

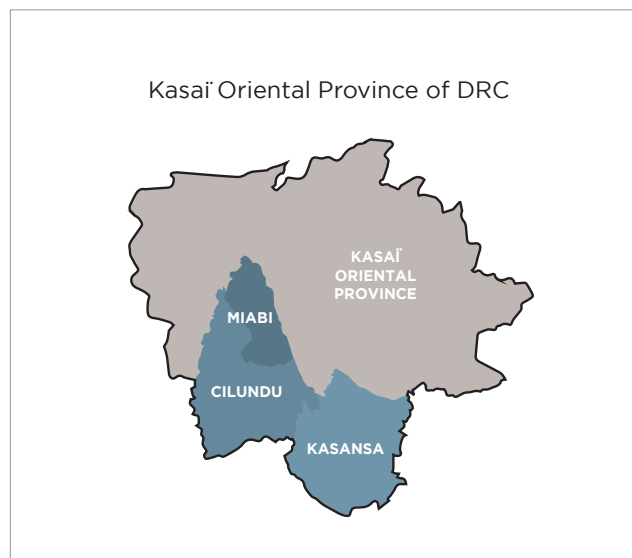


Learning from the Budikadidi Project in the DRC:

INTEGRATION OF THE CARE GROUP MODEL
WITHIN MINISTRY OF HEALTH STRUCTURES

CONTEXT

From 2017–2023, a Catholic Relief Services (CRS)-led consortium implemented the Budikadidi project, a USAID-funded Resilience Food Security Activity (RFSA), in three health zones of the Kasai Oriental Province in the Democratic Republic of the Congo (DRC). The Budikadidi (meaning “self-sufficiency” in Tshiluba) project worked to sustainably improve household nutrition, food security and economic well-being. Budikadidi programming promoted nutrition behaviors via the care group (CG) model, a classic evidence-based intervention often implemented by non-governmental organizations (NGO), which has been adopted by the Ministry of Health. The Budikadidi model leveraged the leadership of local Lead Mothers and Care Group Promoters (CGP) to promote nutrition-focused behavior with other mothers in the communities. This model worked within the Community Animation Cell (CAC) structure, a government-led multisectoral initiative established in each village to increase community engagement and drive local ownership of community development. The CG model has remained fundamental to Budikadidi programming throughout the life of the project and continues to garner active community participation. While Budikadidi staff nurtured solid links with the Central Health Zone Office (BCZS) government structure throughout CG implementation, as the project neared its final year, it was unclear whether the higher-level Provincial Health Division (DPS) was aware of CG programming—a critical factor in sustaining the model post-Budikadidi. To overcome



Budikadidi takes place in the Kasai Oriental Province of the DRC, targeting communities in the Cilundu, Kasansa, and Miabi health zones.

this challenge, the Budikadidi health and nutrition team hosted a series of consultative workshops in July 2022 in each health zone with government (BCZS and DPS) staff, CAC representatives, Lead Mothers and CGPs. This cohort discussed progress and challenges in the integration of the CG model within government community health care systems and launched an official handover plan for government appropriation of the CG model.



Budikadidi staff meet with key stakeholders to discuss the handover of the care group model into government systems in the Miabi Health Zone.

OBJECTIVE

This study was designed to trace the development of the Budikadidi CG model, assess its sustainable integration within government structures and document the project's handover process. The study specifically addressed the following learning questions:

- How and why was the CG model launched? What successes and challenges were experienced in aligning with DRC policy and government health structures?
- What was the long-term process to integrate Budikadidi nutrition programming into government health systems? To what success was this achieved and what lessons were learned?
- What impact did the CG model have in achieving project objectives and promoting sustainability?

FINDINGS

Process

The original Budikadidi design did not include the CG model, rather it proposed Infant and Young Child Feeding (IYCF) support group interventions to promote nutrition practices. Prior to the RFSA refinement period, it was determined that there was minimal evidence of IYCF support groups positively impacting nutrition in the DRC. Instead, the CG model was increasingly integrated into Congolese health systems where it demonstrated positive results in promoting positive nutritional behavior adoption and was promoted by the USAID/Bureau for Humanitarian Assistance (BHA) team. As such, the Budikadidi team pivoted from IYCF support groups to the CG model.

Since the refinement period, Budikadidi has worked alongside the government health system to ensure government buy-in of Budikadidi interventions and support integration of Budikadidi structures. To gain a better understanding of the CG model, key project staff participated in a study tour in Zambia. Upon return, these leaders presented knowledge gained to national and provincial representatives of the DRC's National Nutrition Program (PRONANUT), who were also members of the DPS. While seeking government sign-off to implement the CG model, it emerged that the combination of revitalizing CACs from health to multisectoral structures and the proposed Budikadidi CG model closely aligned with the national approach, Community-Based Nutrition (NAC), creating opportunities for acceptance and integration of the CG model.

METHODOLOGY

The study was launched with a desk review of the project proposal and key reports to construct a timeline of nutrition programming and document changes to the original design. Staff interviews with Budikadidi nutrition staff were held to further track the evolution of the CG model, as well as challenges and recommendations for sustainable impact. The study team was present during the handover workshop series to observe and document the process. In the workshop space, a focus group discussion (FGD) with two government staff and one CAC president was conducted and a survey was completed by 14 workshop participants—Lead Mothers (3), CAC Presidents (3), CGPs (3), Health Zone Officials (2), and Head Nurses (3)—collectively representing the three health zones targeted by Budikadidi.

PRONANUT supported Budikadidi leaders to convene a workshop with nutrition actors across the province during which Budikadidi's CG curriculum, communication materials, and social and behavior change (SBC) tools were developed and formally validated. Budikadidi Technical Leads then led training of trainer (ToT) sessions on the CG model for three technicians and one coordinator from PRONANUT's provincial staff and three Health Zone Chief Medical Officers, who in turn trained the initial 60 CGPs and three Health Zone Community Animators (ACZS). Budikadidi staff met with Head Nurses in the health zones to explain the CG model and encourage their buy-in to support implementation. Together with Head Nurses, the project met with village chiefs, CACs and select Community Health Workers (CHW) to introduce the model, identify households and organize neighborhood groups consisting of 15 households. Lastly, the CAC communicated the CG model to each neighborhood group and supported them in nominating a Lead Mother from within their groups. The final list of nominated Lead Mothers was shared with the CAC and village chief for recordkeeping. Across the three health zones, 5,189 neighborhood groups and 403 CGs were formed.

To support integration of the CG model within the DRC government health system, Budikadidi staff facilitated the participation of Health Zone Chief Medical Officers in the coordination and planning meetings of all project activities and established monthly monitoring meetings to ensure that CGPs

reported their activities to both project staff and Head Nurses.

Key Challenges

Despite the efforts made by Budikadidi, challenges at three levels undermined collaboration between the project and government health systems:

1. Head Nurses resented that Budikadidi resources were invested in direct implementation at the community level instead of passing through/ investing in the existing health structure hierarchy. Staff interviewed for this study referenced the fact that Head Nurses previously managed the CACs (initially, health-focused community structures) with their family members occupying key CAC roles and therefore, accessing different health system opportunities for personal gain. In alignment with national guidance, Budikadidi refreshed the role of CACs to become multisectoral structures, altering election procedures and frustrating some Head Nurses as these adaptations altered the status quo. This tension led to government health staff dismissing Budikadidi's early effort. For example, some Head Nurses and health zone staff failed to report Budikadidi's significant contributions to the BCZS during the cholera outbreak response. Moreover, joint supervision between Head Nurses and project field agents did not start until 2020, three years after project start-up, and continued to be a scheduling challenge as Head Nurses remained resentful. Overall, this dynamic delayed the important buy-in of Head Nurses.

2. At the BCZS level, long-standing relationships with UNICEF meant that government health system staff felt beholden to prioritize UNICEF health/nutrition/WASH priorities, rendering delayed buy-in of Budikadidi approaches from key government stakeholders until after UNICEF recognized their positive impact in the context.
3. The fact that Budikadidi did not, and was not designed to, engage in provincial-level health system capacity strengthening resulted in negative perceptions of the project by provincial actors. In addition to Budikadidi, USAID funded two additional projects in the province—the Integrated Health Program and Integrated Governance Activity—both of which addressed higher level health system strengthening. Aside from a Memorandum of Understanding (MOU) signed between Budikadidi and the Integrated Health Program aimed at strengthening the health system, it appears that there was little coordination between the projects or promotion of USAID's collective health portfolio. As a result, government expectations that each project would invest in provincial staff engagement and capacity strengthening was not effectively mitigated.

Structure

Budikadidi's implementation of the CG model relied on the election of Lead Mothers by women in the neighborhood groups. This election structure empowered CG members and supported their initial buy-in; however, it did not enable Budikadidi to leverage the previously established CHW system. The existing CHW system consisted of

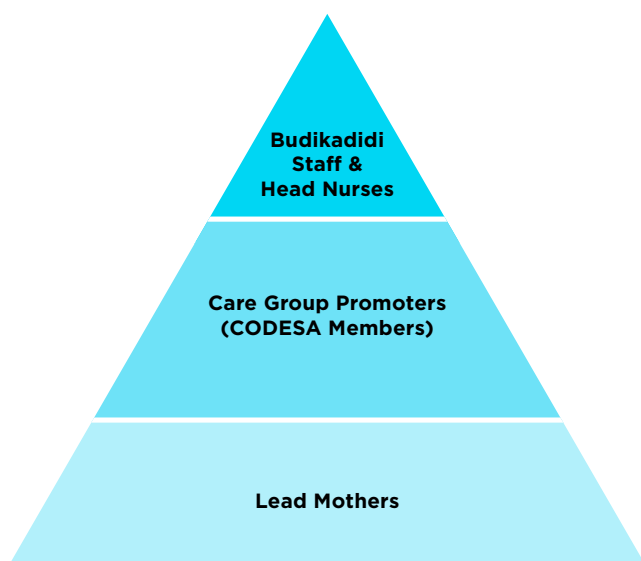


Figure 1: Budikadidi Care Group Structure



Figure 2: Health Zone Structure



A Lead Mother in the Monzo Village demonstrates how to prepare nutritious porridge for pregnant and lactating mothers. Packed with protein, vitamins, and other key nutrients, this porridge helps children over the age of six months achieve proper growth and reduces the risk of malnutrition. . Photo by Jennifer Lazuta/CRS

male and female community members who were already supporting 50 households, on average, to tackle different community health challenges. Early iterations of the Budikadidi CG model tested engaging the same individuals as Lead Mothers/CGPs and Facilitator Couples of the Faithful House (TFH) approach who conduct home visits to encourage joint decision-making and adoption of Budikadidi-promoted practices. This strategy failed to flourish, becoming too heavy of a burden for the couples as it required monthly visits to all neighborhood groups. Additionally, there was a noticeable lack of interest from men in the CG model and therefore, the approach could not serve as an avenue for increased male engagement. The team decided to work with Lead Mothers and CGPs to provide support to mothers while creating a separate TFH structure to provide support to couples. While the Budikadidi CG approach yielded a new structure, the intent was not to create parallel work with the CHWs but to complement

their activities within the health sub-sector of the CAC. CHWs oversee a wide spectrum of health priorities including Integrated Management of Childhood Illness (IMCI), vaccination campaigns and surveillance for early disease detection, while Lead Mothers specifically address nutrition-related health issues within their targeted households.

Budikadidi engaged 5,189 Lead Mothers who were grouped into 403 care groups and supported by 89 CGPs across the three health zones. Each CGP managed five to six groups consisting of 10-14 Lead Mothers, who in turn each supported 10-14 households in their villages. Under the government health structure, besides managing a greater number of households, CHWs also automatically become CAC members and are leveraged for the implementation of all nationwide campaigns for maternal and child health issues. CHWs are directly supervised by the Sanitary/Health Area Development Committee (*Comité de*



Thérèse Mujinga, a Lead Mother in the Monzo village, checks in on Mujinga Kabengela, age 25, who is six months pregnant with her sixth child. There has been supporting Mujinga throughout her pregnancy, encouraging her to go to pre-natal check-ups and eat nutritional foods.

Photo by Jennifer Lazuta/CRS

Développement Sanitaire or CODESA) which co-manage primary health-care facilities, lead the sanitary development activities in their area, and report to Head Nurses; however, each health center managed by Head Nurses is made up of more than 100 CHWs who each cover 50 households, resulting in limited capacity for interaction and supervision compared to the CG model. Conversely, CHWs often have access to in-kind and monetary incentives that are not available to Lead Mothers, a distinction which underscores many women's interests to engage in both roles.

Lead Mothers conduct home visits, promote adoption of improved practices, and track and report on important health/nutrition events. They also participate in community health/nutrition activities such as vaccination campaigns, malnutrition screenings, national immunizations days and medicine distributions. Some Lead Mothers meet monthly with the CHWs and report to the CAC. Within the CG model, however, the connection between Lead Mothers and the CACs is not formalized. While there is a Lead Mother representative within the CAC structure, she is not required to and therefore does not always report on the collective work of Lead Mothers.

CGPs are trained and supervised by Budikadidi staff (health/nutrition zone and technical supervisors) in collaboration with Head Nurses within the CODESA coaching framework and BCZS officials. The three ACZSs provide quarterly training sessions to the CGPs, who meet monthly with the CODESA for the coordination, monitoring and evaluation of health/nutrition challenges and attend regular CODESA meetings as well as occasional CAC meetings. CGPs provide monthly trainings to their cohort of Lead Mothers; supervise and monitor their work by accompanying them during home visits, campaigns and distributions; facilitate participatory learning sessions; track behavior changes; and attend trainings and reporting meetings organized by the health center to pass down to their care group. CGPs are responsible for conducting approximately 8-10 unannounced visits every month to monitor the work of the Lead Mothers. CGPs work with the CAC on an ad hoc basis; for example, during the COVID-19 sensitization campaign, they organized village announcers to raise awareness. However, no direct relationship with the CAC was established with CGPs as their workload is already extensive.

Integration with government structures is critical for sustainability, not only for continued capacity building, supervision and access to financial

resources, but also to motivate local volunteers. By working with the health zone, Budikadidi was encouraged to leverage existing CHWs as CGPs and Lead Mothers, a major contributing factor to the success of the CG model as CHWs already have a skillset in community mobilization and quickly helped increase knowledge on nutrition, health and WASH practices. This also proved ideal as CHWs are motivated by the financial incentives of health campaigns while the Lead Mother is fully entrenched in her community, which yields year-round recognition and respect, and bolsters feelings of connectedness, appreciation and effectiveness, a combination which enables motivation over time.¹ The DPS plans to leverage Budikadidi Lead Mothers' skillsets to execute other donor-funded activities, creating potential opportunities for financial/in-kind incentives.

Handover Process

The process to hand over supervision of the CG model has been continuous over the life of the project, with health zone representatives co-facilitating quarterly trainings and providing supervision to CGPs (a role they envision sustaining post-Budikadidi). In July 2022, a series of workshops was held in each health zone to formalize the integration of Lead Mothers and CGPs as community health actors in the BCZS health system. Bringing together representatives from the Ministry of Health at the provincial, central and health zone level; Head Nurses; Lead Mothers; CGPs; CAC Presidents; Villages Chiefs; and CODESA members, as well as key Budikadidi field staff, the workshop identified roles, responsibilities and reporting lines for sustainability. The workshop agenda included a presentation of the exit strategy, multiple brainstorming sessions, discussions to contextualize integration efforts and a detailed report of next steps.

Through a participatory process, workshop participants were divided into groups and led through mapping exercises by CRS and the DPS. The first activity explored the integration process, identifying roles and responsibilities for coordination, implementation, monitoring and evaluation efforts, and report writing. Participants discussed the motivations and prerequisites for the CG model to be sustained. The final participatory discussion explored the necessary actions needed to maintain Lead Mother engagement. Each group was encouraged to share their recommendations based on the realities they face on the ground. Budikadidi Field Agents were instrumental in

¹ Read the Budikadidi learning brief "[Exploring Community Volunteer Incentive Structures.](#)"

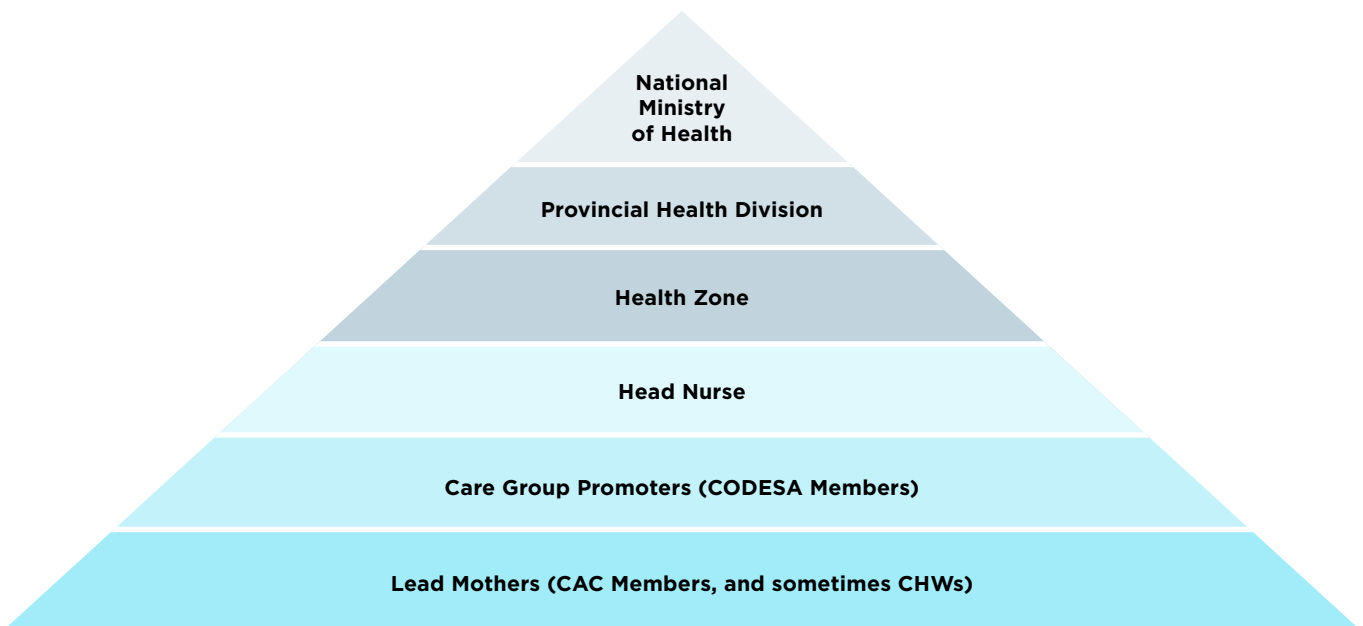


Figure 3: Integrated structure of the CG model into the health system as designed during the handover workshop.

providing contextual nuance to strengthen the feasibility of the integration plan. As a result of these discussions, recommendations and next steps were identified to ensure successful integration within government structures, including:

1. **Lead Mother’s Role and Responsibilities:**

Integrate Lead Mothers into all relevant health and nutrition community-based activities including the health and nutrition sub-committee of the CAC, capitalizing on their experience while ensuring their workload does not increase or impact their role as mothers in their own households. They will remain connected to their 10–14 households, conducting counseling in neighborhood groups and, along with CHWs, supporting health areas in solving priority health problems through community mobilization, malnutrition screening and case referrals, and awareness-raising on key family practices and community health strategies. They will regularly report on their activities to the CGPs and CAC. In health zones where the national NAC strategy operates, Lead Mothers will join IYCF support groups.

2. **CGP’s Role and Responsibilities:** CGPs serve as members of the CODESA, ensuring that lesson plans for new themes identified in the villages they cover are communicated to Lead Mothers and supporting the CHWs with information and feedback through the CAC. They will establish a list of Lead Mothers from each village, monitoring

their attendance and performance in care group activities to provide recommendations on which Lead Mothers have the capacity to also serve as CHWs.

3. **CAC Strengthening:** Revitalize and strengthen health and nutrition sub-committees of the CAC by appointing focal points who report to the CODESA and Head Nurses and who coordinate all health and nutrition activities in the village. Budikadidi staff will collaborate with Head Nurses to support the coaching of focal points in their new roles and the development of coordination sessions for health and nutrition village action plans with all Lead Mothers, CHWs and key stakeholders.
4. **Linking Head Nurses to the CG Structure and CACs:** Budikadidi will merge the care group and health system structures (see Figures 1 and 2) to create a new structure that concretely links Head Nurses to the CG model and CACs (see Figure 3). Budikadidi will organize an orientation session on lesson plans for Head Nurses, which will then be cascaded down by the Head Nurses to CODESA members (including CGPs), CHWs and Lead Mothers. Head Nurses will validate the list of health and nutrition CAC focal points and identify priority themes, organize training sessions for the CGPs, and monitor and report on sub-committee activities.

The handover workshop built upon the collaboration of Budikadidi leadership and the DPS established throughout the life of the project to effectively integrate the CG structure into the government health system. In July 2022, the DPS signed an MOU with Budikadidi leaders to implement and sustain the integrated model as designed during the workshop and as pictured in Figure 3.

Sustainability and Integration

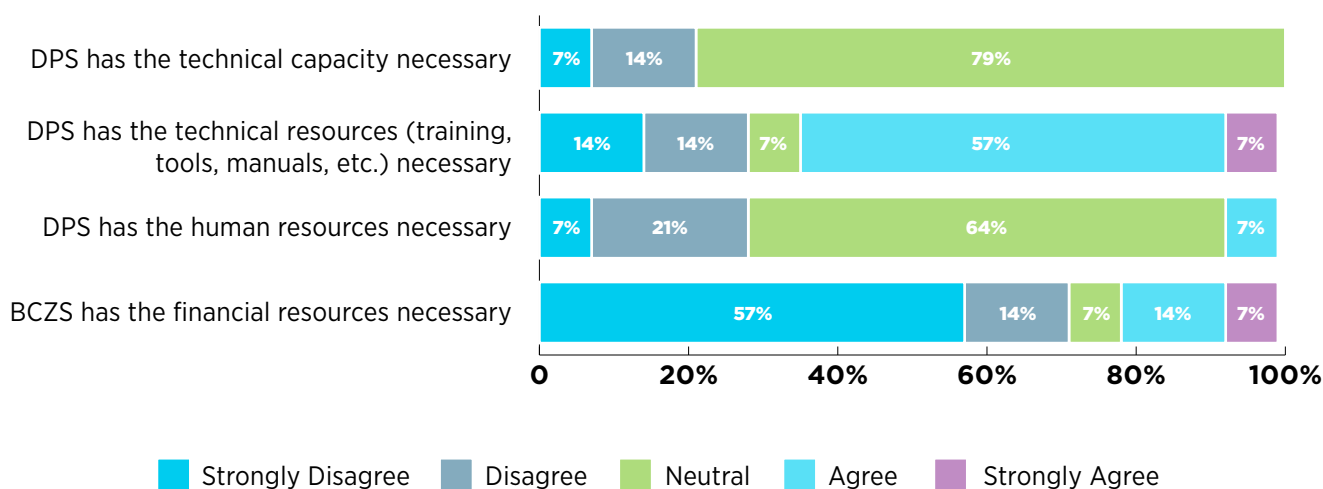
An effective exit strategy that sustains project interventions post-Budikadidi relies on four critical factors as outlined by [USAID/Food and Nutrition Technical Assistance](#): 1) reliable access to resources, 2) technical and managerial capacity, 3) motivation and 4) linkages to relevant government structures. Most handover workshop participants (71%) identified financial resources as a barrier to sustainability. FGD participants stated that government health structures expect Budikadidi to provide financial resources such as motorbikes to facilitate health zone agents' movements to support or monitor Lead Mothers and CGPs. The inability to do so was identified as one of the challenges to sustainability. Besides resources provided by the national government to facilitate community mobilization for national campaigns, health structures below Head Nurses do not receive funding from the government, and it appears there are currently no plans for funding to flow down further to the CACs. As the CG model operates at the health zone level and there have been

challenges creating strong linkages at the provincial level, this may have a negative impact on the availability and flow of funds to the CG structure. Some CACs engage in economic activities (e.g., small-scale livestock) and invest in farmland to generate financial resources to support and sustain their economic activities. However, it is not clear how much of those funds are allocated toward the support of the CG model.

Overall, workshop participants agreed or strongly agreed that the DPS has the technical capacity (79%), technical resources (64%) and human resources (71%) necessary to support the CG model. FGD participants identified several opportunities for the DPS to continue to provide support to the CG model such as engaging the structure to employ national campaigns and requiring other donor-funded projects to leverage the structure for SBC activities. However, FGD participants as well as a few surveyed participants noted that challenges could emerge if additional trainings are limited or if field programming is irregularly supervised.

Additionally, 92% of workshop participants reported feeling motivated to continue support of the CG model. With almost 80% of Lead Mothers having served in their current role since 2018, many have expressed to Budikadidi staff that they intend to continue in their role post-project as they are confident that sharing their knowledge with new mothers is saving lives in their communities. Although they do not receive financial incentives,

Technical and Managerial Capacity to Sustain the CG Model



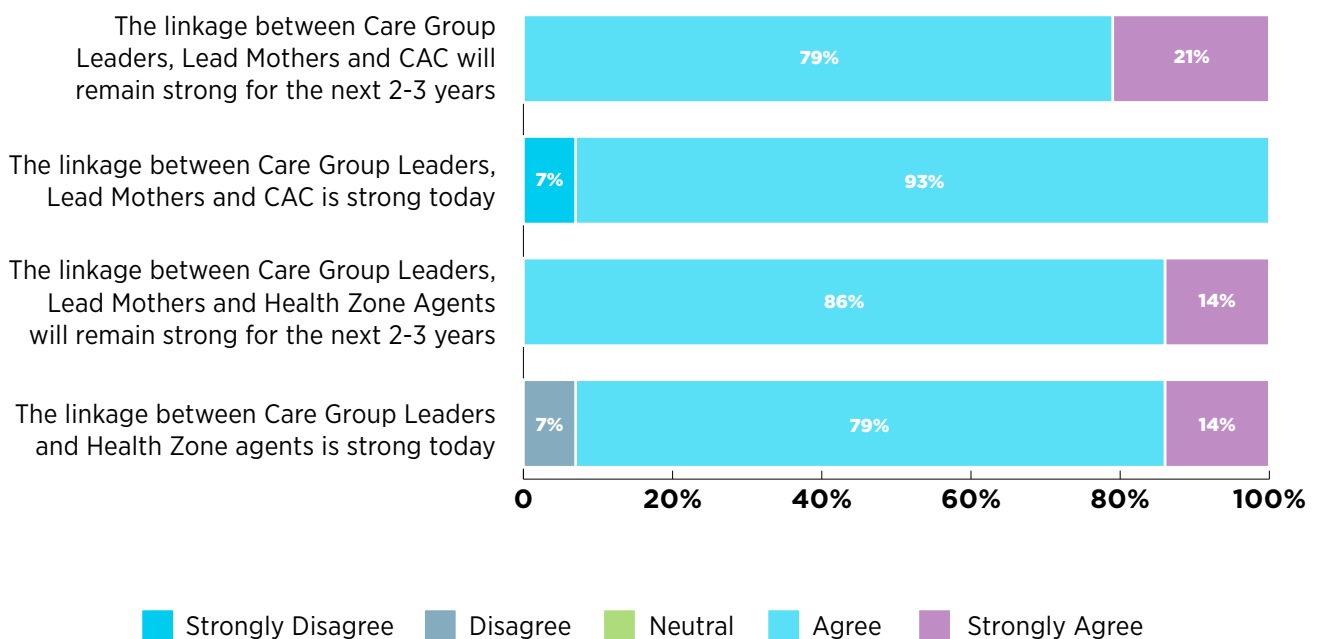
Lead Mothers and CGPs interviewed for a study on community volunteer motivation expressed being motivated by feeling effective in and appreciated for the work they do to serve their communities. They also find motivation in the recognition they receive as technical resources in their communities and the skills they gain from programmatic capacity-building. Additionally, they can connect with their communities through the networks and peer meetings they participate in. Those outside of the CG model, such as CAC members and Head Nurses, stated that their motivation to continue to provide support is due to the quality of the work of Lead Mothers and CGPs. Even though the government health system's regular engagement with the CG model is still very limited due to a lack of financial resources, the government does recognize the structure as a valuable resource (particularly as most Lead Mothers have prior experience as CHWs). Despite this high level of motivation, nearly 36% of the surveyed participants, particularly Lead Mothers and Head Nurses, acknowledged that a lack of monetary incentives would be the biggest challenge to sustainability.

Only 7% of survey participants expressed doubt when reflecting on the strength of current linkages (between care group actors and CACs or health zone agents). Nonetheless, all survey participants were positive when predicting linkage strength in the next two to three years, with 21% strongly agreeing that care group leaders, Lead Mothers and CACs will remain strongly linked, and 14% strongly

agreeing that care group leaders, Lead Mothers and Health Zone agents will remain strongly linked. While early efforts to promote the CG model and create linkages were challenged due to the changes made in the CAC structure and the subsequent fallout with government health structures, Budikadidi has made substantial progress in brokering strong links and integrating the CG model into government systems. Since the 2020 cost-extension, the Budikadidi health team has steadily engaged the health system in leading care group activities, including the identification of topics care groups should cover every month. For example, PRONANUT and the health zone leveraged Budikadidi training funds to train CGPs on malaria. This process contributed to strengthening key linkages while building the capacity of CGPs and Lead Mothers. The health zone has already organized several activities leveraging the CG model without the involvement of Budikadidi staff.

Ninety-three percent of surveyed participants agreed that the CG model is well integrated into the work of the health area; however, a few participants stated that a lack of collaboration between all stakeholders may negatively impact the effective integration of the CG model in the long-run. Indeed, this study revealed the complexity of the government health structure, and while there is an openness to integrate the CG model within it, doing so will require a strong commitment to coordination.

Perceptions of Key Linkages to Sustain the CG Model





As part of a cooking demonstration, a Lead Mother in the Monzo Village teaches other mothers from her village how to make fortified porridge using locally available and affordable ingredients while promoting best nutritional and health practices for pregnant and nursing women and their children.

Photo by Jennifer Lazuta for CRS

DISCUSSION

Findings suggest that Budikadidi will have achieved solid integration of the CG model into existing government health structures by project closure, pointing to the potential for sustainability at the health zone and national level. However, opportunities were missed for earlier mitigation of frustration with and confusion between existing and project-created health structures. Ultimately, sustainability of the CG model would have been strengthened through earlier integration into the health system. The following considerations may assist future project teams in executing early and sustained health system integration:

1. Create linkages through language alignment and participation in local leadership forums.

Projects can carefully adopt similar titles (e.g., CHW Mothers instead of Lead Mothers) to demonstrate layering within the government structure. Additionally, informal engagement of some Lead Mothers in the CAC was a missed opportunity to formalize links between this community-based structure and the health system. Like CHWs, Lead Mothers should be CAC members to bolster their recognition and ease the process of the DPS identifying them for leadership on other health initiatives.

2. Commit to regular collaboration with the government health system. While Budikadidi worked closely with several key actors within the health system, a lack of continuous and direct engagement with stakeholders at the provincial level did not allow Budikadidi to gain early recognition or develop a community of experts to champion the CG model at higher levels, which threatens sustainability. Although necessary structural changes were made to transform CACs, this created tension due to the loss of influence felt by key players in the health system. Early and more open lines of communication, collaboration and coordination with the DPS on the role they play and how this can trickle down to the health zone and Head Nurses may help mitigate these challenges by increasing provincial-level buy-in.

3. Foster clear coordination with donors and implementers. The quality of Budikadidi's engagement with and handover to government health systems could have been strengthened through coordination with other health actors in the zone (including USAID, the United Nations, and other NGOs) to focus investments at various levels within the system and promote greater layering across projects. In practice, this may include other projects leveraging the CG model to continuously build their capacity while also increasing their recognition through additional technical opportunities. During project design,

assessments should be conducted to evaluate the technical and managerial capacity of key actors. A specific health system stakeholder analysis would identify existing capacity development efforts of other donor-funded projects to develop early collaboration plans and leverage one another's investments.

4. Explore avenues for generating finances. NGOs must consistently emphasize that resources provided during the life of a project will no longer be available when the project ends, necessitating early and frequent brainstorming sessions with government health structures to anticipate and overcome this challenge. In the Budikadidi operating environment, CRS and partners can support CACs to generate finances to support their volunteers and community activities, including the CG model. For example, some CACs have received payment for serving as the main point of contact for international organizations implementing donor-funded projects, tasked with finding housing, security, food, and event locations, amongst others. Additionally, project leaders must consistently prioritize collaboration with higher-level health actors as well as donor-funded projects addressing public financial management to explore and advocate for ministerial/provincial budget support of proven community models such as the CG structure.

5. Work towards sustainability from project start-up: The lessons learned from this study reinforce the benefits of nurturing sound linkages amongst health system stakeholders well before the final year of the project to enable a gradual and successful handover from project staff to local structures. Together, project and government leaders can draft a potential handover process during project start-up and then commit to annual assessments of the resources, capacities, motivations and linkages influencing the prioritized health structure. These inputs will inform regular reflection on progress and challenges to date, as well as changes in the operating environment, to adapt plans and continuously build the foundation for sustainability.



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