

# Young Women's Support Groups:

## Empowering young women and improving maternal health

### The challenge: support lacking for young women

On average, women marry between 15 and 16 years old in the north of Nigeria (National Population Commission and ICF Macro, 2009) and their husbands tend to be around seven years older. Differences in age, educational attainment, employment opportunities and the size of social networks mean that many women enter marriage with fewer social, human and financial assets than their husband, which can reduce their bargaining power.



Socio-cultural norms may leave young women without access to health-related information and services. Kunya (which translates broadly as shyness) prevents free expression in the company of older women. In practical terms, this can result in lack of knowledge about the start of sexual activity and this lack of preparation can lead to the hiding of first pregnancies, which reduces demand for antenatal care, access to birth spacing advice and technologies, as well as a lack of preparedness for delivery. Restrictions on physical mobility can reduce opportunities for interaction with peers.

### Key messages:

- 1** Targeted strategies are required to improve maternal, newborn and child health among young married women in the north of Nigeria.
- 2** In communities supported by PRRINN-MNCH, Young Women's Support Groups had positive effects on health-seeking behaviour. The benefits of these groups extended beyond health.
- 3** To reach the least-supported young women, a strategy of 'targeting within an age-specific target group' is essential.

In situations where young women are also deprived of social and moral support, whether from husbands, co-wives, or mothers-in-law, or worse than that, where they are bullied, abused or neglected, they can become extremely vulnerable and isolated. Under-supported women usually carry the greatest burden of ill health and mortality, with important implications for public health strategies.

**21% of young married women fell into the least-supported category in a 2012 PRRINN-MNCH survey. They were less likely to use health services, had the least confidence in looking after themselves or their children, were less likely to be involved in income generation and more likely to have poorly-supportive mothers-in-law.**

### The response: empowering young women

The UK aid and Norwegian government-funded Programme for Reviving Routine Immunisation in Northern Nigeria and Maternal, Newborn and Child Health Initiative (PRRINN-MNCH) began working in four states in the north of Nigeria in 2008. A community engagement approach was designed to address the barriers that

led to poor home-based care of pregnant women and newborns, and restricted the use of health services.

Community discussion groups helped create awareness of MNCH issues and communities were supported to set up systems to tackle maternal delays. This included emergency transport schemes, blood donor schemes and emergency savings schemes. Although the approach was effective for most target groups and led to some positive changes in health-seeking behaviour, young married women were not always reached. The Young Women's Support Group (YWSG) initiative<sup>1</sup> was established to address this gap.

The YWSGs were based on a simple idea – that young women were likely to respond positively to information and support provided by female mentors from their own community who were only slightly older than they were. The mentors were selected from among community health volunteers who had already been trained by PRRINN-MNCH on maternal and newborn health and routine immunisation. Extra training strengthened their facilitation skills and introduced new topics.

1. With funding from the UK Department for International Development through the Girl Hub initiative.

**THIS DOCUMENT IS ONE OF A SERIES OF TECHNICAL BRIEFS THAT DRAW ON THE ACTIVITIES, RESULTS AND LESSONS LEARNED FROM THE PRRINN-MNCH PROGRAMME**

## Box 1. Increased knowledge and changes in practices

*“A pregnant woman and a member of a YWSG in Jigawa started bleeding a few days back, which she knew was a danger sign. Without hesitation she called her husband who had given her standing permission to inform him of her situation and she was carried to the general hospital and admitted there. She was lucky that the pregnancy was not lost.” Jigawa*

*“A YWSG member delivered twins in her house in Lawanti. She said she didn’t used to go to antenatal care, but she now goes regularly and takes her drugs. She delivered successfully.” Yobe*

The mentors helped to establish groups of 10-12 young married women who were 20 years old or below. Committing 2-3 hours a week for 20 weeks – relatively modest inputs – the mentors facilitated discussion groups on a range of topics and supported group members to translate their new knowledge into action. A focus on MNCH-related knowledge and support for accessing services formed the bedrock of the YWSG training curriculum, but the training also included modules on reproductive health and personal hygiene, nutrition and life skills.

Recognising the importance of economic empowerment to young women’s personal agency and status within the household, a module on savings and financial management skills was also included. The mentors worked closely with external organisations such as religious institutions, government agencies and NGOs to link the groups to additional opportunities and resources.

### **The YWSGs aimed to build young women’s human, social and financial assets.**

An important part of the YWSG strategy was to ‘target within the age-specific target group’ (Green et al, 2012). A study implemented by PRRINN-MNCH in 2010 had found that in poorly-resourced rural communities where child deaths were common, most (80%) of the deaths occurred to a minority (20%) of women (Klouda, 2010). The deaths were associated with a lack of social support from the family.

This study had important implications for the YWSG design: it was essential to find a way to reach socially excluded or particularly vulnerable young women. Both the

mentors and the members of the YWSGs were encouraged to explore who these women were, to look at the factors that contributed to their situation and to find ways to include the women in the groups.

**Substantial emphasis was placed on reaching and including the least-supported women in the community in the groups – and improving their access to MNCH services.**

## Box 2. Linking YWSGs with community emergency systems

*“In Gandun Sarki community, Harira, a YWSG member, started suffering prolonged labour in the early hours of the morning. Although her husband was away, another YWSG member, Mairo, was with her. Both noticed that the labour was taking time, so Mairo quickly ran to call a community volunteer and emergency transport scheme driver. Money from the community savings scheme was used to fuel the car and the driver took her to hospital without delay. After arriving at the health facility, Harira delivered a bouncing baby boy.” Katsina*

## Results: improved knowledge and access to services

### **Coverage**

By September 2013, after 12 months, PRRINN-MNCH and its government partners had trained over 4,000 mentors to work with over 2,000 YWSGs in 40 local government areas in four northern states. The groups reached over 24,000 young women. The YWSGs are estimated to have reached around 30% of the target population of young women in communities where the specified age criteria for group membership was adhered to. These were primarily communities that had come on stream later.

Some of the first tranche of YWSGs initially failed to stick to the age criteria for membership, requiring adjustments to their membership in later months. These groups reached a much lower percentage of their target group.

The rapid rollout of the YWSGs, which took place in less than a year, was enabled by several factors:

- The previous knowledge and capacity of PRRINN-MNCH and its government partners when rapidly scaling up community engagement activities from an initial population coverage of 900,000 to 7.6 million
- The receptivity of host communities to the YWSGs due to their previous participation in MNCH-related community engagement activities
- The promotion of the YWSGs by religious leaders, who saw the groups as an important strategy to reach vulnerable and excluded young women

**The YWSGs reached 24,000 women in four states in less than a year. The YWSG model, which uses a cascade training approach, shows good potential to achieve complete coverage of target groups if implemented in a phased manner.**

### **Changes in health knowledge and practices**

The YWSG groups had a demonstrable effect on both health-related knowledge and practice. A knowledge, attitudes and practices (KAP) study in mid-2013 found that members of YWSGs were more likely than non-members to:

### Box 3. Effect of financial management skills training on YWSG members in Katsina

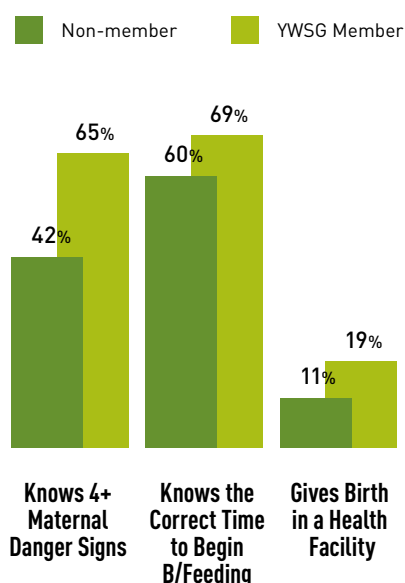
*"From the financial skills I have learnt, it helps me to start selling vegetables for which I have now a weekly income of N500-600."*

*Sahura pounded grain for other families, one of the most menial tasks. Invited by a YWSG friend, she received financial support from the group to start a business. She bought a sewing machine and a spaghetti making machine and taught her younger sisters to use them. She also gave her husband capital to establish a palm oil business and he now makes an average profit of N5,000 per month while she makes an average of N3,000.*

- Know four or more maternal danger signs
- Know when to put a newborn to the breast for the first time
- Give birth in a health facility
- Know the correct immunisation schedule
- Have vaccinated their most recent child
- Have the complete set of vaccinations

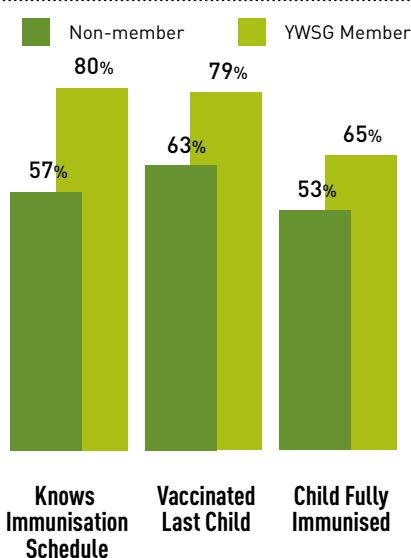
A review of the YWSG initiative in October 2013 found that many YWSG members were able to clearly articulate key health-related messages and show how they had changed their behaviour in response (Box 1).

**Fig 1: MNCH knowledge and practice**



YWSG members were more likely to know about maternal health issues.

**Fig 2: Immunisation knowledge and practice**



YWSG members were also likely to know more about immunisation.

#### Access to community MNCH response systems

Monitoring data gathered from YWSG intervention sites showed that communities were beginning to work together as a 'community health team'. The October 2013 review of the YWSG initiative found that many group members had successfully activated community emergency response systems when experiencing a maternal emergency (Box 2).

#### Other benefits

The effect of the YWSGs extended beyond health, and included improvements in economic status and women's confidence and status within the household (Box 3).

Following training in savings and financial management, the YWSGs were

encouraged to establish group savings schemes – pooled funds that could be used to access health care when needed. Some of these schemes operated as revolving loan funds, where individual group members could apply for a loan to establish or expand an existing income-generating activity. In some areas, the mentors linked the YWSGs to agencies such as the Ministry of Women's Affairs, which provided skills training in income-generation activities such as tailoring or soap-making.

Members of the YWSGs also reported positive changes in their confidence and status within the household and greater capacity to resolve conflicts with husbands and other family members. Some husbands reported greater harmony at home (Box 4).

#### Increased support for the least supported

Members of the YWSGs demonstrated increased awareness of excluded and under-supported young women in their community and willingness to support them (Box 5). Three strategies were used to support these women:

- Taking steps to include under-supported women in group activities
- Increasing their access to community emergency systems such as the emergency maternal care savings schemes or the community emergency transport schemes (ETS)
- Intervening in cases of neglect, abuse or exploitation

The October 2013 YWSG review identified positive examples of how members of the YWSGs had intervened in support of such women.

**The YWSGs place considerable emphasis on identifying young women who need support and inviting them to join the groups.**

#### Implications for policy

By December 2013, the YWSG initiative had been operational for a year. At this early stage, differences in performance between groups, communities and states were evident. Future monitoring and evaluation efforts will need to establish what helps and what hinders the groups to function effectively, and

## Box 4. YWSGs Are empowering for young women

*“Before this time I could hardly talk to people. But now I can talk. This is because of the group activities. I am used to addressing members and the discussions we have in the groups have also helped me.”*

*“Now if I have anything bothering me I am able to discuss it with my husband.”*

*“We can now resolve conflicts among ourselves, our neighbours and even our husbands.”*

*“My husband said he is happy with my participation in the group, that I don't bother him with much trouble about money any longer because I am a bit self-reliant now.”*

what factors enable them to sustain their activities in the medium to long term. The fact that the PRRINN-MNCH-supported YWSGs were embedded in a wider community engagement process was vital to their acceptance by host communities.

Monitoring and evaluation data generated so far give an indication of the potential of these groups to improve MNCH and to empower young women both economically and socially. The next phase of implementation needs to focus on attaining full coverage of the target age group. This will help to ensure that the least-supported women are reached. To achieve full coverage, the number of groups in each community needs to increase from the current average of 3–4 to approximately 11. An expansion of this size is feasible: the YWSG model uses a cascade training approach which lends itself to rapid scale-up.

To ensure that all the YWSGs function effectively, they will require ongoing support from community mentors and from external coaching and mentoring teams who can help maintain group motivation, assist with problem solving and leverage external resources for the groups. These teams may comprise representatives from local government, state ministries, or in the

case of Jigawa, Gunduma councils. Embedding the YWSGs into the everyday work of government agencies so that the initiative becomes part of the government-led MNCH response is a future priority.

## Conclusion

Although PRRINN-MNCH's focus was primarily on improving health-related outcomes, the YWSGs had benefits that extended beyond improvements in health. General improvements in quality of life were evident as some of the young married women developed the confidence and capacity to begin forming their own

social networks and explore opportunities for self-development.

The YWSGs also demonstrated how the least-supported young women, who carry the highest burden of mortality and morbidity, can be reached. In the PRRINN-MNCH-supported communities the YWSGs now need to be scaled up to cover all young married women in the community so that the least-supported women are not missed.

## References

Green, C., et al, 2012, Design of Young Women's Support Groups Initiative, Report Produced for PRRINN-MNCH, February.

Klouda, T., 2010, 'Adjusting Health Strategies to Include Women and Children with Least Social Support', PRRINN-MNCH Policy Brief.

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## Box 5. Evidence of increased support for least-supported young women

*“There was a woman who was interested to join a YWSG, but was afraid that she might not be accepted because she lacked decent wrappers to wear to the meetings. When the members learned of her fears, they not only offered her moral support and encouragement, but also put together N700 and gave it to her to buy a wrapper. She finally became a member of the group.”*

*“A man stopped his wife, who is under-supported, from attending antenatal care. A member of the YWSG and a community volunteer visited the man and advised him on the importance of ANC and facility delivery. The man allowed his wife to go to ANC; he also joined the meetings of the community volunteers to learn about health issues.”*



Partnership for Reviving Routine  
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Maternal Newborn and Child Health Initiative

The PRRINN-MNCH programme works with federal, state and local governments and local communities to improve the quality and availability of maternal, newborn and child health services.

[www.prrinn-mnch.org](http://www.prrinn-mnch.org)  
Email: [info@prrinn-mnch.org](mailto:info@prrinn-mnch.org)



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