training Care Group volunteers and Lead Mothers on adolescent friendly approaches and group dynamics so they can better understand and relate to adolescents. Additionally, a key recommendation is for pairing up of adolescent mothers with older, experienced mothers in the Care Group to encourage a mentor-mentee relationship to contribute to greater social cohesion.

[1] 13 to 19 years of age. The UN defines young people as those aged 10–24, early adolescents as those aged 10–14 years, and late adolescents as those aged 15–19 years

Introduction

In Matabeleland North and South provinces of Zimbabwe, the Amalima program, a United States Agency for International Development (USAID) Office of Food for Peace intervention has been promoting Care Groups since 2014. The program is implemented by a consortium of organisations led by Cultivating New Frontiers in Agriculture[2]. Amalima, a seven- year development food security program whose goal is to improve household food and nutrition security, is being implemented in four food and nutrition insecure districts (Bulilima, Mangwe and Gwanda and Tsholotsho) across the two provinces.

International Medical Corps is responsible for implementing the Care Group approach which has been endorsed by Zimbabwe's Ministry of Health as it promotes optimal maternal and infant and young child nutrition. Care groups are peer to peer support groups of about 10 mothers (pregnant or lactating women and caregivers of young children) that meet on a regular basis. The group sessions are led by a facilitator (Lead Mother), with the objective of imparting knowledge, practices and skills for the adoption of health, nutrition and hygiene behaviours.

Through Care Groups, community volunteers reach mothers and caregivers each month with tailored messages[3] promoting the adoption of recommended infant and young child feeding (IYCF) behaviours. Supporting nutrition in the first 1,000 days[4] is known to improve fetal growth and birth outcomes, reduce stunting, improve economic prosperity, and, ultimately, save lives[5].

Key Features of the Amalima Care Group Approach

- The approach promotes optimal maternal and infant and young child nutrition in the first 1,000 days for prevention of chronic malnutrition
- Care group sessions are participatory and led by trained community volunteers. Amalima has 425 Care Group Volunteers (CGV), and 1,713 Lead Mothers (LM) implementing care groups across the four districts
- The care groups leverage on the multiplier effect to reach large numbers of mothers and caregivers (up to 6,000 each month) with key messages each month
- Community Volunteers use context and culturally appropriate participatory materials in the local language – flipcharts and counselling cards
- A care group consists of up to 10 mothers or caregivers who meet once a month, to cover a session led by a trained Volunteer
- Care group sessions are held on a monthly basis
- The Community Volunteer (Lead Mother) conducts a follow up home visit to the mother/caregiver to offer one on one tailored support, and reach other family members with key messages
- Mothers/caregivers participate in the care group from pregnancy until the child is 2 years of age

Adolescent mothers are encouraged to participate in Care Groups with the specific aim to ensure improved nutrition outcomes for themselves and their children, however their participation in the Care Groups has been low. The Amalima program introduced sport and cooking competitions as interesting activities to attract their participation. Care Group participants also received a recipe book to encourage them to prepare nutritious meals taught during the community cooking sessions. Adolescent mother participation in Care Groups is important as research from the Young Lives study

[2] Other partners include International Medical Corps, The Manoff Group, Organization of Rural Associations for Progress (ORAP), Africare, and Dabane Water Workshops

[3] Care group curriculum includes the following topics: breastfeeding, child feeding and maternal health and nutrition. Messages on hygiene promotion are embedded within the topics

[4] The first 1000 days is the period from conception to a child's second birthday. This period has been identified as the most crucial window of opportunity for interventions to reduce stunting

[5] Black, Robert E., et al. 2008. "Maternal and Child Undernutrition: Global and Regional Exposures and Health Consequences." *The Lancet*, vol. 371, no. 9608, pp. 243–260., doi:10.1016/s0140-6736(07)61690-0.

found that being born to a stunted adolescent mother was associated with a 15 percent increased chance of a child being stunted, compared with being born to a non-stunted older mother[6].

Adolescence is a period of growth and development that is increasingly being recognised as a critical window for optimising the health and well-being of current and future generations[7]. Adolescents are often overlooked as a link to better nutrition in the first 1,000 days and yet prioritizing and engaging adolescents prior to and during the first 1,000 days can accelerate progress on improving nutrition and contribute to meeting multiple Sustainable Development Goals[8]. Adolescence comes with heightened nutritional need, which can be compounded by pregnancy with its additional demands on a mother's nutrient stores. *The Lancet* 2013 series on maternal and child nutrition identifies adolescent girls as a priority focus area for research and programming, due to the dearth of evidence available to inform adolescent nutrition interventions and the importance of ensuring nutritional wellbeing in this age group through puberty and going into motherhood[9]. The need for tailored services for adolescent girls through a life-cycle approach that would ensure good nutritional practices and status throughout the adolescent period, as well as better preparing them going into the critical '1,000 day window of opportunity 'cannot be over emphasised. Globally, growing attention is being paid to the importance of adolescent health and nutrition as evidenced by various strategies, and guidelines that place emphasis on both the needs and opportunities for investing in adolescent health and nutrition[10], [11], [12]. Adolescent pregnancy is a major public health problem, particularly in Africa [6]. Sub-Saharan Africa (SSA) has the world's highest level of adolescent pregnancy estimated at 101 births per 1,000 women aged 15-19 years. In Zimbabwe, the adolescent fertility rate for women aged 15-19 years was 115 births per 1,000 women of the same age in 2015[13]. An assessment of adolescent girl nutrition and dietary practices and roles in Zimbabwe showed that adolescent girls had low levels of knowledge on nutrition, particularly nutrition during pregnancy[14]. A case study conducted by International Medical Corps in Nigeria on adolescent inclusion in the Care Group approach concludes that the Care Group approach provides an opportunity to appropriately target adolescents to achieve improved maternal and child health and nutrition[15].

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[6] Georgiadis, Andreas, and Mary E. Penny. 2017. "Child Undernutrition: Opportunities beyond the First 1000 Days." *The Lancet Public Health*, vol. 2, no. 9, doi:10.1016/s2468-2667(17)30154-8.

[7] Patton GC, Sawyer SM, Santelli JS, et al. Our future: a Lancet commission on adolescent health and wellbeing. The Lancet. 2016 Jun 11;387(10036):2423–78.[Crossref], [Web of Science ®]; Patton GC, Olsson CA, Skirbekk V, et al. Adolescence and the next generation. Nature. 2018 Feb;554(7693):458–66.

[8] United Nations (UN). 2015. *Transforming our World: The 2030 Agenda for Sustainable Development*. New York: United Nations. https://sustainabledevelopment.un.org/post2015/transformingourworld/publ....

[9] Reese-Masterson A, Murakwani P, 2015. Assessment of adolescence girl nutrition dietary practices and roles in Zimbabwe. Emergency Nutrition Network, field exchange article, available at https://www.ennonline.net/fex/52/adolescentgirlnutrition

[10] World Health Organization (WHO). 2018b. *Guideline: Implementing Effective Actions for Improving Adolescent Nutrition*. Geneva: World Health Organization.

[11] Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) (2017): *Report of the Stakeholders Consultation on Adolescent Girls' Nutrition*

[12] The Lancet (2016): *Our future: a Lancet Commission on Adolescent Health and Wellbeing*

[13] National Adolescent Fertility study report, UNFPA, 2016. Available at https://zimbabwe.unfpa.org/sites/default/files/pub-pdf/UNFPA%20NAFS%20Main%20Report%20%202016%20For%20Web.pdf

[14] Reese-Masterson A, Murakwani P, 2015. Assessment of adolescence girl nutrition dietary practices and roles in Zimbabwe. Emergency Nutrition Network, field exchange article, available at https://www.ennonline.net/fex/52/adolescentgirlnutrition

[15] Perera S. M. Case Study on Adolescent Inclusion in the Care Group Approach – the Nigeria Experience. Emergency Nutrition Network, field exchange article, available at https://www.ennonline.net//fex/52/adolescecaregroup

In spite of the Amalima programs innovative activities, the participation of adolescent mothers in Care Groups has remained low, therefore Amalima conducted this research to explore the motivators and barriers for adolescent mother participation in care groups. Findings and recommendations from this study will help inform future strategies for effective engagement of adolescents in Care Groups and other global programs engaging adolescent mothers.

Methodology

This study employed qualitative research methods including Focus Group Discussions (FGD) and key informant interviews (KIIs). Research was conducted in two districts (Gwanda district in Matabeleland South province and Tsholotsho district in Matabeleland North province) across 4 purposively selected villages[16]. The villages were selected as they had high numbers of adolescent mothers.

Study investigators purposively sampled from following groups: 1) adolescent mothers of children 0-23 months attending at least 4 Care Group lessons in the last 6 months, 2) adolescent mothers of children 0-23 months having never attended a Care Group lesson, 3) female relatives of adolescent mothers, and 4) Care Group volunteers and Lead Mothers.

A total of 28 in-depth interviews and 11 focus group discussions were conducted (see table below):

	Gwanda district	**Tsholotsho district**	**Total**	**Participants**	**Participant Details**
In depth interviews	11	10	21	Adolescent mothers participating in care groups	Youngest 16 years old. Eldest 19 years. Median age: 18 years 3/18 married (16.6 %). 20/21 (95.2%) have one child.
In depth interviews	5	2	7	Adolescent mothers not participating in care groups	Youngest 16 years old. Eldest 19 years. Median age: 18 years 2/5 married (40%). All have one child.
Focus group discussions	4	1	5	Family members of adolescents participating in care groups	Mostly female family members (mothers, mothers in law, aunts, grandmothers); 1 male family member
Focus group discussions	2	3	3	Family members of adolescents not participating in care groups	All female family members (mothers, mothers in laws, aunts)
Focus group discussions	1	2	3	Care Group Volunteers and Lead Mothers	6 CGVs; 17 Lead Mothers (all female)

Table 1: Study sample

[16]A district consists of several wards which are further sub-divided into villages.

Semi-structured interview guides were developed separately for the IDIs and FGDs, in accordance with standardised guidance on qualitative research tools[17],[18]. Prior to data collection, all researchers underwent a 3-day training on FGD and KII methodology, including facilitation techniques, note-taking methods, consent acquisition, and ethics of conducting interviews with adolescents. Tools were pre-tested by the researchers with adolescent mothers, family members and project volunteers in Gwanda district.

Data Collection

Data was collected by a team of researchers[19] who have previously conducted similar assessments within the Amalima program areas. Data collection was conducted over a 5 day period in November 2019. During each data collection session, there was a dedicated notetaker. The team also used recorders, and interviews were recorded in the Ndebele language and then transcribed directly into English for data analysis and reporting. IDIs lasted approximately 30 minutes and FGD between 60 minutes to 90 minutes.

Data Analysis

Data was analyzed inductively with a list of codes developed by the researchers. These codes were then be grouped into major themes where all transcripts were coded by two researchers. Any inconsistencies were discussed and resolved until the inter-rater agreement was in the 80th percentile range. After the completion of coding, data was compiled, manually analysed and interpreted and the key themes and quotes of relevance highlighted.

Ethical Considerations

Prior to data collection, the protocol and the data collection tools were reviewed by the Amalima Technical Learning unit team, and IMC's Research and Technical Officer. To protect confidentiality, all discussions were held in a private space and no names were included in transcripts. Verbal informed consent was obtained from all participants. Only members of the research team had access to the recordings and transcripts.

[17] **Malterud**, K. (**2001**) **Qualitative research**: Standards, challenges, and guidelines. Lancet, 358, 483-488. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/11513933

[18] Qualitative Research Methods: a data collector's field guide. Family Health International, North Carolina. Retrieved from http://repository.umpwr.ac.id:8080/bitstream/handle/123456789/3721/Qualitative%20Research%20Methods_Mack%20et%20al_05.pdf?sequence=1

[19] Amalima Lead Nutrition Specialist, Nutrition Coordinator, M&E Coordinator & Nutrition Officers

Results

Key motivating factors for care group participation: adolescent care group mother perspective:

Most adolescent care group mothers highlighted that they participate in Care Groups because they are motivated by the knowledge they get specifically on taking good care of their children. Importantly, one of the mothers stated that *'I learn for my child. I will be going to learn for my child. I learned that my child must eat 5 times as my baby is over 6 months old', and I practised that and my child is growing well'*. They pointed out that they found the pictorial flipcharts[20] useful and interesting. A common sentiment from the mothers was that they had a sense of pride in seeing their children grow healthy and strong, citing that from the Care Groups they had learned about preparing nutritious foods for the child such as enriching the baby's porridge with locally available ingredients had given them valuable knowledge. A mother explained '*I learned how to enrich my baby's porridge with eggs, kapenta[21] fish and mopane worms'*. Some of the mothers mentioned that they found Care Groups to be fun and exciting, as they enjoy cooking demonstrations, sporting activities and the opportunity to interact with other mothers in the Care Groups.

WHAT MOTIVATES ADOLESCENT MOTHERS TO PARTICIPATE IN CARE GROUPS?

- Gaining knowledge on how to take care of their children, and to ensure their children are healthy
- Learning how to prepare nutritious food for their children.
- Learning about hygiene and how to maintain a clean home
- Fun and exciting sessions such as the cooking demonstrations
- Having the opportunity to interact with, and learn from other mothers

Key motivating factors for care group participation: perspectives of family members of adolescent care group mothers:

Family members of adolescent mothers participating in care groups all agreed that adolescent mothers learned a lot about child feeding, childcare and hygiene from the care groups. A family member explained *'Care Groups teach the young mothers about exclusive breastfeeding, even I now know the baby should have nothing other than the mother's milk for the first 6 months. They [the mothers] learn about child feeding practices- exclusive breastfeeding of children under 6months'*. On being asked whether adolescent mothers participating in care groups ever share information with their family members on what they learn about in care groups, most of the focus group participants indicated that the mothers do share information. One family member stated that *'It's important that they share the information with us. They leave their children with us sometimes, so we need to know how to take care of them [the children] when they are away'.*

Key motivating factors for care group participation: perspectives of Care Group Volunteers and Lead Mothers

Care Group Volunteers and Lead Mothers indicated that the adolescent mothers were primarily interested in receiving the supplementary food rations from the program. A Lead Mother stated '*Most of them [adolescent mothers] just want the porridge that is what motivates them*'. In addition, they highlighted that the sporting activities and cooking demonstrations motivated the adolescent mothers. The motivating factors for care group participation that were reported by the adolescent mothers, their family members and Care Group Volunteers (CGV) and Lead Mothers (LM) were similar, apart from what was highlighted by the CGV and LM, that adolescent mothers were motivated by the supplementary food rations.

[20] The program developed A3 size pictorial flipcharts on Breastfeeding, Child feeding and Maternal health and nutrition.
[21] Small dried fish

Adolescent non-care group mothers: perception about care groups and reasons for non-participation

Most of the adolescent non-care group mothers indicated that they had heard about care groups, mostly through the supplementary food ration distribution sessions. The adolescent mothers had a good perception about the care groups recognising them as groups where information on aspects such as good hygiene, breast-feeding and baby feeding was shared. On being asked why they were not participating in care groups, some of the adolescent mothers cited an issue of workload and chores at home. One adolescent mother stated '*I am interested in the care groups, but household chores prevent me from participating. My mother in law says the household chores are important'*. From the focus group discussion with family members of adolescent non-care group family members, one of the participants explained *'They (adolescent mothers) are free to attend lessons as long as they do their chores on time, there is an issue of laziness as some of them are lazy and don't do their chores on time'.* Most of the family members of adolescent non-care group mothers described adolescent mothers as lazy, disrespectful and stubborn, stating that these as the common behavioral traits amongst this group, which contributed to their non-participation in care groups. One of the parents explained *''Children of nowadays lack respect they do not listen to their elders, they tell us what to do yet we are the parents'*.

REASONS FOR NON PARTICIPATIONOF ADOLESCENT MOTHERS IN CARE GROUPS

- Workload and chores at home
- Peer cliques which often leave other adolescents feeling excluded
- Adolescents need permission to participate in care groups, this is not always granted
- Adolescents are only motivated by porridge (supplementary food rations) and not so much the 'learning'
- Some adolescents as young as 14 or 15 do not understand the importance of care groups

Another notable barrier highlighted by the adolescent mothers was that care group attendees pick and select each other making adolescent mothers feeling left out - this happens from the natural selection of care group members that happens in the community. One adolescent mother cited *'People pick and choose who they meet with, it's the same in these groups. There is segregation and discrimination within the community'*. Adolescent peer cliques have been identified as a developmentally important unit of analysis as they form a setting in which adolescents hang around, gain a sense of belonging and receive support[22].

Most of the Care Group Volunteers and Lead Mothers stated that shyness was a key reason for adolescent mothers non-participation in care groups, as one CGV stated '*Older women are more responsive compared to the younger ones who are too shy to attend learning sessions'*. Interestingly, an issue of adolescent mothers being lazy and arrogant was brought up by one of the Lead others who explained *'Older women attend more than adolescent mothers do. Adolescent mothers are lazy and they always need follow-ups, whereas some are just arrogant*'. As the program is distributing supplementary food rations, some of the Care Group Volunteers highlighted that adolescent mothers were mostly motivated by receiving the rations. The discussants also highlighted that very young mothers do not understand the value of the care group lessons with a Lead Mother stating '*Some have babies at a very young age, even from as young as 14 or 15, and it is hard for them to understand the need for care group lessons'.*

[22] Salkind NJ, Rasmussen K. Encyclopedia of educational psychology. London: Sage; 2008. [Google Scholar]

Permission to participate in care group activities

Over half of the adolescent mothers stated that they need permission to take part in care group activities. The rest of the mothers indicated that they need to inform the people they live with (grandmothers, mothers, mothers in law or other family members) before they attend a care group session. One married adolescent mother cited ***'My mother in law is happy because I have brought good changes into the home, I keep my in-laws homestead clean as I have gained lots of knowledge from my care group, a clean home gives my mother in law a sense of pride'.*** All except one of the mothers indicated that no one disapproved of their participation in the care group activities. From the focus group with family members of adolescent mothers in care groups, all participants agreed that adolescent mothers need permission from the family members that they live with to participate in care groups. A family member stated ***'Eighteen and nineteen year olds are young and they still live with their families. As parents, we see them as children, they need to get permission to attend care group sessions'.***

What adolescent care group mothers find interesting or fun about the care group

Most of the mothers indicated that learning about taking care of their babies was interesting for them given that all of them were first time mothers. Most, though not all the adolescent mothers in care groups had participated in the cooking demonstrations where they had prepared a variety of nutritious foods appropriate for child feeding. More than half of the mothers had recipe books from the program and cited that having a recipe book motivated them to participate in the care group sessions. From the researchers perspective it seemed that the care group had become a learning hub for them to learn how to take care of their children. Some of the mothers mentioned that they found the sporting activities, dramas or role-plays, singing and dancing interesting as this gave them time to do something fun with other mothers. The Care Group Volunteers and Lead Mothers all agreed that sporting activities, drama and role play and cooking demonstrations have had a big role in motivating adolescent mother participation.

Adolescent care group mothers opinion about the care group sessions (the topic, length of the lesson, Lead Mother)

It was notable that all of the mothers expressed that the sessions were appropriate for them as they learnt about breastfeeding and child feeding which were important for them. Interestingly, the learning had been internalised, as mothers were able to give specifics such as ***'If the child is 6 months old, you start by giving him or her 3 spoons of porridge. It's important to enrich the porridge, and you can add egg to the porridge to make it more nutritious'.*** On the length of the sessions most mothers indicated that sessions took about two hours and that, a two hour session was preferable. A few of the mothers indicated that the sessions lasted 3 to 4 hours, which was long for them as they had other chores.

Almost all the adolescent mothers spoke positively about the Lead Mother. Of key note they expressed sentiments such as their Lead Mothers being 'kind and patient'. One of the adolescent mothers stated 'She [the Lead Mother] is easy to talk to', and another stated ***'if you do not understand something she [the Lead Mother] explains repeatedly until you do'.***

Extent to which adolescent mothers can freely express themselves and share experiences in care groups

Just over half of the adolescent mothers stated that they are able to freely express themselves during the care group session discussions. One mother stated ***'Yes I am free to express myself. I once***

demonstrated a breast feeding position of the child to the others, it was not difficult for me'. The rest of the adolescent mothers (just under half) stated that they were not always able to freely express themselves during the care group sessions, with one adolescent mother stating, *"I feel free to share experiences…but I have never really shared anything'.* Another adolescent mother pointed out '*we cannot really express ourselves. We express ourselves freely to a lesser… we are scared of being told off or reprimanded'*. On sharing her experiences the adolescent mother went on to say, *'It is hard to come forward and share your story as a young mother because others might laugh at us'.*

Differences in health and nutritional status of children of adolescent care group participants and non-participants: perspectives of Care Group Volunteers and Lead Mothers:

On being asked about the differences in the health and nutritional statuses of children of adolescent mothers in care groups and those not in care groups the Care Group Volunteers and Lead Mothers all agreed that there was a notable difference. The discussants stated that care group members had healthier babies compared to non-care group members, citing '*Care group members have healthy babies compared to non-care group members'*. In addition, they cited that there was a stark difference in child feeding practices between the two groups with one Lead Mother stating '*Care group members give nutritious snacks to their babies like the peanut dumplings they have learned to make at the cooking sessions, while non-care group members usually give non-nutritious corn snacks like jiggies*[23]*'*.

How to make care groups more appealing to adolescents: perspectives of adolescent non care group members and Care Group Volunteers and Lead Mothers

The adolescent non-care group members mostly recommended that care groups should have fun activities like sport, singing and drama to make them more appealing for adolescent mothers. They cited that it was important to ensure there was a competition element built into such activities with prizes to incentivise the winners. In addition, they mentioned that there should not be a culture of 'selection' or peer cliques when it came to care groups, and that the onus was on the Lead Mother to discourage this type of culture.

Adolescent care group mothers preference for adolescent – only or mixed care groups

Most of the adolescent mothers stated that they preferred mixed care groups where adolescent mothers took part in care group sessions together with older mothers. The main reasons cited were that the adolescent mothers were able to learn from the experiences of the older, more mature mothers. One adolescent mother cited *'it's better to have the older mothers in care groups, in our culture we say 'good guidance comes from those who have gone before you'*. Upon further probing, some of the mothers highlighted that within an adolescent only care group they would find it easier to express themselves; but given the option of mixed or adolescent care groups – the mixed care group was most preferred. Interestingly, Care Group Volunteers and Lead Mothers stated that adolescent mothers needed to have their own care group so that they are free to express themselves during the care group sessions.

Discussion

The findings of the study revealed that the Care Group Program provided adolescent mothers with key knowledge on IYCF practices and it was notable that adolescent mothers in Care Groups were adopting the recommended practices. This is a similar to findings from a case study on adolescent

[23] Jiggies are salty corn-snacks usually given to young children as a snack

participation in Care Groups that was conducted in Nigeria[24]. A top motivating factor for adolescent participation in Care Groups was summarized and in the statement 'I learn for my child', as this was echoed by many of the adolescent mothers. It is therefore interesting that this was the best incentive for participating in the Care Groups.

The study also found that adolescent mothers not participating in Care Groups were faced with various barriers. These barriers included workload and chores. Psychosocial factors played a key role as determinants for Care Group participation as evidenced by the existence of peer cliques, that resulted in some of the adolescents feeling left out or excluded. The role of the Care Group Volunteers and Lead Mothers was found to be integral, and key to the success of the Care Groups at community level. However, it was notable that the Care Group Volunteers and Lead Mothers described the adolescent non-Care Group mothers as arrogant, lazy and needing a lot of follow-up. This suggests that there is a 'disconnect' in terms of their understanding of adolescent behaviours and reiterates the need for bridging that disconnect. These findings strongly corroborate with the fact that the Care Group Volunteers and Lead Mothers need to be capacitated on adolescent friendly approaches and group dynamics.

Both the adolescent Care Group participants and non-Care Group participants highlighted the importance of having sporting activities and community cooking sessions as part of the Care Group activities to motivate them to participate in Care Groups. Although, most of the Care Group activities had promoted sports and cooking sessions, these sessions had not been held in recent months therefore some of the participants had never taken part in the activities.

The study found that for both adolescent Care Group, and non-Care Group participants, the need for permission to attend or participate in Care Groups was important as adolescent mothers are seen as children. Permission was therefore integral, however refusal to provide permission was not mentioned as a barrier. This suggests that adolescent family members need to be made aware of the Care Group activities from the on-set, as was noted with family members of adolescent Care Group participants who were all convinced that there was great benefit for adolescent mother participation in Care Group activities.

Finally, it's important to note the importance of maintaining mixed Care Groups over adolescent only Care Groups, as the adolescent mothers seem to place a lot of value in learning from older more experienced mothers. Interestingly, the Care Group Volunteers and Lead Mother perspective favored the formation of adolescent only Care Groups over mixed Care Groups citing that the adolescents would be free to express themselves and overcome any shyness in groups with only their peers.

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[24] Perera S. M. Case Study on Adolescent Inclusion in the Care Group Approach – the Nigeria Experience. Emergency Nutrition Network, field exchange article, available at https://www.ennonline.net//fex/52/adolescecaregroup

Recommendations

As informed by the study findings, we recommend the following:

1. Build the capacity of Care Group Volunteers and Lead Mothers on adolescent friendly approaches so they can better understand and relate to adolescents. The curriculum for training Care Group Volunteers and Lead Mothers should include this component.
2. Train Lead Mothers on key aspects of group dynamics, to better manage the issues of peer cliques, and promote a culture that encourages social cohesion and psychological safety[25] within the Care Group. This will create an environment where Care Group members can feel freer to express themselves, including the shy members within the group.
3. Lead Mothers to prioritize conducting home visits to adolescent mother homes, this is an opportunity to reach and engage with adolescents' family members, and help them understand the importance of adolescent participation in Care Groups.
4. Scale up the use of fun and engaging activities such as sporting activities (netball) and edutainment and community cooking sessions - this was a key recommendation from most of the adolescents as well as the Care Group Volunteers and Lead Mothers.
5. The timing and length of care group sessions needs to accommodate the fact that adolescent mothers need to dedicate time to do other chores.
6. Continue to promote mixed-Care Groups, and pair up adolescent mothers with an older, experienced mother in the Care Group. This can encourage a mentor-mentee relationship, which contributes to the adolescents feeling that they are part of the group, and ultimately greater social cohesion.
7. Share findings from this study with the MoHCC to consider the integration of adolescent-friendly approaches into the National Care Group strategy for Zimbabwe.

Limitations

- The program staff supported the researchers in the data collection and the co-authors of this report were actively engaged in the Amalima implementation of the care group approach, and may not be strictly impartial. However, strong efforts have been made to minimize resultant bias, by using external reviewers throughout the research process.
- During the process of translation from isiNdebele to English there may have been some loss of information, however this is expected to be minor and will have minimal impact on overall quality of data.

Conclusions

In Zimbabwe, the Care Group approach has been endorsed as the vehicle of choice for promoting appropriate IYCF practices that contribute to improvements in early childhood nutrition and improved health outcomes in children. Following the 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 Programming[26]. This study contributes to the best practices in promoting adolescent participation in care groups in Zimbabwe.

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[25] By creating a context where individuals feel psychologically safe to engage, learn, and develop

[26] 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

Given the study findings, there is great benefit in ensuring Care Group approaches build on strategies to promote adolescent participation. The lessons learned and recommendations from the qualitative study can be used to advocate for greater adolescent inclusion in Care Group activities and other programs, as well as giving specific insight on the necessary adaptations that can be made to meet the unique needs of this target population.

Other areas for future research include exploring a model for adolescent only Care Groups. Though, this was not recommended over mixed care groups by adolescent mothers, it was certainly highlighted as an approach of choice by Care Group Volunteers and Lead Mothers. Another area for future research is the extent to which Care Groups can be modified and adapted within the high school setting. This is key, considering that Zimbabwe's Education policy now allows for school going adolescents who fall pregnant to stay in school.