YWCA
MALAWI
by love, serve one another

YOUNG WOMEN'S CHRISTIAN ASSOCIATION OF MALAWI (YWCA)

ANNUAL REPORT 2023

ORGANIZATIONAL PROFILE

The Young Women's Christian Association of Malawi (YWCA) is an affiliate association of the World YWCA, founded in Malawi in 1998[1] and registered with the NGO Board in 2003. YWCA is a women and youth led, membership-based, non-governmental organization (NGO) dedicated to the empowerment of adolescent girls and young women (AGYW). Our vision is a fully inclusive society where justice, peace, health, human dignity, freedom and care for the environment are promoted and sustained by women's leadership. YWCA recognizes the value of all human beings without distinction of race, nationality, class or religion and seeks to promote understanding and co-operation between people of different ethnicities, races and cultures. Towards this end, YWCAs core values include volunteerism, diversity, tolerance, mutual respect, integrity and accountability.

YWCA is committed to advocacy work centered on uplifting the quality of life of AGYW: to empower them to appraise and articulate their needs and thereafter to demand for services from relevant duty-bearers through meaningful participation in decision-making processes; to empower them to become aware of and enjoy their rights, and to perform their duties as productive citizens; and to develop self-reliance and increase their capacity for self-development through education, skills-development and economic empowerment. While YWCA primarily targets AGYW, the organization includes adolescent boys and young men (ABYM) in all interventions – albeit on a smaller scale – due to the absence of the Young Men's Christian Association (YMCA) in the country.

YWCA in Malawi provides Developmental Assistance in the thematic areas of HIV and Sexual Reproductive Health and Rights (SRHR); Mental Health and Psycho-Social Support (PSS); Child Protection (CP); Gender Based Violence/Ending Violence against Women and Girls (GBV/EVAWG); Political Empowerment of [Young] Women (PEW); Leadership, Governance and Active Citizenship; Education; Economic Empowerment and Self-Reliance (SR); and Early Childhood Development (ECD). Humanitarian assistance is provided through participation in the Protection and Health clusters. YWCA currently offers its services in Blantyre, Chikwawa, Machinga, Mulanje and Zomba districts.

KEY ACTIVITIES & OUTPUTS

In 2023, YWCAs interventions were focused on Leadership, Governance and Active Citizenship; GBV; SR; ECD; and HIV & SRHR. YWCA also provided support during Tropical Cyclone Freddy (TCF) recovery efforts. These interventions have been documented as follows:

[1] 22nd April, 1998 registration number C070/1998

DEVELOPMENTAL ASSISTANCE

a. HER Voice Fund

Project title: ***AGYW for Active Citizenship***
Donor: Global Fund through ViiV Healthcare for Positive Action
Principal recipient: Y+ Global
Country Lead: Y+ Malawi
Implementing partner: YWCA
Project location: Blantyre - T/A Machinjiri (GVH Mtenje)
Targets: Primary – 20 AGYW; Secondary – 200 AGYW, 100 ABYM

HER Voice Fund (HVF) is a Global Fund project, funded through ViiV Healthcare-Positive Action and implemented by Y+ Global across 13 priority countries[2]. HER Voice Fund aims at supporting the meaningful engagement and leadership of AGYW and community-based organizations serving AGYW within Global Fund and other related national processes. Since 2020, YWCA has been responsible for implementing HVF annually in Blantyre district through a project titled "AGYW for Active Citizenship", primarily targeting AGYW from Traditional Authority (T/A) Machinjiri – GVHs Mtenje[3] and Mwamadi[4].

The first 3 cycles of AGYW for Active Citizenship (2020-2022), directly benefitted 80 AGYW and indirectly benefitted 160 AGYW and 105 ABYM by capacitating them to actively participate in local governance processes and to engage local and sub-national duty bearers in advocacy for effective and efficient policy implementation through the provision of adequate key youth-centered services, in order to change their own realities and improve their livelihoods; and also by supporting AGYW - including survivors of GBV, towards self-reliance through continued engagement with local governance structures for access to economic empowerment programs, social protection and justice services, and Sexual and Reproductive Health (SRH) services.

[2] Botswana, Cameroon, Eswatini, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Uganda, Zambia and Zimbabwe

[3] GVH Mtenje is located on the outskirts of Blantyre district in the South East area. At the onset of the project, the Blantyre DEC themselves acknowledged that Mtenje is one of the most neglected areas within the district and has categorically received poor service delivery – *if any*, from the local authority as well development partners. Some key governance structures had not yet been established in the area

[4] GVH Mwamadi is more commonly known as Bangwe township – a high density peri-urban settlement along the outskirts of the Blantyre City South East area.

Adolescent and Young People (AYP) from the Mtenje area were mobilized into youth clubs which were established at the Village Headman (VH) level. These clubs have since formed the Mtenje Youth Network, and they are duly registered and fully supported by the District Youth Office (DYO). The network members have been empowered to effectively engage with duty bearers i.e. traditional leadership, ward councilor's and Member of Parliament (MP); and to participate meaningfully in decision-making processes of the Blantyre District Council by regularly participating in Technical Working Group (TWG[5]) and District Executive Committee (DEC) meetings, as well as in local governance processes such as the Village Development Committee (VDC) and Area Development Committee (ADC) meetings. Furthermore, AGYW (including survivors of GBV) have been linked with protection and justice structures: District Social Welfare Office (DSWO) and the Child Protection Worker (CPW) responsible for the Mtenje area; District Gender Development Office (DGDO); Bangwe Police Victim Support Unit (PVSU); Queen Elizabeth Central Hospital (QECH) One Stop Centre; and the Limbe magistrate court.

AGYW were supported to access psycho-social support including Group Inter-Personal Therapy and Individual Counselling through a Mental Health Support Group counselled by DSWO and YWCA staff. AYP were also continually supported to access SRHR information and services through the Youth Friendly Health Services (YFHS) available to them locally (Bangwe Health Centre). In order to boost exposure/experience AGYW are often supported to participate in sub-national processes including youth/SRHR TWG meetings and donor funded processes (e.g. periodic review of the United Nations Convention on the Rights of the Child (UNCRC) (2022); 8th Malawi Mental Health Research and Practice Development Conference (2022), etc.).

The fourth cycle of "AGYW for Active Citizenship" was implemented from April 2023 to February 2024. The project has aimed at supporting AGYW and AYP from Mtenje towards improved access to ARV based HIV prevention technologies and contraceptives while promoting improved access to justice within the GBV referral and follow-up mechanisms. AYP have been empowered to engage and provide services to their peers related to family planning and HIV prevention technologies; effectively utilize digital tools as peer educators and for self-development; and the project also strengthened the GBV referral mechanism at the grassroots level. The following are some of the key impacts for the past year:

[5] Gender; Education; Youth and Sexual Reproductive Health and Rights (SRHR); District AIDS Coordinating Committee (DACC); District Health Medical Team (DHMT) & other key stakeholder meetings i.e. National AIDS Commission (NAC), Malawi Human Rights Commission (MHRC) etc.

i) ENGAGEMENT OF LOCAL GOVERNANCE STRUCTURES for ADVOCACY of AGYW AGENDA

The project engagement meeting with the Gender, Human Rights, Culture, Youth, HIV & AIDS TWG was held on 11th May, 2023 at Blantyre District Council offices. The project was recommended to proceed to the District Executive Committee for final approval, however, it was reflected that in the new Blantyre District Council bi-laws, all gender projects must maintain a minimum ratio of 70:30 gender balance. Therefore, stakeholders recommended the project to DEC on the basis that at least 40% of the direct target group should be adolescent boys and young men (ABYM) especially in consideration of the alarming rates of suicide amongst ABYM in the district (and the country at wide) due to SRH and mental health related issues. In order to adhere to the law of the district and the rules set by the sector heads, YWCA is therefore, focused on targeting the Mtenje Youth Network (membership comprised of 127 AGYW and 83 ABYM) rather than just 20 AGYW in the project. Specific trainings under the project are also being targeted at AGYW (60%) and ABYM (40%) in adherence of the law.

The project was then presented to the DEC on 18th May, 2023 where it was approved for implementation in the district and key stakeholders (i.e. the protection cluster) were assigned supervisory roles to ensure successful implementation of key interventions i.e. capacity building and supervision of the Youth Community Based Distribution Agents (YCBDAs) The protection cluster is also keen on learning best practices in the engagement of ABYM in SRH & mental health services through the project.

And finally, the project was presented to the Mtenje Area Development Committee (ADC) on 23rd May, 2023. The ADC will continue to provide support to the Mtenje Youth Network and will assist in the sensitization of the community on the role of the YCBDAs. The ADC is also committed to the establishment of the Mtenje Community Victim Support Unit (CVSU) in order to improve the management of GBV and sexual exploitation and abuse (SEA) cases in the area. The ADC was responsible for the identification of all key stakeholders to be included in the CVSU according to the guidelines which were provided by the district gender development office (DGDO). The CVSU was officially established and oriented by the DGDO on 2nd November, 2024. The CVSU was launched and introduced to Mtenje community members during the “16 Days of Activism” commemoration on 8th December, 2024.

ii) CAPACITY BUILDING AND EMPOWERMENT OF AGYW

The Community Based Distribution Agents (CBDAs) model was identified by the Mtenje Youth Network as the best means of improving SRHR service delivery to the Mtenje youth.

Community Based Distribution (CBD) is a strategy employed by the Ministry of Health (MOH) to increase provision of SRH services including family planning and HIV prevention services. Empowering the AYP as YCBDAs therefore, will assist to improve access to these SRH services for AYP and the community at large within the Mtenje area considering the nearest health centre is without the recommended 5km radius from the area. It will also improve efficiency in response to emergency situations i.e. GBV and SEA cases.

Under the supervision of the DYO, 20 AYP were selected from all the villages within the Mtenje area to be capacitated as Youth Community Based Distribution Agents (YCBDAs), and on 26th and 27th July 2023, the 20 AYP (12 AGYW, 8 ABYM) were oriented as Youth Community Based Distribution Agents (YCBDAs). The orientation training was provided by the DYO and by the Youth Friendly Health Services (YFHS) coordinator. The 20 YCBDAs have been oriented to understand family planning in Malawi; population and impacts; peer education; YFHS, CBD, and YCBDA models; barriers to young people; sexuality; HIV and STIs; health issues of AGYW and young mothers; and the referral systems. They have monthly refresher sessions with the YFHS on select topics including a special training session on reporting and managing referrals; as well as bi-monthly supervision visits from the YFHS providers at Bangwe Health Centre. Finally, YWCA is mobilizing resources for a full CBDA training (which takes about 3 weeks) to be provided by the Ministry of Health in order for the agents to receive the certification which is necessary for them to distribute multiple forms of HIV prevention and contraceptive technologies, as of now they are distributing condoms, providing peer counselling and strongly relying on making referrals to the HAS responsible for the Mtenje area.

1 AGYW (Mtenje Youth Network) chairperson was supported to attend the launch of the National Youth Policy in Lilongwe on 31st October, 2023. She was the only youth representative from Blantyre district at the event, and she was able to participate in a panel discussion. During the discussion, she articulated the need to improve dissemination of information towards young people. She reflected that although there are still many gaps that need to be addressed, there are also a lot of interventions and services available that the youth are not aware of. She encouraged her peers from other districts to be vigilant and ensure that as many young people as possible are participating in youth clubs within their communities so that they can have the correct information (especially on SRHR issues), and so that they can access more opportunities. Finally, she shared how she was able to lead the Mtenje Youth Network to develop a youth development plan; how the plan has helped to give them direction, and how they are engaging local development committees, the technical working groups as well as donors to push for their advocacy agenda as reflected in the plan.

1 AGYW attended Global Fund GC7 Approved Interventions Feedback Meeting on December, 2023 at Blantyre District Council which was organized by HVF implementing partner Tovwirane. The key intervention discussed was the Youth Community Based Distribution Agents (YCBDA) model, highlighting the Global Fund's intentions to capacitate at least 100 young people in the district in 2024 or 2025. She was able to share some experiences as a newly trained YCBDA in the district, particularly around the high demand for the services (from youth and adults alike), and the effectiveness of using this model to reach young people who shy away from receiving services from health centres.

iii) INCREASING ACCESS TO GBV, CSE AND INTEGRATED HIV & SRH SERVICES FOR AGYW

There are 28 districts in Malawi, and the development agenda for each respective district is articulated and reflected through the District Development Plan (DDP). As stipulated by law, all development funds which are implemented at local level can only respond to the DDP of each particular district. These development funds include the District Development Fund (DDF), Constituency Development Fund (CDF), Local Development Fund (LDF) and all projects supported by and/or implemented by development partners (i.e. UN agencies, GIZ, etc.) as well as CSOs. From June to August, 2023 the Blantyre District Council is facilitating the process of developing the council's DDP which will guide all development plans and projects in the district for 10 years (2023-2033). As such, the AYP from the Mtenje Youth Network are being supported to engage relevant duty bearers towards the inclusion of their development plans in the Blantyre DDP.

There are several processes which contribute towards the development of the DDP. At community level, governance structures are able to provide inputs to the DDP by articulating their specific desired development projects through the development of Village Action Plans (VAPs). VAPs are developed by the Village Development Committee's (VDCs), then consolidated by the Area Development Committee's (ADCs) and thereafter submitted to the District Community Development Office (DCDO) through the Councillor's office. On 27th June, 2023 YWCA supported the Mtenje Youth Network to develop the Mtenje Youth Development Plan which thereafter, was presented and successfully lobbied to their ward Councillor and ADC chairperson for adoption in the Mtenje VAP which will be submitted to the district council in August, 2023 for consolidation into the DDP. Reflected in the Mtenje Youth Development Plan are 3 main agendas:

i. Mtenje Secondary School.
   There is only a primary school with no secondary school within the Mtenje ADC, and the nearest secondary school is located without an 8km radius from Mtenje which is

outside of the recommended 5km radius. As a result, the number of youth from Mtenje who have attained and completed secondary education is very low (currently out of 255 AYP from the Mtenje Youth Network, only 3 ABYM have secondary school leaving certificates). The Youth Network is therefore, demanding for the construction of a modern secondary school building, equipped with adequate facilities including well insulated and ventilated classrooms; administration office block; IT & science laboratories; school hall; sports facilities; teacher's houses; and WASH facilities including menstrual hygiene facilities.

ii. Mtenje Youth Centre.
The youth centre is being demanded for in order to provide a centralized safe space for AYP from Mtenje and surrounding communities to access CSE, SRHR, PSS, HIV & AIDS services; sports and recreational activities including football, netball, volleyball, basketball and cricket; and to acquire specialized TEVET skills i.e. beautician & grooming skills, craftsman carpentry, brick laying, tile laying, welding & fabrication and plumbing.

iii. Mtenje Youth Agricultural Initiative.
The Mtenje Youth Network has opted for a joint agro-enterprise as their main entrepreneurship initiative, given the abundance of fertile arable land and water sources in the Mtenje area. The youth network therefore, demanded for material and technical support in terms of farm inputs and infrastructure for long-term and short-term crop production (i.e. cassava, maize, onion, groundnuts, soya, peas, irish potatoes, sweet potatoes and green vegetables); animal production i.e. for poultry, beef, ham and mutton products); and tree production where they are looking for expert guidance on options of valuable timber and fruit trees and tree farming techniques.

At council level, the DDP development processes require that first the technical teams meet through the various Technical Working Groups (TWGs) to articulate and consolidate sector specific plans which will then be consolidated, awaiting to undergo final vetting and approval by the DEC in August, 2023. YWCA supported 2 AYP to attend the Gender, Human Rights, Culture, Youth and HIV/AIDS TWG on 30th June, 2023 where they were able to contribute towards gender, community development and social welfare sector district development plans. Furthermore, 3 AYP were also supported to participate in the Youth TWG on 4th July, 2023 where they were able to present the Mtenje Youth Development Plan for buy-in from youth stakeholders.

On Friday 13th October, 2023 a Youth Friendly Health Services (YFHS) session was held for the Mtenje Youth Network. During the session, the District Youth Office was able to provide a refresher training for the Youth Community Based Distribution Agents (YCBDAs) in peer counselling as well as providing referrals. The YCBDAs are fully operational in their villages, however, they were only provided with materials (family planning) in August which quickly ran out and they have registered a very high demand for the materials from youth as well as adult community members.

iv) INCREASING ACCESS TO ECONOMIC EMPOWERMENT PROGRAMMES FOR AGYW

Through participation in the Youth TWG, YWCA has been able to successfully lobby for the inclusion of the Mtenje Youth Network in the '*ntchito mbambande*' project which will be implemented by CARE Malawi from 2023-2027. The project is being funded by the European Union through CARE Deutschland and aims at providing relevant, innovative, and labour market oriented digital and green formal and informal TEVET for vulnerable youth, in particular AGYW. The project will be implemented in 5 districts including Blantyre. At the time the project was presented to the TWG, the impact areas for Blantyre had not yet been defined. YWCA was therefore, able to engage CARE Malawi representatives, as well as TWG members and successfully lobbied them to include Mtenje in their impact area by highlighting the skills and capacities which have been imparted to Mtenje youth in order to highlight why they were a good target group for the intervention.

Through the project: innovative, market-responsive digital and green TEVET programmes will be designed and implemented; access to and participation in TEVET programmes for vulnerable youth, in particular adolescent girls, young women, youth with disabilities, and rural youth will be improved; TEVET graduates and out-of-school youth will be supported to commercialize innovations, start-up businesses, and link to labour market opportunities; and TEVET sector-responsiveness will be improved through evidence-based policy dialogues. AGYW from Mtenje will therefore, gain access to specialized [TEVET] skills development in digital skills, agri-TEVET, photovoltaic, fabrication and welding, motorcycle and bicycle repairing.

During the same meeting (13th October, 2023), the youth office also engaged the Mtenje youth network leadership in a discussion concerning their ambitions to establish a thriving agri-business venture as reflected in their development agenda i.e. the Mtenje Youth Development Plan (which was developed with support from HVF in June, 2023). The youth office has committed to engaging key partners including the district agriculture office and AGRICOM to ensure that the network receives adequate technical and material support. The youth office has instructed the network that the first and critical step is to ensure they secure

ownership over land within Mtenje which will be used for the venture. Therefore, the network is currently conducting an exercise to identify at least 10 well-sized arable pieces of land across the different villages within Mtenje. After the exercise is complete, the youth office supported by the agriculture office will then review and select the most ideal land. After which the network will be supported by the youth and community development offices to secure ownership over the land for the Mtenje Youth Network from the traditional leadership. The network has also been supported to open a bank account, and they are in the process of registering a business.

In September, 2023 the community-based governance structures being Village Development Committees (VDCs) and Area Development Committee's (ADCs) were dissolved after completion of their five-year tenures. All the district council's in Malawi are therefore, undergoing a process of supporting the election of new committee's through the District Community Development Office's (DCDOs). The network members have therefore been engaged and are enthusiastic to participate in the election processes to ensure that there is increased youth representation in the local structures. The Community Development Assistant (CDA) responsible for the Mtenje area was invited to the meeting in order to provide a detailed explanation to the network members on the election processes, as well as insights on how best to engage with the communities to ensure that they are supported into these structures during the elections. 5 network members have been proposed as suitable candidates and they are being supported by the network to engage local leaders, and to mobilize youth within their communities to render the necessary support for their election.

b. COMIC RELIEF

Project title: ***Malawi Early Childhood Initiative for Children of Adolescent Mothers (MECIAM)***
Donor: Comic Relief
Principal recipient: Regional Psycho-Social Support Initiative (REPSSI)
Implementing partner: YWCA
Project location: Machinga - T/A Chamba; Blantyre - T/A Machinjiri-Mtenje
Targets: Children from birth to 36 months - 540 children (45 children/CBCC);
Children from 36 months to 59 months - 360 children (30 children/CBCC);
Pregnant girls and adolescent mothers - 540 AMs (45 AMs/CBCC).

The Malawi Early Childhood Initiative for Children of Adolescent Mothers (MECIAM) project was implemented under the Rise and Shine program funded by Comic Relief from 2020 to 2023 in Blantyre and Machinga districts, targeting 8 Community Based Childcare Centers (CBCCs) – 4 in each district. MECIAMs objectives were to deliver quality early childhood care and education (ECCE) to children; provide psychosocial support and build capacity of

adolescent mothers; and engage men in positive parenting sessions. The MECIAM project was phased out of Blantyre and Machinga district council's in December 2022. In 2023 there were final consortium monitoring activities, linking and learning workshops, and an end line survey was carried out for the MECIAM project. The full report has been attached in annexes.

c. COMMUNITY MOBILIZATION EVENTS & CAMPAIGNS

In 2023, YWCA supported the Day of the African Child (DOAC) commemorations in Blantyre and Machinga districts, as well as the "16 Days of Activism against GBV" in Blantyre district through the DSWO and DGDO respectively. YWCA also supported the commemoration of the International Human Rights Day held on 11th December, 2023 in Blantyre by supporting the steering committee with fuel.

The DOAC celebrations took place at Tafika CBO Community Ground in T/A Lundu in Blantyre on 18th August, 2023. In Machinga the event took place on 10th August 2023 in T/A Liwonde under the theme *"The Rights of the Child in the Digital Environment: progress on policy since 2013"*. YWCA supported by donating learning materials (exercise books, pens and crayons) to pupil's as well as lunch allowances for police officers/security in Blantyre district. YWCA supported members of the steering committee in Machinga with lunch allowances.

YWCA was part of the steering committee during the "*16 Days*" commemoration in Blantyre district. The campaign was held on 8th December, 2023 under the theme "*Unite! Invest to Prevent Violence Against Women and Girls*" which was local translated to "*Pamodzi! Tipewe Nkhanza kwa Onse M'Malawi".* The campaign first began by conducting whistle stops in GVH Mtenje (T/A Machinjiri), followed by GVH Mang'omba (T/A Kapeni). Following the whistle stops a solidarity walk was held led by the Salvation Army brass band to Chisawani Primary School (T/A Somba) for the main event were there were pavilions mounted along the grounds from different stakeholders within the GBV space in the district, as well as survivor testimonies, speeches and performances. YWCA was responsible for community mobilization (both in GVH Mtenje and Mang'omba) and also provided financial support for fuel costs.

HUMANITARIAN ASSISTANCE

From 11th to 13th March, 2023 Tropical Cyclone Freddy (TCF) induced torrential rains causing floods in the southern and eastern regions of Malawi. The affected districts included Nsanje, Chikwawa, Mwanza, Neno, Blantyre, Chiradzulu, Balaka, Mangochi, Machinga, Zomba, Phalombe, Mulanje and Thyolo. The cyclone affected over 114,637 households and there were at least 508,244 Internally Displaced Persons (IDPs) being hosted in over 534 camps. YWCA in Malawi currently offers its services in Blantyre, Chikwawa, Machinga, Mulanje and Zomba districts. Consequently, the organization's catchment area in its entirety was affected by TCF and therefore, the HVF Freddy Response Fund was used to support response and recovery efforts in the districts of Blantyre, Chikwawa, Machinga and Mulanje[6].

The Government of Malawi through the Department of Disaster Management Affairs (DoDMA) and assisted by the Humanitarian Country Team (HCT) – led by UNRCO, holds responsibility for coordinating and leading all humanitarian actors in the assessment of disaster impact and needs as well as provision of relief assistance to affected people. DoDMA operates through 11 clusters which are functional at the national level as well as at the district levels[7]:

Shelter, Camp Coordination and Camp Management (CCCM) – Lead: Ministry of Lands, Co-Lead: Malawi Red Cross Society (MRCS);
Water, Sanitation and Hygiene (WASH) – Lead: Ministry of Water and Sanitation, Co-Lead: UNICEF;
Education – Lead: Ministry of Education, Co-Lead: UNICEF;
Agriculture – Lead: Ministry of Agriculture, Co-Lead: FAO;
Protection – Lead: Ministry of Gender, Community Development and Social Welfare, Co-Lead: UNICEF;
Food Security – Lead: DoDMA[8], Co-Lead: WFP;
Nutrition – Lead: Department of Nutrition, HIV and AIDS; Co-Lead: UNICEF;
Transport & Logistics – Lead: Ministry of Transport and Public Infrastructure, Co-Lead: WFP;
Health – Lead: Ministry of Health; Co-Lead: WHO;
Search & Rescue – Lead: Malawi Defense Force (MDF), Co-Lead: MRCS;
Coordination – Lead: DoDMA, Co-Lead: UNRCO.

The Protection Cluster is responsible for ensuring that all issues concerning *Child Protection*; *Protection of Vulnerable Groups* (i.e. elderly people, people with disabilities or injuries,

[6] Zomba is new impact area for YWCA and therefore, the district was not targeted as we did not have existing structures during TCF.
[7] At district level, the District Commissioner (DC) assisted by the Disaster Risk Reduction and Management Officer (DRRMO) coordinates response. Each cluster is headed by the relevant government department and co-led by NGO partners.
[8] DoDMA secretariat

chronically ill persons, people living with HIV/AIDS, adolescents, pregnant and lactating women); *GBV*; and *General Protection* are adequately supported and addressed. The cluster is therefore mandated to: promote the centrality of protection across all clusters and in any overall humanitarian response; ensure that vulnerable populations are supported with their special protection needs; reduce protection threats for the affected populations and protect all vulnerable groups from violence, exploitation, abuse and neglect during disasters whilst ensuring that human rights are respected; mainstream social inclusion, gender, disability and social accountability in humanitarian response; and cushion the socio-economic impact of humanitarian situations on the poor and vulnerable.

As an existing partner in Gender, Youth Development and Child Protection, YWCA supported TCF response and recovery efforts through participation in the protection cluster's in Blantyre, Mulanje and Machinga districts which are headed by the District Social Welfare Office (DSWO). Chikwawa had not yet established protection cluster's during the response period, therefore, coordination was rendered through the Gender and Child Protection TWGs whose efforts were complementary to the Disaster Risk Reduction and Management Office (DRRMO). However, the national level protection cluster has since established and oriented district level structures in all the high-risk districts[9] in preparation for the 2024 rainy/lean season (January – April, 2024).

During the response phase of the cyclone, the Malawi Protection and Social Support Cluster identified and prioritized the following protection issues: overcrowding of displaced women, adolescent girls and children in shelters which increased the risk of occurrence of sexual violence; high figures of Unaccompanied and Separated Children (UASC) in camps; collapsed Community Based Childcare Centers (CBCCs) as well as disruption of children's safe spaces; and disrupted protection services and structures amplified by overwhelmed/overstretched protection service providers.

Partners were therefore coordinated to meet these immediate needs by: creating and distributing IEC[10] materials on GBV/SGBV, PSS, PSEA, and MHM; allocating/deploying extra human resources in the districts to support protection related services; providing blankets and space for post-natal women, and health assistance in general at evacuation camps; fast tracking Mental Health and Psychosocial Services in the evacuation camps and the affected communities for IDPs as well as frontline workers who experienced work related trauma exposure (Vicarious Trauma); strengthening the link between mainstream GBV referral

[9]Nsanje, Chikwawa, Blantyre, Chiradzulu, Zomba, Phalombe, Mulanje, Machinga, Balaka
[10] Information, Education and Communication

services to the evacuation camps; Provision of clothes and dignity kits for women, adolescent girls, children and elderly persons; Establishment of CBCC centers in the evacuation camps; Establishment of safe spaces for children and adolescent girls in the evacuation centers; Promoting gender Mainstreaming across the clusters; Conducting SEA awareness among duty bearers and rights holders; Popularizing Complaints & Feedback Mechanisms (CFM) such Toll Free lines, Suggestion Boxes, Help desk etc.; Provision of Separate Tents for psychological first aid (PFA), safe spaces and CBCCs; Increased security provisions in camps such as lighting as well as Community Policing Forums in all camps and host communities.

YWCA supported the protection cluster in TCF recovery efforts through 2 projects which were implemented in all 5 impact districts i.e. Blantyre, Chikwawa, Machinga, Mulanje and Zomba. The support rendered for TCF recovery has been documented as follows:

a. HER Voice Fund

Project title: ***HVF Freddy Response Fund***
Donor: ViiV Healthcare for Positive Action
Principal recipient: Y+ Global
Implementing partner: YWCA
Project location: Blantyre, Chikwawa, Mulanje and Machinga

KEY IMPACTS

i. Psychosocial service providers or social workers

Due to the high demand for Mental Health and Psycho-Social Services (PSS) following TCF, the Social Workers Association of Malawi (SWAM) mobilized a team of social workers specialized in PSS to be deployed[11] to camps and in safe spaces for children as well AGYW/ABYM. YWCA supported 3 social workers from SWAM to provide PFA and PSS to UASC in Blantyre and Chikwawa districts. A total of 36 children (22 females, 14 male) were targeted in Blantyre and 25 children (13 females, 12 male) were targeted in Chikwawa. They were also tasked to assist key stakeholders and service providers (i.e. police, healthcare providers, child protection workers, CBCC management committee's) to improve their coordination in the management of CFMs in order to improve case management especially on issues related to child abuse. Finally, the social workers coordinated with the relevant departments from Social Welfare, Malawi Police Service (MPS) and UNICEF to transfer 14 children into alternative care.

[11] NGO partners were mobilized to provide financial/material support for the Social Workers.

Figure 1 PSS providers attend to UASC at Mfera Health Center in Chikwawa, October 2023

Figure 2 PSS providers interview UASC at Mfera Health Center in Chikwawa, October 2023

i. Transport costs to access ARVs

In October 2024, YWCA supported 32 AGYW living with HIV/AIDS – *8 each from Blantyre (T/A Machinjiri), Chikwawa (T/A Chapananga), Machinga (T/A Mlomba) and Mulanje (T/A Mabuka)* –with transportation in order to access medical treatment from health facilities. The AGYW were identified through existing YWCA structures in the districts, focusing on those affected by TCF. The District Health and Social Services (DHSS) through the office of the ART (Antiretroviral Therapy) coordinator in each district provided guidance for the AGYW with regards to the facilities which were providing HIV/STI treatments, HTS (HIV Testing Services) and SRH services, as closest to the communities in which the AGYW were from.

ii. Transport costs to healthcare facilities/Other urgent services

In December, 2023 YWCA supported the DHSS in all 4 districts to carry out mobile clinics targeted at communities hosting IDPs which were isolated from health facilities due to the remoteness of the area, or due to communities being cut off from the facilities because of damaged roads and/or bridges. The mobile clinics were carried out by 10 members from the District Health Medical Teams (DHMTs) including the under-5 program coordinator; ART coordinator; GBV coordinator; Family planning coordinator; Youth Friendly Health Services (YFHS) coordinator and the malaria project coordinator. The DHMTs were supported with fuel and communication costs. The budget line for "*Other Urgent Services*" (i.e. activity 3.5) was utilized to support the mobile clinics with refreshments and lunch allowances for the DHMT members. The clinics were conducted in the following areas in each district: *Chikwawa* – T/A Ngabu, T/A Makhwira, T/A Ngowe; *Blantyre rural* – T/A Kunthembwe, T/A Somba, T/A Machinjiri); *Machinga* – T/A Ngokwe, T/A Mlomba, T/A Nchinguza); and *Mulanje* (T/A Mabuka, T/A Tombondiya, T/A Laston-Njema, T/A Sunganinzeru)

Figure 3 Members from Mulanje DHMT conduct team briefing meeting with staff from Mimosa Health Center prior to departing for mobile clinics in Mulanje, December 2023

iii. GBV sessions

YWCA held half-day training sessions on PSEA and S-GBV targeting multi-sector Essential Service Providers (ESPs) at the sub-national level – from health, education, gender, youth, social welfare, community development, police, as well as CSO representatives – in order to enhance the knowledge and capacity of ESPs in addressing PSEA and GBV during emergency response. In Blantyre and Machinga districts, the trainings were held in August, 2023 targeting 15 ESPs in each district. In Chikwawa and Mulanje districts the trainings were held in December, 2023 targeting 20 ESPs in each district. Generally, participants had a very good understanding of GBV as a concept as well as the practicalities of how it occurs in all its various forms within the communities they serve. Discussions were therefore, focused on enhancing awareness on PSEA concepts and policy frameworks, including international and national legal frameworks.

ESPs were trained on best practices and tools to identify PSEA and GBV cases during humanitarian crisis, and to effectively manage cases by providing survivor-centered support to survivors of PSEA and GBV using the appropriate referral systems. Discussion was also focused on strengthening coordination amongst the ESPs to ensure that SEA cases are managed in an effective manner and that survivors gain access to justice. Prevention strategies were explored of which 'male engagement' was discussed at length and the general consensus was that it would be the most effective strategy to challenge cultural and religious norms which perpetuate SEA and GBV. Finally, the ESPs were engaged in a discussion centered on promoting the integration of PSEA and GBV prevention and response into their regular activities through utilization of CFM tools as well as through conducting regular safety audits in health facilities, schools and relief camps. YWCA was recognized by the national level Protection cluster for the capacity building of ESPs and through the HCT, we were incorporated into the PSEA In-Country Network in November, 2023.

Figure 4 Cross-section of ESPs in Machinga during training on GBV/PSEA in August, 2023

Figure 5 ESPs engaged in plenary discussion during GBV/PSEA training in Mulanje, December 2023

iv. Adherence sessions

In December, 2023 YWCA held half-day training sessions on Child Protection in Emergencies (CPiE) in Blantyre, Chikwawa, Machinga and Mulanje districts targeted at 20 key ECD stakeholders in each district. The training focused on imparting knowledge on the key principles as well as the minimum standards which guide child protection efforts in humanitarian action; helping participants understand the various terms and challenges surrounding Unaccompanied and Separated Children (UASC) and how to prevent or manage separation of families; as well as strengthening the coordination of the Child Protection Working Group's during humanitarian crisis.

It was observed that the majority of the participants in all 4 districts had a limited – *if any* – understanding on the mandate of the Child Protection (CP) sub-group within the protection cluster, which was for the most part alluded to continuous turn-over of cluster members as well as due to lack of operational TORs. Furthermore, there were no specific schedules for meetings and the CP sub-groups tend to only meet when needs arise. It is common practice that the sub-groups take advantage of the quarterly progress update meetings which are held by NGO partner in order to provide reports to the relevant technical groups at council level. The CP coordination platform for the district teams were therefore, strengthened through the orientation and partners resolved to use 5W mapping as a tool to foster activity coordination of cluster activities, partner engagement and resource mobilization. Furthermore, the CP sub groups resolved to strengthen coordination with grass-roots protection mechanisms i.e. Village Civil Protection Committees (VCPCs), CBCC management committees, Community Victim Support Units (CVSUs), etc., in order to improve service delivery and to relieve the over-burdened Child Protection Workers (CPWs).

Figure 6 Cross section of ECD stakeholders during training on Child Protection in Emergencies in Machinga, December 2023

Figure 7 Participant illustrating a point during plenary in the CPiE in Emergencies training for ECD stakeholders in Chikwawa, December 2023

v. Procurement of Food Hampers

In August, 2023 YWCA procured 20 50kg bags of maize which were distributed to 20 YWCA care providers across the 4 districts (5 in each district). YWCA mobilized extra resources to procure 10 extra bags of maize and to have all the maize processed to maize flour because most of the communities in each the caregivers reside in were still experiencing prolonged periods of electricity black-outs due to the damage caused to infrastructure by TCF. Furthermore, additional resources were mobilized to procure sugar and salt for our care providers. The hampers were delivered in the districts together with the dignity packs from 14th to 17th August, 2023.

Figure 8 Food hampers are delivered to YWCA care providers in T/A Mlomba - Machinga district as some CBCC care providers look on

vi. Procurement of Non-Food Items (NFIs) – Dignity packs, Blankets, Seed packs

In August, 2023 YWCA also procured 20 blankets which were again distributed to the 20 care providers across the 4 districts, as well as dignity packs (comprised of 6 packs of sanitary pads,

2 bottles of lotion and 2 bottles for glycerin) for 100 AGYW, 25 in each district. These items were delivered in the districts together with the food hampers from 14th to 17th August, 2024. In December, 2024 YWCA also procured 20 5kg bags of maize seed which were delivered to the YWCA care providers. As a sustainability strategy, all CBCCs which are supported and/or serviced by YWCA are supported to have community gardens (managed by the CBCC management committee's) in order to ensure that school feeding programs are not disrupted by lack of funding. The seeds will therefore, be utilized by the CBCC management committee's in the CBCC gardens. The seeds were delivered to the districts during the trips made for the CPiE training sessions.

Figure 9 AGYW pose for a group photo with YWCA programmes manager after receiving their dignity packs in T/A Mabuka - Mulanje, August 2023.

b. UNICEF

Project title: ***Addressing the Gender Challenges in Emergency Preparedness and Response in Cyclone Freddy affected areas***
Donor: UNICEF
Principal recipient: NGO Gender Coordination Network (NGOGCN)
Implementing partner: YWCA
Project location: Machinga and Zomba

YWCA is a long-standing member of the NGO Gender Coordination Network (NGOGCN) in Malawi who were responsible for implementing a Freddy recovery project titled '*Addressing the Gender Challenges in Emergency Preparedness and Response in Cyclone Freddy affected areas*'. The project was funded by UNICEF – cluster co-lead, from June-August, 2023. NGOGCN operates through its member organizations, and YWCA was selected as the implementing partner responsible for Machinga and Zomba districts under the project.

Key Outputs:

i) Gender Safety Audits – targeted at camps, communities hosting IDPs, and health facilities catering to IDPs) Zomba (T/As Mwambo and Nkagula) on 20th June, 2023. Machinga (i.e. T/As Kapoloma and Kawinga) on 21st June, 2023.
ii) Coordination and Capacity Building Workshop for Multi-Sector Essential Service Providers on PSEA and GBV Zomba on 7th July, 2023. Machinga on 5th July, 2023.
iii) Targeted Awareness Campaigns – in communities hosting IDPs on GBV Related Laws, PSEA Essential Services, and Referral Pathways Zomba (i.e. T/As Nkagula and Mwambo) on 7th & 8th July, 2023. Machinga (i.e. T/A Sitola and T/A Chamba) on 6th July, 2023.
iv) The Gender Equality and Social Inclusion (GESI) survey in IDP host communities Zomba (i.e. 247 respondents from T/As Mwambo and Nkagula) from 9th to 10th August, 2023. Machinga (i.e. 205 respondents from T/A Kawinga) on 11th August, 2023.

Best Practices:

Some best practices observed were the presence of healthcare service providers who were able to provide Psychological First Aid (PFA). These were few and were supported by medical programmes i.e. Baylor College of Medicine); there was information on Protection services (including information on survivor centred support services) in most of the evacuation centres; and the engagement of host communities in hosting IDPs as well as community policing.

Challenges & Areas of Improvement:

- Shelter - Following decommissioning of camps, there were many IDPs who had not been given materials (i.e. tarpaulin/family tents, mosquito nets, buckets, cooking utensils and food items). IDPs were 'forced' out of camps in some areas.
- Protection - There was need for increased security for IDPs – a lot of complaints registered on missing food and personal belongings; congested evacuation shelters; no gender separation of toilets and bathrooms in evacuation camps, no lockable toilets and bathrooms in evacuation camps; poor coordination of stakeholders in management of GBV/SEA cases.
- Law enforcement/health workers need capacity development (issues of abuse and mistreating affected person's).
- Transport – Destruction of key infrastructure (i.e. roads and bridges); poor efficiency in food delivery to evacuation camps as well as lack of coordination with other clusters (i.e. protection, nutrition/health).
- WASH – Poor hygiene and sanitation system. Due to water levels, IDPs were are unable to dig latrines and therefore, forced to relieve themselves in bushes; lack of functioning clean water points – IDPs in some areas were digging pools/dams to access drinking water without access to water treatment chemicals, i.e. high risk of cholera outbreak.
- Health/Nutrition - Mobile clinics not conducted often enough, health issues such as HIV/AIDS, malaria, hypertension & diabetes were not adequately addressed; high registered cases of flu/cough and malaria; poor lighting in most facilities catering to IDPs; lack of PPE and medicine

Figure 10 Images taken during Safety Audit at Namisunju Primary School camp in Zomba (T/A Mwambo) showcasing GBV and SEA risks at the camp. On the right is an image of the women's toilets located next to the men's bathroom which is obscured within the bamboo

Key Recommendations - Mainstreaming Protection:

- PROTECTION – Establish resource base for provision of ECE, PSS and nutrition screening & support for children in camps to be deployed within the first 3 days of camp establishment.

  Implement Capacity Building Initiative targeting service providers at community level (i.e. ADCs, CVSUs, ACPCs, VCPCs, etc.) in protection preparedness and response. This should include capacity in collection of sex and age disaggregated data and standardization of protection data collection tools.

  Prioritize and mobilize resources towards Mental Health and Psycho-Social Services (PSS) for those displaced, as well as for frontline workers who experience work related trauma exposure (Vicarious Trauma).
- SHELTER – Prioritize protection needs during pre-identification of emergency shelters to ensure that these are well equipped and maintained (i.e. lighting, gender-separated lockable toilets & bathrooms, user-friendly for PWDs and good MHM systems).

  Consider gender needs of men in camps – address the issue of sex needs as a basic need/right. Lack of family tents and issues of overstaying in the camps (6 weeks+).

- COORDINATION – Procurement and prepositioning of protection risk mitigation items and supplies. The district council's as first responders need family tents, torches, wrapping materials (for temp. toilets and bathrooms), sleeping mats, blankets, clothes (ideally gender neutral warm clothing i.e. tracksuits), menstrual hygiene materials, mobile toilets, buckets, etc.
- EDUCATION - Re-building of education structures/schools – good MHM systems; dignity packs for female learners; lockable toilets; PSEA/SGBV IEC distribution and referral systems training for education service providers.
- HEALTH - Improve protection at health facilities – fencing, lockable gender-separated toilets, lockable gender-separated showers, lighting, address needs for private consultation rooms, user-friendly for PWDs, need for more PSS service providers in facilities, PSEA/SGBV capacity building for community-based health service providers, accessibility (re-building of damaged roads and bridges leading to facilities).
- FOOD SECURITY - Address issues of SEA in distribution of food items and other relief items.

Other Key Outcomes:

- There were 12 SEA cases reported through the Social Welfare Office in Machinga (T/A Sitola) following the targeted awareness campaigns in July, 2023. 10 of those cases have been concluded with 1 conviction.
- Through participation in the project, in July 2023 YWCA was invited to join and has since been an active participant in the national level Malawi Protection and Social Support Cluster in the GBV and CP Areas of Responsibility (AoRs). YWCA was responsible for developing GBV messages for humanitarian settings (including key advocacy messages), which have been adopted by the cluster and disseminated to all disaster high-risk districts. YWCA also participated in the orientation exercise of the district-level protection clusters (focused on GBV AoR) in Mulanje (December, 2023) and Zomba (January, 2024), and we continue to participate actively in the cluster offering technical expertise at the national level, and technical as well as financial expertise at the district levels.
- From 19th to 20th December, 2023 YWCA participated in a Strategic Plan development workshop for the Early Childhood Development Coalition (ECD Coalition) in Malawi. We successfully lobbied for the inclusion of 'provision of ECD services during humanitarian crises' in the new strategic plan (2024-2029).

ANNEXES

REPSSI
Love | Care | Protection for Every Child

IMPROVED OUTCOMES FOR ADOLESCENT MOTHERS THROUGH PSYCHOSOCIALLY-INFORMED MCHC

Malawi Endline Report

2022

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Project done in collaboration with

This project was implemented in collaboration with the Young Women Christian Association in Malawi (YWCA), the Ministry of Gender, Community Development and Social Welfare (MGCDSW), the Ministry of Health and the Malawi Early Childhood Initiative for Children of Adolescent Mothers (MECIAM) project.

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COMIC RELIEF

Table of Contents

Executive Summary

Malawi is home to an estimated 18 628 747 people. Early and unplanned pregnancy is a major problem in Malawi, and adolescent motherhood comes with many challenges. In response, REPSSI and partners implemented targeted interventions aimed at supporting adolescent mothers in Blantyre and Machinga districts of Malawi.

After obtaining ethical clearance from the University of Pretoria, non-probability purposive sampling was used to collect data before and after the onset of the intervention, with the consent of participants. Responses to the questionnaire were recorded on a tablet during one-on-one interviews. The scales used included the Child & Youth Resilience Measure-Revised (Jefferies et al, 2018); the Patient Health Questionnaire-9 (Kroenke et al, 2001); and the Rosenberg SelfEsteem Scale (Rosenberg, 1965). In addition to the above, the questionnaire also included demographics (e.g., sex, age, school attendance, number of children, marital status, living status, support from father of child, and more); access to SRHR-related services in the last 6 months; parental stress levels; and experiences of IPV.

The primary analysis focused on the description of the wellbeing status of respondents. Data was imported into STATA v14 for statistical analysis. Both descriptive and inferential statistics were conducted to examine the distribution of all variables, assess relationships between variables, and determine differences between groups.

Results Overall

A total of 237 baseline and endline responses were collected from Blantyre (118, 50%) and Machinga (119, 50%) in Malawi. 100% of respondents were female (adolescent mothers). The ages of respondents ranged between 14 to 25+ years. The majority of respondents (55%) were 18 to 20 years old.

From baseline to endline, 17% more respondents (64% to 81%) indicated they looked after younger children at home, and 5% more respondents (54% to 59%) indicated that they looked after sick people at home. Respondents were also asked about the losses they have experienced in their lives. At baseline, 3% more respondents (10% to 13%) indicated that their mother had passed away, and 3% more respondents (21% to 24%) indicated that their father had passed away. More than half of the sample at baseline and endline (57%) indicated that someone close to them had died.

4% less respondents (50% to 46%) indicated that they were currently married. Of these, the majority at endline (43%) indicated that they were 17 years or younger when they got married. The youngest age that respondents at endline reported they were married at was 14 years old (3%). Of those who have never been married, 11% fewer respondents (11% to 0%) said that they would not like to get married, while 27% more respondents (8% to 35%) said that they would like to get married between the ages of 26 and 30 years from baseline to endline. All respondents (100%) indicated that they have been pregnant. At endline, 78% of mothers had one child, 20% had two children, and 2% had three or four children.

Overall, access to SRHR services increased from baseline to endline, and numerous changes were statistically significant. Including that 15% more respondents got a cervical cancer vaccination (6% to 21%); 11% more respondents received condoms (5% to 16%), 9% more respondents (62% to 71%) were tested for HIV, and 11% more respondents (43% to 54%) indicated that they received ART.

The Child & Youth Resilience Measure-Revised (CYRM-R) was used to assess resilience. For this group, the average resilience score decreased significantly by 2.1 (64.8 to 62.7). However, both scores indicate high levels of resilience. The scale also has two subscales: personal resilience and caregiver resilience. Caregiver (or relational) resilience relates to characteristics associated with the important relationships shared with either a primary caregiver or a partner or family. Personal resilience includes intrapersonal and interpersonal items. These are linked as both dimensions depend on individuals' social ecologies to reinforce their resilience. The mean personal resilience score also decreased significantly by an average of 2.0 points (38.0 to 36.0), while the average caregiver resilience score decreased slightly by 0.2 points (26.9 to 26.7). Overall, 44% of respondents (105) showed increased resilience from baseline to endline.

The Brief Resilience Scale (BRS) was also used to assess the resilience of the adolescent mothers. For this group, the mean score increased significantly by 1.0 point (17.7 to 18.7). Both scores indicate moderate resilience according to this scale. Overall, 52% of respondents (123) increased in their BRS scores from baseline to endline.

With regards to depression, the mean PHQ-9 score decreased by 0.6 points (4.6 to 4.0). Both scores indicate mild depression or mental health distress. Overall, 48% of respondents (113) had decreased levels of depression at endline compared to baseline. Furthermore, the mean selfesteem score for this group increased by 0.5 points (25.9 to 26.4). These scores are within the normal self-esteem range. Half of respondents (119, 50%) increased in their self-esteem scores from baseline to endline.

The maximum number of adults per household was 8 while the minimum was 0. The mean number of adults living in the households at baseline was 2.8 (SD: 1.6), with 42% of those adults being employed (mean: 0.6; SD: 0.8). At endline, the mean number of adults living in the household was 2.8 (SD: 1.4), with 50% of those adults being employed (mean: 0.7; SD: 0.9). Positively, 27% more mothers (18% to 45%) had their own source of income. The most common type of support that mothers received from the father of their child(ren) was material support (59% to 57%), followed by financial support (46% to 57%), while one-third of mothers (33% to 36%) said they did not receive any support from the father of their child(ren). The mean score on the Parental Stress Scale decreased significantly by 3.7 points (45.9 to 42.2). Overall, 62% of mothers showed decreased parental stress from baseline to endline.

Respondents were asked to what degree they felt safe at home and in the community, and to what degree they felt unsafe. All three changes from baseline to endline were found to be statistically significant: 4% more respondents (54% to 58%) reported feeling safe in their homes "A lot"; 1% less respondents (7% to 6%) indicated that they did not feel safe in their community at all; and 7% less respondents from baseline (21%) to endline (14%) reported that they don't feel safe "A little".

Mothers were asked about their experiences of intimate partner violence (IPV). The average number of IPV forms the mothers were exposed to increased significantly by 1.6 points (0.6 to 2.2). The average number of IPV forms that children had witnessed also increased significantly by 1.5 points (0.2 to 1.7). Almost all changes from baseline to endline were statistically significant, including that 18% more mothers (4% to 22%) reported that their partner hit them with a fist or object, kicked, or bit them, and 13% more mothers reported that their child had witnessed this (3% to 16%).

The developmental levels of the children of the adolescent mothers were assessed using the Malawi Developmental Assessment Tool (MDAT). A total of 189 baseline and endline responses were collected. Most of the children lived in the Machinga district (62%) and 38% lived in Blantyre. 48% of children were female and 52% were male. At endline, the youngest child was 2 years old and the oldest was 6 years old, with the mean age being 3 years and 6 months. The majority of children at endline were developmentally on track or ahead. Overall, 82% of children at endline were on track or ahead in their development across the domains assessed. In each domain, 89% of children were on track or ahead in gross motor development, 84% were on track or ahead with their social development, 82% were on track or ahead with their fine motor development, and 74% were ahead or on track with their language development.

Results by Site

Of the total sample, 118 (50%) respondents were from Blantyre and 119 (50%) were from Machinga. At endline, the youngest Blantyre respondent was 14 and the youngest Machinga respondent was 17. Most of the respondents from Blantyre (59%) and Machinga (57%) were between 19 to 21 years old.

5% more Blantyre respondents (63% to 68%) and 27% more Machinga respondents (66% to 93%) indicated that they help to look after younger children at home from baseline to endline. 6% fewer Blantyre respondents (53% to 47%) but 15% more Machinga respondents (55% to 70%) reported that they help to look after sick people at home. Both of these differences were statistically significant only for Machinga respondents.

4% more Blantyre respondents (10% to 14%) and 4% more Machinga respondents (9% to 13%) said their mother had passed away, and 4% more Blantyre and Machinga respondents (21% to 25%) said that their father had passed away from baseline to endline. At endline, 52% of respondents from Blantyre and 69% of respondents from Machinga indicated that someone close to them had died.

11% more Blantyre respondents (58% to 69%) and 0% more Machinga respondents (73%) at baseline and endline indicated that they were currently married or had been married before. For Blantyre respondents, the majority at baseline (39%) indicated they would like to get married at the age of 25 years, while most respondents at endline (28%) indicated age 25 or 30 . For Machinga respondents, 16% at baseline and 18% at endline indicated they would like to get married at 25, and 15% at endline also indicated they would like to get married over the age of 30.

Numerous statistically significant changes from baseline to endline in access to SRHR services were found, with notable differences between sites. For instance, 22% more respondents from Blantyre received condoms (3% to 25%), while 1% less respondents from Machinga received condoms (8% to 7%). 23% more respondents were tested for HIV (50% to 73%) in Blantyre, while 5% less (74% to 69%) respondents in Machinga were tested for HIV.

There were statistically significant differences in the change scores between Blantyre and Machinga respondents for resilience (BRS but not CYRM-R), depression, and self-esteem scores. On average, respondents from Blantyre CYRM-R resilience scores decreased significantly from 66.8 at baseline to 63.2 at endline, and respondents from Machinga average resilience scores decreased slightly (and non-significantly) from 62.9 at baseline to 62.1 at endline. On average, Machinga respondents' BRS [resilience] scores increased significantly by 1.9 points (16.8 to 18.8),

while Blantyre respondent's scores decreased slightly (and non-significantly) by 0.1 points (18.7 to 18.6). Blantyre respondents average PHQ-9 scores increased slightly (and non-significantly) by 0.3 points (3.8 to 4.1), while Machinga respondents' average depression scores decreased significantly by 1.6 points (5.5 to 3.9). Lastly, Machinga respondents' average self-esteem scores

increased by 1.4 points (25.1 to 26.5), while Blantyre respondents average self-esteem scores decreased by 0.4 points (26.7 to 26.3). Again, the change in self-esteem scores from baseline to endline was significant for Machinga respondents , but not for Blantyre respondents. Some notable changes in psychosocial wellbeing include:

- 25% more Blantyre respondents (21% to 46%) and 16% more Machinga respondents (14% to 30%) indicated that they talk to their family/caregiver(s) about how they feel "A lot"
- 5% more Blantyre respondents (17% to 22%) and 8% more Machinga respondents (9% to 17%) strongly agreed with "I tend to bounce back quickly after hard times"
- 2% less Blantyre respondents (7% to 5%) and 4% less Machinga respondents (10% to 6%) reported feeling down, depressed or hopeless "Nearly every day"
- 23% more Blantyre respondents (41% to 64%) and 12% more Machinga respondents (18% to 30%) strongly agreed with "I feel that I'm a person of worth, at least on an equal plane with others"
- 35% more Blantyre respondents (40% to 75%) and 24% more Machinga respondents (26% to 50%) strongly agreed with "I enjoy spending time with my child(ren)"
- "My child(ren) is an important source of affection for me" where the number of Blantyre respondents who strongly agreed increased by 28% (47% to 75%) and the number of Machinga respondents who strongly agreed increased by 25% (39% to 54%)

Respondents were asked to what degree they felt safe at home and in the community, and to what degree they felt unsafe. Three changes from baseline to endline were found to be statistically significant (two for Blantyre respondents and one for Machinga respondents). Notable differences between sites included that 2% more Blantyre respondents (42% to 44%) compared to 8% fewer Machinga respondents (44% to 36%) said they feel safe in their community "A lot".

The mean number of IPV forms that Blantyre mothers were exposed to increased by 1.9 points (0.4 to 2.3), while the mean number of IPV forms that Machinga mothers were exposed to also increased by 1.3 points (0.8 to 2.1). The mean number of IPV forms that Blantyre children had witnessed increased by 1.8 (0.3 to 2.1) and for Machinga children this increased by 1.2 (0.2 to 1.4). Overall, instances of IPV and children witnessing IPV increased significantly from baseline to endline. 18% more Blantyre mothers (4% to 22%) and 17% more Machinga mothers (4% to 21%) reported that "My partner hit me with a fist or object, kicked, or bit me". The number of Blantyre respondents who indicated that their child had witnessed this increased by 14% (3% to 17%), and the number of Machinga respondents who indicated the same increased by 12% (2% to 17%) from baseline to endline.

Conclusion

For the adolescent mothers in this project, this report considers the levels of psychosocial wellbeing (including resilience, mental health, and self-esteem), SRHR access, parental stress levels, safety, and experiences of IPV at a baseline and endline level. The report also considers the developmental levels of the children of the adolescent mothers using the MDAT. Whilst many positive changes were found, the findings are nuanced, and should be considered in light of the context in which this intervention took place, especially related to the COVID-19 pandemic. Notably, the results showed significant increases in rates of IPV. At the same time, respondents also showed improvements in psychosocial wellbeing, with 52% of respondents showing increased resilience on the BRS, 48% showing decreased depression, and 50% showing increased self-esteem. The differences between Blantyre and Machinga mothers on psychosocial wellbeing

indicators were also interesting to note. Most of the children were on track or ahead in their development at endline, with some improvements from baseline to endline. Overall, the most significant change occurred in relation to parental stress, as 62% of adolescent mothers showed decreased levels of parental stress from baseline to endline. This intervention therefore shows promise as a way to support adolescent mothers and their young children. However, it should be kept in mind that the intervention faced several challenges linked to COVID-19, and many other factors could play a role in influencing the outcomes measured. Research such as this is important to consider as part of the monitoring, evaluation, and learning processes behind any intervention, and these results can be used going forward to ensure a successful and fruitful intervention is in place. Further qualitative research will provide greater insight into the implementation of this intervention and could contextualise these findings further.

List of Acronyms

AGYW	Adolescent girls and young women
AIDS	Acquired Immune Deficiency Syndrome
ALHIV	Adolescents living with HIV
ART	Antiretroviral therapy
BRS	Brief Resilience Scale
CYRM-R	Child and Youth Resilience Measure-Revised
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
IUD	Intrauterine Device
MCHC	Maternal and Child Health Care
MDAT	Malawi Developmental Assessment Tool
MECIAM	Malawi Early Childhood Initiative for children of Adolescent Mothers project
MGCDSW	Ministry of Gender, Community Development, and Social Welfare
MHPSS	Mental Health and Psychosocial Support
NGO	Non-Government Organisation
PHQ-9	Patient Health Questionnaire-9 item
PMTCT	Prevention of mother-to-child transmission
PSS	Psychosocial Support
REPSSI	Regional Psychosocial Support Initiative
RIATT-ESA	Regional Interagency Task Team-Eastern and Southern Africa
SADC	Southern Africa Development Community
SGBV	Sexual and Gender-Based Violence
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
YWCA	Young Women Christian Association of Malawi (YWCA)

List of tables

Background of partners

REPSSI has worked in East and Southern African Region since 2002 and has established itself as the leading African psychosocial support organisation. REPSSI contributes to the growing body of evidence for psychosocial and mental wellbeing as a critical enabler of social, health and education outcomes for children, adolescents, and youth. Its success is demonstrated by its role as technical advisor to the Southern African Development Community (SADC) and its technical resources and large pool of social service workforce whose psychosocial support expertise are sought after. REPSSI is also the secretariat for RIATT-ESA, the most effective regional advocacy platform for children and HIV in the region. In its fifth strategic phase (2021-2025), REPSSI envisions that all girls, boys, and youth enjoy psychosocial and mental wellbeing. The organisations mission is to lead in innovative Mental Health and Psychosocial Support (MHPSS) interventions to transform policy and practice for girls, boys, and youth in Africa to reach their potential. REPSSI has set the following strategic outcomes to achieve its goal:

1. Enhanced health, SRHR, and HIV outcomes for children, adolescents & mothers through MHPSS
2. Enhanced protection and sustainable livelihoods through MHPSS
3. Education and Early Childhood Development is enhanced through MHPSS
4. Disaster risk reduction and enhanced humanitarian response through MHPSS

The Young Women Christina Association of Malawi (YWCA MW) is a women-led not-for-profit association aimed at working with women. Its vision is of a fully inclusive world where justice, peace,

health, human dignity, freedom and care for the environment are promoted and sustained by women's leadership. The main goals of the organisation are to develop the leadership and collective power of women and girls, support individuals, their families and communities at critical times and promote gender equality and community strength. The organisation is dedicated to the empowerment of the community, especially women, youth and children, to realize their potential as human beings and to contribute to a just society, through rights-based and sustainable interventions.

YWCA MW recognises the equal value of all human beings without distinction of race, nationality, class or religion and seeks to promote understanding and cooperation between people of different nations, races and groups. Its advocacy, programmes and services develop the leadership and collective power of women and girls. Key thematic areas include: economic empowerment; SRHR; ending child marriages, young women leadership and education.

The **Ministry of Gender, Community Development and Social Welfare (MGCDSW)**, through the District Social Welfare Offices in Blantyre and Machinga provided the officers who carried out the field data collection both at baseline (October, 2020) and Endline (May, 2022 for the Adolescent Mothers and November, 2022 for the Children of the Adolescent Mothers). The field data collection at both baseline and endline was preceded by training on the tools and general research methodology facilitated by REPSSI. The data collection was aided by the use of tablets which cut down on some challenges faced by paper-based data collection approaches such as missing pages, illegible data capture, time for data entry for analysis and so on. A total of 4 data collectors were deployed per district who included social welfare officers, assistant social welfare officers and community child protection workers. These were supervised/supported by REPSSI and/or YWCA staff who oversaw the data collection exercises.

Context

Malawi has an estimated population of 19 million people (51% female) with an average life expectancy of 65 years (World Bank, 2021). It is a land-locked country and most well-known for Lake Malawi which spans about a third of Malawi's area. The largest city is Lilongwe (the capital), followed by Blantyre. Poverty in Malawi is a problem, where half of the population (50.7%) live below the national poverty line (World Bank, 2021).

Figure 1. Malawi (Google Maps, 2022)

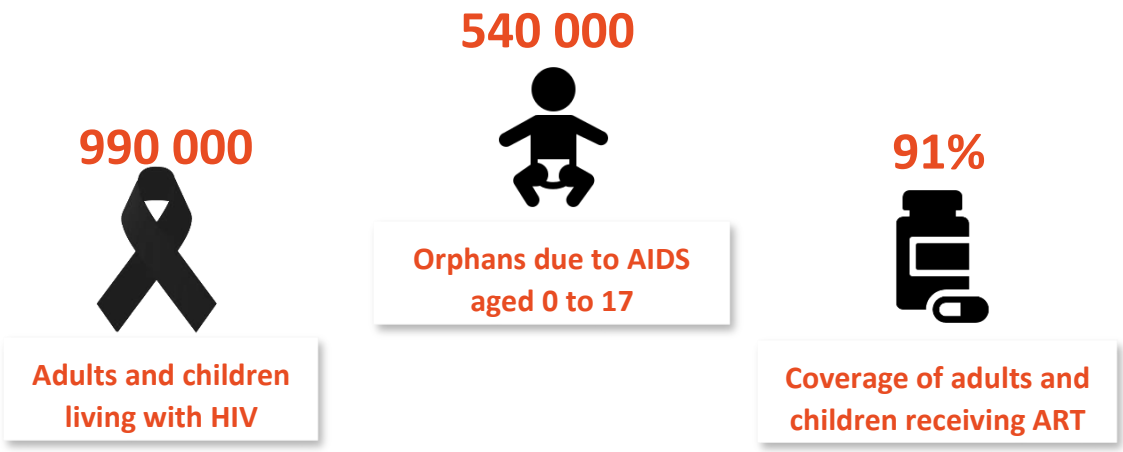
Figure 2. Lake Malawi (creator: Skip Russel, under CC licence available at https://www.flickr.com/photos/skipr/7761577014)

Adolescent pregnancy

Adolescent pregnancy is also a problem in Malawi, with the adolescent birth rate being 131 births per 1000 girls between the ages of 15 and 19 (World Bank, 2021). Moreover, girls aged 15 to 19 years old are twice as likely to die during childbirth when compared with women 20 years and older, and complications during pregnancy and childbirth are the leading cause of death for young women between 15 and 19 years in Malawi (UNFPA, 2020). Commonly cited reasons for early pregnancy include unplanned pregnancy, early marriage, sexual violence, wanting a child, poor knowledge of contraceptives, and limited knowledge of and access to sexual and reproductive health (SRH) services (Ehlers, 2010; Kurebwa, 2017; Mbawa et al., 2018). Unplanned motherhood comes with many challenges, such as poorer educational and employment outcomes due to failure to complete formal education, socio-economic difficulties, lack of comprehensive age-appropriate sexuality education; intimate partner violence (IPV) which impacts on risk and health-seeking behaviour, social isolation, stigma, and inadequate access to quality SRH information, commodities and services. Young mothers in Malawi and elsewhere often experience challenges such as these, which are all linked to poor mental health outcomes such as depression (Mbawa et al., 2018; Kurebwa, 2017). Research has shown that interventions aimed at promoting SRHR knowledge in Malawi, particularly in girls-only clubs (see Manda et al., 2021, for example), have proven effective at reducing risky sexual behaviour which is a risk factor for negative health outcomes such as unplanned pregnancy, HIV and other STIs, and violence (WardPeterson, 2017).

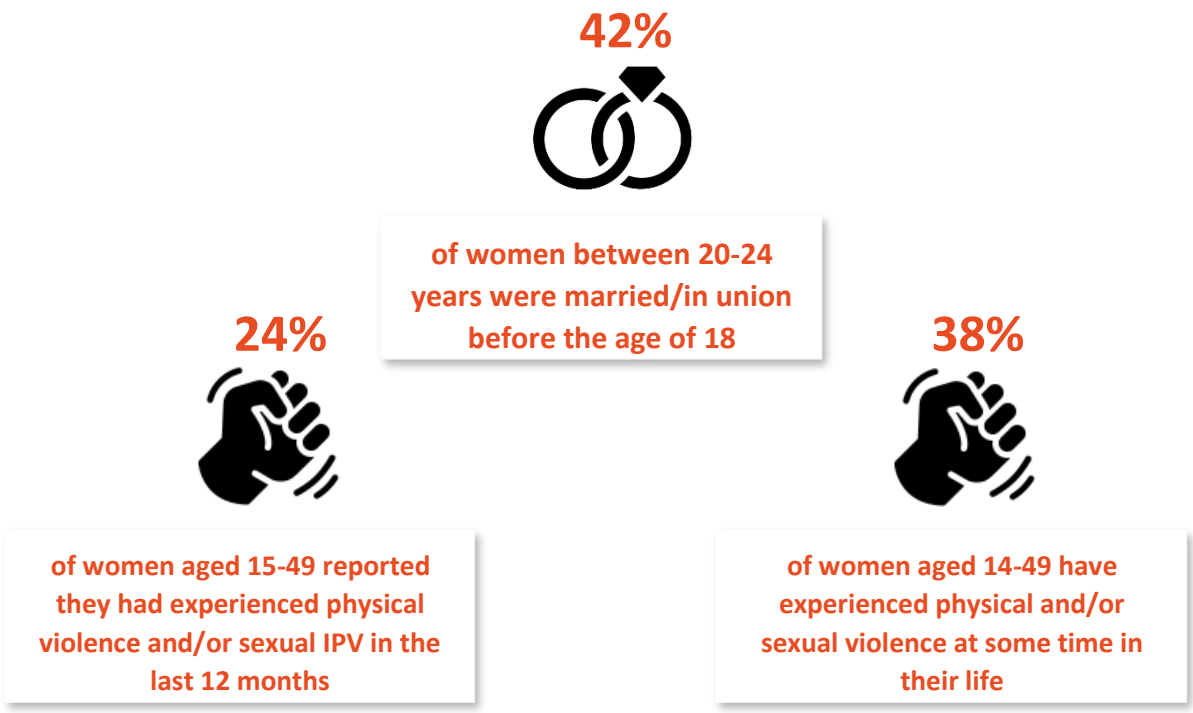
HIV

According to UNAIDS (2021), the HIV and AIDS situation in Malawi is described by the following statistics:



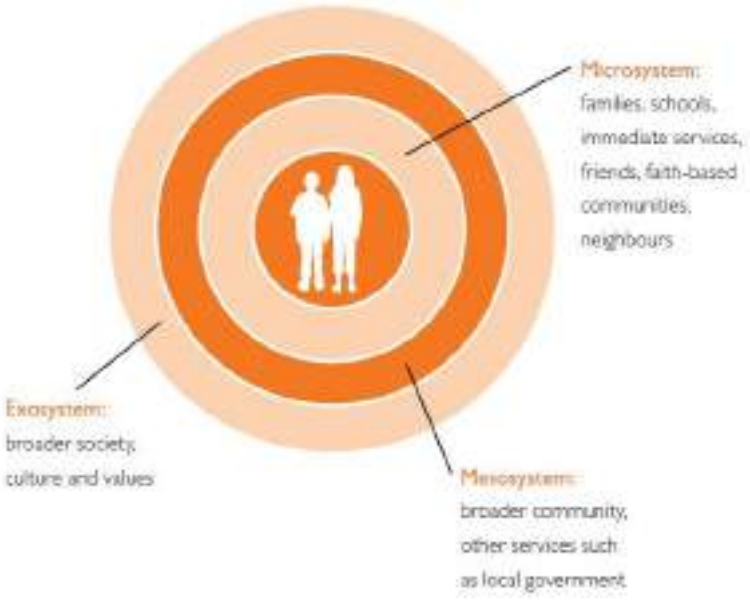
Violence

Intimate Partner Violence (IPV) is a profound and widespread problem in many countries, including Malawi, impacting almost every aspect of life. IPV (which disproportionately affects women and girls) is systemic, and deeply entrenched in institutions, cultures, and traditions (BMC International Health and Human Rights, 2020). Although accurate statistics are challenging to obtain for many reasons (including the fact that many incidents of IPV are not reported), it is evident Malawi has particularly high rates of IPV, with the prevalence of IPV increasing steadily. Common risk factors associated with IPV are young age, low economic status, cohabitation, and rural residence. Moreover, it has been found that women of reproductive age are at a high and increasing risk of IPV (BMC International Health and Human Rights, 2020) and about 38% of women aged 15 to 49 years have experienced physical and/or sexual intimate partner violence at some point in their lifetime (Malawi National Statistical Office, 2016). Furthermore, 24% of women between 15 to 49 years old reported experiencing physical and/or sexual intimate partner violence in the last 12 months, and along with this, 42% of women between the ages of 20 and 24 years were married or in union before the age of 18 (Malawi National Statistical Office, 2016; UNICEF, 2018).



COVID-19

REPSSI's focus on psychosocial and mental wellbeing and the links between this wellbeing and social, health and education outcomes for youth means that one needs to take a number of factors into consideration which can influence this wellbeing. To do this, and to fully make sense of and interpret the results presented in this report, it is important to consider the context this project has been taking place in – specifically in relation to COVID-19. To do this, let us consider Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1979) which can be used as an approach to better understand the effects of COVID-19 disruptions on individuals. This theory explores how one's environment is multi-layered, and how these layers create a larger ecological system which impacts directly on a person.



COVID-19 has impacted all layers of this system, as individuals, networks, communities, and society have been affected in a multitude of ways. To better understand these impacts, one study conducted by Gittings et al (2021) qualitatively explored and documented the experiences, challenges, and coping strategies of adolescents from the Western and Eastern Capes of South Africa during the Level 4 COVID-19 lockdown. The findings from this research highlighted some of the broader-level consequences of the COVID-19 pandemic responses, such as aggravated poverty, job losses, changes in the provision of social services, heightened domestic violence, as well as increased food insecurity. Deaths due to the redirection of critical resources to respond to the pandemic, housing losses, increased mental illness, increased adolescent pregnancy, and school dropouts have also been highlighted as grave broader-level consequences of the COVID19 pandemic in many countries (Yoshikawa et al, 2020; Octavius et al., 2020). Of course, these broader-level challenges have an impact on individuals (as demonstrated by the above ecological systems model) including increased stress levels and reduced psychosocial wellbeing. For example, Sikhangezile and Modise (2020) found that during COVID-19, Zimbabwean youth have been experiencing stress, depression, a lack of psycho-social support at home, a loss of feeling of control over one's life, low self-esteem, and a loss of aspiration.

Lockdown itself has been shown to have affected young people's mental health, as it has effectively cut them off from sources of social support from extended family and friends. This support can be critical in helping individuals cope with negative feelings of helplessness, anxiety, and depression. As many schools were closed due to lockdowns, young people were especially cut off from their peers and friends, meaning that young, school-going people have experienced a lack of peer support, academic learning, play, and opportunities to learn social skills (Sikhangezile & Modise, 2020; Jansen, 2020). Loades et al. (2020) share this sentiment and in their systematic review of the impact of isolation and loneliness due to COVID-19 on the mental health of children and adolescents, they point out that children and adolescents are more likely to experience high rates of depression (and potentially anxiety) during and after enforced isolation ends, and this may increase the longer enforced isolation goes on. In line with this, a MIET Africa report on the impact of COVID-19 on SADC youth (based on the analysis of data from interviews, an online survey, and focus group discussions with 381 respondents) showed that 62% of the youth

respondents reported feeling sadder due to lockdowns, and just under three-quarters of the youth respondents reported feeling more worried now than they did before the pandemic (2021). One source of stress is concerns over either one contracting the virus oneself, or fears that family members or loved ones will fall ill. In this MIET Africa research, 82% of respondents reported being worried about being infected by COVID-19 themselves, and 83% were concerned about the health of family members (MIET Africa, 2021). This report also highlighted increased instances of substance abuse by adolescents during lockdown, as well as an increase in gender-based violence. One cause of this increase in violence was that lockdowns required people to stay home, meaning that there was closer proximity between victims and perpetrators. Being forced to stay home also meant that accessing justice and protective services was difficult. Child Helplines in Zimbabwe, South Africa and Madagascar noted a 15–27% increase in calls received from young people reporting gender-based violence, with cases of forced marriage also being reported (MIET Africa, 2021).

Along with the above, it is also important to consider who is most affected by what has been discussed, and that some individuals will be affected more negatively than others for a variety of reasons. Gittings et al (2021) highlight that these negative consequences discussed above may be especially prominent amongst young people living in contexts of precarity and limitation. Young parents, working class individuals, those with pre-existing mental health challenges, and those who are already lacking sufficient social support were highlighted as being most affected by the negative consequences of COVID-19 (Gittings et al, 2021; Parker, Morris & Hofmeyr, 2020). Therefore, the effects of COVID-19 not only create new challenges, but also intensify existing vulnerabilities and inequalities. It is therefore vital to keep in mind these kinds of COVID-19related impacts on the micro-, meso-, and exo-systems in terms of how these have impacted the beneficiaries of this project, the families and peers of beneficiaries, project implementers and staff, government and social services, and communities, and to consider these impacts alongside the results presented in this report.

Background of the intervention

The project, through the Association of Early Childhood Development (AECD) and the MGCDSW trained and refresher-trained the Caregivers respectively. A total of 12 Caregivers per district, that is 3 per CBCC were recruited and trained at each CBCC. The caregivers were trained using the nationally approved curriculum for CBCC caregivers. The targeted CBCCs were Madalitso CBCC in Mondiwa village, Mwaiwathu CBCC in Nkhukuteni village, Mtendere CBCC in Butao village and Chisomo CBCC in Mtenje village in Blantyre; Mchema CBCC in Mchema village, Yamikani CBCC in Mdalachibwana village, Yankho CBCC in Misewe village and Titukulane CBCC in Mang'anda village in Machinga district. The caregivers engaged in early childhood and care education (ECCE) activities with children in the target CBCCs. A second cadre of Young Mother Champions (YMCs) were recruited and trained in all the 8 CBCCs cited above as well. These were 16 per district, that is 4 per CBCC. The YMCs engaged in MHPSS sessions with the pregnant girls and adolescent mothers targeted by the project in/around the 8 CBCCs in Blantyre and Machinga. The training curriculum for the YMCs was an adapted/abridged version of the REPSSI Short Course on Babies and Young Children (REPSSI, 2015) retitled Survival to Thriving: How to support the brains, minds and psychosocial wellbeing of babies and young children (REPSSI, 2017).

The adolescent mothers at each centre/CBCC were split into A and B thereby each group participating in the sessions twice a month for the duration of the project. These activities

included self-care for the pregnant girls or adolescent mothers, prevention of gender based violence, HIV and AIDS and ART (Anti-Retroviral Therapy) among others. The bulk of the activities during the sessions which the YMCs held with the pregnant girls and/or adolescent mothers focused on activities which the pregnant girls and/or adolescent mothers needed to engage in with their unborn children or those already born (generally under-fives). The Survival to Thriving Manual has a total of 28 sessions/activities. Some of these are Brain Development – Nurture and Thrive; Brain Cells; Brain Nutrition; Stimulation; How do Young Children Learn?; Risk Factors for Development of Babies and Young Children; Resilience; Language Development; Further Ways to Support Language and Cognitive Development; Caregiver Wellbeing; Gender Based Violence. By and large, these topics/activities require the pregnant girls and/or adolescent mothers to acquire the knowledge and skills in how to engage in the said topics with their born or unborn children and be appreciative of some of the reasoning behind some of the undertakings.

The project also had a third tier at community level. This cadre was that of CBCC Parent Management Committees. These comprised members of the respective CBCC communities identified by the community leadership and the community members to provide management and backstopping support to the CBCCs. Each CBCC thus had 10 committee members who also elected each other into different offices to facilitate their work. The CBCC Parent Management Committees supported the Caregivers and Young Mother Champions in their day-to-day work. Furthermore, the committees led community mobilisation initiatives particularly since there were CBCC construction or renovation works at all of the CBCCs. The CBCC Parent Management Committees also led the communities in getting involved at the CBCCs such as by providing their services such as preparation of porridge which the children eat at the CBCCs among other roles.

The final cadre was that of Assistant Social Welfare Officers and Child Protection Workers from the MGCDSW and Nurses or Environmental Health Surveillance Assistants from the MoH who were trained in Youth Friendly Heath Services (YFHS) by the Sexual and Reproductive Health Department of the Ministry of Health. The YFHS providers stepped in to support the YMCs during sessions with the pregnant girls and adolescent mothers where more specialist facilitation of the sessions was required depending on the topic to be delivered.

Over and above the foregoing, the MECIAM project held periodic joint monitoring and learning with the relevant Technical Working Groups (TWGs), mostly through the offices of the District Social Welfare Officers. There were also bi-annual review meetings as well as annual learning workshops that were held with all key stakeholders from national (MGCDSW – ECD dept and MoH – SRHR dept), district (DSWO and DHO) down to community level leadership and project cadres. This ensured shared learning. During capacity building events and/or national monitoring events, the relevant TWGs and/or Offices (DSWO and DHO) were also involved in order for them to appreciate some of the learnings or milestones in the project. For instance, the project held a national capacity building workshop in Monitoring, Evaluation and Learning as well as a subsequent national level monitoring event in which all mentioned stakeholders took part. The second and final national capacity building event was on Advocacy and Communication where also all project and relevant district assembly/council offices or TWGs also participated. Such joint undertaking enhanced common ground on the project between and amongst all concerned stakeholders.

Background of the beneficiaries in this project

Participants were adolescent mothers who benefitted from the improved SRHR for adolescent mothers through MHPSS (funded by Sweden) and their young children who are beneficiaries of the MECIAM (Malawi Early Childhood Initiative for children of Adolescent Mothers) project funded by Comic Relief. The projects were implemented in 4 Community-Based Child Care Centres (CBCCs) in each of two districts, Blantyre and Machinga, in the southern region of Malawi. The initial total being 180 per district, with 360 Adolescent Mother beneficiaries in total. By the time of the endline study the project had 295 adolescent mothers still on the project and had lost the others to drop out, relocation outside the project area, employment (piece work) and marriage among other reasons. The study participants were Adolescent Mothers who volunteered to be beneficiaries of the project and their young children. Traditional Authority (TA) Machinjiri and TA Chamba were the targeted TAs in Blantyre and Machinga respectively.

Methodology

Research design

Non-probability purposive sampling was used whereby adolescent mothers involved in the intervention were invited to participate. An adolescent's decision to participate in the research or not did not affect their eligibility to participate in the intervention. Consent was obtained from caregivers (for those under 18) or directly from participants over 18. Adolescents for whom consent was obtained were contacted and asked the questions by a data collector who entered their responses on a tablet. Data was collected before and after the onset of the intervention with the participants. Once all responses were collected, data was uploaded into a cloud-based server which uses data encryption in transit, at rest, and on all backups. Only one person had complete access to all the data including identifying data (the principal investigator). Confidentiality was maintained throughout all study procedures by storing locator information separate from participant data. No identifying data was extracted from the database for analysis. The only limit to confidentiality was in the case of a team member learning of child abuse, in which case mandatory reporting requirements for Malawi would have been followed. This was not found in this sample.

Given the research design, quantitative data collection and analysis was used. Data was collected through well-structured questionnaires. Screening for psychosocial wellbeing was done using existing validated and reliable measures. Measures used included: the Child & Youth Resilience Measure-Revised (Jefferies et al, 2018); the Patient Health Questionnaire-9 (Kroenke et al, 2001); and the Rosenberg Self-Esteem Scale (Rosenberg, 1965). In addition to the above, the questionnaire also included demographics (e.g., sex, age, school attendance, number of children, marital status, living status, support from father of child, etc.); access to SRHR related services in the last 6 months; parental stress levels; and experiences of IPV. A summary of the scales and interpretation of scores can be found in the table below.

Given the research design, quantitative data collection and analysis was used. Data from the mothers was collected through well-structured questionnaires and the assessment of the children were done through direct observation and interaction with the children. Screening for psychosocial wellbeing was done using existing validated and reliable measures including the Child & Youth Resilience Measure-Revised (CYRM-R, Jefferies et al, 2018); the Patient Health Questionnaire-9 (PHQ-9, Kroenke et al, 2001); the Rosenberg Self-Esteem Scale (Rosenberg, 1965), and the Malawi Developmental Assessment Tool (MDAT). In addition to the above, the questionnaire also included demographics (e.g., sex, age, highest grade completed, school

attendance, reason for drop-out, number of children, marital status, living status, support from father of child); access to SRHR related services in the last 6 months; feelings of safety, the Parental Stress Scale, the Brief Resilience Scale (BRS), and the Composite Abuse Scale Revised – Short Form (CASR-SF). A summary of the scales and interpretation of scores can be found in the table below.

Scale	What it covers		
Demographic	Comprehensive demographic information including: • Geographic information • Gender • Age • Schooling • Type of dwelling • Access to basic services • Hunger • Caregiver/family information • Losses experienced • Marriage • Pregnancy		
Psychosocial wellbeing	What it measures scales:	Possible range	Higher score indicates
Child & Youth Resilience Measure-Revised (CYRMR)	Resilience, and social connectedness	17-85	Better resilience or more resilience enablers
Patient Health Questionnaire-9 (PHQ-9)	Measure of mental health (specifically depression)	0-27	More symptoms of depression
Rosenberg Self-Esteem Scale	Self-esteem	10-40	Higher levels of self-esteem
Feeling safe	If they feel safe in different places and overall		
Sexual Reproductive Health Access	Access to several SRH services in last six months		
Thematic area – IMPROVED OUTCOMES FOR ADOLESCENT MOTHERS THROUGH PSYCHOSOCIALLY INFORMED MCHC			
Scale	What it measures	Possible range	Higher score indicates
Brief Resilience Scale (BRS)	Resilience	6-30	Better resilience
Parental Stress Scale	Parental stress levels	18-90	Higher parental stress levels
Composite Abuse Scale Revised – Short Form (CASR-SF)	Experiences of Intimate Partner Violence in the last 6 months and if their children witnessed it	0-15	More experiences of Intimate Partner Violence

Malawi Developmental Assessment Tool (MDAT)	The MDAT evaluates development across four domains namely gross motor, fine motor, language, and social skills.	No range	There are a total of 136 items on the MDAT, all with a yes/no response format.

The primary analysis focused on the description of the wellbeing status of respondents. Data was imported into STATA v14 for statistical analysis. Both descriptive and inferential statistics were conducted to examine the distribution of all variables, assess relationships between variables, and determine differences between groups.

Ethical considerations

Ethical clearance for the research was obtained through the University of Pretoria in South Africa as the same data will be collected across different countries. While the questionnaire posed no more than minimal risk to participants, we implemented additional safety monitoring by taking steps to minimise any potential risk through the careful training and selection of data collectors, sensitive data collection procedures, and the development of a distress protocol. The Distress Protocol outlined what steps must be taken if abuse, maltreatment, or mental health problems are suspected and included contact details of relevant organisations that participants can be referred to within the country. Participants benefitted from participation in the interventions, not directly from the accompanying research.

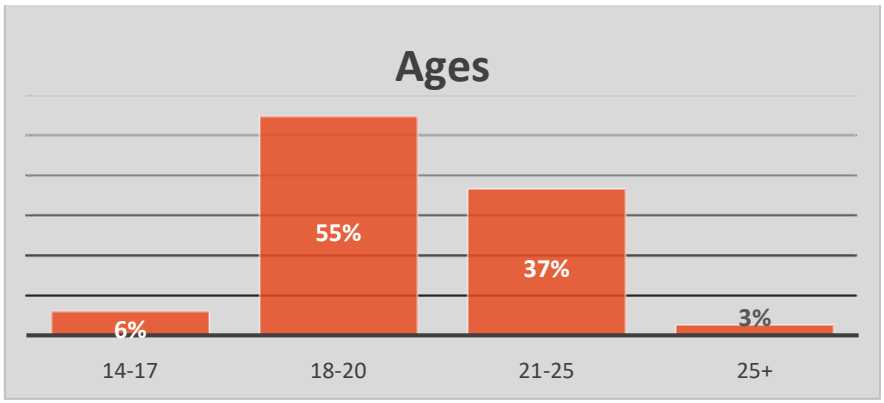
Limitations

This study does have several limitations which should be noted. Firstly, there is no control group which will limit the degree to which changes can confidently and solely be attributed to the intervention, as there may have been other factors at play which have not been controlled for. Also, this sample includes participants in specific interventions, so are not randomly selected. This limits the generalisability of this research as the sample is not entirely representative of a larger population. However, these results do provide evidence of significant change for a number of individuals who were involved in this intervention, specifically related to psychosocial wellbeing and parental stress levels of the adolescent mothers. Future research could include qualitative analysis to investigate what the participants themselves thought could be contributing factors to their change in scores (both positive and negative changes). Future research could perhaps also consider why changes have not been as significant or as positive as was hoped, and how the intervention can be adapted to ensure maximum positive impact can be considered.

Results Overall

Demographic Information

Although 349 baseline responses were collected, this report is based on respondents for which baseline and endline data was collected. A total of 237 baseline and endline responses were collected from Blantyre (118, 50%) and Machinga (119, 50%) in Malawi. This represents a 68% retention rate of respondents from baseline to endline. 100% of respondents were female (adolescent mothers). The ages of respondents ranged between 14 to 25+ years. The majority (55%) were 18 to 20 years old.



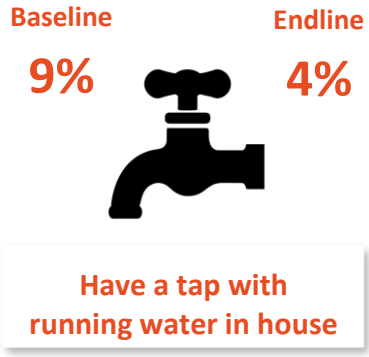
93% of respondents (220) at baseline and endline were not in school. Respondents indicated that there were a range of reasons for their not being in school. The majority indicated dropping out due to pregnancy (140, 64%); followed by not having enough money (54, 25%); failing (4, 2%), losing interest in school (4, 2%), having finished school (4, 2%), or dropping out because they got married (2, 1%).

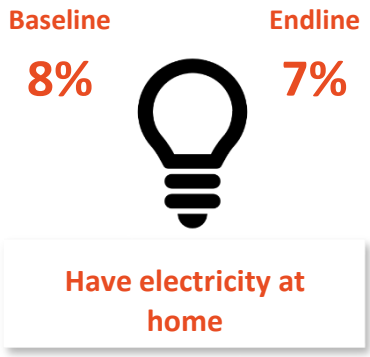
At baseline, most respondents indicated that they lived in a hut made of tradition materials (39%), or a house made of steel sheets on its own plot (31%). At endline, most respondents (45%) indicated that they live in a house made of brick, and 40% of respondents indicated that they lived in a hut made of traditional materials. These differences were statistically significant[12].

Type of home	Baseline	Endline	Change	
House made of brick	27%	45%	18%	↑
Hut made of traditional materials	39%	40%	1%	↑
House made of steel sheets on its own plot	31%	13%	-18%	↓
House made of steel sheets in a back yard	3%	1%	-2%	↓
Block of flats	0%	0.4%	0.4%	↑
Living on the street	0.4%	0.4%	0%	-

Table 1. Frequency of type of home

At baseline, 9% of the respondents (22) indicated that they had a tap with running water in their house, compared to 4% of respondents (10) at endline. This increase was statistically significant[13]. Furthermore, 8% (19) indicated that they have electricity connected to their house at baseline, and 7% (17) reported this at endline. This difference was not statistically significant[14].





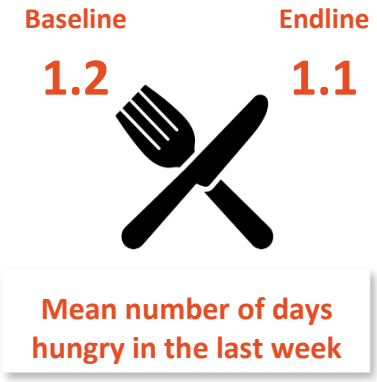
2% less respondents (4) indicated that they went to sleep hungry one or more days in the past week (56% at baseline to 54% at endline), while 37% of respondents at baseline and 38% at endline indicated that they had two or more days hungry in the last week. The mean number of

[12] p = 0.000
[13] p = 0.028
[14] p = 0.729

days respondents went to bed hungry in the last week was 1.2 at baseline and 1.1 at endline, which was not a statistically significant change[15]. Poverty is a known risk factor for mental health conditions (WHO, 2022A; Gittings et al., 2021). In early 2020, prompted by the COVID-19 pandemic, an acute global recession left millions of people unemployed and promoted a rise in

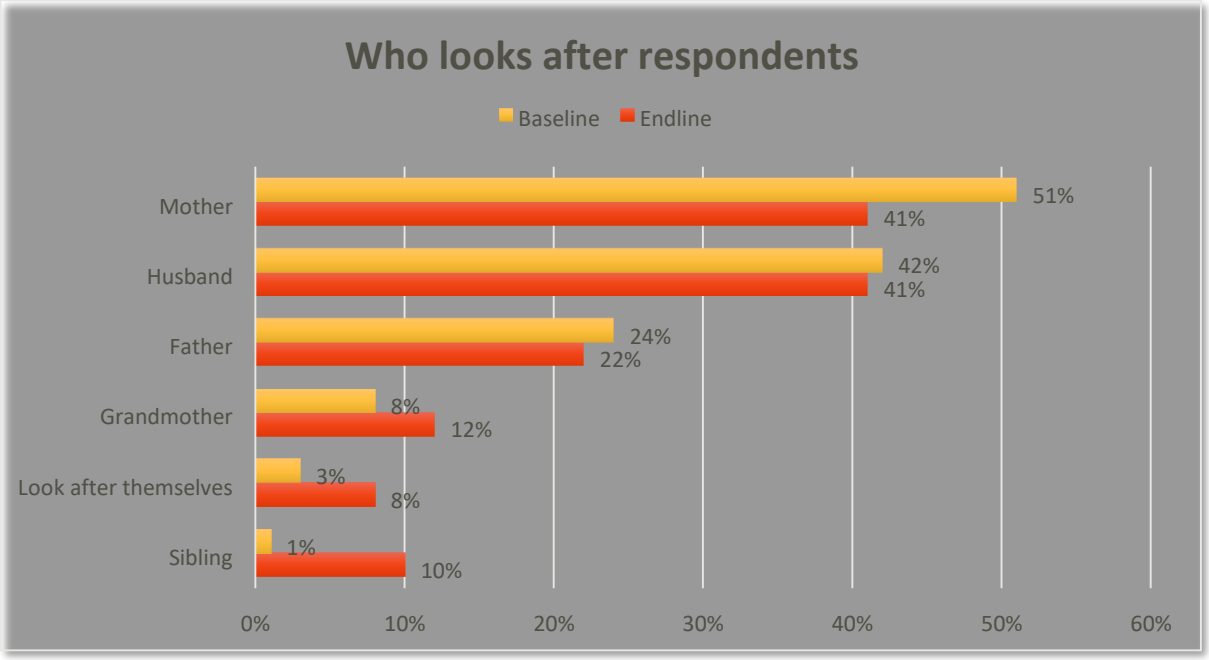
[15] p = 0.594

extreme poverty (Mahler et al., 2021). COVID-19 has also exacerbated many health and social inequalities (WHO, 2022A). For instance, families whose children rely on school feeding programmes could no longer had access these when schools closed due to the pandemic. According to a report released by Statistics South Africa, Measuring Food Security in South Africa: Applying the Food Insecurity Experience Scale, almost 24% of South Africans in 2020 were affected by moderate to severe food insecurity, while almost 15% experienced severe food insecurity. Food insecurity can have lasting detrimental effects for development, physical and mental health, and psychosocial wellbeing.



When asked who looks after them, three changes from baseline to endline were found to be statistically significant. 51% of respondents at baseline said that their mother looks after them, which decreased significantly to 41 at endline[16]. 9% more respondents (1% at baseline to 10% at endline) indicated they are looked after by their sibling[17], and 5% more respondents looked after themselves from baseline (3%) to endline (8%)[18].

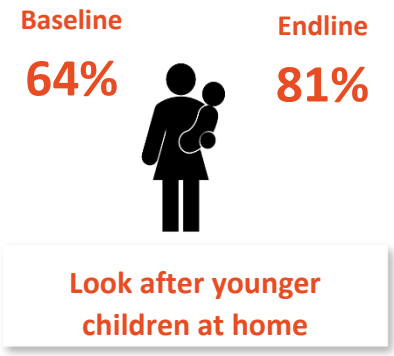
[16] p = 0.034
[17] p = 0.000
[18] p = 0.000

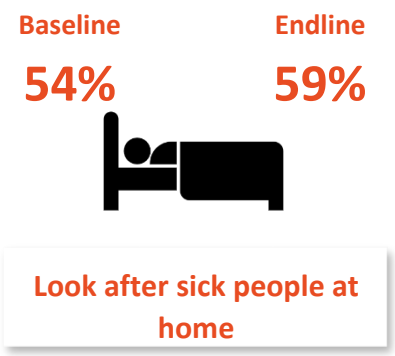


17% more respondents from baseline (64%) to endline (81%) indicated they looked after younger children at home, which was a statistically significant increase [19] . Slightly more

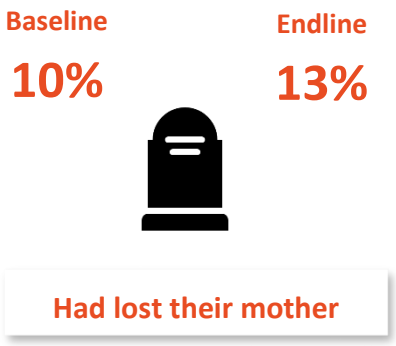
[19] p = 0.000

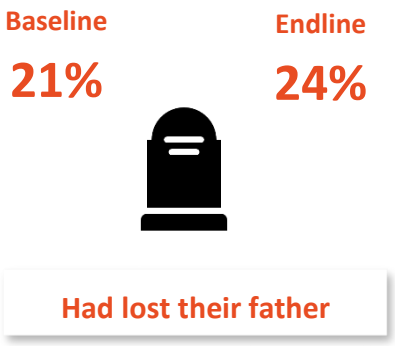
respondents (54% at baseline to 59% at endline) indicated that they look after sick people at home, which was not a statistically significant change[20].





Respondents were asked about the losses they have experienced in their lives. At baseline, 10% of respondents (23) indicated that their mother had died, and 21% (50) indicated that their father had died. At endline, this increased to 13% (31) who had lost their mother[21] and 24% (58) who had lost their father[22]. Neither of these changes were statistically significant. More than half of the sample at baseline and endline (57%) indicated that someone close to them had died[23]. During COVID-19, many people experienced major adversities, such as getting ill or witnessing suffering or death, which, like any adversity, can negatively impact mental health (WHO, 2022A).





Most respondents (50%) indicated that they were currently married at baseline, and this decreased to 46% at endline. 4% less respondents had never been married at endline (30%) compared to baseline (34%). At baseline, 16% answered that they had been married before but are no longer married, and this increased to 24% at endline. These differences were not statistically significant[24]. At endline, 43% of respondents (72) indicated that they were 17 years or younger when they got married, and 29% indicated that they got married at 18 years old. The youngest age that respondents at endline reported they were married at was 14 years old (3%).

[20] p = 0.354
[21] p = 0.512
[22] p = 0.680
[23] p = 1.000
[24] p = 0.087

Of those that were married, 50% (84) indicated that it was their choice to get married, with 21% of respondents (35) indicating that they felt pressure to get married. Of those that felt pressure to get married, 83% (29) indicated that close family was the most common source of pressure, followed by extended family (34%), in-laws and/or their partner's family (11%), friends (3%), and other (not specified) (3%). Of those who have never been married, 11% (25) at baseline said that they would not like to get married, which decreased significantly to 0% at endline[25]. The respondents who indicated that they would like to get married at some point were asked at what age they would like to get married. 27% more respondents said that they would like to get married between the ages of 26 and 30 years from baseline (8%) to endline (35%)[26]. Positively, 24% of respondents at baseline (12) indicated that they would like to get married aged 19 or younger, and this decreased to 0% at endline. The ages at which respondents who have never married but would like to get married are presented below:

Age group	Age at which you were married			Age at which you would like to get married		
	Baseline	Endline		Baseline	Endline	
>20	100%	97%	↓	44%	13%	↓
21-25	0%	3%	↑	48%	51%	↑
26-30	0%	0%	-	8%	35%	↑
30<	0%	0%	-	0%	1%	↑

Table 2. Age groups by married and wanting to get married

All respondents (100%) indicated that they have been pregnant. At baseline, the majority (92%) indicated they have one child and 8% indicated having two children. At endline, 78% of respondents had one child, 20% had two children, 1% (3 respondents) had three children, and one respondent indicated having four children. These changes were statistically significant[27].
83% indicated that their first pregnancy was not planned, and 43% said the same of the second pregnancy. One respondent (25%) indicated that their third pregnancy was unplanned, and one respondent indicated that her fourth pregnancy was planned.

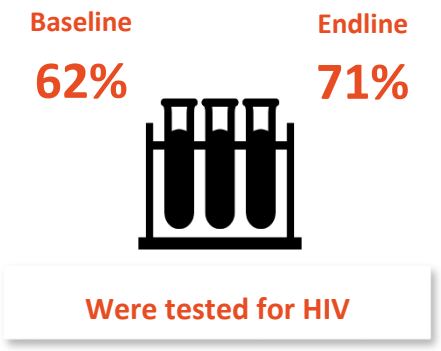
Sexual Reproductive Health

Access to SRH Services

Respondents were asked if they had accessed several forms of sexual reproductive health services in the previous six months. Overall, access to SRHR services increased from baseline to endline and numerous changes were found to be statistically significant. For instance, 15% more respondents got a cervical cancer vaccination (6% at baseline to 21% at endline); 11% more respondents who were pregnant received PMTCT (16% at baseline to 27% at endline), and 11% more respondents received condoms (5% at baseline to 16% at endline). 62% of respondents

[25] p = 0.000
[26] p = 0.012
[27] p = 0.000

were tested for HIV at baseline and this increased significantly to 71% at endline, and significantly more respondents also indicated that they received ART (43% at baseline to 54% at endline).



The table below breaks down the responses to each question in the SRH services questionnaire:

Question	Yes Baseline	Yes Endline	p

Got condoms	5%	16%	↑	0.000
Been tested for HIV	62%	71%	↑	0.041
Been tested for STIs	35%	33%	↓	0.628
Received ART	43%	54%	↑	0.022
Received pre-exposure prophylaxis (PrEP)	2%	7%	↑	0.004
Received post-exposure prophylaxis (PEP)	2%	5%	↑	0.066
Got an Intrauterine Device (IUD)	3%	8%	↑	0.015
Got the pill	7%	6%	↓	0.853
Got a birth control injection	44%	48%	↑	0.407
Antenatal check-ups for your baby – while pregnant	35%	26%	↓	0.036
Gave birth at a clinic or hospital	29%	21%	↓	0.043
Postnatal check-ups for you or your baby	58%	41%	↓	0.000
Help with breastfeeding from a healthcare worker	21%	28%	↑	0.069
Got sanitary pads	2%	5%	↑	0.066
Got a cervical cancer vaccination	6%	21%	↑	0.000
Question	Yes Baseline	Yes Endline		p
PMTCT (only pregnant girls)	16%	27%	↑	0.004

Table 3. Responses to questions on access to sexual reproductive health services

Psychosocial wellbeing

Resilience enablers

The Child & Youth Resilience Measure-Revised (CYRM-R) was used to assess resilience. The tool score can range between 17 and 85. Cronbach's alpha for the 17 items of the CYRM-R scale showed the questionnaire reached the acceptable reliability level, $\alpha = 0.85$. For this group, the mean score was 64.8 at baseline, the lowest score was 32 and the maximum was 85. At endline the mean score decreased to 62.7, with 28 being the lowest score and 85 being the highest score. This change was found to be statistically significant[28]. However, both scores indicate high levels of resilience. The scale also has two subscales: personal resilience and caregiver resilience. At baseline, the mean personal resilience score was 38.0 and scores ranged between 20 and 50. At endline, the mean personal resilience score decreased to 36.0 with scores ranging between 19 and 50. The mean caregiver resilience was 26.9 at baseline (ranging between 8 and 35), which decreased slightly to 26.7 at endline (ranging between 9 and 35). The change in personal resilience score was

[28] p = 0.018

statistically significant[29], but not the change in caregiver resilience[30]. Overall, 44% of respondents (105) showed increased resilience from baseline to endline. At baseline, 68% of respondents showed high levels of resilience (as indicated by a score of 63 or more), and this decreased significantly to 54% at endline[31].

Respondents showing increased resilience on the CYRM-R

CYRM-R score group	Baseline	Endline	% change	
17-39 (Low)	2%	4%	2%	↑
40-62 (Moderate)	30%	42%	12%	↑
63-85 (High)	68%	54%	-14%	↓

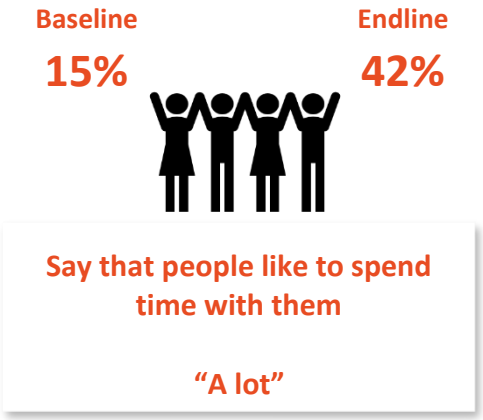
Table 4. Frequency of resilience score group

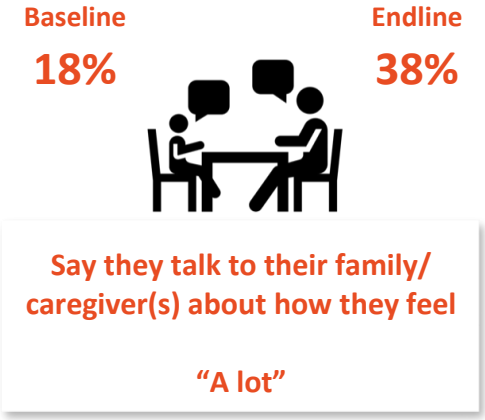
When looking at responses to individual questions on the CYRM-R, all but one change from baseline to endline was found to be statistically significant. The largest changes occurred in the following areas:

- 27% more respondents responded with "A lot" to the statement "People like to spend time with me" (15% at baseline and 42% at endline)
- 20% more respondents (18% at baseline and 38% at endline) selected "A lot" for the statement "I talk to my family/caregiver(s) about how I feel"
- "I get along with people around me" where 19% more respondents from baseline (19%) to endline (38%) selected "A lot"

[29] p = 0.000
[30] p = 0.691
[31] p = 0.013

- 17% more respondents (35% at baseline to 52% at endline) said that getting an education is important to them "A lot"
- The number of respondents who selected "A lot" for the statement "I like the way my family/caregiver(s) celebrates things" increased from 21% at baseline to 39% at endline (18% more)





The table below breaks down the responses to each question in the CYRM-R:

Question	Response	Baseline	Endline		p
I get along with people around me	Not at all	3%	5%	↑	0.000

	A lot	19%	38%	↑	
Getting an education is important to me	Not at all	2%	3%	↑	0.000
	A lot	35%	52%	↑	
I know how to behave/act in different situations (such as school, home, and church)	Not at all	2%	5%	↑	0.000
	A lot	22%	39%	↑	
My parent(s)/caregiver(s) really look out for me	Not at all	5%	7%	↑	0.031
	A lot	27%	34%	↑	
My parent(s)/caregiver(s) know a lot about me (e.g., who my friends are, what I like to do)	Not at all	5%	6%	↑	0.001
	A lot	20%	35%	↑	
If I am hungry, there is enough to eat	Not at all	12%	10%	↓	0.042
	A lot	15%	16%	↑	
People like to spend time with me	Not at all	5%	0.4%	↓	0.000
	A lot	15%	42%	↑	
I talk to my family/caregiver(s) about how I feel (e.g., when I am hurt or sad)	Not at all	5%	7%	↑	0.000
	A lot	18%	38%	↑	
I feel supported by my friends	Not at all	11%	17%	↑	0.000
	A lot	13%	12%	↓	
I feel that I belong/belonged at my school	Not at all	12%	30%	↑	0.000
	A lot	15%	20%	↑	
	Not at all	4%	6%	↑	0.099

Question	Response	Baseline	Endline		p
My family/caregiver(s) care about me when times are hard (e.g., if I am sick or have done something wrong)	A lot	26%	30%	↑	
My friends care about me when times are hard (e.g., if I am sick or have done something wrong)	Not at all	11%	15%	↑	0.000
	A lot	11%	12%	↑	
I am treated fairly in my community	Not at all	13%	21%	↑	0.000
	A lot	16%	19%	↑	
I have chances to show others that I am growing up and can do things by myself	Not at all	5%	5%	-	0.000
	A lot	19%	30%	↑	
I feel safe when I am with my family/caregiver(s)	Not at all	2%	4%	↑	0.000
	A lot	34%	40%	↑	
I have chances to learn things that will be useful when I am older (like cooking, working, and helping others)	Not at all	0.4%	3%	↑	0.000
	A lot	29%	32%	↑	
I like the way my family/caregiver(s) celebrates things (like holidays or learning about my culture)	Not at all	3%	7%	↑	0.000
	A lot	21%	39%	↑	

Table 5: Responses to all questions on the CYRM-R

One direct impact of COVID-19 has been lockdown and social restrictions, which was implemented to protect people's health, but at the same time reduced social connections that contribute to mental health (WHO, 2022A). Studies show that children and adolescents have been more affected than older adults (Octavius et al., 2020; WHO, 2022B). Extended school closures interrupted routines and social connections, meaning that young people missed out on learning and experiences expected for healthy development. Disruption and isolation can fuel feelings of anxiety, uncertainty and loneliness, and can lead to negative mental health outcomes (WHO & Regional Office for Europe., 2021). For some children and adolescents, being made to stay at home is likely to have increased the risk of family stress or abuse, which are known risk factors for mental health problems (Piquero et al., 2021; Gittings et al., 2019). In line with this, a 2021 MIET Africa report on the impact of COVID-19 on SADC youth showed that 62% of the youth respondents reported feeling sadder due to lockdowns, and just under three-quarters of the youth respondents reported feeling more worried now than they did before the pandemic. This could explain the overall decrease in average resilience sores from baseline to endline found in this study.

At the same time, whilst some people may be more affected by the pandemic due to a variety of reasons (WHO, 2022A), many people have also shown resilience to new stresses and vulnerabilities caused by COVID-19. They have reported healthy coping mechanisms, for example linked to regular contact with friends and family and informal community-based support (Mental Health Foundation, 2020). In the present study, 27% more respondents said that people like to spend time with them a lot, and 20% more respondents said they talk to their family/caregiver(s) about how they feel a lot, which suggests that they do have social support. Social connection and cohesion such as this has been shown to foster resilience (WHO, 2022A).

Resilience

The Brief Resilience Scale (BRS) was also used to assess resilience. The tool score can range between 6 to 30, with higher scores indicating higher resilience. Cronbach's alpha for the 6 items of the BRS scale showed the questionnaire reached the acceptable reliability level, $\alpha = 0.67$. For this group, the mean score was 17.7 at baseline which increased significantly to 18.7 at endline[32]. Both scores indicate moderate resilience. The minimum score was 6 and the maximum score was 30 at both baseline and endline. According to the BRS, 52% of respondents (123) increased in their resilience scores from baseline to endline. The majority of respondents (67% at baseline and 64% at endline) showed moderate levels of resilience (as indicated by a score between 14 and 21 on the BRS). Positively, 6% more respondents (13% at baseline to 19% at endline) showed high levels of resilience.

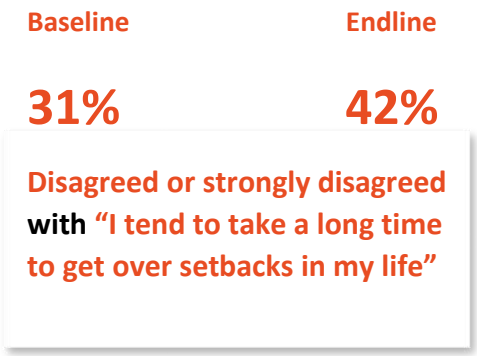
Score group	Baseline	Endline	Change	
6-13 (Low)	20%	17%	-3%	↓
14-21 (Moderate)	67%	64%	-3%	↓
22-30 (High)	13%	19%	6%	↑

Table 6. Frequency of resilience score group

Only one change from baseline to endline was found to be statistically significant, whereby 11% more respondents (31% at baseline to 42% at endline) disagreed or strongly disagreed with "I tend to take a long time to get over setbacks in my life". Other changes which were not statistically significant may also be interesting to consider:

- 10% more respondents disagreed or strongly disagreed with "It is hard for me to snap back when something bad happens" (32% at baseline and 42% at endline)
- 51% of respondents at baseline agreed or strongly agreed with "It does not take me long to recover from a stressful event", and this increased to 55% at endline (4% more)
- Less respondents disagreed or strongly disagreed with "I tend to bounce back quickly after hard times from baseline (26%) to endline (22%)

[32] $p = 0.021$



The table below breaks down the responses to each question in the BRS. Note that the percentages reported include respondents who agreed/strongly agreed or disagreed/strongly disagreed.

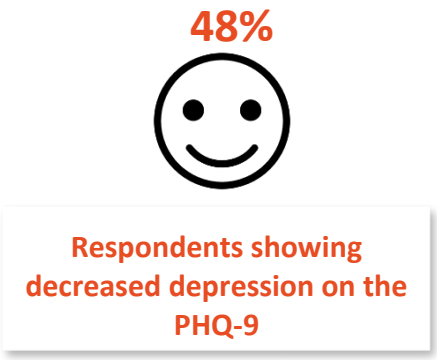
Question	Response	Baseline	Endline		p
I tend to bounce back quickly after hard times	Agree	62%	62%	-	0.436
	Disagree	26%	22%	↓	
I have a hard time making it through stressful events	Agree	53%	52%	↓	0.926
	Disagree	33%	33%	-	
It does not take me long to recover from a stressful event	Agree	51%	55%	↑	0.469
	Disagree	32%	32%	-	
It is hard for me to snap back when something bad happens	Agree	54%	46%	↓	0.086
	Disagree	32%	42%	↑	
I usually come through difficult times with little trouble	Agree	48%	49%	↑	0.927
	Disagree	38%	37%	↓	
I tend to take a long time to get over setbacks in my life	Agree	58%	46%	↓	0.024
	Disagree	31%	42%	↑	

Table 7: Responses to all questions on the BRS

Mental health

Mental health was measured using the PHQ-9, which has a possible range of between 0 and 27 with a higher score indicating higher levels of mental health distress. Cronbach's alpha for the 9 items of the PHQ-9 scale showed that the questionnaire reached the acceptable reliability level, $\alpha = 0.78$. For this group, the mean score was 4.6 at baseline which decreased to 4.0 at endline. Both scores indicate mild depression or mental health distress. This change was not statistically significant[33]. Scores ranged between 0 and 22 at baseline, and between 0 and 21 at endline. Overall, 48% of respondents (113) had decreased levels of depression at endline compared to baseline. In addition, 6% less respondents were categorised as having moderate depression (12% at baseline to 6% at endline), and 3% more respondents showed no signs of mental health distress according to the PHQ.

[33] $p = 0.085$

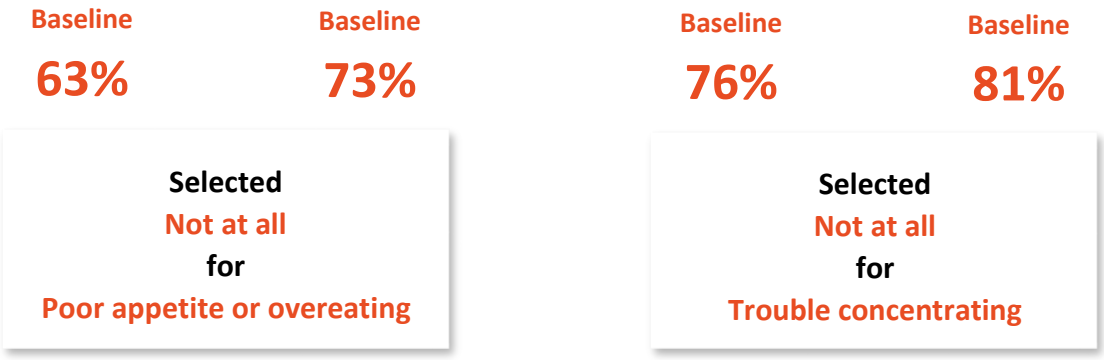


Score group	Baseline	Endline	Change	
0 (None)	16%	19%	3%	↑
1-9 (Mild)	70%	74%	4%	↑
10-18 (Moderate)	12%	6%	-6%	↓
19-27 (Severe)	1%	1%	0%	-

Table 8: Frequency of mental health score group

Three changes from baseline to endline were found to be statistically significant:

- At baseline, 63% of respondents reported having poor appetite or overeating "Not at all", and this increased to 73% at endline
- 7% more respondents selected "Not at all" for "Moving or speaking so slowly that other people could have noticed. Or the opposite" (70% at baseline to 77% at endline)
- "Feeling bad about yourself - or that you're a failure or have let yourself or your family down" where 6% more respondents (62% at baseline to 68% at endline) selected "Not at all"



The table below outlines responses to each item on the PHQ-9.

Question	Response	Baseline	Endline		p
Little interest or pleasure in doing things	Not at all	46%	46%	-	0.136

	Nearly every day	8%	12%	↑	
Feeling down, depressed, or hopeless	Not at all	55%	46%	↓	0.052
	Nearly every day	8%	5%	↓	
Trouble falling asleep, staying asleep, or sleeping too much	Not at all	65%	61%	↓	0.514
	Nearly every day	5%	4%	↓	
Feeling tired or having little energy	Not at all	57%	56%	↓	0.559
	Nearly every day	6%	4%	↓	
Poor appetite or overeating	Not at all	63%	73%	↑	0.016
	Nearly every day	4%	1%	↓	
Feeling bad about yourself - or that you're a failure or have let yourself or your family down	Not at all	62%	68%	↑	0.032
	Nearly every day	4%	1%	↓	
Trouble concentrating on things, such as reading the newspaper or watching television	Not at all	76%	81%	↑	0.212
	Nearly every day	4%	1%	↓	
Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	Not at all	70%	77%	↑	0.004
	Nearly every day	4%	1%	↓	
Question	Response	Baseline	Endline		p
Thoughts that you would be better off dead or of hurting yourself in some way	Not at all	84%	87%	↑	0.135
	Nearly every day	1%	1%	-	

Table 9: Responses to all questions on the PHQ-9

Many people have reported increased mental health problems, such as depression and anxiety, since the COVID-19 pandemic began (WHO, 2022A, WHO, 2022B; COVID-19 Mental Disorders Collaborators, 2021). There have also been indications of more widespread suicidal thoughts and behaviours driven by factors such as low social support, poor physical health, loneliness, isolation, and pre-existing mental health difficulties (WHO, 2022B). Therefore, while the improvements in mental health distress in this study were slight and not statistically significant, they nevertheless show positive change for many respondents against a backdrop of increasing mental health stressors. As mentioned previously, positive coping mechanisms such as social connections have been shown to increase resilience and help mitigate mental health difficulties such as depression (WHO, 2022A).

Self-esteem

Self-esteem was measured using the Rosenberg Self-esteem Scale, which has a possible range of between 10 and 40 with a higher score indicating higher levels of self-esteem. Cronbach's alpha for the 10 items of the scale showed the questionnaire did reach an acceptable reliability, $\alpha =$

0.58. For this group, the mean score was 25.9 at baseline which increased to 26.4 at endline, which was not a statistically significant change[34]. These scores are within the normal self-esteem range. At baseline, scores ranged between 18 and 37, and at endline scores ranged between 16 and 38. Half of respondents (119, 50%) increased in their self-esteem scores from baseline to endline.

50%

Respondents showing improved self-esteem

When looking at responses to individual items on the scale, all but one change from baseline to endline was found to be statistically significant, including;

- "I wish I could have more respect for myself" where 33% of respondents at baseline compared to 51% at endline strongly agreed (18% more)
- 17% more respondents strongly agreed with the statement "I feel that I'm a person of worth, at least on an equal plane with others" from baseline (30%) to endline (47%).
- "On the whole, I am satisfied with myself" where 13% more respondents (34% at baseline to 47% at endline) strongly agreed
- The number of respondents who strongly agreed with the statement "At times I think I am no good at all" increased from 6% at baseline to 17% at endline
- 11% more respondents from baseline (6%) to endline (17%) strongly disagreed with the statement "All in all, I am inclined to feel that I am a failure"

Baseline **30%** **Endline** **47%**

Strongly agreed with "I feel that I'm a person of worth, at least on an equal plane with others"

Baseline **6%** **Endline** **17%**

Strongly disagreed with "All in all, I am inclined to feel that I am a failure"

The table below breaks down the responses to each question in the Rosenberg Self-Esteem Scale.

Question	Response	Baseline	Endline	p

[34] p = 0.161

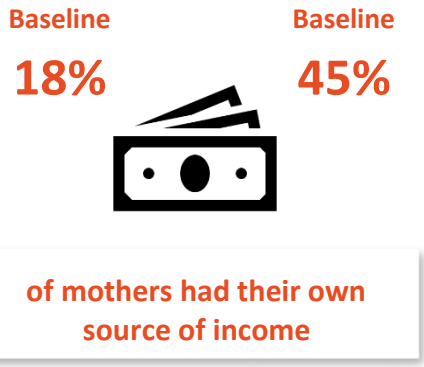
On the whole, I am satisfied with myself	Strongly Agree	34%	47%	↑	0.016
	Strongly Disagree	6%	5%	↓	
At times I think I am no good at all	Strongly Agree	6%	17%	↑	0.000
	Strongly Disagree	5%	8%	↑	
I feel that I have a number of good qualities	Strongly Agree	11%	19%	↑	0.022
	Strongly Disagree	4%	7%	↑	
I am able to do things as well as most other people	Strongly Agree	23%	24%	↑	0.591
	Strongly Disagree	4%	5%	↑	
I feel I do not have much to be proud of	Strongly Agree	11%	19%	↑	0.026
	Strongly Disagree	5%	8%	↑	
I certainly feel useless at times	Strongly Agree	9%	16%	↑	0.021
	Strongly Disagree	9%	14%	↑	
I feel that I'm a person of worth, at least on an equal plane with others	Strongly Agree	30%	47%	↑	0.002
	Strongly Disagree	3%	2%	↓	
I wish I could have more respect for myself	Strongly Agree	33%	51%	↑	0.001
	Strongly Disagree	1%	1%	-	
All in all, I am inclined to feel that I am a failure	Strongly Agree	8%	10%	↑	0.001
	Strongly Disagree	6%	17%	↑	
I take a positive attitude toward myself	Strongly Agree	15%	19%	↑	0.047
	Strongly Disagree	3%	7%	↑	

Table 10: Responses to all questions on the Rosenberg Self-esteem Scale

In this study, average self-esteem scores of respondents increased from baseline to endline. Literature has also shown that women are more affected than men by adversities such as the COVID-19 pandemic (COVID-19 Mental Disorders Collaborators, 2021). They were, and continue to be, more likely to be financially disadvantaged due to lower salaries, fewer savings, and less secure employment than their male counterparts. Women also experience a large brunt of the stress in the home, especially when they provided most of the additional informal care required by school closures. Given that the literature has shown the negative impact of COVID-19 on adolescents and youth, including increased stress, depression, a lack of psychosocial support, and low self-esteem, amongst others (Sikhangezile & Modise, 2020), it is encouraging that adolescent mothers (who face many additional challenges linked to this) are able to increase their selfesteem against a backdrop of mounting mental and physical health stressors.

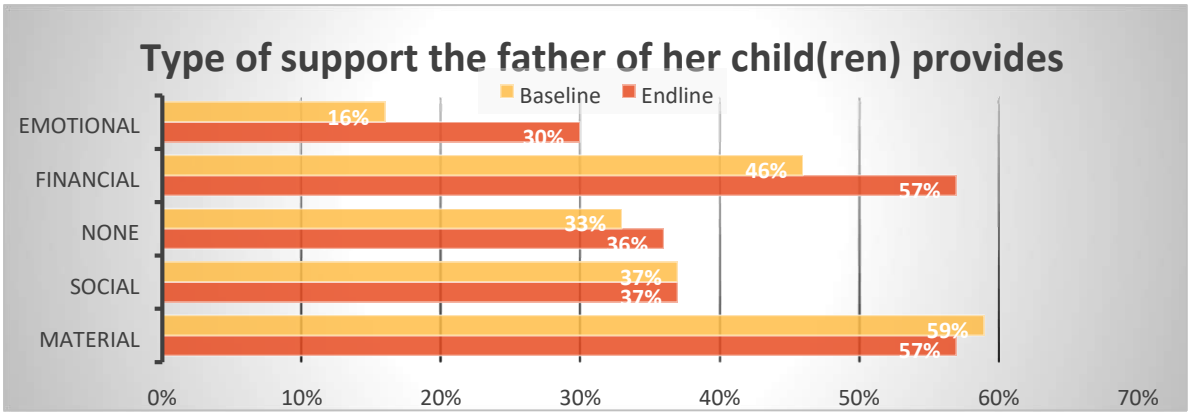
About the mothers

Mothers were asked a few questions relating to themselves and to the other adults living in their households. Most mothers had given birth to one child at baseline (87%) and endline (81%), followed by 5% of mothers at baseline and 16% of mothers at endline having given birth to two children. Mothers who had given birth to 3 or 4 children increased from baseline (0%) to endline (2%). These differences were statistically significant [35]. The maximum number of adults per household was 8 at baseline and endline, while the minimum was 0 at baseline and 1 at endline. The mean number of adults living in the households at baseline was 2.8 (SD: 1.6), with 42% of those adults being employed (mean: 0.6; SD: 0.8). At endline, the mean number of adults living in the household was 2.8 (SD: 1.4) [36], with 50% of those adults being employed (mean: 0.7; SD: 0.9)[37]. Neither change was statistically significant. At baseline, 18% of mothers (42) had their own source of income, and this increased significantly to 45% (106) at endline[38]. However, 131 (55%) relied on others for income at endline.



Mothers were asked about the type of support provided by the father of her child(ren). Two changes from baseline to endline were found to be statistically significant. 14% more mothers (16% at baseline to 30% at endline) indicated that they received emotional support[39], and 11% more indicated that they received financial support (46% at baseline to 57% at endline)[40]. 33% of mothers at baseline and 36% at endline said they did not receive any support from the father of their child(ren).

[35] p = 0.000
[36] p = 0.730
[37] p = 0.193
[38] p = 0.000
[39] p = 0.001
[40] p = 0.017



Parental Stress Levels

Scores on the Parental Stress Scale can range from 18 to 90, with a higher score indicating increased parental stress levels. Cronbach's alpha for the 18 items of the scale showed the questionnaire did reach an acceptable reliability, $\alpha = 0.77$. The mean score at baseline was 45.9 and this decreased significantly to 42.2 at endline[41]. At both baseline and endline, scores ranged between 20 and 68. Overall, 62% of mothers showed decreased parental stress from baseline to endline. In addition, the majority of respondents at baseline (73%) had moderate levels of parental stress, which decreased to 53% at endline, while 21% more respondents showed mild parental stress at endline (47%) compared to baseline (26%).

Score group	Baseline	Endline	Change	
18-41 (Mild)	26%	47%	21%	↑
42-66 (Moderate)	73%	53%	-20%	↓
67-90 (Severe)	1%	0.4%	-0.6%	↓

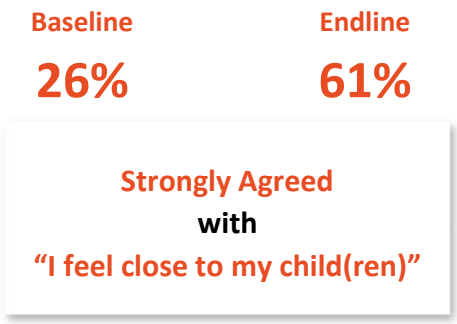
Table 11: Frequency of parental stress score group

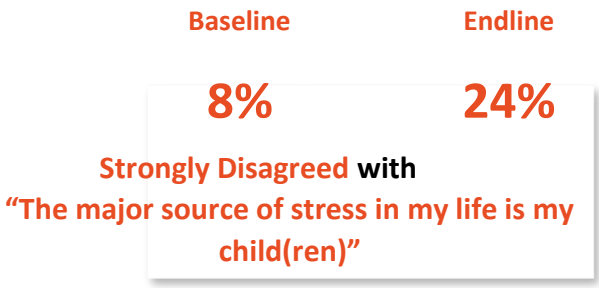
All but one change from baseline to endline was found to be statistically significant. The following positive changes were found:

- 35% more mothers from baseline (26%) to endline (61%) strongly agreed with the statement "I feel close to my child(ren)"

[41] p=0.000

- From baseline (31%) to endline (65%), 34% more mothers strongly agreed with the statement "I find my child(ren) enjoyable"
- 33% of mothers at baseline strongly agreed with the statement "I enjoy spending time with my child(ren)" compared to 62% at endline (29% more)
- "Having child(ren) gives me a more certain and optimistic view for the future" where 25% more mothers strongly agreed (32% at baseline to 57% at endline)
- 22% more mothers (from 43% at baseline to 65% at endline) strongly agreed that their child(ren) is/are an important source of affection for them
- 40% of mothers at endline strongly agreed that they are satisfied as a parent, compared to 24% at baseline (a 16% increase)
- 16% more respondents (8% at baseline to 24% at endline) strongly disagreed with "The major source of stress in my life is my child(ren)"
- The number of mothers who strongly disagreed with "The behaviour of my child(ren) is often embarrassing or stressful to me" increased from 34% at baseline to 49% at endline (15% more)
- "I am happy in my role as a parent" where 16% more mothers strongly agreed (24% at baseline to 40% at endline)





On the other hand, the following changes were not as positive:

- 17% more mothers from baseline (13%) to endline (30%) strongly agreed with "If I had it to do over again, I might decide not to have child(ren)".
- At baseline, 6% of mothers strongly disagreed with the statement "There is little or nothing I wouldn't do for my child(ren) if it was necessary" and this increased to 16% at endline
- "Having child(ren) has been a financial burden" where 11% of mothers at endline strongly agreed, which is a 5% increase from baseline (6%)
- At endline, 15% of mothers strongly agreed with the statement "I feel overwhelmed by the responsibility of being a parent" compared to 8% at baseline (7% more)

The table below breaks down the responses to each question in the Parental Stress Scale.

Parental Stress Scale	Response	Baseline	Endline		p
I am happy in my role as a parent	Strongly Agree	24%	40%	↑	0.000
	Strongly Disagree	3%	6%	↑	
There is little or nothing I wouldn't do for my child(ren) if it was necessary	Strongly Agree	12%	11%	↓	0.000
	Strongly Disagree	6%	16%	↑	
Caring for my child(ren) sometimes takes more time and energy than I have to give	Strongly Agree	10%	12%	↑	0.000
	Strongly Disagree	5%	18%	↑	
I sometimes worry whether I am doing enough for my child(ren)	Strongly Agree	12%	15%	↑	0.153
	Strongly Disagree	5%	11%	↑	
I feel close to my child(ren)	Strongly Agree	26%	61%	↑	0.000
	Strongly Disagree	1%	1%	-	
I enjoy spending time with my child(ren)	Strongly Agree	33%	62%	↑	0.000
	Strongly Disagree	0.4%	0.4%	-	
My child(ren) is an important source of affection for me	Strongly Agree	43%	65%	↑	0.000
	Strongly Disagree	0%	0%	-	
Having child(ren) gives me a more certain and optimistic view for the future	Strongly Agree	32%	57%	↑	0.000
	Strongly Disagree	2%	1%	↓	
The major source of stress in my life is my child(ren)	Strongly Agree	10%	13%	↑	0.000
	Strongly Disagree	8%	24%	↑	
Having child(ren) leaves little time and flexibility in my life	Strongly Agree	8%	8%	-	0.000
	Strongly Disagree	11%	22%	↑	
Having child(ren) has been a financial burden	Strongly Agree	6%	11%	↑	0.007
	Strongly Disagree	13%	20%	↑	
It is difficult to balance different responsibilities because of my child(ren)	Strongly Agree	5%	8%	↑	0.031
	Strongly Disagree	13%	21%	↑	
The behaviour of my child(ren) is often embarrassing or stressful to me	Strongly Agree	4%	4%	-	0.001
	Strongly Disagree	34%	49%	↑	
If I had it to do over again, I might decide not to have child(ren)	Strongly Agree	13%	30%	↑	0.000
	Strongly Disagree	22%	24%	↑	
I feel overwhelmed by the responsibility of being a parent	Strongly Agree	8%	15%	↑	0.000
	Strongly Disagree	10%	17%	↑	
Having child(ren) has meant having too few choices and too little control over my life	Strongly Agree	6%	10%	↑	0.001
	Strongly Disagree	12%	23%	↑	
I am satisfied as a parent	Strongly Agree	24%	40%	↑	0.000
	Strongly Disagree	3%	5%	↑	
I find my child(ren) enjoyable	Strongly Agree	31%	65%	↑	0.000
	Strongly Disagree	0.4%	0.4%	-	

Table 12: Responses to Parental Stress Scale

Levels of parental stress were found to decrease significantly in this study. Overall, there were significant improvements in positive attitudes towards motherhood. For instance, 35% more mothers strongly agreed that they feel close to their children. At the same time, 7% more mothers

also indicated that they feel overwhelmed by the responsibility of being parent. Erfina et al. (2019) highlight the complexities of [adolescent] motherhood and the mixed feelings of joy and worry associated with this role (Erfina et al., 2019). While motherhood (and particularly adolescent motherhood) comes with many challenges, their children appear to be a great source of strength in this study.

Safety

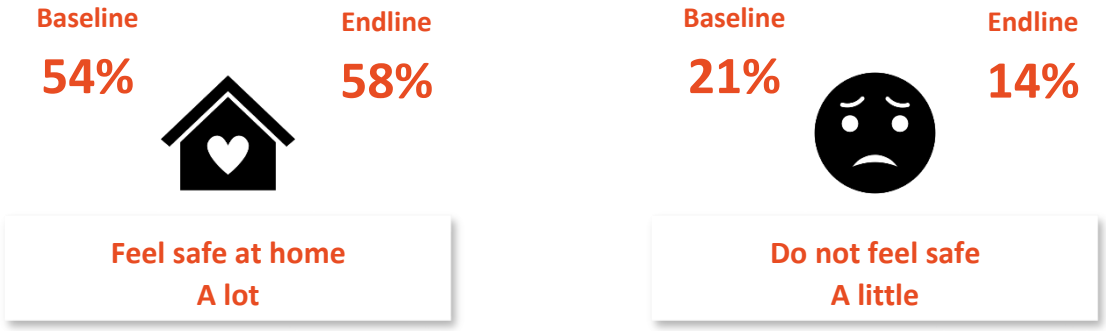
Feeling safe

Respondents were asked to what degree they felt safe at home and in the community, and to what degree they felt unsafe.

All three changes from baseline to endline were found to be statistically significant:

- 54% of respondents at baseline reported that they feel safe in their homes "A lot" and this increased to 58% at endline. At the same time, 23% of respondents at baseline indicated that they feel safe at home "Quite a bit", and this decreased to 14% at endline.
- 1% less respondents indicated that they felt safe in their community "Not at all" from baseline (7%) to endline (6%). On the other hand, 11% less respondents reported feeling safe in their community "Quite a bit" (22% at baseline to 11% at endline).

7% less respondents from baseline (21%) to endline (14%) reported that they don't feel safe "A little".



Question	Response	Baseline	Endline		p
I feel safe at home	Not at all	6%	5%	↓	0.031
	A lot	54%	58%	↑	
I feel safe in my community	Not at all	7%	6%	↓	0.007
	A lot	43%	40%	↓	
I don't feel safe	Not at all	58%	55%	↓	0.006
	A lot	10%	7%	↓	

Table 13: Responses to all safety questions

Intimate Partner Violence

The mothers were asked about their experiences of intimate partner violence (IPV). At baseline, 80% of mothers reported that they had been in an intimate relationship before which increased

significantly to 88% at endline[42]. 64% said they were currently in an intimate relationship at baseline, and this decreased slightly to 61% at endline[43]. Of these, 27% said that they were currently afraid of their partner at the time of baseline, while 20% reported this at endline (which was not statistically significant)[44].

The IPV scale assessed the exposure of the mother and the child to 15 forms of IPV in the last three months. The mean number of IPV forms the mothers were exposed to was 0.6 at baseline, which increased significantly to 2.2 at endline[45]. For the children, the mean number of IPV forms that they had witnessed was 0.2 at baseline, which increased significantly to 1.7 at endline[46]. Overall, experiences of IPV increased significantly from baseline to endline, and the number of incidences of children witnessing this also increased. All but one change was found to be statistically significant on the IPV scale, with the largest changes having occurred in the following areas:

- 18% more mothers (4% at baseline to 22% at endline) reported that "My partner hit me with a fist or object, kicked or bit me", and 13% more mothers reported that their child had witnessed this (3% at baseline to 16% at endline).
- 20% of mothers at endline reported that their partner had told them they were crazy, stupid, or not good enough, which is a 16% increase from baseline (4%). In addition, 12% more mothers (2% at baseline to 14% at endline) indicated that their child had witnessed this.
- "Threatened to harm or kill me or someone close to me" where 2% of mothers at baseline compared to 14% at endline indicated this (12% more). 11% of children at endline had witnessed this compared to 1% at baseline.
- 12% more mothers also reported that their partner kept them from seeing or talking to their family or friends (3% at baseline to 15% at endline), and 11% more mothers reported their child had witnessed this (1% at baseline to 12% at endline).
- At baseline, 3% of mothers reported that their partner had harassed them by phone, text, email or social media, and this increased to 15% at endline (12% more), while 9% more mothers reported that their child had witnessed this (1% at baseline to 10% at endline).

[42] p=0.018
[43] p=0.498
[44] p=0.180
[45] p=0.000
[46] p=0.000

of mothers said their partner(s) hit them with a fist or object, kicked, or bit them

of mothers reported their child had witnessed them being hit with a fist or object, kicked, or bitten

The following table breaks down the responses to each question in the IPV Scale:

My partner(s):	Response	Baseline	Endline		p
Blamed me for causing their violent behaviour	% happened to them	6%	14%	↑	0.002
	% child witnessed it	3%	11%	↑	0.003
Shook, pushed, grabbed, or threw me	% happened to them	7%	17%	↑	0.001
	% child witnessed it	2%	12%	↑	0.000
Tried to convince my family, children, or friends that I am crazy or tried to turn them against me	% happened to them	3%	14%	↑	0.000
	% child witnessed it	1%	11%	↑	0.000
Used or threatened to use a knife or gun or other weapon to harm me	% happened to them	3%	13%	↑	0.000
	% child witnessed it	1%	11%	↑	0.000
Made me perform sex acts that I did not want to perform	% happened to them	9%	15%	↑	0.058
	% child witnessed it	2%	12%	↑	0.000
Followed me or hung around outside my home or work	% happened to them	2%	13%	↑	0.000
	% child witnessed it	1%	11%	↑	0.000
Threatened to harm or kill me or someone close to me	% happened to them	2%	14%	↑	0.000
	% child witnessed it	1%	11%	↑	0.000
Choked me	% happened to them	2%	13%	↑	0.000
	% child witnessed it	2%	10%	↑	0.000
Forced or tried to force me to have sex	% happened to them	9%	15%	↑	0.031
	% child witnessed it	3%	11%	↑	0.002
Harassed me by phone, text, email or using social media	% happened to them	3%	15%	↑	0.000
	% child witnessed it	1%	10%	↑	0.000
Told me I was crazy, stupid, or not good enough	% happened to them	4%	20%	↑	0.000
	% child witnessed it	2%	14%	↑	0.000

Hit me with a fist or object, kicked or bit me	% happened to them	4%	22%	↑	0.000
	% child witnessed it	3%	16%	↑	0.000
Kept me from seeing or talking to my family or friends	% happened to them	3%	15%	↑	0.000
My partner(s):	Response	Baseline	Endline		p
	% child witnessed it	1%	12%	↑	0.000
Confined or locked me in a room or other space	% happened to them	1%	11%	↑	0.000
	% child witnessed it	1%	11%	↑	0.000
Kept me from having access to a job, money, or financial resources	% happened to them	5%	15%	↑	0.000
	% child witnessed it	2%	12%	↑	0.000

Table 14: Responses to IPV Scale

This study has found significant increases in exposure to violence in this sample of adolescent mothers in Malawi. Other studies (e.g., Fouché et al., 2020; Gittings et al., 2021; MIET Africa, 2021; Piquero et al., 2021) have also highlighted increases in gender-based violence (GBV) as a result of COVID-19 lockdown. Child Helplines in Zimbabwe, South Africa, and Madagascar noted a 15 to 27% increase in calls received from young people reporting gender-based violence, with cases of forced marriage also being reported (MIET Africa, 2021). One cause of this increase in violence was that lockdowns required people to stay home, meaning that there was closer proximity between victims and perpetrators, and that accessing justice and protective services was difficult. COVID-19 lockdowns and the increased vulnerabilities of adolescent mothers could explain the significant increases in rates of IPV in this study.

Developmental levels of the children

Malawi Developmental Assessment Tool

The developmental levels of the children of the adolescent mothers were assessed using the Malawi Developmental Assessment Tool (MDAT). The MDAT was developed and validated in Malawi and is a culturally appropriate developmental tool for assessing children aged 6 years and younger in Africa (Gladstone et al., 2010). The tool evaluates development across four domains namely gross motor, fine motor, language, and social skills. There are a total of 136 items on the MDAT, all with a yes/no response format.

Data Collection

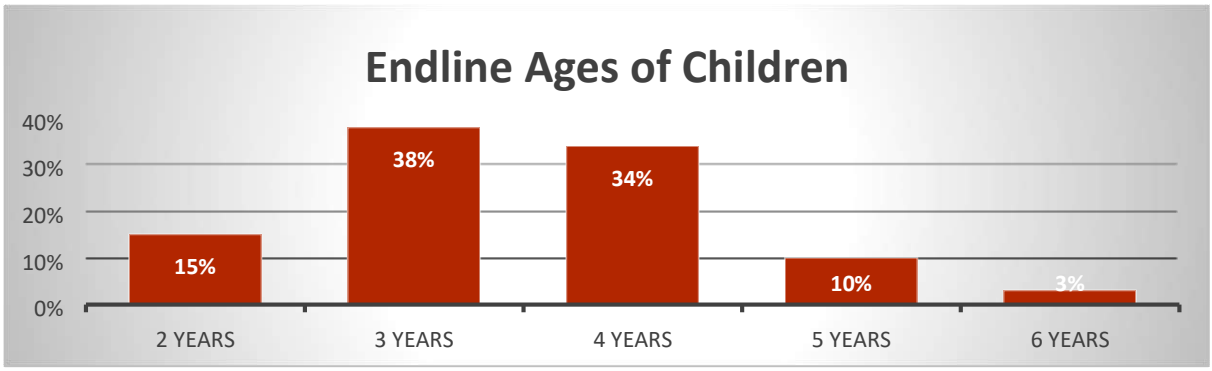
Two versions (v5 and v7) of the MDAT were used to collect the data. The data was recorded directly onto tablets and cleaned prior to statistical analyses. Data was uploaded to an online software application designed to analyse MDAT responses[47]. Using the MDAT scores, the software produces Z-scores and categorises children using a pass/fail method. Children who score 2 or more standard deviations (SDs) below the mean are considered to have failed. For this report, a more conservative approach was used, whereby children were categorised as developmentally "on track" if they scored within 1 SD above or below the mean, "ahead" if they scored higher than 1 SD above the mean, and "behind" if they scored higher than 1 SD below the mean. This was done for each of the four domains (gross motor, fine motor, language, and social skills) and overall. Thereafter, this data was used for further statistical analyses using STATA v14 to obtain descriptive data and comparative analyses.

Category	Z-score
Behind	>1 SD below mean
On track	Within 1 SD above or below mean
Ahead	>1 SD above mean

Sample

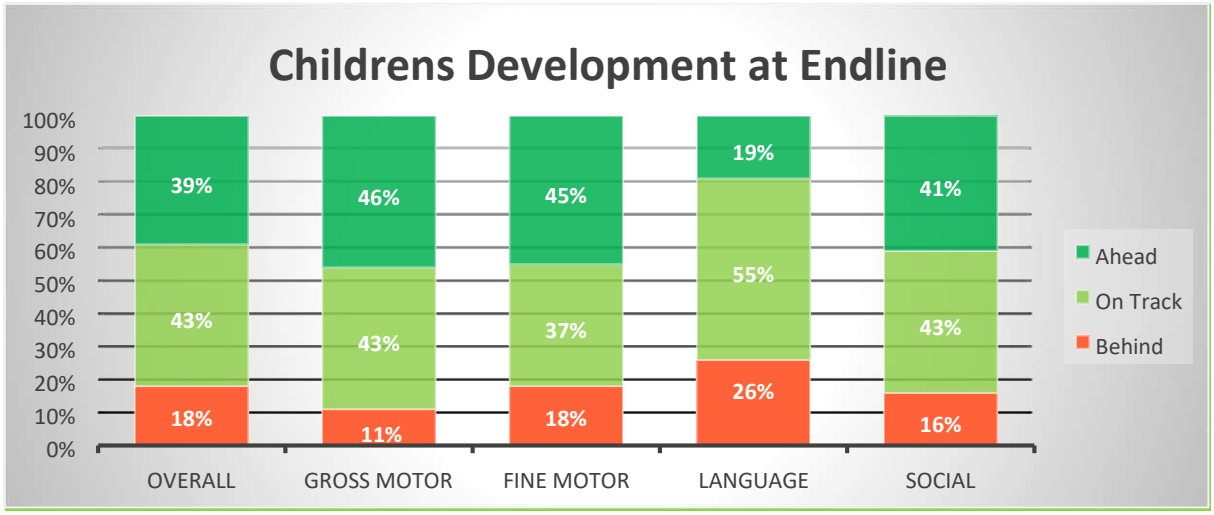
While 255 baseline responses were collected for the MDAT, a total of 189 baseline and endline responses were collected. This translates to a 74% retention rate, which is good. Most of the children lived in the Machinga district (62%) and 38% lived in Blantyre. 48% of children were female and 52% were male. At baseline, children ranged in age from 1 month to 5 years and 7 months, with a mean age of 1 year and 5 months. At endline, the youngest child was 2 years and 3 months old, and the oldest was 6 years old, with the mean age being 3 years and 6 months. Most children were 3 (38%) or 4 (34%) years old.

[47] https://kieran-bromley.shinyapps.io/mdat_scoring_shiny/



Results

The majority of children at endline were developmentally on track or ahead, both overall and in each domain. However, of some concern is that 26% of children were found to be developmentally behind in language skills, followed by fine motor (18%) and social (16%) skills. Most children are developing well in the gross motor domain with 89% being on track or ahead at endline.



Overall development

Overall, 7% more children were developmentally behind (11% at baseline to 18% at endline) and 16% fewer children were developmentally on track (59% at baseline to 43% at endline). Positively, 9% more children were developmentally ahead (30% at baseline to 39% at endline). The majority of children (82%) were on track or ahead with their development overall at endline.

Category	Baseline	Endline	Change	
Behind	11%	18%	7%	↑
On track	59%	43%	-16%	↓
Ahead	30%	39%	9%	↑

Table 15. Categories for development overall

Figure 1 below demonstrates the distribution of children according to their MDAT score and age. Plotted on the y-axes are Z-scores which represent a standardised value of the distance between

the individual child's raw MDAT score and the population mean. The bold line in the centre indicates the population mean (value 0). Individuals who scored more than two SDs below the mean are denoted by orange or red circles, indicating they are very behind. Follow up is recommended for these cases. As can be seen from the figure, more children scored more than 2 SDs below the mean at endline compared to baseline. Most of these children at endline tended to be between the ages of 2 and 4 years old. The majority of children, however, were on track or ahead.

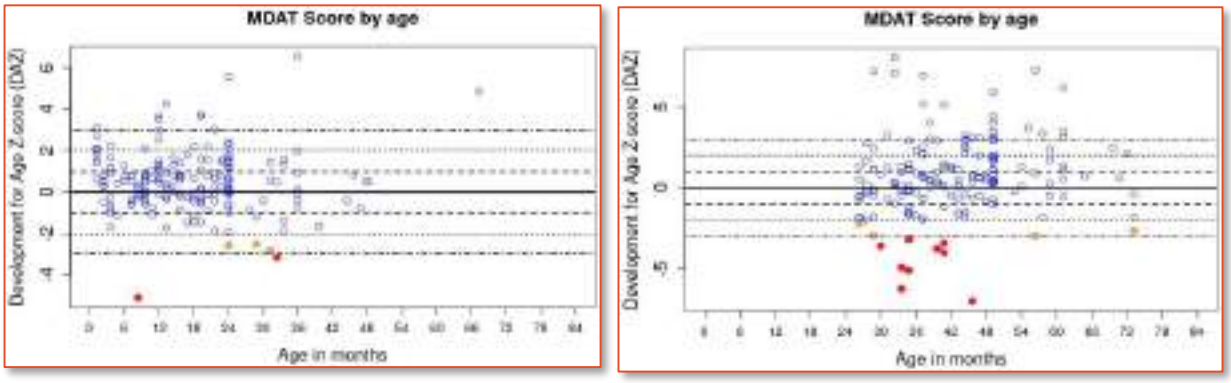


Figure 1. Baseline (left) and endline (right) MDAT Z-scores plotted against age (in months) for the full model

Gross motor development

For the gross motor domain, 5% more children were developmentally behind (6% at baseline to 11% at endline) and 10% fewer children were developmentally on track (53% at baseline to 43% at endline). Positively, 5% more children were developmentally ahead (41% at baseline to 46% at endline). The majority of children (89%) were on track or ahead with their gross motor development at endline.

Category	Baseline	Endline	Change	
Behind	6%	11%	5%	↑
On track	53%	43%	-10%	↓
Ahead	41%	46%	5%	↑

Table 16. Categories for gross motor development

As can be seen from Figure 2 below, slightly more children from baseline to endline scored less than 2 SDs below the mean and are therefore developmentally behind in gross motor skills development for their respective ages. These children tended to be between 2.5 and 4 years of age. However, most children scored above the population mean, indicating they are on track or ahead. There is also a clear downward trend to be seen at endline, where children between the ages of 2 and 4 scored higher than 2 SDs above the mean, with none of the older children showing the same.

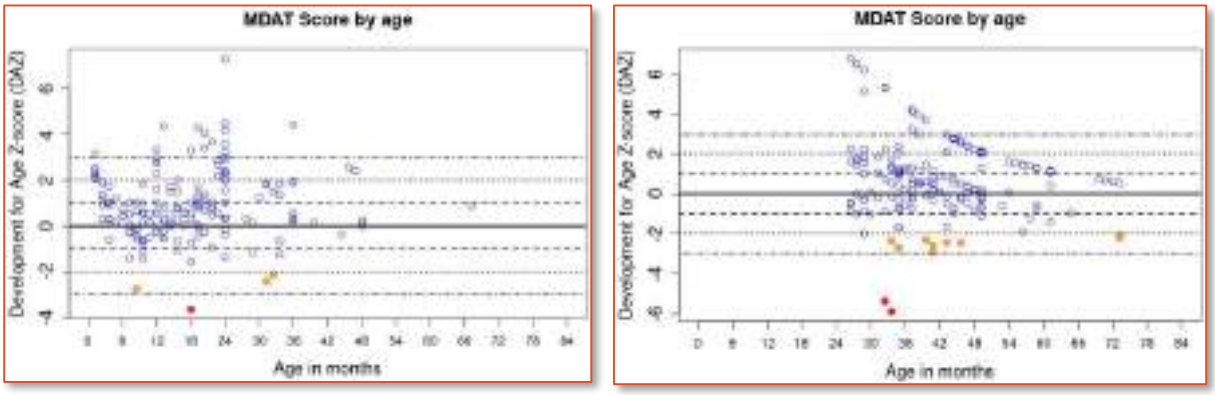


Figure 2. Baseline (left) and endline (right) MDAT Z -scores plotted against age (in months) for gross motor development

Fine motor development

For the fine motor domain, 15% fewer children were developmentally on track (52% at baseline to 37% at endline). Positively, 7% fewer children were developmentally behind (25% at baseline to 18% at endline) and 22% more children were developmentally ahead (23% at baseline to 45% at endline). The majority of children (82%) were on track or ahead with their fine motor development at endline.

Category	Baseline	Endline	Change	
Behind	25%	18%	-7%	↓
On track	52%	37%	-15%	↓
Ahead	23%	45%	22%	↑

Table 17. Categories for fine motor development

As can be seen from Figure 3 below, more children from baseline to endline performed poorly in the fine motor domain. Most of the children doing poorly were between the ages of 2 and 4 years old. However, it is also evident that some children scored very highly at endline (more than 4 SDs above the mean). It is also notable that one child at baseline scored around 12 SDs below the mean, which was no longer the case at endline.

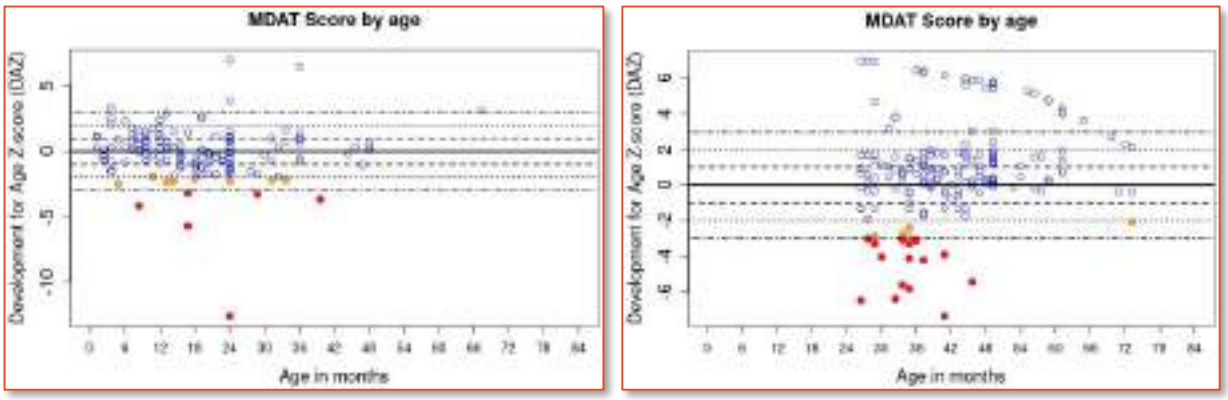


Figure 3. Baseline (left) and endline (right) MDAT Z -scores plotted against age (in months) for fine motor development

Language development

In terms of language development, 9% more children were developmentally behind (17% at baseline to 26% at endline), and 12% fewer children were developmentally ahead (52% at baseline to 55% at endline). Positively, 3% more children were developmentally on track (52% at baseline to 55% at endline). The majority of children (74%) were on track or ahead with their language development at endline.

Category	Baseline	Endline	Change	
Behind	17%	26%	9%	↑
On track	52%	55%	3%	↑
Ahead	31%	19%	-12%	↓

Table 18. Categories for language development

As seen in Figure 4 below, more children performed poorly in the language domain from baseline to endline. Again, most of the children doing poorly were between the ages of 2 and 4 years old. However, it is also evident that some children between the ages of 2 and 4 years scored very highly at endline (more than 3 SDs above the mean). Most of the children were on track or ahead with their language development.

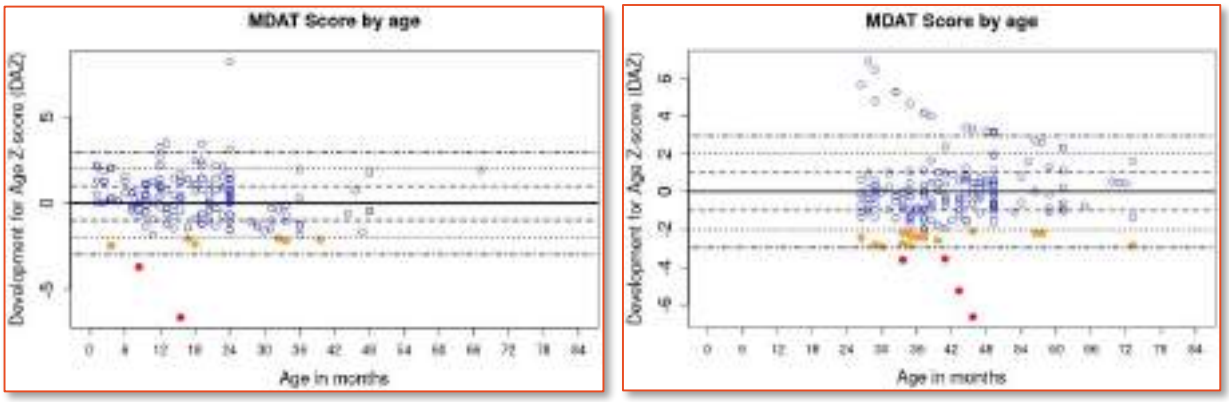


Figure 4. Baseline (left) and endline (right) MDAT Z-scores plotted against age (in months) for language development

Social development

The number of children who were developmentally behind in their social development did not change from baseline to endline (16%). However, 19% more children were developmentally ahead from baseline (22%) to endline (41%). Most of the children at endline (84%) were developmentally on track or ahead.

Category	Baseline	Endline	Change	
Behind	16%	16%	0%	-
On track	62%	43%	-19%	↓
Ahead	22%	41%	19%	↑

Table 19. Categories for social development

As seen in Figure 5 below, roughly the same number of children scored less than 2 SDs below the mean at baseline and endline. Most of these children at endline were between the ages of 2 and 4 years old, with 2 children being 4.5 to 5 years old. There is an almost linear trend downwards starting from around the age of 2 years (4 SDs) down to age 6 (towards the population mean of 0 SDs). This suggests that younger children are doing better in their social development compared to the older children. Again, the majority of children were on track or ahead of their social development.

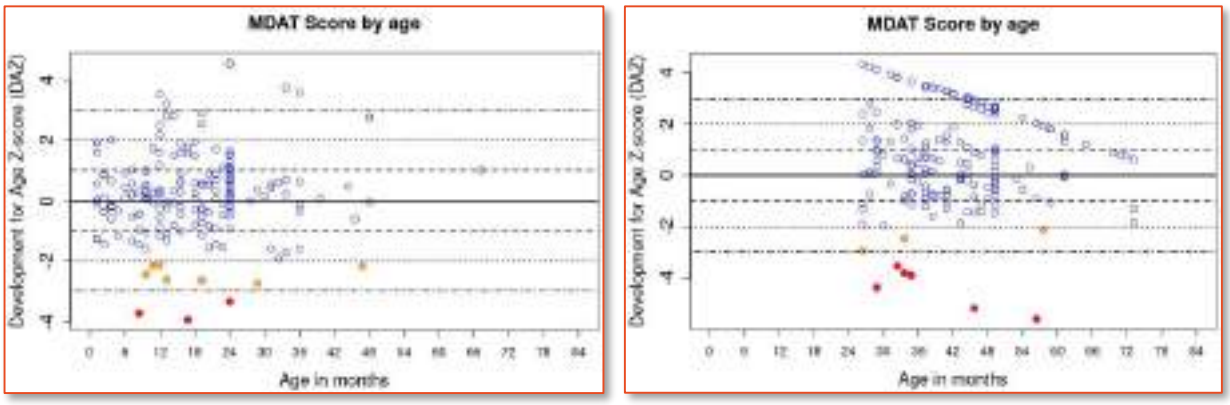
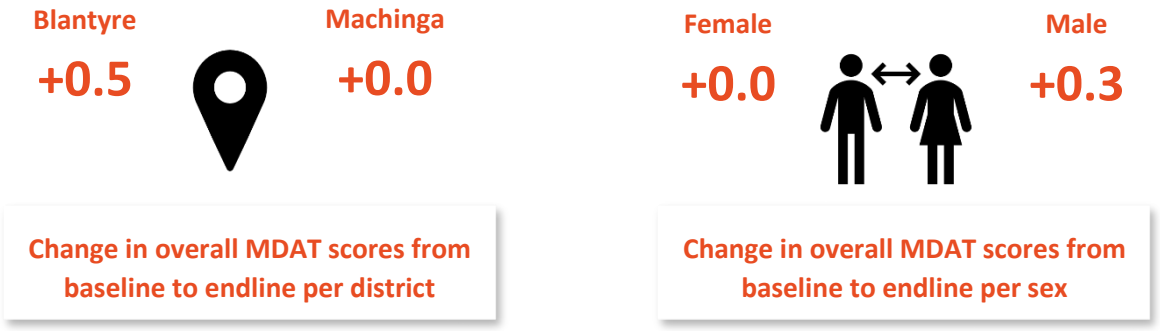


Figure 5. Baseline MDAT Z-scores plotted against age (in months) for social development

Comparisons

At baseline, children who lived in the Blantyre district had significantly higher mean overall MDAT scores (z=0.8) compared to children who lived in the Machinga district (z=0.3)[48]. This was sustained at endline, with children living in Blantyre obtaining significantly higher mean overall MDAT scores (z=1.3) compared to children who lived in the Machinga district (z=0.3)[49]. However, it can be noted that there are more children in Machinga (118) than in Blantyre (70) which could account for this difference. It can also be noted that children living in Blantyre increased by 0.5 points from baseline to endline, while the average score for respondents living in Machinga did not change. In addition, the difference between female and male children was not statistically significant at baseline (0.6 vs. 0.5)[50] or endline (0.6 vs. 0.8)[51]. Male children's average overall MDAT scores increased by 0.3 points while female children's average scores remained the same from baseline to endline.

[48] p = 0.031
[49] p = 0.010
[50] p = 0.713
[51] p = 0.612

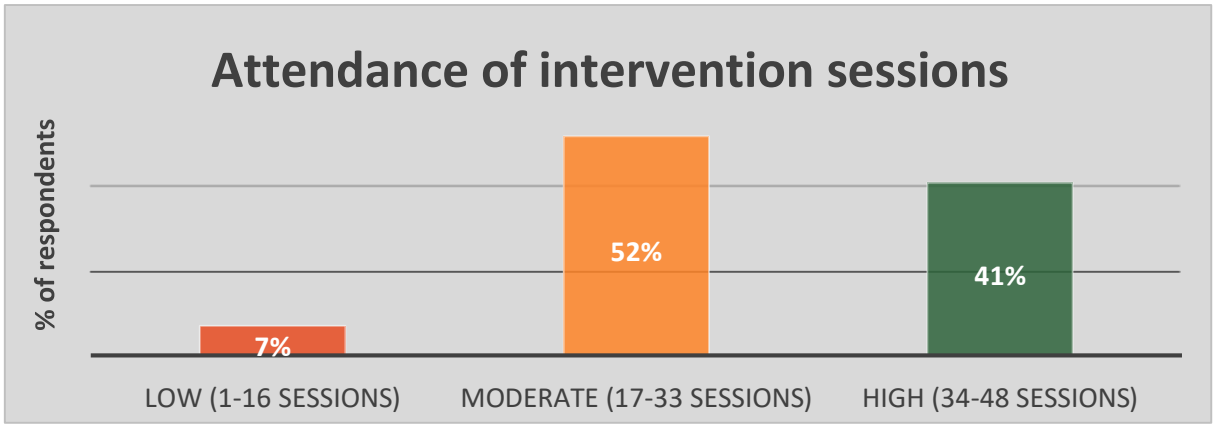


Conclusion

In summary, most of the children in this sample seem to be reaching their developmental milestones across all domains assessed. Some domains of concern have been highlighted, particularly language whereby 26% of children were behind in this skill for their age. Further qualitative research could consider some of the reasons why children might be behind in their language development.

Attendance of Intervention Sessions

The average number of intervention sessions that mothers attended was 30.7, ranging between a minimum of 1 and a maximum of 48. Attendance was categorised as low (attending between 116 sessions); moderate (17 to 33 sessions); and high attendance (34 to 48 sessions). The majority of respondents (52%) had moderate attendance, followed by 41% with high attendance, and only 7% of mothers attended 16 sessions or fewer.



Correlations

The associations between resilience, self-esteem, depression, and parental stress scores were compared against other variables. The table below outlines only the statistically significant associations, including whether the correlation was positive [+] or negative [-], and the significance value (p).

Variable		Resilience	Self-esteem	Depression	Parental Stress
Feeling safe at home	r	+	+	-	-
	p	0.000	0.023	0.006	0.005

Feeling safe in community	r p	+ 0.000			
More intervention sessions attended	r p				+ 0.035
Having electricity at home	r p				- 0.025
Helping to look after younger children at home	r p	+ 0.000	+ 0.006	- 0.015	
Helping to look after sick people at home	r p	+ 0.000	+ 0.001		
Having own source of income				- 0.049	
Increased resilience scores on the CYRM-R	r p		+ 0.000	- 0.000	- 0.000
Decreased depression scores on the PHQ-9	r p	+ 0.000	+ 0.000		
Increased self-esteem scores	r p	+ 0.000		- 0.000	- 0.002

Table 20: Significant associations between psychosocial wellbeing and other variables

In this study, it was found that the factors associated with increased resilience include feeling safe at home and in the community, as well as helping to look after younger children and/or sick people at home. Change in resilience scores on the CYRM-R was also positively correlated with change in resilience scores on the BRS, which suggests good content/construct validity of these scales for measuring resilience[52]. Feeling safe at home and helping to look after younger children at home were also significantly associated with increased self-esteem and decreased depression scores. Helping to look after sick people at home was also associated with higher levels of selfesteem. In addition, mothers who had their own source of income also showed statistically significantly lower levels of depression. As expected, resilience scores were positively correlated with self-esteem and negatively correlated with depression, indicating that people with higher resilience are more likely to have higher self-esteem and less mental health distress.

The factors associated with decreased parental stress include feeling safe at home and having electricity at home. Whilst the latter may not be a direct relationship, it could be that mothers who have electricity at home have a higher quality of life compared to those who do not. Having attended more intervention sessions was associated with a statistically significant increase in parental stress levels. However, it could also be that mothers who were experiencing more parental stress attended more intervention sessions as a way to cope with the stress and seek support.

In addition to increased resilience, self-esteem, and decreased depression, helping to look after younger children was also associated with a significant decrease in IPV scores. Respondents who did help to look after younger children at home had significantly lower average IPV scores (1.3) compared to those who did not (2.9)[53]. Similarly, respondents who helped look after younger

[52] p = 0.010

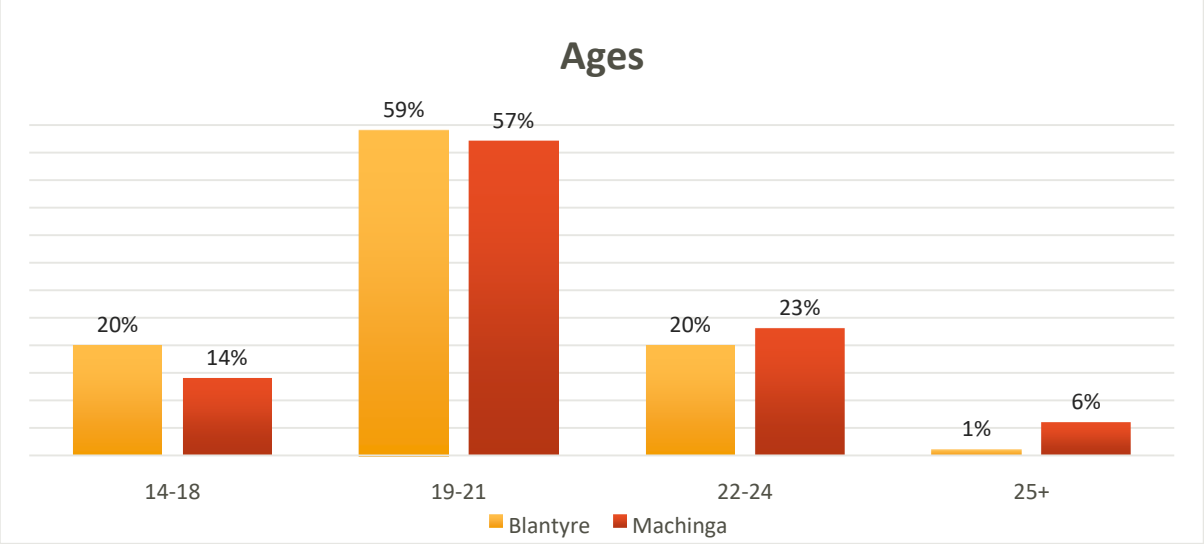
[53] p = 0.044

children at home had significantly lower average child witness scores (1.2) compared to those who did not help look after younger children at home (2.7) [54]. In addition, the children of respondents whose mothers had passed away had witnessed significantly more instances of IPV (3.4), on average, compared to respondents whose mother was still alive (1.2)[55]. Not knowing whether their father was alive was also associated with significantly higher child witness scores (5.3), on average, compared to respondents who had lost their father (2.5) and those who had not (1.1)[56]. In addition, respondents who did not know whether their father was alive showed significantly increased parental stress (7.3) compared to those whose father had passed away (0.6) and those whose father was still alive (-4.9). This also indicates that respondents who had not lost their father showed significantly greater decreases in parental stress.

Results by Site

Demographic information

Of the total sample, 118 (50%) respondents were from Blantyre and 119 (50%) were from Machinga. At endline, the youngest Blantyre respondent was 14 and the youngest Machinga respondent was 17, whilst the maximum age for Blantyre and Machinga respondents was 25+. Most of the respondents from Blantyre (59%) and Machinga (57%) were between 19 to 21 years old.



At baseline, most Blantyre respondents lived in a hut made of traditional materials (47%) or a house made of steel sheets on its own plot (42%). At endline, most respondents from Blantyre indicated that they live in house made of brick (67%)[57]. Most Machinga respondents indicated that they live in a house made of brick at baseline (44%), and this decreased to 24% at endline, while 27% more Machinga respondents (31% at baseline to 58% at endline) indicated that they

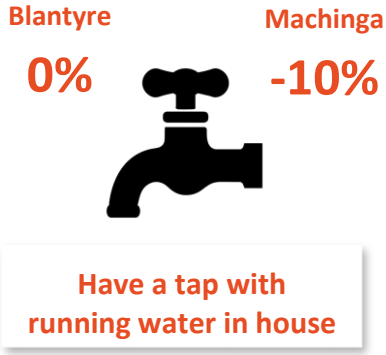
[54] p = 0.044
[55] p = 0.041
[56] p = 0.040
[57] p = 0.000

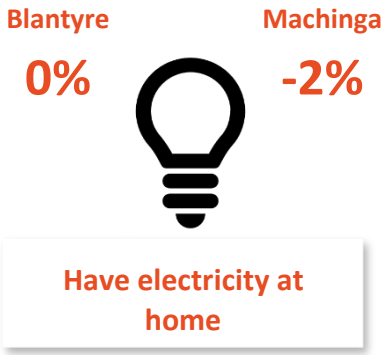
live in a hut made of traditional materials[58]. These differences were statistically significant for both Blantyre and Machinga respondents.

Type of home	District	Baseline	Endline	Change	
House made of brick	Blantyre	10%	67%	57%	↑
	Machinga	44%	24%	-20%	↓
Hut made of traditional materials	Blantyre	47%	21%	-26%	↓
	Machinga	31%	58%	27%	↑
House made of steel sheets on its own plot	Blantyre	42%	9%	-33%	↓
	Machinga	20%	17%	-3%	↓
House made of steel sheets in a back yard	Blantyre	1%	3%	2%	↑
	Machinga	4%	0%	-4%	↓
Block of flats	Blantyre	0%	0%	0%	-
	Machinga	0%	1%	1%	↑
Living on the street	Blantyre	0%	0%	0%	-
	Machinga	1%	1%	0%	-

Table 21. Frequency of type of home by site

At baseline, 5% (6) of Blantyre respondents compared to 13% (16) of Machinga respondents reported having a tap with running water in their home. At endline, this remained the same at 5% (6) of Blantyre respondents (0% more)[59] but decreased significantly to 3% (4) of Machinga respondents (10% fewer)[60]. 11% (13) of Blantyre respondents compared to 5% (6) of Machinga respondents indicated that they had electricity connected to their house at baseline. This again remained the same for Blantyre respondents at endline (13, 11%)[61] but decreased to 3% (4) of Machinga respondents[62]. Neither of these changes were statistically significant.





At baseline, 56% of Blantyre respondents and 56% of Machinga respondents reported that they went to sleep hungry more than once in the past week. This remained the same for Machinga

[58] p = 0.000
[59] p = 1.000
[60] p = 0.005
[61] p = 1.000
[62] p = 0.516

respondents at endline[63], but decreased slightly to 51% for Blantyre respondents[64]. Neither of these changes were statistically significant. At baseline, the average number of days that respondents from Blantyre went hungry stayed the same from baseline to endline (1.1), while the mean number of days decreased slightly for Machinga respondents from 1.3 at baseline to 1.2 at endline. Again, neither of these differences were statistically significant.

Days hungry	Blantyre			Machinga		
	Baseline	Endline		Baseline	Endline	
0	44%	49%	↑	44%	44%	-
1	22%	16%	↓	16%	16%	-
2	18%	22%	↑	18%	21%	↑
3	14%	8%	↓	17%	14%	↓
4	1%	4%	↑	1%	3%	↑
5	1%	0%	↓	0%	1%	↑
6	0%	1%	↑	2%	0%	↓
7	0%	0%	-	3%	1%	↓

Table 22: Frequency of days hungry by site

When asked who looks after them, two changes from baseline to endline were found to be statistically significant: 16% more respondents (1% at baseline to 17% at endline)[65] indicated that their sibling looks after them, and 6% more indicated that they look after themselves (1% at baseline to 7% at endline)[66]. The majority of respondents in Blantyre and Machinga said they are looked after by their mother and/or their husband.

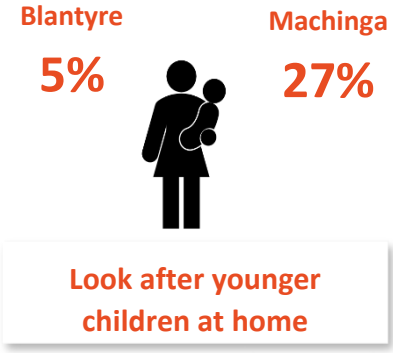
Who looks after you?	Blantyre			Machinga		
	Baseline	Endline		Baseline	Endline	
Mother	48%	40%	↓	54%	43%	↓
Husband	42%	41%	↓	42%	40%	↓
Father	23%	24%	↑	24%	20%	↓
Grandmother	7%	14%	↑	10%	11%	↑
Sibling	1%	17%	↑	2%	3%	↑
Grandfather	2%	2%	-	2%	1%	↓
Aunt	2%	2%	-	0%	1%	↑
I look after myself	1%	7%	↑	4%	10%	↑
In-laws	1%	1%	-	0%	0%	-
Stepmother	1%	0%	↓	0%	2%	↑

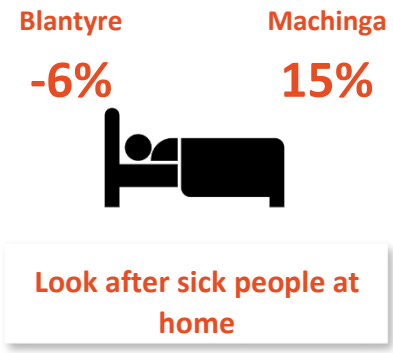
[63] p = 0.513
[64] p = 0.169
[65] p = 0.000
[66] p = 0.017

Stepfather	1%	0%	↓	0%	0%	-
Uncle	0%	0%	-	1%	0%	↓

Table 23: Frequency of who looks after respondents by site

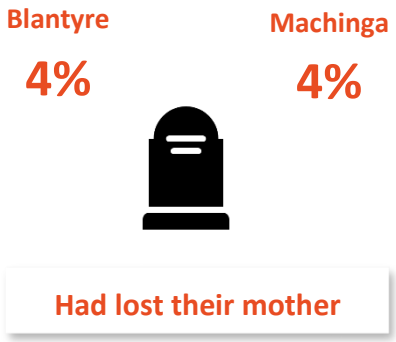
63% of Blantyre respondents at baseline compared to 68% at endline reported that they help look after younger children at home (5% more)[67], while 66% of Machinga respondents at baseline compared to 93% at endline indicated that they help to look after younger children at home (27% more)[68]. At baseline, 53% of Blantyre respondents and 55% of Machinga respondents reported that they help to look after sick people at home, which decreased to 47% of Blantyre respondents (6% fewer)[69] but increased to 70% of Machinga respondents at endline (15% more)[70]. Both of these differences were statistically significant for Machinga respondents but not for Blantyre respondents.

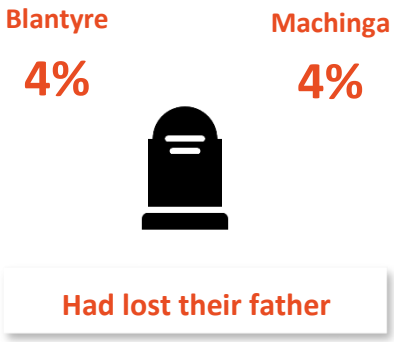




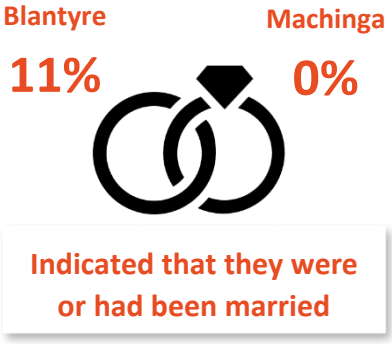
Respondents were asked about the losses they have experienced in their lives. At baseline, 10% (12) of Blantyre respondents and 9% (11) of Machinga respondents said their mother had passed away, and this increased to 14% (16) for Blantyre respondents (4% more)[71] and 13% (15) for Machinga respondents at endline (4% more)[72]. Further, 21% (25) of Blantyre and Machinga respondents at baseline said that their father had passed away, and this increased to 25% (29) of Blantyre[73] and Machinga[74] respondents at endline (4% more). At endline, 52% of respondents from Blantyre and 69% of respondents from Machinga indicated that someone close to them had died.

[67] p = 0.412
[68] p = 0.000
[69] p = 0.362
[70] p = 0.023
[71] p = 0.421
[72] p = 0.708
[73] p = 0.825
[74] p = 0.825





58% (51) of Blantyre respondents indicated that they were or had been married at the time of baseline, and this increased to 69% (64) at endline[75]. At baseline and endline, 73% (68) of Machinga respondents were currently married or had been married before[76]. Respondents who had not been married but indicated they would like to get married at some point were asked at what age they would like to get married. At baseline, the mean age that Blantyre respondents wanted to get married was 23 which increased significantly to 25 at endline[77]. The mean age that Machinga respondents indicated wanting to get married increased significantly from 16 at baseline to 25 at endline[78]. For Blantyre respondents, the majority at baseline (39%) indicated they would like to get married at the age of 25 years, while most respondents at endline (28%) indicated age 25 or 30 [68] . For Machinga respondents, 16% at baseline and 18% at endline indicated they would like to get married at 25, and 15% at endline also indicated they would like to get married over the age of 30.



Sexual Reproductive Health

Access to SRH Services

Respondents were asked if they had accessed several forms of sexual reproductive health services in the previous six months. In general, access to SRHR services increased from baseline to endline, and numerous changes were found to be statistically significant (highlighted in bold in the table). For instance, significantly more respondents from Blantyre received condoms (22% more); 23% more were tested for HIV, 17% more received ART, and 8% more received PrEP or PEP. 23% more Blantyre respondents also received a cervical cancer vaccination (8% at baseline to 31% at endline). The number of Machinga respondents who received PrEP also increased slightly yet significantly from 0% at baseline to 3% at endline. There were also significant decreases in

[75] p = 0.130
[76] p = 0.245
[77] p = 0.009
[78] p = 0.000
[68] p = 0.077

Machinga mothers antenatal and postnatal check-ups, and the number of mothers who indicated that they have birth at a clinic or hospital also decreased from baseline (22%) to endline (4%). 10% more Machinga mothers (10% at baseline to 20% at endline) indicated that they received help with breastfeeding from a healthcare worker.

The table below outlines access to SRHR services by site.

Items	Blantyre			Machinga		
	Baseline	Endline		Baseline	Endline	
Got condoms	3%	25%	↑	8%	7%	↓
Been tested for HIV	50%	73%	↑	74%	69%	↓
Been tested for STIs	42%	44%	↑	29%	22%	↓
Received ART	42%	59%	↑	44%	48%	↑
Received PrEP	3%	11%	↑	0%	3%	↑
Received PEP	0%	8%	↑	3%	2%	↓
Got an Intrauterine Device (IUD)	3%	7%	↑	3%	9%	↑
Got the pill	6%	8%	↑	8%	4%	↓
Got a birth control injection	54%	52%	↓	34%	45%	↑
Antenatal check-ups for your baby – while pregnant	41%	43%	↑	29%	9%	↓
Gave birth at a clinic or hospital	36%	37%	↑	22%	4%	↓
Postnatal check-ups for you or your baby	63%	43%	↓	53%	40%	↓

Help with breastfeeding from a healthcare worker	31%	36%	↑	10%	20%	↑
Got sanitary pads	2%	4%	↑	2%	5%	↑
Got a cervical cancer vaccination	8%	31%	↑	4%	10%	↑
PMTCT (only pregnant girls)	15%	40%	↑	17%	14%	↓

Table 24: Responses to questions on access to sexual reproductive health services by site

Psychosocial wellbeing

Resilience enablers

The Child & Youth Resilience Measure-Revised (CYRM-R) was used to assess resilience. On average, respondents from Blantyre resilience scores decreased significantly from 66.8 at baseline to 63.2 at endline[79], and respondents from Machinga average resilience scores decreased slightly from 62.9 at baseline to 62.1 at endline[80]. Only the change from baseline to endline for Blantyre respondents was statistically significant, and the differences between Blantyre and Machinga was not significant[81].

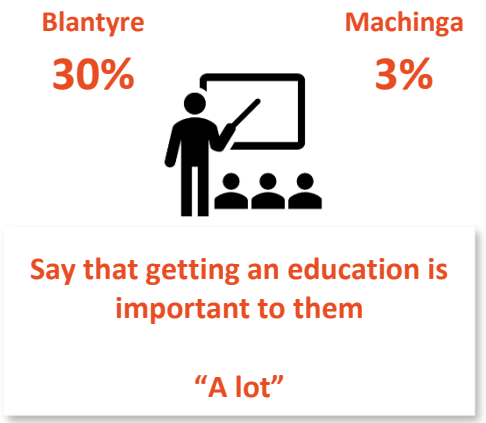
Almost all changes from baseline to endline were found to be statistically significant, including:

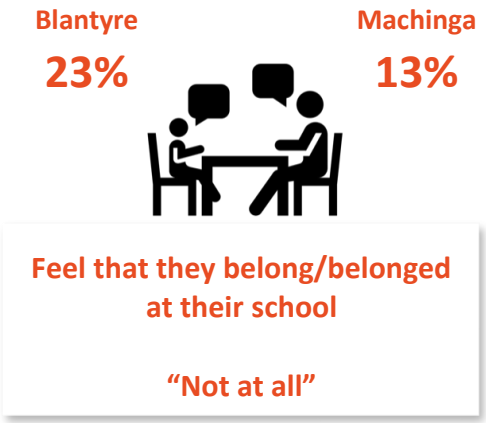
- "Getting an education is important to me" where 39% of Blantyre respondents at baseline responded with "A lot" and this increased to 69% at endline (30% more)
- The number of Blantyre respondents who felt that people like to spend time with them "A lot" increased by 29% from baseline (19%) to endline (48%), and the number of Machinga respondents who indicated the same also increased from 12% at baseline to 36% at endline (24% more)
- At baseline, 21% of Blantyre respondents compared to 14% of Machinga respondents indicated that they talk to their family/caregiver(s) about how they feel "A lot", and this increased to 46% of Blantyre respondents (25% more) and 30% of Machinga respondents (16% more)
- 23% more respondents from Blantyre (19% at baseline to 42% at endline) and 13% more respondents from Machinga (4% at baseline to 17% at endline) selected "Not at all" in response to the statement "I feel that I belong/belonged at my school"
- The number of respondents who indicated that they get along with the people around them "A lot" increased from 26% at baseline to 42% at endline for Blantyre respondents (16% more), and from 11% at baseline to 34% at endline for Machinga respondents (23% more)

[79] p = 0.007

[80] p = 0.521

[81] p = 0.122





The table below breaks down the responses to each question in the CYRM-R Scale by site:

Questions	Site	A lot		Not at all		p
		Baseline	Endline	Baseline	Endline	
I get along with people around me	Blantyre	26%	42%	1%	4%	0.000
	Machinga	11%	34%	4%	5%	0.000
Getting an education is important to me	Blantyre	39%	69%	1%	4%	0.000
	Machinga	31%	34%	3%	3%	0.048
I know how to behave/act in different situations (such as school, home and church)	Blantyre	26%	50%	2%	9%	0.000
	Machinga	18%	28%	3%	1%	0.154
My parent(s)/caregiver(s) really look out for me	Blantyre	24%	38%	3%	11%	0.003
	Machinga	30%	30%	6%	3%	0.507
My parent(s)/caregiver(s) know a lot about me (for example, who my friends are, what I like to do)	Blantyre	24%	38%	3%	10%	0.001
	Machinga	17%	32%	8%	3%	0.011
If I am hungry, there is enough to eat	Blantyre	15%	18%	16%	8%	0.000
	Machinga	15%	13%	8%	12%	0.663
People like to spend time with me	Blantyre	19%	48%	4%	0%	0.000
	Machinga	12%	36%	5%	1%	0.000
I talk to my family/caregiver(s) about how I feel (for example when I am hurt or sad)	Blantyre	21%	46%	6%	9%	0.000
	Machinga	14%	30%	5%	4%	0.006
I feel supported by my friends	Blantyre	16%	16%	10%	16%	0.011
	Machinga	9%	8%	12%	18%	0.001
I feel that I belong/belonged at my school	Blantyre	14%	20%	19%	42%	0.000
	Machinga	17%	19%	4%	17%	0.000

My family/caregiver(s) care about me when times are hard (for example if I am sick or have done something wrong)	Blantyre	24%	26%	4%	11%	0.149
	Machinga	28%	34%	4%	2%	0.282
My friends care about me when times are hard (for example if I	Blantyre	14%	10%	9%	17%	0.004
Questions	Site	A lot		Not at all		p
		Baseline	Endline	Baseline	Endline	
am sick or have done something wrong)	Machinga	9%	14%	13%	13%	0.000
I am treated fairly in my community	Blantyre	23%	21%	10%	23%	0.000
	Machinga	8%	17%	16%	19%	0.010
I have chances to show others that I am growing up and can do things by myself	Blantyre	25%	31%	3%	7%	0.000
	Machinga	13%	29%	8%	3%	0.002
I feel safe when I am with my family/caregiver(s)	Blantyre	37%	42%	3%	4%	0.023
	Machinga	30%	39%	2%	3%	0.022
I have chances to learn things that will be useful when I am older (like cooking, working, and helping others)	Blantyre	34%	25%	0%	5%	0.000
	Machinga	24%	39%	1%	1%	0.000
I like the way my family/caregiver(s) celebrates things (like holidays or learning about my culture)	Blantyre	24%	43%	4%	7%	0.004
	Machinga	18%	34%	3%	7%	0.018

Table 25: Responses to all questions on the CYRM-R by site

Resilience

There was a statistically significant difference between Machinga and Blantyre respondents' BRS change scores from baseline to endline[82]. On average, Machinga respondents' scores increased by 1.9 points (from 16.8 at baseline to 18.8 at endline), while Blantyre respondent's scores decreased by 0.1 points (from 18.7 at baseline to 18.6 at endline). The average change from baseline to e-ndline was significant for Machinga respondents [83] but not for Blantyre respondents[84]. Machinga and Blantyre responses on the BRS were quite different, and a few changes were found to be statistically significant. For instance, 17% of Blantyre respondents compared to 9% of Machinga respondents at baseline strongly agreed with "I tend to bounce back quickly after hard times". By the time of endline, 22% of Blantyre respondents (5% more) and 17% of Machinga respondents (8% more) strongly agreed with this statement. While 13% more Machinga respondents strongly disagreed with "I tend to take a long time to get over setbacks in my life" from baseline (0%) to endline (13%), and 6% more Blantyre respondents strongly disagreed with this statement from baseline (9%) to endline (15%).

[82] p = 0.008

[83] p = 0.000

[84] p = 0.905

Blantyre	Machinga
5%	8%

Strongly agreed with "I tend to bounce back quickly after hard times"

Blantyre	Machinga
10%	-3%

Strongly disagreed with "I have a hard time making it through stressful events"

The table below breaks down the responses to each question in the BRS Scale by site:

Question	Site	Strongly Agree		Strongly Disagree		p
		Baseline	Endlin e	Baseline	Endline	
I tend to bounce back quickly after hard times	Blantyre	17%	22%	7%	10%	0.048
	Machinga	9%	17%	5%	5%	0.055
I have a hard time making it through stressful events	Blantyre	8%	13%	10%	20%	0.105
	Machinga	8%	11%	5%	2%	0.514
It does not take me long to recover from a stressful event	Blantyre	15%	11%	9%	15%	0.234
	Machinga	7%	10%	4%	2%	0.041
It is hard for me to snap back when something bad happens	Blantyre	10%	8%	8%	15%	0.354
	Machinga	4%	10%	3%	8%	0.101
I usually come through difficult times with little trouble	Blantyre	10%	14%	5%	16%	0.002
	Machinga	7%	8%	12%	8%	0.021
I tend to take a long time to get over setbacks in my life	Blantyre	8%	14%	9%	15%	0.106
	Machinga	15%	8%	0%	13%	0.000

Table 26: Responses to Brief Resilience Scale by site

Mental health

The difference between Blantyre and Machinga PHQ-9 change scores was found to be statistically significant[85]. On average, Blantyre respondents PHQ-9 scores increased by 0.3 points (3.8 at baseline and 4.1 at endline), while Machinga respondents' average depression scores decreased by 1.6 points (5.5 at baseline and 3.9 at endline). The average change scores from baseline to endline was significant for Machinga respondents[86], but not for Blantyre respondents[87].

A few changes from baseline to endline were found to be statistically significant, including;

- 29% more Machinga respondents (47% at baseline to 76% at endline) selected "Not at all" for the statement "Poor appetite or overeating". On the other hand, 10% less Blantyre respondents said the same (79% at baseline to 69% at endline)
- The number of Blantyre respondents who reported feeling down, depressed or hopeless "Nearly every day" decreased by 2% from baseline (7%) to endline (5%), and the number of Machinga respondents who felt this way decreased by 4% (10% at baseline to 6% at endline)
- "Trouble falling asleep, staying asleep, or sleeping too much" nearly every day was reported by 3% more Blantyre respondents (1% at baseline to 4% at endline) and 6% less Machinga respondents (9% at baseline to 3% at endline)

[85] p = 0.009

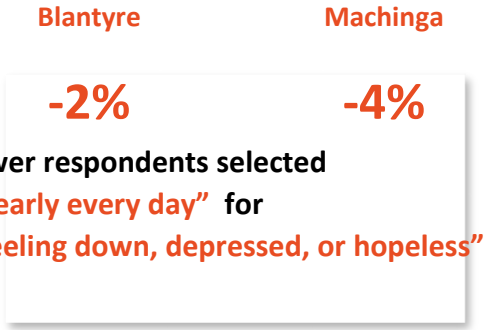
[86] p = 0.005

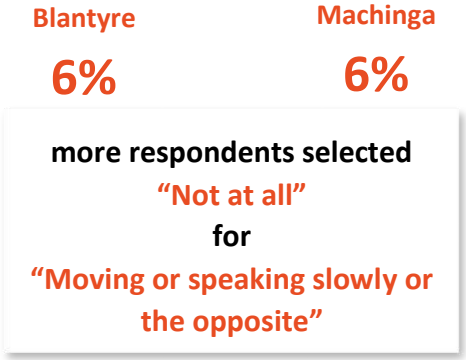
[87] p = 0.557

 At baseline, 69% of Blantyre respondents compared to 72% of Machinga respondents reported moving or speaking slowly or the opposite "Not at all", and this increased to 75% of Blantyre respondents (6% more) and 78% of Machinga respondents (6% more)

 "Feeling bad about yourself - or that you're a failure or have let yourself or your family down" "Not at all" was reported by 16% more Machinga respondents (50% at baseline to 66% at endline), and 3% less Blantyre respondents (73% at baseline to 70% at endline)

 92% of Machinga respondents compared to 75% of Blantyre respondents at baseline selected "Not at all" for the statement "Thoughts that you would be better off dead or of hurting yourself in some way". At endline, 86% of Blantyre respondents and 87% of Machinga respondents reported this





The table below outlines the responses to each question on the PHQ-9 scale per site.

Question	Site	Not at all		Nearly every day		p
		Baseline	Endline	Baseline	Endline	
Little interest or pleasure in doing things	Blantyre	44%	39%	10%	19%	0.082
	Machinga	49%	54%	6%	6%	0.784
Feeling down, depressed, or hopeless	Blantyre	67%	42%	7%	5%	0.000
	Machinga	43%	50%	10%	6%	0.338
Trouble falling asleep, staying asleep, or sleeping too much	Blantyre	79%	58%	1%	4%	0.007
	Machinga	52%	64%	9%	3%	0.105
Feeling tired or having little energy	Blantyre	71%	59%	3%	3%	0.236
	Machinga	43%	52%	10%	5%	0.340
Poor appetite or overeating	Blantyre	79%	69%	3%	0%	0.012
	Machinga	47%	76%	6%	2%	0.000
Feeling bad about yourself - or that you're a failure or have let yourself or your family down	Blantyre	73%	70%	4%	1%	0.008
	Machinga	50%	66%	4%	2%	0.108
Trouble concentrating on things, such as reading the newspaper or watching television	Blantyre	84%	83%	2%	0%	0.517
	Machinga	68%	79%	6%	3%	0.119
Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	Blantyre	69%	75%	3%	1%	0.009
	Machinga	72%	78%	4%	1%	0.268
Thoughts that you would be better	Blantyre	75%	86%	1%	1%	0.031

off dead or of hurting yourself in some way	Machinga	92%	87%	2%	2%	0.579

Table 27: Responses to all questions on the PHQ-9 by site

Self-esteem

The difference between Blantyre and Machinga change scores on the Rosenberg Self-Esteem Scale was statistically significant[88]. Machinga respondents scores increased by an average of 1.4 points (from 25.1 at baseline to 26.5 at endline), while Blantyre respondents average self-esteem scores decreased by 0.4 points (from 26.7 at baseline to 26.3 at endline). Again, the change in self-esteem scores from baseline to endline was significant for Machinga respondents[89], but not for Blantyre respondents[90].

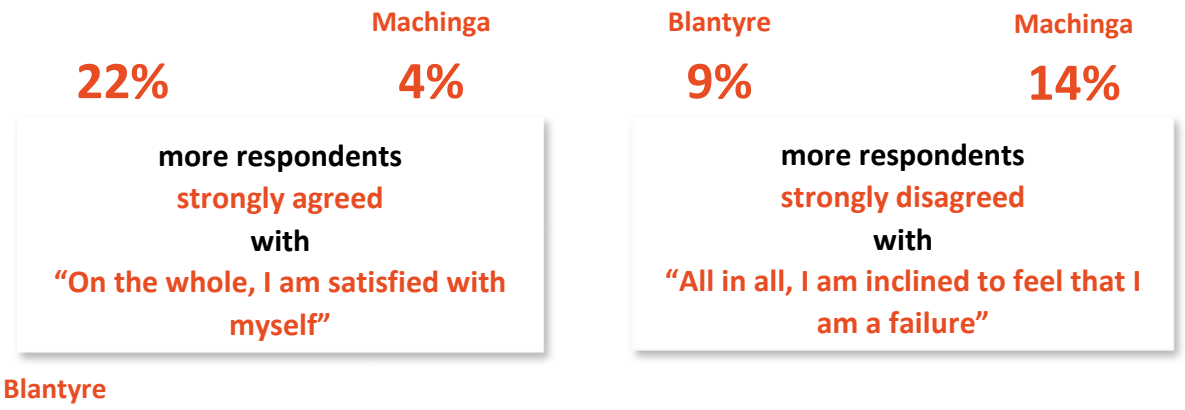
A number of statistically significant differences were found, including:

- 23% more Blantyre respondents (41% at baseline to 64% at endline) and 12% more Machinga respondents (18% at baseline to 30% at endline) strongly agreed with the statement"I feel that I'm a person of worth, at least on an equal plane with others"
- "On the whole, I am satisfied with myself" where 22% more Blantyre respondents (40% at baseline to 62% at endline) compared to 4% more Machinga respondents (29% at baseline to 33% at endline)
- The number of respondents who strongly disagreed with the statement "All in all, I am inclined to feel that I am a failure" increased by 9% for Blantyre respondents (8% at baseline to 17% at endline) and 14% for Machinga respondents (4% at baseline to 18% at endline)
- 14% of Blantyre respondents at baseline compared to 24% at endline strongly agreed with "I feel that I have a number of good qualities". Similarly, 8% of Machinga respondents at baseline compared to 14% at endline strongly agreed with this statement.
- "I take a positive attitude toward myself" where 2% more Blantyre respondents (26% at baseline to 28% at endline) and 7% more Machinga respondents (4% at baseline to 11% at endline) strongly agreed

[88] p = 0.004

[89] p = 0.001

[90] p = 0.380



However, there were some changes which were not as positive:

- At baseline, 41% of Blantyre respondents and 26% of Machinga respondents strongly agreed with "I wish I could have more respect for myself", and this increased to 64% of Blantyre respondents (23% more) and 39% of Machinga respondents (13% more) at endline
- 17% more Blantyre respondents strongly agreed with "I certainly feel useless at times" (6% at baseline to 23% at endline) while 3% less Machinga respondents said the same (12% at baseline to 9% at endline)
- At baseline, 6% of Blantyre respondents and 6% of Machinga selected "Strongly Agree" in response to "At times I think I am no good at all", and this increased to 22% of Blantyre respondents (16% more) and 12% of Machinga respondents (6% more) at endline

The table below outlines the responses to each question on the Self-esteem scale per site:

Question	Site	Strongly Agree		Strongly Disagree		p
		Baseline	Endline	Baseline	Endline	
On the whole, I am satisfied with myself	Blantyre	40%	62%	9%	7%	0.007
	Machinga	29%	33%	3%	3%	0.678
At times I think I am no good at all	Blantyre	6%	22%	6%	8%	0.001
	Machinga	6%	12%	4%	8%	0.027
	Blantyre	14%	24%	3%	10%	0.014

I feel that I have a number of good qualities	Machinga	8%	14%	5%	4%	0.404
I am able to do things as well as most other people	Blantyre	32%	30%	2%	3%	0.214
	Machinga	13%	18%	5%	6%	0.709
I feel I do not have much to be proud of	Blantyre	13%	25%	4%	6%	0.018
	Machinga	9%	13%	5%	9%	0.006
I certainly feel useless at times	Blantyre	6%	23%	12%	13%	0.002
	Machinga	12%	9%	7%	14%	0.116
I feel that I'm a person of worth, at least on an equal plane with others	Blantyre	41%	64%	3%	0%	0.002
	Machinga	18%	30%	2%	4%	0.085
I wish I could have more respect for myself	Blantyre	41%	64%	2%	2%	0.003
	Machinga	26%	39%	1%	1%	0.118
All in all, I am inclined to feel that I am a failure	Blantyre	5%	16%	8%	17%	0.004
	Machinga	12%	3%	4%	18%	0.000
I take a positive attitude toward myself	Blantyre	26%	28%	2%	6%	0.351
	Machinga	4%	11%	5%	8%	0.007

Table 28: Responses to all questions on the Rosenberg Self-esteem Scale by site

Parental Stress Levels

The difference between Blantyre and Machinga respondents' change in average parental stress levels was not statistically significant[91]. Blantyre respondents' average parental stress scores decreased by 3.3 (from 44.6 at baseline to 41.3 at endline), while Machinga respondents' average parental stress scores decreased by 4.1 (from 47.2 at baseline to 43.1 at endline). Average parental stress scores decreased significantly for respondents from Blantyre[92] and Machinga[93].

The majority of changes from baseline to endline were found to be statistically significant, with some noticeable site differences being:

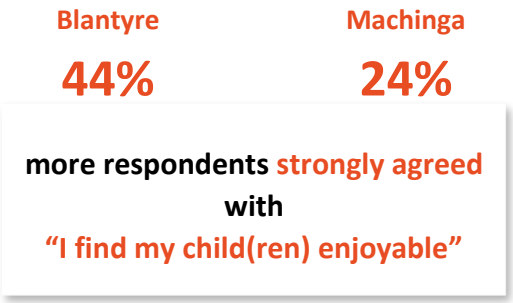
- 35% more Blantyre respondents from baseline (40%) to endline (75%) strongly agreed with "I enjoy spending time with my child(ren)", and 24% more Machinga respondents also strongly agreed with this statement from baseline (26%) to endline (50%)
- At baseline, 11% of Blantyre respondents compared to 4% of Machinga respondents strongly disagreed with the statement "The major source of stress in my life is my child(ren)", which increased to 38% of Blantyre respondents (27% more) and 11% of Machinga respondents (7% more) at endline
- 77% of Blantyre respondents and 45% of Machinga respondents at endline strongly agreed with "I feel close to my child(ren)", which is a 36% increase from baseline for Blantyre respondents (41%) and a 34% increase from baseline for Machinga respondents (11%)

[91] p = 0.553

[92] p = 0.010

[93] p = 0.000

- "My child(ren) is an important source of affection for me" where the number of Blantyre respondents who strongly agreed increased by 28% (47% at baseline to 75% at endline) and the number of Machinga respondents who strongly agreed increased by 25% (39% at baseline to 54% at endline)
- 37% of Blantyre respondents at baseline and 66% at endline strongly disagreed with "The behaviour of my child(ren) is often embarrassing" (29% more), while the number of Machinga respondents who said this remained the same at baseline and endline (31%)
- 82% of Blantyre respondents at endline compared to 38% at baseline strongly agreed that they find their child(ren) enjoyable (44% more), and 48% of Machinga respondents at endline compared to 24% at baseline said the same (24% increase)
- On the other hand, 30% more respondents from Blantyre (19% at baseline to 49% at endline) strongly agreed with "If I had it to do over again, I might decide not to have child(ren)", and 5% more Machinga respondents indicated the same (7% at baseline to 12% at endline)



The table below outlines the responses to each question on the Parental Stress scale per site:

Question	Site	Strongly Agree		Strongly Disagree		P
		Baseline	Endline	Baseline	Endline	
I am happy in my role as a parent	Blantyre	36%	48%	3%	8%	0.009
	Machinga	13%	31%	3%	4%	0.002
There is little or nothing I wouldn't do for my child(ren) if it was necessary	Blantyre	17%	15%	6%	22%	0.001
	Machinga	7%	7%	7%	9%	0.012
Caring for my child(ren) takes more time and energy than I can give	Blantyre	8%	15%	10%	28%	0.001
	Machinga	12%	9%	1%	8%	0.013
I sometimes worry whether I am doing enough	Blantyre	8%	16%	8%	14%	0.024
	Machinga	15%	14%	3%	7%	0.219
I feel close to my child(ren)	Blantyre	41%	77%	2%	0%	0.000
	Machinga	11%	45%	1%	2%	0.000
I enjoy spending time with my child(ren)	Blantyre	40%	75%	1%	0%	0.000
	Machinga	26%	50%	0%	1%	0.000
My child(ren) is an important source of affection for me	Blantyre	47%	75%	0%	0%	0.000
	Machinga	39%	54%	0%	0%	0.013

Having child(ren) gives me a more certain and optimistic view for the future	Blantyre	40%	62%	3%	0%	0.004
	Machinga	24%	52%	2%	2%	0.000
The major source of stress in my life is my child(ren)	Blantyre	8%	10%	11%	38%	0.000
	Machinga	12%	16%	4%	11%	0.002
Having child(ren) leaves little time and flexibility in my life	Blantyre	8%	9%	11%	28%	0.000
	Machinga	8%	8%	10%	17%	0.000
Having child(ren) has been a financial burden	Blantyre	6%	16%	19%	27%	0.013
	Machinga	7%	7%	8%	13%	0.322
It is difficult to balance different responsibilities	Blantyre	5%	11%	16%	20%	0.321
	Machinga	5%	5%	9%	21%	0.021
The behaviour of my child(ren) is often embarrassing	Blantyre	5%	4%	37%	66%	0.000
	Machinga	3%	3%	31%	31%	0.457
	Blantyre	19%	49%	22%	25%	0.000
If I had it to do over again, I might decide not to have child(ren)	Machinga	7%	12%	22%	24%	0.593
I feel overwhelmed by the responsibility of being a parent	Blantyre	12%	21%	13%	26%	0.002
	Machinga	5%	9%	7%	8%	0.203
Having child(ren) has meant having too few choices	Blantyre	4%	10%	14%	28%	0.015
	Machinga	8%	10%	10%	18%	0.125
I am satisfied as a parent	Blantyre	37%	50%	2%	9%	0.001
	Machinga	10%	29%	3%	2%	0.001
I find my child(ren) enjoyable	Blantyre	38%	82%	0%	1%	0.000
	Machinga	24%	48%	1%	0%	0.001

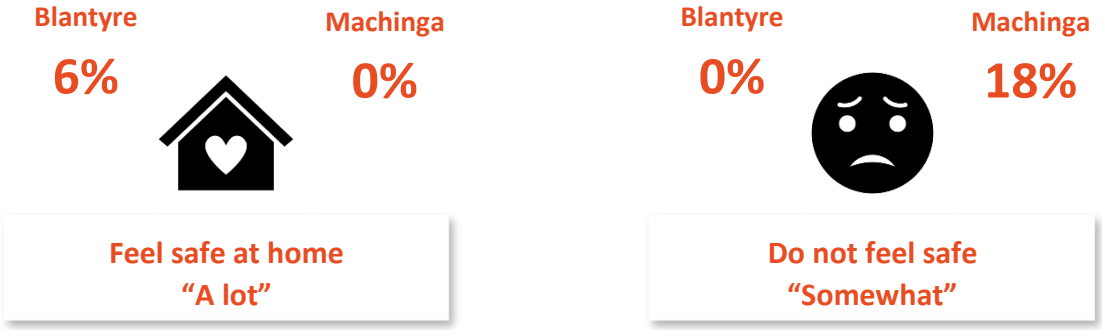
Table 29: Responses to Parental Stress Scale by site

Safety

Feeling safe

Respondents were asked to what degree they felt safe at home and in the community, and to what degree they felt unsafe. Three changes from baseline to endline were found to be statistically significant (two for Blantyre respondents and one for Machinga respondents), as follows:

- "I feel safe at home" where the number of Blantyre respondents responding with "A lot" increased from 52% at baseline to 58% at endline (6% more), while the number of Blantyre respondents responding with "Quite a bit" decreased from 36% at baseline to 18% at endline (18% fewer)
- 2% more Blantyre respondents indicated that they felt safe in their community "A lot" from baseline (42%) to endline (44%), and 21% less Blantyre respondents indicated that they felt safe in their community "Quite a bit" from baseline (36%) to endline (15%)
- 13% of Machinga respondents at baseline compared to 31% at endline selected "Somewhat" for the statement "I don't feel safe" (18% more)



Question	Site	A lot			Not at all			p
		Baseline	Endline		Baseline	Endline		
I feel safe at home	Blantyre	52%	58%	↑	3%	4%	↑	0.012
	Machinga	57%	57%	-	10%	5%	↓	0.170
I feel safe in my community	Blantyre	42%	44%	↑	8%	8%	-	0.001
	Machinga	44%	36%	↓	7%	5%	↓	0.436
I don't feel safe	Blantyre	10%	7%	↓	74%	76%	↑	0.879
	Machinga	9%	8%	↓	42%	34%	↓	0.000

Table 30: Responses to all the safety questions by site

Intimate Partner Violence

At endline, 9% more mothers from Blantyre (from 72% at baseline to 81% at endline)[94], and 8% more Machinga mothers (87% at baseline to 95% at endline)[95] reported that they had been in an intimate relationship before. 52% of Blantyre mothers and 51% of Machinga mothers at baseline indicated that they were currently in an intimate relationship at baseline, and this decreased slightly to 51% of Blantyre respondents at endline [96], but increased to 55% of Machinga respondents at endline [97]. Of these, 5% of Blantyre mothers at endline said that they were currently afraid of their partner (which is a 9% decrease from 14% at baseline)[98], while 16% of Machinga mothers at endline said the same (a 2% increase from 14% at baseline)[99].

[94] p = 0.126
[95] p = 0.040
[96] p = 0.207
[97] p = 0.174
[98] p = 0.068
[99] p = 0.804

Blantyre **-8%** Machinga **2%**

of mothers said that they were currently afraid of their partner

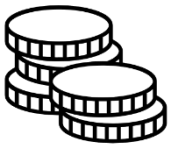
The mean number of IPV forms that Blantyre mothers were exposed to was 0.4 at baseline, which increased significantly to 2.3 at endline [100]. Similarly, Machinga mothers were exposed to an average of 0.8 forms of IPV at baseline, and this increased significantly to 2.1 at endline[101]. The difference between Blantyre (1.9) and Machinga (1.3) average change scores was not statistically significant[102]. Overall, experiences of IPV increased significantly from baseline to endline for both Blantyre and Machinga mothers, and numerous statistically significant changes were found, including:

- 18% more Blantyre mothers (4% at baseline to 22% at endline) and 17% more Machinga mothers (4% at baseline to 21% at endline) reported that "My partner hit me with a fist or object, kicked or bit me"
- At baseline, 3% of Blantyre mothers compared to 6% of Machinga mothers reported that their partner "Told me I was crazy, stupid, or not good enough", and this increased to 16% of Blantyre mothers (13% more) and 24% of Machinga mothers (18% more) at endline
- "My partner tried to convince my family, children, or friends that I am crazy or tried to turn them against me" where 15% more Blantyre mothers from baseline (2%) to endline (17%), compared to 7% more Machinga mothers from baseline (3%) to endline (10%)
- 19% of Blantyre mothers at endline reported that their partner had shook, pushed, grabbed, or threw them, which is a 16% increase from baseline (3%)

Blantyre **18%** Machinga **17%**

of mothers said their partner(s) hit them with a fist or object, kicked, or bit them

Blantyre **13%** Machinga **8%**



of mothers reported their partner(s) kept them from having access to a job, money, or financial resources

[100] p = 0.000
[101] p = 0.001
[102] p = 0.375

The following table breaks down the responses to each question in the IPV Scale:

My partner(s):	Site	Baseline	Endline		p
Blamed me for causing their violent behaviour	Blantyre	5%	14%	↑	0.005
	Machinga	6%	13%	↑	0.083
Shook, pushed, grabbed, or threw me	Blantyre	3%	19%	↑	0.000
	Machinga	9%	14%	↑	0.284
Tried to convince my family, children, or friends that I am crazy or tried to turn them against me	Blantyre	2%	17%	↑	0.000
	Machinga	3%	10%	↑	0.038
Used or threatened to use a knife or gun or other weapon to harm me	Blantyre	2%	14%	↑	0.000
	Machinga	3%	13%	↑	0.009
Made me perform sex acts that I did not want to perform	Blantyre	5%	16%	↑	0.002
	Machinga	13%	13%	-	0.591
Followed me or hung around outside my home or work	Blantyre	1%	14%	↑	0.000
	Machinga	3%	12%	↑	0.029
Threatened to harm or kill me or someone close to me	Blantyre	1%	14%	↑	0.000
	Machinga	3%	13%	↑	0.002
Choked me	Blantyre	3%	14%	↑	0.000
	Machinga	1%	11%	↑	0.001
Forced or tried to force me to have sex	Blantyre	6%	17%	↑	0.001
	Machinga	11%	13%	↑	0.500
Harassed me by phone, text, email or using social media	Blantyre	2%	13%	↑	0.000
	Machinga	5%	17%	↑	0.008
Told me I was crazy, stupid, or not good enough	Blantyre	3%	16%	↑	0.000
	Machinga	6%	24%	↑	0.000
Hit me with a fist or object, kicked or bit me	Blantyre	4%	22%	↑	0.000
	Machinga	4%	21%	↑	0.000
Kept me from seeing or talking to my family or friends	Blantyre	2%	16%	↑	0.000
	Machinga	4%	13%	↑	0.012
Confined or locked me in a room or other space	Blantyre	2%	12%	↑	0.000
	Machinga	0%	11%	↑	0.001
Kept me from having access to a job, money, or financial resources	Blantyre	3%	16%	↑	0.000
	Machinga	6%	14%	↑	0.057

Table 31: Responses to IPV Scale

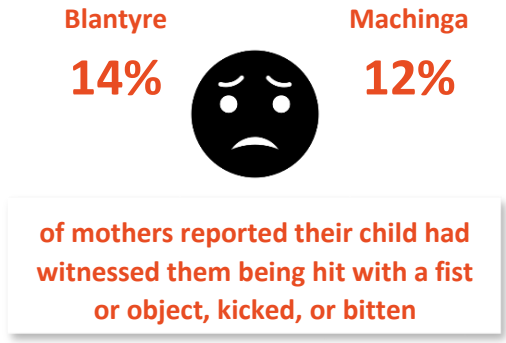
For the children, the mean number of IPV forms that Blantyre children had witnessed was 0.3 at baseline, which increased significantly to 2.1 at endline[103]. Similarly, Machinga children witnessed an average of 0.2 forms of IPV at baseline, and this increased significantly to 1.4 at endline[104]. The

[103] p = 0.000

[104] p = 0.001

difference between Blantyre (1.8) and Machinga (1.2) average change scores was not statistically significant[105]. Overall, instances of children witnessing IPV increased significantly from baseline to endline. All changes were found to be statistically significant on the Child Witness Scale, with the largest changes having occurred in the following areas:

- The number of Blantyre respondents who indicated that their child had witnessed "My partner hit me with a fist or object, kicked or bit me" increased by 14% (3% at baseline to 17% at endline), and the number of Machinga respondents who indicated the same increased by 12% (2% at baseline to 17% at endline)
- "My partner Kept me from seeing or talking to my family or friends", where 14% more Blantyre mothers (1% at baseline to 15% at endline) and 8% more Machinga mothers (1% at baseline to 9% at endline) reported that their child had witnessed this
- At baseline, 2% of Blantyre mothers and 2% of Machinga mothers reported that their child had witnessed "My partner told me I was crazy, stupid, or not good enough" and this increased to 16% of Blantyre mothers (14% more) and 12% of Machinga mothers (10% more)
- 13% of Blantyre mothers and 8% of Machinga mothers at endline reported that their child had witnessed their partner threaten to harm or kill them or someone close to them, which is a 13% increase from baseline (0%) for Blantyre mothers and a 6% increase from baseline (2%) for Machinga mothers



The following table breaks down the responses to each question in the Child Witness Scale:

Child witness:	Site	Baseline	Endline		p
Blamed me for causing their violent behaviour	Blantyre	3%	13%	↑	0.000
	Machinga	3%	8%	↑	0.046
Shook, pushed, grabbed, or threw me	Blantyre	3%	14%	↑	0.000
	Machinga	1%	10%	↑	0.003
Tried to convince my family, children, or friends that I am crazy or tried to turn them against me	Blantyre	0%	14%	↑	0.000
	Machinga	1%	8%	↑	0.005
Used or threatened to use a knife or gun or other weapon to harm me	Blantyre	1%	14%	↑	0.000
	Machinga	2%	8%	↑	0.018
Made me perform sex acts that I did not want to perform	Blantyre	3%	14%	↑	0.000
	Machinga	1%	9%	↑	0.003

[105] p = 0.301

	Blantyre	1%	14%	↑	0.000
Child witness:	Site	Baseline	Endline		p
Followed me or hung around outside my home or work	Machinga	1%	7%	↑	0.037
Threatened to harm or kill me or someone close to me	Blantyre	0%	13%	↑	0.000
	Machinga	2%	8%	↑	0.038
Choked me	Blantyre	3%	13%	↑	0.000
	Machinga	1%	8%	↑	0.021
Forced or tried to force me to have sex	Blantyre	5%	14%	↑	0.000
	Machinga	1%	8%	↑	0.005
Harassed me by phone, text, email or using social media	Blantyre	2%	12%	↑	0.000
	Machinga	1%	8%	↑	0.022
Told me I was crazy, stupid, or not good enough	Blantyre	2%	16%	↑	0.000
	Machinga	2%	12%	↑	0.002
Hit me with a fist or object, kicked or bit me	Blantyre	3%	17%	↑	0.000
	Machinga	2%	14%	↑	0.001
Kept me from seeing or talking to my family or friends	Blantyre	1%	15%	↑	0.000
	Machinga	1%	9%	↑	0.003
Confined or locked me in a room or other space	Blantyre	1%	12%	↑	0.000
	Machinga	0%	9%	↑	0.001
Kept me from having access to a job, money, or financial resources	Blantyre	3%	14%	↑	0.000
	Machinga	1%	9%	↑	0.007

Table 32: Responses to the Child Witness Scale

Conclusion

For the adolescent mothers in this project, this report has considered the levels of psychosocial wellbeing (including resilience, mental health, and self-esteem), SRHR access, parental stress levels, safety, and experiences of IPV at a baseline and endline level. The report has also considered the developmental levels of the children of these young mothers using the MDAT. The findings are complex and nuanced and should be considered in light of the context in which this intervention took place, especially related to the COVID-19 pandemic.

Notably, the results showed significant increases in IPV. Whilst other literature has also shown stark increases in GBV following lockdown (Piquero et al., 2021; Gittings et al., 2021; MIET Africa, 2021), these findings are concerning and highlight the need to address the high rates of violence experienced by adolescent mothers in Malawi. The research also highlighted the particular vulnerabilities of adolescent mothers who are orphans. Children of respondents whose mothers had passed away had witnessed significantly more instances of IPV, on average, compared to respondents whose mother was still alive. Respondents who did not know whether their father was alive and whose father had passed away showed significantly higher child witness scores, on average, compared to respondents who had not lost their father. In addition, respondents who did

not know whether their father was alive and those whose father had passed away showed significantly increased parental stress compared to those whose father was still alive.

At the same time, respondents also showed improvements in psychosocial wellbeing, with 52% of respondents showing increased resilience on the BRS, 48% showing decreased depression, and 50% showing increased self-esteem. The differences between Blantyre and Machinga mothers on psychosocial wellbeing indicators were also interesting to note. In general, Machinga respondents showed greater improvements in their average resilience, depression, and selfesteem scores compared to Blantyre respondents. Given the short length of the intervention combined with the focus on adolescent motherhood, a large change in psychosocial wellbeing scores was not initially expected. Although it was hoped that participation would at least maintain psychosocial wellbeing against a backdrop of increased stressors (such as those caused by COVID-19). Therefore, the increases in psychosocial wellbeing (particularly for Machinga respondents) are encouraging.

It is also interesting to note that parental stress levels decreased almost equivalently between the two sites, despite the differences in psychosocial wellbeing. Overall, 62% of adolescent mothers showed decreased levels of parental stress from baseline to endline. This could be a notable success of the intervention given its focus on adolescent mothers. This study also found significant associations between helping to look after younger children at home and improvements in resilience, self-esteem, and depression. This suggests that being a mother or a caretaker in the home (and feeling safe at home) are factors which are associated with improved psychosocial wellbeing. In addition, helping to look after younger children was also associated with a significant decrease in IPV scores and child witness scores.

Overall, the majority of the children of the adolescent mothers included in this report were developmentally on track or ahead, both overall and in each domain (gross motor, fine motor, language, and social). However, it was noted that a quarter of children were behind in their language development. On the other hand, most children are developing well in the gross motor domain with 89% being on track or ahead.

Research such as this is important to consider as part of the monitoring, evaluation, and learning processes behind any intervention, and these results can be used going forward to ensure a successful and fruitful intervention is in place. These results provide important information to the programme team in terms of the changes that have happened for those participating in the intervention. What is encouraging is that those who participated in the intervention showed a positive change in terms of parental stress, which is what the programme focuses on. In addition, decreased parental stress levels were associated with significant improvements in resilience and self-esteem, suggesting that interventions such as these aimed at reducing parental stress can positively impact psychosocial wellbeing in turn. There were also some improvements in children's development, with more children being ahead in their overall development at endline compared to baseline. This intervention therefore shows promise as a way to support adolescent mothers and their children. While some changes were not as positive, these provide evidence for areas which can be improved. It should also be kept in mind that the intervention faced several challenges linked to COVID-19, and many other factors could play a role in influencing the outcomes measured. Further qualitative research will provide greater insight into the implementation of this intervention and could contextualise these findings further. It is therefore recommended that further qualitative research be conducted.

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