



Takunda

care

Care Group, Water Point, Ward Food and Nutrition Security Committee (WFNSC), and Ward Water and Sanitation Sub-committee (WWSSC) Inventory Report

Takunda Resilience Food Security Activity

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LIST OF ACRONYMS

CG	Care Group
IEC	Information Education Counselling
MOHCC	Ministry of Health and Child Care
NGO	Non-Governmental Organization
USAID	United States Agency for International Development
VPM	Village Pump Minder
WFNC	Ward Food and Nutrition Committee
WWSSC	Ward Water Sanitation Sub-Committee
WPUC	Water Point User Committee

GLOSSARY OF TERMS

Term	Description
Care Group (CG)	A group of 10–15 Care Group Volunteers (CGVs) led by a Promoter
Care Group Volunteer (CGV)	Volunteers who meet with the Promoter
	Usually nominated for this position by the Neighbour Women (NW)
Co-ordinator	Hired to directly oversee the Supervisors and monitor the CG program; reports to the project manager
Neighbour group (NG)	A group of 10–15 women that meet with the selected CGV
	The CGV shares new health sessions with this group every two weeks, meeting as a group or individually (through home visits)
Neighbour women	Women in the NG who meet with the CGV once every two weeks to hear a new health session
Pregnant and lactating women (PLW)	The primary beneficiaries of the CG approach; the aim is to make sure that all, or nearly all, PLW are part of a CG structure (usually as NW or CGVs)
Promoter	A community member hired to train and supervise the CGVs in their community
Supervisor	Hired to directly supervise and train Promoters in each community and to monitor the CG program
Supportive supervision	A process of observation and feedback from each Care group successive level in the CG approach that contributes to strong and mutually respectful working relationships, builds skills and productivity, and creates a sense of unity in working together toward common goals

EXECUTIVE SUMMARY

Takunda seeks to promote sustainable, equitable, and resilient food, nutrition, and income, directly impacting 301,636 people in Manicaland and Masvingo provinces in Zimbabwe. This report presents the findings of the Care Group, Water Points and Committees, Ward Food and Nutrition Security Committee (WFNSC), and Ward Water and Sanitation Sub-committee (WWSSC) Inventory of the Takunda Resilience Food Security Activity. The overall objective of the study was to undertake an inventory of existing Care Groups and Neighbor Women's Groups in Takunda target communities, understand their configuration, level of functionality, and other social, cultural, and structural issues affecting their operations to identify Takunda entry points for continued support to these groups in the most efficient, effective, and sustainable manner.

To ensure the sustainability of behavior change efforts, Takunda intends to enhance the capacity of existing community-level structures to support Nutrition and WASH activities implemented through the Care Group and other approaches. These include Ward Food and Nutrition Security Committees (WFNSCs) and Ward Water and Sanitation Sub Committees (WWSSC). This study also sought to determine the existence of these committees and their level of functionality. The study also sought to establish the existence and functionality of water points and their accompanying Water Point User Committees (WPUCS) in all the communities in Takunda's area of operation.

The study revealed that Care Groups were formed through NGO assistance in collaboration with MoHCC, targeting women of childbearing age (15-49 years) and caregivers of children under 2 and 5 years. Specific NGOs and projects mentioned were World Vision and CARE through the ENSURE project in Buhera, Chivi, and Zaka, and Practical Action through the INSPIRE program in Mutare.

Care Groups

In all the four Takunda operational districts and wards, there were 1,871 Neighbor Women Groups, a total of 21,997 Neighbor Women, 10,108 children 0-23 months, and 15,998 children 24-59 months benefiting from the care groups. More than half (55%) of the groups were in Mutare District, where the INSPIRE project supported Care Group implementation up to May 2021. The study revealed that in the Takunda operational districts and wards, 1,100 Neighbor Women groups (59%) were functional at data collection, with Mutare having the highest level of functionality (69%). This is attributed to the recently ended INSPIRE project in May 2021. Integration of activities during care group meetings motivated groups to continue meeting and conducting sessions as they accessed different services simultaneously. Services mentioned were: Vitamin A supplementation, nutrition screening, growth monitoring, and income-generating activities.

Resources like stationery, information, Education Communication (IEC), visibility materials, scales, and MUAC tapes were cited as factors enhancing the functionality of the Care Groups.

One of the main challenges highlighted for non-meeting of care groups was the COVID-19 pandemic that disrupted many activities across all Takunda areas of operation. The ban on gatherings, shortage of PPE, and fear of contracting the virus made it difficult for the expected monthly activities to be carried out. An additional challenge was that a remarkable number of women from the apostolic group were not allowed to attend care groups, as their spouses feared that they would be given contraceptives or misinformation, which goes against their religion.

WFNSC and WWSSC

The findings revealed that only seven of the 92 Takunda wards had a WFNSC. The study also showed that all the seven existing WFNSCs were functioning. The lack of mentorship, support, and supervision from the District Food Nutrition and Security Committee was indicated as one of the barriers to WFNSC non-functioning. Lack of resources like refreshments, transport, and reporting tools were also highlighted as barriers. The inventory showed that the WWSSC did not exist in the majority (82) of the Takunda wards. Ten wards had WWSSC, and these were functional. Lack of mentorship, support visits from the District Water and Sanitation Sub-Committee, and lack of transport and stationery were cited as the main barriers.

Water Points and Water Point User Committees

Boreholes are the primary communal water source for domestic use across the four districts. Most of the boreholes are fitted with bush pumps as a water lifting mechanism. Data collected showed that the four districts have a cumulative figure of 1,694 water points where 75% (1,270) were boreholes, 22% (369) were deep wells, 1% were springs, 0.5% were piped water schemes, 0.5% were shallow wells, and elephant pumps constituted another 1%. Of these water points, 65% (1,115) were functioning, while 35% were water points that were not functioning. Further analysis of the data revealed that 36 Takunda clusters have no access to safe drinking water within their boundaries. Community members from these clusters reported that they obtain water from rivers, unprotected water sources, family wells, and neighboring clusters.

Public water points reached during the inventory had water user committees, while 10% had no user committees. There was no consistency in the collection of water user fees; in most cases, community members contribute money whenever there is a breakdown, especially for the payment of the VPM. The user committees concurred that boreholes reported an extended downtime due to poor fundraising and lack of commitment to pay user fees by households with individual water sources such as shallow wells, deep wells, and mechanized boreholes. There are still communities relying heavily on donor support and have shunned the community-based management responsibility.

Across all the districts, 77% of the total water points have access to village pump mechanics. The average ratio of Village Pump Mechanics to the number of water points they serve was 1:29. In addition to inconsistencies of user fee payments, VPM indicated unavailability of spares in the local market and lack of technical support from the District Development Fund, which is the responsible authority.

Recommendations

The inventory has provided Information that Takunda will use to make decisions on entry points for its interventions and structures that it can work with. Based on the information provided, some of the structures, such as the Ward Food and Nutrition Committees, will need to pursue a collaborative effort with the district-level structures to strengthen them. There is confirmation of an opportunity for Takunda to test for the viability of a complete cost recovery water system involving Water User Committees and Pump Operators/Mechanics, as water users only pay fees for repairs instead of deliberately having a maintenance fund in place. In the pilot, there is an opportunity for Takunda to rope in the private sector, especially on improving access to spare parts, as the findings indicated no involvement of the private sector. The data indicated that 35% of the assessed water points are not functioning; it is recommended that Takunda review its target for water points rehabilitation and compare it with constructing new water points for potable water. Priority for water points rehabilitation or construction of new ones should be given to the 36 clusters that were found to have no access to safe drinking within their boundaries.

INTRODUCTION

Takunda is a five-year (2020-2025), \$55 Million, CARE-led, USAID-funded Resilience Food Security Activity (RFSa). The project aims to achieve Sustainable, Equitable, and Resilient Food, Nutrition, and Income Security in Masvingo Province (Zaka and Chivi districts) and Manicaland Province (Buhera and Mutare districts) by improving income, nutritional status, and resilience to shocks and stressors of vulnerable households, women, and youth. Purpose 2 of Takunda's three project purposes contributes to this goal through initiatives to improve the nutritional status of women of reproductive age (15-49 years), adolescent girls (10-14 years), and children under the age of five years. Specifically, Purpose 2 aims to achieve sustainable improvements in three critical areas: (1) Improving consumption of nutritious foods among children, adolescent girls, and women of reproductive age (2) Increasing utilization of maternal, newborn, child health, and WASH services. Key to the achievement of P2 outcomes is behavior change promotion, and Takunda has chosen a variety of approaches, including the Care Group model, to facilitate this.

In Takunda's operational areas, the Care Group approach has been implemented by a few organizations. ENSURE, the USAID-funded Development Food Assistance Program (DFAP), and the Livelihoods and Food Security Programme (LFSP) collaborated with the MOHCC. This study sought to derive learning from the experiences of these past activities to avoid possible pitfalls and increase the chances of success, effectiveness, and sustainability of these groups. Through this study, Takunda carried out an inventory of the existing Care Groups and their Neighbor Women Groups to understand their configuration, current level of functionality, and coverage to identify entry points for implementing the Care Groups.

The study also sought to determine the existence of community-based committees and their level of functionality. The study also sought to establish the existence and functionality of water points and their accompanying Water Point User Committees (WPUCs) in all the communities in Takunda's area of operation.

Problem Statement

The achievement of positive outcomes in Takunda's Purpose 2 is dependent on a sound behavior change model and support structures. Care Groups (one of the models that Takunda will be using to promote Nutrition and WASH behaviors) and their accompanying Neighbor Women Groups were established in some Takunda communities with support from different stakeholders. Takunda did not have a clear understanding of the coverage of these groups and their configuration and functionality. Likewise, WFNSCs, WWSSCs, and WPUCs had been set up in some of Takunda's project areas with support from the government and other stakeholders. However, these committees were not established in all the relevant areas, and some are no longer functional.

Justification

Purpose 2 aims to improve the nutritional status of women of childbearing age, adolescent girls, and children under the age of five through various initiatives. The promotion of Nutrition and WASH behaviors through the Care Group model is key to the achievement of this outcome; therefore, it was imperative for Takunda to assess the status of the Care Groups and Neighbor Women Groups, how they were established, how they operated, challenges faced, and opportunities that the project can leverage for effective and sustainable implementation. In addition, Takunda will utilize support structures such as the WFNSC and WWSSC. Therefore, the project needed to determine the existence and functionality of these committees. Access to water is also critical to achieving the project's outcomes. Additionally, the project needed to inventory existent water points and the committees that govern their functionality. The study generated information to clarify the issues mentioned above and guide Takunda in implementing its Nutrition and WASH activities more effectively and sustainably.

Key Research Objectives

This study aimed to undertake an inventory of existing Care Groups, Neighbor Women Groups, WFNSCs, WWSSCs, and Water Points in Takunda target communities, understand their configuration, level of functionality, and other social, cultural, and structural issues affecting their operations to identify Takunda entry points for continued support to these groups most effectively and sustainably. Specifically, the study sought to:

- a) Estimate the total number of Care Groups and Neighbor Women Groups in Takunda operational areas.
- b) Estimate the total number of women and children under 2 and under 5 years being reached by these groups.
- c) Assess the level of training for Care Group Model (CGM) coordinators, village health workers (VHWs), Lead Mothers, and, where possible, Male Champions and lead Grandmothers.
- d) Determine the Care Group configuration – the behaviors of focus, structure, and reporting mechanisms and how they link and collaborate with rural health centers, the Ministry of Health and Child Care (MoHCC).
- e) Establish the current functionality levels and factors influencing the functionality of Care Groups and Neighbor Women Groups.
- f) Understand structural and operational factors that hindered and enhanced care group activities focusing on linkages, motivation, recourses, and capacity.
- g) Identify and recommend possible points of entry that facilitate the establishment and or revitalization of care groups in a manner that enhances full functionality, efficiency, and effectiveness in promoting behavior change and sustainability.

LITERATURE REVIEW

Care Groups

Most desired health and nutrition outcomes depend on sustainable behavior change. A lot of attempts to increase adoption of health and nutrition behaviours have not yielded positive results as shown by the current levels of IYCF and some maternal health and nutrition indicators (e.g., the Zimbabwe national continued breast feeding of 67%; the minimum acceptable diet of 6%; and the vitamin A supplementation for 12-59 months at 53%) that have remained low (Zimvac, 2021). Behaviors are not easy to change, hence the need to plan for behavior change. Specifically, there is a need to select an effective behavior change model and develop effective processes to facilitate the behavior change. Takunda will use the Care Group Model as the vehicle for behavior change promotion. The primary aim of the Care Group is to work toward the reduction of maternal and child mortality and malnutrition (e.g., Essential Nutrition Actions and Essential Hygiene Actions) (Henry Perry M. M., 2015).

A Care Group is a group of 10–15 lead mothers that are elected by Neighbour Women. Neighbour Women are mothers/care givers who reside less than a one hour walk from the lead mother (Henry Perry M. M., July 31, 2014). Peer selection of Care Group lead mothers helps to identify the most effective recruits. The Care Group members meet regularly for training and supervision facilitated by the VHW. The VHW who is the Care Group Promoter is supported by Care Group Supervisors. The care group supervisors are nurses at local clinics, EHT, other WFNSC members including NGO staff who are supervised by care group coordinators. The care group coordinators are project managers, district nutritionists/district health executive team, and DFNSC including NGO staff. Ideally the Care Group methodology should reach 100% of the households in the targeted group and should attain at least 80% monthly coverage of households within the target group. The Care Group methodology has been proven to be effective in achieving coverage of key health and nutrition behaviors in numerous settings and holds promise as a way to scale-up proven practices at the household level while leveraging existing structures and building local capacity (Henry Perry M. M., July 31, 2014).

The success of the Care Group methodology is anchored in the availability of adequate resources for capacity building of staff and volunteers to ensure robust structures and effective cascading of information (Pamela Ncube – Murakwani, 2020). Care Group supervisors and Care Group promoters need support from care group coordinators on a regular basis, and must be well resourced with tools to make their work effective (e.g., transportation and educational materials/visual tools like flip charts, story books, counselling cards, food flash cards, etc.) (Pamela Ncube – Murakwani, 2020). Flexible management and supervision that enable the Care Group principles to be upheld while adjusting to local contextual realities and implementation hurdles is also recommended (MPH, 2015).

One of the weaknesses of the Care Group approach as implemented so far has been its dependence on NGOs to develop and facilitate the activities. The Care Groups stop meeting once the Non-Governmental Organization (NGO) support is withdrawn. In many settings, the model is yet to be taken up by the government health system. Working with volunteer community health workers has been shown in

Burundi in a project by Concern Worldwide to be sustainable and effective (Henry Perry M. M., July 31 ,2014) . Integrating Care Groups into existing Ministry of Health and Child Care (MOHCC) structures and creating partnerships during training, monitoring, and supervision has been shown to bring about sustainability (Henry Perry M. M., 2015)

Food and Nutrition Security Committees

Food and Nutrition Security committees (FNSCs) are government ministries, local authorities, traditional leadership, UN agencies/ civil society working in food and nutrition security, the private sector, and academia. FNSCs are mandated to promote a cohesive local response to household food and nutrition insecurity through coordinated multi-sectoral action to promote and ensure adequate food and nutrition security for all people in Zimbabwe, particularly amongst the most vulnerable population groups. FNSCs coordinate food and nutrition at the sub-national level by providing a platform for interaction amongst relevant Government Ministry representatives, partners, and civil society organizations (Food and Nutrition Council, 2018). The sub-national FNSCs are chaired by the Ministry of Agriculture and co-chaired by Social services; MoHCC is the secretariate. FNSCs are expected to hold meetings on a regular (monthly) basis or more frequently as required and ensure that food and nutrition issues are discussed in a timely manner. Representatives from UN/NGOs and the private sector have roles to play as part of the FNSC, i.e., actively engaging and contributing to planning processes of the FNSCs and, where possible, providing technical, communication, logistical, and material resources for the functioning of the FNSCs. The work of FNSC are guided by the following principles

- To be relevant at sub national level as a platform to promote food and nutrition security
- To reinforce collaboration across levels, between sectors, minimize duplication among partners and foster collective accountability towards a shared goal in f and n security
- To strengthen the application of policy into practice and to ensure research informs policy and planning

To foster nationally owned, community driven and context specific programmes that effectively contribute towards f and n security (Food and Nutrition Council, 2018).

Water and Sanitation Sub Committees (WWSSC)

The National WASH policy of Zimbabwe gave a mandate to the National Action Committee (NAC) to be a one-stop-entry into and monitoring, supervisory, and resource mobilization hub for the water, sanitation, and hygiene (WASH) sector in Zimbabwe. The NAC was formed in 1985, focusing on Rural Water and Sanitation Supply. NAC is an interministerial steering board coordinating WASH activities at the National level. At the Provincial level, the Provincial Water and Sanitation Sub Committee (PWSSC) coordinates WASH activities and reports to NAC. Likewise, the District Water and Sanitation Sub Committee (DWSSC) reports to the PWSSC. At the ward level, the Ward Water and Sanitation Sub Committee (WWSSC) oversees all WASH activities and reports to the DWSSC (National Action Committee, 2017). There is a clear

coordination structure from the national to ward level. All development players in WASH are mandated to work through the established structure. At the ward level, the Ward Water and Sanitation Subcommittee (WWSSCC), also comprised of government officers from various ministries, is responsible for community mobilization and supervision of project processes. The committees received trainings and later cascaded these trainings to project structures at the ward level (Care International, 2017).

Water Point Management Committees(WPMC)

The Government policy on rural development aims to ensure adequate and safe water and sanitary facilities to rural communities. The Zimbabwe Rural WASH Subsector Public-Private Partner (PPP) Framework -2003 has encouraged communities to leverage private sector capital to fund the operation and maintenance of rural WASH infrastructure. Despite the massive financial injection into the development of water and sanitation facilities by development partners and government, this has not been matched with a corresponding operation and maintenance package in Zimbabwe since 1980. The government introduced then Community Based Management (CBM) approach encouraged communities to take ownership of the operations and Maintenance (O&M) of their water points (National Action Committee, 2005). N. A. C The CBM implementation guide was prepared by the National Action Committee (NAC), for use by the institutions and organizations in the water and sanitation sector (National Action Committee 2005). According to the CBM guidelines the communities are responsible for the development and O&M of water points. The communities are also supposed to monitor the performance of water supply systems and repair non-functional ones. This then lead to the formation of Water Point Management Committee (WPMC) a group of trained volunteers who manage water points). The CBM guidelines also stipulate that decision making on the type of technology rests with the community of users. However, a study by Kativhu et al. (2018) revealed that there is a dichotomy of theory and practice in the implementation of the CBM approach in different districts of the country. This dichotomy negatively impacted financial, technical, social, and institutional factors of sustainability. Despite the weaknesses that the CBM model has demonstrated in sustaining water supply systems the approach has undoubtedly brought many benefits (Lockwood et al. 2003). In light of its weaknesses, practitioners in the WASH sector have advocated for other approaches such as self-management and Private Public Partnerships (PPPs) to be considered for sustainability to be achieved. According to Butterworth et al. (2013) the proposed approaches should not replace CBM, but rather complement CBM in the areas where it is failing.

METHODOLOGY

Study Methodology

The Care Group inventory study used quantitative and qualitative methods to collect data in all four Takunda districts. Separate inventory tools were developed to collect data on the Care Groups, WFNSC, WWSSC, and water points. Village Health Workers (VHWs) registers with lists of the lead mothers/fathers, gender champions, and neighbor women and children were used to take an inventory of Care Group members. VHWs from randomized control trial (RCT) villages were excluded from the study. For WWSSC

and WFNSC, a questionnaire was administered to the respective committee chair and secretariat across the 92 wards, where the questions were based on recall of and reference to the meeting records. Water point inventory was done through interviews with village pump minders, water point committee chairs, secretaries, village heads, and village health workers at a convenient gathering point for all. The questionnaires were administered based on the data collected per village and the RCT villages were also excluded from the study. Focus group discussions (FGDs) were used to collect in-depth information on how the groups were formed and barriers and enabling factors to continued care group activities. FGDs were conducted separately with Village Health Workers (VHWs), Care Group Leaders, and Care Group Neighbor Women. Key informant interviews (KIIs) were conducted to triangulate information from the FGDs on Care Group functionality and determine how the groups linked with the relevant ministries. KIIs were conducted with district-level MoHCC, Ministry of Youth, and Agritex staff, as well as ward-based MoHCC staff and VHWs.

Sampling and Sample Size

The study respondents for FGDs were purposively selected from functional and non-functional care groups, with 50% coming from each category. Functionality was determined by whether the group has still been meeting in the last six months. A total of 15 VHW groups, 13 Care group leaders groups, and seven neighbor women groups were interviewed across the four districts. The groups were selected and mobilized before the interviews. KII respondents were also purposively selected based on previous knowledge and engagement with Care Groups. A total of 28 key informants were selected across the four districts. District and ward level key informants were selected from the Ministry of Health and Child Care (MoHCC), Ministry of Agriculture, Water, Fisheries, Land and Rural Resettlement, Ministry of Youth, Sports Arts and Culture, and Ministry of Women Affairs, Small and Medium Enterprises.

Data Collection Tools

The study used the following study tools:

- a) Care Group Mapping Form-Annexure 1
- b) Care Group Inventory Focus Group Discussion Guide-Annexure 2
- c) Care Group Inventory KII Questionnaire- Annexure 3
- d) WWSSC and WFNSC Inventory Form- Annexure 4
- e) Water Point Inventory, Existence of WPMC & Functionality Form-Annexure 5

See Annexures 1-5 for all the data collection tools.

RESULTS

Care Groups

Existing Care Groups

The study revealed that Care Groups were formed through NGO assistance in collaboration with MoHCC, targeting women of childbearing age (15-49 years) and children under 2 and 5 years. Specific NGOs and projects mentioned were: World Vision and CARE through the ENSURE project in Buhera, Chivi, and Zaka and Practical Action through the INSPIRE program in Mutare. The ENSURE project rolled out Care Groups in six out of twenty-two Takunda wards in Buhera, eight out of twenty-three Takunda wards in Chivi, and nine out of twenty-three Takunda wards in Zaka. The INSPIRE program implemented Care Groups in all the twenty-four wards that Takunda covers (Table 1).

Table 1: Existing Neighbor Women Groups

District	# Neighbor Women Groups	Neighbour Women	# Children 0-23	# Children 24-59	Total Children	Still Meeting	Avg # of Meetings (6 Months period)
Buhera	369	4,194	2,580	3,852	6,432	161 (43.6%)	1
Chivi	197	2,026	1,259	1,631	2,890	109 (55.3%)	3
Mutare	1,030	12,858	4,934	8,522	13,456	709 (68.8%)	3
Zaka	275	2,919	1,335	1,993	3,328	121 (44.0%)	1
Total	1,871	21,997	10,108	15,998	26,106	1,100 (58.8%)	2

Across the four districts in the Takunda operational wards, there were 1,871 neighbor womengroups, a total of 21,997 neighbor women, 10,108 children 0-23 months, and 15,998 children 24-59 months benefiting from the Care Groups. More than half (55%) of the groups were in Mutare District, where the INSPIRE project supported Care Group implementation up to May 2021. Under the ENSURE project, neighbor wome Groups comprised a group of 8-15 women. However, 18% (339/1,871) of these groups exceeded the recommended maximum number of Care Group Clients for effective learning.

The groups received nutrition, WASH, maternal health, and child care lessons. The ENSURE program targeted children 6-23 months and pregnant and lactating women with their supplementary feeding program (SFP). These SFP clients were eligible to be part of Care Groups. Infant and Young Child Feeding (IYCF) support groups formed by MOHCC were common in the wards not covered by the ENSURE program across the three districts. VHWs facilitated these groups. The ENSURE Care Group structure had Coordinators at the district level (nutritionists, nurses, and environmental health technicians), supervisors at the facility level (EHT, Nurse and Ward Nutrition Coordinator, Agritex, Women Affairs, and

Gender), and promoters at the village level (VHWs), with Care Group Leaders (lead mother/ father) supervising groups of neighbor women.

The selection criteria followed the recommended guidelines in literature where 8-15 mothers formed a group based on the proximity of their households. VHWs were responsible for sensitizing the community leaders (village heads), who then mobilized their communities to initiate the care group formation process. The neighbor women selected their CGL, but in some instances, respondents indicated that the VHWs selected the Care Group leaders then each CGL assembled the group of neighbor women. The respondents reported that they just found themselves in the groups and did not know anything about the process in one area. Care Group leaders were said to have been selected based on the CGL selection criteria. These include their interest in health issues, literacy, ability, willingness to lead others, and a good reputation in the community.

Promoted Behaviors

Care Groups were reported to meet monthly, conducting various health, nutrition, hygiene, and gender sessions. They were guided by the behavior change calendars developed by ENSURE and INSPIRE. For IYCF groups, the VHWs conducted sessions using counseling cards only. The behaviors that were being promoted included:

- a) Washing hands at five critical times
- b) Appropriate meal frequency and variety
- c) Feeding children vitamin A-rich foods
- d) Consumption of iron-rich foods by women of childbearing age
- e) Use of long handle cups to fetch water
- f) Seeking ANC and PNC services
- g) Gender division of labor
- h) Promotion of WASH enabling facilities

In addition, the respondents participated in cooking demonstrations, VSLAs, growth monitoring, and established home gardens.

Care Group Functionality

The study revealed that in the Takunda operational districts, 1,100 neighbor women groups (59%) were functional at the time of data collection. Figure 1 shows Care Group functionality by the district. Mutare district has the highest number of functional neighbor women groups (69%). This is attributed to NGO support through the INSPIRE project, which ended three months before data collection. The least functional groups were found in Buhera (44%) and Zaka district (44%). Funding in the other three districts had ended 18 months before data collection.

In the last six months before the study, the care groups conducted an average of two meetings. This was attributed to the COVID-19 perpetuated restrictions that prohibited community gatherings. However, it should be noted that both the ENSURE and INSPIRE projects had ended; therefore, there was minimal support from NGOs.

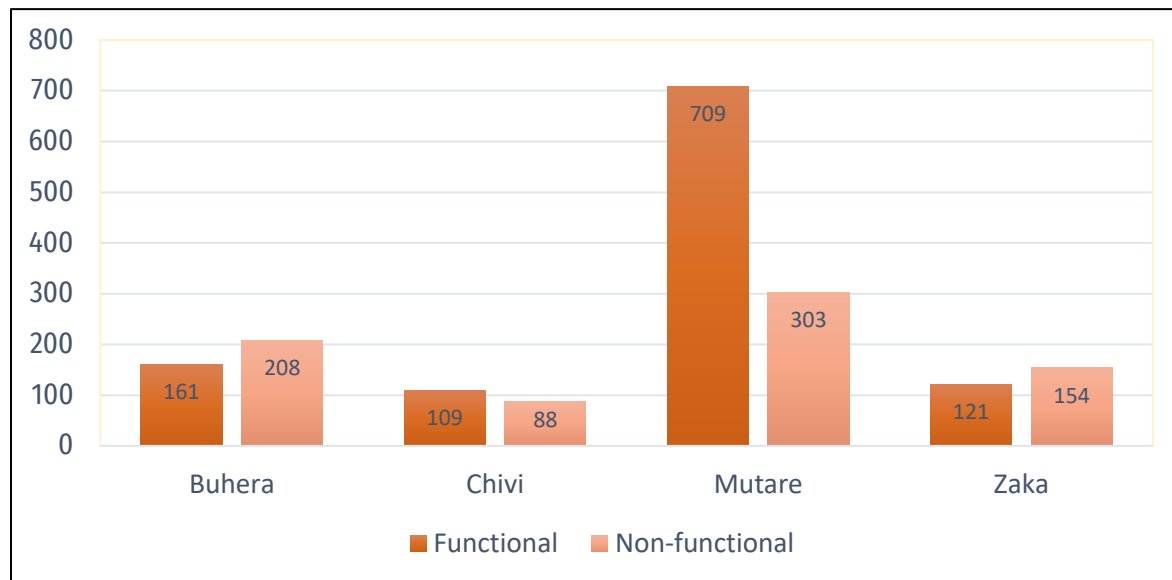


Figure 1: Neighbor women Group Functionality by District

Factors Influencing the Functionality of Neighbor women Groups

The study subjects mentioned various factors that influence the functionality of care groups at different levels. The enhancers have been presented below based on the four sustainability factors followed by the barriers that hinder Care Group operations.

Motivation

During the study period, functional Neighbor womenGroups were those that also participated in income-generating activities like VSLAs, poultry groups, and nutrition gardens. These activities were important in keeping the groups together, and they also helped generate resources needed to adopt the promoted behaviors. Participants from all the FGDs mentioned that the women got support from their spouses to continue with Care Group activities when they bring home tangible materials like money, soap, t-shirts, etc.

The training was identified as another motivating factor. The VHW groups highlighted a need for Care Group supervisors and program staff to train the Care Group leaders as this will ensure the quality of training and build the Care Groups Leaders' confidence. Recognition of VHWs and Care Group leaders through regular support, supervision, and mentorship visits was highlighted by key informants and VHWs

as a key feature in keeping the volunteers motivated, knowing that their supervisors are noticing the good work they are doing in the communities.

Findings indicate that there may be a relationship between the distribution of supplementary feeding rations and participation in Care Groups. It was mentioned that participation in Care Groups reduced when the distribution of rations ended. This was evident since Care Group participation decreased, and in some instances, it stopped when the distribution of rations ended. Integration of activities during Care Group meetings motivated groups to continue meeting and conducting sessions as they accessed different services simultaneously. Services mentioned are Vitamin A supplementation, nutrition screening, growth monitoring, and income-generating activities. Respondents to the KIIs mentioned that volunteers could be motivated through incentives such as refreshments, visibility regalia, corn soya blend cereal, and allowances; the FGD participants also mentioned these incentives.

The KII respondents also mentioned the following as key motivating factors for Care Group functionality:

- a) Regular meetings, support, mentorship, and supervision by the relevant stakeholders at the village, ward, and district level.
- b) The nutrition and nursing departments staff indicated proper VHW and Lead Mothers training, community-led selection of LMs, and information sharing through exchange visits.
- c) Practical demonstration for some promoted behaviors like cooking demonstrations.
- d) Involvement of spouses and immediate family in Care Group activities.
- e) Engagement of community leaders from inception and during Care Group activities.
- f) The proximity of Care Group member households.

Resources

The findings from the study showed that groups function better when there are sufficient resources like stationery, information, Education Counselling (IEC), and visibility materials. Planning the meetings on the traditional community non-working days (chisi) holidays made the convening of Care Groups easier since there are limited activities done on these days. The MoHCC (nutrition and nursing departments) indicated the availability of scales and MUAC tapes as essential factors in enhancing the functionality of the Care Groups.

Capacity

Well-trained Care Group Leaders and VHWs were cited as significant driving factors behind viable and functional Care Groups. The VHWs and Ward-based vital informants highlighted the need for supervisors and program staff to participate in the training of Care Group Leaders to ensure the quality of training.

The well-equipped Care Group Leaders and VHWs were able to conduct sessions through edutainment, sports, and games, which were reported to be critical elements that enabled groups to be functional.

Women enjoy care group meetings better when entertainment is attached to the sessions. Some respondents highlighted that edutainment allows them to relax and shed off the stress that may be coming from the home sphere while gaining knowledge. CGLs and NW reported that Care Groups function correctly if the leaders have good communication skills to foster group cohesion. Agreeing on operational terms allows groups to continue meeting. Groups function better when women share experiences with respect for each other and their leaders. Other Care Group Leaders reported that groups continue to function when mothers realize gains and positive results.

Linkages

Minimum support, mentorship, and supervision provided by the stakeholders at the village, ward, and district level to the CGL and VHWS was mentioned as being critical in sustaining CG activities. The engagement of community leaders by VHWS and making them lead in mobilizing their communities for the Care Group formation process ensures the support of these leaders as they are involved early in the process.

Barriers

The following are the barriers that were mentioned by the study subjects;

- a) The global COVID-19 pandemic disrupted many Care Groups' activities across all Takunda areas of operation. The ban on gatherings, shortage of PPE, and fear of contracting coronavirus made it difficult for the expected monthly activities to be carried out.
- b) A small proportion of the Care Group members failed to attend meetings due to a lack of support from their spouses. During the FGDs, it was revealed that some women are not allowed to attend Care Group meetings by their husbands as they don't see any tangible results from the Care Groups. Hence, the spouses view the meetings as a waste of time.
- c) A remarkable number of women from the apostolic group were not allowed to attend care groups, as their spouses feared that they would be given contraceptives or misinformation, which goes against their religion.
- d) Poor sensitization during CG formation resulted in some women linking their participation in care groups with the SFP; this made them stop attending Care Group meetings when they got discharged from the SFP.
- e) Competing livelihoods activities contributed to the poor performance of care groups. Due to different personal and family needs, Care Groups' members were sometimes unable to attend the monthly activities as they were engaged in livelihoods activities such as pfumvudza¹, petty trade, casual labor.

¹ Pfumvudza is a climate smart farming method that include minimum soil tillage, mulching, pot holing among other conservation practices

- f) Relocation or dropping out of Care Group Leaders also contributed to the non-functionality of these groups as they took along to find a replacement. This also resulted in some Care Group Leaders having more clients than expected as some clients joined groups closer to them.
- g) The study also revealed that the stigmatization of a few extremely poor women and mothers of disabled children hindered their participation in Care Group activities.
- h) For VHW and CGLs, lack of incentives and resources to conduct meetings demotivated them from actively following up on members who are slow to adopt behaviors. Care Group clients reported that lead mothers had stopped mobilizing them to attend a monthly meeting.
- i) A few respondents indicated that conflicts emanating from IGAs such as VSLAs led to disbanding of some of the Care Groups.
- j) The GoZ stakeholders alluded to the barriers mentioned above. They cited lack of collaboration from the development partners .and IGAs training and donor dependency as the some impediments to Care Group functionality.

Ward Food and Nutrition Security Committees

Existing WFNSCs

The findings revealed that only seven of the 92 Takunda wards had a WFNSC (Table 2). The study also showed that all the seven existing WFNSCs were functioning. In Buhera, the functional WFNSCs are linked to community gardens, where the Agritex, MOHCC, and community leadership are targeting households with women of childbearing age to grow nutritious crops for the benefit of the community. However, the structures mentioned above were not capacitated on data management, reporting, and tracking of the context-specific nutrition-specific and sensitive interventions.

Table 2: Existing WFNSCs

District	# Wards	WFNSCs Interviewed	WFNSCs Existing	WFNSCs Functioning
Buhera	22	22	4	4
Chivi	23	23	0	0
Mutare	24	24	3	3
Zaka	23	23	0	0
Total	92	92	7	7

Barriers and Enhancers to the Existence and Functionality of WFNSC

A total of 92% (85/92) of WFNSCs from across the four districts (Mutare, Buhera, Chivi, and Zaka) are not functional due to the following reasons:

- a) Some of the WFNSCs were not trained.
- b) Relocation of the trained cadres resulted in the loss of institutional memory that affected the convening of meetings.
- c) Lack of mentorship, support, and supervision from the District Food Nutrition and Security Committee.
- d) Lack of resources like refreshments, transport, and reporting tools.
- e) Some travel long distances to attend meetings, yet there were not given transport allowances.
- f) Resource constraints on conducting virtual meetings (no data bundles and compatible devices) and poor network coverage were cited as hindrances in some of the wards.
- g) The District Food Nutrition and Security Committees lacked resources to conduct routine monitoring, support, supervision, and mentorship visits. The significant hindrances mentioned were transport challenges and unavailability of refreshments

Ward Water and Sanitation Sub Committees

Existing WWSSCs

The inventory showed that the WWSSC did not exist in the majority (82) of the Takunda wards. Ten wards had WWSSC, which were functional. See Figure 2 below.

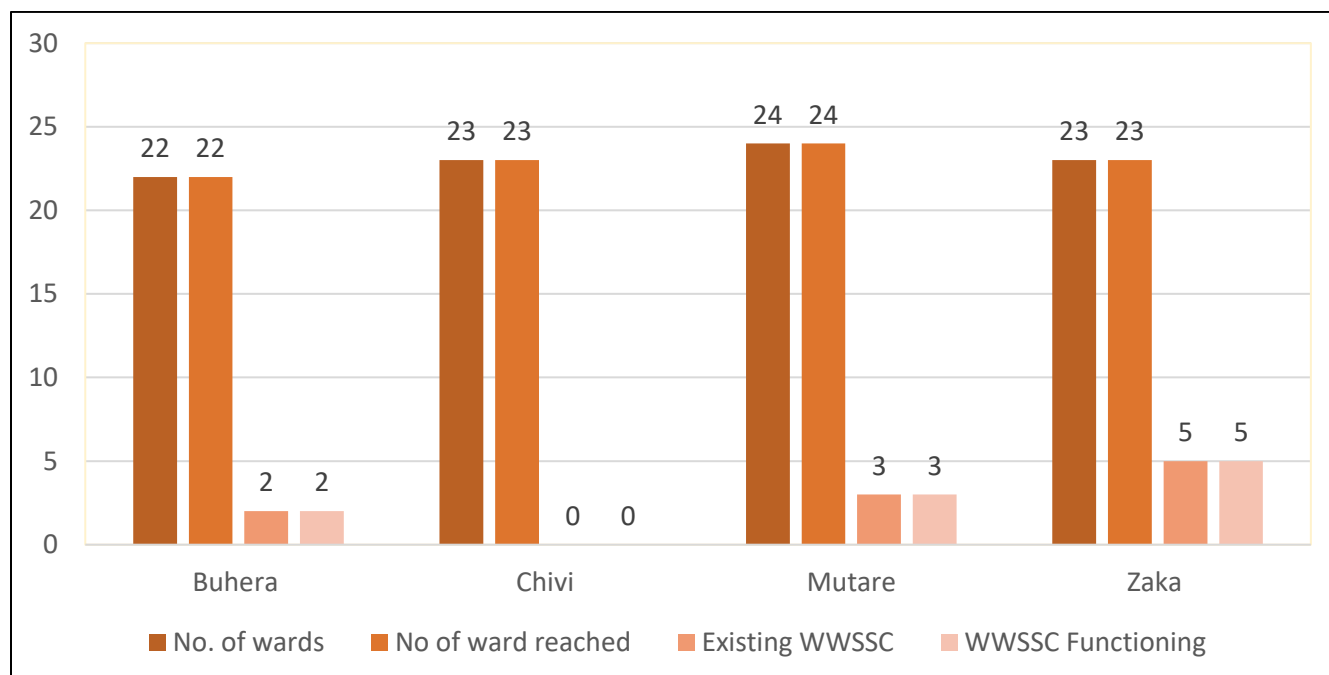


Figure 2: Number of Existing WWSSCs by District

Barriers to the Existence and Functionality of WWSSC

The nonexistence of WWSSC is attributed to several issues, which include but are not limited to:

- Lack of mentorship, support visits from the District Water and Sanitation Sub-Committee, and lack of transport and stationery.
- No budget was allocated to establish/train WWSSC at the ward level. WWSSCs have been established in other wards through a partnership with NGOs.
- A high attrition rate of government workers who constitute the required quorum.
- The WWSSC consists of a government worker.
- Donor dependency – some community members are used to receiving handouts and do not make an effort to improve their livelihoods, assuming that they will get handouts. Some WWSSC alluded that it is difficult to function and implement water sanitation projects with communities with high dependency syndrome, i.e., repair water point/sanitation construction

- f) Undefined roles and responsibilities of the WWSSC members.
- g) Lack of collaboration among the government stakeholders at ward level.
- h) Low level of motivation among government workers.

Enhancers of the functionality of WWSSCs

The following list of factors was mentioned to influence the functionality of WWSSCs positively. Some of the enhancers may be beyond the scope of the project. The availability of the factors listed below will sustain the functionality of WWSSCs.

- a) The WWSSC is established and trained by the District team (District Water Supply and Sanitation Sub-Committee- DWSSC). There is a need for periodic supportive and exchange visits and mentorship to enhance the functionality of the WWSSC. Currently, this is minimal due to limited resources like vehicles and fuel by the District Team.
- b) Provision of a monitoring and coordination budget to both DWSSC and WWSSC, UNICEF supports DWSSC monitoring visits with fuel and lunches though the budget is not enough.
- c) The WWSSC requires reorientation and training to define its roles and responsibilities. Some of the WWSSC members are new and not trained in this job. The reorientation training needs to be supported with lunches and fuel for transport.

Water points

Existing Water Points and Types

Boreholes are the major communal water source for domestic use across the four districts. Most of the boreholes are fitted with bush pumps as a water lifting mechanism (Table 3). Data collected showed that the four districts have a cumulative figure of 1,694 water points where 75% (1,270) were boreholes, 22% (369) were deep wells, 1% were springs, 0.5% were piped water schemes, 0.5% were shallow wells, and elephant pumps constituted another 1%. Springs were only found in the Zaka District, while elephant pumps were reported only in Chivi and Zaka (*see Table 3 below*).

Table 3: Existing Water Points and Types

District	Number of wards	Number of clusters		No. of Water Points Reached	Water Points/Sources by Type					
		Reached	Target		Boreholes	Deep Wells	Piped Water Schemes	Spring	Shallow Wells	Elephant Pumps
Buhera	22	91	91	340	255	82	0	0	3	0
Chivi	23	87	87	364	337	20	3	0	0	4
Mutare	24	89	89	569	393	173	0	0	3	0
Zaka	23	100	100	421	285	94	5	21	3	13
Totals	92	367	367	1,694	1,270	369	8	21	9	17

Further analysis of the data revealed that 36 clusters have no access to safe drinking water within their boundaries. Community members from these clusters reported that they obtain water from rivers, unprotected water sources, family wells, and neighboring clusters.

Level of the Functionality of Water Points

The data collected across the four districts indicated that the level of functionality of water points was 65% (1,115), while 35% were water points that were not functioning (Figure 3).

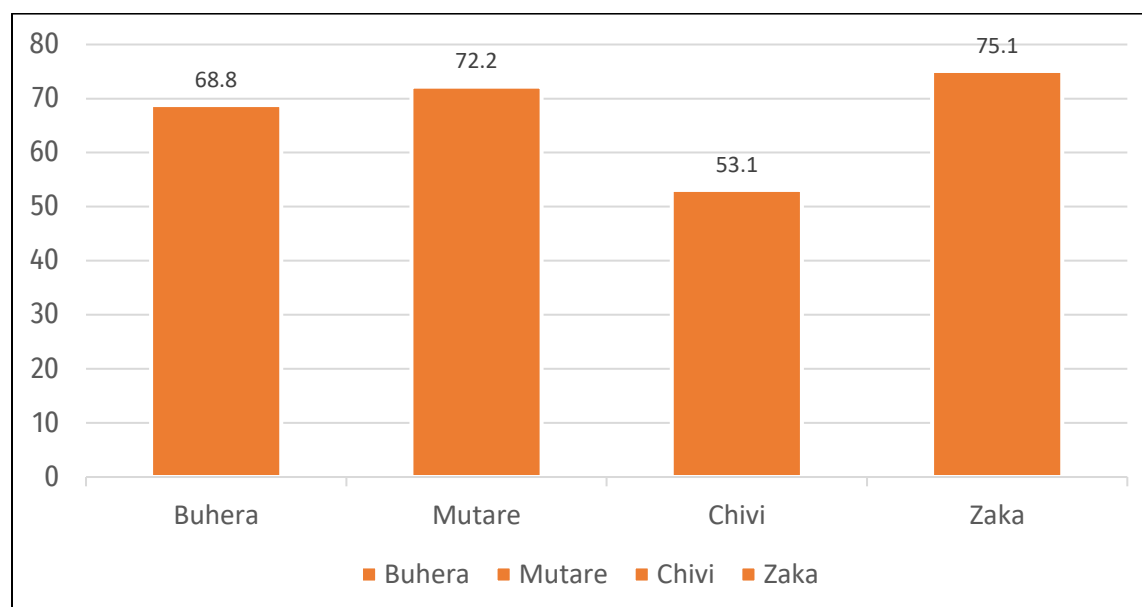


Figure 3: Proportion of Functional Water Points by District

According to Figure 3 above, Chivi recorded the least number of functional water points, 53.1%, followed by Buhera and Mutare, 68.8% and 72.2%, respectively. Zaka District recorded the highest rate, 75.1% of functional water points. The water points reported to be functional had a sizeable number with mechanical faults (partially functional) that reduced the efficiency of the water point, while a few were fully functional.

The WPMC members interviewed mentioned that there was no consistency in collecting water user fees. In most cases, community members contribute money whenever there is a breakdown, especially for the payment of the VPM. The downtime is prolonged because the WUC does not have revolving funds. The council supports major maintenance works through the local councilor. NGOs sometimes help in borehole maintenance. There is no evidence of Private Public Partnership engagement in all the interviewed WPMCs. This is a knowledge gap in all WPMC as they need to be capacitated in leveraging private sector capital to fund the operation and maintenance of water points.

Water Point User Committees

The community-based management strategy implores that all water infrastructure or water points should have community-based management committees responsible for operating and maintaining the water points to ensure a sustainable supply of safe drinking water. Public water points reached during the inventory had water user committees, while a few had no user committees. The WPMC enumerated has an average of 5-7 members, with women constituting the highest number.

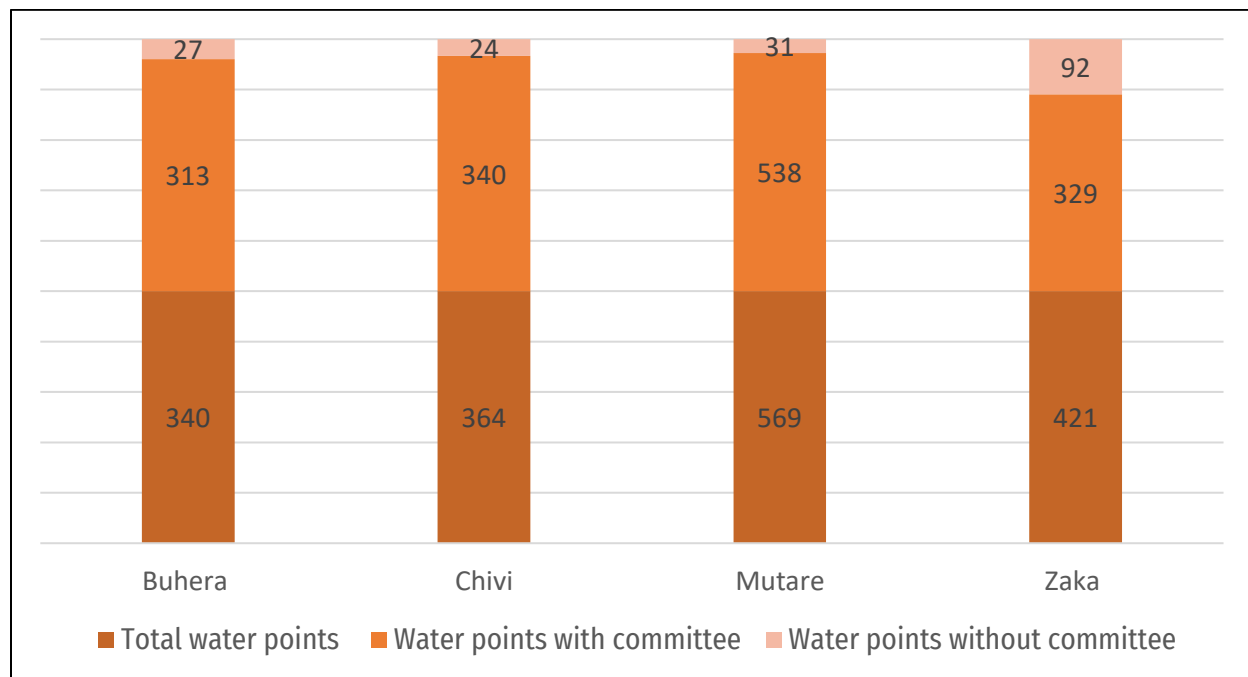


Figure 4: Distribution of Water Point User Committees by District

Figure 4 above illustrates that 10% of the 1,694 water points had no water user committees. Zaka recorded the highest proportion (21.8%) of water points without committees, followed by Buhera and Chivi that recorded (7.9%) and (6.6%) respectively. Mutare had the lowest proportion (5.4%) of water points with no WUC. The water user committees' level of efficiency and functionality was reported to vary from one committee to another. The user committees concurred that boreholes reported an extended downtime due to poor fundraising and lack of commitment to pay user fees by households with individual water sources such as shallow wells, deep wells, and mechanized boreholes. There are still communities relying heavily on donor support and have shunned the community-based management responsibility.

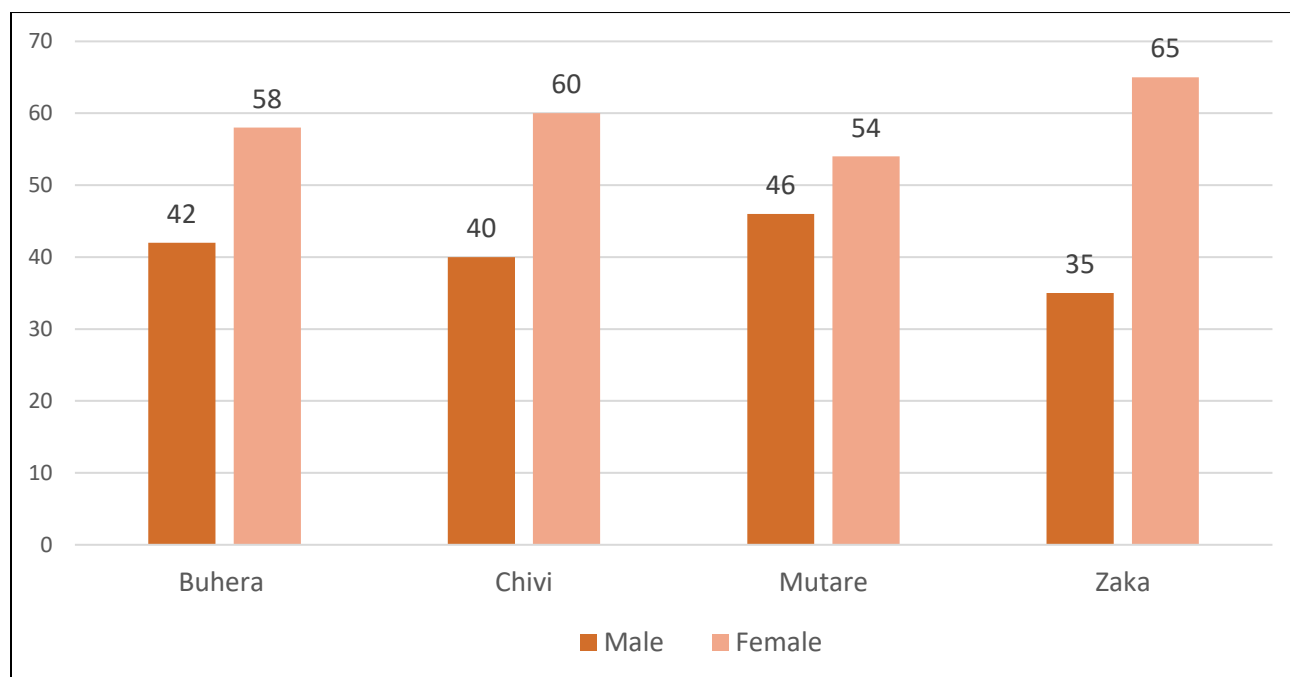


Figure 5: WUC Gender Composition

Figure 5 above shows that the WUC has more women than men. Zaka and Chivi reported higher women in executive positions than the other two districts. Most user committee members were reported to be elderly, which affected the functionality of the WUCs. Roughly 70% of the WUC have mostly elderly people. Elderly people are no longer active but have institutional memories about water development in their respective communities. The youth are blocked from holding positions in WPMC as they are considered highly mobile and unstable. Most women in the water point committees do not hold influential positions or are involved in decision-making. Takunda has to influence the incorporation of young people and women in WUC.

Table 4: Access to Village Pump Mechanics

District	# of VPM	WP with Access to VPM	WP Functional	VPM Ratio
Buhera	17	334	234	1:20
Chivi	9	321	263	1:36
Mutare	12	537	302	1:45
Zaka	15	330	316	1:22
Total	53	1,522	1,115	1:29

Seventy-seven percent of the total water points have access to village pump mechanics (Table 4). In Mutare and Zaka, one VPM serves at least three wards. While in Buhera and Chivi, VPMs serve more than three wards. The average ratio of Village Pump Mechanics to the number of water points they serve was 1:29. This demonstrates that the workload for the VPM was high and could compromise quality and efficiency. The table also illustrates that a high proportion (27%) of the water points with access to a VPM were not functional.

Barriers to Operation and Maintenance of Water Points

Water points user committees and VPMs cited several challenges that affected efficiency and quality of work in borehole rehabilitation. They summarized the challenges as follows:

- a) The Village Pump Minders (VPM) lacks technical support from the responsible authorities such as the District Development Fund and Rural District Councils. The borehole maintenance team uses the three tiers system, which means that village maintenance is referred to Ward and the district mostly on complicated maintenance. Ward level is not adequately staffed; hence some boreholes that require complicated maintenance may be on breakdown for over two years. In Chivi, some boreholes have broken down for over two years, and the VPM reported that the maintenance challenges are beyond his capacity.
- b) Lack of mechanical tools - they are expensive and rotate among VPMs. Some VPM reported not maintaining the boreholes because they do not have access to mechanical tools or the set is not enough.
- c) Trained VPM are scarce, with VPM traveling across wards/clusters to maintain a broken-down borehole. The communities have to cover for high transport costs between water points. Some water points are not accessible, and the VPM has to walk, resulting in prolonged downtime.
- d) The high workload for the VPM. The lowest VPM borehole ratio is 1:20, which means each VPM has to cover 20 geographically spaced boreholes, hence prolonging the downtime.

- e) Unavailability of borehole spares (i.e., leather cup, pipes, rods, cylinder) in the local market. The cheapest and smallest spares like leather cups are not readily available in the local markets. Economically the transport cost to buy leather cups is double the cost of the leather cups. Generally, most hardware does not want to stock borehole spares because of their long shelf life.
- f) Most WUC were quick to point out that they can not have revolving funds on the unstable economy in Zimbabwe, i.e. currency can change anytime and inflation. Water user fees are not being collected or are not consistent. There is no penalty for the users who are not paying the water user fees. No bylaws for water user fees; hence when boreholes breakdown much time is spend on mobilizing funds because the revolving funds are not available.

Enhancers to the Operation and Maintenance of Water Points

For water point management to be effective and efficient, the users recommended several practices that can be adopted, which are as follows:

- g) Training of new VPM to reduce the workload on the current practicing VPMs.
- h) Providing VPM tools to enhance the quality of service.
- i) Periodic refresher training for WUCs on Community Based Management.
- j) The curriculum/Manual of the WUC training should include the Private-Public Partnerships approach – including mapping of possible private sector players to train WUC and offer other services.
- k) Conservation works on and around Water Point should also be included in the WUC manual. This includes assessing the water system environment and mitigating measures to sustain the system. The resilience design includes gully reclaiming, re-filling of water table through contours around the water system.
- l) Exchange visits to facilitate look and learn on best practices.
- m) Capacitating on starting income-generating activities.
- n) Community leadership involvement is crucial as it can help mobilize and authenticate water user fees. According to the Traditional Leaders' Act, the traditional leaders are development leaders in the village and have the mandate to sue those who are not cooperating.
- o) Women should also be considered for leadership positions in WUC. Women are affected by the unavailability of water hence should be involved in decisions of things that matter to them.
- p) The EHT should carry out periodic Water Quality Testing and sanitary surveys and inform the community of the results.

CONCLUSION

Overall, this study has revealed that the coverage of Care Groups was low in some districts as most of them were rolled out with support from NGOs. The Care Groups had different configurations and did not meet the expanded CG model that Takunda intends to use. The study also showed that a high proportion (56% in Zaka and Buhera) of the Care Groups stopped functioning soon after the NGO funding ended. This shows inadequate support and recognition from the ward level structure to motivate the CG volunteers to continue implementing CG activities. This study showed that training or capacity-building motivated Care Group Leaders enhanced their confidence. Recognition of VHWs and Care Group Leaders through regular support, supervision, and mentorship visits was highlighted as a key motivating factor.

Linking the Care Group activities with the SFP and lack of monitoring and supportive visits were cited as some of the major hindrances to the functionality of Care Groups. In addition, inadequate support from household members was mentioned as a factor that reduced the participation of women in Care Groups. The COVID-19 restrictions disrupted many care groups activities across all Takunda areas of operation as training and meetings could not be done. The average number of Care Group meetings was two in the last six months, indicating that many care groups could not meet during this period.

The main barriers to the existence and functionality of WFNSCs cited were lack of resources, support, and training. This study also revealed that WFNSCs and the WWSSCs that are supposed to coordinate the implementation of food & nutrition and WASH intervention at a local level were not existing in most wards. Only 7 and 10 wards of the 92 Takunda wards had WFNSCs and WWSSCs, respectively.

Takunda aims to reach out to 77,211 households across the four districts in five years. This household target needs 1,544 boreholes. The Sphere² and national standards stipulate that one borehole should serve 50 HH. Considering the collected data and gaps in water supplies in terms of functional and broken-down water points, Takunda will need to rehabilitate between 429 and 579 boreholes and drill the remainder to serve the HH target adequately. One cited example is Ward 22 in Buhera District, where cluster 12 has two villages with 239 HHs that had no approved basic water supply. If Buhera district rehabilitated all the non-functional water points, it will report as achieving its district target but will still fall short on accessibility. The Buhera scenario is rampant across the four districts of Takunda.

The study showed that many WUC did not have a revolving fund and that funds are only collected when there is a breakdown. Many water points have access to a VPM, but they are not functioning. This indicates that a lot more factors are contributing to the downtime.

² The Sphere community sets standards for humanitarian action and promotes quality and accountability

<https://spherestandards.org>

RECOMMENDATIONS

- a) Based on the existence and configurations of Care Groups in the Takunda targeted areas, it is recommended that Takunda employ three different entry strategies for Care Group activity depending on the situation in each location.
 - Takunda will establish Care Groups, starting in wards where they were not already in existence.
 - Where Care Groups exist but are not functional, Takunda will resuscitate them, ensuring that the configuration meets Takunda's expectation
 - Where Care Groups exist and are functional, Takunda will strengthen them based on the identified gaps and aim to improve them to meet the expanded Care Group model and integrate gender to create an enabling environment for more supportive husbands/spouses.
- b) For sustainable adoption of IYCF, Maternal Health and Nutrition, and WASH practices that will impact the nutritional status of WRA, adolescent girls, and children under the age of five years, lobbying the MOHCC to commit resources to improve coverage of Care Groups will be conducted. This furthers the work that was already started with the predecessor ENSURE program.
- c) During community mobilization, it is essential that benefiting from the SFP is not linked with participating in Care Groups. The CG sensitization script should guide the sensitization messaging.
- d) Integrating Care Groups with Income Generating Activities creates an enabling environment for increased adoption and sustainability of behaviors.
- e) Provision of adequate and easy-to-use job aids that are tailor-made for the local context will enhance comprehension of concepts by Care Group participants.
- f) Strengthening linkages of community-based committees to government agencies – Takunda, together with the DFNSC and the DWSSC, should develop a plan to resuscitate the WFNSCs and the WWSSCs and capacitate them to coordinate F&N and WASH activities at the grass-roots level.
- g) Selection of youths and women in decision-making positions and empowering them to make the decisions.
- h) Level of functionality of water points – data indicates that 35% of the assessed water points are not functioning. It is recommended that Takunda review its target for water points rehabilitation and compare it with constructing new water points for potable water. Priority for water points rehabilitation or construction of new ones should be given to the 36 clusters that were found to have no access to safe drinking water within their boundaries.

- i) Capacitating Village Pump Minders will reduce downtime to repair boreholes and improve the sustainable supply of drinking water. There may be a need to identify and train new Village Pump Minders in some cases.
- j) Collaborative efforts are recommended to strengthen water points user committees' governance structures. The study showed that many WUC did not have a revolving fund and that funds are only collected when there is a breakdown. This confirms the opportunity that Takunda has of testing for the viability of a full cost recovery water system involving Water User Committees and Pump Operators/Mechanics. In the pilot, there is an opportunity for Takunda to rope in the private sector, especially on improving access to spare parts, as the findings indicated no involvement of the private sector.

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ANNEX – DATA COLLECTION TOOLS

Care group Inventory Focus group Discussion Guide for VHWs, CGLs and neighbor women

Date	Name of Interviewer		
Name of Note taker			
District	Ward		Village
Number of FGD Participants			

1. How were the care groups formed? How were the CGLs/Lead mothers selected? How can this process be improved?
2. What are the typical activities you conduct in a month?
3. Can you describe a care group that is functioning properly?
4. What makes it easy for you to conduct these monthly activities?
5. What makes it difficult for you to conduct these monthly activities?
6. Who encourages you to continue doing care group activities?
7. Who discourages you from doing care group activities?
8. What do you think needs to be done for you to continue doing care group activities, who do think should do these things or ensure that they are done?

Care group Inventory KII Questionnaire

Date	Name of Interviewer		Designation:
District	Ward:		Village:
Name of Interviewee			Designation:
Department			

1. For how long have you worked with Care Groups?
2. Describe your role in Care Groups
3. How do Care Group activities contribute to your key result areas?
4. Do you report Care group activities in your routine work reports? Yes No
 - a) If yes give example of the information you include in your reports
 - b) If no why?
5. Can you describe a well-functioning Care Group?
 - 5.1. What factors do you think enables Care groups to function as expected?
6. What factors do you think hinders/prevents Care groups from functioning as expected?
7. What do you think should be done to differently or more to enable Care Groups to function as expected?
8. Who should do these things or ensure that they are done?

Water Point Inventory, Existence of WWSSC and WFNSC & functionality Form

DISTRICT:		WWSSC						WFNSC					
Ward #	Health Facility Name	Exist		Date of last meeting		# of meetings in the last 6 months		Exist		Date of last meeting		# of meetings in the last 6 months	
		Chairperson	Secretary	Chairperson	Secretary	Chairperson	Secretary	Chairperson	Secretary	Chairperson	Secretary	Chairperson	Secretary

Water Point Inventory, Existence of WPMC and functionality Form

District WardVIDCO

Name of Interviewer

Village Name	Name of Water Point – as in RDC records	Type of Water point	Is water point Functioning (Y/N)	If No since when	Beneficiary Households	Name of VPM	Respondent and position	WPC (Y/N)	Composition of WPC By Gender		Contact Details for WPC
									M	F	

Care Group Mapping Form

Date					Ward								
District					Vidco								
Nearest Health Facility													
					Name of Interviewer								
#	Village	VHW	SEX	Phone Number	Name of Care Group Leader	Sex	Name of Gender Champion	Sex	# of Clients	# of children 0-23	# of children 24 – 59	Meetings Y/ N	# of meetings in the last 6 months
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													