



**Case Study on Adolescent  
Inclusion in the Care Group  
Approach- the Nigeria  
Experience**

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The Case Study on Adolescent Inclusion in the Care Group Approach- the Nigeria Experience was made possible by a grant from the USAID Technical and Operational Performance Support (TOPS) Program. The TOPS Micro Grants Program is made possible by the generous support and contribution of the American people through the United States Agency for International Development (USAID). The contents of the materials produced under this grant do not necessarily reflect the views of TOPS, USAID or the United States Government.

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**Acknowledgements:**

International Medical Corps would like to recognize the invaluable time and input from the following Headquarters and Field staff:

Caroline Abla  
Director, Nutrition and Food Security

Iris Bollemeijer  
Nutrition Advisor, Nutrition & Food Security

Amelia Reese- Masterson  
Research Advisor, Nutrition and Food Security

Nura Shehu  
Monitoring and Evaluation Officer, International Medical Corps Nigeria

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Nutrition Coordinator, International Medical Corps Nigeria

The authors would also like to especially extend our thanks and appreciation to the communities in Kebbe LGA, the community leaders, Care group Promoters and Lead Mothers, adolescent girls, and husbands of adolescent girls for their willingness to be interviewed, and sharing their opinions and suggestions with us.

The Case Study on Adolescent Inclusion in the Care Group Approach- the Nigeria Experience is made possible with support from the American people, delivered through the U.S. Agency for International Development (USAID).

Photographs: all photos taken by Shiromi M. Perera



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## **ABBREVIATIONS AND ACRONYMS**

ANC	Antenatal Care
ECHO	European Commission's Humanitarian aid and Civil Protection department
FGD	Focus Group Discussion
KII	Key Informant Interview
MDG	Millennium Development Goals
PNC	Postnatal Care
SDG	Sustainable Development Goals
TOPS	Technical and Operational Performance Support (as in The TOPS Program)
USAID	U.S. Agency for International Development
WASH	Water, Sanitation and Hygiene

## ABSTRACT

As organizations begin to move beyond the Millennium Development Goals (MDGs) and begin focusing their attention on achieving the Sustainable Development Goals (SDGs), many in the global health community have realized that in order to better achieve such goals adolescents need to be a more significant part of the efforts. The Care Group approach can be an entry point for appropriately targeting adolescents to achieve improved maternal and child health and nutrition. Early marriage, and in turn early childbearing, is a significant issue in Nigeria. Early childbearing, as well as rapid repeat pregnancies, when a girl's body is still in the process of maturing, can lead to negative health outcomes for both mother and child, which can be further exacerbated by poor nutrition and hygiene throughout the lifecycle. International Medical Corps is working to address malnutrition in Nigeria through a Care Group approach in the North West state of Sokoto since 2014. In Kebbe, adolescent girls were included as a pilot with the specific aim to promote optimal birth and health outcomes. A qualitative assessment, specifically Key Informant Interviews (KII) and Focus Group Discussions (FGD), was conducted with key stakeholders in order to describe the experience of adolescent girl inclusion in Care Groups and highlight barriers, facilitators, and lessons learned. According to participants, the Care Group Program contributed to increased knowledge and improved practices among adolescent girls in a) preventing malnutrition by maintaining a healthy nutritional status for themselves and their families, b) preventing illness in their households, and c) seeking health services and facilities when necessary. The most notable development that Key Informants pointed to was the change in behaviors exemplified by increasing acceptability among husbands and the community towards including married adolescent girls in weekly Care Group activities. Adolescent mothers who were once isolated from social activities and interaction with peers are now encouraged to attend the program, not miss any sessions and pay close attention to lessons. While this indicates the possibility of change in social and cultural norms, further research is required to confirm such a shift. Recommendations are provided on how to overcome barriers for including adolescents and strengthen program quality to include adolescent girls in Care Groups and meet their unique needs.

## INTRODUCTION

Nigeria is a nation of young people, with almost one-third of its 158 million population existing between the ages of 10- 24 years. Early marriage, and in turn early childbearing, is a significant issue and is usually related to religion, geography, education and economic factors. The majority of girls in rural areas are more likely to be married before the age of sixteen years if they are Muslim and live in Northern Nigeria. According to the 2013 DHS, nearly half

of Nigerian women were married by the age of 18 years and on average will give birth to about 5.5 children in their lifetime. Twenty-three percent of girls 15-19 years of age had given birth or were pregnant with their first child, with the median age of first birth being 20 years. Adolescent fertility in rural areas is double that of urban areas. Additionally, young mothers (15-19 years) are more likely to have shorter birth intervals than their older counterparts.<sup>1</sup>

Early childbearing, as well as rapid repeat pregnancies, when a girl's body is still in the process of maturing, can lead to negative health outcomes for both mother and child, such as increased risk of obstructed labor, preterm deliveries, stillbirths, low birth weight, and maternal and neonatal mortality.<sup>2</sup> Adolescents are already a nutritionally vulnerable group due to their high energy and nutritional requirements for development, and pregnancy further increases this demand. While very little information exists on the nutritional status of Nigerian adolescents, data on adolescent mothers (15-19 years) indicates that 23% are considered thin, 6% overweight or obese and 5% stunted (low height-for-age).<sup>1</sup> Undernutrition can delay growth and maturation, which further increases the risks associated with adolescent pregnancy.<sup>2,3,4</sup> Malnutrition has the potential to span generations, where undernourished girls give birth to low-birthweight babies, the consequences of which extend into adulthood and therefore create an intergenerational cycle of malnutrition.<sup>5</sup>



1 Nigeria 2013 DHS Final Report

2 WHO (2005). Nutrition in adolescence- Issues and Challenges for the Health Sector. Issues in Adolescent Health and Development.

3 Bhutta ZA et al. 2013. Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? *Lancet* 382:452-77.

4 Black RE et al. 2013. Maternal and child undernutrition and overweight in low-income and middle-income countries. *Lancet* 382:427-51.

5 UN and IPRI (2000). 4<sup>th</sup> Report on the World Nutrition Situation: Nutrition Throughout the Life Cycle.

To break this intergenerational cycle of malnutrition it is therefore critical to not only improve the nutritional status of malnourished adolescent girls prior to and during pregnancy, but also their children. Optimal breastfeeding practices play an important role and can have an impact on children's mental and physical development. While breastfeeding is nearly universal in Nigeria, only 17% of children under 6 months are exclusively breastfed and only 64% above 6 months received complementary feeding. Nonexclusive breastfeeding (with solid food, water and other liquids) during the first 6 months of life and the lack of appropriate complementary food after 6 months of age can increase the risk of illnesses and even mortality in infants. Children's nutritional status has changed minimally over the last decade in Nigeria. The data indicates that almost 29% of Nigerian children are considered underweight. Stunting, which is found in 37% of children under 5 years, is more common in rural areas (43%) compared to urban areas (26%), and most prevalent in the North West zone (55%). Wasting (low weight-for-height) is less common (18%) and is most prevalent in the North West (27%). In the North West State of Sokoto the prevalence of stunting is as high as 52%, while wasting is 19%.<sup>1</sup>

Reduced access to health services during pregnancy and delivery can further increase risks of morbidity and mortality. According to the 2013 DHS, access rates were the lowest in rural areas, the Northern Region and more specifically the state of Sokoto. While 61% of mothers reported consulting a skilled health provider for antenatal care (ANC) at least once during their pregnancy, 46% of mothers younger than 20 years reported not receiving ANC. Women in Sokoto were the least likely to receive ANC from a skilled provider (17%). These low access rates are also reflected in the percentage of deliveries taking place in health facilities. Overall, 36% of births were delivered in a health facility, this was the lowest in Sokoto where only 5% of births were delivered in a health facility. Additionally, women less than 20 years of age were found to be more likely to deliver at home (74%).<sup>1</sup>

International Medical Corps is working to address malnutrition in Nigeria through a Care Group approach in four Local Government Areas (LGAs) in the North West state of Sokoto since 2014. A Care Group, which is a group of 10-15 trained volunteer community-based health educators, creates a multiplying effect to equitably reach every beneficiary household through interpersonal behavior change communication. These groups also provide the structure for a community health information system which can report new pregnancies, births and deaths detected during house visits. The Care Group approach aims to improve nutrition, health, WASH and IYCF practices among mothers and their children under 5 years, contributing to improved nutrition outcomes.<sup>6</sup> In Kebbe LGA, Phase II of the ECHO funded program focused on addressing gaps in women's nutrition, however due to funding cuts the program was implemented for 3 months instead of the full

6 months. The Program established a Care Group Program with 60 Care Group Lead Mothers supporting 900 mothers in 5 health facility catchment areas. Adolescent girls were included in Care Groups as a pilot with the specific aim to promote optimal birth and health outcomes. This represents one of the first times adolescent girls have been actively included in an International Medical Corps Care Group model.

The overall objective of the Case Study was to describe the experience of adolescent girl inclusion in Care Groups, highlighting key learning points (barriers, boosters, and best practices) both for International Medical Corps staff who plan to include adolescents in Care Groups, and for the wider food security/nutrition community in order to more effectively tailor programs to include adolescent girls and meet their unique needs.

The **specific aims** of the Case Study were:

1. Identify rationale and approaches for including adolescents in Care Groups
2. Describe Care Group participants' (including adolescent girls') experiences with and perspective on adolescent inclusion in Care Groups within the Nigeria context
3. Highlight and explain barriers to adolescent girl participation and learning through Care Groups (including how these were overcome)
4. Highlight and explain facilitating factors ("boosters") to adolescent girl participation and learning through Care Groups
5. Summarize best approaches to including adolescents in Care Groups
6. Summarize any clear outputs and outcomes from the program, focusing on the potential of the Care Group model for addressing nutritional needs of adolescent girls and their children (including prevention of low birth weight).

## METHODOLOGY

An assessment team comprised of 5 local interviewers utilized qualitative methods, specifically 40 Key Informant Interviews (KII) and 7 Focus Group Discussions (FGD), with key stakeholders in order to collect information to achieve the aforementioned objectives. Four villages in the Kebbe LGA were chosen for the case study, these were located in the Ungushi, Girkao, Unbutu and Margai Wards. These villages within these 4 Wards were chosen since they were observed to have had the most adolescent girls involved in Care Groups. Adolescent girls were selected through purposive sampling by Kebbe Care Group Promoter Supervisors. KIIs were chosen to be conducted with adolescent girls over FGDs due to sensitivities surrounding adolescent girl participation, as well as beneficiary preference of holding interviews at home. Additionally, all interviews with adolescent girls were conducted by female interviewers. A total of 25 girls were interviewed. Four International Medical Corps program

<sup>6</sup> Care Groups Info, from <http://caregroups.info/>

staff that had been involved with the Care Group program were also interviewed, these included the Nutrition Country Coordinator, M&E Officer, and 2 Care Group Promoter Supervisors.

Tool development was done in accordance with standardized guidance on qualitative research tools.<sup>7</sup> Prior to data collection, all staff involved with facilitating and recording FGDs and KIIs underwent a 3-day training on FGD and KII methodology, including facilitation techniques, note-taking methods, consent acquisition, and ethics of conducting interviews with adolescents. Prior to KIIs and FGDs, verbal consent was acquired from all participants. Study data was translated and transcribed, following which the qualitative data analysis software MAXQDA11 was used to code and analyze all data for themes, subthemes, and quotations of relevance.



Also, the other 3 LGA's where International Medical Corps implements the program are a mix of rural and urban areas where the challenges tend to vary. Kebbe is located 60kms from the Sokoto state Capital and is the 11<sup>th</sup> highly populated LGA in the state, with a total population of 162,650. The livelihood profile of the LGA is 15% agrarian and 80% pastoralist. The usual crops for farming are millet, sorghum

and beans, with harvesting during the major rainy season. The population experiences a hunger season from the months of June to August. The remoteness of Kebbe's villages pose a challenge because of the lack of development, such as lack of electricity, transportation issues due to no access roads and therefore difficulty in accessing a health facility, and socio-cultural issues. The LGA has 53 health staff that cover the hospital, 2 PHC/BHC, 19 dispensaries and 14 private rural drug vendor/ pharmacies. The Community Leaders were

able to only provide a rough estimate of the number of adolescent girls present in their villages: approximately 125 adolescent girls in Ungushi village, 165 in Unbutu village and 176 in Margai village. Promoters and Lead Mothers indicated that many of the girls were married by the age of 19 years, gave birth to about 6-7 children in their lifetime and did not practice healthy spacing between each child.

**Table 1. Approach and Sample**

Assessment Type	Groups/ Key Informants	Number per Ward Location (n= # of participants)			
		Ungushi	Girkau	Unbutu	Margai
Focus Group Discussions	Care Group Lead Mothers	1 (n=7)	1 (n=6)	1 (n=8)	1 (n=11)
	Husbands of adolescent girls who participated in the Care Groups	1 (n=9)	1 (n=11)	1 (n=7)	
Key Informant Interviews	Adolescent Girls	10	5	5	5
	Care Group Lead Mothers	1	1	1	1
	Care Group Promoters	1	1	1	1
	Community Leaders	1		1	1

In addition, during KIIs, Adolescent Key Informants were tested on 18 Knowledge, Attitude and Practice (KAP) questions in order to measure how much they had learned and retained from their Care Group Sessions. Topics covered by questions included nutrition (ex: exclusive breastfeeding and complementary and mixed feeding), hygiene (ex: hand washing practices), and health of children (ex: when to seek health services when child is ill).

## Kebbe LGA Background

Kebbe LGA was chosen for this qualitative assessment due to challenges faced as a result of the remoteness of the villages where the Care Group program was being implemented, as well as for the specific interests of Promoters and program staff in targeting adolescents.

**Table 2. Ward Demographics**

Ward Name	Total Population	Population of pregnant Women	Population of Women with child bearing age	Population of Under five years
Ungushi	12,768	638	2,809	2,554
Umbutu	25,663	1,283	5,646	5,133
Girkau	16,390	820	3,606	3,278
Margai	28,324	1,416	6,231	5,665
<b>Kebbe LGA</b>	<b>162,650</b>	<b>8,133</b>	<b>35,783</b>	<b>32,530</b>

<sup>7</sup> Family Health International (2005). Qualitative Methods: A Data Collector's Field Guide.

## ASSESSMENT LIMITATIONS

- The assessment team did not conduct a FGD with husbands of adolescents in Margai due to difficulties in recruiting enough participants. This limited comparison between villages during data analysis.
- The Community Leader in Girkau was unavailable for a KII during the assessment period, which limited the comparison between village community leaders during data analysis.
- Facilitators did not always probe adequately, resulting in a loss of some in-depth information.
- There were minor issues during the process of translation from Hausa to English resulting in some loss of information.

## RESULTS

### KII Adolescent Girl Background

All 25 adolescent key informants were married and aged 15 to 19 years old, 5 girls were currently pregnant and 24 girls had children with ages ranging from 8 months to 3.8 years, with the 17-19 year olds already having 2-3 children (see Table 1 for more details). Girls stated they became pregnant for the first time between the ages of 13 and 17 years, with the majority becoming pregnant at 15 years. Twenty-four of the girls (96%) attended antenatal care (ANC) during their most recent or current pregnancy, making an average of 4 visits to the health facility, and attended postnatal care (PNC) (96%) following the birth of their children. None of these girls gave birth to preterm babies, only 1 girl gave birth to a small sized baby, while 18 girls had normal or average sized babies and 5 girls had large sized babies (weight of newborns were unknown and therefore an estimate of size was given). Only 3 girls had been enrolled in a formal school, one of them attending primary level and the other 2 attending secondary level.

**Table 3. Adolescent KII Participant Demographics**

Age (years)	Age of marriage (#)	Age during first child birth (#)	Currently pregnant (#)
13		1	
14		7	
15	1	13	1
16	2	3	
17	4	1	
18	13		2
19	5		2

**Household Decisions about Meals and Care of Children:** When adolescent girls were asked who in their household decided on the type of food to be purchased, in all cases it was their husband that made the decision. Husbands were also responsible for deciding

on the type of meals to be prepared in all cases except for 3 households, in which the adolescent girls made the decision themselves. However in almost all of the households, except in 2 households, it was the adolescent girl that made the decision on who would eat first. The girls explained that since they were responsible for cooking the meals then they were also responsible for which members eat first. Unfortunately, participants were not probed further about which family members were served first. In 17 of the households the husbands made the decisions related to the care of the children, while in 5 households the decision was joint between husband and wife, and in 3 households the decision was made by the wife.

**Access to Money:** Of the 25 adolescent girls, 6 girls depended on their husbands for access to money, while the other 19 girls had access to money through involvement in petty trade. Their businesses included the selling and sowing of clothes, selling of detergent, kerosene, cold drinks and sachet water, spices (maggi, salt, dried pepper), palm oil, and the making and selling of food (groundnut cake, millet porridge, rice and beans) in the community.

### Knowledge, Attitude and Practice (KAP) Questions

Results from the KAP questions indicated that adolescent key informants had understood and retained a significant level of what they had been taught during their Care Group Sessions. More specifically, they had answered correctly an average of 96% of “knowledge” questions, 91% of “practice” questions, and 86% of “attitude” questions. Participants were more likely to incorrectly answer the knowledge question about low birth weight babies and how long to wait to take a sick child to the hospital. Unfortunately no previous KAP survey has been conducted among this group and therefore the increase in knowledge, attitude and practice could not be assessed.

### Recruiting Adolescents into the Care Group Program

Initially when trying to establish the Care Group program, International Medical Corps program staff approached village Community Leaders to explain the intentions and benefits of the proposed program. Once community leaders provided approval for the program, they were involved in the process of recruiting Care Group Promoters, as well as creating awareness in the community about the program. Community awareness was also accomplished through town announcers and a session for other elders in the community to discuss the program. The recruited Promoters had warned that it would be a challenge to recruit adolescent girls into the program because their husbands did not allow them to be engaged in social activities or even interact with their peers.

Husbands needed to provide permission for outsiders to even enter the household. Therefore access to adolescents was achieved through Community Health Volunteers (CHV) who were recruited and trained to be Care Group Lead Mothers. These CHV's were part of a 5-year USAID funded program called TSHIP (targeted status high impact project) and had been trained to focus on maternal and neonatal health. International Medical Corps further trained them on screening and referral for malnutrition, IYCF counseling and child care practices. CHV's were members of the community, they were grandmothers or mothers, and were therefore highly respected. These Lead Mothers, and at times in coordination with Community Leaders, then set out recruiting mothers through community mobilization and house-to-house visits, explaining to couples the aim and benefits of the program and encouraging husbands to provide permission for their adolescent wives to join the program. Twenty-four of the adolescents girls had initially heard about the Care Group from a Lead Mother, oftentimes during a house visit. One girl initially heard about the Care Group from her husband, and then through the Lead Mother who visited her house.

When asked why adolescents were specifically being recruited, International Medical Corps program staff explained that while implementing a Community Management of Acute Malnutrition (CMAM) program in the local government health facilities, it was observed that most of the mothers were adolescents, who were on average 17-18 years old, and their children had very low bodyweights and were malnourished. In addition, the caring practices of children among adolescent mothers was found to be very poor compared to older mothers. The Care Group Promoter from Margai also explained why adolescents were recruited

into the program: *“The reason why adolescent girls were included in the program is that these are young girls, some of them are just giving birth for the first time. Including them in the Care Group program will help them to understand so many things pertaining to health issues, like how to take care of themselves and their children, family planning, exclusive breastfeeding and eating of a nutritious diet when they are pregnant and breastfeeding.”*

The Community Leaders also agreed about the benefits of including adolescents, explaining that since many of the girls entered into married life before 19 years of age, many did not know how to take care of themselves and their families or have anyone to advise them on such things. According to the culture, prior to marriage an elderly woman from the community will speak with a girl about what is expected from her as a wife, but this is the only time that such things will be discussed. Leaders also added that since these adolescent girls are married it was easier to include them in groups, however had they been unmarried then there would have been challenges since unmarried girls are even more restricted from leaving their household compounds.

## Decision about Attending the Care Group

The decision to attend the Care Group Program was made by husbands of 24 adolescent girls, with two of these receiving joint permission from their mother-in-laws. This was confirmed by the majority of husband FGD participants who stated that they provided permission for their wives to attend. One of the adolescent girls received permission solely from their mother-in-law, this usually happens when



the husband is travelling away from the village for work. Permission by the husband was therefore integral for adolescent girls to attend the program, however refusal to provide permission was rare, especially after lead mothers and community leaders reached out to them. The Leader in Ungushi explained how he responded if any issues arose about attendance: *“I intervened when there were challenges like refusal of some community members. That is if a man refused to allow his wife to attend, I intervened by advising him to let her attend because the program is very important.”*

Husbands realized the importance of the program and also wanted their wives included if they saw the adolescent wives of other men attending the program. During the program, 9 of the adolescent girls received support from mother-in-laws, 2 girls from father-in-laws and 1 girl from her mother to participate in the Care Groups. Lead Mothers described how husbands would encourage their wives to pay attention during house visits and to attend sessions. *“Most of the time it is their husbands that*



*usually remind them of our days of visits and they also encourage them to participate in the care group session and the husband will also learn what I teach her,”* said a Lead Mother from Girkau.

## Feelings about Care Group Program

The Community Leaders were happy about the presence of the Care Group program in their communities. The leader from Unbutu said, *“I feel very happy and excited about the program because it provides health education to the women at their door steps.”* The leader from Ungushi pointed out that the program was important in improving their women’s and children’s health status. Lead Mothers were happy to include adolescent girls, explaining that the knowledge they received would help to ensure the future health of their communities.

All of the adolescent girls indicated that they were happy being part of the program because they were taught important lessons on nutrition, personal and environmental hygiene, and family planning. One girl from Girkau stated: *“I was taught how to take care of myself, my house and my children.”* Many of these girls explained that they had not known how to properly prepare nutritious meals for their families, the importance of eating 3 nutritious meals a day, the reasons for maintaining a proper diet during pregnancy and lactation, the importance of keeping their children and home clean, appropriate WASH practices, the importance of attending ANC visits or delivering at the health facility. Another girl from Unbutu shared her feelings about the program, saying, *“I like the program because before, I didn’t take good care of my children’s health like bathing them regularly, washing their clothes, and cleaning my [household] environment.”* Many of the girls described noticing positive changes within their family in regards to their health and well-being. *“I feel happy being part of this program because my family’s health has changed through this program, before I did not know that eating without washing hands can cause someone to have diarrhea, but through this program I learnt that it is good to wash hands before and after eating so as to prevent illness,”* explained an adolescent girl from Unbutu.

All adolescent participants said they would recommend this program to other adolescents and suggested reaching out to other adolescent girls through house visits, during ceremonial gatherings, Arabic (religious) school and through their husband’s married friends.

## Missed Sessions

The majority of adolescent girls had not missed any of the Care Group sessions, however 6 girls missed at the most one session due to taking care of sick relatives or friends and attending funerals or special ceremonies. This was confirmed by husbands of adolescents, who said that the only reasons for missing a session would have been

due to a serious issue, otherwise their wives would even put aside housework in order to attend the weekly session. Since Lead Mothers are members of the same community, they made sure to schedule sessions during times that all mothers were free to attend and therefore reducing the chances of girls missing any sessions.

## Incentives for Attending Care Groups

Many of the adolescent girls explained that the knowledge they had acquired was the best incentive for attending the program. They found the picture flipcharts to be very useful and interesting. Adolescent girls were encouraged by their Lead Mother's peaceful and friendly manner, as well as her ability to treat them as equals. Since the Lead Mothers were not strangers, but known and trusted members of the community, adolescent girls felt confident and comfortable to speak freely with them. A couple of the girls explained that seeing the improvement in the health of their children had encouraged them to continue participating. Program staff explained that these girls were incentivized to attend because they wanted to avoid pregnancy or child related health issues because they had personally experienced them or knew of people who had experienced such problems and as a result did not want to undergo similar experiences. Additionally, 5 of the girls were encouraged by the fact that many of their friends were participating in the program. Even though monetary or material incentives are not provided through the program, Lead Mothers, Promoters and Community Leaders suggested providing laundry soap, bathing soap, vitamin A, deworming tablets, and folic acid for pregnant mothers as incentives.

## Session Topics and Overall Curriculum

The curriculum and specific sessions were not tailored towards adolescent girls. Program staff explained that both adolescents and older women required knowledge on all offered topics, which were based off of the National Counselling card. All of the adolescent girls, community leaders and lead mothers felt that all the session topics were beneficial and would not recommend making any changes, explaining that current topics were relevant to both adolescents and older mothers. An adolescent girl said *"To be honest all the topics are very useful."* Another girl added *"All the topics are good for our health and the health of our children."* Husbands felt comfortable with the curriculum, finding all topics to be appropriate and necessary. The community leaders were even comfortable with the inclusion of family planning as a session topic especially since the girls were married, stating that in their opinion family planning helps make *"women and children healthier and stronger"*. While the majority of girls were satisfied with the topics that were covered, 4 girls suggested the provision of additional information on malnutrition, family planning, exclusive

breast feeding and complementary feeding. International Medical Corps program staff suggested adding a session on the importance and benefits about immunizations and more detailed information on malaria prevention and treatment, as it is one of the most common and most fatal diseases in the community, especially during the rainy season. Also, program staff suggested that adolescents be given additional information about each of the session topics since they were so young and new to marital life and motherhood, whether this required extra time just for adolescents following the sessions or an extra session each week only for adolescents. Program staff pointed out that if extra sessions were necessary then more educated lead mothers may be necessary in order to pass along more detailed information.

When adolescent girls were asked which session they preferred, they listed a range of topics, however exclusive breast-feeding, attending ANC visits, family planning and personal and environmental hygiene practices were amongst the most popular responses. *"I was taught that if a child is exclusively fed, he will look healthier than the child who receives water from birth to 6 months, so to me if I deliver this pregnancy I will make sure I practice this exclusive breastfeeding to my second child from*



*what I learned in this care group program,” explained an adolescent from Unbutu about what she had been taught and her decision to practice exclusive breastfeeding with her next child. An adolescent girl from Ungushi described the impact of practicing exclusive breastfeeding with her second child: “The topic I liked was exclusive breastfeeding, it impressed me because my recent child was exclusively breastfed, so there is a difference between my first and second child because the second child is healthier than the first one.”*

Many of the girls were also interested about the session on family planning. Lead Mothers had indicated that many girls had no knowledge about family planning. However for girls that knew about family planning, many were ashamed to go to the hospital to receive contraceptives. Following the session on family planning, the girls felt more comfortable to ask questions and seek services. It was clear that as a result of the program they now understood the importance of practicing healthy timing and spacing of their children for both their health and that of their children. An adolescent from Ungushi explained the results of practicing healthy timing and spacing between her children: *“It made me space my children and to also have rest before giving birth to another child. It also made me live a healthier life by having enough food to give my children.”*

## Impact of Care Group Attendance on Household Meal Preparation

All of the adolescent girls indicated that they prepared or participated in meal preparation for their families. Following attendance at Care Group sessions, each of these girls explained that they had changed the process of meal preparation in their households. One participant explained, *“Attending this care group program has changed what I cook in my house because before I didn’t know that adding fish, meat, beans, and vegetables to my meals is very important... now through the advice those lead mothers have given me it has really changed what I cook and how I cook meals in my house.”* Another girl said, *“It has changed my cooking because I learned how to prepare nutritious food for my family, like beans and sweet potato porridge, soya beans pap (porridge), and vegetables to be mixed with egg.”* Prior to the program many of the girls indicated that they did not know how to prepare nutritious meals: *“The food I cooked was not as nutritious as the ones I’m preparing now.”* The Lead Mothers introduced the girls to locally available fruits and vegetables (ex: beans, salad, tomatoes, sweet potato, soya bean, guinea corn), eggs, fish, and meat. Additionally, the girls were taught new recipes such as soya bean pap and millet pap. Lead Mothers explained the importance of creating mixed combinations of foods per meal and also having a variety of food throughout the day. This was discussed by one adolescent mother who said, *“Now I don’t repeat food for my child, I always change the kind of*

*food I give him.”* The sessions also impacted the hygiene practices of adolescent girls, teaching them about hand-washing prior to meal preparation and maintaining a clean environment.

Lead Mothers educated the girls on what kinds of food pregnant and lactating mothers should eat, such as the three main classes of food, as well as consuming food rich in protein and iron, and those that are energy providing. The Lead Mothers also had an impact on husbands and the types of food they purchased for their households. One adolescent girl stated, *“The lead mother advised my husband to buy meat, fish, eggs, milk and fruit when I am pregnant for me to eat so that I can be healthy. My husband [now] buys nutritious food for my children as well.”*

## Impact of Care Group Program on Health Seeking Behaviors and Overall Health in the Community

Community Leaders noticed that as a result of attending the program, adolescent girls were accessing health services, such as ANC and PNC, more than they had previously. They also noticed that the health of these adolescent girls and their children were visibly improving. The Leader from Ungushi said, *“I have noticed that health seeking behaviors among adolescent girls has increased very well. I witness a very long queue during ANC days here in our facility and also during immunization days for their children. Also, most of the adolescent girls if not all, are delivering in the health facility instead of at home as before. Before we used to have a lot of problems during delivery which has reduced now. Another thing I noticed is the improvement in personal hygiene, a lot of children are looking cleaner than before because of the program.”* The Unbutu leader added, *“To my surprise some are practicing family planning without the consent of their husbands. I have [also] noticed a lot of improvement in the reduction of mortality rate in the community due to increases in ANC and PNC attendance, and increase in birth deliverance in the hospital. Also there is a lot of improvement in child health because people now know the importance of sleeping under mosquito nets.”* This is significant since only after 3 months of program implementation, the community continues to experience change in health seeking behavior.

Health facilities have reported to program staff that they had experienced increases in attendance for ANC, PNC, deliveries and immunizations. The following table shows the percentage increase in service attendance and immunizations in health facilities in the 4 Wards since the start of the program. Increases have been recorded in the majority of facilities, with increases as high as 300% in some health facilities. It should be noted that we cannot attribute all of these increases to the program without further research.

**Table 4.** Range of % increase post-program in access to services and immunizations in health facilities of the 4 Wards.

	Range of % Increase
<b>Health Services</b>	
ANC	3–46
PNC	21–48
<b>Immunizations</b>	
BCG	0–58
Measles	0–44
OPV	-24–28
IPV	2–300
Tetanus Toxoid	0–74
Yellow Fever	-2–70
HBV	-38–225

Lead Mothers and Promoters have noticed additional changes in adolescents' health seeking behaviors and practices, including: seeking health care when noticing certain signs and symptoms during pregnancy, eating nutritious meals during pregnancy and lactation, preparing nutritious meals for their children, early initiation of breastfeeding, practicing exclusive breastfeeding, reduced illness and therefore reduced hospital visits, taking sick children to the hospital without delay, bathing themselves and their children, washing dirty clothes, practicing menstrual hygiene, hand washing before cooking, eating or feeding their children. Exclusive breastfeeding used to be a significant challenge, with many mothers feeding newborns water or cow's milk immediately after birth or providing food before their infants turned 6 months of age. Adolescent girls had expressed fear over their babies dying if only fed breastmilk for the first 6 months of life. However following the program many FGD and KII participants discussed how adolescent mothers had increasingly practiced exclusive breastfeeding, which was apparent as their children, compared to their previous children that had not been exclusively breastfed, were looking much healthier and experienced little to no sickness, such as diarrhea, and therefore required fewer to no visits to the health facility.

It was apparent from the information husbands were sharing during the FGD's that they had also benefited from their wife attending the program as they were now more knowledgeable about nutrition, hygiene and family planning issues. Additionally, several of the husbands explained how the program had helped them change their own beliefs and practices. A couple of the husbands spoke about how they previously believed in taking herbs to cure sickness instead of accessing health care services, but now

they had begun to take their family to visit the hospital for care. They also began to identify the signs and symptoms of malaria and no longer attributed them to spiritual attack. Also, a few husbands discussed that before their wives started using modern methods of contraception, they would wear waist beads that contained charms or soaked a sweeping broom and drank the water in hopes of preventing pregnancy. Not only were husbands influenced by the program, but so were other family members, friends and neighbors who may have been present during house visits and would have also gained valuable knowledge from the lead mothers. These house visits also provided Lead Mothers with the opportunity to access unmarried adolescent girls who were present in the household with nutrition, WASH, and hygiene information. Adolescent girls had likewise taken the knowledge gained during the sessions and shared with other adolescents that were not part of the program. *"I recommend the program to other adolescent girls. I reach them with this information if I pay any of them a visit at home, or during a ceremonial party. I tell them the importance of the Care Group program and also pass the knowledge I acquire from the program,"* stated an adolescent from Girkau.

## Feelings about Adolescent- Only Care Groups

When asked whether they preferred Care Groups which consisted of only adolescents, 23 of the 25 adolescent key informants, 58% of husband focus group participants, only 14% of Lead Mother focus group participants, 2 of the 4 Lead Mother key informants and 1 of the 4 Promoter key informants, said they preferred adolescent- only groups. Adolescent girls explained that they did not feel comfortable being in the presence of older women and feeling unable to freely ask questions and discuss what is on their minds. *"I feel happy about having an adolescent girls only Care Group. From my perspective it is better we should be separated from the adult women in this program, because I feel shy to ask questions even if I have any questions to ask, but I can't ask if in the presence of the adult woman",* explained an adolescent participant from Ungushi. Many of the other girls also described feelings of shyness, and some girls even experiencing fear, especially when their mother-in-laws or other female relatives were part of the same group. Lead Mothers and husbands explained that these feelings of shyness were due to cultural issues and affected an adolescent's level of participation and ability to learn during the group sessions. *"I feel an adolescent girl should be separated from adult women so that the adolescent will fully participate in the program,"* suggested an adolescent participant from Margai. Additionally, another girl explained that adolescents having their own care group would allow them to learn faster from their peers. The Community Leader from Margai also agreed that adolescents should be separated not only because they will feel free to participate, but also there will be no possibility of adolescents somehow disrespecting the older

women, such as speaking too aggressively or impolitely. To address feelings of shyness or fear experienced by adolescent girls, the Lead Mothers came up with solutions, such as asking for alone time with adolescents at the end of the session, asking the older women to leave the room momentarily or making house visits to speak privately with the adolescents. One Lead Mother from Unbutu explained her solution: *“Some adolescent girls don’t feel free in front of their mother-in-laws due to cultural beliefs. I address this issue by advising the mother-in-law to give us space for me to talk to her in private so that she can concentrate on the session.”* Additionally, Lead Mothers ask for privacy during house visits when adolescents feel shy due to the presence of their husbands, mother-in-laws or other relatives and neighbors. Program staff have at times separated adolescents into a different group than their mother-in-laws, explaining to the mother-in-laws that their daughter-in-law may not fully participate in her presence. For those adolescent participants, husbands, community leaders, Lead Mothers and Promoters that did not agree with adolescent only groups, their reasoning for continuing with mixed groups were: adolescents could learn from the more experienced older women, the adult women would force girls to focus during sessions, and the adult women could help girls later recollect anything forgotten from the teachings. Additionally, the Leaders from Unbutu and Ungushi thought that the presence of older women would serve as motivation for adolescents in terms of attendance and would lead adolescents to pay more attention to the session.

## Additional Recommendations for Improving the Program

One of the husbands from Unbutu recommended that the husbands be included in the future in order to also increase their awareness. International Medical Corps program staff also suggested providing sessions for husbands with special topics on how to take care of their families. Additionally, staff recommended including Traditional Birth Attendants (TBA) into the program, by training them to become Lead Mothers. TBAs are highly respected and trusted members of the community, who have been trained on pregnancy and other related issues and have been provided with supplies by NGO’s for safe home delivery. These TBAs would strengthen the program as Lead Mothers because they have the additional technical knowledge they can provide to beneficiaries.

## CONCLUSIONS AND RECOMMENDATIONS

Adolescent Girls from the Kebbe LGA in Sokoto, Nigeria often enter into marriage and childbearing at very young ages. The majority of the girls interviewed have very little to no prior knowledge on how to take care of themselves, their children or their households. As the future matriarchs

of these communities, it is critical to provide these girls with appropriate knowledge and practices related to nutrition and health, especially since their children were observed to be vulnerable to malnourishment and illness. Intervention at an early stage with young mothers can contribute to producing healthier families and healthier communities, and lead to eventually breaking the intergenerational cycle of malnutrition in the Kebbe LGA.

The findings of this Case Study revealed that International Medical Corps’ Care Group Program provided adolescent girls with useful knowledge and information on practices to a) prevent malnutrition by maintaining a healthy nutritional status for themselves and their families, b) prevent illness in their households, and c) seek health services and facilities when necessary. Additionally, this study found that following the program, adolescent girls have high levels of knowledge on breastfeeding and complementary feeding practices, maintaining healthy diets during pregnancy, and hygiene practices, and are largely pleased with the Care Groups. To accomplish this success, however, programmers had to first overcome certain cultural and social barriers in order to either include or allow adolescent girls to fully participate in Care Groups. Barriers included: a) the isolation of adolescent girls in household compounds and reduced attendance in social activities and interaction with peers, and b) cultural sensitivities causing girls to feel shy and uncomfortable to participate in the presence of older members of the Group. The following recommendations, based upon the key findings and lessons learned, focus on further overcoming barriers for adolescent inclusion in Care Groups and strengthening program quality for them:

### Overcoming Barriers for Including Adolescent Girls in Care Groups

Community and family buy-in is critical when targeting adolescent girls for inclusion in Care Groups. The following recommendations pertain to the “who” and “how” of obtaining appropriate buy-in for adolescent inclusion.

- I. Obtain Necessary Buy-In from Critical Stakeholders:
  - a) Community Leader’s permission for introducing Care Group programming in community.
  - b) Husband’s permission for including their adolescent wives in the program.
  - c) Permission by Mother-in-law’s or other heads of households when husbands are away from the village for work.
- II. Develop and Utilize Appropriate Processes for Acquiring Community and Family Buy-In:
  - a) The use of CHVs as Lead Mothers, who were trusted members of the community, was critical in gaining the buy in from key stakeholders for the inclusion of adolescents in Care Groups. Also, adolescent girls felt confident and comfortable to speak freely due to their familiarity with Lead Mothers.
  - b) Community mobilization and house to house visits by Lead Mothers provided awareness amongst

community members regarding the specific objectives and expected health and nutritional benefits of including adolescent girls.

- c) Direct intervention by Lead Mothers and Community Leaders with husbands that refused to provide permission to include their adolescent wives.

Once the program received acceptance by community members and most importantly husbands, then many of these same individuals that acted as initial barriers ended up becoming facilitators, many of whom encouraged adolescent mothers to attend and pay close attention to sessions.

### III. Develop New Approaches for Adolescent Girls:

- a) Aside from reaching girls through community mobilization and house visits, they can also be reached through other social platforms and gatherings, such as: Arabic (religious) school and ceremonial gatherings.
- b) Utilize adolescent Care Group members to recruit their peers.
- c) While it is culturally difficult to include unmarried adolescent girls in Care Group sessions, they were still reached through house visits by Lead Mothers. Specific messages targeting these unmarried girls should be developed focusing on pre-conception education and counseling on nutrition and health.

### Strengthening Quality of Care Group Program

#### I. Cater Session Structure and Topics to Adolescent Girls:

- a) Provide an extra session each week or extra time following weekly sessions for adolescent girls with the aim of reinforcing the knowledge shared during each topic. This should not be a complete repetition of the week's session topic, but rather an opportunity to review what was taught, provide further details if needed, reinforce key messages, and spending time problem solving to ensure adolescents are able to implement lessons learned. The use of more educated Lead Mothers may be necessary in order to pass along more detailed technical information.
- b) Train Traditional Birth Attendants (TBA's) as Lead Mothers to provide more detailed technical information and provide higher coverage for the program in remote areas where current Lead Mothers have not reached.
- c) Provide additional detailed information to adolescent girls on session topics related to malnutrition, family planning, exclusive breastfeeding and complementary feeding. The current information provided was limited and needed to be more in-depth.
- d) Provide additional session topics on 1) sexual and reproductive health, including basic sexual education tailored for adolescent girls, 2) the importance and benefits of immunizations, 3) Early Childhood Development (ECD), and 4) malaria prevention and treatment.

#### II. Adapting Groups/ Sessions and House Visits:

- a) Form Adolescent- Only Care Groups to address participation anxiety in the presence of older Care Group Members.
- b) For mixed age Groups, provide opportunities after sessions for Lead Mothers to speak privately with adolescent girls. Additionally, ensure separation of adolescent girls from their mother-in-laws or other relatives by placing them in different groups.
- c) Care Group Sessions and house visits specifically targeting husbands. Since husbands are responsible for making decisions on the type of food purchased and type of meals prepared, as well as decisions related to the care of children, they need to be educated on the importance and benefits of a healthy diverse diet and seeking health services without delay.
- d) House visits targeting unmarried adolescent girls to provide them with knowledge relating to pre-conception health and nutrition topics.

#### Program M&E and Capacity Building:

- a) Disaggregate data by age in order to capture information and inform programmers on number and distribution of adolescent girls in the various Care Groups. Due to high levels of illiteracy among Lead Mothers, it is recommended that either pictorial representations are developed (young girl mother versus older mother) or Care Group Promoters and Supervisors can help with collecting this data.
- b) Provide adolescent sensitive and specific training and monitoring for Care Groups.
- c) Provide pre- and post- KAP surveys for Care Group monitoring and improvement.
- d) Conduct a barrier analysis survey with Lead Mothers to understand cultural determinants on inclusion of adolescent girls.
- e) Strengthen linkages with the health facilities: 1) ensure all participants receive folic acid, vitamin A, deworming if/when necessary, 2) assess birth weight and other nutrition/health indicators from Care Group participants.

The Care Group approach provides an opportunity to appropriately target adolescents to achieve improved maternal and child health and nutrition. The lessons learned and recommendations from this Case Study can be used to advocate for greater adolescent inclusion in programs, as well as giving specific insight on how to adapt programs to fit the unique needs of this target population.