



African Population and  
Health Research Center



# Action to Empower Adolescent Mothers in Burkina Faso and Malawi

The PROMOTE Project Pilot Randomized  
Controlled Trial

Baseline Survey Results

MARCH 2024

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## Acronyms

AGI-K	Adolescent Girls Initiative- Kenya
APHRC	African Population and Health Research Center
CBCCs	Community-Based Childcare Centers
CHW	Community Health Worker
CSR	Centre for Social Research
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
IDRC	International Development Research Centre
ISSP	Institut Supérieur des Sciences de la Population
IUD	Intrauterine Device
RCT	Randomized Controlled Trial
RGPH	Recensement Général de la Population et de l'Habitation
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UNIMAREC	University of Malawi Research Ethics Committee

# Executive Summary

In Burkina Faso and Malawi, as in many countries in sub-Saharan Africa, girls' and women's health as well as their social and economic wellbeing are negatively impacted by early sexual debut and childbearing. The "Action to empower adolescent mothers in Burkina Faso and Malawi (PROMOTE)" project seeks to estimate the effect of three interventions on: 1) adolescent mothers' (re)entry into school or vocational training, and 2) their sexual and reproductive health, as well as mental health. The three interventions are cash transfers conditioned on (re) enrollment in school or a vocational training program, subsidized childcare, and life skills training offered through adolescent mothers' clubs, which are facilitated by community health workers. A pilot randomized control trial (RCT) implemented in Ouagadougou (Burkina Faso) and Blantyre (Malawi) and targeting 270 adolescent mothers in each country will be used to compare the effects of the interventions. This report describes the study and summarizes the findings from the baseline survey.

## Key findings

### Sociodemographic characteristics

- More than 80% of adolescent mothers in both countries were aged 18 - 19 years.
- 38% of adolescent mothers in Burkina Faso and 31% of those in Malawi were married or living with a partner as if married.
- Nearly all adolescent mothers had only one child (98% in Burkina Faso and 94% in Malawi).
- Education and training
  - Eleven percent of adolescent mothers in Burkina Faso had never attended school. Only one girl in Malawi had never attended school.
  - Only 9% and 11% of adolescent mothers in Burkina Faso and Malawi, respectively were still in school at the time of the survey.
  - In Burkina Faso, 29% of adolescent mothers expressed a desire to return to school, compared to about 60% of adolescent mothers in Malawi.
  - Majority of the adolescent mothers expressed an interest in learning a trade (83% in Burkina Faso and 97% in Malawi).

### Sexual and reproductive health

- In both countries, majority of adolescent mothers had their first sexual intercourse between the ages of 15 and 17, years with the earliest reported age of first sex being 11 years.
- All adolescent mothers in Burkina Faso and Malawi reported that they were aware of the existence of contraceptive methods. The mostly commonly known methods in both countries were injectables, implants, male condoms and contraceptive pills.
- Most respondents in Burkina Faso (51%) and Malawi (71%) were using some type of contraception. The most commonly used methods of contraception were implants, injectables and male condoms with variations across the study sites.
- 15% of adolescent mothers in Burkina Faso and 11% of those in Malawi who had sex in the last week preceding the survey reported that they had sex with men (including boyfriends, casual or one-time partners, or 'blessers') to gain financial or material support.
- Nearly all adolescent mothers had heard about HIV. Almost all respondents in Malawi (95%) reported that they knew where to get HIV testing, while in Burkina Faso, 78% of adolescent mother knew where one could get tested.

- Majority of the respondents in Malawi (90%) reported that they had knowledge of other sexually transmitted infections (STIs), while half (50%) in Burkina Faso reported the same. While the percentage of respondents who had heard about STIs was high in Malawi, knowledge about the signs and symptoms was generally low with 42% of the respondents not knowing signs and symptoms of STIs in women.

### Intimate partner violence

- There was a higher prevalence of violence experienced by the adolescent mothers in Malawi. About 65% of the adolescent mothers in Malawi, and 40% in Burkina Faso reported that they had experienced some form of violence in their intimate relationships.

### Mental health

- 23% of adolescent mothers in Burkina Faso and 19% in Malawi reported moderate to severe depressive symptoms.

### Financial literacy

- Only a few adolescent mothers in both countries had a bank account (3% in Burkina Faso and 1% in Malawi)
- A significant number of adolescents reported that they planned their finances (58% in Burkina Faso and 76% in Malawi).
- Only 8% and 13% of adolescent mothers in Burkina Faso and Malawi, respectively, had written down their financial plan.

### Childcare

- About two in every five adolescent mothers did not receive any financial assistance from the father of their child.

## Implications

The findings highlight the challenges faced by adolescent mothers living in resource-constrained urban settings. We found that majority of the adolescent mothers surveyed were out of school. However, many expressed interest in either returning to school or learning a trade. In terms of SRH knowledge and behavior, the baseline findings suggest that many may be at risk for poor SRH outcomes because of low levels of SRH knowledge, involvement in transactional sex and low levels of contraceptive use. While there were substantial differences between adolescent mothers in Burkina Faso and Malawi, the findings have similar implications and underscore the value of interventions that seek to enhance adolescent mothers' social, economic, health and education assets.

## Introduction

In Burkina Faso and Malawi, as in many other countries in sub-Saharan Africa, early sexual debut and childbearing negatively impact girls' and women's health as well as their social and economic wellbeing. This subsequently contributes to gender disparities in educational attainment and economic involvement.

The "Action to empower adolescent mothers in Burkina Faso and Malawi (PROMOTE)" project seeks to estimate the effect of three interventions on: 1) adolescent mothers' (re)entry into school or vocational training, and 2) their sexual and reproductive health (SRH), as well as mental health. The three interventions are cash transfers conditioned on (re)enrollment in school or a vocational training program, subsidized childcare, and life skills training offered through adolescent mothers' clubs, which are facilitated by community health workers. A pilot randomized control trial (RCT) implemented in Ouagadougou (Burkina Faso) and Blantyre (Malawi) and targeting 270 adolescent mothers in each country will be used to compare the effects of the interventions. This report summarizes the interventions and the findings from the baseline survey.

We hope to maximize the translation of the evidence into policy and action through strategic communication of research findings using various knowledge products tailored to diverse groups of end-users, and sustained engagement with key stakeholders and decision-makers from the outset. Furthermore, we anticipate that this project will produce a cadre of researchers in Burkina Faso, Kenya, and Malawi who will be competent in conducting, overseeing, and assessing robust mixed-methods intervention research that addresses the needs of parenting adolescents through a structured mentorship approach from more experienced researchers.

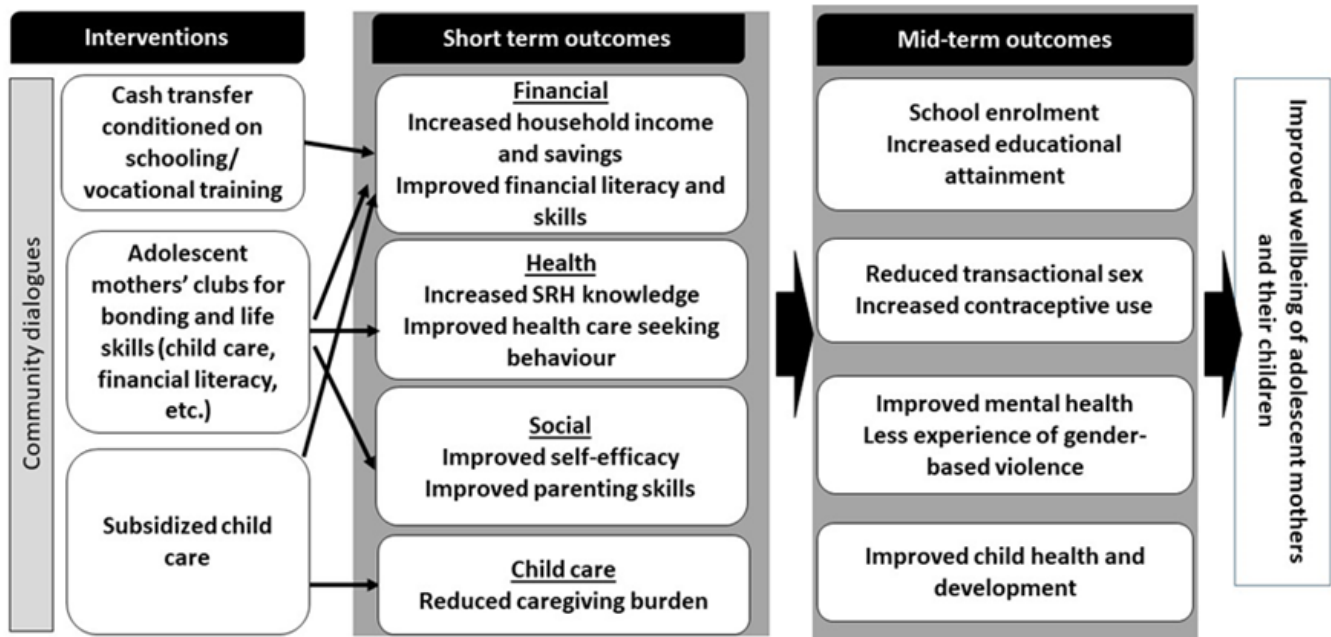
## Theory of Change

The ecological framework, which emphasizes the significance of a supportive environment—legal, political, economic, and sociocultural—for adolescents' health and development, serves as the foundation for our research. Numerous factors that function at various levels—individual, interpersonal, organizational, community, and policy—as well as their interactions with one another, impact on behaviors and outcomes on the health and wellbeing of adolescent mothers.

At the individual level, our interventions seek to empower adolescent mothers by enhancing their social, economic, health and education assets. We achieve this through the provision of conditional cash transfers and life skills training on various aspects including financial literacy, SRH and nurturing childcare. To enhance interpersonal support, adolescent mothers are brought together in groups known as adolescent mothers' clubs, which are moderated by community health workers (CHWs). The CHWs also support adolescent mothers by providing referrals to relevant health facilities in the community. Further, the clubs create a social support network for adolescent mothers. Our intervention also includes vouchers for subsidized childcare in registered childcare centers.

Given the potential for contamination, the project does not include a community-wide intervention. However, we have held sensitization meetings with community and religious leaders, health workers, social workers, teachers, parents, and adolescent mothers in the study settings. During these meetings, community members have discussed the root causes of adolescent pregnancies and possible approaches to support parenting adolescents.

To inform system-level change, as part of our research uptake activities, we will document and strategically share project PROMOTE learnings with relevant stakeholders including decision-makers, civil society organizations, academia, and research experts, and the project partners in Burkina Faso and Malawi. Figure 1 summarizes our theory of change.



**Assumptions:** schools and vocational colleges are open to admitting adolescent mothers; adolescent mothers are willing to enrol in school or vocational training; adolescent mothers and their families are willing to use subsidized child care; adolescent mothers are available and willing to participate in the adolescent mothers' clubs; community health workers are effective in delivering life skills training content; supportive community norms, laws and policies.

Figure 1. PROMOTE Theory of Change

## PROMOTE interventions

The PROMOTE project seeks to test the effect of three interventions: a conditional cash transfer, subsidized childcare, and life skills training offered through adolescent mothers' clubs. The interventions are implemented over the course of 12 months.

### Conditional cash transfers

The cash transfer intervention is conditioned on the (re)enrollment in a school or vocational training program. Eligible adolescents receive approximately US\$ 30 (US\$ 10 per month) every three months. The amount of the transfer is in line with the Government of Malawi's Social Cash Transfer Programme. The project utilizes mobile money platforms, which are common methods of conducting financial transactions in Burkina Faso and Malawi.

### Subsidized childcare

Adolescent mothers eligible for childcare support receive vouchers for childcare in select daycare centers in the two study sites. Girls who receive the vouchers are entitled to 12 months of subsidized childcare. In Malawi, we are working with community-based childcare centers (CBCCs). These centers depend on nominal contributions from the community and parents that use the service, which go towards the running of these centers.

At project inception, the project team mapped out childcare centers and conducted interviews with the managers of these facilities to understand the level of financial support needed. The information obtained helped to identify specific centers where the adolescent mothers can leave their children and allowed the team to establish a reasonable voucher amount. Adolescent mothers receive 12 vouchers and hand over one voucher to the respective childcare center at the beginning of every month. In each study setting, the field teams retrieve the vouchers from each childcare center as a way of monitoring the intervention, as well as to determine the exact amount to be transferred to each childcare center.

## Adolescent mothers' clubs

The adolescent mothers' clubs are held every two weeks for 12 months at a convenient and safe venue within the community. During the club meetings, adolescent mothers receive life skills training facilitated by trained community health workers. Given their role as a bridge between the community and the health sector, working with community health workers is critical in facilitating access to SRH and child health services for adolescent mothers and their children.

The community health workers use a curriculum adapted from the Population Council's *Adolescent Girls Initiative-Kenya (AGI-K) Safe Spaces curriculum*; the *Mphatlalatsane (Early Morning Star) Health and Nutrition Programme Manual*; the *Maternal and Child Health Handbook* and the *Parenting for Lifelong Health Programme for Young Children (Facilitator manual)*. The curriculum covers financial literacy, nurturing childcare, mental health, SRH, gender-based violence, conflict resolution, among other topics.

The clubs also offer a safe space for adolescent mothers to interact, share their experiences, and receive psychosocial support from community health workers and peers. The project anticipates that the collectivism the club creates will boost adolescent mothers' self-esteem, a resource they need to address the stigma associated with early childbearing.



# Methods

## Study design

We will conduct a pilot RCT to estimate the effect of the interventions on adolescent mothers' (re)entry into school or vocation training (primary outcome) and on SRH outcomes and mental health (secondary outcomes). By collecting and analyzing cost data, we will also estimate the most cost-effective interventions to increase adolescent mothers' (re) entry into school or vocational training. After completing a baseline survey, adolescent mothers were randomly assigned to one of three study arms:

- Arm 1: Life skills training only
- Arm 2: Life skills training and subsidized childcare
- Arm 3: Life skills training, subsidized childcare and cash transfer

Following the interventions, adolescent mothers will complete an endline survey. The RCT design is summarized in Figure 2. In subsequent sections we describe the methods adopted for the baseline survey. Further details on the methods are available elsewhere<sup>1</sup>.

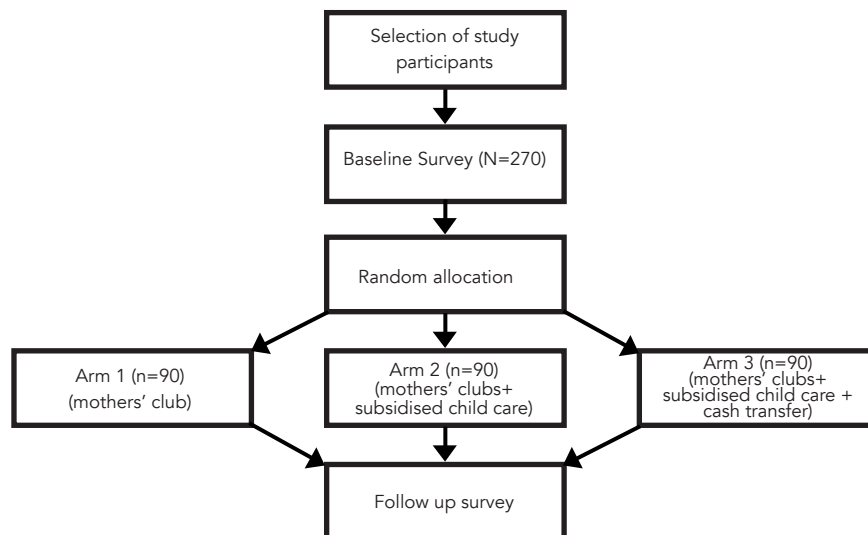


Figure 2. Pilot randomized controlled trial design for the PROMOTE Project

## Study sites

In Burkina Faso, the baseline study was conducted in Ouagadougou, which is located in the heart of the province of Kadiogo. The city's population is young, with 47.3% under the age of 20 and a median age of 16.1. In a previous study on lived experiences of pregnant and parenting adolescents, around 82% were out of school, with 23% reporting that they had dropped out due to pregnancy<sup>2</sup>. Among out-of-school adolescents in Burkina Faso, 39% wanted to return to school, while 79% wanted to have an income-generating activity.

1 Kabiru, C.W., Munthali, A., Sawadogo, N. et al. Effectiveness of conditional cash transfers, subsidized child care and life skills training on adolescent mothers' schooling, sexual and reproductive health, and mental health outcomes in Burkina Faso and Malawi: the PROMOTE Project pilot randomized controlled trial protocol. *Reprod Health* 20, 166 (2023). <https://doi.org/10.1186/s12978-023-01706-9>

2 <https://aphrc.org/publication/rapport-comprendre-les-experiences-des-adolescentes-enceintes-et-meres-dans-la-region-du-centre-au-burkina-faso/>

In Malawi, the study was conducted in Blantyre City in southern Malawi. By 2018, the population of the city was estimated at just over 800,000, with 24% of the population aged between 10 and 19 years. A previous study<sup>3</sup> in Blantyre showed that poverty, sexual violence, COVID-19-related school closures, inequitable gender norms and lack of access to accurate contraceptive information and services make girls vulnerable to early and unintended pregnancy. That study found that most girls who participated in the study got pregnant outside of marriage and consequently faced social exclusion from their peers, parents, and communities. While most relied on their parents to provide for them and their babies, others depended on their partners. However, all these girls faced dire financial situations, sometimes lacking food and other basic needs. In the same study, 94% of the pregnant and parenting adolescents were out of school and about half of them dropped out because of pregnancy. Notably, 76% wanted to return to school if provided with financial and childcare support, while 93% wanted to learn vocational skills<sup>4</sup>.

## Study participants

Our study participants included adolescent mothers aged 10 - 19 years with children aged one to three years. To be eligible to participate in the study, adolescent mothers also had to be able to speak and understand the main language used in the mothers' clubs, to have resided in the study site for at least one year and to provide consent or assent for participation. For adolescent mothers younger than 18 years who were living with their parents or guardians, parental consent was also needed.

## Sampling

A sample size of 270 girls in each site was deemed sufficient to meet the study objectives, with multi-stage sampling used to select the study participants. In Burkina Faso, 32 enumeration zones with the highest number of pregnant and parenting adolescents in a previous study<sup>5</sup> were purposively selected from the 2006 general population and housing census sampling frame (updated in 2017). In Malawi, eight high-density wards in Blantyre city were randomly selected. In each ward, all enumeration areas were clustered in groups of three and seven clusters within each ward randomly selected. A listing of all households in the selected enumeration zones (Burkina Faso) and clusters (Malawi) was conducted to identify adolescent mothers. In Malawi, 288 adolescent mothers from urban Blantyre participated in the survey. In Burkina Faso, 276 adolescent mothers participated in the quantitative survey.

## Data collection, management and analysis

Quantitative data collection in Burkina Faso and Malawi took place from November 2022 to April 2023. Female field interviewers were trained by APHRC and the in-country study teams and divided into three teams, with a supervisor heading each team. An individual questionnaire was administered to each eligible adolescent mother after obtaining informed consent. All survey data were electronically collected on password-protected Android tablets using SurveyCTO. Data were synchronized daily to a secure server. The research team conducted regular data quality checks. The survey data were transferred to STATA for further cleaning and analysis. Descriptive statistics were used to examine adolescent mothers' socio-demographic, behavioral, and attitudinal characteristics and their lived experiences, including circumstances about their pregnancies, reactions to their pregnancies, and health status.

3 <https://aphrc.org/publication/understanding-the-experiences-of-pregnant-and-parenting-adolescents-in-blantyre-southern-malawi-3/>

4 <https://aphrc.org/publication/understanding-the-experiences-of-pregnant-and-parenting-adolescents-in-blantyre-southern-malawi-3/>

5 <https://aphrc.org/publication/rapport-comprendre-les-experiences-des-adolescentes-enceintes-et-meres-dans-la-region-du-centre-au-burkina-faso/>

## Ethical Considerations

The protocol was approved by the African Population and Health Research Center's Ethics Review Committee, the Ministère de l'Économie, des Finances et de la Prospective in Burkina Faso (No. 2022/001589/MEFP/SG/DGCOOP/DCB/ZAAPC/kp), Burkina Faso's National Health Research Ethics Committee (Ministère de la Santé et de l'Hygiène Publique) (No. 2022-11.228) and the University of Malawi Research Ethics Committee (UNIMAREC) (P. 08/33/176). The data collection teams in both sites were trained on research ethics. Participation in the study was voluntary, and informed consent was obtained from all study participants before the administration of questionnaires. Adolescent mothers younger than 18 years who were living on their own or with a partner were considered emancipated minors. For adolescent mothers younger than 18 years who were living with a parent or guardian, informed consent was obtained from their parent or guardian and assent obtained from the adolescent mother.



## Key findings

### Socio-demographic characteristics

Most adolescent mothers (84% in Burkina Faso and 83% in Malawi) were aged 18-19 years. While nearly two-thirds of adolescent mothers in Burkina Faso were Muslim (62%), majority of adolescents in Malawi (87%) were Christian. Fewer than half of the adolescent mothers in both countries were married or living with a partner (39% in Burkina Faso and 31% in Malawi). Nearly all adolescent mothers had only one live birth (93% in Burkina Faso and 94% in Malawi). The sociodemographic characteristics of adolescent mothers are summarized in Table 1.

**Table 1. Adolescent mothers' socio-demographic characteristics, Burkina Faso and Malawi**

Characteristics	Burkina Faso n (%) N = 276	Malawi n (%) N = 288
Age		
10 - 17	44(15.9)	50(17.4)
18 - 19	232(84.1)	238(82.6)
Religion		
Christianity	106(38.4)	249(86.5)
Islam	170(61.6)	39 (13.5)
Marital Status		
Married (living with partner as married)	107(38.8)	88(30.5)
Separated/divorced/not living with partner	76(27.5)	50(17.4)
Single/Other	93(33.7)	150(52.1)
Living situation		
Lives with neither parent	135(48.9)	135(46.9)
Lives with one parent	53(19.2)	90(31.2)
Lives with both parents	88 (31.9)	63(21.9)
Number of live births		
1	266(93.4)	271(94.1)
2 or More	10(3.6)	17(5.9)
Own/has access to a mobile phone	240(87.0)	109(38.0)

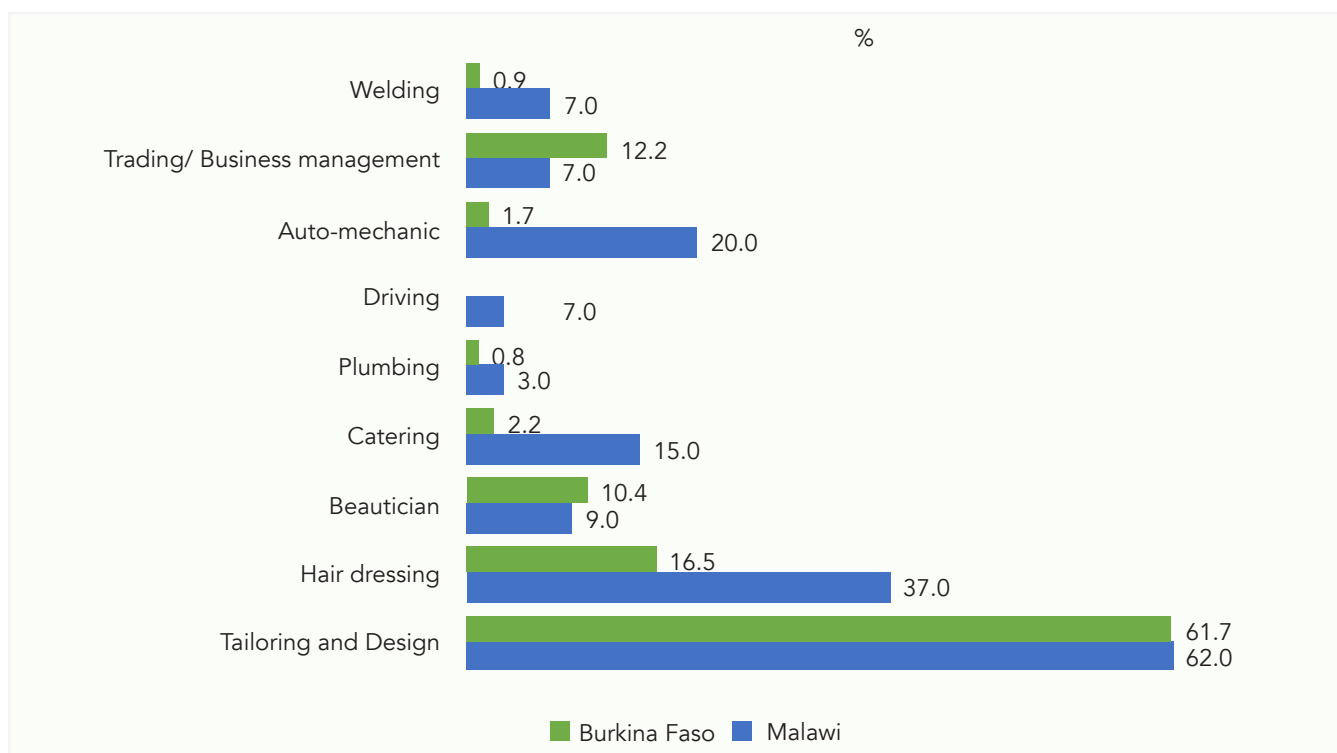
## Education

Almost all adolescent mothers had ever attended school (89% in Burkina Faso and 100% in Malawi). Of those who had ever attended school, 62% in Burkina Faso and 46% in Malawi had attained secondary or higher education. Only 9% (n=23) and 11% (n=32) of adolescent mothers in Burkina Faso and Malawi, respectively were still in school at the time of the survey. In Burkina Faso, 29% of adolescent mothers expressed a desire to return to school, compared to about 60% of adolescent mothers in Malawi.

**Table 2. Schooling status and interest in schooling and learning a trade, Burkina Faso and Malawi**

	Burkina Faso n (%)	Malawi n (%)
Highest level of education		
Primary	93(33.7)	156 (54.4)
Secondary/Post-secondary	154(55.9)	131 (45.6)
Never attended school	29(10.5)	1(0.4)
Currently in school	23(9.3)	32(11.2)
Desire to go/return to school	79(28.6)	172(59.7)
Desire to learn a trade	230(83.4)	279(96.9)

Further, majority of the adolescent mothers expressed an interest in learning a trade (83% in Burkina Faso and 97% in Malawi). In Burkina Faso, 62% of the adolescent mothers indicated interest in pursuing a vocational training in tailoring and design, hairdressing (16.5%), trading and business (12%) and in beauty (10%). In Malawi, adolescent mothers were interested in pursuing vocational training in tailoring and design (62%) followed by hairdressing (37%), auto mechanics (20%) and catering (15%) (Figure 3).



**Figure 3. Choice of vocational training (%) among adolescent mothers in Burkina Faso and Malawi**

## Reasons for being out of school

In Burkina Faso, among out-of-school adolescent mothers, lack of materials and resources like school fees, getting pregnant, needed to earn money, other reasons (such as terrorism and death of a father) and need to earn money were the top five reasons why girls were not in school as shown in Figure 4. Similarly, in Malawi, lack of materials and resources like school fees, marriage, pregnancy, needed to earn money and having completed secondary school were the top five reasons why adolescent mothers were not in school.

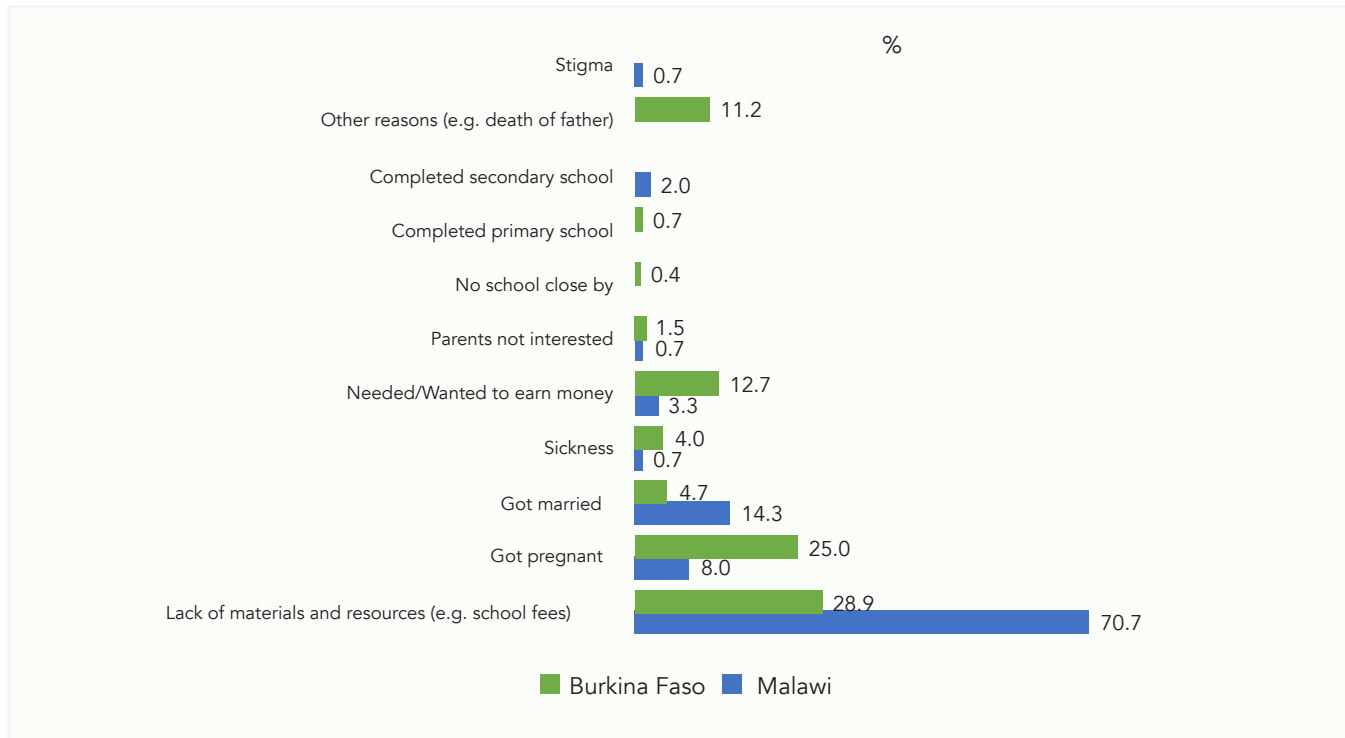


Figure 4. Reasons why adolescent mothers are out of school

## Perceived health status

During the baseline survey, adolescent mothers were asked to rank their perceived health status on a 10-point scale with 1 being very poor and 10 being excellent health. As shown in Figure 5, most adolescent mothers reported that they were in relatively good health with nearly a third in both countries (34% in Burkina Faso and 32% in Malawi) describing their health as excellent. No adolescent mother in Burkina Faso and only 2% of adolescent mothers in Malawi described their health as very poor.

In both Burkina Faso and Malawi, fever was the most frequently reported health issue among adolescent mothers, with a prevalence of 25% and 32%, respectively (Table 3). Recurring fatigue or weakness was also commonly reported, affecting 20% of adolescent mothers in Burkina Faso and 18% in Malawi.

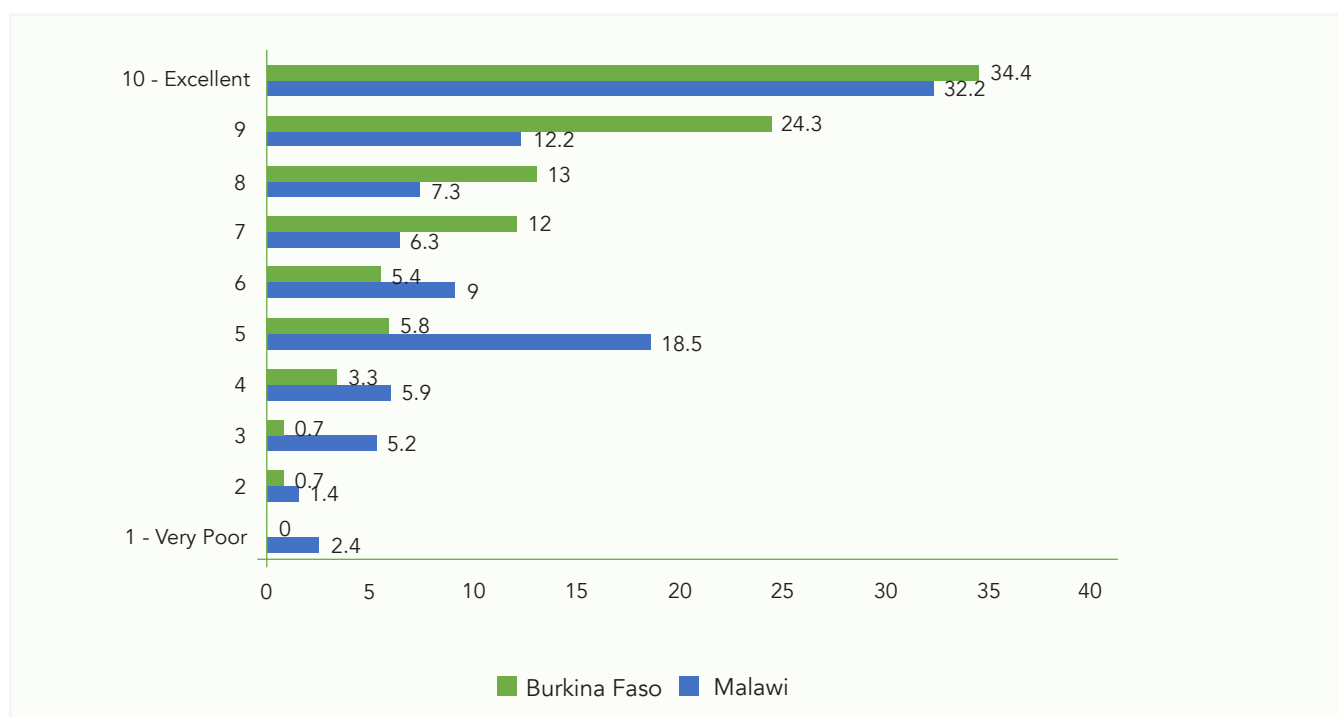


Figure 5. Self-reported rating of health status in the past month

Table 3. Percentage of adolescent mothers with health problems in the past 1 month in Burkina Faso and Malawi

Health Problem	Burkina Faso N = 276	Malawi N = 288
Fever	24.6	31.9
Recurring fatigue/weakness 3 days and more	19.6	18.1
Recurring coughing or shortness of breath for more than 3 days	15.9	14.6
Rapid weight loss	12.0	18.1
Recurring diarrhea	8.7	19.8
Night sweat	6.2	12.2
Recurring vomiting for more than 3 days	1.8	3.1

More than half of adolescent mothers in Burkina Faso (59%) and about 67% in Malawi had visited a health center in the six months prior to the survey (Table 4). The most frequently used facilities by those who sought medical assistance were public health clinics (66% in Burkina Faso and 63% in Malawi) and public hospitals (18% in Burkina Faso and 34% in Malawi).

**Table 4. Health facility utilization by adolescent mothers in Burkina Faso and Malawi**

	<b>Burkina Faso N = 276</b>	<b>Malawi N = 288</b>
Adolescent mothers who used a health facility for any service in past 6 months	163(59.1)	194(67.4)
Type of health facility used	N=163	N=194
Public health clinic	108(66.3)	123(63.4)
Public hospital	29(17.8)	66(34.0)
Private hospital	24(14.7)	4(2.1)
Mission hospital	13(8.0)	1(0.5)
Private health clinic	3(1.8)	13(6.7)

## SRH knowledge

### Knowledge of HIV/AIDS

Nearly all adolescent mothers had heard about HIV. Almost all Malawi respondents (95%) reported that they knew where to get HIV testing, while in Burkina Faso 78% of adolescent mothers knew where one could get tested. On HIV prevention and transmission, most respondents in Malawi (82%) knew that consistent condom use during sex can prevent HIV infection and nearly all (94% in Malawi and 88% in Burkina Faso) were aware that having one uninfected sexual partner who has no other sexual partner can prevent HIV infection.

In general, 94% of the adolescent mothers knew that a healthy-looking person can be HIV-positive. Most respondents in Malawi rejected the three common most misconceptions about HIV with only 17% of adolescent mothers in Malawi agreeing that HIV can be transmitted through mosquito bites, while 7% agreed that HIV can be transmitted by sharing food with someone with HIV or through witchcraft.

**Table 5. HIV/AIDS knowledge among adolescent mothers in Burkina Faso and Malawi**

	<b>Burkina Faso N = 276</b>	<b>Malawi N = 288</b>
	n (%)	n (%)
Heard about HIV/AIDS	269 (97.5%)	288 (100%)
Knowledge of where to get HIV testing	209(77.7%)	273(95.1)
<b>% of adolescent mothers who are aware of mother-to-child transmission of HIV during:</b>		
Pregnancy	186(69.1)	223(77.7)
Delivery	199(74.0)	207(72.1)
Breastfeeding	196(72.9)	254(88.5)

	Burkina Faso N = 276	Malawi N = 288
<b>% who agree that HIV can be transmitted via:</b>		
Mosquito bites	59(21.9)	46(17.1)
Sharing food	65(24.5)	20(7.0)
Witchcraft	47(17.5)	19(6.6)
<b>% who believe that people can reduce the risk of HIV transmission by:</b>		
Consistent condom use	238(88.5)	236(82.2)
Having one uninfected partner	236(87.7)	269(93.7)
Abstinence	220(81.8)	254(88.5)

In both countries, most adolescent mothers demonstrated knowledge regarding mother-to-child HIV transmission. Most respondents in Malawi (78%) and Burkina Faso (69%) understood that HIV can be transmitted during pregnancy; 72% in Malawi and 74% in Burkina Faso were knowledgeable about HIV transmission during delivery. Furthermore, 89% of respondents in Malawi and 73% in Burkina Faso knew that HIV can be transmitted during breastfeeding.

### Knowledge of other STIs

Majority of the adolescent mothers in Malawi reported that they had knowledge of other STIs (90%), while half (50%) in Burkina Faso reported the same. While the percentage of adolescent mothers who had heard about STIs was high in Malawi, knowledge about the signs and symptoms was generally low with 42% of them not knowing signs and symptoms of STIs in women. Among the symptoms of STIs in women, the majority of adolescent mothers in Burkina Faso mentioned itching (54%), genital discharge (23%) and foul-smelling discharge (17%). In Malawi, only 1 in 10 adolescent mothers mentioned itching and foul-smelling discharge (14%) as symptoms of a STI. The findings indicated that less-known symptoms in both countries were, burning pain during urination, abdominal pain, swelling in groin area, genital warts, and genital pain/ulcer.

Adolescent mothers in both countries were less familiar with male symptoms of STIs. About six in ten adolescent mothers in both Malawi and Burkina Faso did not know any STI symptoms in men. The most well-known symptom in Burkina Faso was itching of anus (27%) and genital ulcers and sores in Malawi (12%).

**Table 6. Knowledge of STI symptoms among adolescent mothers in Malawi and Burkina Faso**

	<b>Burkina Faso n (%)</b>	<b>Malawi n (%)</b>
Knowledge of other STIs symptoms	136 (50.5)	259 (90.2)
Knowledge of STIs symptoms in women		
Abdominal pain	20 (7.3)	20 (6.9)
Genital discharge	64 (23.2)	12 (4.2)
Malodorous discharge	46 (16.7)	40 (13.9)
Burning pain on urination	27 (9.9)	32 (11.1)
Pain/Genital ulcer	8 (2.9)	81 (28.1)
Genital Warts	11 (4.0)	19 (6.6)
Swelling in the groin area	18 (6.5)	27 (9.4)
Itching	148 (53.6)	34 (11.8)
Other	8 (2.9)	30 (10.4)
No knowledge of STIs symptoms in women	87 (31.5)	122 (42.4)
Knowledge of STIs symptoms in men		
Penile discharge	23 (8.3)	11(3.8)
Anal discharge	2 (0.7)	1(0.3)
Burning pain on urination	15 (5.4)	25(8.7)
Genital pain/ulcer	11 (4.0)	34(11.8)
Swelling in groin area	8 (2.9)	28(9.7)
Inability to retract foreskin	9 (3.3)	3(1.0)
Itchy anus	76 (27.5)	1(0.3)
Itchy throat	7 (2.5)	2(0.7)
Pelvic pain	8 (2.9)	10(3.5)
Other	13 (4.7)	20(6.9)
No knowledge of STIs symptoms in men	173 (62.7)	180(62.5)

## Contraceptive knowledge

All adolescent mothers in Burkina Faso and Malawi reported that they were aware of the existence of contraceptive methods. As shown in Table 7, the mostly commonly known methods in both countries were injectables, implants, male condoms and contraceptive pills. Fewer than half of the adolescent mothers (40% in Burkina Faso and 48%) reported that they had heard about emergency contraception.

**Table 7. Number and percentage of adolescent mother reporting that they had heard different contraceptive methods**

	Burkina Faso N (%)	Malawi N (%)
Knowledge of contraceptive methods		
Pills	255 (92.4)	277 (96.2)
Intrauterine device (IUD)	151 (54.7)	244 (84.7)
Injectables	260 (94.2)	286 (99.3)
Implant	265 (96.0)	284 (98.6)
Male condom	261 (94.6)	270 (93.8)
Female condom	131 (47.5)	226 (78.5)
Periodic abstinence/ Rhythm method	148 (53.6)	175 (60.8)
Withdrawal	123 (44.6)	208 (72.2)
Emergency contraception	110 (39.9)	137 (47.6)

## Knowledge of ovulation

More than three-quarters (80%) of adolescent mothers in Burkina Faso and all adolescent mothers in Malawi reported that there are days when a woman has a greater chance of becoming pregnant if she has unprotected sex (Table 8). Just over half of adolescent mothers in Burkina Faso (51%) and almost 25% of those in Malawi said that the most fertile period was just after the end of menstruation. About a third of adolescent mothers in each country said that it was halfway through the menstrual cycle.

**Table 8. Knowledge of fertile period among adolescent mothers in Burkina Faso and Malawi**

	Burkina Faso N=276	Malawi N=288
Awareness of when a woman is likely to become pregnant if she has unprotected sex	220 (79.5%)	288 (100%)
When is a woman most fertile:		
Just before the onset of menstruation	22 (10.0%)	113 (39.4%)
During menstruation	4 (1.8%)	4 (1.3%)
Just after the end of menstruation	113 (51.5%)	71 (24.6%)
Halfway between two periods	78 (35.5%)	98 (33.9%)
Don't know	3 (1.4%)	2 (0.8%)

## Contraceptive use

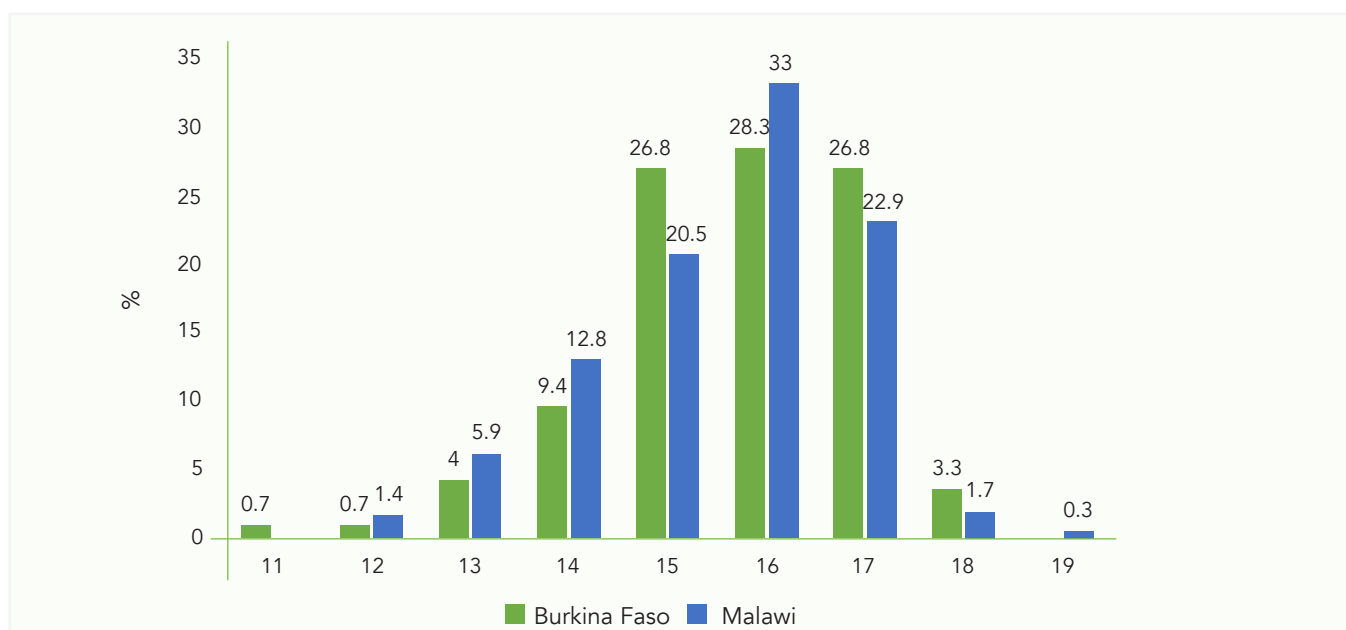
Most respondents in Malawi (71%) and just over half in Burkina Faso (51%) were using some type of contraception. The most commonly used methods of contraception were implants, injectables and male condoms with variations across the study sites. A higher proportion of adolescent mothers in Burkina Faso were using implants (52%) compared to Malawi (34%). A higher proportion of adolescent mothers in Malawi were using injectables (54%) than those in Burkina Faso (18%). Few adolescent mothers reported the use of pills, female condoms and exclusive breastfeeding.

**Table 9. Current contraceptive use among adolescent mothers in Burkina Faso and Malawi**

	Burkina Faso n (%)	Malawi n (%)
Current contraceptive use	142(51.4)	206(71.2)
<b>Current contraceptive method</b>		
Pills	6 (4.2)	6 (2.9)
IUD	1 (0.7)	-
Injectables	26 (18.3)	111 (53.9)
Implants	74 (52.1)	70 (34.0)
Male condom	27 (19.0)	11 (5.3)
Female condom	1 (0.7)	1 (0.5)
Breastfeeding	11 (7.8)	1 (0.5)
Emergency contraception	-	1 (0.5)
Other(abstinence)	4 (2.8)	-

## Sexual behavior

In both countries, majority of adolescent mothers had their first sexual intercourse between the ages of 15 and 17 years with the earliest reported age of first sex being 11 years (Figure 6).



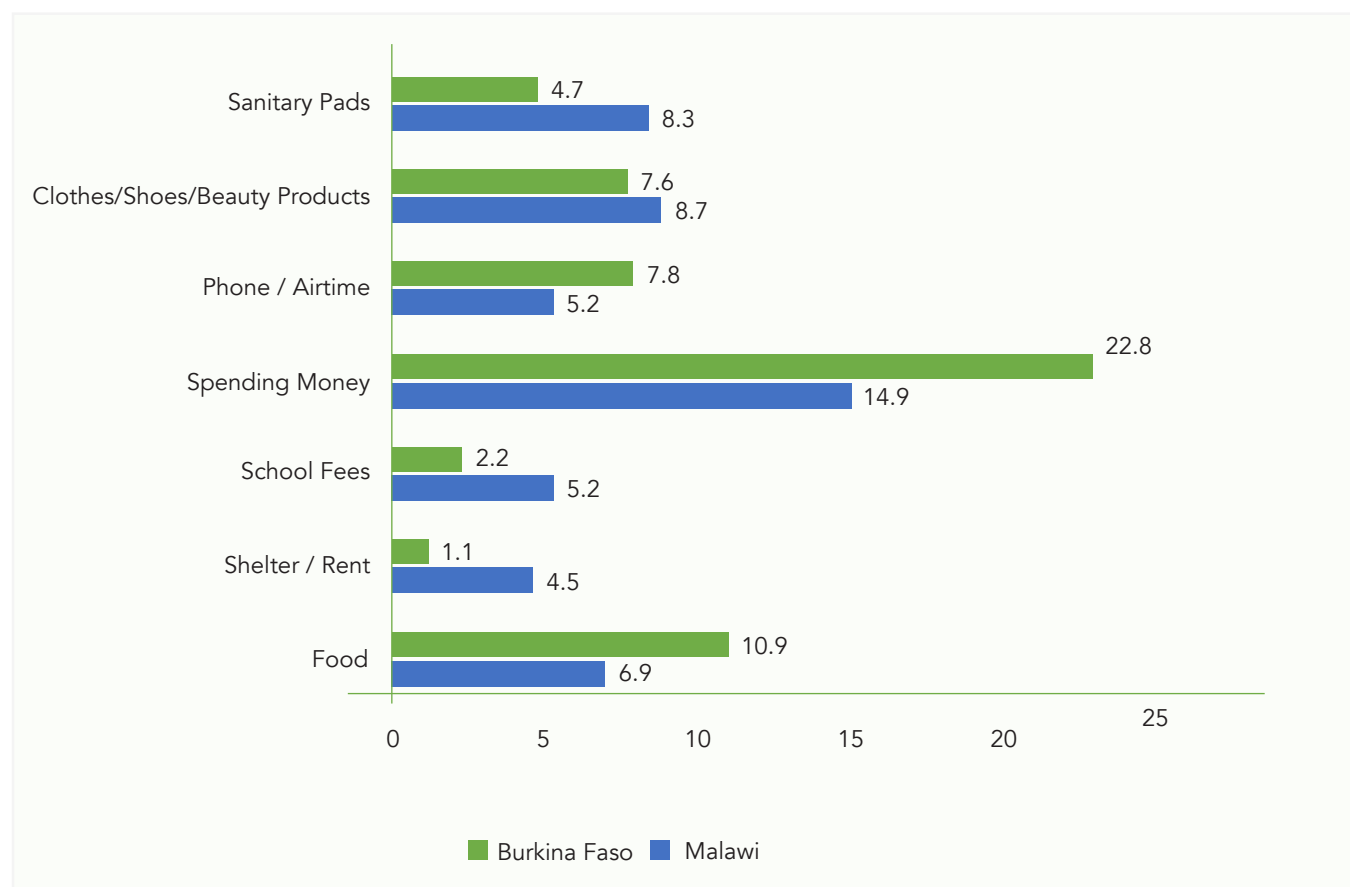
**Figure 6. Proportion of adolescents reporting first sexual intercourse at specific ages**

Among adolescent mothers who reported sexual intercourse within the year, 3% in Burkina Faso and 11% in Malawi reported no sexual partner in the last 6 months while 14% and 7% in Burkina Faso and Malawi, respectively reported two or more partners (Table 10). Eleven percent of adolescent mothers in Malawi and 15% of those in Burkina Faso who had sex in the last week preceding the survey reported that they had sex with men (including boyfriends, casual or one-time partners, or ‘blessers’) to gain financial or material support.

**Table 10. Percentage distribution adolescent mothers by number of sexual partners in the last six months and transactional sex in the last week.**

	Burkina Faso N=276	Malawi N=288
Number of sexual partners in the last six months		
0	2.8	11.3
1	83.2	81.4
2+	14.0	7.4

As shown in Figure 7, the reasons for engaging in transactional sex differed. In Burkina Faso, 23% of adolescent mothers reporting transactional sex reported that they did so for money compared to 15% of adolescent mothers in Malawi.



**Figure 7. Reasons for engaging in transactional sex among adolescent mothers**

## Gender attitudes

The survey included several sections that assessed adolescent mothers' gender attitudes. While most adolescent mothers in Malawi agreed with the statement: **'It is okay for a woman to refuse her husband sex'** (80%), slightly less than half in Burkina Faso (46%) agreed with the same statement (Table 11). Most respondents in Burkina Faso agreed with the statement: **'If a husband and wife disagree on using family planning, the husband's opinion should come first'** (81%), whereas less than half of the respondents in Malawi (40%) agreed with the statement.

More respondents in Burkina Faso (66%) than Malawi (47%) agreed with the statement: **'It is a man's right to have sex with his wife whenever he wants'**. Only one in ten respondents in Malawi agreed with the statement: **'Polygamous marriages are part of culture, so they should continue'** while 42% in Burkina Faso agreed. In terms of similarities in perceptions, the majority in both countries disagreed with the statement: **'If a man does not hit his wife, it means he doesn't love her'**. Moreover, most respondents in both countries agreed with the statement: **'It's okay for a man to cook for his family'**.

**Table 11. Percentage of adolescent mothers endorsing gender attitude items in Burkina Faso and Malawi**

	Burkina Faso N=276	Malawi N=288
Percentage of respondents who agree with the statement:		
A wife should be able to refuse her husband sex	46.4	80.2
It is OK for a man to cook for his family	64.1	83.0
Polygamous marriages are part of culture, so they should continue	42.4	8.7
It is better if a family arranges a girls' marriage than her choosing herself	19.9	3.5
If a man does not hit his wife, it means he doesn't love her	5.4	5.9
It is a man's right to have sex with his wife whenever he wants	66.3	46.5
If a young woman in this community were aged 25 and unmarried, people would respect her	35.1	44.1
If a husband and wife disagree on using family planning, the husband's opinion should come first	80.8	40.3

## Intimate partner violence

Adolescent mothers who were in a relationship at the time of the survey (n=184 in Burkina Faso and n=172 in Malawi) were asked if they had experienced any emotional, physical, or sexual violence from their partners in the past six months. About 65% of the adolescent mothers in Malawi, and 40% in Burkina Faso reported that they had experienced some form of violence in their intimate relationships. In Malawi, about a third of the adolescent mothers who reported violence experienced emotional (36%), physical (47%) and sexual violence (34%) (Table 12). Similarly, in Burkina Faso, 34% of adolescent mothers who reported violence experienced emotional abuse, with 21% and 11% experiencing physical and sexual violence, respectively.

**Table 12. Percentage of adolescent mothers reporting intimate partner violence (physical, emotional, sexual)**

	Burkina Faso n = 184	Malawi n = 172
Experience with forms of violence or abuse	n (%)	n (%)
Emotional abuse	62 (33.7)	62 (36.0)
Physical violence	38 (20.7)	80 (46.5)
Sexual violence	21 (11.4)	68 (33.7)
*Note: multiple responses allowed		

## Mental health

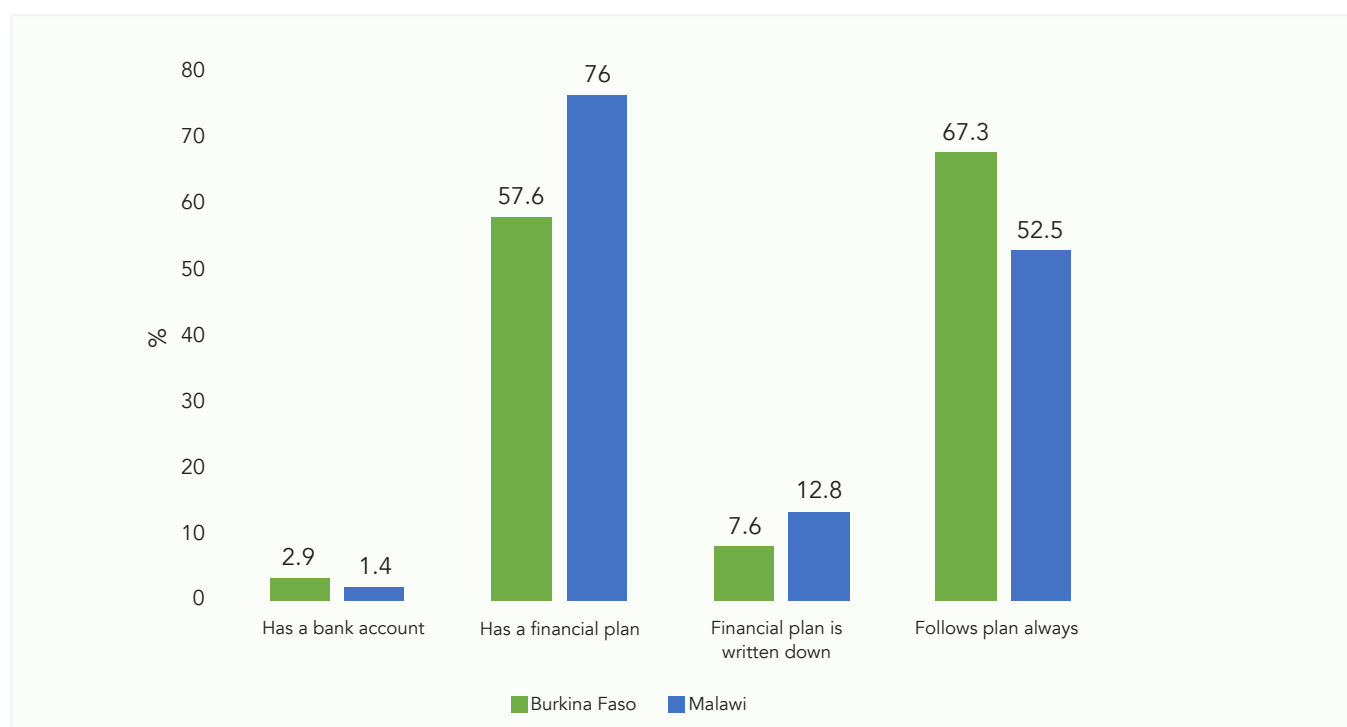
Twenty three percent of adolescent mothers in Burkina Faso and 19% in Malawi reported depressive symptoms (Table 13).

**Table 13. Percentage of participants who reported depressive symptoms**

	Moderate to severe depressive symptoms	Minor to mild symptoms
Burkina Faso N = 276	64(23.2)	212(76.8)
Malawi N = 288	55(19.1)	233(80.9)

## Financial literacy

Although only a few adolescent mothers in both countries had a bank account (3% in Burkina Faso and 1% in Malawi), a significant number of adolescents reported that they planned their finances (58% in Burkina Faso and 76% in Malawi). However, only 13% and 8% of adolescent mothers in Burkina Faso and Malawi, respectively, had written down their financial plans (Figure 8).



**Figure 8. Proportion of adolescent mothers reporting that they had a bank account and finance plan**

To assess adolescent mothers' financial literacy, they were asked about formal and informal ways of saving money. Majority of adolescent mothers in Burkina Faso mentioned a bank account (83%) as a formal savings method (Table 14). Conversely, in Malawi, 42% of adolescent mothers identified mobile money transfer systems like Airtel money and Mpamba as formal saving methods, with only 27% mentioning bank accounts as formal saving methods.

**Table 14. Percentage of adolescent mothers identifying formal and informal ways of saving money**

Ways of saving money	Burkina Faso		Malawi	
	Formal	Informal	Formal	Informal
Bank/bank account	82.6	0.4	27.1	0.3
Savings groups/Village Savings and Loan Associations/Merry-go-round	3.9	1.8	1.7	4.2
Home bank/under mattress/hole	0.0	24.6	11.1	61.1
Box/closet	1.5	7.6	8.7	10.8
With a friend	0.0	5.1	1.7	2.4
With a parent or guardian	1.8	5.4	0.7	0.7
In a savings group/chama	0.7	11.6	2.8	1.7
Investments	0.0	0.7	3.5	0.0
Airtel money/Mpamba	7.9	41.3	41.7	11.5
Don't know	0.7	0.7	1.0	3.1

Three scenarios were read out to the adolescent mothers to assess their knowledge of the difference between a budget and financial plan. Only one in four answered correctly, demonstrating a lack of understanding of the difference between a budget and a financial plan. The rest either answered incorrectly (33%) or did not know the answer (41%). Nearly three out of four adolescent mothers disagreed with the statement: **'Only people with a lot of money can save'**.

## Childcare

The parent-child relationship is very crucial as it lays the foundation for the child's personality, life choices and overall character. The study sought to understand the relationships between the adolescent mothers and their children. As shown in Table 14, most adolescent mothers regularly bonded with their children. However, about half (52%) and four-fifths (79%) of adolescent mothers in Burkina Faso and Malawi, respectively, rarely or never rewarded their child when they did something well or showed a new skill. Most mothers in Burkina Faso (70%) and Malawi (67%) rarely or never involved their child in household chores.

**Table 15. Interactions with children**

How often the following happened in the past month	Burkina Faso		Malawi	
	Never/ Rarely	Sometimes/ Often/Always	Never/ Rarely	Sometimes/ Often/Always
<b>A.</b> Playing with child	13.8	86.2	15.3	84.7
<b>B.</b> Stand back and let child work through tasks s(he) might be able to solve on his/her own	45.3	54.7	46.9	53.1
<b>C.</b> Invite child to play a game with you or share an enjoyable activity	28.9	71.0	25.7	74.3
<b>D.</b> Notice and praise your child's good behavior	37.7	62.3	34.4	65.6
<b>E.</b> Teach child new skills	37.0	63.0	39.1	60.1
<b>F.</b> Involve your child in household chores	70.3	29.7	67.4	32.6
<b>G.</b> Reward your child when he /she did something well or showed a new skill	52.2	47.8	78.5	21.5
<b>H.</b> Stick to your rules and not change your mind	57.6	42.4	67.7	32.3
<b>I.</b> Speak calmly with your child when you were upset with him or her	44.6	55.4	52.1	47.9
<b>J.</b> Explains what you wanted your child to do in clear and simple ways	55.8	44.2	65.3	34.7
<b>K.</b> Tell your child what you wanted him or her to do rather than tell him/her to stop doing something	55.8	44.2	59.0	41.0
<b>L.</b> Tell your child how you expected him/her to behave	55.4	44.6	62.5	37.5
<b>M.</b> Set rules on your child's behavior that you were able to enforce	68.1	31.9	61.5	38.5
<b>N.</b> Make sure your child followed the rules you set all or most of the time	67.8	32.3	62.2	37.9

All adolescent mothers living with their partners reported receiving financial assistance from their child's father. They were also asked to rate the level of financial support they received from the fathers of their children. Twenty percent of adolescent mothers in Burkina Faso and slightly more than a quarter in Malawi (27%) said it was good; while 25% in Burkina Faso and 17% in Malawi rated the same as fair (Table 16).

**Table 16. Rating of financial assistance respondents receive from the father of their children**

	<b>Burkina Faso N=276</b>	<b>Malawi N=288</b>
Rating of financial assistance received		
Good	20.3	27.1
Fair	24.6	17.4
Poor	15.6	7.6
No support	39.5	47.9

## Implications

The findings highlight the challenges faced by adolescent mothers living in resource-constrained urban settings. We found that majority of the adolescent mothers surveyed were out of school. However, many of them expressed interest in either returning to school or learning a trade. In terms of SRH knowledge and behavior, the baseline findings suggest that many adolescent mothers may be at risk for poor SRH outcomes because of low levels of knowledge, involvement in transactional sex and low levels of contraceptive use. While there were substantial differences between adolescent mothers in Burkina Faso and Malawi, the findings have similar implications and underscore the value of interventions that seek to enhance adolescent mothers' social, economic, health and education assets.



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