

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

## I. Introduction and Background

Adolescents and youth (10–24 years of age) constitute almost one-quarter of the world’s population, with more than 80% of this group living in low- and middle-income countries (LMICs)<sup>1</sup>. The UN defines young people as those aged 10–24, early adolescents as those aged 10–14 years, and late adolescents as those aged 15–19 years<sup>2</sup>. Adolescence is a period of growth and development that is increasingly being recognised as a critical window for the health and well-being of current and future generations<sup>3</sup>. Worldwide, 16 million girls aged 15–19 years give birth every year<sup>4</sup>, and a 2014 World Health Organization (WHO) report showed that the global adolescent birth rate was 49 per 1000 girls aged 15 to 19 years old<sup>5</sup>.

Adolescent pregnancy is a major public health problem, particularly in Africa<sup>6</sup>. Sub-Saharan Africa (SSA) has the world’s highest level of adolescent pregnancy estimated at 101 births per 1,000 women aged 15-19 years. An estimated 21 million girls aged 15 to 19 years—and 2 million girls under the age of 15—become pregnant each year, predominantly in LMICs<sup>7</sup>. In 2015, the adolescent fertility rate for women aged 15-19 years in Zimbabwe was 115 births per 1,000 women of the same age<sup>8</sup>. According to the 2012 National Population Census, adolescents aged 10-19 years constitute 24% of the total population of Zimbabwe<sup>9</sup>, and most men and women become sexually active during adolescence<sup>10</sup>. Evidence from the Demographic and Health Surveys and the AIDS Indicators Surveys<sup>11</sup> show that median age at first sexual intercourse among 20–24-year-old women ranges from a low of 16 years or younger in Chad, Mali and Mozambique to a high of 19.6 in Senegal. In the rest of Sub-Saharan Africa, the median age is about 18.5 years. Among young men of the same age-group in Sub-Saharan Africa,

<sup>1</sup> United Nations Population Fund. World population dashboard [Internet]. (2017). [cited 2018 Mar 14]. Available from: <https://www.unfpa.org/data/world-population-dashboard>

<sup>2</sup> [https://www.unicef.org/sowc2011/pdfs/SOWC-2011-Main-Report\\_EN\\_02092011.pdf](https://www.unicef.org/sowc2011/pdfs/SOWC-2011-Main-Report_EN_02092011.pdf)

<sup>3</sup> Patton GC, Sawyer SM, Santelli JS, et al. Our future: a Lancet commission on adolescent health and wellbeing. *The Lancet*. 2016 Jun 11;387(10036):2423–78. [Crossref]. [Web of Science®]; Patton GC, Olsson CA, Skirbekk V, et al. Adolescence and the next generation. *Nature*. 2018 Feb;554(7693):458–66.

<sup>4</sup> United Nations Children’s Fund, Progress for Children: A Report Card on Adolescents. New York, 2012. Retrieved from [https://www.unicef.org/publications/files/Progress\\_for\\_Children\\_-\\_No.\\_10\\_EN\\_04232012.pdf](https://www.unicef.org/publications/files/Progress_for_Children_-_No._10_EN_04232012.pdf)

<sup>5</sup> WHO. Adolescent Pregnancy. Geneva: World Health Organization; 2014. Available from: <http://www.who.int/mediacentre/factsheets/fs364/en/>

<sup>6</sup> Conde-Agudelo A, Belizán JM, Lammers C. Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: cross-sectional study. *Am J Obstet Gynecol*. 2005;192(2):342–9.

<sup>7</sup> World Health Organization (WHO). 2018a. *Adolescent Pregnancy Fact Sheet*. Geneva: World Health Organization. <http://www.who.int/mediacentre/factsheets/fs364/en/>.

<sup>8</sup> National Adolescent Fertility study report, UNFPA, 2016. Available at <https://zimbabwe.unfpa.org/sites/default/files/pub-pdf/UNFPA%20NAFS%20Main%20Report%20%202016%20For%20Web.pdf>

<sup>9</sup> ZimStat, Census Results 2012, Zimbabwe National report. [http://www.zimstat.co.zw/sites/default/files/img/publications/Population/National\\_Report.pdf](http://www.zimstat.co.zw/sites/default/files/img/publications/Population/National_Report.pdf)

<sup>10</sup> A Glasier et al. Sexual and Reproductive health, a matter of life and death. *Lancet* 2006; 368:1595-60. Available at <https://www.ncbi.nlm.nih.gov/pubmed/17084760>

<sup>11</sup> Khan, Shane, and Vinod Mishra. 2008. Youth Reproductive and Sexual Health. DHS Comparative Reports No. 19. Calverton, Maryland, USA: Macro International, available at <https://dhsprogram.com/pubs/pdf/CR19/CR19.pdf>

the median age at first sexual intercourse ranges from a low of 16.9 in Mozambique to a high of 19.6 in Ghana.

Interventions that target adolescent mothers are often overlooked when working to improve nutrition during the first 1,000 days after newborn birth. To bridge this gap, the Amalima project has implemented Care Groups to improve nutrition outcomes for the adolescent mother and her child<sup>12</sup>. Care Groups are participatory, community-level nutrition education groups that consist of up to 10 mothers or caregivers. These groups are facilitated by a Lead Mother (LM) who is trained by community-based Village Health Workers (VHWs) called Care Group Volunteers (CGVs). The CGVs exist in the Ministry of Health and Child Care (MoHCC) structure and receive training on the Care Group approach<sup>13</sup>. The Care Group curriculum promotes hygiene interventions and covers topics related to maternal nutrition, breastfeeding, and child feeding.

Adolescent mother participation in Care Groups can improve fetal growth and birth outcomes, reduce stunting, and improve economic prosperity for both the mother and child<sup>14</sup>. Research from the Young Lives study found that being born to a stunted adolescent mother is associated with a 15 percent increased chance of a child being stunted, in comparison to being born to a non-stunted older mother<sup>15</sup>. These findings support a case study conducted in Nigeria, funded by the USAID Technical and Operational Performance Support (TOPS) Program on Adolescent Inclusion in the Care Group Approach, that stressed the importance of providing adolescent girls with appropriate knowledge and practices related to nutrition and health due to the vulnerability of their children to malnutrition and illness<sup>16</sup>. The case study suggested that the Care Group Approach provides an opportunity to appropriately target adolescents to achieve improved maternal and child health and nutrition.

The Amalima Care Group program has over 400 CGVs and over 1,700 LMs—with volunteers reaching up to 6,000 mothers and caregivers per month. Volunteers promote the adoption of recommended infant and young child feeding (IYCF) behaviours to reduce chronic nutrition and improve health, WASH<sup>17</sup> and IYCF practices for mothers and their children under two years of age.

To attract adolescent mothers to Care Groups, the Amalima program introduced sport and cooking competitions. Care Group participants received a recipe book to encourage them to prepare the nutritious meals that were taught during the cooking demonstrations. Despite these innovative activities, participation of adolescent mothers in Care Groups has remained low; as a result, Amalima

---

<sup>12</sup> Care groups are peer to peer support groups of about 10 mothers (pregnant or lactating women and caregivers of young children) that meet on a regular basis. The group sessions are led by a facilitator (lead mother), with the objective of imparting knowledge, practices and skills for the adoption of health, nutrition and hygiene behaviours. The care group approach or model has the advantage of being able to reach a large number of caregivers using trained community health workers or volunteers.

<sup>13</sup> Care group curriculum includes the following topics: breastfeeding, child feeding and maternal health and nutrition. Messages on hygiene promotion are embedded within the topics

<sup>14</sup> Black, Robert E., et al. 2008. "Maternal and Child Undernutrition: Global and Regional Exposures and Health Consequences." *The Lancet*, vol. 371, no. 9608, pp. 243–260., doi:10.1016/s0140-6736(07)61690-0.

<sup>15</sup> Georgiadis, Andreas, and Mary E. Penny. 2017. "Child Undernutrition: Opportunities beyond the First 1000 Days." *The Lancet Public Health*, vol. 2, no. 9, doi:10.1016/s2468-2667(17)30154-8.

<sup>16</sup> Perera S. M. Case Study on Adolescent Inclusion in the Care Group Approach – the Nigeria Experience. Emergency Nutrition Network, field exchange article, available at <https://www.enonline.net/fex/52/adolescecaregroup>

<sup>17</sup> Water, sanitation and hygiene

conducted this study to explore the motivators and barriers for adolescent mother participation in Care Groups.

## 2. Research Objectives

The primary objective of this study is to describe the experience of adolescent mother (under 19 years old) inclusion and participation in Care Groups and to highlight key barriers to and facilitators for participation in Care Groups. The study aims to answer the following questions:

1. What are the reasons for adolescent mother participation in Care Groups?
2. What are the reasons for adolescent mother non-participation in Care Groups?

The study findings will enable Amalima and its partners to learn from, document and disseminate information from the collected experiences. Furthermore, the findings of the study will be used to inform any future programs undertaken in Zimbabwe.

## 3. Methods

### a. Study Design

A qualitative research approach was selected for this study. Qualitative research provides an in-depth understanding of attitudes, perceptions, and beliefs – giving the researchers a rich appreciation of the motivators and barriers for adolescent participation in the care group’s activities<sup>18</sup>. The flexible nature of qualitative research allows greater spontaneity in the interaction between the researcher and study participants—encouraging adolescent mothers to freely respond in great detail to any questions. To this effect, the study will primarily use open-ended questions.

Against this background, the research aims to explore factors that facilitate or limit (and/or inhibit) adolescent mothers participation in Care Groups. To date, little to no research has been done on Care Group participation in Zimbabwe.

### b. Study Area and Sample

The research was conducted in two districts (Gwanda District in Matabeleland South Province and Tsholotsho District in Matabeleland North Province) across four purposively selected domains (two in Gwanda, two in Tsholotsho). An assessment team of twelve local researchers employed In-Depth Interviews (IDI) and Focus Group Discussions (FGD) with adolescent mothers, families of adolescent mothers, CGVs and LMs. Four villages from the two districts were selected due to their high numbers of adolescent mothers. The study included IDIs and FGDs with both adolescent mothers who participate in Care Groups and adolescent mothers who do not. Additionally, family FGDs were held with family members of the adolescents, and with CGVs and LMs. The sample of adolescent mothers was purposefully selected. Purposive sampling is defined as the selection of study units that are chosen according to certain characteristics which enable detailed exploration and understanding of the themes the researcher is studying. For adolescent mothers participating in Care Groups, the researchers were guided by the following inclusion criteria:

---

<sup>18</sup> Mack, N., Woodsong, C., Macqueen, K. M., Guest, G., and Namey, E. 2005. *Qualitative Research Methods: A Data Collector’s Field Guide*. Family Health International: Research Triangle Park, NC. Retrieved from [http://repository.umpwr.ac.id:8080/bitstream/handle/123456789/3721/Qualitative%20Research%20Methods\\_Mack%20et%20al\\_05.pdf?sequence=1](http://repository.umpwr.ac.id:8080/bitstream/handle/123456789/3721/Qualitative%20Research%20Methods_Mack%20et%20al_05.pdf?sequence=1)

- Adolescent mothers of children 0-23 months consistently attending care group lessons. Consistent attendance was defined as a mother/caregiver having participated in at least four care group sessions in the last six months.
- An adolescent mother who has received at least three home visits from a LM in the last 6 months.

For adolescent mothers not participating in Care Groups, the researchers were guided by the following inclusion criteria:

- Adolescent mothers of children 0-23 months not attending Care Group lessons<sup>19</sup>.

In total, the following in-depth interviews and focus group discussions were held:

	Gwanda District	Tsholotsho District	Total	Participants
In depth interviews	11	10	21	Adolescent mothers participating in Care Groups
In depth interviews	5	2	7	Adolescent mothers not participating in Care Groups
Focus group discussions	4	1	5	Family members of adolescents participating in Care Groups
Focus group discussions	2	3	5	Family members of adolescents not participating in Care Groups
Focus group discussions	1	2	3	Care Group Volunteers and Lead Mothers

A total of 28 semi-structured, in-depth interviews and 13 focus group discussions were conducted. IDIs and FGDs were stopped when the researchers reached a saturation point. In qualitative research where the sample size is small, the saturation point is the point at which a larger sample size ceases to contribute new evidence (Ritchie, Lewis & Elam (2003)).

### c. Study Tools

Tools were developed in accordance with standardised guidance on qualitative research tools<sup>20,21</sup>. Prior to data collection, all researchers underwent a three-day training on FGD and IDI methodology, including facilitation techniques, note-taking methods, consent acquisition, and ethics of conducting interviews with adolescents. Prior to conducting IDIs and FGDs, verbal consent was acquired from all study participants.

## 4. Data Collection Technique and Procedures

Data was collected through IDIs using interview guides. Focus group discussions were conducted with 8-10 participants using focus group discussion guides. All the IDIs and FGDs were conducted at a central location in the selected wards. Interviews and FGDs were conducted in the local language, *isiNdebele*.

<sup>19</sup> Mother/caregiver has never participated in care group sessions

<sup>20</sup> Malterud, K. (2001) Qualitative research: Standards, challenges, and guidelines. *Lancet*, 358, 483-488. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/11513933>

<sup>21</sup> Qualitative Research Methods: a data collector's field guide. Family Health International, North Carolina. Retrieved from [http://repository.umpwr.ac.id:8080/bitstream/handle/123456789/3721/Qualitative%20Research%20Methods\\_Mack%20et%20al\\_05.pdf?sequence=1](http://repository.umpwr.ac.id:8080/bitstream/handle/123456789/3721/Qualitative%20Research%20Methods_Mack%20et%20al_05.pdf?sequence=1)

#### 4.1 Data processing and analysis

Study data were translated from *isiNdebele* to English and transcribed, after which manual qualitative data analysis was used to code and analyse all data for themes, subthemes, and relevant quotations. Data was analyzed inductively using a list of codes developed by the researchers. These codes were then grouped into themes.

## 5. Key Findings

### What Motivates Young Mothers?

- Young mothers are motivated by learning or gaining knowledge on how to take care of their child's hygiene and health
- The young mothers are also motivated by fun interesting activities such as:
  - Netball (competitions) *"we bought our own ball, and compete with other care group members"*
  - Cooking demonstrations *"I would never miss a (cooking) demo session"*
  - Singing and Drama
- The young mothers highlighted that they are motivated to participate in Care Groups if the LMs are easy to approach *"the Lead Mother makes it easy for us to be comfortable...she gives every one of us attention"*

### Barriers:

- Care group attendees can form cliques leaving some adolescent mothers to feel left out - this is from the natural selection of care group members that happens in the community.
- Adolescents feel shy and uncomfortable expressing themselves during the sessions – *"I feel free to share experiences...but I have never really shared anything"*.
- Workload/chores at home *"I am interested in the Care Groups, but household chores prevent me from participating. My mother in law says the household chores are important"*.

### Other interesting findings:

- 81% of adolescents are not married and live with their parents/grandparents
- LMs play a key role in mobilizing mothers, including adolescent mothers to participate in Care Groups
- Adolescents need permission from parents / guardians to attend sessions *"we see them as children, they need to get permission"*.
- CGV/LM/Family perception of adolescent mothers: they are shy / stubborn / lazy / arrogant / need regular follow up/too young to recognize the importance of Care Groups.

### Adolescent Only or Mixed Care Groups?

Most adolescents (26/27) prefer mixed Care Groups (meeting together with older mothers) citing the importance of learning from the older mothers' experience and guidance as key *"indlela ibuzwa kwabaphambili"* [guidance from more experienced women is important].

## 6. Recommendations

- Train Care Group Volunteers and Lead Mothers on adolescent friendly approaches so they can better understand and relate to adolescents.
- Pair up adolescent mothers with an older, experienced mother in the care group. This can encourage a mentor-mentee relationship which contributes to greater social cohesion.
- Prioritize LMs conducting home visits to adolescent mother homes, especially important as most adolescent mothers require permission to participate in Care Groups.
- Scale up the use of sporting activities (netball); this was a key recommendation from most of the adolescents.
- Scale up community cooking demonstrations as adolescents value the practical learning and learn easily from the practical sessions.