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Using creative research methodologies to understand adolescent nutrition realities in Kenya and Uganda

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Abstract

Adequate nutrition is critical to the rapid growth and increased energy and micronutrient demands that characterize the adolescent life stage. This study aimed to learn from adolescents and key stakeholders about adolescents' experiences of achieving adequate nutrition, and how to best engage this age group in programming.

Exploratory qualitative methods included participatory workshops, creative methods such as photovoice and social network mapping, key informant interviews and focus group discussions at national, district/county and community level. Data collection was conducted from April-August 2017 and research sites included Moroto in Uganda and Samburu in Kenya.

Adolescents were found to play a key role in their families' health and nutrition. They often had significant influence over household diet, cultivating land, buying and preparing food, and contributing financial resources. Adolescents had heavy workloads that contribute to high energy expenditure. Their diets and food choices were influenced by the need for energy and to satisfy hunger, and by limited resources; long-term consequences of diet were rarely a factor.

Issues that affect adolescents were found to shape their food experiences, including household economy, income-generating activities, agricultural practices, social norms, education and school attendance, sexual and reproductive health and service delivery issues.

Governments and development organisations should expand their perception of adolescents as a target for health, nutrition and development initiatives, recognizing the important place they occupy in society. Interventions should respond to the complex realities of an adolescent's life, and be mindful of the responsibilities, priorities and preferences that adolescents may have. Adolescents and key influencers should be engaged through multiple avenues or platforms that are mutually supportive.

Introduction

Adolescence is a time of significant brain development (Blum et al., 2014) and physical growth at a pace exceeded only by the critical first 1000 days (Thurnham, 2013). As identified in Sustainable Development Goal 2, Zero Hunger, addressing the nutritional needs of adolescents is one of the key steps towards achieving the objective of ending malnutrition by 2030. The 2013 'Maternal and Child

Nutrition Series' published by *The Lancet* and the Scaling Up Nutrition (SUN) movement have also played a key role in highlighting that nutrition interventions should be tailored to adolescents. Interventions to improve access to education, delay marriage, and prevent early pregnancies can contribute to improving adolescent girls' nutrition so they can reach their full potential (Horton, 2013; SUN, 2016; Thurnham, 2013; Black et al., 2013; Finlay et al., 2011).

Adolescents constitute nearly a quarter of the population in Kenya (22%) and Uganda (26%) (UNICEF, 2014; UBOS, 2016). In line with the global shift of attention towards adolescents, there is increased engagement and mobilisation of multi-sectoral actors around the adolescent agenda in both countries. There is, however, a lack of evidence globally to guide the development and delivery of strategic nutritional messages and interventions for this specific target group.

Research Design and Methods

The research is part of a four-country study that also included Cambodia and Guatemala, although this paper presents findings from Kenya and Uganda. The research had four overall objectives: 1) to assess the experiences, needs and priorities of adolescents regarding their nutrition; 2) to understand the programmatic environment and current practices for effectively engaging adolescents; 3) to establish preferences from adolescents for how they want to be engaged in programming; and 4) to establish user-centred recommendations for adolescent- friendly, context-specific nutrition interventions.

The mixed-methods study in Kenya and Uganda was conducted between March and December 2017. A country landscape analysis of adolescent programming recorded key stakeholders working with adolescents (in and beyond the health sector) in each country. It then identified the focus, timeframe and location of interventions, the target group (age, ethnicity, gender), the modes of engagement and the key programme implementers. A total of 47 INGOs, NGOs, UN agencies and other institutions working with adolescents were mapped in Kenya, and 28 in Uganda. In a second phase, formative qualitative research elicited perspectives, experiences and suggestions from adolescents and their communities. Participatory workshops with adolescents used a range of creative methodologies to document their voices including photowalks, graffiti walls, drawings, clay modelling and social network mapping.

In Kenya, research activities included 312 participants (219 of whom were adolescents), and in Uganda they included 312 participants, (210 of whom were adolescents). Participants comprised of 10- to 19-year-olds and other influential persons including in peri-urban and rural pastoral communities in Moroto, Uganda and Samburu, Kenya. The full analysis of qualitative data used thematic analysis developed specifically for analysing data generated through applied research.

Results

<u>Defining 'adolescence'</u>

Adolescence is commonly understood as the life stage between the end of childhood and the beginning of adulthood. Conceptually, the UN defines adolescence as spanning the age range of 10-19 years, although others argue for 10-24 years (Sawyer et al., 2018). Adolescence is a dynamic concept, both culturally and historically. The length, the progression and even the existence of adolescence as an interim life stage differ widely across cultures.

Neither Kenya nor Uganda had a standardised definition or age range for adolescence applied across laws and policies, and there were marked disparities between the terminology adopted at the national level and community-level definitions of adolescence.

Age was rarely used to indicate different life stages at the community level. Adults and adolescents across the research sites identified adolescence as a period of physical and cognitive growth. Physical changes were emphasised in all research sites, particularly the start of menstruation for girls and

increasing strength for boys, and physical changes were often the trigger for social adjustments that shifted the position of an adolescent in his or her household and community. Socio-cultural markers dominated communities' definitions of adolescence including circumcision and other initiation ceremonies, and marriage and parenthood.

Increasing responsibilities for girls revolved around household chores, primarily sourcing, preparing and cooking food, and caring for younger siblings. In Samburu, Kenya, adolescent boys (*morans*, meaning warriors) assumed responsibility for the security of the community and for taking care of the cattle. Being reliant on parents was often described as a marker of childhood and fostering independence and self-reliance was therefore a key component of adolescence. Markers of adulthood could be observed in individuals considerably younger than 18/19 years old.

A percentage of adolescents in all sites were found to exclude themselves from services aimed at '*youth'* and/or adolescents as they self-identified as adults (given that they were already married, had a child, were engaged in employed work and/or had assumed household responsibilities).

Diet

Many adolescents described having a uniform diet, often eating the same meal multiple times each week or, in some cases, every day. In Moroto, Uganda, adolescents described most commonly eating a meal of green vegetables, boiled or cooked with onions, tomatoes and oil; *posho*, a mix of sorghum flour, water and oil cooked into a thick paste; and beans if they have been harvested, or, if they can be afforded, bought in the market. Even in areas that depended on livestock, meat was rarely consumed. In Samburu, Kenya, the daily diet suggested an overconsumption of certain food groups such as starchy carbohydrates like *lochoro*, a mixture of flour and water. Ceremonies such as circumcision and marriage that were held a several times per year were viewed as the few occasions when everyone, regardless of personal wealth, could eat meat. In general, the diets of participants across the countries were limited in quantity, diversity and overall quality.

Food responsibilities

Across the research sites, adolescents played a key role in sourcing and preparing food for their households, and often had a high level of responsibility for their own food consumption. In Samburu, unmarried adolescent girls were involved in buying and preparing foodstuffs, occasionally helped by younger adolescent boys. Married adolescent girls and mothers were responsible for buying and preparing food for their husbands and children. In Moroto, adolescents explained that the recent drought had made mothers and female caregivers *'busier*', thus placing a greater responsibility on adolescent girls.

Factors affecting adolescent nutrition

Seven interrelated themes were found to influence adolescents' access to adequate and healthy food.

Income-generation activities

Lack of funds was often raised as a significant barrier to purchasing food, and many adolescents who participated in the research were engaged in income-generating activities to contribute resources to their household economy (see Table 1). Participants discussed income-generating activities synonymously with household responsibilities, highlighting the expectation that children and adolescents had to work. As a teacher in Moroto concluded, '*children are used for survival purposes*'.

Table 1 – Income-generating activities described by adolescents

	Kenya		Uganda	
	Girls	Boys	Girls	Boys
Washing plates / clothes	■		■	
Washing cars				●
Babysitting	■		■	
House girls / domestic work	■		■	
Scavenging (plastic, metal)	■	●		
Collecting, selling firewood	■		■	
Making, selling charcoal	■		■	
Brewing, selling alcohol	■		■	
Cooking, selling street food		●		●
Selling water				●
Work on construction sites		●		●
Work in stone quarries		●	■	●
Work in open cast mines			■	●
Work in factories				
Agricultural labour	■	●	■	●
Driving motorbike taxis				●
Security guard				●
Prostitution	■			

■ - Girls ● - Boys

Climate and agricultural practices

Climate issues were highlighted by adolescent participants in Samburu and Moroto, where recent bouts of dry weather had resulted in poor harvests and low-quality yields. Adolescents in both sites noted that the health of their livestock was threatened, animals were producing less milk and less meat was available for consumption. Animal deaths had reduced household assets at the very time that families needed to sell livestock to buy food from the market. In their participatory workshops, adolescents photographed the barren land and empty granaries as important features of their lives. They confirmed that the lack of rain was compounded by poor post-harvest storage practices.

'*Boy with carcass*'.
Photo by 15-19 year old girl, Samburu, Kenya.

'*A picture of thirst*'.
Photo by 10-14 year old girl, Moroto, Uganda.

'*This is our drought*'.
Photo by 10-14 year old girl, Moroto, Uganda.

'*The granaries are empty*'.
Photo by 10-14 year old girl, Moroto, Uganda.

Social norms and restrictive food practices

Across all sites there was general agreement that boys ate more than girls. In Moroto, a common narrative amongst male participants was that girls, who did most of the cooking, '*tasted*' the food whilst they were preparing it, so were expected to eat less during meal times.

Gender-specific eating practices were also evident for boys in Samburu, where a boy could no longer eat food prepared by his mother following his circumcision. He was prohibited from eating in front of women and had to eat in the company of at least one other circumcised boy.

In Samburu, participants confirmed that pregnant women (including adolescent girls) were restricted as to the quantity and type of food they could eat in order to limit the foetus size and reduce the risk of obstructed labour. In Moroto it was reported that many food taboos were not currently observed due to general food shortages, which meant that, in effect, everybody had a restricted diet. As one adolescent girl concluded, *'is there any food I am not allowed to have? No, any food I can find I can eat*'.

Security and Alcohol

In Samburu, where *morans* acted as livestock herders and key protectors of their villages, hunger was linked explicitly to cattle raiding. One local government representative explained, '*if you don't have anything to eat, you must fight to get at least some milk, some meat when you are away from home with the animals'*. Insecurity from cattle raiding and highway banditry further affected access to food as it limited market and trade routes and restricted the provision of external support to the area.

In both Moroto and Samburu, adolescents were also heavily involved in the brewing business and girls documented both brewing and selling alcohol in their participatory workshops. Selling alcohol was a major source of income and a way to generate sufficient resources to buy food. In Moroto, alcohol was also considered a food source in itself. Adolescent girls reported drinking one or two cups per day ('*it's like our breakfast*'), and both there and in Samburu, the residue created during the brewing process was eaten *'to fill the stomach*'.

Education and school attendance

School attendance was seen as a protective factor against a range of adolescent vulnerabilities that had the potential to impact nutritional status. Many younger adolescents (10-14 years) engaged in the study attended school, but most of the older adolescents (15-19 years) had dropped out due to competing responsibilities including income-generation activities and household duties. Participants in all settings confirmed that girls who were not in school were more likely to marry earlier and that non-attendance was actually interpreted as an indication that a girl was ready to marry. It was noted in Moroto, that school attendance could reduce a girl's bride price and this was a factor in caregivers not sending their daughters to school. Across all sites, there was general consensus that if a girl became pregnant, she would likely drop out of school.

Sexual and reproductive health

Sexual and reproductive health was raised as a central issue that affected adolescents' nutritional status, particularly related to adolescent pregnancy as a direct consequence of low contraception rates, early sexual debut, early marriage, sexual violence and HIV. The legal age of consent in Kenya and Uganda is 18 years, but many adolescent girls were said to marry younger in Moroto and Samburu. Bride price was seen to be an important source of immediate income and, as it was often paid in the form of cattle, a positive way to replenish a dwindling herd. This was evident at the time of the research when the recent dry weather had left many families with limited resources (depleted livestock, food reserves and money).

Service provision

Health facilities are an important avenue for nutrition services, yet many adolescent mothers who participated in the study had not attended antenatal care (ANC). Adolescents across the research sites did not regularly interact with health facilities and regarded them as '*places for sick people*', rather than for preventative care. Negative community attitudes towards early pregnancy made pregnant adolescents feel ashamed, and they described their '*fear*' of having to describe a health issue to medical professionals and of being judged by other community members waiting at the facility. Other key barriers included distance to the facility, long waiting times, and drug shortages.

Throughout the research school was recognised as a direct means to address child and adolescent nutrition including through school feeding programmes supported by a range of government, NGOs and WFP. In Moroto, school meal provision was reported as a primary motivator for school attendance, and as one teacher asserted, '*if there is no smoke from the kitchen, children will not come to school*'. Another school teacher expressed concern that school was being used as a '*feeding centre',* that children were coming at break-time for food, but then leaving to continue their household duties or income-generating labour.

Engaging Adolescents

Understanding how to effectively engage adolescents is essential for assessing how nutrition-specific and nutrition-sensitive interventions can be delivered and best related to other components of the 'adolescence equation'. Across the research sites, there was a high level of consistency in the priorities and needs adolescents articulated in relation to their engagement (see Table 2).

Table 2 – Adolescent participants' preferences for engagement in programming

'Come to us, fit around our lifestyle'
Adolescents stressed the importance of accessibility and preferred to be 'reached' in places they already frequented and at convenient times. Interventions must be tailored to fit the often-chaotic lifestyles of adolescents and must recognise their competing priorities.
'Show us real experiences'
Adolescents confirmed they found 'real life' stories to be the most engaging and affective way of sharing and learning from experiences. Across all research sites, adolescents emphasised their desire to have activities for young people facilitated by youth leaders who were close to them in age and who had shared similar experiences and challenges growing up.
'Make it entertaining'
Great importance was attributed to the need for activities to be primarily entertaining, as well as informative and understandable. The use of music to attract and sustain the attention of adolescents was highlighted. Dance and sports activities were also popular.
'Use our groups, don't group us'
Adolescents also suggested grouping according to life stages: married girls and young mothers should be engaged separately from unmarried girls; older boys separately from younger boys; and some suggested that in-school adolescents should be engaged separately from those who were out of school.
'Speak our language
The importance of conversing with adolescents in their local language was stressed. Adolescents highlighted the benefit of tailoring language not only to fit with their dialect, but also their colloquialisms. They also stressed the need to be spoken to with respect in order for them to feel comfortable engaging with services and programmatic interventions

'Ask us, include us'

Adolescents suggested that rather than passive or one-directional methods of conveying information (such as billboards, brochures and posters), they wanted to be included in interpersonal activities. This would give them a chance to ask questions and to ensure that their voices were heard and opinions recognised.

'Be fair'

Adolescents stressed that different and multiple modes of engagement may be needed to interact with adolescents, but that all engagement should be transparent. The importance of trust and privacy was repeatedly emphasised and adolescents were wary of information or situations they perceived to be discriminatory.

'Include the people around us'

Because of the of the important gatekeeper roles that caregivers played in their lives, adolescents emphasised that initiatives directed at their engagement should also involve their families, or at least secure their buy-in.

'With food, we need energy now'

The need to show the immediate benefit of food was highlighted across the field sites in each country. Adolescents reported that having energy was their priority to ensure they could complete their daily workload. This focus on the present should be carefully considered in adolescent nutrition programming and to create opportunities to set new and healthy trends.

'And build us for the future'

Adolescents wanted engagement activities to build their skills and interests. They were most receptive to learning when it was incorporated into activities they enjoyed and were good at and which prioritised issues they identified to be important.

Discussion and Conclusions

The research used creative and participatory methods to gather new empirical data on the experiences, needs and priorities of adolescents regarding their health and nutrition, and sustainable development. It highlights that adolescents are both knowledgeable and practical about the often-competing issues facing them as individuals and in relation to their households and communities. In conclusion, a series of user-centred recommendations are made:

<u>Increasing the visibility of adolescents</u>

The definition of 'adolescence' at the national level is not consistent, and it is defined differently across sectors and ministries. The tendency at both policy and programmatic levels to group adolescents with 'children', 'youth' or 'women of reproductive age' reduces the visibility of adolescents, hampers the identification of adolescent-specific problems, and limits the development of appropriate strategies and programme design to meet their specific needs. Although it may not be possible to agree on definitions and terminology across all sectors, it is important that measures be taken to prevent adolescents' needs from being insufficiently addressed. This will require focused advocacy with national stakeholders and partners to ensure their commitment to this age group, regardless of the terminology used.

Similarly, the definitions of adolescence at the national level are rarely consistent with definitions used at the community level. This results in some adolescents self-identifying in ways that prevent them from seeking youth-orientated services. 'Adolescents' must not be interpreted as a homogenous or standard group. Within this age group, different life-stages occur and should be accounted for.

Influencing adolescent nutrition

Increasing communication and information about nutrition alone will not improve the diet or healthy behaviour of adolescents. Rather, interventions should adopt a systems-based approach and address the nutritional needs of adolescents in the context of and in combination with other key components of their lives. Restrictive social norms, sexual and reproductive health issues including early marriage and teenage pregnancy, and access to education are critical components related to improving nutritional status and wellbeing. Communication and information should be combined with improved access to healthy food and other services.

Across the study, it was noted that reducing household poverty by increasing income-generation opportunities for caregivers and household heads is key. This will reduce the burden on adolescents to contribute to the household economy. If adolescents do need to work, then safe income-generating opportunities should be designed around keeping adolescents in school (e.g. scheduling activities for adolescents during non-school hours and at weekends; supporting household incomes on the condition that children and adolescents attend school). For older adolescents and those who do not attend school, vocational training that develops business skills and provides resources such as start-up equipment is an important avenue of constructive engagement.

Engaging with adolescents

Adolescents should be engaged as active participants in the design, implementation and monitoring of interventions. Programmes should be sensitive to the needs, preferences and priorities of adolescents. During the research, adolescents across all four countries clearly articulated suggestions that should be operationalised (see Table 2).

Adolescents took a high level of responsibility for their own food choices, and often for food preparation for their household. They can therefore be agents of change for family members and their broader communities. In addition to receiving information about nutrition and nutrition-related services for their own wellbeing, adolescents should be considered primary targets for cascading knowledge and improving the nutrition of other vulnerable groups (e.g. children under five).

Securing the buy-in and support of key influencers is vital in both generating demand and facilitating the timely utilisation of programmes and services. Several key influencers in the lives of adolescents were identified, including caregivers and parents, particularly mothers, aunts and grandmothers (for younger adolescents); husbands and mothers-in-law (for married female adolescents); older siblings; peers (for older adolescents); teachers (for those in-school); and community leaders (for adolescent girls and boys of different ages).

The needs of adolescents are dynamic and there is no ‘one size fits all’ delivery channel. Interventions should respond to the complex realities of an adolescent’s life and, rather than being an additional burden, should be mindful of the conflicting responsibilities they may have. Adolescents should be engaged through multiple avenues or platforms that are mutually supportive.

Entry points for policy and programming

Policy and programming entry points need to be strengthened and expanded. Currently most adolescent programming is selective and localised. Actors already engaging adolescents in other sectors should be encouraged to include nutrition in their activities. Similarly, actors already active in the nutrition, food and agricultural sectors should be encouraged to expand their policies and further tailor interventions to better reach adolescents. The positive effect of joint investments must be better demonstrated and a stronger business case made to both donors and ministries of finance.

Many adolescents are included in activities that are orientated towards adults. In acknowledging this, programmes should be aware of the special needs of adolescents and modify their services

appropriately. Services aimed at women of reproductive age should purposefully try to reach all adolescents, and services aimed at pregnant women should ensure that pregnant adolescents are effectively included. Services must be presented in a way that helps adolescents see them as directly relevant and inclusive, particularly in terms of preventative as well as treatment-orientated services. Normalising health facility visits for younger adolescents (e.g. 10-14 years) could help move away from the negative association between health facility attendance and sexual reproductive health issues.

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