Reaching Out to Teen Mothers in Malawi

Reproductive health, according to the World Health Organization (WHO), incorporates not only physical but mental and social well-being. Moreover, reproductive health is not a concern only at certain moments—such as pregnancy or childbirth—in a woman’s (or a man’s) life, but is a continuum from childhood through old age. Save the Children (SC) took this holistic approach in its work with teenagers in Malawi, where one in three girls is married and/or has experienced at least one pregnancy before her 20th birthday.

SC’s adolescent reproductive and sexual health (ARSH) Malawi programming certainly worked with young people, their families and communities to educate the youth about reproduction and health; to build the teens’ skills in decision-making and life choices; and to provide the means to prevent unwanted pregnancy and sexually transmitted infections (STIs) including HIV. But, with help from USAID and its own resources, SC also worked with young women who were already mothers. Traditionally, these teens are expected to devote themselves wholly to their children and husbands, and this includes dropping out of school and ceasing to socialize with their peers. In short, despite their age, teen mothers are expected to behave as mothers and not as teens.

SC chose instead to reach out to these teens primarily as teens, with similar needs and interests as their peers, and secondarily as mothers and wives. The Flex Fund project aligned with SC’s overall ARSH goal: “Adolescents contribute positively to their well-being and the betterment of society.” In the southern Mangochi district, SC worked with more than 2,000 teen mothers to help them achieve that positive contribution via support groups called Teen Mothers Clubs (TMCs), giving them access to family planning (FP) information and methods and, most importantly, helping young women exercise their right to re-enroll in school and complete their secondary education.

Malawi, home to nearly 14 million people, is among the most densely populated and least developed countries in the world. Its total fertility rate is high (5.6 children per woman) and contraceptive prevalence is low (28%). At 37 years, life expectancy in Malawi has plummeted, due largely to an adult HIV/AIDS prevalence rate of 15 percent. Young Malawian women are three to five times more likely than young men to be infected with HIV, yet only six percent of sexually active 15 to 19-year-old women report using condoms. Overall, adolescents in Malawi are disproportionately affected, and upwards of 20 percent of people aged 15 to 23 are HIV-positive.

Nearly 30 percent of Malawian girls aged 15 to 19 report being married and a third of adolescent women will have been pregnant or given birth by the time they reach 20. Most of these births occur within marriage or in union, yet pregnancy among unmarried teens has increased in recent years. This can be attributed to a host of issues, including poverty, early...
sexual debut, lack of awareness of reproductive health and contraception, non-use of FP, and relationships with older men. Teen pregnancy, of course, is associated with poor health outcomes for woman and baby, but its effects reach beyond health. In Malawi, it can encompass stigmatization of young mothers, school dropout, and decreased likelihood that an adolescent will resume schooling after her baby is born.

Save the Children began working in Malawi in 1983, and in the southern Mangochi district in 1993. Among its earliest concerns in Mangochi was adolescent reproductive and sexual health. In 1999, SC launched *Nchanda ni Nchanda* (Youth to Youth), a five-year program that used an array of approaches to improve the reproductive and sexual health of people aged 10 to 25. *Nchanda ni Nchanda* implemented peer-to-peer education within youth clubs; established 39 youth resource centers; engaged health providers in SC’s hallmark Partnership-Defined Quality approach to increase their understanding of ARSH needs and their ability to provide youth-friendly health services; and trained young community-based distribution (CBD) agents to counsel and provide FP services to fellow adolescents.

At project’s end, SC interviewed hundreds of young men and women, and found that those who had been exposed to *Nchanda ni Nchanda* reported later sexual debut, greater use of dual protection (condoms plus a second modern method) and positive changes vis-à-vis ABC messages (that is, abstinence, be faithful, and correct and consistent condom use). Use of modern contraceptives among participating women rose from 13 to 23 percent.

Still, the birth rate among Malawian teens remained high and access to contraceptives remained low. The 2004 Demographic and Health Survey reported that women aged 15 to 19 still had one of the highest overall unmet needs for FP (26 %), and that the greatest unmet need was in Mangochi district (33%).

*Nchanda ni Nchanda* clearly made positive changes for young people in Mangochi, but problems of teen pregnancy and early marriage remained widespread. SC decided to continue its work with adolescents, using private funding sources. In 2006, SC attracted additional funding from USAID’s Office of Population and Reproductive Health’s Flexible Fund Program; it combined resources and launched the 27 month project. In it, SC built upon several interventions from *Nchanda ni Nchanda* and targeted 35,000 youth in Chimwala, Mponda, and Namkumba in eastern Mangochi district.

Even as the project continued to promote delayed marriage, delayed sexual debut and use of modern contraceptives, SC reached out to an important segment of the youth population: teen mothers.
In USAID’s Flex Fund project, SC’s goal was to improve the health of women aged 10 to 24 and their children through increased voluntary use of FP services. SC laid out these intermediate results:

1. Increased access to FP services for targeted youth;
2. Improved quality of facility- and community-based FP services;
3. Improved knowledge, acceptance of and interest in using FP services and other protective practices among targeted youth; and
4. Improved social and policy environment for delaying marriage and motherhood, and for youth reproductive health

SC knows that the ramifications of teen motherhood go far beyond physical health; this is certainly the case in Malawi. Married or single, teen mothers quickly find themselves marginalized. They are expected to remain at home and have virtually no avenues for continued personal growth.

Reaching out to teen mothers requires an approach that accounts for the whole person: her physical, mental, and social health. To this end, SC offered FP and SRH-specific information and interventions to teen mothers, and helped them fulfill other aspects of their well-being, as described below.

Teen Mothers Clubs

In Nchanda ni Nchanda and subsequent work, SC developed a large network of youth clubs in Mangochi; it initially used these clubs as a venue to link married girls and teen mothers with unmarried girls who were attending school. The rationale was that teen mothers would find the prospect of re-enrolling in school easier and more enticing if they socialized regularly with schoolgirls. At the same time, schoolgirls could learn valuable lessons from their peers who had become young mothers.

But community support was not enough. Teen mothers also felt alienated from the interests and concerns of their age-mates who were not parents. SC chose to establish clubs for teen mothers only that could act as a stepping stone to general youth club participation. In the TMC, a participant noted, “We can talk about issues that really matter to us and are relevant to our lives, which we can’t discuss during regular youth club meetings.” The TMC provided young women a venue in which to discuss their common concerns—openly and without stigma—and to get support from fellow teen mothers and friends.

SC established 36 TMCs, whose total membership grew to 2,035 young women. Each TMC met once or twice a week, on a schedule agreed-upon by members. Group members facilitated their own club meetings.

One young mother commented that being a part of the TMC helped her be more independent, which she hoped “will lead to employment and a brighter future.” Other teens expressed the value of learning how to take care of their children and the importance of birth spacing.
One young woman, after learning how to negotiate FP and condom use with her partner, acknowledged, “If I knew then all that I know now, I wouldn’t be a teen mother today.” She credits her participation in the TMC with giving her the tools necessary to make positive life choices.

**Meeting Teen Mothers’ FP Needs**

The TMC created a convenient space for reaching teen mothers, who have higher unmet need for FP than their non-parent peers. TMC members received health information on a variety of topics, and each club was linked to one or more local youth CBD agents who could provide FP advice and methods, including oral contraceptives and condoms. Many teen mothers sought FP services from the agents or health centers.

One young woman said, “Initially we were afraid to use contraceptives, but after learning about the benefits and side effects, we were able to choose a method to help us manage our fertility and return to school.”

In 15 in-depth interviews with teen mothers at the end of the project, many reported improved knowledge about FP and greater ability to successfully negotiate contraceptive use with their partners. They also said that the male motivators helped their husbands become more supportive of FP. Reaching out to the husbands of teen mothers was used as a successful strategy to increase family planning use and increase frequency of communication about family planning, as per an operations research study on the use of male outreach workers in this project. The teens shared anecdotes about how husbands used their bicycles to bring their wives to the FP clinic, reminded them of their appointments, and encouraged them to visit the youth CBD agents or health centers for contraceptives.

“‘Youth CBD agents were widely successful in increasing contraceptive uptake among this group. Unfortunately, the project’s monitoring framework did not disaggregate contraceptive acceptance by type of acceptor; that is, it did not differentiate between teen mothers and other users. Therefore, it is not possible to examine numeric evidence of FP use and changes in FP use among this group."

**Changing Attitudes**

With time, and with members’ growing confidence, the TMCs became a springboard for outreach to other teenagers. Club members went door to door; performed music, dance and drama; and participated in community meetings. “The main focus of our community outreach is to educate other adolescents about unwanted pregnancy and the difficulties of being a teen mother,” stated one TMC member.

Not only was this a clear shift in attitude from community members’ initial opinion that young mothers should remain at home, it also marked adults’ new acceptance of discussing FP and related topics with young people. SC’s situation analysis had revealed that parents, community leaders, teachers, and chiefs believed that access to and knowledge of FP would increase youth promiscuity. The project continuously involved these individuals—whom it calls “gatekeepers” to mark their important role in youths’ lives—in its activities.

One such activity was role modeling in support of FP services. A team of four gatekeepers, plus two in-school teen mothers and one teacher, raised awareness with community members and schoolgirls about the benefits of FP, the dangers of teen pregnancies and the Ministry of Education (MoE) policy on teen mothers’ re-enrollment in school (see “Returning to School,” section below). In one hallmark event, a Traditional Authority Chief stood in the presence of five village chiefs and more than 200 community members, and advocated that parents should delay marrying off their daughters and instead keep them in school.

In another innovation, SC invited initiation counselors—the women and men who guide children’s initiation into adulthood—to participate in the project. Overall, 150 such counselors attended an ARSH workshop where FP messages were developed and incorporated, along with HIV prevention practices, into messages passed on to initiates. The counselors discussed and debated the importance of FP, as well as the dangers and merits of certain traditional practices, such as those that lead to early pregnancy and young motherhood, thereby compromising the health status of girls. As a whole, the counselors were very responsive to including FP and RH messages in their initiation instructions.
Returning to School

SC’s approach to ARSH demands that teens be treated as whole people struggling to transition successfully to adulthood. Naturally, then, the problem of teen mothers dropping out of school was a topic of interest to project staff. SC’s intervention to help teen mothers return to the classroom was perhaps the most complex aspect of the project.

One of the greatest barriers we face in helping teen mothers back to school is the family. If her family does not value the role of education or understand how secondary education will help to achieve her goals, they are less likely to support her return to school.

Rose Kamawachale,
District Education Officer, Mangochi

In Malawi, only 31 percent of girls complete primary school and a mere 11 percent graduate from secondary school.\textsuperscript{xiv} Girls’ dropout rate is higher than boys; it is attributed to family responsibilities, early marriage, and pregnancy.\textsuperscript{v} Many young women lose interest in school due to crowded classrooms and an unsupportive community environment. Clearly, Malawian girls face many challenges in completing their secondary education, and teen mothers face even tougher odds.\textsuperscript{xvi, xvii}

Malawi’s MoE does have a policy to allow teen mothers back to school if they follow some rather cumbersome procedures (see box below);\textsuperscript{xviii} but most teachers, parents and students were not aware of it. Young mothers in Mangochi rarely re-enrolled, and the few who tried reported discrimination and ridicule at the hands of teachers, friends and relatives.

“One teen mother’s husband threatened her life when she tried to go back to school,” said a TMC member.

SC intervened by raising awareness about the MoE policy and the importance of re-enrollment. Community members and parents were encouraged to support mothers’ education and learned of the benefits to the women, their children, and indeed communities as a whole. Teachers and school officials also learned of the readmission policy and the importance of supporting teen mothers’ return to and retention in school.
In the Flex Fund project’s first year, 53 teen mothers returned to school; 10 more returned in year two. Remaining in school was an ongoing challenge for these 63 teen mothers: They continuously struggled to balance their limited time and resources to meet their educational goals and their families’ needs. The young women clearly expressed, however, that they saw FP as one means of delaying their next pregnancy to improve their options in life.

Youth CBD agents also promoted a return to school. Aliness Dangalira, an agent in Katema stated, “I have talked to many teen mothers about returning to school after the birth of their babies. I think it is important for [them] to continue attending school so that they can have better opportunities.”

I wanted other girls to know that your life is not over after teen motherhood. You can go back to school and do something with your life.

Mpondasi TMC member

SC staff visited and counseled some of the teen mothers, preparing them to be assertive and prevent pregnancies before achieving their educational goals. Further, SC worked with local NGOs, the District Education Office, and secondary schools to locate financial assistance for young mothers wishing to re-enroll. Finally, project staff encouraged teens who had returned to school to participate actively in TMCs alongside those who had not, so that members could learn from each others’ experience.

During meetings, we discussed how to negotiate contraceptive use and help prevent sexually transmitted infections. I was able to convince my (now) husband to go for voluntary counseling and testing before we were married.

Aris, teen mother

Catherine’s Story

As a child, Catherine dreamed of becoming a nurse. Her family supported her goal, and she benefited from SC education programs in her village of Chilapa. Yet once she finished local primary school, her family struggled to pay for her uniform, school supplies and, transportation to and from secondary school. Catherine was encouraged to find a boyfriend who would help cover these costs. At first she resisted, but before long she found herself halfway through her junior year and pregnant. She was devastated when she was forced to leave school and return home. Worse, Catherine later delivered a stillborn baby.

Catherine and her family desperately sought a way for her to return to school. Having heard of the MoE policy allowing teen mothers to re-enroll, her father walked for two days to SC’s office in Mangochi to learn if the organization could offer further help to his daughter.

SC succeeded in finding funds so that Catherine could return to school. There, she has exceeded all expectations: Her grades are excellent and she is an advocate for higher education within her community. Catherine will soon be the first woman from Chilapa to graduate from high school.

Neighbors who doubted the value of sending a teen mother back to school now see Catherine as a positive example. Many parents have encouraged their own daughters who are teen mothers to return to school.

“Some girls who get pregnant think their lives are over and they should just get married, but this is not the case,” says Catherine. “I encourage [them] to go back to school and do something for themselves.” She adds that her desire to set a positive example for her peers is one of her strongest motivations.

When asked what she would like to do after graduation, Catherine, now 19, responds with a big smile, “I would like to attend university and become a nurse.”
Key Findings

- The societal norms surrounding teen motherhood were deeply entrenched, including the belief that a young mother must forgo her education to raise her child and take care of her husband. Even after discussion and evidence of changing social support, some parents refused to provide money or child care to a daughter, or daughter-in-law, wishing to return to school.

- Teen mothers who did return to school often struggled to remain there. Major obstacles at home were financial resources, time, and child care. As one teen explained, “When I get home from school my parents hand me my child. I had no time in the afternoon to study and no money to buy candles for studying in the evening. I eventually had to drop out of school because the challenges became too great.”

- Stigma and harassment in school were further obstacles. “Some teen mothers are laughed at by their peers…others face discrimination from teachers who believe getting pregnant is a disciplinary issue. “In my school we take action against students who harass teen mothers. However, not all schools have the same supportive environment that we do,” explained the headmaster of a private secondary school in Mangochi.

- And yet, teen mothers who did return to school were often as successful in their studies as they were before dropping out. The District Education Officer estimated that 75% of returnees graduated from secondary school.

- For every girl who received funding to return to her studies, at least five did not. “It is common that we send a list of six teen mothers who seek funding … to the District Education Office, but only one girl out of six will receive financial support,” explained an assistant health worker in Kukalanga.

- Getting just one young woman back into school requires extensive outreach: with the teen herself, with her family, and with her community. SC’s essential allies in this outreach included local schools and NGOs that provided school fees.

- School fees are necessary, of course, but remaining in school means that money is needed for uniforms, school supplies, and transportation. Teen mothers may also need help to pay for child care. Community support and awareness is key, not only to achieving improved financial support for these girls but also to breaking the vicious cycle in which young women have few real options except early marriage or exchanging sex for money, both of which lead to early pregnancy and dropout.

- Malawi’s MoE was instrumental in educating staff to roll out the teen mother policy. In Mangochi, it was the District Education Officer who sensitized staff and encouraged a welcoming environment for returning teen mothers. A strong policy environment paired with community mobilization proved to be the correct formula for a successful program.

- Teen mothers must be linked with youth CBD agents and youth-friendly health providers who can offer contraceptives, information, and advice. Note that specific approaches for teen mothers and married adolescents are needed: Their needs differ greatly from those of girls who are not married or do not have children.

- “Sometimes we meet on the patio of a house or at the local school; but we need a private space where we can openly share the challenges of teen motherhood,” clarifies a member of the Mpondasi club. This group gathered supplies, mixed cement, and hand-molded bricks to build their own TMC clubhouse. Unfortunately, the rains destroyed their bricks; but these women have not lost hope that they will one day have their own meeting room.

A young mother breastfeeds her baby in the Mangochi District of Malawi
sexualhealth.html!PHPSESSID=aa775e6e6a88655fe605da60831f0ff3.

UNICEF. 2009. State of the World's Children 2009. New York. This is the number of children who
would be born per woman if she lived to the end of her childbearing years and bore children at each
age in accordance with prevailing age-specific fertility rates.


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