Mid-Term Review of the Care Group Model Used in Five Pilot Districts in Zimbabwe

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Abstract: Stunting has remained the nutrition condition of public health concern affecting one in three children under the five years Zimbabwe. Causes of stunting are multiple and poor infant and young child feeding (IYCF) practices are among the top factors associated with stunting. IYCF indicators in Zimbabwe are not performing very well with 61% of children 0 to 5 months being exclusively breastfed, and only 7% of children 6 to 23 months receiving minimum acceptable diet (MAD). The care group approach been piloted in 5 districts to promote and influence behaviour change towards uptake of optimal IYCF practices. The paper assesses progress made in the implementation of the approach after six months of implementation. Results show that implementation of the care group approach, with appropriate coordination structures at community level, yields considerable improvement in health, IYCF, and water and sanitation hygiene (WASH) behaviours and practices. Community level initiatives like income generating activities, food production, and cooking demonstrations are proving to be the sustainability pillars for the care group approach. Conclusively, with proper leadership and coordination, care groups help to affect behaviour change in improving the health, nutrition and caring practices for children.

Key words: Care group, stunting, behavior, sustainability, IYCF.

1. Introduction

Chronic malnutrition, also known as stunting (defined as a height that is more than two standard deviations below the World Health Organization (WHO) child growth standards median) is one of the leading causes of infant and child mortality globally mainly affecting children in low- and middle-income countries [1-4]. Globally, approximately 156 million children are stunted, with the highest rates being in Sub-Saharan Africa and Asia [5-7]. Stunting rates in Africa have remained high at around 40% for more than a decade and the decline has been too small to achieve global targets for stunting reduction even though it is one of the best indicators of human capital development [5, 8-10]. Caused by inadequate nutrient

intake and frequent infections over a long period of time, stunting affects a child's physical growth, health, emotional development, brain development and cognitive ability [10]. The World Health Assembly identified stunting as one of the six global targets to be achieved by 2025. The prevalence of stunting in Zimbabwe is at 24% as compared to 26% in 2018 [11-14].

Appropriate infant and young child feeding practices are known to improve nutrition status of children [15]. In Zimbabwe, exclusive breastfeeding rate has improved remarkably from 41% in 2014 [16] to 61% in 2018 [12, 17]. MAD remains worrisome, with only 7% of our 6-23 months children receiving the acceptable diets, far below the national target of 50% [13]. Since the causes of stunting are multi-faceted, the approaches to addressing it should also be multi-sectoral [3, 4]. In this regard, it is increasingly

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recognized that community and household level actions are critical for stunting reduction [4, 15, 18]. To promote and influence behaviour change towards uptake of optimal health, infant and young child feeding (IYCF) practices, the care group approach is being piloted for one year in five rural districts of Zimbabwe which are Mwenezi, Chiredzi, Mutasa, Chipinge and Beitbridge. Four of the pilot districts (Mwenezi, Chiredzi, Chipinge and Mutasa) had existing food and nutrition security structures which were spearheading the Multisectoral Community Based Model (MCBM) for stunting reduction, providing an enabling environment for the introduction of the care group model [19]. Beitbridge district leveraged on efforts of the UK Soccer Aid funding which had partially supported the implementation the model.

After six months of project implementation, there is need to look back and see how it is performing in reaching out to pregnant and lactating mothers and children 0 to 24 months. The main purpose of the review is to assess progress in implementation of the care group approach being piloted in Zimbabwe and document key lessons learnt to inform future programming. The paper describes the care group approach methodology being piloted in Zimbabwe, the process and the findings of the mid-term review; the successes, challenges, and key lessons from implementation as well as recommendations for scale up of the care group approach to more districts in the country.

2. Methods

2.1 *The Care Group Model Being Implemented in Zimbabwe*

A care group is a group of 10-15 volunteers, community-based health educators who regularly meet together with project staff for training and supervision [20]. The care group model is an innovative community-based strategy for improving nutrition, maternal, neonatal, and child health in resource-constrained setting [21, 22]. Generally, care

groups increase coverage and behaviour change by creating a large network of volunteer women [23]. The care group model is cost-effective as it has a multiplier effect reaching to an increased number of the target population (pregnant and lactating women and children under 5 years) with monthly behaviour change messages on IYCF, water, sanitation and hygiene (WASH), social protection, antenatal care and gender. This is achieved through the capacitation of identified lead mothers who in turn reach out to neighbour women within their proximity. This provides a convergence platform where both nutrition specific and sensitive interventions can be delivered to the community and the model reporting system falls within the existing government framework for easy coordination and sustainability.

The program utilized the care group model in which volunteer mothers (lead mothers) were trained in key health and nutrition topics. The care groups are made up of about 10 volunteers (care group leaders—lead mothers) who report to the health promoter (Village Health Worker). Each lead mother has 8-12 households (neighbour women) with either a pregnant woman or a mother/caregiver of a child less than 24 months of age. All the lead mothers live within reasonable walking distance of the neighbour women meeting place and their assigned households. The primary target group is pregnant and lactating women as well as caregivers of children below the age of two years. The targeting process was influenced by the first 1,000 days of life being the window of opportunity from conception until a child's second birthday, during which the effects of malnutrition can be reversed.

As guided by the barrier analysis conducted by Nutrition Action Zimbabwe, influencing groups (male advocates and elderly women) were incorporated to address the existing gender and cultural issues affecting adoption of health and nutrition behaviours. The elderly women have groups of neighbour elderly women (mothers-in-law and grandmothers) and the male advocates target all men in the community

(men's fora). These elderly women and male advocates conduct monthly meetings and household visits where they have gender dialogues focusing on issues affecting the adoption of health and nutrition behaviours being promoted by lead mothers within their communities.

The established Ward Food and Nutrition Security Committee (WFNSC) plays a supervisory role at ward level. The committee is constituted by different government extension workers including the Agriculture Extension Worker (AEW) who provides technical support to the groups on nutrition sensitive agriculture, the nurse who supports the groups on nutrition specific activities, the Environmental Health Technician (EHT) who supports with Water and Sanitation Hygiene (WASH) activities and the Gender officer helps the community on gender issues. The District Food and Nutrition Security Committee (DFNSC) plays the supervisory role in the WFNSC with the District Nutritionist being the secretariat (Fig. 1).

2.2 Implementation Tools

Counselling cards and story books are used during monthly meetings and home visits to facilitate

delivery of behaviour change sessions. These two books use pictures and stories to help the neighbour women to easily conceptualize and influence behaviour change towards optimum nutrition outcomes. Lead mothers, male advocates and elderly women are guided by programme implementation manuals and monthly meeting guides during their meetings. After the meetings they use their specific reporting tools to compile monthly reports that will be submitted to the village health worker who will consolidate the reports for onward transmission to the health facility and to the district.

2.3 Key Behaviours Being Promoted

Table 1 below highlights the key behaviours that are being discussed and promoted.

2.4 Monitoring and Evaluation

At household level monitoring is done by the lead mother during monthly household visit. The lead mother visits households to monitor and support the families as they implement behaviours discussed during the group meetings. The findings and progress

Fig. 1 The care group model structure being implemented in Zimbabwe.

Table 1 Promoted behaviours under the care group approach.

Theme	Key behaviours being promoted
WASH, Health and Nutrition behaviours	<ul style="list-style-type: none"> • Wash hands at the five critical times • Draw water from a safe protected water source • Improve women's health and nutrition during pregnancy and lactation through antenatal and postnatal care • Feed your baby food from at least 4 food groups per day (Four-Star Diet) • Meal frequency • Exclusively breastfeed your baby for the first 6 months
	<ul style="list-style-type: none"> • Respect, non-violence and open communication in relationships (GBV) • Household Decision making • Division of labour and workload sharing • Fatherhood and caregiving • Access and control of income and productive resources • Intra-household negotiation and decision making/gender socialization
Gender mainstreaming	

are recorded in the household handbook that is kept at household level each time the lead mother visits the household.

The health promoter is responsible for monitoring and evaluation at community level. Monitoring and evaluation tools that are used for this purpose are the quality improvement and verification forms which are completed when the promoter conducts the meetings. Quarterly meetings are conducted with all the lead mothers and VHWs at ward level led by the ward food and nutrition security committees.

The design of the programme is such that there is baseline, midterm and end line evaluation. Baseline assessment was done at the beginning of the programme and the mid-term assessment was done after six months.

3. Results

Below are key observations that were noted during the mid-term review exercise.

3.1 Capacity Building on the Care Group Approach

The main emphasis of the care group approach was to capacitate targeted communities with appropriate health, IYCF, WASH and gender practices for the attainment of optimum health and nutrition. Trainings were done to lead mothers, village health workers, elderly women, and male advocates (Picture 1). A total of 1,354 (89%) out of the targeted 1,530 lead mothers have been trained on the care group model while 594 (70%) village health workers out of the targeted 855

were trained (Table 2). A mop up training exercise is already underway for the remaining targeted lead mothers and village health workers.

The barrier analysis conducted at the inception of the project identified elderly women and male partners as key barriers to the adoption of the promoted behavior. To further enhance the impact of the project, elderly women and male advocates have been intentionally targeted and are being capacitated with basic IYCF and gender knowledge. Their role is to champion and advocate for the adoption of the recommended behaviours through peer to peer support, dialogue counseling (Picture 2), public addresses and home visits. To date, more than 90% of the targeted male advocates and elderly women were trained (Table 3).

3.2 Adoption of Critical Water and Sanitation and Hygiene Behaviours

Hygiene promotion is an integral component for enhancing attainment of nutrition indicators. Care groups are also promoting construction of tippy tapes for hand washing, rubbish pits for disposal of waste material, construction of toilets for human excreta disposal and construction of double staged pot racks for household hygiene. Table 4 below summarizes the key achievements to date.

3.3 Coordination

The deliberate targeting of village heads as key agents in reaching out to communities and disseminating

Table 2 Training of lead mothers and VHW on the care group approach.

District	Lead mothers			Village health workers		
	Target	Trained to date	% Achieved	Target	Trained to date	% Achieved
Chipinge	343	359	105	191	148	78
Chiredzi	342	322	94	191	120	63
Mutasa	274	104	38	153	34	22
Mwenezi	343	322	94	191	185	97
Beitbridge	228	247	108	129	107	83
Total	1,530	1,354	89	855	594	70

Picture 1 Lead mothers and VHW trained on care groups in Chiredzi.**Table 3 Number of male advocates and elderly women trained on the care group approach.**

	Male advocates			Elderly women		
	Target	Trained	% Reach	Target	Trained	% Reach
Chipinge	54	47	98	54	50	104
Chiredzi	54	52	96	54	52	96
Mutasa	36	41	114	36	57	158
Mwenezi	66	54	77	66	30	107
Beitbridge	60	53	88	60	57	95
Total	270	247	92	270	246	91

Table 4 Adoption of WASH behaviours.

Indicator	Project target	Chipinge	Chiredzi	Mutasa	Mwenezi	Beitbridge	Cum. total March-Aug.	% Reach
Number of households with new tippy taps	6,994	433	1,036	490	1,114	297	3,370	48
Number of households with new pot racks	6,354	610	780	494	612	55	2,551	40
Number of households with new rubbish pits	6,354	485	47	477	345	121	1,475	23
Number of new toilets constructed	6,994	186	0	331	70	13	600	9

Picture 2 Care group meeting in session using the dialogue counseling process.

the promoted behaviours within the care group approach to pregnant, lactating mothers and care givers of children 0-24 months was observed in visited communities. The village heads provide support mechanisms to mobilize villagers to attend to meetings, enforce the adoption of the behaviours as gatekeepers of societal norms. Village heads are supporting the mobilization of women of child bearing age to belong to a care group as a way of enhancing participation by everyone. The use of food and nutrition security

committees at provincial, district and ward levels was observed as an important coordination structure within the care group approach. In communities where the committees were active, implementation and coordination was observed to be working well. Project participants, lead mothers and village health workers managed to elaborate the role of each of the sector members within the food and nutrition security committees and they were able to articulate how they benefitted from each of the sector members.

“...*Panotaramudhumenipekuisambeu, ndinomuvhunzakuti line rangu re ma carrots nema cabbage ririkupi*” remarked one of the VHWs during the field support visit. This can be translated as, “When the agriculture extension officer helps farmers prepare vegetable beds I ask for inclusion of carrots and cabbages as well”.

3.4 Visible Change in Promoted Behaviours

Promoted behaviours are being put into practice as was evidenced by the construction of new WASH enabling facilities. This includes tippy tapes, rubbish pits and double staged pot racks. A new version of the

tippy tapes (*Musagovana* meaning does not share excreta) is now being promoted in ward 7 in Mwenezi district (Picture 3). This is stronger and more sustainable as it involves a metal tin and uses locally available resources.

The testimonies and messages presented through interviews showed a shift in practice towards the appropriate behaviours being promoted through the care group approach. This covered a wide range of practices which include breast feeding, meal variety, meal frequency, hygiene and sanitation. A good example was a testimony given by one of the village health workers in Chiredzi Ward 22 where she admitted

Picture 3 Improved version of the tippy tape in Ward 7 Mwenezi.

that she was involved in traditional treatment of sunken fontanels and getting payment in form of chicken... *“ndaitombokweshawonhowandichidiahukudzevanhu ...”*. Both the local leadership and stakeholders working in the targeted areas visited agreed that there was a reduction of open defecation in programme areas as more households are constructing toilets as a result of support through the care groups.

It was observed that the care group approach facilitates the production of certain crops which were ordinarily perceived to be for certain people e.g. Karanga tribes in the neighboring districts in terms of their cultures. Knowledge gained through the healthy harvest module has promoted the growing of a variety of crops such as peas, ground and round nuts, sorghum, millet. This was further enhanced through the training of care groups on food preservation and storage of different crops such as dried okra, leafy vegetables and fruits, which has also helped to improve on food variety for the pregnant and lactating mothers. Trainings on seed banks through seed selection and storage have helped in self-sustenance in light of the increased costs of agricultural inputs. This has worked together to improve household food access. It was also noted that there was an improved health seeking behaviour where care group mothers are now demanding for services at health facilities. Such services relate to child immunization, early ANC booking and HIV counseling and testing services.

3.5 Sustainability

Discussions with stakeholders and care group clients during the field visit showed that the sustainability of care groups is much based on the additional components being incorporated during the care groups. These include growth monitoring, cooking competitions, income generating activities to mention some. This has even resulted in the increased participation of males due to the perceived economic value being attached to the care group activities. Community centered income generation projects using

locally available resources have been prioritized with support from the local leadership. Each care group has unique sustainability initiatives helping to keep the group together. Examples of such initiatives include income generating activities like baking of buns in Mwenezi Ward 8, internal savings and lending (ISALs) which are helping in cement procurement for toilet construction in ward 4 in Mwenezi; bushveld chicken and goat project in Ward 22 of Chiredzi.

The identified pillars of strength in the care groups include:

- Peer to peer education—information sharing through peer to peer is more effective in influencing change of behaviour.
- Existing government structures such as traditional leaders and FNSCs on the ground in the implementation of the care group model.
- Use of locally available resources which are cost effective.
- Replicable of the initiatives—youths also taking similar activities on board through formation of a man's group which is now involved in goat and fish production.
- Inclusion of other households who are not necessarily within the target group paving way for quick and sustainable adoption of promoted behaviours.
- Varied topic covered during the sessions thus making them continue coming anticipating for more and diverse lessons.

3.6 Gender Mainstreaming

The inclusion of a gender component in the care group approach where male partners and elderly women are equally targeted as agents of change among their peers through community dialogues has provided a good opportunity to ensure that barriers identified during the barrier analysis are addressed. The active participation of male counterparts during the care group activities has given new perspectives where women can freely move to and participate in care

groups. Males are also encouraging their partners to attend care group meetings and follow up with their partners on issues discussed during the care group meeting. As a result of this, lead mothers in Chiredzi Ward 4 testified that there was an improvement in attendance of women who were previously not allowed by their husbands to attend care group meetings. This direct involvement of men and their appreciation of the recommended behaviours provided an enabling environment for women to practice the promoted behaviour.

4. Discussion

Care groups were established from the beginning of 2019 to promote behavior change towards recommended nutrition and health practices. At the time of evaluation 70% of village health workers and 89% of targeted lead mothers had received training of care group model. With plans in place to complete the remaining village health workers and lead mothers, the project was already yielding huge results. Trainings were proved to be effective as evidenced by quality presentations by neighbor women who articulated all behaviours shared to them by lead mothers during their sessions. Results also show that many care group clients had adopted the new behaviors being promoted and this was evidenced by construction of sanitation and hygiene enabling facilities, redesigning of a new and more durable tippy tap, rubbish pits and pot racks at their households. By the month of August 2019, 3,370 tip taps, 2,551 pot racks, 1,475 and 600 toilets had been constructed at care group clients' households. This was achieved within a short space of time. Serano et al. [24] indicated that care groups can lead to rapid behavior change particularly in emergency settings. Testimonies provided clearly indicated a shift in practice towards the adoption of new behaviors promoted through the care group model and they covered behaviours such as exclusive breastfeeding, meal variety, meal frequency, hygiene and sanitation.

According to Perry et al. [20], similar care group

projects in Cambodia, Mozambique, Malawi, Kenya and Rwanda have resulted in huge decline in mortality for children below 5 years and also improved outcomes for key maternal, infant and young child health indicators. The care group approach showed a ripple effect especially in Chiredzi district where several livelihood projects such as fisheries and piggery were initiated discussed during care groups are being driven by men in full support of the motive for household optimal nutrition status. This formative led to a hybrid care group that also targeted elderly women and male advocates to advocate and champion the adoption of recommended behaviors through peer to peer support, home visits and public addresses. A similar project implemented by World Vision in Manicaland and Masvingo provinces in Zimbabwe also identified that most barriers that affect optimal IYCF are gender related and noted the involvement of men as a key component of care groups.

Results of this assessment showed that income generating activities were a key sustainability component. The activities allowed for empowerment of women to own resources and be independent in light of food provision for their children. This is in line with previous studies such as qualitative assessments carried out as part of mid-term or final evaluations of many care group projects which documented the empowering nature of care group volunteers, the participating mothers and the community [20]. Integration of the care groups with other existing health and nutrition groups e.g. health clubs allowed for the community to have these meetings but benefit from more interventions.

The practical based training approach used in the care group meetings, capacitated neighbour women with the ability to further cascade the knowledge to other mothers thus creating a multiplier effect and ensuring sustainability of knowledge dissemination systems in the community. Field observations revealed that neighbour women were now in a position to articulate the nutrition education to different audiences

spreading the knowledge even in the absence of the lead mother. Care groups are also offering cooking demonstrations which will manifest into competitions with winners receiving varied prizes to help them support or initiate new income generating activities meant to enhance food and nutrition security for targeted pregnant, lactating mothers and care givers of children less than 2 years. The cooking demonstration allowed for the mothers to conceptualize new skills in preparation of nutritious food especially focusing on locally available foods. Motivation can also be a pillar of sustainability in the model—the constant support by the partner officers and government stakeholders on the ground has been encouraging the groups to be meeting more often. According to Serano et al. [24], care group volunteers later on become reference point for the communities even after the project has ended.

The improvement of health seeking behaviours as evidenced by mothers' demanding for services at health facilities positions the care group model as a sure way to improve specific health and nutrition indicators that the health system has been struggling to improve. The care group model can be utilized for other health interventions in TB treatment, HIV programming and addressing gender issues in the communities. By providing a platform where mothers can learn from other mothers in the same communities and circumstances as them, the model allows for increased adoption of behaviours. African communities have long positioned men as key decision makers in the home. The involvement of men and elderly women in the activities by establishment of male advocates groups and elderly women dialogues, created a gateway to incorporate men and elderly women into health and nutrition programming allowing them to be patrons of adoption of recommended health and nutrition behaviours. With the men in front, mothers are now more open to participate and receive the much-needed support at household level to adopt the behaviours. Elderly women have power and authority especially on decisions pertaining to feeding of the

young children if the daughter-in-law stays together with the mother-in-law.

4.1 Key Recommendations

Effective utilization of locally available resources can enhance the realization of promoted behaviours. Recommendation: pregnant, lactating mothers and care givers of children under 2 years should be sensitized on indigenous and locally available foods to enhance their food and nutrition status. Recipes formulated during cooking demonstrations are documented for future referencing.

Programme communication should clearly show the complementary role being done by partners on the ground for sustainability.

There is need for continued capacitation of governance structures through provision of monitoring and support visit resources. Recommendation: this can be made possible through development/reviewing to tools that are user friendly and periodic provision of resources such as vehicles and fuel for facilitate the monitoring process.

The current community targeting system in the country which is based on observable gaps has resulted in rewarding of "lazy" poor performing communities while those taking initiative are not being rewarded. Recommendation: it is important for implementing partners to take note to local solutions by targeted pregnant and lactating mothers to address their context specific drivers of stunting and directly support them. This can take the form of subsidizing cement procurement for households which have already mobilized bricks and dug pits for toilet construction, provision of fencing material and tools to already functional nutrition gardens etc. This will motivate other groups to start their projects as well.

There is need for all health and nutrition behaviour change agents (village health workers, male advocates, elderly women, lead mothers) that should be trained together to facilitate in-depth discussions on cross sectional issues affecting the communities.

Recommendation: implementing partners should promote an integrated and holistic way of rationalizing implementation strategy to ensure that similar messages are cascaded by the behaviour change agents.

The limited resources reduced the ward level cadres' capacity to monitor and mentor care group activities as well as conduct periodic reviews of the intervention. Recommendation: ward level cadres would need to ride on existing partner support and resources to allow them to carry out monitoring activities and periodic reviews. Resources allowing there can also be capacitation of governance structures through provision of monitoring and support visit resources.

Utilization of the devolution systems can empower the local leadership to be pushing the agenda for nutrition. By encouraging the care groups to start their own project, when the donor funded projects come those who would have already initiated their projects would be supported, to further motivate others to start projects as well.

Coordination was a challenge in wards that did not have health facilities. Recommendation: the nutrition governance structures (WFNSC) would have to take an active role in ensuring smooth reporting is conducted. There would also be a need for the VHWs to coordinate with the nearby HF to ensure that the statistics are included in the normal health reporting system.

In Mwenezi the group that was observed to have started a bun production project was a real solution to the bread challenges that are currently being experienced in the communities. Recommendation: with increased market linkages and business management and expansion training community initiatives, such as these, have the potential to develop into viable livelihood opportunities for the communities. Capacity building in production training for the implementation of high value projects like piggery, poultry and goat production can also ensure sustainable IGAs in the communities. Crafting and registration of constitutions will also help to guide the operation of the groups in their IGAs.

4.2 Key Lessons

One of the key weaknesses of the care group model has been its dependence on NGOs to develop and facilitate activities. Once the NGO support is withdrawn, the projects are not usually taken up by the governance health systems [20]. However, this specific model utilized existing government structures for training and supervision of the care group activities. The facilitators for the training were government line ministries and departments to allow for sustainability and mentorship.

All health and nutrition behaviour change agents should be trained together to facilitate in-depth discussions on cross-sectional issues affecting the communities.

By training the VHWs and lead mothers in the same seating, it allowed for the retaining of the traditional reporting structure where the VHW would be the supervisor and the lead mother would now be reporting to the VHW.

The program learnt that the involvement of the community leaders allowed for sustainability of the intervention as they would spear head the wider adoption of behaviours, smoothen women's participation in the activities, and engagement of other community groups e.g. men and elderly women.

Involvement of males and elderly women in the care group activities allowed for wider adoption of behaviours and reduced resistance of interventions at household level. Increase of articulation of nutrition issues by men partnered with gender sensitive programming allowed for more effective behaviour change approach.

The approach proved to be a low-cost model to promote health and nutrition activities. Mostly knowledge was disseminated, and the communities then pushed the agenda on their own.

Communities took motivation from the constant support visits from partner officers and government stakeholders which allowed for the groups to convene their activities more often. Visibility materials also

encouraged the lead mothers and VHWs as it distinguished from others in the community as cadres proficient in health and nutrition issues.

5. Conclusion

In low resource settings, care group approach can still be one of the best approaches to promote behaviour change among communities. Within a short space of time after implementation, some remarkable results were already reported in communities that are implementing the care groups. Implementation of the care group approach, with appropriate leadership, monitoring and coordination structures at community level, yields considerable improvement in health, IYCF, and water and sanitation hygiene (WASH) behaviours and practices. Community level initiatives like income generating activities, food production, and cooking demonstrations are proving to be the sustainability pillars for the care group approach. The use of existing government structures and local leadership at community level is key to the success of implementation of the care group approach. The challenges that are faced during implementation are best addressed by the communities themselves using home grown solutions. Communities are still hooked up in gender role dynamics and involvement of both men and women in care groups helps to overcome.

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Conflict of Interests

The authors declare no potential conflicts of interest

with respect to the research, authorship, and/or publication of this article. They further declare that the opinions expressed in this paper are those of the authors and do not necessarily reflect the views of UNICEF.

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