Republic of Malawi
Ministry of Health

YOUTH-FRIENDLY HEALTH SERVICES TRAINING MANUAL

PARTICIPANTS HANDBOOK

Second Edition
Revised November 2016

CONTENTS

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
BLM	Banja La Mtsogolo
CBDA	community-based distribution agent
CHAM	Christian Health Association of Malawi
CHBC	community home-based care
COC	combined oral contraceptive
CPD	cephalo-pelvic disproportion
FANC	focused antenatal care
HIV	human immunodeficiency virus
HPV	human papilloma virus
HPP	Health Policy Project
HTC	HIV testing and counselling
IEC	information, education, and communication
ITN	insecticide-treated bed net
LGBT	lesbian, gay, bisexual, and transgender
MDG	Millennium Development Goal
MDHS	Malawi Demographic and Health Survey
MOH	Ministry of Health
PEP	post-exposure prophylaxis
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission of HIV
POP	progestin-only pill
RHD	Reproductive Health Directorate
SRH	sexual and reproductive health
SRHR	sexual and reproductive health rights

STI	sexually transmitted infection
UN	United Nations
USAID	United States Agency for International Development
VIPP	visualisation in participatory programmes
VMMC	voluntary medical male circumcision
VSU	Victim Support Unit
WHO	World Health Organization
YCBDA	youth community-based distribution agent
YFHS	youth-friendly health services

GLOSSARY

Categories of youth. Early adolescents: ages 10–14; late adolescents: ages 15–19; young people: ages 10–24 (United Nations).

Cephalo-pelvic disproportion (CPD). Occurs when a baby's head or body is too large to fit through the mother's pelvis. It is believed that true CPD is rare, but many cases of "failure to progress" during labour are given a diagnosis of CPD.

Contraceptive use. The percentage of all women and men ages 15–19 who are using any form of contraception. "Modern" methods are pills, intrauterine contraceptive devices, injectables, implants, female and male condoms, emergency contraception, and female and male sterilisation. "Any" methods include not only modern but also traditional methods, such as rhythm/periodic abstinence and withdrawal (Ministry of Finance, Economic Planning and Development, 2013, Malawi Youth Data Sheet).

Depression. A mental disorder characterised by low moods and a decrease in functional activity.

Demographic dividend. The accelerated economic growth that may result from a decline in a country's mortality and fertility, a change in the age structure of the population (increased number of working-age adults), and the increased ratio between a productive labour force and nonproductive dependents.

Embolus. A blood clot, air bubble, piece of fatty deposit, or other object that has been carried in the bloodstream to lodge in a vessel and cause an embolism.

Ectopic pregnancy. A pregnancy in which the foetus develops outside of the uterus, typically in a fallopian tube.

Gender. Socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.

Gender-based violence. Violence targeted at girls, boys, women, and men based on the gender roles assigned to them. This violence often arises from unequal power relationships between men and women, and women are the victims (United Nations International Research and Training Institute for the Advancement of Women, United Nations Population Fund, 2010).

Haemorrhage. An escape of blood from a ruptured blood vessel, especially when profuse.

Harmful cultural practices. A social, cultural, or religious practice that, on account of sex, gender, or marital status, does or is likely to undermine the dignity, health, or liberty of any person or to result in physical, sexual, emotional, or psychological harm to any person (Malawi Gender Equality Act, 2013).

Obesity. Weight that is 20 percent above the standard weight for a person's height.

Obstetric fistula. Commonly referred to as fistula, this is a hole between the vagina and rectum or bladder caused by prolonged obstructed labour, often leaving the woman incontinent, with involuntary release of urine, faeces, or both.

Premature labour. Regular contractions of the uterus resulting in changes in the cervix that start before 37 weeks of pregnancy. Changes in the cervix include effacement (the cervix thins out) and dilation (the cervix opens so that the foetus can enter the birth canal).

Primi gravida. A woman who is pregnant for the first time.

Psychoactive substance. A substance that, when taken into the system, affects mental processes, consequently affecting other social and biological dimensions of human life.

Psychosis. An abnormal mental condition in which one loses contact with reality and exhibits personality changes and thought disorders.

Schizophrenia. A mental disorder characterised by abnormal psychosocial behaviour and inability to recognise what is real in one's environment.

Septicaemia. Blood poisoning, especially that caused by bacteria or their toxins.

Sexual abuse. Any sort of nonconsensual sexual contact.

Stunting. When one is too short for one's age as measured by medical standards for height.

Stress. A state of mental or emotional tension resulting from adverse or very demanding circumstances. It may lead to feeling sad and low, loss of appetite, difficulty in sleeping, and being fearful, tense, or panicky.

FOREWORD

Youth are the window of hope for the development of this country. As such, they need proper care and guidance to ensure that they remain healthy and productive. Young people have needs and challenges that affect their growth and development. However, many young people and the adults around them either are unaware of these needs or what to do about them. Others have problems accessing services that address their needs.

The Malawi Youth-friendly Health Services (YFHS) Training Manual aims to improve the way service providers respond to the needs of young people and improve providers' ability to communicate with other stakeholders to improve young people's health.

This training package is not a clinical manual. It is intended for trained registered health service providers offering preventive, curative, and promotive health services to youth. The manual will be useful to doctors, clinical officers, nurses, and other professionals such as psychologists, social workers, teachers, youth development workers, community-based distribution agents, and youth peer educators, as well as young people themselves. To be eligible for training, service providers will need to have at least a Junior Certificate (JCE) and experience in community work. Ability to communicate in English (both spoken and written) will also be a key selection criterion. Anyone lacking the above minimal criteria will be oriented especially on effective communication with young people, issues affecting young people, laws and policies affecting young people in health service delivery, and the YFHS standards (Unit 7 of this training package). Having such a broad target audience should ensure that the training package benefits from insights and perspectives from a broad range of stakeholders and service providers.

The training package is expected to be implemented as a stand-alone five-day workshop. Participants will

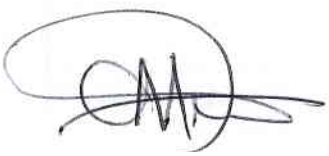
- Become more knowledgeable about the characteristics of young people, their needs, and aspects of youth health and development
- Gain skills in effective communication with young people; challenge their own attitudes affecting their capacity to deliver services to young people; and acquire an understanding of laws, policies, and standards for YFHS delivery
- Be better equipped with facts and figures to argue for increased investment in young people's health and development
- Be better able to provide health services that respond to young people's needs and be sensitive to their preferences
- Prepare a personal plan to carry out the changes they will make in their work with and for young people

Other capacity-building programmes organised by the Ministry of Health (MOH) and its partners are in place to equip participants with specific clinical skills in youth healthcare. The training package does not intend to duplicate these, but where relevant, facilitators should refer to the materials during the training workshop and make them available to participants. Facilitators should be flexible enough to gauge the level of capacity of their participants and tailor the materials in this training package to complement these capacity-building materials.

In practical terms, the training package will provide participants with ideas and practical tips to answer two fundamental questions:

- What do I, as a health-service provider, need to know and do differently if the person who walks into my clinic is 16 years old, rather than 6 or 36?
- How can I help other influential people in my community understand and respond better to the needs and problems of young people?

This training operationalises the *National Youth Friendly Health Services Strategy 2015–2020.* It was developed in line with the World Health Organization (WHO) recommendations of YFHS competency for providers in three domains: (1) basic concepts in adolescent health and development, and effective communication; (2) law, policies, and quality standards; and (3) critical care of adolescents with specific conditions. Through this manual, the MOH expects that service providers will be able to re-examine and re-orient their work to address the needs and problems of youth, as clearly reported in the 2014 YFHS evaluation study for Malawi. This manual is intended to help service providers associated with the government, the Christian Health Association of Malawi, nongovernmental organisations, and all other stakeholders review, redesign, and develop programmes and policies focusing on the promotion of health services that are friendly to young people in Malawi.



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Chief of Health Services

ACKNOWLEDGEMENTS

The *Malawi Youth-friendly Health Services (YFHS) Training Manual* culminates the concerted efforts of many people who developed the Malawi Youth-Friendly Health Service Standards and adapted WHO's 2006 Orientation Programme on Adolescent Health for Health-care Providers. This work significantly informed the content of the training package. WHO supported the first edition of the YFHS training package in 2011. The Reproductive Health Directorate (RHD) is indebted to the USAID-funded Health Policy Project (HPP) and Health Policy Plus (HP+) project for financing the development of the second edition. This new edition has given us the opportunity to update material and include emerging issues, aligning with several policy documents released after 2011.

The RHD would therefore like to sincerely express its gratitude and appreciation to all individuals, partner agencies, and collaborating institutions for their support and valuable contributions during the process of developing this manual.

The RHD is grateful to the National Technical Sub-Committee on Youth-Friendly Health Services for facilitating the development of the first and second editions of the training materials.

The RHD would like to sincerely thank Chisomo Zileni (lead consultant), who led the revision process to create the second edition, and Marjorie Marciera (external consultant), who supported this process. Particular thanks go to the pretesting team that helped refine the YFHS manuals: Annie Kachigamba—Lilongwe DHO, Rodney Chaula—Kasungu DHO, Maria Sanena-Ndolo—MSF, Nissily Mushani—AFIDEP, and Victoria Chopi—Baylor. Special recognition is due to the following stakeholders for their input during the entire process: the USAID-funded HPP and HP+ projects, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the National Youth Council of Malawi (NYCOM), Banja La Mtsogolo (BLM), Farm Radio, Baylor Children's Hospital, Youth Net and Counselling (YONECO), and the Lilongwe and Kasungu District Health Offices.

PREFACE

Youth-friendly health services (YFHS) have been implemented through the oversight of the Reproductive Health Directorate (RHD) in Malawi since 2007 in accordance with the *Youth-Friendly Health Services National Standards* (2007). YFHS are high-quality services that are relevant, accessible, attractive, affordable, appropriate, and acceptable to young people. The first edition of the *YFHS Training Manual (Facilitators Guide and Participants Handbook)* was developed in 2011 to ensure that service providers fully comply with the minimum health package of the national standards and increase young people's acceptability and use of these services.

A recent evaluation of the YFHS programme revealed that only 31.7 percent of young people have heard of YFHS and 13 percent have ever used these services. Poor provider attitude was cited as one of the main barriers to the programme's use (E2A Project and University of Malawi, 2014). In response, and in recognition of emerging trends in youth and adolescent sexual and reproductive health (SRH), the RHD, with support from the USAID-funded Health Policy Project (HPP) and Health Policy Plus (HP+) project, has revised the training package. This second edition of the *Facilitators Guide* includes all resources necessary to train service providers on YFHS. For each topic, the guide offers an introduction, suggested activities, video clips, and handouts. The manual also seeks to respond to service providers' needs as defined in the *National Youth Friendly Health Services Strategy 2015–2020* and is itself one of that strategy's implementation approaches.

Malawi's YFHS strategy aims to involve service providers from multiple sectors and at varied levels to effectively and efficiently deliver YFHS to young people ages 10–24 years. Few standardised training resources are available for professionals and volunteers concerning youth sexual and reproductive health rights (SRHR). This resource aims to help fill this gap in two ways:

1. Provide a workshop curriculum that can easily be adapted to specific situations, including those in resource-poor areas
2. Support a YFHS skills-building approach that focuses on enhancing providers' capacity to consistently and ably deliver high-quality services that are relevant, accessible, attractive, affordable, appropriate, and acceptable to young people

The second edition was developed in line with the World Health Organization definition of YFHS competency as having three domains: (1) basic concepts in adolescent health and development, and effective communication; (2) law, policies, and quality standards; and (3) critical care of adolescents with specific conditions.

THE SCOPE AND LIMITS OF THE MALAWI YFHS TRAINING PACKAGE

The scope and limits of the training package are informed by the YFHS standards. The standards have identified three areas of focus in the minimum package of services to address the health needs of young people:

- Health promotion
- Delivery of health services
- Referral and follow-up

The interventions in these areas are to be provided within the framework of the national healthcare delivery system. Furthermore, the standards have identified the services to be provided within the normal clinical standards and procedures as approved by the Ministry of Health (MOH). The services to be provided must also be in line with Malawi's Essential Health Package (EHP).

The services are listed below.

At the community level

- Contraceptive services, including condoms
- HIV testing and counselling
- Referral to health facilities or other service delivery points

At the health centre level

- Contraceptive services, including condoms
- Prevention, diagnosis, and management of sexually transmitted infections (STIs)
- Antenatal, delivery, and postnatal care services
- Post-abortion care
- Prevention of mother-to-child transmission of HIV (PMTCT)
- HIV testing and counselling
- Treatment of sexual abuse victims
- Referral to hospitals or other service delivery points
- Counselling and referral for nutrition, substance abuse, and mental health
- Voluntary medical male circumcision (VMMC)

At the hospital level

All of the services above, plus the following:

- Post-abortion care
- Treatment of sexual abuse victims, including post-exposure prophylaxis (PEP)
- Reproductive health cancer screening
- Provision of antiretroviral drugs

Health promotion and counselling during service delivery at all levels

- STIs
- Family planning
- Reproductive health cancers, including human papilloma virus (HPV) vaccine
- Psychosocial support
- Substance abuse
- Nutrition
- HIV and AIDS
- Sexual abuse
- Maternal healthcare
- Adolescent growth and development
- VMMC

OVERALL AIM OF THE YFHS TRAINING PROGRAMME

The overall aim of the YFHS training programme is to introduce and orient service providers to the special characteristics of young people and the appropriate approaches to address selected priority health needs and problems of young people.

Expected outcomes of the training programme

It is expected that at the end of the programme, participants will

- Be more knowledgeable about the characteristics of young people's development
- Be more sensitive to the needs of young people
- Be better equipped with SRHR information and resources
- Be more knowledgeable about the policies and guidelines regarding young people
- Be better able to provide youth-friendly health services
- Prepare a personal plan for the changes they will make in their work with and for young people

Intended participants

The following participants (among others) will benefit from this curriculum:

- Health service providers
- Adolescents, young people, and youth
- Representatives of other relevant professional groups (e.g., youth development workers, social workers, psychologists, nutritionists, police, and teachers)

Training programme units

Table 1 lists the units in the training programme. All participants must complete all of these units unless the curriculum is being used for refresher training, which will cover specific topics chosen by the facilitators.

TABLE 1. Content of the training programme

UNIT	TITLE
1	Getting started and basics
2	Adolescence and public health
3A	Introduction to sexual and reproductive health and young people
3B	Pregnancy prevention and fertility regulation in young people
3C	Care of adolescents during pregnancy and childbirth
3D	Unsafe abortion and young people
3E	Sexual and physical abuse and young people
3F	Sexually transmitted infections and young people
3G	HIV and AIDS and young people
4	Nutrition and young people
5	Substance abuse and young people
6	Mental health and young people
7	Providing young people with the health services they need

This unit provides information on the following:

1. Definition of youth-friendly health services (YFHS)
2. What a YFHS facility looks like
3. The four pillars of good customer service
4. Characteristics of effective communication
5. Definition of empathy
6. The purpose of values clarification
7. Steps in the counselling process

UNIT 1.
GETTING STARTED AND BASICS

HEALTH SERVICES: JUST A GLIMPSE!

YFHS are defined as services that are accessible, acceptable, and appropriate for adolescents and youths. They are in the right place at the right price (free where necessary) and delivered in the right style to be acceptable to young people. They are effective, safe, and affordable. They meet the individual needs of young people who return when they need to and recommend these services to friends. (See Box 1.)

BOX 1. What to expect at a YFHS facility

- Policies, strategies, and guidelines that govern delivery of services to adolescents and youths
- Competent providers and staff who are trained and competent in adolescent and youth development and needs
- Providers who are not judgmental and do not provide unsolicited advice
- Services that are provided in a private and confidential manner to adolescents and youths
- Drop-in clients welcome and appointments arranged with ease and speed
- Opening and closing hours that are convenient and flexible, especially for adolescents and young people
- A prominent sign posted on the facility clearly advertising the availability of YFHS to the community
- Recreational equipment and infotainment to motivate youth participation and uptake of services
- Referral systems that are in place and confidential
- Planning of health services that involves adolescents, youths, and the community
- Services that all adolescents and young people can afford
- Collection, analysis, and reporting of data to improve service provision

Let's get the basics right!

CUSTOMER CARE: OUR CLIENTS, OUR PATIENTS, OUR BUSINESS

Knowing how to effectively communicate with adolescents and youths, especially when they are seeking health services, is a skill. Many young people are sensitive to what is said of them and how others interpret their ways of doing things. Every provider should know the basics of how to approach and communicate with youth. ***Customer care is said to be an art of marketing, focused on understanding the needs of the customer and striving to satisfy them.*** (See Box 2.)

BOX 2. What every provider should know

Clients (adolescents and youths) are customers.

Effective communication is important.

Your values and beliefs should not affect your professional judgment.

Show empathy (put yourself in your clients' shoes; see through their eyes).

CUSTOMER SERVICE

Customer service means anticipating and satisfying the needs of your customers (adolescents and youths) in a consistent and dependable manner. Good customer service entails helping the customer, even when the service the customer requests is not available. (See Box 3.)

BOX 3. Exceptional customer service has three key characteristics

SKILLS: Knowing how to complete all of the tasks within your job function

KNOWLEDGE: Experience and lessons learned from doing your job

ATTITUDE: The energy, positive feelings, and enthusiasm you bring to your work when dealing with customers (adolescents and youths)

FOUR PILLARS OF CUSTOMER SERVICE

What makes health institutions or providers competitive is how they make their clients or patients as welcome and comfortable as most adolescents and youths expect. Good work with adolescents and youths rests on four pillars of service:

1. Professional service

- Knowing your job
- Knowing the institutional standards, procedures, and policies
- The way you speak and carry yourself, and your hygiene standards
- Having pride in what you do

2. Personal service

- See clients or patients as guests and treat them as individuals
- Respect their rights
- Ensure that their environment is well-maintained

3. Warm service

- Entails doing everything with sincerity

4. Responsive service

- Responding promptly to clients' needs
- Taking time to listen to clients and their concerns

BOX 4. Customers are

- The most important people in your workplace
- Not dependent on you; you are dependent on them
- Not interruptions to your work; they are the purpose of it
- There to be served; you are not doing them a favour by serving them
- Part of your institution
- Not just statistics; they are human beings
- Not people to challenge by matching wits and intelligence
- People who have wants; it's your job to fill those wants
- Deserving of the most courteous and attentive treatment you can give them
- The lifeblood of every institution; you are there to serve them

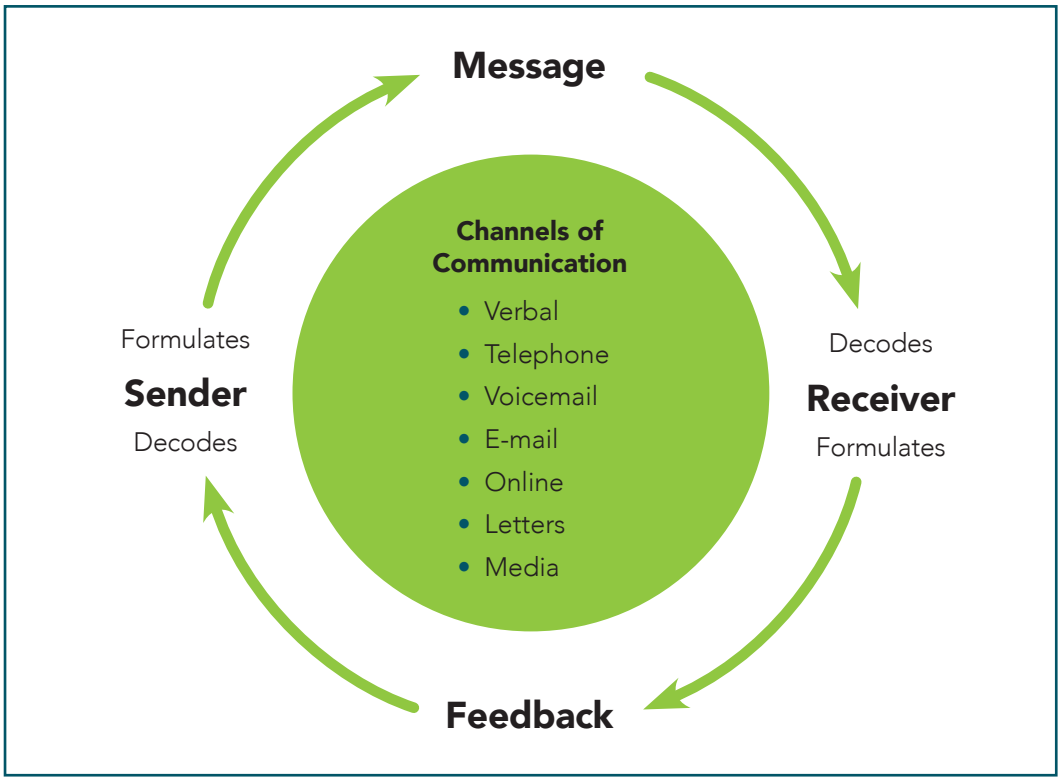
COMMUNICATION

Communication is a key component in customer care and the single most important element of work with adolescents and youths. Communication is a process that involves two or more people. That process is the transmission of information, feelings, and thoughts through words or actions and symbols. For providers working with adolescents and young people, communication has the following purposes:

- Establishing rapport
- Providing information
- Answering questions
- Clarifying concerns
- Motivating
- Persuading
- Encouraging

Communication is the transmission of information from a sender to at least one receiver using a specific channel. It is a dynamic and interactive process, as Figure 1 shows.

FIGURE 1. Verbal and nonverbal communication



Communication can be verbal (speaking or writing) or nonverbal (using the body to signal messages). The following acronyms and their corresponding skills will help you understand and remember these two types of communication:

- **CLEARR** (for verbal communication)
- **ROLES** (for nonverbal communication)

BOX 5. Verbal communication skills

C – Clarify
L – Listen carefully
E – Encourage
A – Acknowledge
R – Reflect
R – Repeat

BOX 6. Nonverbal communication skills (body language)

R – Relax
O – be Open
L – Lean towards the client appropriately
E – make Eye contact as appropriate
S – Sit comfortably

To provide good customer care, an effective communicator needs to have both sets of skills.

DEALING WITH YOUR ATTITUDES AND BELIEFS

In Malawi, providers working with young people come from different backgrounds that have shaped their beliefs and attitudes. Beliefs and attitudes are acquired, not inborn; they are learned and actualised over time. Thus, they may be difficult to shed, but they can and do change with experience and knowledge. Addressing and challenging your own beliefs and attitudes can keep them from becoming barriers to your ability to communicate effectively and provide good customer care and service.

Box 7 highlights how attitudes and beliefs affect communication, and how to deal with them.

BOX 7. How attitudes and beliefs affect communication

Providers are likely to be biased and therefore judgmental.

Providers might provide counselling based on their own beliefs and attitudes, which clients could reject as unsolicited advice.

Providers who express their biases are likely to lose the respect of adolescents and young people, who would respond by shunning those providers' services.

Providers' biases can engender loss of trust.

How to deal with attitudes (self-reflection)

Acknowledge these attitudes and recognise that they may be influencing your work performance or interactions with others (values clarification).

Take some time to reflect on your feelings and attitudes. Consider how your attitudes may influence your behaviour.

Decide whether you think you can overcome these feelings by yourself.

If you don't feel you can overcome these feelings by yourself, decide who you could ask for assistance. It is very important for you to identify someone with whom you can have an honest, soul-searching conversation. Possible sources of advice are colleagues, supervisors, friends, or family.

VALUES CLARIFICATION

Every person has values, and often they affect how one makes decisions. Because you work with adolescents and youths, your personal values must not affect your professional service. Values clarification is meant to facilitate your awareness of your personal values, helping you understand how they might affect service delivery. Knowledge of your own values can help you to have a more open approach to issues and significantly minimise your judgmental attitudes. Values clarification self-assessment is important for the provision of good customer care.

EMPATHY

Empathy means imagining yourself in someone else's shoes and asking yourself how you would like to be treated if you were in that person's situation. Imagining being in such a difficult situation and knowing that you would need a certain type of help promotes better understanding of the issues affecting young people and others. This fosters better delivery of services that rarely is judgmental.

Counselling and the counselling process

Given the challenges that adolescents and youths face every day, they will often need support to make informed decisions, and counselling is often the right setting. Providers working with adolescents and youths need to understand the basic concepts of counselling so they can help their clients effectively and appropriately.

PREPARATION FOR COUNSELLING

In preparation for any counselling session, providers must take the following steps:

- Ensure that a private, well-lit, and well-ventilated room or space is available for the meeting so others cannot hear your discussion.
- Ensure that the meeting place is clean.
- Ensure that you and the client have something to sit on and a table (if needed).
- Assemble any teaching aids you might need.
- Ensure that you have a pen and paper.
- Ensure that all phones are on silent so they won't disturb your conversation.

BOX 8. Counselling

What it is:

The process of providing factual information, professional guidance, and assistance in resolving personal and psychological problems

What it is not:

Providing your personal, value-laden opinions and unsolicited advice

PROCESS OF COUNSELLING

A counselling session entails six basic steps:

- **G** – Greeting (this step facilitates the building of rapport)
- **A** – Ask
- **T** – Tell
- **H** – Help
- **E** – Explain
- **R** – Reassure

BOX 9. The counselling process (GATHER)

Step 1. GREET your client(s)

Greet your client (or clients) respectfully and with kindness, and make them comfortable (always smile).

Offer a chair (if available) or something to sit on.

Introduce yourself first and then ask your client's name.

Assure the client that everything said will be confidential.

Step 2. ASK

Ask the client what you can do for him or her.

It is very important to use open-ended questions ("Please tell me what I can do for you today.") rather than closed-ended questions ("Are you feeling better today?") An open-ended question has to be answered in sentences. A closed-ended question can be answered with just one word.

Step 3. TELL

Provide clear and correct information on the issues under discussion.

Step 4. HELP

Help the client choose an appropriate action.

After receiving the information in Step 3, the client is equipped to make an informed decision. Your job is to ensure that the client feels free to ask as many questions as necessary to understand the issues.

Once the client has cleared up any concerns, support him or her to choose a viable course of action with minimal consequences.

Step 5. EXPLAIN

At this point, you should take time to explain what the service chosen by the client entails. For example, if the choice is a VMMC, give the client detailed information about it.

Step 6. REASSURE OR RETURN FOR NEXT VISIT

Always reassure your client that the conversation you have just had will stay private and confidential.

Always schedule for a return visit, if possible.

Record information in the client's file register or book, if one is available.

Thank the client politely, say goodbye, and encourage a follow-up visit.

Counselling requires practice and open-mindedness; your skills will improve with time. Table 2 summarises some key differences between effective and ineffective counselling skills.

TABLE 2. Traits of effective and ineffective counselling

AS AN EFFECTIVE COUNSELLOR, YOU	AS AN INEFFECTIVE COUNSELLOR, YOU
• Exhibit genuineness: are a reliable, factual source of information • Create an atmosphere of privacy, respect, and trust • Communicate effectively: for example, engage in a dialogue or open discussion • Are nonjudgmental: offer choices and do not criticise the client's decisions • Are empathetic • Are comfortable with sexuality • Make the client comfortable and ensure his or her privacy • Talk at a moderate pace and with appropriate volume • Present messages in clear, simple language that the client can understand • Ask questions of the client to make sure that he or she understands the message • Demonstrate patience when the client has difficulty expressing himself or herself, or understanding the message • Identify and remove obstacles • Maintain confidentiality by not sharing client information with others in or out of the clinic without client permission. The exception is cases of abuse; explain this to the client • Provide referrals for relevant client situations	• Interrupt conversations: talk to other people and/or speak on the telephone during a counselling session • Are judgmental: for example, you make decisions for the client • Do not make the client comfortable and ensure his or her privacy: for example, you provide counselling in the presence of other people without the client's consent and break confidentiality • Are a poor nonverbal communicator: for example, you look away and frown • Lack knowledge of reproductive health issues • Are uncomfortable with sexuality • Are difficult to understand: you talk rapidly and at an inappropriate volume or use language that the client cannot understand • Do not ask questions of the client to make sure that he or she understands the message • Do not demonstrate patience when the client has difficulty expressing himself or herself, or understanding the message • Are not empathetic; for example, you are rude and do not try to understand the client's problems or needs • Rush through the counselling session

Law, policies, and procedures regarding young people's access to health services: what should guide us in service provision

- **HIV testing**
  Any person age 13 and above should be considered mature enough to give full and informed consent for HIV testing and counselling (HTC). However, HTC for adolescents under age 13 should be done with the knowledge of their parents or guardians unless this is not possible and the testing is for provision of treatment and care services.

- **Contraceptive provision**
  There is no minimum age for accessing contraceptives. Adolescents and youth can access any contraceptive of their choice at any time.

- **VMMC**
  Adolescents ages 10–17 need the consent of a parent or guardian to undergo VMMC. Any person age 17 and older can make a voluntary choice.

- **Abortion**
  Performing an abortion is illegal and can be performed only to save the life of the mother. This law is in the process of being changed.

- **Postabortion care**
  This is legal and can be offered to all women, whether or not they have had an unsafe abortion.

- **Lesbian, gay, bisexual, and transgender (LGBT) persons**
  LGBT persons have much higher rates of depression and suicide because of the increased violence they have suffered and the rejection that they feel from society. In our respective roles in health, social welfare, and law enforcement, it is our duty to protect all individuals from violence and provide them services when needed. In Malawi, many LGBT persons are discriminated against and sometimes charged under various laws. It is not legal to treat those who are LGBT with violence.

Summary

Effective communication is the number one skill for work with adolescents. All of those who work with young people should practise honest introspection about their attitudes, beliefs, and values so they do not hamper their communication with young people.

As seen in the unit, our customers are key and are kings/queens! Adolescents and young people, like any other client accessing services, should receive respect, privacy, and confidentiality.

When providers do self-evaluations and clarify own values, they stand a far better chance of effectively communicating with young people. When they are challenged by their personal values and beliefs, friends and colleagues are an important resource to help clarify these challenges.

This unit provides information on the following:

1. Definitions of the terms adolescents, young people, and youths
2. Demographic and socioeconomic information on adolescents
3. Priority health problems affecting adolescents in Malawi
4. Why we need to invest in the health and development of adolescents and young people
5. Guiding principles for promoting the health and development of adolescents and young people
6. What healthcare providers need to do when working with and for adolescents

UNIT 2.
ADOLESCENCE AND PUBLIC HEALTH

DEFINITIONS OF THE TERMS ADOLESCENTS, YOUNG PEOPLE, AND YOUTH

a. Adolescents
WHO defines "adolescents" as those ages 10–19. "Adolescence" is a developmental phase rather than a fixed period.

b. Very young adolescents
Those between the ages 10–14 are now being recognised as a specific age group with special programming needs.

c. Young people
Defined as those ages 10–24.

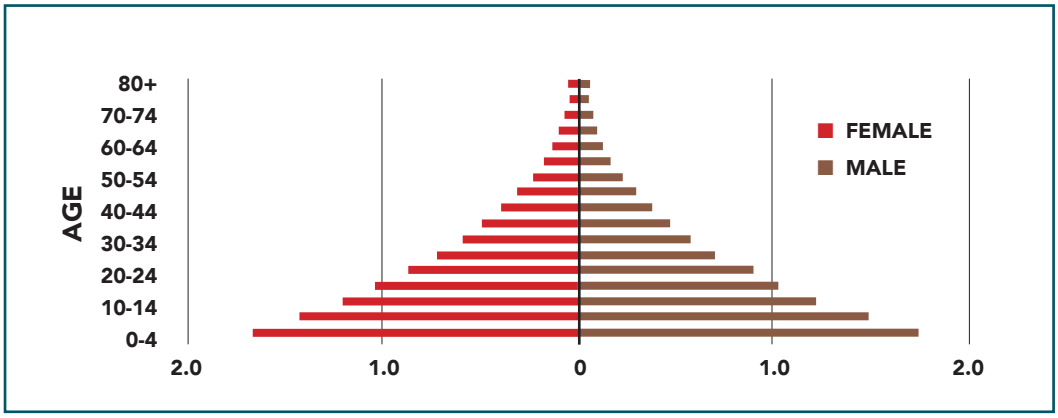
d. Youth
Defined as those ages 15–24.

The Malawi National Youth Policy of 2013 defines young people as boys and girls from ages 10–35, regardless of marital status, economic status, and parity. This training programme focusses on those ages 10–24 (Ministry of Youth and Sports, 2013).

DEMOGRAPHIC AND SOCIOECONOMIC INFORMATION ON YOUNG PEOPLE

According to the 2014 State of the World Population report of the United Nations Population Fund, there were nearly 1.8 billion young people (ages 10–24) in a world with 7.3 billion inhabitants. In Malawi, the total estimated population was 15.8 million, based on 2008 population and housing census report projections. Young people (ages 10–24) accounted for 32 percent of Malawi's total population, and adolescents (ages 10–19) accounted for 24.5 percent as of that year. This means that there are nearly 5 million young people in Malawi in need of YFHS. As Figure 2 shows, the majority of the population is under 65 years of age. This presents a great opportunity for the country's development, especially if these young people stay healthy.

FIGURE 2. Projected Malawi Population in 2020 (in millions)



Literacy and education

Malawi's literacy rate has improved over time and continues to do so. In 2010, 65 percent of people ages 15 years and older were literate. According to Malawi's 2014 endline survey for the Millennium Development Goals (MDGs), literacy among young people (ages 15–24) was at 75.1 percent (72.4% for females and 77.8% for males) (NSO, 2015). This clearly shows a positive trend in educational achievement in the country.

Employment

With few adolescents able to complete secondary school and gain access to tertiary education, formal employment becomes very challenging. This poses one the biggest barriers to access to SRH services by adolescents and young people because decent work and opportunities have been shown to be a key determinant of young people's access to SRH, services, and self-empowerment.

In Malawi today, unemployment among adolescents and young people is a big challenge. A substantial proportion seeks work in the informal sector. More young men (60.3%) than young women (36.5%) reported being engaged in some form of work. The majority (65.8%) work in the agricultural sector, which is seasonal, low-paying, and dangerous. Nearly 40 percent of children and adolescents between ages 5–17 years are child labourers.

Poverty

At least 40 percent of Malawians live at or below the poverty line, with a total annual consumption of K85,852 (US$1 = 714 Malawian Kwacha; 2016). Poverty hits families that have lost one or both parents particularly hard. According to the 2010 Malawi Demographic and Health Survey (MDHS), 18 percent of children and adolescents age 18 or younger are orphans (NSO, 2011). They are likely to live in extreme poverty, making them more vulnerable to such SRH risks as early marriages, unwanted pregnancy, and STIs (including HIV).

PRIORITY HEALTH PROBLEMS AFFECTING ADOLESCENTS IN MALAWI

In Malawi, as adolescents and young people grow up, they face many health challenges that can keep them from developing to their full potential. Acknowledging and understanding how these health challenges affect adolescents and young people is key to managing and preventing them. Box 10 lists these challenges.

BOX 10. Health problems affecting adolescents

Reproductive health problems

- HIV and AIDS (to be discussed in Unit 3G)
- Early and unprotected sex
- Sexually transmitted infections (to be discussed in Unit 3F)
- Cancer of the cervix (to be discussed in Unit 3A)
- Adolescent pregnancy and child marriage
- Violence, sexual abuse, and exploitation (to be discussed in Unit 3E)
- Obstetric fistula
- Unsafe abortion (to be discussed in Unit 3D)

Other health problems

- General health problems (malaria, urinary tract infections, anaemia)
- Other general health problems common in Malawi such as respiratory tract infections (e.g., pneumonia), skin problems, and diarrhoea
- Substance use and abuse (tobacco, alcohol, and other substances; to be discussed in Unit 5)
- Mental health problems (to be discussed in Unit 6)
- Nutritional problems and eating disorders (to be discussed in Unit 4)
- Endemic and chronic diseases
- Harmful traditional cultural practices

Early and unprotected sex

Malawi's Family, Divorce and Marriage Act (2015) says that girls under age 18 may not marry without parental consent. Yet the practice of child marriage continues in the shadows. In Malawi, nearly 2 in 10 adolescents (16%) have already engaged in sex by age 15 (14.7% of girls and 18.2% of boys), hastening the age of marriage. Many lack access to condoms to protect themselves from pregnancy and STIs, including HIV. According to the country's 2014 endline survey for the MDGs, among those ages 15–24, nearly 70 percent of males and 57 percent of females reported using a condom the last time they had sexual intercourse.

Adolescent pregnancy and child marriages

With more girls starting to have sex very early, coupled with low condom use (only 40% of sexually active boys ages 15–19 are using condoms, according to the 2010 MDHS), it is not surprising that the adolescent birth rate is high. One-third (31%) of all women ages 20–24 had experienced childbirth before the age of 18 (early childbearing) (NSO, 2011). Such a trend results in high incidence of early marriage. The 2014 MDG endline survey report showed that half of all currently married women ages 20–49 had married before age 18. In sharp contrast, only 9.1 percent of men ages 20–49 years were married by age 18. These data indicate the greater risk for teenage girls of undesirable SRH outcomes.

As for contraceptive use among adolescent girls, only 30 percent of unmarried sexually active girls and 25 percent of married girls ages 15–19 years were using a modern contraceptive. Thus, it is not surprising that early childbearing is so high.

Obstetric fistula

An obstetric fistula—commonly referred to as a fistula—is a hole between the vagina and rectum or bladder that is caused by prolonged, obstructed labour. The result is often chronic involuntary release of urine, faeces, or both. Obstructed labour—common among young women—is the largest documented cause of fistula, with 75 percent of all women with a fistula reporting obstructed labour.

Traditional cultural practices/harmful cultural practices

A harmful practice is defined as a social, cultural, or religious practice that—because of sex, gender, or marital status—does or is likely to undermine the dignity, health, or liberty of any person or result in physical, sexual, emotional, or psychological harm to any person (Gender Equality Act, 2013).

The Gender Equality Act (2013) prohibits such harmful practices. Some examples are chiharo (widow inheritance), kulowa kufa (widow cleansing), fisi (initiation sex), chimwanamaye (spouse swapping), and bulangete la mfumu (pimping of a young virgin to a visiting traditional leader).

In Malawi, harmful cultural practices are prohibited.

According to the Gender Equality Act (2013), a person who engages in a harmful practice has committed an offence and can be fined K1,000,000 or imprisoned for five years!

Even so, unfavourable traditional cultural practices in Malawi are still widespread in some parts of the country. Worse, some practices related to marriage, rites of passage, and death could predispose adolescents and young people to early sexual debut, unprotected sex, unplanned pregnancy, early marriage, and STIs, including HIV. During these practices, young women or men may be asked to have sex (often without protection) with partners who in most cases are older and whose status regarding HIV and other STIs is unknown.

According to a 2005 study by the Malawi Human Rights Commission (MHRC, 2005), some of these harmful cultural practices are polygamy, chokolo, chitengwa, gwamula, kuchotsa mafuta, kulowa kufa, jando (traditional male circumcision—especially risky if razor blades are shared), kutomera, and kupimbira, among others.

Not all cultural practices are bad. Some can be harnessed to be more protective for adolescents and help them deal with the shocks of puberty and growing up while guarding them from HIV. Examples are jando and chinamwali. The boxes below list some cultural practices (harmful and not) in Malawi, by type.

BOX 11. Cultural practices related to marriage

- Polygamy, chokolo, chimeta masisi, bonus wife, bonus husband, bride price, chitengwa, chikamwini
- Fisi for procreation
- Fisi for initiation
- Kupimbira/kupawira

BOX 12. Cultural practices related to rites of passage

- Chinamwali, including makuna
- Jando
- Nyau/gule wa mkulu
- Female genital mutilation
- Gwamula
- Kuchotsa mafuta

BOX 13. Cultural practices related to funerals and other occasions

- Kulowa kufa
- Kuchotsa/kugoneka mizimu (no sexual intercourse taking place)
- Kuchotsa/kugoneka mizimu (sexual intercourse taking place)
- Kugona msiwa (women only sleep in the funeral vigil room)
- Kugona msiwa (men only sleep in the funeral vigil room)
- Kugona msiwa (both men and women sleep in the funeral vigil room)

BOX 14. Cultural practices related to pregnancy

- Preference for a boy as first-born child
- Preference for a girl as first-born child
- No preference for sex of first-born child

WHY INVEST IN THE HEALTH AND DEVELOPMENT OF ADOLESCENTS AND YOUNG PEOPLE?

BOX 15. Three reasons to invest in adolescent health

1. **Health benefits for the individual adolescent for his or her current and future health and the intergenerational effects**
    - Investing in adolescent health and development will reduce the burden of morbidity and mortality in later life because healthy behaviours and practices adopted during adolescence tend to last a lifetime.
    - Today's adolescents are tomorrow's parents, teachers, and leaders.
    - What they learn today, they will teach to their own and other children tomorrow.
2. **Economic benefits: improved productivity, return on investments, and averted future health costs**
    - Better-prepared and healthy adolescents will result in productivity gains when they enter the workforce.
    - Return on investments made in early childhood health and development will be safeguarded by continuing attention to adolescent health.
3. **As a human right: adolescents (like other age groups) have a right to achieve the highest attainable health**
    - The United Nations Convention on the Rights of the Child, which has been ratified by nearly every government in the world, declares that young people have a right to life, development, and (in Article 24) the "highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health."

GUIDING PRINCIPLES FOR PROMOTING AND PROTECTING THE HEALTH AND DEVELOPMENT OF ADOLESCENTS AND YOUNG PEOPLE

Some guiding principles have been developed to help providers and other stakeholders working with adolescents and young people. Malawi's health programming for adolescents and young people has two main goals:

1. Promote healthy development in adolescents
2. Prevent and respond to health problems if and when they arise

To meet these goals, the following broad interventions have been proposed:

- The creation of a safe and supportive environment
- The provision of information
- The building of life skills
- The provision of health and counselling services
- The designation of both specific settings wherein these interventions can be delivered and the players who could deliver them (both adults and adolescents)

The framework of the national healthcare delivery system is comprehensive, and there are many challenges in translating this broad vision into reality. The framework lists key challenges: building political commitment, identifying priorities for action, sustaining the implementation of programmes, and monitoring and evaluating them. Based on experiences around the world, it outlines the guiding concepts (Box 16) that should underpin our work with adolescents, as well as keys to success.

BOX 16. Guiding concepts for planning for adolescent health and development

Adolescence is a time of risk and opportunity.

- Adolescence is not only a time of risk but is also a time for an individual to grow and develop (physically, psychologically, and socially) to his or her full potential in preparation for adulthood.

Not all adolescents are equally vulnerable.

- Adolescents are not a homogeneous group. Their needs for health information and services depend on their age, stage of development, and circumstances. Because of their circumstances, some adolescents tend to be more vulnerable than others to health and social problems.

Adolescent development underlies the prevention of health problems.

- The prevention of health problems (and problem behaviours) is even more important; this can be accomplished through actions to enhance protective factors (such as positive relationships with parents and teachers, and a positive school environment) and reduce the risk factors (such as early initiation of unprotected sex and the use of tobacco, alcohol, and other drugs).

Health problems have common roots and are interrelated.

- Research shows that the health problems of adolescents are interrelated because the underlying behavioural causes of many of these problems are the same.

The social environment influences adolescent behaviour.

- A safe (free from danger of disease and injury) and supportive (nurturing) environment is critical for an individual to develop to his or her full potential, and to be healthy.

Gender considerations are fundamental.

- It is important to have a good understanding of the biological differences in the growth and development of males and females (through the years of adolescence) and the different ways in which they are affected by health problems. Equally important is a good understanding of the different social and cultural influences on males and females, and how they affect the way in which adolescent males and females view themselves and relate to others.

WHAT HEALTHCARE PROVIDERS NEED TO DO WHEN WORKING WITH AND FOR ADOLESCENTS

A fundamental principle in serving adolescents is "putting them at the centre"—making their needs and problems, thoughts and feelings, and viewpoints and perspectives central to your work with them. Some key issues are listed in Box 17.

BOX 17. Putting adolescents and young people at the centre

1. Regarding the adolescent as an individual, not just a case of this or that problem
2. Striving to understand the specific needs of each individual adolescent
3. Acknowledging—and heeding—the viewpoints and perspectives of the adolescent in line with his or her evolving capacity
4. Taking into primary consideration the best interests of the adolescent when making decisions or taking actions that affect him or her
5. Respecting the rights of the adolescent (as laid out in the United Nations Convention on the Rights of the Child) while at the same time taking into account the rights and responsibilities of parents
6. Striving to prevent personal beliefs, attitudes, preferences, and biases from influencing one's professional assessment and actions

One approach health workers can use to understand adolescents is summarised in Box 18. It consists of a checklist of questions to carry out a rapid assessment so as to provide information on the psychological and social dimensions of an adolescent's life. It can be used in combination with a medical history.

BOX 18. HEADSS

Areas addressed by the HEADSS approach to assess the psychological and social circumstances of adolescent clients

H – Home

E – Education and employment; eating and exercise

A – Activities and peer relationships

D – Drug use, including cigarettes and alcohol

S – Sexuality

S – Suicide and depression (including mood and possible psychiatric symptoms)

SOURCE: Government of Western Australia Department of Health, Adolescent Health Services. Available at: http://www.pmh.health.wa.gov.au/general/CACH/docs/manual/4%20School%20Aged%20Children/4.5/4.5.3/4.5.3.3%20HEADSS%20Adolescent%20Psychosocial%20Risk%20Assessment.pdf.

BOX 19. Important to note!

Because many of the factors that affect adolescent health and development are interrelated, they cannot be completely addressed by the health sector alone. Healthcare providers should work with other sectors—educational, religious, and social—to address collectively the health issues of adolescents. Health staff can also become more aware of the roles and responsibilities of the other sectors, and be well-informed about the services available to adolescents outside of the health sector. As you will see in the later units, healthcare providers can do many things within the health sector to make their services more youth friendly.

Summary

Adolescence in Malawi has its challenges—some specific to SRH and some more general. Young people often do not understand how these challenges may affect their lives in the future, let alone how to prevent them. Most of the challenges adolescents meet truly are preventable, but adolescents need someone knowledgeable to reach out to them.

A wise government would, as much as possible, invest in adolescent growth and development to capitalise on the demographic dividend: that is, the accelerated economic growth that may result from a decline in a country's mortality and fertility, a change in the age structure of the population (increased number of working-age adults), and the increased ratio between a productive labour force and nonproductive dependents. Investing in adolescents not only has health and economic benefits; it is also a human rights issue.

In creating programs to support adolescents, service providers need to understand that a myriad of issues affects their clients' well-being. Thus, a multidisciplinary approach is needed. The HEADSS model is a valuable tool in achieving a comprehensive assessment of adolescent clients that will help providers understand them better.

This unit provides information on the following:

1. Definitions of sexual and reproductive health
2. Anatomy and physiology of the male and female reproductive organs
3. Puberty
4. Initiation of sexual relations in young people
5. How adolescents and young people express sexual feelings
6. Protective and risk factors influencing young people's sexual behaviour
7. Consequences of unprotected sexual relations
8. Cervical cancer
9. Promoting the sexual and reproductive health of young people
10. What healthcare providers can do to improve adolescents' access to sexual and reproductive health information and services

At the end of this unit, see also Annex 1: Case Studies.

UNIT 3A.
INTRODUCTION TO SEXUAL AND REPRODUCTIVE HEALTH AND YOUNG PEOPLE

DEFINITIONS OF SEXUAL AND REPRODUCTIVE HEALTH

Sexual health

The term "sexual health" describes the absence of illness and injury associated with sexual behaviour and a sense of sexual well-being. It has been defined as "… the positive integration of physical, emotional, intellectual and social aspects of sexuality. Sexuality influences thoughts, feelings, interactions and actions among individuals, and motivates people to find love, contact, warmth and intimacy. It can be expressed in many different ways and is closely linked to the environment in which people live (WHO, n.d.)."

Reproductive health

WHO defines reproductive health as "… a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide when and how often to do so. Implicit in this last condition are the rights of men and women on issues of sexual and reproductive health (WHO, n.d.)."

Sexual and reproductive health and rights (SRHR)

SRHR entails the rights of all individuals to make decisions concerning their sexual activity and reproduction free from discrimination, coercion, and violence. On issues of access to SRHR, therefore, individuals are able to choose whether, when, and with whom to engage in sexual activity, to choose whether and when to have children, and to access the information and means to make these choices.

Box 20. Sexual and reproductive health rights

- Right to seek, receive, and impart information related to sexuality
- Right to receive sexuality education
- Right to have respect for bodily integrity
- Right to choose your partner
- Right to decide to be sexually active or not
- Right to have consensual sexual relations
- Right to have consensual marriage
- Right to decide whether or not and when to have children
- Right to pursue a satisfying, safe, and pleasurable sexual life

ANATOMY AND PHYSIOLOGY OF THE MALE AND FEMALE REPRODUCTIVE ORGANS

As children grow up and reach puberty, several changes take place in their bodies. Most of the time, they do not know when to expect these changes or how they come about. To understand changes in their bodies, adolescents must understand the male and female reproductive systems and how they work.

- **The male reproductive organs and their functions**

  In sperm production, sperm cells usually mature when a boy reaches the ages of 15 or 16. However, sperm production and ejaculation happen around ages 12–14. During this period, boys often experience "wet dreams" (ejaculation at night). Having wet dreams is normal; so is not having them. Sperm can live inside a woman's body (uterus) for 72 hours (three days) from the time of ejaculation.

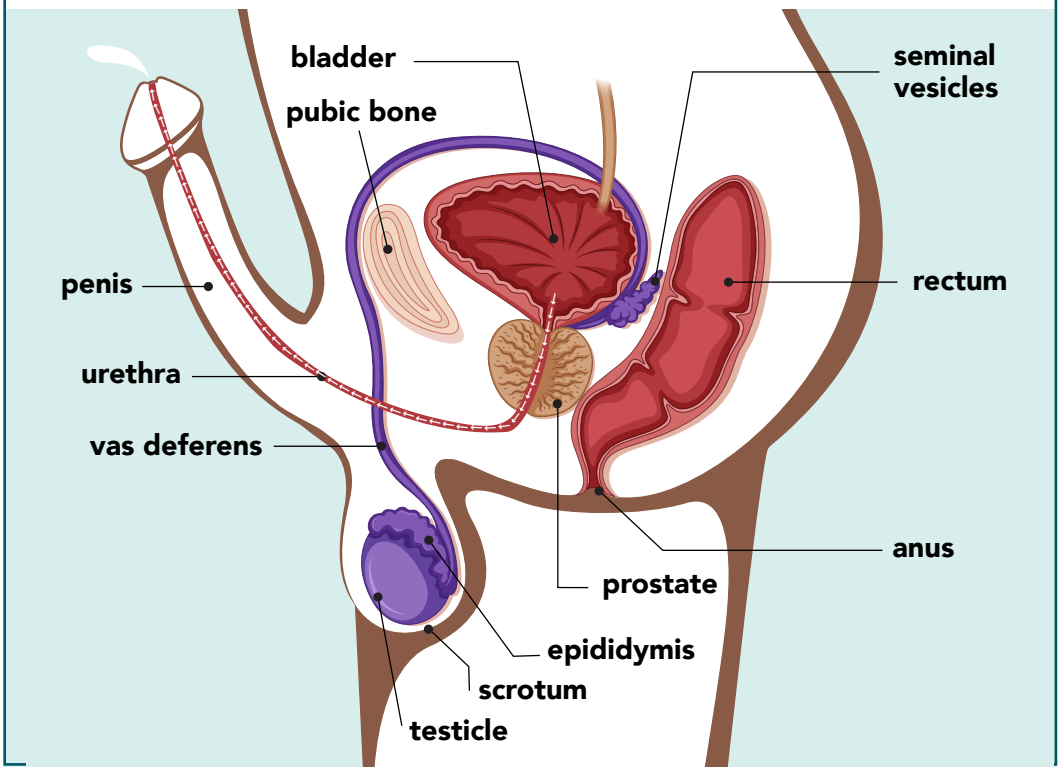
BOX 21. Sperm production

Testicles: produce sperm cells

Epididymis: where sperm cells mature (become capable of fertilising an egg)

Vas deferens: sperm travel through this tube to the penis, mixing with seminal fluid to make semen

Penis: where sperm are ejaculated from the body



- **The female reproductive organs and their functions**

  In girls, the menstrual cycle can begin as early as age 8 and as late as age 16. In each menstrual cycle, eggs can live 12–24 hours from the time of ovulation. Normally, only one egg is fertilised (resulting in pregnancy); if multiple eggs are fertilised, a girl or woman can become pregnant with multiple foetuses. During menstruation, most girls will have abdominal cramps that can be alleviated by taking analgesics (pain killers). Girls bleed during menstruation, so good hygiene is very important.

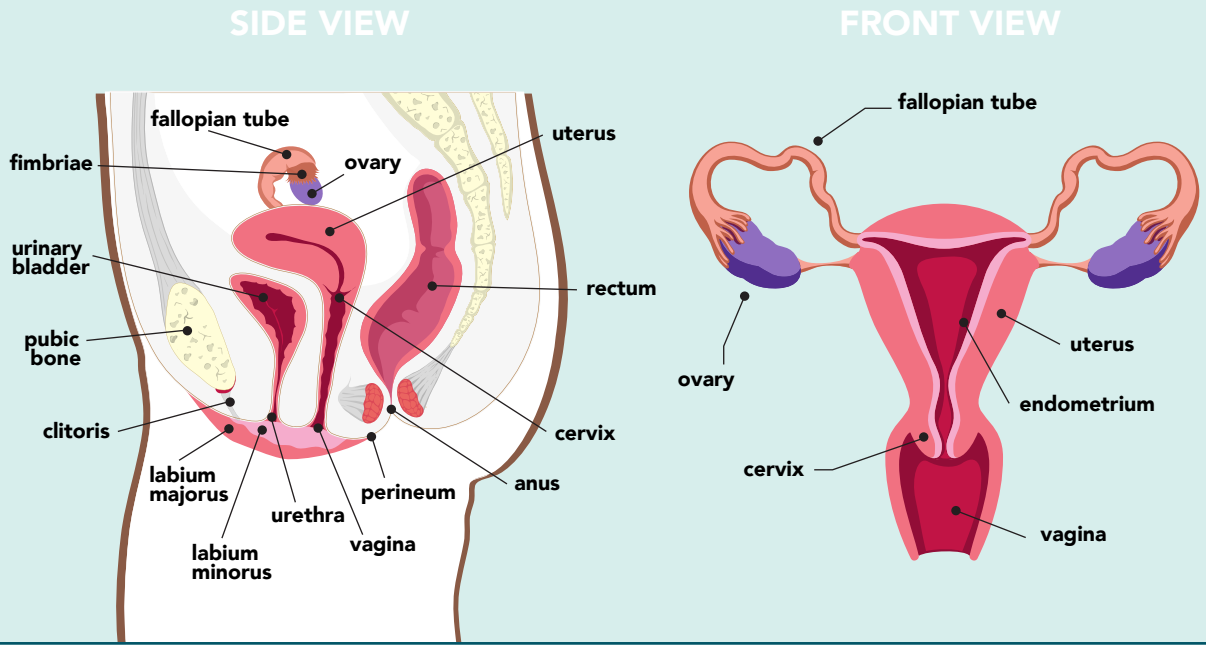
Box 22. Female reproductive organs

Ovaries: where ova are produced and released approximately every 28 days

Fallopian tube: ova travel through here; fertilization by a sperm cell typically occurs here

Endometrium: where a fertilized ova attaches; when fertilization does not occur, it sheds through a process known as menstruation

Uterus: holds the developing foetus



What are the implications of menstruation and sperm maturation?

- Menstruation and sperm maturation mean that a female can produce a baby if she has penile/vaginal sexual intercourse with a male.
- Because ovulation occurs before bleeding, a girl can get pregnant before her first period (menstruation).

BOX 23. What occurs during fertilisation, conception, and implantation?

1. During intercourse between a male and a female, the penis enters the vagina.
2. After ejaculation, the sperm travels up the vaginal canal towards the uterus.
3. The sperm meets the egg in the outer portion of the fallopian tubes.
4. The fertilised egg travels down the fallopian tube into the uterus.
5. The fertilised egg attaches itself to the lining of the uterus.
6. The fertilised egg uses the lining of the uterus for nourishment.
7. The fertilised egg takes nine months to grow completely into a full-term baby.

BOX 24. Personal hygiene

Frequent bathing

- Cleansing the body and genital area reduces odour. This is recommended for both boys and girls at least twice a day if possible, and especially for girls during menstruation.
- Bathing regularly and wearing clean clothes keeps a person smelling clean and fresh.
- Using deodorant (locally available deodorants like bicarbonate of soda can also be used) is advised.
- Keeping the skin clean and free of excess oil is the best way to prevent acne.
- Washing the skin two or three times a day with regular soap may be enough for some adolescents, whereas others need to use a special soap with ingredients that kill bacteria.

Avoiding vaginal infections

- Avoid sharing clothing that has been exposed to a vaginal infection and poor personal hygiene, as this may spread vaginal infections.
- Some vaginal infections, such as yeast infections, are common among adolescent girls.
- Keep the vulva clean and dry by bathing frequently and wearing cotton underwear.
- Wipe from front to back after using the toilet to keep bacteria from faeces away from the vaginal opening.
- Avoid tight-fitting clothing, such as nylon underwear or tight jeans, especially in warm climates.
- Avoid using irritating chemicals, such as commercial douches, bubble baths, hygiene sprays, and deodorised tampons.

PUBERTY

- Puberty refers to the physiological changes that occur in early adolescence (sometimes beginning in late childhood), which result in the development of sexual and reproductive capacity.
- Physical growth and development are manifest in a growth spurt, during which there are marked changes in the size and shape of the body.
- Differences between boys and girls are accentuated. For instance, girls experience breast development and hip enlargement, whereas boys develop "man-like" musculature.
- These changes are accompanied by others, such as the appearance of axillary and pubic hair in both boys and girls, changes in the pitch of the voice, and the appearance of facial hair in boys.
- There is rapid maturation of the sexual organs. The onset of menstruation and the initiation of sperm production are important milestones at this time (discussed in the next section).

THE NATURE AND SEQUENCE OF CHANGES INTO ADULTHOOD

Table 3 shows the growth and developmental stages adolescents go through as they transition into adulthood.

TABLE 3. Adolescent and young adult growth and developmental stages

CHARACTERISTIC	AGES 10–13	AGES 14–16	AGES 17–19	AGES 20–24
Independence	Challenges authority (parents, teachers); rejects childhood; desires privacy	Moves away from parents and towards peers; begins to develop own values	Begins work/higher education; enters adulthood and possibly marriage, and reintegrates with family	Completely independent, possibly with dependents (spouse, children)
Cognitive development	Finds abstract thought difficult; seeks decision-making authority; has mood swings	Starts developing capacity for abstract thought; responds to consequences of behaviour	Establishes abstract thought; improves problem solving; can better resolve conflict	Can solve problems, resolve conflict, and make rational decisions
Peer group	Has intense friendships with members of the same sex	Forms strong peer bonds and explores ability to attract partners; peers influence behaviour	Less influenced by peers in making decisions; relates to individuals more than peers	Can balance the needs of self and others on the basis of healthy interaction
Body image	Is preoccupied with physical changes; critical of appearance; anxious about puberty (start of body changes)	More interested in looking attractive	Usually comfortable with body image and accepts personal appearance	Has reached sexual and physical maturity
Sexuality	Begins to feel attraction to others; may masturbate/ experiment with sex; females may have started menstruation	Shows increased sexual interest; may struggle with sexual identity; some will initiate sex; boys may have wet dreams; girls have started menstruation	Begins to develop serious intimate relationships that replace group relationships	Is ready to enter a committed relationship or is already in one

Adapted from the PSI 2009 YFHS Training Manual.

INITIATION OF SEXUAL RELATIONS BY YOUNG PEOPLE

Age at first sexual intercourse in Malawi

- Among those ages 20–49, the median age at first sexual intercourse is reported to be age 17.3 for women and age 18.5 for men.
- Among those ages 15–24, young women are more likely to start sex earlier (age 17.3) than young men (age 18.5).

BOX 25. Initiation of sex by females early in their lives could be due to a number of factors, such as the following:

- Traditional and cultural practices of sexual initiation that girls in some circles are encouraged to try
- Other traditional practices, such as kupimbira, in which sex with a young girl is offered to cancel a debt
- Poor socioeconomic status, forcing girls to marry while young in exchange for support in the parents' home
- Coerced sex

How adolescents and young people can express sexual feelings safely

There are many other ways of expressing sexual feelings that do not involve penetration (vaginal, anal, and oral sex) and are safe regarding preventing pregnancy and infection from HIV and other STIs. Examples of these behaviours are the following:

- Holding hands
- Hugging
- Kissing
- Rubbing bodies
- Masturbation
- Mutual masturbation

Protective and risk factors influencing young people's sexual behaviour

A range of factors influence aspects of young people's sexual behaviour (such as the initiation of sex, the type and number of sexual partners, and the use of any form of contraception).

BOX 26. Risk and protective factors for early sexual initiation

- **Friends who are sexually active.** Adolescents who believe their friends are sexually active are more likely to start sexual intercourse early.
- **Engaging in other risky behaviours.** Adolescents who engage in other risk behaviours, such as using alcohol and drugs, are more likely to start sexual intercourse early.
- **A positive relationship with parents.** Adolescents who have a positive relationship with their parents are less likely to start sexual intercourse early.
- **A positive relationship with teachers.** Adolescents who have a positive relationship with teachers are less likely to start sexual intercourse early.
- **Having spiritual beliefs.** Adolescents who have spiritual beliefs are less likely to start sexual intercourse early.
- **SRHR information.** Receiving this information early helps delay sexual initiation.
- **A life plan.** Having a life plan helps prevent risky behaviours, including early or unprotected intercourse.

Consequences of unprotected sexual relations

BOX 27. Direct consequences of unprotected sex

- Unplanned pregnancy
- HIV infection
- Other STIs
- Cervical cancer

CERVICAL CANCER AND HUMAN PAPILLOMA VIRUS

Definition

Cancer of the cervix is caused by HPV, which is the most common viral infection of the reproductive tract and is transmitted sexually. The peak time for infection is shortly after becoming sexually active; the first sexual contact is often deemed the first point of exposure to HPV.

Scope of the problem in Malawi

- Recent evidence suggests an increasing number of new cases of cervical cancer in Malawi.

- Cervical cancer is the third most common form of cancer.
- It is the most common form of cancer among women, accounting for 30 percent to 45 percent of their cancer burden.
- According to the results of a survey, every year Malawi experiences about 2,300 cervical cancer cases, and more than 1,600 women die of cervical cancer (Msayamboza et al., 2016).

BOX 28. Risk factors for cervical cancer

Sexual intercourse is the most common risk factor for transmission of HPV. Persistent HPV infections can lead to precancerous lesions of the cervix and cervical cancer. Other risk factors are the following:

- Early sexual debut
- Multiple sexual partners
- Suppression of the immune system (for this reason, HIV-positive women have a greater risk of HPV infection and development of cervical cancer)
- Smoking
- Unhygienic practices of sexual partners (e.g., not cleaning the glans of the penis)

Signs and symptoms of cervical cancer

Usually appearing in later stages of the disease, some examples of the signs and symptoms of cervical cancer are the following:

- Irregular menstruation
- Abnormal vaginal bleeding after sexual intercourse
- Pain in the pelvis, back, or leg
- Fatigue, weight loss, loss of appetite
- Vaginal discomfort or odorous discharge

As the disease progresses, more severe symptoms may arise.

Interventions addressing cancer of the cervix

Interventions at primary, secondary, and tertiary levels of prevention exist to control cervical cancer, as follows:

- HPV vaccine
- Cervical cancer screening programs
- Early treatment programs

HPV vaccine. This vaccine protects against about 95 percent of HPV infections. The vaccine is given to girls ages 9–13. At this age, the majority of girls have not yet had sexual contact and thus have not been exposed to HPV, which can compromise the vaccine's effectiveness. Two vaccines are available; both require administering three doses over a period of six months.

Cervical cancer screening programs. These programs have the following components:

- Identification of abnormalities of the cervix in an asymptomatic population (those with no signs and symptoms of cervical cancer)—especially women (the priority being between ages 30–49), who should undergo cervical cancer screening at least once every five years.
- Three tests are used in screening programs.
- Information, education, and communication (IEC) on screening and treatment programs also prioritise women living with HIV.

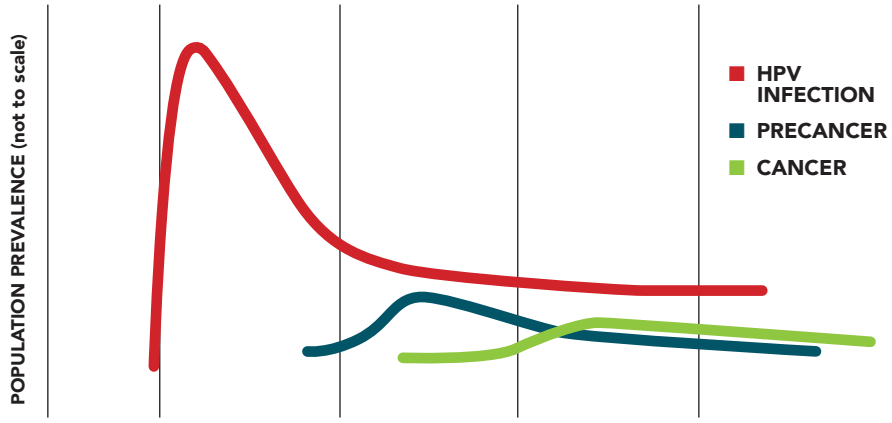
In Malawi, testing services are available in some health facilities. Eligible groups of young women should be provided with information and support to access these services.

Treatment of cervical cancer

- Like other cancers, cervical cancer in advanced stages is incurable but can be treated.
- Cryotherapy, surgery, chemotherapy, and radiotherapy are the common treatment options available.

Figure 3 shows the prevalence of cervical cancer by age. The figure shows that the risk of HPV infection is greatest during adolescence (around age 15) and decreases as one gets older. This figure points to the need for a more robust prevention program among girls ages 9–13.

FIGURE 3. Cervical cancer prevalence, by age



PRIMARY PREVENTION
Girls 9-13 years
- HPV vaccination

Girls and boys, as appropriate
- Health information and warnings about tobacco use
- Sexuality education tailored to age and culture
- Condom promotion/ provision for those engaged in sexual activity
- Male circumcision

SECONDARY PREVENTION
Women > 30 years of age

Screening and treatment as needed
- "Screen and test" with low cost technology VIA followed by cryotherapy
- HPV testing for high risk HPV types (e.g., types 16, 18 and others)

TERTIARY PREVENTION
All women as needed

Treatment of invasive cancer at any age
- Ablative surgery
- Radiotherapy
- Chemotherapy

PROMOTING THE SEXUAL AND REPRODUCTIVE HEALTH OF YOUNG PEOPLE

The common agenda for action in adolescent health and development of the United Nations Population Fund, the United Nations Children's Fund, and WHO calls for the implementation of a package of responses tailored to meet the special needs and problems of adolescents. It calls for the provision of information, skills, counselling, and health services, and the creation of a safe and supportive environment, based on the following precepts:

- Information helps adolescents understand how their bodies work and what the consequences of their actions are likely to be. It dispels myths and corrects inaccuracies.
- Adolescents need social skills that will enable them to say no to sex with confidence and negotiate safer sex, if they wish to do so. If they are sexually active, they also need physical skills, such as the ability to use condoms correctly.
- Counselling can help adolescents make informed choices, increasing their self-confidence and helping them feel in more control of their lives.
- Health services can help well adolescents stay well and ill adolescents get back to good health.
- As adolescents undergo physical, psychological, and social changes and development, a safe and supportive environment in their families and communities can enable them to undergo these changes with less risk, more confidence, and the best prospects for a healthy and productive adulthood.

What can healthcare providers do to improve young people's access to sexual and reproductive health information and services?

Adolescents seek clues about sexual life from a variety of sources: parents, siblings, peers, magazines, books, and other mass media. Although they receive a great deal of information from diverse sources, not all of it is correct and complete. Many adolescents lack information concerning the physical changes that occur during adolescence, the implications of those changes, and how to take care of themselves. In many societies, this is because sexuality is a sensitive topic.

As a healthcare provider, you have the following opportunities:

- You can be a valuable source of accurate information and support to the adolescents you serve. You can present them with facts, respond to their questions, and provide reassurance.
- You can work with your colleagues to make your services more sensitive and responsive to the needs of the adolescents you serve. We will discuss this in detail in Unit 7.

- In many societies, parents and other community members believe that the provision of information on sexuality to adolescents does more harm than good. As a healthcare provider, you know this is not true. You can engage parents and communities to make them aware of the value of sharing information on sexuality with young people.
- You can become familiar with life skills education in Malawi's school curriculum, which among other things aims to equip young people with SRH information.

Psychosocial issues pertaining to sex and sexuality for adolescents

Among the many physical changes occurring during adolescence, changes in the reproductive health system are among the most prominent and important. In this transition period, adolescents and young people may have many questions about sex and sexuality. Providing information and psychosocial counselling can help them make informed decisions. The following are examples of the questions young people have:

I am not ready for sex but how do I say "NO"?

A girl and a boy who are dating may have different expectations about engaging in sexual activity. One may want to abstain, whereas the other may want to explore, despite sociocultural expectations of abstinence at this stage. On a date, verbal expressions, body expressions, and how one dresses are forms of language that may be interpreted differently by boys and girls. A boy may misinterpret the way a girl says "no" to mean "yes" instead. The way a person dresses, talks, or expresses herself is never an excuse for rape. Boys should not initiate sexual activity unless the girl has firmly said "yes." Sexual activity must always be mutually consensual, with explicit consent given by both parties.

What if I am being pressured to have sex?

Too many young people fall victim to sexual pressure for fear of being rejected or failing to conform to their peers' expectations. Providers should give young people appropriate information to help them withstand the pressures of having sex when they are not ready. Providing access to life skills education, individualised counselling, and group education for young girls on sex and sexuality are critical components of psychosocial support. Young people need to be told that if they truly love someone, they will respect his or her desire to save sex for later and lovingly choose to embrace that decision. You can say, "Take heart! Many young people choose to save sex for marriage. Be patient! True love will wait."

Is "safe sex" really safe?

Young people receive information from different sources and may be confused about how safe "safe sex" really is. Safe sex generally refers to engaging in sexual activity with significant reduced risk of acquiring STIs, including HIV, and becoming pregnant. The safest way to prevent STIs and unwanted pregnancy is to abstain from sex. Malawi's policy on SRHR promotes young people's access to condoms and other modern contraceptive methods. Appropriate information should be given to them on the effectiveness of these methods so they can make informed decisions. Counselling for psychosocial support is warranted for young people who contract an STI or become pregnant against their wishes owing to condom or contraceptive failure.

Does sexual intercourse hurt the first time?

Having sex for the first time can be painful, especially for girls. As the penis enters the vagina, it can stretch and tear the hymen (the thin layer of skin that partially covers the entrance to the vagina). This may be painful. The tear may bleed again the next few times the girl has sex, but eventually the bleeding stops. The pain can be reduced if the girl is relaxed the next time she has sex. Lubricants can also help to minimise the pain. (Some girls who have never had intercourse lose their hymens during sport or through the use of tampons.)

Is there anything wrong with masturbation?

No. Many young people may engage in masturbation and wonder about it. Does it have any effect on the body, mind, or social relationships? Masturbation is when a girl rubs her clitoris with her own hand until she has an orgasm, or when a boy rubs his penis with his own hand until he ejaculates. Masturbation is perfectly normal and has no negative consequences. It is safe sex.

As a young person, what should I do when I feel sexual desires?

As adolescents transition to adulthood, they often do feel sexual desires. Some distract themselves through physical exercise, studying, helping at home, or participating in youth groups. Others take a cold shower to cool down. Masturbation is also an option; it has no consequences and it is safe.

I think my penis is too small. Should I worry?

Many adolescents and young men have great concern about their penis size and think that it will not satisfy their lover. The average penis size is 10–18 centimetres long (4–7 inches); many are shorter or longer. Young people discuss this concern among themselves but rarely with service providers. As a provider, you can allay fear and anxiety, and reassure your clients. You should also dispel the myth that small penises are infertile.

Can a girl get pregnant if a boy pulls out before ejaculating?

Yes. Even if a boy pulls out of the vagina before ejaculating, the lubricating fluid that leaks before and during sex can contain sperm and make a girl pregnant.

Summary

Growing up is one of the biggest challenges adolescents face. They may not know what to anticipate, and they do not have experience to deal with any shocks that come their way. The shocks of puberty often cause adolescents to doubt whether they are normal or not. Teaching adolescents how they can identify physical changes in their bodies, such as menstruation, wet dreams, and the growth of pubic hair, should allay their anxiety and make them feel comfortable about who they are and how their bodies are changing.

Cervical cancer is a preventable disease, but currently few young people in Malawi know about it or the services available to prevent it. Programs are needed to increase awareness.

ANNEX 1. CASE STUDIES

CASE STUDY 1

Chimwemwe, a 14-year-old girl in Lilongwe, from a rural village in Mchinji, attended a girls' boarding school. Her closest friend Maria was in the same class; they were the two star students. Chimwemwe came from a rural village in Mchinji. Maria was the daughter of a prosperous businessman in Lilongwe. They were both virgins and members of the Student Christian Organisation of Malawi (SCOM). One weekend in their final year in secondary school, they became friends with two boys from the nearby school while attending a student camp. They ended up having sex for the first time. This was one month before the school holidays. The following month they missed their menstrual periods. Could they be pregnant?

Maria's mother, being well to do, took her for an abortion; Maria continued with school.

Chimweme's teachers started suspecting that she might be pregnant. She kept her fear that she was pregnant to herself. She was frequently unwell and moody, and her performance in class deteriorated. The school nurse was summoned to examine her, and the nurse sent her to a clinic. Chimwemwe had to miss class to get to the clinic during working hours. Her pregnancy was confirmed and, according to the school's policy, she was immediately suspended and given a letter to take to her parents. Chimwemwe was devastated. She had no money to go home. Her parents were elders in their church and would be horrified if they knew what had happened.

Terrified, she went to the local clinic to seek help. Being the only young woman in the clinic, she felt self-conscious because all of the adult patients and workers kept staring at her. The health workers said they could not help her. The nurse on duty scolded her for her immoral behaviour and told her that she would not receive any services without her parents' consent. Chimwemwe left school and travelled to Mtandire to see her uncle, a construction worker. When her uncle returned from work in the evening, Chimwemwe feigned sickness and told him that she had been sent away because of school fees. The uncle sympathised with her but could not raise any money. He then sent a letter by post to Chimwemwe's parents, asking them to send the money.

Chimwemwe was now four months pregnant and her condition became more difficult to hide. At six months, her uncle's wife noticed the pregnancy. Her uncle was furious and chased her out of his house. Lonely, with no money and nowhere to go, Chimwemwe accepted accommodation from a young man in the neighbourhood. Two months later, at a nearby health centre, Chimwemwe delivered a boy prematurely. The baby had to be kept in the nursery for two weeks. When Chimwemwe was discharged from the hospital, she found that the young man who had accommodated her had moved. She was now desperate: a 15-year-old with a premature newborn, no money, and homeless. Chimwemwe took refuge in the only place that would accept her. A businesswoman selling gin in a slum employed her to help serve her customers. That became Chimwemwe's life.

CASE STUDY 2

Malita, a 12-year-old girl, lived with two younger brothers and her parents in Blantyre. Hers was a middle-class family, and her parents cared for and loved their children very much. Malita was a happy child. She was a good student and liked by her teachers and her classmates.

One day, when Malita was in class, she noticed that her underpants were wet and she was uncomfortable. When she looked down at her dress, she saw that it was splotched with blood. The girl sitting beside her noticed this, too, and told the teacher about it. The teacher stopped the lesson, took Malita to the staff room, and asked her to use the toilet to clean herself and apply a pad. Malita was bewildered and shocked.

Her teacher explained the situation to the other teachers who were present, told her to sit in a corner of the staff room, and went back to her class. None of the other teachers took any notice of her. Malita sat in silence for two hours till the school day came to an end. She did not know what was happening to her, and prayed hard that there was nothing seriously wrong with her. After all the teachers had left, she tiptoed outside to check if the coast was clear, went to her classroom, took her things, and walked home, covering her soiled dress.

When she reached home, she burst into tears and told her mother what had happened. Her mother signalled her to be silent, shooed Malita's brothers out of the room, and took her to the bathroom. Her mother told her that this was a sign that Malita was no longer a girl. Her mother told her what to do and said that the bleeding would last for a few days. She also told her that this would happen every month for the rest of her life. Malita went to bed with her mind in a whirl. She had many, many questions and decided to speak to Ulemu, a girl in a senior class whom she knew.

This unit provides information on the following:

1. Contraceptive use among adolescents and young people
2. Definition of contraceptives
3. Barriers to contraceptive use among adolescents
4. Providing adolescents with contraceptive information and services
5. Counselling for informed choice of a contraceptive method

At the end of this unit, see also Annex 1: Role Plays.

UNIT 3B.
PREGNANCY PREVENTION AND FERTILITY REGULATION IN YOUNG PEOPLE

CONTRACEPTIVE USE AMONG ADOLESCENTS AND YOUNG PEOPLE

Definition of Contraceptives

Refers to artificial methods used to prevent pregnancy by interfering with the normal process of ovulation, fertilisation, and implantation

As Table 4 shows, contraceptive use by young people is low, especially in the younger age ranges.

TABLE 4. Contraceptive use among adolescents and young people

AGE RANGE	MODERN CONTRACEPTIVE PREVALENCE RATE	USE OF CONDOMS AT LAST SEX
	Females	Males
15–19	9.0	14.2
20–24	33.1	29.7
Currently married		
15–19	26.4	9.9
20–24	38.0	29.9
Sexually active, unmarried		
15–19	30.0	41.8
20–24	50.7	61.3

Barriers to contraceptive use among adolescents

Adolescents often find it difficult to obtain the contraceptives they need. In Malawi, adolescents and young people are unable to use contraceptives for the following reasons:

- Unfavourable provider attitudes
  - Poor communication skills and inability to understand young people's needs
  - Provision of unsolicited advice
  - Refusal to provide long-acting reversible contraceptives
- Adolescents' fear of being labelled promiscuous
- HIV testing requirements before accessing other services
- Adolescents' lack of knowledge of family planning service sources
- Adolescents' misinformation on how to prevent pregnancy
- Adolescents' discouragement from community leaders
- Adolescents' shyness and embarrassment
- Adolescents' fear about getting contraception
- Cost of accessing the services (long distance to facilities; some facilities charge for services)
- Perceived restrictive policies (adolescents and young people under age 18 are often asked to seek parental consent, especially for long-acting methods)
- Stockouts of family planning commodities in most institutions

MINIMUM AGE FOR CONTRACEPTIVE USE IN MALAWI

Service guidelines allow for youths age 16 and up to access contraception without parental consent. However, the SRHR policy stipulates that ALL sexually active persons, including youths, can access any method of their choice.

Providing adolescents with contraceptive services

Some adolescents may have temporary sexual relationships and multiple partners, which puts them at a high risk of acquiring HIV and other STIs. Sexually active adolescents need to be aware of the importance of protection against both pregnancy and STIs, including HIV. In Malawi, there is no law or policy that bars adolescents and young people from accessing any type of contraceptive of their choice. Thus, it is wrong for providers to refuse to provide any contraceptive method based on their personal values or beliefs.

Table 5 lists contraceptive methods available in Malawi that adolescents and young people can use if they wish. Sterilisation is not recommended for young people.

TABLE 5. Available contraceptive methods for young people

METHOD	EFFECTIVENESS AGAINST PREGNANCY		PROTECTION AGAINST STIS/HIV	COMMENTS AND CONSIDERATIONS
	As Commonly Used	Used Correctly and Consistently		
Abstinence and non-penetrative sex	Not effective	Very effective	Protective against HIV and other STIs	Most effective method for dual protection; only provides dual protection when used correctly and consistently
Male condom	Somewhat effective	Effective	Protective against HIV and other STIs	Only provides dual protection when used correctly and consistently
Female condom	Somewhat effective	Effective	Protective against HIV and other STIs	Only provides dual protection when used correctly and consistently
Combined oral contraceptives (COCs)	Effective	Very effective	Not protective	Only protective against pregnancy when used correctly and consistently; if at risk of STIs/HIV, recommend switching to condoms or using condoms along with this method
Progestin-only pills (POPs)	Very effective (during breastfeeding)	Very effective (during breastfeeding)	Not protective	Only protective against pregnancy when used correctly and consistently; if at risk of STIs/HIV, recommend switching to condoms or using condoms along with this method
Long-acting hormonals: injectables or implants	Very effective		Not protective	If at risk of STIs/HIV, recommend switching to condoms or using condoms along with this method
Copper intrauterine device (IUD)	Very effective		Not protective; insertion of an IUD in a woman with an STI increases the risk of pelvic inflammatory disease	Use of IUDs among women at risk of STIs/HIV is generally not recommended (unless other, more appropriate methods are not available) If an IUD user becomes at risk of STI, treatment of STI is possible without removing it; however, in some cases, recommend switching to condoms or using condoms along with this method
Fertility awareness-based methods	Somewhat effective	Effective	Not protective	Only protective against pregnancy when used correctly and consistently; if at risk of STI/HIV, recommend switching to condoms or using condoms along with this method
Lactational amenorrhoea (LAM) during first 6 months postpartum	Effective	Very effective	Not protective	
Withdrawal	Not effective	Low effectiveness	Not protective	Not ideal method but can be used with fertility awareness-based methods for pregnancy prevention if other methods are not feasible

Medical eligibility for available contraceptive methods

A brief review of method-specific medical, service delivery, and counselling considerations for adolescents is provided in Table 6. This table covers issues that are most important when providing contraceptive methods to adolescents.

TABLE 6. Medical, service delivery, and counselling considerations for adolescents

METHOD	DUAL PROTECTION	AGE RESTRICTION	AVAILABILITY/ ACCESSIBILITY	SIDE EFFECTS	OTHER IMPORTANT COUNSELLING POINTS FOR ADOLESCENTS	COMMENTS/ CONSIDERATIONS
Abstinence and non-penetrative sex	Yes	No age restriction	None	None	• Can be used even by those who have already begun sexual activity • To prevent pregnancy, avoid vaginal intercourse • To prevent STIs/HIV, also avoid anal and oral sex • Examples of sexual activity: hand holding, hugging, massaging, kissing, mutual masturbation • Emphasise need to use condom or other method if penetrative sex is initiated	• Most effective method for dual protection • Requires high level of motivation and self-control • Counselling can help with issues of motivation and peer pressure
Male condom	Yes	No age restriction	Easily available in most places	Usually no side effects (local irritation possible)	• Explain and demonstrate correct use • Requires partner communication/negotiation • Requires supplies at home (fear of discovery may be an issue)	Important method because it provides dual protection
Female condom	Yes (data limited)	No age restriction	• Availability limited in many places • High cost may be a constraint	Usually no side effects (local irritation possible)	• Explain and demonstrate correct use • Use can be controlled by woman • Requires supplies at home (fear of discovery may be an issue)	Important method because it provides dual protection
Low-dose COCs	No	No age restriction	• Requires clinic visit in many places • May be available through community-based distribution agents (CBDAs)	May include nausea and headache	• Explain and demonstrate correct use • Recommend also using condom if at risk of HIV and other STIs • Requires daily regimen • Requires supplies at home (fear of discovery may be an issue)	A widely used method among adolescents, although correct and consistent use may be an issue
POPs	No	No age restriction	• Requires clinic visit in many places • May be available through CBDA	Fewer side effects than COCs or long-acting hormonals (injectables and implants)	• Explain and demonstrate correct use • Recommend also using condom if at risk of HIV and other STIs • Requires strict daily regimen • Requires supplies at home (fear of discovery may be an issue)	• Stricter regimen than COCs • Good option for breastfeeding women after first 6 weeks postpartum

TABLE 6. Medical, service delivery, and counselling considerations for adolescents *(continued)*

METHOD	DUAL PROTECTION	AGE RESTRICTION	AVAILABILITY/ ACCESSIBILITY	SIDE EFFECTS	OTHER IMPORTANT COUNSELLING POINTS FOR ADOLESCENTS	COMMENTS/ CONSIDERATIONS
Emergency contraceptive pills (POPs or COCs)	No	No age restriction	Requires clinic visit in many places	May include nausea vomiting (much less likely with POP regimen)	• Not meant for repeated use • Discuss initiation of a regular method	Important method when intercourse may be unplanned, unprotected
Injectables; depot medroxyprogesterone acetate (DMPA) and norethisterone enanthate (NET-EN)	No	Not first method of choice for those under 18, as there is a theoretical risk of affecting bone development in general	Requires clinic visit every 2 or 3 months	Irregular bleeding, amenorrhoea or weight gain	• Recommend also using condom if at risk of HIV and other STIs • Often delay in returning to fertility • No daily regimen required • No supplies required at home (can be private)	• May be a good method for those desiring hormonal method without a daily regimen • Side effects the main reason for discontinuation and if they occur, method cannot be quickly discontinued
Combined injectables: Cyclofem and Mesigyna	No	No age restriction	Requires clinic visit every month	Nausea or headache	• Recommend also using condom if at risk of HIV and other STIs • No daily regimen required • No supplies required at home (can be private)	May be a good method for those desiring hormonal method without a daily regimen
Copper intrauterine device (IUD)	No	• No age restrictions • Safe for use among sexually active adolescents and young people	Clinic visit required for insertion and removal	Sides effects may include excessive bleeding or pain during menstruation	• Recommend also using condoms if at risk of HIV and other STIs • No delay in return to fertility • No daily regimen required • No supplies needed at home (can be private)	• Not a good choice for those at risk of STIs/HIV (more than one sexual partner or whose partner may have more than one sexual partner) • Nulliparous women may be at slightly at higher risk of expulsion
Fertility awareness-based methods	No	No age restriction	Available at any time to anyone	No side effects	• Explain correct use • Recommend also using condoms if at risk of HIV and other STIs • Requires partner communication	• Important for adolescent to understand her/his fertility • May not be as effective in younger women whose menstrual cycles are irregular • May be difficult to use for couples who have sex infrequently

TABLE 6. Medical, service delivery, and counselling considerations for adolescents *(continued)*

METHOD	DUAL PROTECTION	AGE RESTRICTION	AVAILABILITY/ ACCESSIBILITY	SIDE EFFECTS	OTHER IMPORTANT COUNSELLING POINTS FOR ADOLESCENTS	COMMENTS/ CONSIDERATIONS
Lactational amenorrhoea (LAM)	No	No age restriction	Can be used during six months postpartum when exclusively breastfeeding and amenorrhoeic	No side effects	• Explain and demonstrate correct use • Recommend also using condoms if at risk of HIV and other STIs	Important option for breastfeeding women
Cycle beads	No	No age restriction	Available at any time	No side effects	Needs comprehensive counselling on how to use them	Important method for those who prefer natural family planning method
Withdrawal	No	No age restriction	Available at any time to anyone	No side effects	• Explain correct use • Requires partner communication/ negotiation	Important method to discuss, as it may be the only method available in some places

Counselling for contraceptive method through informed choice

In helping adolescents and young people choose which contraceptive to use, healthcare providers must provide them with information about the methods available and help them consider their merits and downsides of each. In this way, they will guide their adolescent clients to make well-informed and voluntary choices of the method most suitable to their needs and circumstances (taking eligibility, practicality, and legality into consideration). For details on the generic counselling process, please refer to Unit 1 (the "GATHER" process). The information provided should address the following points:

- Name of the method
- The effectiveness of the method
- Protection against STIs, including HIV
- The common side effects of the method
- The potential health risks and benefits of the method
- Return to fertility after discontinuing use of the method
- Where the method can be obtained and how much it costs

TABLE 7. Special considerations in contraceptive method counselling

MARRIED ADOLESCENTS AND YOUNG PEOPLE	It is important to remember that some adolescents and young people seeking contraception services are married. Their contraceptive needs are similar to those of married adults but they may have other special information needs. In terms of counselling issues, married adolescents may be particularly concerned about their return to fertility after discontinuing use of a method.
UNMARRIED ADOLESCENTS	Unmarried adolescents may be less likely to seek contraceptive services at health facilities because of embarrassment and fears that staff may be hostile or judgmental, or that their parents might learn of their visit. Adolescents need to feel that they are respected, that their needs are taken seriously, and that they have the right to use contraception if they desire.
ADOLESCENTS WHO HAVE BEEN COERCED INTO HAVING SEX	Adolescents who have been subjected to sexual coercion and abuse will require special care and support. Emergency contraception is part of a package of services that should be made available in such circumstances.
ADOLESCENTS LIVING WITH HIV AND AIDS	Adolescents living with HIV have the right to choose the contraceptive of their choice. Most important are the effects that the contraceptive and antiretroviral therapy (ART) may have on each other, and any necessary additional guidance required as a result.

Summary

- Adolescents are entering their reproductive years ill-prepared to protect and safeguard their sexual and reproductive health.
- For all adolescents, and especially those sexually active outside the context of marriage, access to appropriate information and services—and the assurance of confidentiality—are particularly important.
- To help ensure that sexually active adolescents use contraceptives, contraception information and services must be made readily available through a variety of delivery points, including community-based points and outreach services.
- By providing quality services that respect adolescents' rights and respond to their needs, reproductive health programmes will contribute to the overall health and well-being of adolescent clients and their communities.

ANNEX 1. ROLE PLAYS

Role Play 1

You are a nurse-midwife in a district hospital. Along with the other members of your small obstetrics-gynaecology team, you run a daily antenatal outpatient clinic. One Friday morning as you walk into your clinic, you see two teenage girls huddled together in a corner of the waiting room. One of them is obviously crying, and the other appears to be trying to console her. You say to yourself that this is a sight you have seen several times before—maybe yet another unintended, unwanted pregnancy. When it is their turn, your suspicions are proved right. The two young women are ages 15 and 16. They are students at a nearby secondary school. The one in tears tells you that her period is delayed by four weeks, and she suspects that she is pregnant. On gentle questioning, she tells you that she had unprotected intercourse only once with a young man who is her neighbour. You carry out an examination and request a urine test for pregnancy. You ask them to wait for the results. An hour and a half later, the laboratory results come back. The urine test for pregnancy is negative. You call the two women into the room to share the news with them. Both of them start sobbing in relief.

ROLES: Nurse-midwife, two girls ages 15 and 16

Role Play 2

You are a female clinical officer in your mid-40s. You run a clinic in Zingwangwa township that has been well-established over the past 10 years. One evening, your nurse ushers in a young woman you have not seen before. The woman waits until the door is firmly closed and then leans forward to speak to you in a soft voice that is almost a whisper. She says that she is 19 years old, just married, and has moved into the neighbourhood to live with her husband and his extended family. She smiles when you congratulate her and says that she is happy with her husband but is under a lot of pressure from her in-laws to have a baby as soon as possible. She wants to wait for some time, as she also has just started a new job that promises to send her abroad to study. She seeks your advice. Apparently, her husband agrees but feels unable to resist the pressure of his parents.

ROLES: Doctor, 19-year-old young woman

This unit provides information on the following:

1. The scope of adolescent pregnancy and childbirth in Malawi
2. Factors that influence young women's pregnancy
3. Risks associated with pregnancy, childbirth, and the postpartum period in adolescence
4. Care of adolescents during pregnancy, childbirth, and the postnatal period

At the end of this unit, see also Annex 1: Role Plays.

UNIT 3C.
CARE OF ADOLESCENTS DURING PREGNANCY AND CHILDBIRTH

THE SCOPE OF ADOLESCENT PREGNANCY AND CHILDBIRTH IN MALAWI

In Malawi, slightly over one out of every four teenagers (26%) has started childbearing. The adolescent pregnancy rate is higher in rural areas (27%) than urban areas (21%).

The global average rate of births per 1,000 females ages 15–19 years is 65. However, in Malawi, there are more births among adolescents than the global average. Table 8 shows average birth rates in Malawi among adolescents ages 15–19 and youths ages 20–24, with variations between urban and rural areas.

TABLE 8. Rate of births in Malawi per 1,000 females, ages 15–24

15–19 years	152 / 1,000
20–24 years	269 / 1,000
15–19 years: rural	162 / 1,000
15–19 years: urban	109 / 1,000
20–24 years: rural	285 / 1,000
20–24 years: urban	206 / 1,000

SOURCE: 2010 MDHS.

Factors contributing to teenage pregnancy

A range of social, cultural, biological, and service delivery factors contribute to the high levels of adolescent pregnancy and childbirth. These factors are shown in Box 29.

BOX 29. Factors influencing adolescent pregnancy and childbirth

- Early marriage and pressure for adolescent girls to have children.
- Initiation of sexual activity in early adolescence.
- Adults and peers in their social circle often may coerce adolescent girls into having sex. Pregnancies can result from such assaults.
- Low education levels indirectly lead to early marriages.
- Socioeconomic hardships force young girls into sexual exploitation and prostitution.
- Alcohol and substance abuse may be associated with unprotected sexual activity, leading to unwanted pregnancies.
- Poor sexual and reproductive health information and education affect adolescents' decision making.
- Barriers to sexual and reproductive health services hinder the abilities of adolescents to obtain the contraceptive services they need.

Risks associated with pregnancy and childbirth in young people

Pregnancy and childbirth are riskier for the health of the mother and baby in adolescence than in adulthood. This is attributable both to biology and the social environment. A young maternal age combined with low social status and inadequate access to healthcare contribute to the high maternal mortality in adolescents reported in many developing countries. The risks are high in the antenatal period, during labour, and in the postpartum period (Table 9). Babies born to adolescent mothers also have higher risks.

TABLE 9. Pregnancy complications occurring more commonly in adolescents than in adults

ANTENATAL PERIOD	LABOUR AND DELIVERY	POSTPARTUM PERIOD	FOR THE BABY
• Pregnancy-induced hypertension • Anaemia during antenatal period • STIs/HIV • Higher severity of malaria	• Pre-term birth • Obstructed labour	• Anaemia during postpartum period • Pre-eclampsia/ eclampsia • Postpartum depression • Obstetric fistula	• Low birth weight • Perinatal and neonatal mortality • Inadequate childcare and breastfeeding practices • High morbidity and mortality rates

WHY ARE THESE COMPLICATIONS WORSE IN ADOLESCENTS THAN IN ADULTS?

1. Young adolescents are not mature enough for the strain imposed on them by pregnancy.

    - First, in physical terms, their pelvic bones are not fully mature; as a result, cephalo-pelvic disproportion could potentially occur.
    - Second, young adolescents may continue to grow during pregnancy. What this means is that there is a potential for competition between the mother and the foetus for the nutrients required for growth and development.

2. Compared to older women, adolescents and young people are less empowered to make decisions about matters affecting their health (as well as other matters).

    - If married, the husband is likely to be older, better educated, and the principal family wage-earner. In some cultures, the husband's mother and sister(s) are likely to have a greater say in decision making in matters concerning the household than the young wife. If single, the shame of premarital pregnancy may leave her voiceless or even a family outcast. Also, young adolescents may not be psychologically prepared for motherhood. This could result in mental health problems such as depression.

3. Adolescents are more likely to enroll later and to make fewer health facility visits for antenatal care (ANC).

    - The stigma associated with premarital pregnancy makes unmarried adolescents hide their pregnancies as long as they can. On the other hand, married adolescents may not know the value of ANC; even if they do, they may be unable to obtain such care.

4. In many places, adolescents deliver at home.

    - They come to—or are brought to—the hospital only as a last resort, often with serious complications. The factors that contribute to this are as follows:
        - Social and cultural norms may dictate that they deliver at home.
        - They may be afraid of hospitals.
        - They may have heard discouraging stories about mistreatment by hospital staff (and especially labour room staff).
        - They may be unable to bear the hospital charges, or even the cost of private transport to get there.

5. In many places, pregnant adolescents—especially unmarried ones—are treated with scant respect by medical and nursing staff, as well as clerical and other staff.

    - Many healthcare workers are not conversant with the issues and needs of adolescents and young people. As a result, antenatal visits and the delivery experience can be unpleasant for the young person, and also of inadequate technical quality.

Care of adolescents during pregnancy, childbirth, and the postnatal period

EARLY DETECTION OF PREGNANCY

The early detection of pregnancy is an important first step in drawing the adolescent into ANC.

- Healthcare providers and other adults in more regular contact with the adolescent, including family members, are responsible for creating a supportive environment in which she feels able to share information about her situation.
- Healthcare providers need to be aware that a young adolescent may not know she is pregnant. This may be because she may not remember the dates of her last menstrual period or because her periods are not regular.
- If the adolescent is unmarried, she may want to hide her pregnancy or even to terminate it. Being on the lookout for tell-tale signs of early pregnancy (such as nausea) will help ensure that an early detection of pregnancy is made and the adolescent receives the care and support she needs.

ANTENATAL CARE

Repeated contacts with the healthcare system are an opportunity to detect and treat problems that commonly affect pregnant adolescents. It is therefore important for adolescents and youths to be aware of ANC services.

ANC provides a valuable opportunity for the provision of information and counselling support that adolescents and youths need. In Malawi, a focused antenatal care (FANC) approach is used, with at least four antenatal visits recommended for all pregnant women unless the pregnancy has complications. Box 30 describes the FANC approach and FANC services available to adolescents and youths in Malawi.

BOX 30. The focused approach to antenatal care (FANC)

- Identification and surveillance of the pregnant woman and her expected child
- Recognition and management of pregnancy-related complications, particularly pre-eclampsia
- Recognition and treatment of underlying or concurrent illness
- Screening for conditions and diseases such as anaemia, STIs (particularly syphilis), HIV, mental health problems, and/or symptoms of stress or domestic violence
- Preventive measures, including tetanus toxoid immunisation, deworming, iron and folic acid supplements, intermittent preventive treatment of malaria in pregnancy, and insecticide-treated bed nets (ITNs)
- Advice and support to help the woman and her family develop healthy home behaviours, and a birth and emergency preparedness plan to
  - Increase awareness of maternal and newborn health needs and self-care during pregnancy and the postnatal period, including the need for social support during and after pregnancy
  - Promote healthy behaviours in the home, including healthy lifestyles and diet; safety and injury prevention; and support and care in the home, such as advice and adherence support for preventive interventions like iron supplementation, condom use, and use of ITNs
  - Support care-seeking behaviour, including recognition of danger signs for the woman and the newborn as well as transport and funding plans in case of emergencies
  - Help the pregnant woman and her partner prepare emotionally and physically for the birth and care of their baby—particularly preparing for early and exclusive breastfeeding and essential newborn care, and considering the role of a supportive companion at birth
  - Promote postnatal family planning/birth spacing

COUNSELLING DURING PREGNANCY

As indicated previously, healthcare providers should seek to understand the situation of their adolescent patients and provide them with the information and counselling support that meet their needs. In addition, pregnant adolescents may have questions and concerns of their own. They must be given an opportunity to raise and discuss them. Counselling support should cover the following:

- Life situation of the adolescent, including her marital status and socioeconomic situation
- Support available to her from her husband/partner, family members, friends, and others
- Options available to her regarding the pregnancy (e.g., in some places, discreet arrangements are available for handing the child over for adoption soon after birth)
- Support that she needs and the social support services for which she is eligible
- Access to health services for routine ANC and in case of emergency
- Plans for the delivery
- Plans for the care of the baby
- Plans for continuing with her education or work after the delivery
- Good nutrition
- Malaria prevention
- Cessation of any substance use and abuse
- HIV and AIDS

Counselling should also address HTC. In addition to opening the door to ART for PMTCT and preventing or reducing viral multiplication in the mother's body, knowing her HIV status will enable the HIV-positive adolescent to take the necessary steps to prevent transmission to others. For those who test HIV negative, it provides an opportunity to reinforce the message of STI/HIV prevention.

MANAGEMENT OF LABOUR AND DELIVERY

If the pregnancy in an adolescent is uneventful, complications such as anaemia are treated adequately, and labour starts at term, the infant is not at increased risk. However, if the adolescent is severely anaemic, postpartum haemorrhage can be dangerous. In very young adolescents, pre-term and obstructed labour are more likely to occur. Although in general labour is not riskier in adolescents than in adults, some adolescents clearly are at high risk for specific reasons. If the labour is a potentially high-risk one, it is advisable to encourage hospital delivery. In some places, "waiting mothers" shelters have been established to help ensure that women likely to require institutional delivery do not find themselves stranded at home because no one is around to accompany them to the hospital or transportation is not available or affordable.

POSTPARTUM CARE

Postpartum care includes the prevention, early diagnosis, and treatment of postnatal complications in the mother and infant. It also includes the provision of information and counselling on breastfeeding, nutrition, contraception, and care of the baby. The adolescent mother will require support on how to care for herself and her baby. Many adolescents—especially those in difficult social situations—do not receive adequate ANC or the support of their partners and families, so postpartum care is even more important for them.

CONTRACEPTION

Many too-early repeat pregnancies are unplanned—the result of absent or inadequate contraception. The postpartum period presents a good opportunity for taking concrete steps to prevent pregnancy and promote the use of condoms for dual protection from pregnancy and HIV/other STIs.

NUTRITION OF THE MOTHER

The lactating adolescent needs adequate nutrition to meet her own bodily needs as well as the extra needs required for breast-milk production. Refer to Unit 4 for further discussion of nutrition.

BREASTFEEDING

WHO has made recommendations concerning breastfeeding. A young adolescent—especially one who is single—requires extra support to breastfeed successfully. Exclusive breastfeeding is recommended during the first six months of life; breastfeeding supplemented with nutrition from other sources should continue until a child turns two. Adequate maternal nutrition—especially for adolescents—needs to be encouraged to ensure the mother's and baby's good health.

For an HIV-positive mother, counselling should include information about the risks and benefits of infant feeding options, with specific guidance to help her choose the option most suitable for her situation. The final decision should be the woman's, and she should be supported in her choice. When replacement feeding is acceptable, feasible, affordable, sustainable, and safe, avoidance of all breastfeeding by HIV-positive mothers is recommended.

THE FIRST WEEKS AND MONTHS AS A YOUNG MOTHER

An unmarried adolescent mother or one without a partner faces problems when her family and community disapprove of her behaviour. In such circumstances, her health and well-being and that of the baby are at risk. Maintaining ongoing contact through home visits has been shown to be helpful in reducing rates of child abuse and maltreatment. In addition to support with baby care, the adolescent will benefit from support to plan her future.

Summary

- Pregnancy in adolescence is common.
- Many factors contribute to adolescent pregnancy.
- Adolescents have higher maternal mortality than adults.
- Babies born to adolescents also have higher mortality.
- Many of the complications arising during pregnancy and delivery have worse outcomes in adolescents.
- There are important issues for healthcare providers to be aware of in caring for adolescents through pregnancy, labour, delivery, and the postpartum period.
- Promoting safe pregnancy and childbearing in adolescence requires a concerted effort beyond the health sector. Three key actions are increasing girls' access to education and job opportunities, enhancing the status of women and girls in society, and improving their nutritional status.

ANNEX 1. ROLE PLAYS

Role Play 1

A doctor, the nurse-in-charge, and two other nurses are conducting a ward round in the maternity ward of a government hospital. There are around 25 patients in the ward. About a third of them are adolescents. The team arrives at the bedside of a 14-year-old girl who has been admitted with severe anaemia (complicating her pregnancy). Her haemoglobin is 7 gm/dl.

As they reach the bed, the nurse-in-charge starts berating the girl loudly. "You had no business to have sex before getting married and no business getting pregnant. You play around and we all have to work to take care of you." The girl starts weeping silently. Her mother hangs her head in shame. The doctor is clearly embarrassed by this outburst. He gently tries to intervene…

ROLES: Doctor, nurse-in-charge, 14-year-old girl, mother

Role Play 2

A teacher at a boarding school comes in to the casualty unit of a district hospital with a 16-year-old school girl (who is in school uniform). The teacher says that the girl has been complaining of severe lower abdominal pains and wonders whether she has menstrual cramps.

On examination, the clinical officer on duty confirms a full-term pregnancy. The girl has concealed her pregnancy from her family and the teachers at school by binding her abdomen tightly. The girl is in labour. Her cervix is 4 centimetres dilated. After sending the girl to the labour ward, the clinical officer sends for the doctor on call to help explain matters to the teacher.

ROLES: Doctor, clinical officer, teacher

This unit provides information on the following:

1. Definition of unsafe abortion
2. The scope of unsafe abortion in Malawi, including the legal status of abortion
3. Why adolescents and youths seek unsafe abortion
4. Factors contributing to the risk of complications and death due to unsafe abortion in adolescents
5. The medical, psychological, and social consequences of unsafe abortion
6. Detection of and referral for unsafe abortion
7. What needs to be done to prevent unsafe abortion

At the end of this unit, see also Annex 1: Role Plays.

UNIT 3D.
UNSAFE ABORTION AND YOUNG PEOPLE

DEFINITION OF UNSAFE ABORTION

- WHO defines unsafe abortion as, "a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both" (WHO, 2007).
- Skilled professionals in a suitable environment to terminate pregnancy perform safe abortion. Safe abortion prevents the deaths and complications that can result from unsafe abortion.

THE SCOPE OF UNSAFE ABORTION

Malawi law allows abortion only if the life of the mother is at risk and the procedure can save her life. According to an incidence study conducted in 2009, the following results provide an overview of abortions in Malawi (MOH, Ipas, and UNFPA, 2010):

- 24 abortions occur for every 1,000 women (ages 15–49)
- 11.2 abortions occur per 100 live births
- 70,194 induced abortions occurred in 2009
- Approximately half of all women seeking abortion services were age 25 and below
- 22.7 percent of those seeking abortion do so because of contraceptive failure

Abortion and law in Malawi

Under the Malawi Penal Code of 1930 (Sections 149–151), the performance of abortions is generally illegal. A person who unlawfully uses any means with intent to procure an abortion is subject to 14 years' imprisonment. A pregnant woman who unlawfully uses any means or permits the use of such means with intent to procure her own abortion is subject to seven years' imprisonment. A person who unlawfully supplies or procures anything whatever, knowing that it is intended to be unlawfully used to procure an abortion, is subject to three years' imprisonment.

Nonetheless, abortions can be legally performed in Malawi to save the life of the pregnant woman. Section 243 of the Penal Code provides that a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon an unborn child for the preservation of the mother's life if the performance of the operation is reasonable (for more information, see: http://www.un.org/esa/population/publications/abortion/profiles.htm).

In July 2015, the Special Law Commission was set up to review Malawi's abortion laws and came up with the following recommendation.

PROPOSED GROUNDS FOR LAWFUL TERMINATION OF PREGNANCY

The Special Law Commission resolved and agreed that abortion law in Malawi should be liberalised (i.e., institute a conditional relaxation of the restrictions) as opposed to being decriminalised, to accommodate certain justifiable instances in which termination of a pregnancy should permissible. Therefore, grounds for a woman to terminate a pregnancy, in addition to saving the life of a pregnant woman, would be when termination is necessary to prevent injury to the physical or mental health of a pregnant woman; when a severe malformation of the foetus would affect its viability or compatibility with life; and when the pregnancy is the result of rape, incest, or defilement.

However, victims of these sexual offences would be given an opportunity to decide on their own whether to continue with the pregnancy or not.

Women seeking to terminate a pregnancy that results from abuse are required to report their abuse to the police to create a record of the crime in the form of a police report. The police report will suffice as evidence that the pregnancy was the result of a sexual offence and that health service providers can terminate the pregnancy.

Why adolescents and youth access unsafe abortion

The choice to have an abortion is not easy. Adolescents often state a number of reasons for resorting to abortion:

- **Education.** Pregnant girls who fear expulsion from school or the interruption of their studies may believe that they have no choice but to terminate their pregnancy.
- **Economic factors.** Because young women have fewer economic resources to care for a child, it is not surprising to find economic pressures influencing their decision to seek an abortion.
- **Social condemnation.** In societies where a pregnancy before marriage is considered immoral, adolescent girls choose termination of pregnancy to avoid bringing shame and condemnation on themselves and their families.
- **Having no stable relationship.** This reason is encountered more commonly among adolescents than adults.
- **Failed contraception.** Contraceptive use among young women is low. Those who use a method often do so inconsistently and incorrectly. Also, they tend to use methods that are inherently less effective than others.
- **Coerced sex (including rape and incest).** Cross-cultural data show that a larger percentage of rape and sexual abuse incidents occur among young women than among adults.

In countries where abortion laws are restrictive, the rich are often able to obtain safe abortion from competent, well-trained providers at exorbitant fees. The rich are therefore less likely to suffer the consequences of unsafe abortion. The poor, in contrast, are forced to seek the services of clandestine, unqualified providers with all of the attendant complications.

Factors contributing to abortion complications in adolescents

Several factors determine the magnitude and severity of unsafe abortion:

- **Delays in seeking care.** Delay in seeking safe abortion services is the largest single factor in determining the risk of complications and death due to unsafe abortion among young women. Young women, like some adults, may delay seeking help even after complications develop because they do not know they are pregnant, do not want to admit it, or may not know where to obtain help. If they do know, they may not be able to go there because factors such as cost prevent them from doing so. Also, they may be unwilling to go because of the attitudes and behaviours of healthcare workers.
- **Resorting to unskilled providers or traditional means.** Young girls are more likely than adult women to seek abortion from unskilled providers. The younger the woman, the more likely that her abortion will be self-induced or carried out by a nonmedical person.
- **Use of dangerous methods.** Young women are more likely than adults to use dangerous methods for abortion, such as inserting objects in the cervix, placing herbal preparations in the vagina, or taking preparations derived from modern and traditional systems of medicine—either orally or by injection.
- **Legal obstacles.** Because abortion is legal in Malawi only to preserve the pregnant woman's life, most induced abortions are unsafe.
- **Service delivery factors.** Some providers are not skilled enough to provide a safe abortion. Moreover, equipment and medication to perform a safe abortion might not be available. Both circumstances lead to unsafe abortion.

The consequences of unsafe abortion

BOX 31. Medical consequences

The major short-term complications are as follows:

- Cervical or vaginal lacerations, infection, haemorrhage; perforation of the uterus, bowel, or both; tetanus; pelvic infection or abscess; and intrauterine blood clots

The major long-term medical complications are as follows:

- Secondary infertility, spontaneous abortion in a subsequent pregnancy, and an increased likelihood of both ectopic pregnancy and pre-term labour

BOX 32. Psychological consequences

Those who have unsafe abortions

- Are two to four times more likely to commit suicide
- Are more likely to have troubled relationships
- Are generally in need of more counselling and guidance regarding abortion
- Are nearly three times more likely to be admitted to mental health hospitals than women in general

BOX 33. Social and economic consequences

Those who have unsafe abortions

- Often leave school and face disapproving attitudes, even ostracism, from their community
- Risk being thrown out by their families
- Have greatly reduced life chances owing to the spiral of events stemming from having obtained an unsafe abortion
- Face imprisonment

Detecting unsafe abortion and referral for treatment

In theory, the detection of unsafe abortion or its complications should not differ between young and adult women.

There is a history of a missed menstrual period(s), followed by an attempt to terminate the unwanted pregnancy, either by oneself or with the assistance of a friend or clandestine provider. In places where abortion is illegal, the illicit provider often merely induces bleeding and leaves it to the woman to go to a hospital for an evacuation later.

In such circumstances, a young woman may present with a history of vaginal bleeding and complications of sepsis and anaemia.

Unlike adult women, young women (particularly very young girls) are often not willing and sometimes not able to provide an accurate history. This is especially so when the young girls are accompanied by their parents, relatives, or others because of fear and embarrassment at having had sexual relations.

Compared with adults, young women having an unsafe abortion are more likely to fit the following descriptions:

- Be unmarried
- Be pregnant for the first time
- Have a longer gestation up to the time of abortion
- Have used dangerous methods to terminate the pregnancy
- Have resorted to illegal providers
- Have delayed seeking help
- Have come to the health facility alone or with a friend, rather than with the partner
- Have ingested substances that interfere with treatment
- Have more established complications

Box 34. Bear in mind

A healthcare provider should bear in mind that unwanted pregnancy may be the real presenting problem, though other symptoms may be reported, and should observe the young person's conduct and behaviour carefully. This will assist in ensuring that the diagnosis of unsafe abortion is not missed. Employ a gentle, reassuring manner and tactfully ask the girl's parents or guardians to wait outside the consulting or examining room. This will enable the healthcare provider to have a private and confidential conversation with the girl.

REFERRAL

Referrals for any suspected unsafe abortion should be done with urgency. In those health facilities not providing services to support management of unsafe abortion, providers, youths, parents, and the community at large should be oriented on where to refer all such suspected cases. Examples of places for referral are health centres, district hospitals, and Christian Health Association of Malawi (CHAM) facilities equipped to provide the necessary services.

Referrals should also cover access to psychosocial support services because in some cases the girl might not have deliberately aborted the pregnancy but rather lost the baby due to other reasons, such as miscarriage.

Psychosocial issues pertaining to unsafe abortion

Abortion may have psychosocial effects on young people. The effects, although likely greater for the girl, may also bother the young man who was responsible for the pregnancy. In addition to the biomedical services that address physical health, intense psychosocial counselling may be warranted.

An assessment by the provider will identify those in need of further counselling. It is important at this stage to address the specific questions these young girls may have. Examples of these are as follows:

- Fear that they will not conceive again
- Belief that they have committed a grave sin and therefore are condemned and deserve punishment
- Suicidal intentions
- Social alienation, especially if their peers or the community know about their status

Taking time to understand and address each fear in an open and nonjudgmental manner will go a long way towards improving the girl's psychosocial environment. In some cases, her fears may not be unfounded; for example, owing to complications of the reproductive system, she indeed may not be able to conceive again. If this is the case, provide appropriate information and help the young woman to accept her situation.

A multidisciplinary team involving social workers, counsellors, health workers, and religious leaders may be necessary. This team should be available to provide support, but only with the girl's consent and in a manner with which she is comfortable.

Summary

- Unsafe abortion is common among young women in many countries.
- Young people obtain abortions for a broad range of social, economic, and cultural reasons.
- Young people undergoing unsafe abortions tend to be single, pregnant for the first time, and have obtained their abortions later in their pregnancies than adult women.
- They are more likely to have resorted to illegal providers and to have used dangerous methods for inducing abortion.
- They tend to present later and with more entrenched complications.
- They tend to face more barriers than adults in accessing and using the health services they need.
- They are less likely to come in for post-treatment follow-up.
- The management of unsafe abortion should include post-abortion counselling and should address contraception in addition to other issues.

ANNEX 1. ROLE PLAYS

Role Play 1

A 14-year-old girl, dressed in her school uniform, comes during school hours to see the duty medical officer in the casualty department of a district hospital. She explains to the doctor that she thinks she is pregnant and wants a termination. She does not want to talk about who the father might be, even on probing. She tells him that she is the first-born in a family with six children. She attends a local Catholic secondary school and lives with an uncle who is her local guardian and is paying for her upkeep. Her parents are poor farmers living in a rural area. The girl believes that her future education and her relationship with her family will be irrevocably damaged by carrying through with this pregnancy. She says that she is depending on the support of the duty medical officer to find a solution.

The doctor seems willing to consider assisting her, but the nurse on duty is a staunch Christian who believes that abortion is murder.

ROLES: The doctor, the girl, and the nurse

Role Play 2

A young woman (age 18) has died in a hospital while under the care of a certain middle-aged male doctor. The cause of death was septic incomplete abortion (performed elsewhere). Two months before her death, the woman had come to the hospital seeking an abortion. She had met with this doctor, who had told her that he could not perform the procedure because it was illegal. This doctor now has to break the news of her death to the family and he has both her parents and her sister in his office.

The sister breaks down sobbing and angrily reveals what had happened two months earlier when her sister came to the hospital for help.

The doctor wants to comfort the family but of course his own part in the matter makes this difficult. He feels torn between his own guilt, his genuine sympathy for the family, and his real concerns about safeguarding his position.

ROLES: The doctor, the young woman's parents, and the 21-year-old sister

This unit provides information on the following:

1. Understanding the meaning of the terms "sexual violence" and "sexual assault"
2. Scope of sexual and physical abuse in Malawi
3. Health consequences of sexual and physical assault
4. Legal implications of sexual assault and rape
5. Service provision to survivors of physical and sexual assault
6. Treatment and prophylaxis for survivors of sexual assault and rape
7. Procedures for reporting to the police

At the end of this unit, see also Annex 1: Case Studies.

UNIT 3E.
SEXUAL ABUSE AND PHYSICAL ABUSE AND YOUNG PEOPLE

This section is an adaptation of the Malawi *National Guidelines for Provision of Services for Physical and Sexual Violence*. Some sections inserted here have been copied verbatim from the guidelines.

UNDERSTANDING SEXUAL VIOLENCE AND SEXUAL ASSAULT

Sexual violence

Sexual violence is defined as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work" (WHO, 2003).

BOX 35. Caution!

Any person working with people who have been raped should be aware of the differences between myth and fact. Personal beliefs and attitudes towards rape need to be examined and challenged. It is essential that healthcare workers and other related service providers understand the need for impartiality. It is not the role of the healthcare worker to make judgments about the veracity of rape allegations, nor about the innocence or guilt of the alleged perpetrator. This is for the investigators and the courts to decide.

Sexual assault

A subcategory of sexual violence, sexual assault usually includes the use of physical or other force to obtain or attempt sexual penetration. It includes rape, defined as "the physically forced or otherwise coerced penetration—even if slightly—of the vulva or anus, using a penis, other body parts or an object." It may also include oral penetration (WHO, 2003).

Rape as defined by the Laws of Malawi (Penal Code [Cap 7:01,132])

Any person having unlawful carnal knowledge of a woman or girl, without her consent, or with her consent if the consent is obtained by force or means of threats or intimidation of any kind, or by fear of bodily harm, or by means of false representations as to the nature of the act, or in case of a married woman, by personating her husband.

LGBT persons

LBGT refers to persons who are lesbian, bisexual, gay, or transgender.

On June 17, 2011, the UN passed a resolution (Resolution of Sexual Orientation and Gender Identity, A/HRC/17/L.9/Rev.1) expressing concern about prejudice and violence against LGBT persons.

Health services are provided to all persons regardless of their sexual orientation.

LGBT persons have much higher rates of depression and suicide because of the increased violence they have suffered and rejection they experience by society. In our respective roles in health, social welfare, and law enforcement, it is our duty to protect all individuals from violence and provide them services when needed.

BOX 36. Note

In Malawi, many LGBT persons are discriminated against and sometimes charged under various laws. It is not legal to treat those who are LGBT with violence, and all LGBT persons have the right to provision of services.

Persons with disabilities

Persons with disabilities are those who have long-term physical, mental, intellectual, or sensory impairments which, in interaction with barriers in the community, may hinder their full and effective participation in society on an equal basis with others (Article 1, United Nations Convention on the Rights of Persons with Disabilities).

Special considerations: When we work with persons with disabilities, we should focus on their abilities rather than defining them by their disabilities. Moreover, we should not be dismissive of their claims of abuse: they are full and equal citizens.

Persons with disabilities are more vulnerable to violence than others, on average, because they are more dependent on others for help. Those "helpers" know they are in a position of power over the person with the disability.

Scope of sexual and physical abuse in Malawi

There has been substantial documentation of the extent of sexual and physical abuse among young people in Malawi. Table 10 shows the prevalence and patterns of sexual and physical abuse.

TABLE 10. Prevalence and patterns of sexual and physical abuse in Malawi

TYPE OF ABUSE, BY AGE GROUP	FEMALES (%)	MALES (%)
18- to 24-year-olds reporting experiencing any sexual abuse before age 18	21.8	14.8
18- to 24-year-olds reporting experiencing any unwanted attempted sex before age 18	11.5	9.7
18- to 24-year-olds reporting experiencing physically forced sex before age 18	5.1	1.0
18- to 24-year-olds reporting experiencing any pressured sex before age 18	1.9	1.0
18- to 24-year-olds reporting experiencing any unwanted completed sex before age 18	6.7	1.9
18- to 24-year-olds reporting that first incident of sexual intercourse was unwanted before age 18	37.7	9.8
13- to 17-year-olds reporting experiencing any sexual abuse in the past 12 months	22.8	12.7
13- to 17-year-olds reporting experiencing any sexual touching	10.5	6.8
13- to 17-year-olds reporting experiencing any unwanted attempted sex	13.1	7.8
13- to 17-year-olds reporting experiencing any physically forced sex	2.0	0.3
13- to 17-year-olds reporting experiencing any pressured sex	1.8	1.0
13- to 17-year-olds reporting experiencing any unwanted completed sex in the past 12 months	3.4	1.4
13- to 17-year-olds who had ever had sex reporting that first incident of sexual intercourse was unwanted	52.0	16.8

SOURCE: Ministry of Gender, Children, Disability and Social Welfare et al., 2014.

Health consequences of sexual and physical assault

The common health consequences of sexual and physical assault are the following:

- Pregnancy that may or may not be desired
- Sexual dysfunction
- Unsafe abortion
- Infertility
- STIs, including HIV
- Pelvic pain and urinary tract infections
- Physical injuries
- Psychological trauma

Legal implications of sexual assault and rape

Rape and sexual assault, both in adults and in children, is against the laws of Malawi. This means that all cases of rape can be prosecuted in court. Both the Child Care, Protection and Justice Act No. 22 of 2010 and the Protection of Domestic Violence Act Parts X and XI consider the key roles of the police, the courts, and witnesses in assisting children and adult survivors of sexual assault and domestic violence.

According to the Medical Council Act and Nurses & Midwives Act (1995), all healthcare workers registered at either the Medical Council or the Nurses and Midwives Council are competent to write and provide a medical report on a case of sexual assault and rape, which can be considered a legal document in court. It is therefore important for the medical record to be legible and accurately documented, signed, and dated by the healthcare worker who undertakes the physical examination.

Service provision to survivors of physical and sexual assault

The Prevention of Domestic Violence Act No. 5 of 2006 encourages service providers to render assistance to the survivor of domestic violence as the circumstances require, including the following services:

- Making arrangements for the survivor of domestic violence to find suitable temporary shelter and to obtain medical treatment, as needed
- Ensuring that the survivor of domestic violence has access to information about the range of service providers and the kind of support available

BOX 37. Useful techniques for dealing with survivors

The following strategies and techniques are helpful when dealing with survivors of sexual violence:

- Greet the survivor by name; use their preferred name. Make them your central focus.
- Introduce yourself to the survivor and tell them your role (e.g., nurse, doctor).
- Ensure privacy for history taking, examination, and counselling.
- Aim for an attitude of respect and professionalism within the boundaries of your survivor's culture.
- Maintain a calm demeanour (attitude). A frightened survivor will want to be in the company of people who are not frightened.
- Be unhurried; give them time.
- Maintain eye contact; be empathetic and nonjudgmental as your survivor recounts their experiences.
- Aim to limit the number of healthcare workers attending to the survivor: one-on-one care works best in sexual assault cases.
- Ask the survivor if they want to have a specific person present for support. Ask the survivor if they have any questions.

Treatment options

TABLE 11. Treatment and prophylaxis for survivors of sexual assault and rape

EMERGENCY CONTRACEPTION	STIS	POST-EXPOSURE PROPHYLAXIS (PEP) TO PREVENT HIV
Unless the survivor is currently using contraceptive methods or is pregnant, post-coital oral contraception (emergency contraception) should be issued as soon as possible, and certainly within 72–120 hours of the assault.	Survivors of sexual assault may contract an STI, including HIV, as a direct result of the assault. It is recommended that routine presumptive therapy after sexual assault be given because follow-up with the survivor can be difficult, and the survivor may be reassured if offered treatment for possible infection.	PEP refers to the treatment of hazardous exposures to HIV using ART. This therapy, started immediately after exposure to HIV may prevent HIV infection, although this protection is not 100 percent. Treatment should be initiated as soon as possible—certainly within 72 hours of exposure. Although the risk of acquiring HIV from a single act of sexual intercourse is low, rape is commonly associated with assault and genital tract trauma, which increases the risk of HIV transmission. A rapid HIV test must be conducted after counselling, and the survivor should be provided with the test results.

BOX 38. Important note for service providers

It is not the healthcare worker's responsibility to determine whether a person has been raped. That is a legal determination. The healthcare worker's responsibility is to provide appropriate care and to record the history and other relevant information that can be provided to the police and used for their investigations and/or social welfare for follow-up support.

In the past, it has been routine to request a letter from the police before a survivor of sexual assault or rape could be attended to. Now, a survivor of sexual assault or rape must be attended to immediately upon arrival in the health facility. **By law, the survivor is not required to produce a letter from the police before he or she can be attended to.** Insisting on a police letter will impose a great burden on the survivor and cause unnecessary delays, and must be avoided at all times.

Counselling

Counselling plays an important part in the management of assaulted survivors because it can reduce post-traumatic stress disorder. Not all survivors of sexual assault react in the same way. Some experience immediate psychological distress, whereas others develop short-term and long-term psychological problems. The amount and length of social support required by survivors of assault vary enormously, depending on the degree of psychological trauma suffered and the survivor's own ability to cope. Be empathetic. Advise about post-traumatic symptoms, such as guilt, fear, shame, anger, insomnia, nightmares, mood swings, suicidal thoughts, or self-destructive behaviour, which may be experienced.

BOX 39. Key issues to note during counselling of survivors

Stress the following points with the survivor:

- Explain that counselling will help to facilitate recovery.
- List the history of events carefully, ask about the survivor's concerns, and address them appropriately.
- Explain that the survivor did not deserve to be sexually violated.
- Reinforce that the assault was not the survivor's fault—that it was NOT caused by her behaviour or manner of dressing. No person ASKS to be sexually assaulted.
- Stress that sexual assault is an issue of power and control.
- Refer the survivor for psychological support as available or necessary (survivor support groups, social worker, psychologist, etc.).
- Assess the safety of the survivor and the possibility of recurrence.
- Discuss the legal implications and procedures for notifying the police/ Survivor Support Unit.

Follow-up care

Follow-up is always necessary to identify things which might have been missed on the initial visit, as well as other infections that have long incubation periods: syphilis, Hepatitis B, and HIV sero-conversion.

Procedures for reporting to the police

Survivors of sexual assault and rape should be encouraged to report these crimes to the police immediately after receiving medical care. This is an individual choice, however, and should not be forced.

BOX 40. Reporting to the police

- It is the responsibility of any professional (healthcare provider, teacher, police officer, etc.) to protect children from further sexual abuse.
- If the guardians of a child survivor do not wish to pursue the case, the healthcare provider must report the case to the police.
- Determining whether abuse or rape has occurred is left to the police and its investigators, not to the person who reports the alleged crime.
- Police should encourage and assist all survivors presenting at the police station to go to the nearest healthcare facility as soon as possible, preferably before legal processes commence, because both PEP and emergency contraception become less effective with time.
- It is also suggested that the police open a case even before the survivor goes to hospital, which can then be followed up and confirmed by the medical record.
- An individual responsible for the interface between the hospital and survivor should collect the form either from the police or the hospital and facilitate processing of the case.

Victim Support Units (VSUs) were established in 2001 with the aim of protecting, promoting, and upholding the rights of victims and survivors of various forms of criminal and civil activities, especially vulnerable women and children. The VSUs were established as part of the Police Reform Programme, in which the police were expected to diversify their services and provide assistance in a holistic manner.

In recent years, with the help of some key stakeholders and civil society organisations, VSUs have been established with service providers such as police officers, healthcare workers, social workers, and legal service providers. These providers have helped handle cases of gender-based violence, HIV and AIDS-related violence, or other human rights abuses taking place in communities.

VSUs offer different services to different people. The most important services are the following: counselling, first aid, advice, referrals, private interviews, gender and domestic violence support, help for children, and general sensitisation on human rights and policing.

Through the VSU, the Community Policing Services Branch invites every citizen in the country to help safeguard and advance the rights and interests of all people, especially women and children. The VSUs and Community Policing Services Branch urge the public to report cases of gender-based violence, HIV and AIDS-related violence, and other human rights abuses.

If anyone has been or is being sexually abused, or is aware or suspects that another person, including a child, has been or is being abused anywhere, they can help by doing any of the following:

- Write an anonymous letter and drop it in any police suggestion box.
- Visit the nearest police formation and give a report.
- Call any police formation.

Every report of such abuse must be treated as a priority and should be attended to according to the minimum standards outlined in the guidelines above.

ANNEX 1. CASE STUDIES

CASE STUDY 1. How the police deal with people who have been sexually assaulted

Linda is a 20-year-old third-year student at a college in Blantyre. She is popular and bright, and likes going out to local entertainment places. Linda also likes to have a few alcoholic drinks when she is relaxing. One day, a group of boys from her class organised a small party in one of their rooms and invited Linda and her best friend, Memory.

After a few hours of drinking and dancing, Memory left the party to go to sleep but Linda stayed. At about 2 a.m., Linda came back to the room crying inconsolably, her mini-skirt torn. Memory asked her what had happened, and Linda explained that after Memory had left, she was alone with two boys who then forced themselves on her and took turns having sexual intercourse with her. She tried to call out for help but could not be heard over the loud music. Memory consoled her friend, called a taxi, and convinced Linda to go to the nearest police station. At the station, they met a male police officer who immediately started berating Linda for drunkenness and dressing provocatively. "You brought it upon yourself," he said. "What were you doing dressed like that in a man's room?"

CASE STUDY 2. How healthcare workers deal with people who have been sexually assaulted

Linda is a 20-year-old third-year student at a college in Blantyre. She is popular and bright, and likes going out to local entertainment places. Linda also likes to have a few alcoholic drinks when she is relaxing. One day, a group of boys from her class organised a small party in one of their rooms and invited Linda and her best friend Memory.

After a few hours of drinking and dancing, Memory left the party to go to sleep but Linda stayed. At about 2 a.m., Linda came back to the room crying inconsolably, her mini-skirt torn. Memory asked her what had happened, and Linda explained that after Memory had left, she was alone with two boys who then forced themselves on her and took turns having sexual intercourse with her. She tried to call for help but could not be heard over the loud music. Memory tried to console her friend, but saw that she was bruised and bleeding from the mouth. Memory took Linda to the nearest hospital. There the nurse on duty refused to help until she had obtained a police report.

CASE STUDY 3. How family members deal with people who have been sexually assaulted

Lusungu is a 14-year-old girl from Mzimba. Her parents are poor and have asked her uncle, who lives in Blantyre, to employ her as a housemaid. Every month, Lusungu has been sending money to her parents to help with the farming at home. After staying with her uncle for six months, her aunt was sent abroad to study. At about the same time, her uncle started forcing her to have sexual intercourse with him. Every time this happened, he threatened that he would send her home if she revealed what was happening. This went on for some time, and Lusungu missed her period for two months. One day, her uncle, who was quite a heavy drinker, came home late and wanted to have sexual intercourse with Lusungu. When she refused, he beat her and expelled her from the house with only transport money. She went to her village, where she explained her predicament to her mother. Her mother was very angry that Lusungu had been fired and shouted at her.

This unit provides information on the following:

1. Definition of STIs
2. Magnitude of STIs among adolescents and young people
3. The factors contributing to STIs in young people
4. Signs and symptoms of common STIs in Malawi
5. Consequences of STIs among adolescents and young people
6. Treating and referring a young person with an STI
7. Preventing acquisition or recurrence of STIs
8. Factors that hinder young people's prompt access to STI treatment
9. STI referral and linkages with the community or outreach programmes
10. Responding to psychological needs and helping young people deal with any social implications

At the end of this unit, see also Annex 1: Case Studies, and Annex 2: Role Play.

UNIT 3F.
SEXUALLY TRANSMITTED INFECTIONS AND YOUNG PEOPLE

DEFINITION OF SEXUALLY TRANSMITTED INFECTIONS (STIS)

Sexually transmitted infections (STIs) are infections transmitted from one person to another, primarily by sexual contact. Some STIs can be transmitted by exposure to contaminated blood and from a mother to her unborn child.

BOX 41. Relationship between STIs and HIV and AIDS

STIs, especially those involving genital ulcers, facilitate the transmission of HIV between sexual partners. The prevention and treatment of STIs therefore needs to be a key component of a strategy to prevent the transmission of HIV.

MAGNITUDE OF STIs AMONG ADOLESCENTS AND YOUNG PEOPLE

Epidemiological data for Malawi indicates that STIs are a major health risk to all sexually active adolescents. (See Box 42.)

BOX 42. National data on self-reported STIs among young people in Malawi

- Among those ages 15–19, 0.7% of females and 0.4% of males report having symptoms of STIs.
- Among those ages 20–24, 1.4% of females and 2.2% of males report having symptoms of STIs.
- The prevalence of STIs is the same in rural areas (3.8%) and urban areas (3.7%).
- The prevalence of STIs is higher in the southern region (13%) and central region (12%) than the northern region (6%).

Source: 2010 MDHS.

WHAT FACTORS INCREASE YOUNG PEOPLE'S RISK FOR STIS?

A number of factors increase young people's risk of acquiring an STI, including the following:

- Unprotected sexual intercourse
- Sex with multiple partners
- Lack of sexual experience and skills in self-protection (i.e., correct and consistent use of condoms)
- Lack of adequate information about STIs and how to avoid contracting them
- Lack of access to preventive services and protective supplies (such as condoms)
- Pride: adolescent boys in many cultures feel they have to prove themselves sexually; in some cultures, they may even regard STIs as "warrior marks" to indicate the transition to adulthood
- Exposure during sexual assault

SIGNS AND SYMPTOMS OF COMMON STIs IN MALAWI

Those working with young people need to be able to identify the signs and symptoms of different STIs. Table 12 summarises them.

TABLE 12. Malawi's most common STIs

RANK	NAME OF STI	CURABLE?	INFECTED PART	INCUBATION PERIOD	SIGNS AND SYMPTOMS
1	HIV (AIDS is a potential consequence of acquiring HIV)	No	Immune system	Acute HIV infection period could be two to four weeks	HIV infection signs and symptoms are often nonspecific; many people can live 10 years or more before experiencing any of them. Below are some of the common ones: • Weight loss • Diarrhoea • Fatigue • Enlarged or sore lymph nodes • Persistent fever and/or night sweats
2	Gonorrhoea	Yes	Penis and female genitalia	1–4 days	Most common sign is purulent (profuse) discharge through the vagina in women and the urethra in men. Other symptoms are: • Conjunctivitis (mostly in newborns and children) • Pharyngitis • Peri-anal itching • Arthritis
3	Syphilis	Yes, with early treatment	Penis and female genitalia	9–90 days (very infectious during this phase)	One or more ulcers: usually painless, with a hard base; do not bleed. Swollen lymph nodes: often bilateral and painless.
4	Chancroid (Chindoko)	Yes	Penis or vagina	3–7 days	Ulcer (usually more than one): large, with irregular edges; painful; bleeds easily. Lymph nodes may be painful and develop into abscesses.
5	Herpes	No	Penis or vagina	2–10 days	Small ulcers that start off as itchy and painful blisters. Herpes has no cure but medications can help shorten outbreaks and decrease their severity. Blisters generally heal in 10–14 days but are likely to recur on an average of five times/year.
6	Genital HPV and genital warts	No	Penis and vagina	1–6 months	Genital HPV is most often symptomless. Certain strains may cause cancer of the cervix, anus, and penis. Other strains may cause genital warts. There is no cure for HPV; however, there is a preventive vaccine, and genital warts can be treated with medication.

TABLE 12. Malawi's most common STIs *(continued)*

RANK	NAME OF STI	CURABLE?	INFECTED PART	INCUBATION PERIOD	SIGNS AND SYMPTOMS
7	Trichomoniasis (extremely common in Malawi)	Yes	Penis and vagina		In women: Frothy, foul-smelling vaginal discharge; inflamed vagina, vulva, perineum, and inner thighs. In men: Usually asymptomatic but may cause urethral discharge or balanitis.
8	Bacterial vaginosis	Yes	Vagina		Grey vaginal discharge.
9	Candida albicans: Not always an STI; may also develop during pregnancy, while using oral contraceptives, with diabetes, or while using antibiotics	Yes	Penis and female genitalia		In women: Vaginal discharge (white, cheesy); vulvo-vaginal inflammation. In men: Itchy erythematous rash.
10	Lyphogranuloma venereum	Yes	Penis and female genitalia	1–6 weeks	Usually one ulcer that is painless and small, and often unnoticed. Lymph nodes may be painful and develop into abscesses (buboes: swollen lymph nodes in the armpit or groin).
11	Scabies and pubic lice	Yes	Penis and female genitalia		Scabies is an infestation of the skin caused by the scabies mite. Pubic lice are tiny insects that attach themselves to the skin and hair in the pubic area and cause itching.
12	Hepatitis B	No	Liver		Usually has no symptoms.

Source: MOH, 2013

Consequences of STIs among adolescents and young people

The consequences of STIs contracted during adolescence are more severe than those contracted in adulthood. Young women are more susceptible to acquiring STIs than are males, for the following reasons:

- The surface of the vagina is larger than that of the penis.
- The ejaculate volume deposited in the vagina is greater than the vaginal secretions to which men are exposed.
- Cervical cells extend to the outer surface of the cervix (a condition called ectopy). These cells are vulnerable to infections such as chlamydia.
- Young women are less likely to experience symptoms, so most STIs go undiagnosed.
- Acquiring an STI puts young women at greater risk of reproductive cancers and infertility.

BOX 43. Consequences of STIs

- Blinding eye infections or pneumonia in newborns (gonorrhoea)
- Chronic abdominal pain or infertility in women (gonorrhoea and chlamydia)
- Spontaneous abortion (syphilis)
- Ectopic pregnancy (gonorrhoea and chlamydia)
- Cervical cancer (HPV)
- Infertility in men (gonorrhoea and chlamydia)
- Increased risk of HIV infection (most ulcerative STIs)
- Irreversible damage to the brain and heart (late in the course of acquired syphilis)
- Extensive organ and tissue destruction in newborns (congenital syphilis)
- Social disruption (e.g., divorce of infertile wives; spousal abuse following disclosure of the condition)
- Death (AIDS and untreated syphilis)

Treating and referring a young person with an STI

Good customer care buttressed by excellent communication skills is a priority for the treatment of adolescents and young people with STIs.

- The qualities of an effective counsellor discussed in Unit 1 are key to the effective treatment of adolescents and young people who have STIs.
- All service providers working with young people should strive to be effective counsellors, leaving their personal biases aside.
- Providers should follow the GATHER counselling process described in Unit 1.

BOX 44. STI management referrals

When you suspect that a client has an STI, you should refer the client to services promptly. Early treatment increases the chances of full recovery and also minimises risks of complications.

When making referrals, do the following:

- Assure the clients of confidentiality.
- Inform them that it could be an STI that needs immediate attention.
- Inform them of the place where they can get treatment, such as government health facilities, CHAM facilities, and other private providers.
- Ask them to inform their partners and go with them for care.
- Encourage a follow-up visit.

Preventing infection and recurrence of STIs

Youth presenting for treatment of an STI would have had unprotected sexual contact with an infected person. They will therefore need information, skills, and supplies to avoid infections in the future. As a health provider, you can help in the following ways:

- Promote and encourage abstinence
- Promote and encourage condom use
- Facilitate education on how they can identify and recognize signs and symptoms of STIs
- Promptly treat STIs or refer for immediate management
- Encourage young women and men to notify their partners if they suspect or have been treated for an STI
- Encourage early diagnosis and treatment if they suspect an STI

Healthcare providers should make every effort either to assist clients directly in these ways or refer them to other organisations. Young patients should be encouraged to inform their partner(s) about their infection and encourage their partner(s) to seek treatment.

Factors that hinder prompt access to STI treatment among young people

Several factors complicate access to services in health facilities by adolescents and young people (E2A Project and University of Malawi, 2014).

- Fear of being tested for HIV. (Clients with STIs are asked if they know their HIV status; if they do not, they are asked if they can be tested. This can be intimidating for young people.)
- Embarrassment because they do not want to be seen by people they may know.
- Fear of negative reactions from healthcare workers.
- Lack of information about available services (e.g., youth may not know about clinics or YFHS centres, where and when services are provided, or how much services cost).
- Lack of knowledge about the asymptomatic nature of some STIs or (especially among young women) not knowing the difference between normal and abnormal discharges. (Failure to recognize signs and symptoms of STIs prevent young people from seeking help.)

STI referral and linkages with community or outreach programmes

For existing services to reach more young people, more active means of informing youth about them should be prioritised. Staff with a special interest in working with young people should be identified and encouraged to network with outside agencies to establish referral mechanisms and communication channels that will raise awareness of the availability of services. The following steps can be used to create a referral system:

- Have a referral book or cards in which you can document those referred.
- List the names of organisations and institutions supporting young people with different services.
- List these sites' addresses and telephone numbers, and the names of contact persons (ensure that these staff are trained in YFHS).
- Make this list available to all service providers.
- Ensure that all referrals made for adolescents and young people are confidential.

RESPONDING TO PSYCHOLOGICAL NEEDS AND HELPING YOUNG PEOPLE DEAL WITH ANY SOCIAL IMPLICATIONS

An STI should be correctly diagnosed and managed. At the same time, healthcare providers need to assess the psychological state of the young person and his or her social circumstances so that appropriate advice or referral to other services can be made. This is especially important in cases of STIs resulting from rape or sexual abuse.

- Counselling aims to help individuals understand their situation, examine the available options, and make sound decisions.
- Counsellors are trained to help clients make decisions about life situations, including how to avoid STIs.
- The counsellor should arrange for the young person to return to the health facility so the effectiveness of the treatment can be assessed. The purpose of such a visit must therefore be explained clearly.
- A healthcare provider should use the opportunity presented by the young person's presence at the health facility to determine his or her need for other services that the health centre could provide (e.g., contraceptive services).
- The counsellor should provide information on other forms of assistance that are available, such as referrals to other agencies or organisations providing social support.

Note

In practice, it is impossible to force people to identify or even notify their partner(s). People may not know or remember their partners. Even if they do, they may be unwilling to identify or notify them.

Summary

STIs are an important public health problem. Healthcare providers should give special consideration to STIs in young people for the following reasons:

- Young people run special risks of exposure to STIs, with young girls being especially vulnerable.
- The consequences of infection and disease contracted at a young age are more severe than those contracted in adulthood.
- Diagnosis of STIs in young people can be more problematic.
- Effective treatment of STIs in young people faces a number of constraints.
- Referrals can ensure quick management and reduce the risk of complications.

Given the above factors, healthcare providers should make every effort to manage their young patients with great sensitivity and awareness of their special needs and vulnerabilities.

ANNEX 1. CASE STUDIES

CASE STUDY 1

A 16-year-old woman has come to the clinic in the district hospital of a semi-urban area because she has a vaginal discharge and some painful sores around the vagina. She is received curtly by the duty nurse, who briefly examines the young woman and asks her a few questions. She then calls in a junior female doctor. As the nurse moves around the examination room, slamming drawers and banging metal trays, she mutters quite audibly: "Shameless girl, stealing husbands, deserves her punishment." The patient remains silent and starts weeping silently. The doctor is appalled by the nurse's brusque manner and harsh words. As she completes the examination, she is gentle and courteous with the young woman, which appears to inflame the nurse further. The doctor gives the client the appropriate medication and asks her to come back for review in a week.

Question to pose: If you were the junior doctor, how would you deal with this situation?

CASE STUDY 2

An 11-year-old girl is brought to a peri-urban clinic by her mother because she has noticed that her daughter has genital sores. No meaningful history can be obtained from the mother or the child on how and when the sores started. The girl is examined behind a screen while her mother sits in the same room. Examination reveals that the child has florid vulval condylomata—strongly suggestive of syphilis. The nurse-in-charge, a mature and experienced woman, takes the child into another room. After several minutes of gentle but persistent probing, the girl tells the nurse that her uncle has been "playing" with her and warned her that if she told anyone he would kill her.

Question to pose: If you were faced with such a situation in this setting, how would you deal with it?

ANNEX 2. ROLE PLAYS

Role Play 1

An adolescent male who comes in for treatment of an STI has obviously had unsafe sex with an infected person. He needs help to avoid these infections in the future. In this role play, the healthcare provider has an opportunity to give the patient information that builds on his knowledge and experience and is relevant to his stage of development and circumstances, and to teach him skills enabling him to cope with the realities of his everyday life. In addition, the healthcare worker has the opportunity to provide the young man with condoms. If the healthcare worker cannot provide these, he or she should at least direct the client to an individual or organisation that can do so.

Role Play 2

A young woman, like the young man in the previous role play, needs to be given information tailored to her special needs. She must also have the skills to put this information to use. In addition, if she is sexually active, she will require condoms and contraceptives to avoid STIs and an unwanted pregnancy. The additional challenge facing the doctor in this role play is that of introducing the sensitive subject of sexuality into the discussion.

This unit provides information on the following:

1. HIV in Malawi
2. Risk and protective factors in HIV transmission
3. Young women's vulnerability to HIV
4. Key HIV prevention strategies young people can access through health services
5. Advocacy in HIV prevention: discussing who has a role
6. Questions the health worker should ask when planning HIV prevention services for young people
7. Role of voluntary medical male circumcision (VMMC) in risk reduction
8. Youth-focused strategies to promote HIV testing and counselling
9. Role of health personnel in supporting young people living with HIV to maintain optimal health
10. Positive prevention for these young people
11. Psychosocial issues especially pertinent to young people living with HIV
12. Effective ways to help young people living with HIV transition to adult services

UNIT 3G.

HIV AND AIDS AND YOUNG PEOPLE

HIV IN MALAWI

Malawi has one of the highest HIV prevalence rates in the world (see Box 45). It is estimated that the country has about 1 million people living with HIV (PLHIV); of these, 850,000 are ages 15 years and above. Women are at greater risk than men of acquiring HIV, owing to their physiology, gender, and socioeconomic inequalities, among other reasons. For instance, among those ages 15–19, HIV prevalence is nearly three times higher among females than males.

BOX 45. A statistical picture of HIV in Malawi

- The national adult HIV prevalence rate is 10.6 percent.
- HIV prevalence among young people breaks down as follows:
  - Male: 1.3%; female: 4.2% (ages 15–19)
  - Male: 2.8%; female 6.4% (ages 20–24)
- Overall, prevalence is higher among young women than among young men.
- Adolescents ages 14–19 experience 3,200 new infections annually.
- An estimated 170,000 children ages 0–14 are living with HIV.
- The share of those ages 15–19 ever tested for HIV is 44.1%.
- Overall, 4 percent of young people ages 15–24 have tested positive for HIV:
  - 2.7% of those ages 15–19
  - 4.7% of those ages 20–24

SOURCES: NSO and ICF Macro, 2011; National AIDS Commission and UNAIDS, 2013

RISK AND PROTECTIVE FACTORS IN HIV TRANSMISSION

- Risk factors are individual and contextual influences that either encourage or are associated with one or more behaviours that may lead to negative health outcomes or may discourage behaviours that could prevent a negative health outcome.
- Protective factors are individual and contextual influences that discourage one or more behaviours leading to negative health outcomes or encourage behaviours that prevent negative health outcomes. Protective factors can also lessen the likelihood of negative consequences from risk factors.

In Malawi, as shown in Table 13, demographic, structural, economic, social, biological, and cultural factors interact to influence the transmission of HIV. Examples of these factors are age, education, region of residence, circumcision status, relative wealth or poverty, religion, and exposure to media. Other factors are awareness of HIV and AIDS, level of stigma, and the HIV status of those in one's social networks. Also playing a part are sexual and related behaviours such as condom use, marital status, number of sex partners, and whether or not one's sex partners are members of populations key to the epidemic (e.g., sex workers or injecting drug users). These factors can be protective against HIV or increase the risk of transmission.

TABLE 13. Risk factors and protective factors for HIV

RISK FACTORS	SIGNIFICANT PROTECTIVE FACTORS	OTHER PROTECTIVE FACTORS
• Lack of information • Unprotected sex (anal and vaginal) • Sex work • Becoming a sex worker at an early age • Multiple and concurrent sexual partners • Current or past history of genital ulcers • Current or past history of STIs • Early age of sexual debut • Having sex with older men • Being sexually violated • Living on the street • Being a migrant worker • Living without parental support • Being orphaned as a child or affected by HIV • Being caught in disaster-prone and disaster-affected areas • Being born of an HIV+ mother	• Consistent and correct use of condoms • Having a partner who has undergone VMMC • Reduced number of sexual partners	• Getting tested for HIV • Positive relationships with parents, teachers, and other adults in the community • Feeling valued • Positive school environments • Exposure to positive values, rules, and expectations • Having spiritual beliefs • Having a sense of hope for the future

For most young people, the important messages that will protect them from the risk of HIV are the following:

- Delaying sexual debut
- Reducing the number of sexual partners
- Using condoms correctly and consistently

VULNERABILITY TO HIV

Vulnerability is a measure of an individual's or community's inability to control the risk of acquiring HIV. Vulnerability recognizes that for some people, avoiding exposure to HIV is not a matter of choice.

Vulnerability increases the likelihood of negative health outcomes. Social and contextual risk factors make many young people vulnerable to HIV acquisition. Examples are gender norms, relations among different age groups, race, social and cultural norms and value systems, geographic location, and economic status.

- Studies show that many young people are vulnerable to acquiring HIV because they do not believe the virus is a threat to them.
- Many others are vulnerable because they do not know how HIV is transmitted, do not know how to protect themselves from HIV, or lack access to such preventive services as circumcision and condoms.
- Many adolescents do not go to school and do not have access to information about HIV.
- Other adolescents who do have information about HIV lack opportunities to develop the life skills they need to act on what they know.

BIOLOGICAL SUSCEPTIBILITY TO HIV

Biological susceptibility refers to the increased physical risk of acquiring HIV. Women are probably more susceptible than men to HIV because of the greater area of mucous membrane exposed during sex, the greater quantity of fluids transferred, the higher viral content of male fluids, and the micro-lesions that can occur in vaginal tissue from sexual penetration.

Girls and young women may be especially susceptible to the virus. All else being equal, a 14-year-old girl may have a higher risk of acquiring HIV than a 30-year-old woman for the following reasons:

- **Immature genital tract.** In girls and young women, inadequate mucosal defence mechanisms and the immature lining of the cervix are poor barriers against infection. Once exposed to the virus, girls and young women are more susceptible than boys, young men, or adults of either sex due to the anatomy of the developing cervix and vagina. Also in girls and young women, the thin lining and relatively low acidity in the vagina facilitate transmission.
- **Undeveloped genitalia more easily damaged during forced sex.** Non-consensual sex involving undeveloped genitalia can lead to trauma and therefore increase the chance of transmission upon exposure to HIV. In some settings in Malawi, there is a high rate of coerced sex among girls and young women. In a number of studies, many young women report that they were unwilling and coerced into their first sexual experience. Forced sex is always physically traumatic and, for those with developing genitalia, even more so, allowing for increased risk of infection through skin tears.
- **STIs in sexually active young people.** STIs among sexually active people also increase their chances of contracting and transmitting HIV. The HIV-positive partner has heightened infectivity due to the shedding of more viral ribonucleic acid (RNA) in vaginal or seminal fluid. Herpes simplex virus and genital ulcer disease are STIs known to encourage the spread of HIV. Prevention of STIs and early, correct treatment are important components in an HIV prevention strategy. The presence of an untreated STI (ulcerative or non-ulcerative) can increase the risk of both acquiring and transmitting HIV by a factor of up to 10. Improvement in the management of STIs can reduce the incidence of HIV infection in the general population by about 40 percent (WHO, 2001).

BOX 46. Gender and HIV

In HIV epidemics in which the main route of transmission is heterosexual sex, as is the case in Malawi, young women are disproportionately affected due to biological as well as socially defined gender differences. Gender norms allow men and boys to have multiple concurrent sexual partners and accept or encourage older men to have sexual relations with younger women, leading to infection rates that are much higher among young women than young men.

Gender power imbalances, patterns of sexual networking, and age mixing are all important factors in HIV transmission, especially for young women. As a result of cultural traditions, young women may be ignorant of the facts of sexuality and HIV because they are not "supposed" to be sexually knowledgeable, whereas young men may be ignorant because they are "supposed" to be sexually all-knowing.

Young women often lack the power to negotiate safe sex. Young women (who are often more socially, economically, and physically vulnerable than men) may be unwilling to learn their HIV status or share that information for fear of violence and/or abandonment if the HIV result is positive.

Societies must address issues that affect the vulnerability of women and girls (e.g., gender-based violence, poverty, property rights, and education) and also issues that affect the vulnerability of boys and young men (e.g., visits to sex workers, poverty, injecting drug use, and negative attitudes to sexuality).

Healthcare workers have a role in developing programmes that empower women and girls and reduce their vulnerability and risks for HIV. These programmes should be part of comprehensive SRH strategies.

Adapted from the World Health Organization.

KEY HIV PREVENTION STRATEGIES FOR YOUNG PEOPLE THROUGH HEALTH SERVICES

Aims of HIV prevention initiatives

- Prevent transmission of HIV for all people who are HIV negative or HIV positive (whether they know their status or not) to reduce the number of new infections
- Help people who are HIV negative (whether they know their status or not) to stay negative
- Promote testing and counselling for people who do not know their HIV status

Young people need information and skills to bring about behaviour change. They need to understand the concepts of risk behaviour, such as unprotected sex and the use of alcohol and drugs, the possible consequences of such behaviour, and how to avoid them. They need access to a range of information, life skills, and HIV prevention methods (including information on the advantages of delaying sexual activity, practicing safer sex, negotiating condom use and correct use of condoms, and the importance of sterile needles and syringes) to be able to opt for healthful choices in risky situations. Comprehensive prevention means encouraging young people and supporting them to be aware of their options for a safe life, and assisting them to make the right choices for their individual circumstances.

The most significant services for the prevention and care of HIV among young people have the following characteristics:

- Strengthen the ability of young people to avoid infection, including information and counselling interventions
- Reduce risks by providing condoms to those who are sexually active
- Provide diagnosis, treatment, and care for STIs, including HIV

HIV prevention services must be offered to young people when they attend any health services department (tuberculosis clinic, STI clinic, ANC clinic, family planning clinic, and SRH clinic and services). These services need to be youth friendly (available, accessible, acceptable, appropriate, and effective) for all young people.

Key prevention strategies for young people cannot be the same for all of them, but must be adapted to the different needs of boys and girls, children in and out of school, younger and older adolescents, and married and unmarried young people. A concise list of these strategies follows.

1. Information and education on HIV and safer sex

Many young people say they need more education on sexuality and HIV prevention to help them practise responsible sexual behaviour. It has been shown that young people can responsibly protect themselves and others if they receive support. Postponing their first sexual activity and reducing the number of sex partners can significantly protect young people from HIV. Behaviour change communication can help young people develop positive behaviours. The messages and the way they are given are very important for young people, who want to hear not only what they cannot do, but also what they can do.

2. HIV testing and counselling

Provider-initiated testing and counselling and voluntary counselling and testing services need to be available from all health services and in the community. By knowing their HIV status, young people can strive to remain HIV negative or, if they test positive, access ART early.

3. Access to male and female condoms

The use of condoms to prevent the exchange of body fluids during sex is an essential element of HIV prevention and also offers protection from pregnancy. Safer sex depends on the correct and consistent use of condoms, so condom provision must be accompanied by clear instructions on their use for every act of penetrative sex. Female condoms offer women an option that may give them more control but, in comparison with male condoms, they require more counselling and assistance to be used correctly and are more expensive and less available.

4. Management of sexually transmitted infections

STIs greatly facilitate HIV transmission between sexual partners, so treating and preventing them is an important step in HIV prevention. In some settings, STI rates among young people are high. Effective and early treatment of STIs is an essential part of HIV prevention. For more information, please see Unit 3F, Sexually Transmitted Infections and Young People.

5. Voluntary medical male circumcision

VMMC is one of the most promising strategies to prevent the transmission of HIV and other STIs, such as genital herpes. The procedure significantly reduces the risk of HIV transmission to a circumcised partner and is discussed in more detail later in this unit.

ADVOCACY IN HIV PREVENTION: WHO HAS A ROLE?

HIV prevention requires a broad response from all members of society to ensure an environment in which young people feel safe; supported; and able to protect themselves from HIV at home, school, work, and in the community.

Young people

Young people need to be trained to spread messages and promote responsible behaviour among their peers.

Parents and other adults in the community

Adults, in their professional roles as teachers, sports coaches, and religious leaders, can help adolescents avoid behaviours that put them at risk of acquiring HIV. Community members need to be trained, supported, and provided with the tools to work with young people who are most vulnerable to acquiring HIV.

Public idols who are role models for young people

Celebrities such as musicians, film stars, and sports figures can act as role models for young people through their personal lives and their performances to encourage young people to adopt and maintain healthy behaviours.

Public and private sector

Politicians and bureaucrats can influence the social, economic, and political environment and help to shape favourable policies in the fight against HIV. Private companies and organisations are in a prime position to provide youth-focused, HIV-related communication for behaviour change, testing and counselling, laboratory and clinical services, and drug distribution and dispensation.

The media

The public image of sexuality and HIV in the media influences young people. Media provides the power to share information with large audiences. Codes of practice, regulations, and education for members of the media are needed to ensure responsible advertising and programming.

People living with HIV

People living with HIV have a role in HIV prevention. Their personal role is to ensure they do not transmit HIV to any other person. They may also choose a public role as a supporter or activist on behalf of other PLHIV, as an educator or speaker on prevention of HIV or living with HIV, and as an advocate of the rights of PLHIV. People living with HIV are frequently subject to discrimination and human rights abuses. A strong network of PLHIV can provide mutual support and a voice at local and national levels; such a network can be a particularly effective way to tackle HIV stigma.

QUESTIONS FOR THE HEALTH WORKER WHEN PLANNING HIV PREVENTION SERVICES FOR YOUNG PEOPLE

1. WHAT IS HAPPENING IN MY COMMUNITY WITH YOUNG PEOPLE AND HIV?

Talk to young people and young PLHIV to find out the risk and protective factors in their lives, where transmission may be occurring, and what needs they identify to prevent transmission of HIV. Encourage them to plan and contribute actively to developing HIV prevention services.

2. WHAT CONTRIBUTION CAN I MAKE TO HIV PREVENTION?

Begin by looking for anything you could do. Start small. Learn from what has been done elsewhere. Look for support from young people, other professionals, and community members. Start by talking about the issues of HIV and young people to colleagues and community members.

3. WHAT BARRIERS ARE THERE (IN MYSELF, MY WORK ENVIRONMENT, AND MY COMMUNITY) THAT COULD HINDER MY CONTRIBUTION?

The issue of HIV and young people raises many sensitive issues around sexuality and sex. Health workers, young people, and community members often feel uncomfortable discussing and addressing such issues. If health workers are to work successfully with young people on HIV, they must examine their attitudes and practices, and reflect on the material in the WHO Orientation Programme on Adolescent Health for Health-care Providers. Discrimination against PLHIV exists among health workers and in health services. Identify and examine reasons why young people cannot or may choose not to go to health services in your community (e.g., legal restrictions, the attitudes of personnel, and lack of confidentiality or privacy).

4. WHAT CAN I DO TO OVERCOME THESE BARRIERS?

Look for formal and informal ways to discuss sexuality and HIV with members of your community. Help them to see the importance of the issues and the consequences for young people of not addressing HIV prevention. Health workers have an important professional responsibility to address these sensitive issues, even if they do not themselves approve or condone the behaviours and lifestyles of the affected young people. All health workers have a responsibility to act with respect and professionalism by following proper procedures with all people, including PLHIV. Talk with others about what you have learned and the changes that you plan in your practice. Look for help from others to overcome barriers to developing HIV prevention services in your community.

5. WITH WHOM DO I NEED TO WORK?

Contact people who are already working with HIV and young people in your community or region and learn from their experiences (youth groups, nongovernmental organisations [NGOs], health professionals, teachers, peer support groups, community leaders, etc.). Identify difficult areas of this work (e.g., issues of consent and confidentiality with patients who are minors) and discuss what can be done in practical terms. Join or develop networks of people working on these issues for support and to share information. Plan together so that the strategies and HIV prevention messages youth hear and see are consistent and complementary.

VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC)

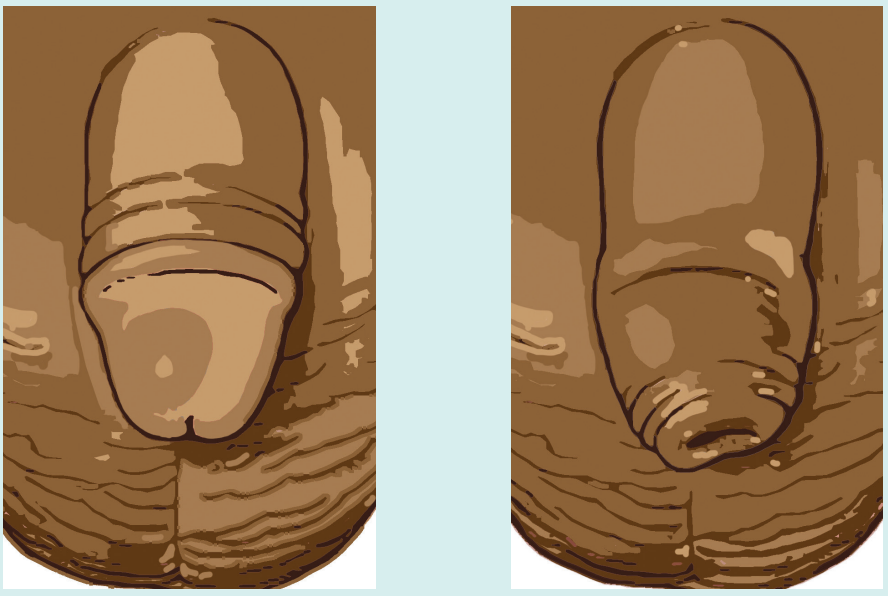
What is male circumcision?

Circumcision is the surgical removal of the foreskin—the fold of skin that covers the head of the penis. It is widely practised for religious and traditional reasons, often within the first two weeks after birth or at the beginning of adolescence as a rite of passage into adulthood. It may also be performed for medical reasons to treat problems involving the foreskin. Figure 4 shows the circumcised and uncircumsised penis.

BOX 47. Minimum age for VMMC in Malawi

Adolescents ages 10–17 years need the consent of a parent or guardian to undergo VMMC. Any person age 17 and above can make a voluntary choice.

FIGURE 4. Circumcised and uncircumcised penis



Circumcised Penis

Uncircumcised Penis

HOW CIRCUMCISION IS PERFORMED

During a circumcision, the foreskin is freed from the head of the penis (glans) and removed. When done in a newborn baby, the procedure is simpler and quicker than in adolescents and adults. Superficial wound healing after circumcision in adults generally takes five to seven days. However, about four to six weeks are needed for the wound to heal fully. In babies and young boys, the healing time is considerably shorter.

BENEFITS AND RISKS

Table 14 shows the benefits and risks of VMMC.

TABLE 14. Benefits and risks of voluntary medical male circumcision

BENEFITS	RISKS
• It is easier to keep the penis clean. • There is a reduced risk of acquiring HIV. • There is a reduced risk of some STIs, especially ulcerative diseases, such as chancroid and syphilis. • There is a reduced risk of cancer of the cervix in female sex partners. • There is a reduced risk of penile cancer. • There is a reduced risk of urinary tract infections in childhood. • Circumcision prevents inflammation of the glans (balanitis) and the foreskin (posthitis). • Circumcision prevents the potential development of scar tissue on the foreskin, which may lead to phimosis (inability to retract the foreskin) and paraphimosis (swelling of the retracted foreskin, resulting in inability to return the foreskin to its normal position).	• Pain • Bleeding • Haematoma (formation of a blood clot under the skin) • Infection at the site of the circumcision • Increased sensitivity of the glans penis for the first few months after the procedure • Irritation of the glans; meatitis (inflammation of the opening of the urethra) • Adverse reaction to the anaesthetic used during the circumcision

Male circumcision and HIV infection

Malawi has adopted VMMC as a key strategy to reduce HIV prevalence among males. Research has shown a lower risk of infection in circumcised men than in uncircumcised men, as well as a lower prevalence of HIV in populations where male circumcision is common.

BOX 48. Possible biological explanations for the protective effect of male circumcision

The foreskin contains high concentration of cells of Langerhans, which have receptors for HIV entry.

Circumcision reduces the risk of HIV acquisition by taking off these cells through the removal of the non-keratinised skin that makes up the foreskin (prepuce).

Circumcision also reduces HIV transmission by reducing the risk of acquiring STIs and by reducing micro trauma and abrasions.

Linking male circumcision to other male sexual and reproductive health services

Male circumcision should be regarded as an entry point for sexual, reproductive, and other health services for men, including the following:

- Sexual and reproductive health education and counselling
- Screening and treatment for STIs
- Counselling and testing for HIV (with referral for care and support for those testing positive)
- Family planning education, counselling, and services, including provision of condoms and long-acting reversible contraception for female partners
- Evaluation and management of infertility
- Counselling on gender issues, including promotion of respect for women's and girls' sexual and reproductive health needs and rights, and the importance of preventing gender-based violence
- Education about cancers of the male reproductive organs (testes, penis, and prostate) and cervical cancer
- Counselling for alcohol dependence and other substance abuse, which are associated with a number of health risks
- HIV testing and counselling (HTC) for young people

The concept of HTC has been broadened from simply making these services available to those who ask for it. However, in all testing and counselling situations (both voluntary and provider initiated) the patient always retains the right to refuse.

HTC is an important entry point to prevention, care, treatment, and support. It is a crucial prevention intervention for people who test negative.

HIV testing must be offered in concert with the 4 Cs: confidentiality, informed consent, counselling, and condoms.

BOX 49. What more do adolescents and young people need to know about VMMC?

- Male circumcision does not provide full protection against HIV but appears to reduce the risk of infection by 50–60%.
- It gives little or no protection against STIs that affect the urethra, such as gonorrhoea and chlamydia.
- It provides no protection against acquisition of HIV from unsafe injections or infected blood products, or through receptive anal intercourse. It also does not prevent pregnancy.
- To reduce the risk of STIs, including HIV, and the risk of unwanted pregnancy, comprehensive education and information programmes are needed, as well as services for contraception and STI prevention and management.
- A possible consequence of promoting male circumcision for HIV prevention is that circumcised men may perceive themselves as immune and subsequently increase their exposure to HIV, thus ignoring other important strategies to reduce risk.
- In many societies where male circumcision is performed as a rite of passage to adulthood, the circumcision festival period is also used to educate young men about health and social issues. These cultural traditions can be harmonised with modern clinical practice to ensure the safety of circumcision and educate young men about a number of SRH issues.

IMPORTANCE OF HIV TESTING AND COUNSELLING FOR YOUNG PEOPLE

1. Knowing their HIV status and receiving counselling and support can enable individuals in the following ways:

- *Initiate or maintain behaviours to prevent acquiring or transmitting HIV.*

  Learning about one's HIV sero-status, with counselling support, can occur at a time when young people are open to making changes in their risk behaviour. This empowers those who are HIV negative to remain so and those with HIV to access care and prevent transmission to others. Correct and consistent condom use must be actively promoted by all HTC services.

- *Gain early access to specific HIV-positive prevention, support, care, and treatment services.*

  The earlier young people know they are HIV positive, the sooner they can receive counselling and support and start on ART, thereby reducing the risk of transmitting HIV and protecting themselves, their partners, and their loved ones.

- *Access strategies to prevent transmission from mothers to their infants.*

  In Malawi, mother-and-child health clinics can offer HTC and antiretroviral drugs for PMTCT as soon as pregnant women test positive for HIV (Option B+). This helps to reduce significantly the transmission of HIV from mother to child.

BOX 50. Minimum age of HTC consent in Malawi

Any person age 13 and above should be considered mature enough to give full and informed consent for HTC. However, HTC for adolescents below age 13 should be done with the knowledge of their parents or guardians unless this is not possible and the testing is for provision of treatment and care services.

2. Knowing their HIV status and receiving counselling and support can help communities in the following ways:

- *Reduce the denial, stigma, and discrimination that surround HIV.*

  Communities that normalise the process of including HIV sero-status as part of general health-seeking behaviour have a greater chance of tackling the stigma and discrimination associated with the disease.

- *Mobilise support and appropriate responses.*

  Community mobilisation can be facilitated if more people know their HIV status. In communities where people have a friend or relative with HIV, the stigma associated with the virus can be less and support for PLHIV can grow.

BOX 51.

WHO does not recommend mandatory HIV testing as an effective public health strategy. Mandatory testing is not ethical and does not respect the human rights of an individual.

Special considerations in HIV testing and counselling among young people

- *Do not discount the potential for HIV in young people.*

  It is important for health workers to consider that their young clients may be HIV positive, given this age group's particular vulnerability to the virus. Health workers should therefore encourage young clients to consider being tested. Those who decline the test must be invited to come back when they are ready; meanwhile, they should be provided with links to other support services in the community.

- *Understand the issues of consent and confidentiality in HTC of minors.*

  As with any patient, consent and confidentiality are important considerations with minors who come for HIV testing, especially if they are not accompanied by an adult. Each situation is different. If possible, an assessment should be made of the young person's risk for HIV, the possibility of not returning for testing, and his or her capacity to understand informed consent. Health workers should take into account the best interests of young persons and their evolving capacities. All health discussions with minors should be kept confidential, unless unlawful.

  Parents or guardians should not be informed of an adolescent's HIV status without the explicit consent of the adolescent, who is deemed capable of providing informed consent. The Convention on the Rights of the Child states this clearly: "Information on the HIV status of children may not be disclosed to third parties, including parents, without the child's consent" (UN, 2003).

- *Remember that your first meeting with a young person may be your only meeting.*

  Take advantage of the initial session with a young person, as it may be your only chance to communicate the reality of HIV and the importance of living safely. Because the client may not come back, be sure to provide educational materials and links to community services and peer support.

- *Promote beneficial disclosure.*

  All PLHIV need support to cope with living positively. Support from family and close friends can be particularly important, but clients can access this support only if family or close friends know their HIV status. Counselling can help them to understand the benefits of revealing their HIV status. They may need to think about this and even to practise, through role play, how to tell friends and family. Peer support groups are especially valuable opportunities for clients to share their concerns and experiences, and counselling can help clients decide who to tell and how to go about it.

- *Take the opportunity given by a negative HIV test.*

  An HIV-negative test result is an opportunity to discuss risk behaviour and promote behaviour change with young persons. Prevention education and risk-reduction counselling can help them to consider, plan, and implement changes in their HIV risk behaviour. Promotion of condom use should be part of all counselling sessions and should include distribution of condoms, as appropriate.

- *Promote future counselling of the client together with the client's sexual partner.*

  Couples counselling can help to avoid a situation in which the partner who receives a positive test result is blamed. It is also an opportunity to discuss condom use. With a discordant couple (when one person is HIV positive and the other is negative or of unknown HIV status), couples counselling can provide support to each partner to help them cope with the situation. However, there are situations where couples counselling is not possible.

- *Promote safer sex and harm reduction.*

  Safer sex includes delaying first sexual activity, reducing the number of sexual partners (or delaying sexual activity in a new relationship), and using condoms correctly and consistently. Harm reduction includes strategies and approaches that reduce the physical and social harms associated with risk-taking behaviour. Harm reduction among sex workers includes correct and consistent use of condoms.

- *Promote peer counselling by other young PLHIV.*

  Young people need the support and practical experience of other people in their situation who are coping well with living with HIV.

For young people who refuse HIV testing, the health worker should take the following steps:

- Counsel them on the benefits of testing
- Identify and discuss their barriers to testing
- Provide emotional support and refer them to peer counselling
- Assess their intention to test at a later date
- Offer a follow-up appointment

YOUNG PEOPLE LIVING WITH HIV

Management of HIV in young people includes these services:

- Care
- Treatment
- Support
- Positive prevention for young people living with HIV
- Transitioning to adult services
- Counselling, which is an integral part of all of these services

The aim of these services is to help young people living with HIV to do the following:

1. STAY HEALTHY AND LIVE POSITIVELY

Positive living can help young people living with HIV to live full and healthy lives. Counselling and support can help them improve their self-esteem and confidence, with the aim of protecting their own health and avoiding passing the virus to others. Health workers can support the efforts of young people living with HIV to prevent other infections, take part in physical activity, avoid harmful treatments, and maintain good nutrition. They can refer these young people to other community services for emotional and peer support (e.g., young PLHIV support groups and post-test clubs).

2. ADHERE TO CARE AND TREATMENT

Young PLHIV may need to take medication for a range of infections and illnesses. Adolescents who acquired HIV through perinatal transmission may have begun ART in childhood. Otherwise, as HIV progresses, they may require ART. Adherence to all treatments is important. Adherence to ART is important for the health of the individual and to reduce the risk of drug resistance.

3. UNDERSTAND THE BENEFITS OF DISCLOSING HIV STATUS TO FAMILY, SEXUAL PARTNER(S), AND CLOSE FRIENDS

PLHIV may hesitate to reveal their HIV status to others for fear of stigma and discrimination. To receive the support of family and friends, young people living with HIV will need to face the difficult task of telling them their HIV status. Adolescents infected through perinatal transmission may not know that they are HIV positive, though they have probably suspected. However, there is a risk of disclosing HIV status in an unsupportive setting; women, in particular, may be at risk of domestic violence.

4. COPE WITH STIGMA AND DISCRIMINATION TOWARDS THEMSELVES AND THEIR LOVED ONES

Health workers have an important role to play in combating stigma and discrimination and helping young people living with HIV cope with the ways stigma and discrimination can affect them, their families, and their loved ones. Unfortunately, stigma and discrimination against PLHIV persist in health centres. Young people living with HIV should be involved in developing and planning HIV support services. This can lead to improved use and ownership of services, and can reduce stigma and present a positive role model to healthcare workers and patients.

BOX 52. Young people and HIV stigma and discrimination

HIV-related stigma is when unfavourable attitudes, beliefs, and policies are directed at people perceived to have HIV or AIDS, as well as to their loved ones and others (close associates, social groups, and communities).

HIV-related discrimination results when actions differentiate people based on stigma (e.g., a confirmed or suspected HIV sero-status). Persons associated in the public mind with HIV or AIDS—e.g., men who have sex with men, sex workers, people who inject drugs, and the family members and associates of PLHIV—may also face discrimination.

HIV-related stigma, discrimination, and human rights violations are serious barriers to progress in understanding HIV; providing care, support, and treatment; and alleviating the impact of the epidemic.

Discrimination occurs when ill-informed people or institutions treat individuals unfairly or unjustly because of their presumed or actual HIV status. It can occur through actions or failures to act, and can result in violations of human rights.

Patterns of prejudice, which include devaluing, discounting, discrediting, and discriminating against these groups of people, play into and strengthen existing social inequalities—especially those of gender, sexuality, and race—that are at the root of HIV-related stigma.

These factors contribute to HIV-related stigma:

- HIV is a life-threatening disease.
- People are afraid of contracting HIV.
- The disease is associated with behaviours such as having many sexual partners that are already stigmatised in many societies.
- PLHIV are often considered responsible for having acquired the virus.
- Religious or moral beliefs lead some people to believe that HIV is the result of a moral fault (such as promiscuity or "deviant sex") that deserves to be punished.

Stigma and discrimination discourage people from getting tested for HIV. They also discourage those who are HIV positive from obtaining needed services because to do so could reveal their HIV status.

Positive prevention

Positive prevention for young people includes all strategies that increase the self-esteem and confidence of young people living with HIV, with the aim of protecting their own health and avoid passing the virus to others.

Improving the self-esteem and confidence of young people living with HIV has many benefits at the individual, family, and community levels. Positive prevention recognizes the rights and needs of PLHIV and can empower them, help them to take charge of their lives, and encourage them to take responsibility for preventing HIV transmission. Positive prevention focuses on communication, information, and support; safer and healthier sex; harm reduction; PMTCT; and STI management. The concept of positive prevention is expanding and can also include provision of safe drinking water, insecticide-treated bed nets to prevent malaria, and screening and chemoprophylaxis (e.g., co-trimoxazole and isoniazid) for tuberculosis.

An important part of positive prevention is counselling, with the following aims:

- Supporting positive living (emotional, psychological, and physical), which can help PLHIV to live healthily and take responsibly for their health.
- Assisting PLHIV to learn how to enjoy a healthy sexual life without fear of transmitting the virus to their loved ones.
- Involving PLHIV and associations of PLHIV in community activities.

Positive prevention requires the meaningful involvement of young people living with HIV in the planning and implementing of HIV strategies. They can work with service providers to develop relevant and useful strategies. They can provide a unique perspective and provide credibility and relevance to the local context. They also give a face to HIV. When programmes enlist young people living with HIV and organisations focus on them (where these exist), they become emissaries to the wider community whose efforts can increase awareness, decrease stigma and discrimination, and increase the use of services.

Psychosocial issues especially pertinent to young people living with HIV

For most people, sexual activity begins during adolescence; in general, sex is an important part of the lives of young people. Young people living with HIV need practical support to deal with their questions, concerns, and fears around being HIV positive, wanting to have friendships and to be loved, and having or wanting to have sexual relations and children. Like all people, PLHIV have the right to have intimate relationships and children.

Those who work with young people living with HIV say that, in general, the following questions express their clients' greatest concerns. Health workers may find it hard to raise and discuss these sensitive issues, and young people themselves may not be able to voice their concerns. The following questions and answers can help health workers talk with young people about these issues.

1. WILL ANYONE WANT TO HAVE SEX WITH ME IF THEY KNOW I AM HIV POSITIVE?

PLHIV can continue to have sex. However, there is a high risk of HIV transmission if a person who is HIV positive has sex without a condom. Explain to the client the need to always use a barrier to prevent contact with blood or sexual fluid. Condoms are the most common barriers for men. Female condoms can protect the vagina or anal area during sex. There is no way to know how risky it is for two HIV-positive people to have unprotected sex regarding exposure to a different strain of the virus or some other STI. Using a condom, though, will reduce these risks. Stress the importance of using condoms correctly and consistently every time the client has sex. Stress, too, the importance of disclosing one's status to a partner before there is any risk of HIV transmission and acknowledge that doing so is not easy. Explain that counselling and support from other young people living with HIV can help the client to understand the options for enjoying a healthy sexual life as a person living with HIV.

2. WILL I BE ABLE TO HAVE CHILDREN?

Like all people, PLHIV have the right to have children. HIV-positive women and couples have the right to choose for themselves whether they want to have children or not. Affirm the value of sexual and reproductive services, including counselling, as tools to understand one's reproductive choices and the health risks for the unborn child, thus equipping the client to make informed decisions.

Encourage couples counselling; if the client's situation makes this impossible, however, support the client's decision.

3. WILL I DIE EARLY?

Some young people may not understand the difference between HIV and AIDS. They may think that a positive test result means they will die soon. With more effective drug regimens and earlier detection, it is possible to remain healthy for many years. But the reality is that many young people living with HIV will die earlier than they would without HIV.

Emotional and spiritual support can alleviate depression, help to prevent suicidal ideas, and help deal with the strong emotions associated with having a chronic and fatal condition. This support can come from many individuals and settings, both formal and informal. For young people, peer support is especially important. If peer support is not available, the health worker can be active in starting a peer support group for young people living with HIV.

4. I AM TOO YOUNG TO HAVE A CHRONIC DISEASE.

Adolescence is a special time in people's lives. All people have dreams for the future, so to learn that one must live with HIV is shocking news at any age. Young people can have trouble imagining how they are going to live their whole lives with a chronic disease when they feel that their lives have only just begun. All of their desires for relationships, family life, and career are overshadowed by the news. The health worker can play an important role in providing the young person with hope and helping him or her to perceive that life can continue—and be meaningful—even in the presence of HIV. Health workers can also provide referrals to peer support.

5. I CAN'T TELL ANYONE THAT I AM HIV POSITIVE.

Many people are naturally fearful of telling family, friends, and sexual partners that they are HIV positive. Young people should be encouraged to understand the benefits of telling family and friends their HIV status. They need the support of this social network to help them cope with living positively. They can also benefit from sharing their fears and concerns with other young people living with HIV. However, they will need encouragement and support to tell others their status, and all concerned must be aware of the risk of disclosing positive HIV status in unsupportive settings.

Through counselling, clients can be made aware of the benefits of disclosing their HIV status to selected people who can support them to live positively. Ultimately, though, the young person must always be the one who decides whom to tell, and when.

6. I AM AFRAID THAT PEOPLE WILL REJECT ME, SHUN ME, OR BE VIOLENT TOWARDS ME.

Many people with HIV experience stigma and discrimination. Acts of discrimination against PLHIV can range from inappropriate comments to violence. Information and education about HIV can help moderate the fears and misconceptions of people in the community and reduce stigma and discrimination. As more people learn their HIV status, being HIV positive can become less of a stigma. HIV can have a negative impact on education and work opportunities. Young people will need support and advice on how to manage such future opportunities.

Young people living with HIV may have feelings of loneliness and isolation. They may lose friends because they are HIV positive. They may also be wary of revealing their status to anyone (sex partner, peers, family members, school officials, etc.) for fear of the negative consequences that disclosure can have. Although this may be true for anyone, young people have heightened difficulty because, to a certain extent, they base their self-worth on what other people think of them.

Stigma and discrimination are serious barriers to HIV prevention.

7. CAN I STILL SMOKE, DRINK, GO OUT, AND HAVE FUN LIKE MY FRIENDS?

Young people living with HIV should be encouraged to live the same life as their friends, but they may need to be more aware of maintaining their good health and avoiding activities that jeopardise it.

Health workers should ask permission before giving young people living with HIV information on how to stay healthy. Young people will decide for themselves their limits and the risks they will take. General information on healthy living (nutrition, hygiene, exercise, adequate rest, avoiding smoking, moderate alcohol use, etc.) is important. They will also need practical information on HIV transmission, substance use, negotiating and practising safer sex, and ART adherence.

Remind young people that substance use can impair judgement, making them more susceptible to pressure to engage in unwanted or unprotected sex. Using substances can also interfere with adherence to their medication.

Transitioning to adult services

As adolescents living with HIV move towards adulthood, they need help preparing for the shocks that can accompany the transition to adult services. People and providers trained to support adolescents living with HIV can follow some basic steps, shown in Box 53.

BOX 53. General principles for effective transition from adolescent to adult HIV services

- Tailor your approach to the needs of the client.
- Identify providers of adult care who are willing to care for adolescents and young adults.
- Begin the transition process early and ensure communication between the paediatric/adolescent and adult care providers before and during the transition.
- Develop and follow an individualised transition plan for the patient in the paediatric/adolescent clinic. Also develop and follow an orientation plan in the adult clinic. Plans should be flexible to meet the client's needs.
- Use a multidisciplinary transition team, which may include peers who are in the process of transitioning or have transitioned successfully.
- Address comprehensive care needs as part of the transition, including the medical, psychosocial, and financial aspects of transitioning.
- Allow adolescents to express their opinions.
- Educate HIV care teams and staff about transitioning.

CONCLUSION
Successful approaches to working with young people who have HIV

- Youth participation in planning and implementation of programmes
- Comprehensive life skills and sex-and-relationships education in and out of school
- Peer-led programming to inform and encourage young people to protect their health
- YFHS offering HTC and services for the diagnosis and treatment of STIs
- Community-based programmes and education for young men and women to tackle sexual coercion and other forms of violence
- Sustained media campaigns using communication channels that young people find credible and acceptable to promote gender-equitable norms and HIV prevention education

This unit provides information on the following:

1. Definition and importance of good nutrition
2. The status of nutrition in Malawi
3. Groups of food necessary for good nutrition
4. Linkages between nutrition and HIV and AIDS
5. Signs and symptoms of malnutrition
6. Consequences of poor nutrition among adolescents and young people
7. Promotion of good nutrition

UNIT 4.
NUTRITION AND YOUNG PEOPLE

DEFINITION AND IMPORTANCE OF GOOD NUTRITION

Nutrition is generally defined as how any living organism changes and uses food for life. Food is anything that a person eats or drinks. From food we get nutrients—the part of food that an organism must have for life and health. The cliché that "we are what we eat" reflects the necessity of good nutrition for human health and survival.

Although good nutrition is essential for all age groups, adolescent developmental processes warrant specific considerations.

THE STATUS OF NUTRITION IN MALAWI

Information on the status of adolescent nutrition in Malawi, as in many other parts of the world, is limited because it is not routinely collected. Nonetheless, nutrition indicators in the under-five age category suggest that Malawi faces a big problem. According to the 2010 MDHS:

- 47 percent of children under age five are stunted (too short for their age)
- 20 percent of children are severely stunted
- 4 percent of children are wasted or too thin
- 13 percent are underweight

Stunted growth of children is an indicator of under-nutrition and is typical of poor nutrition experienced over a long period.

BENEFITS OF GOOD NUTRITION

The effects of poor nutrition in early childhood may be felt both during the adolescent stages and later in life. It is therefore imperative that young people have access to good nutrition to promote their good health and survival.

Box 54. Benefits of good nutrition

- Promotes good physical and mental growth and development through all stages of life
- Boosts the body's immunity to protect against infection (most antibodies are formed from proteins)
- Supplies vitamins, which form enzymes, which in turn help in metabolising
- Promotes optimal brain function
- Facilitates good functioning of all systems of the body (e.g., digestive, reproductive, nervous)
- Supports regeneration of body cells
- Develops and maintains healthy bones and skin

GROUPS OF FOOD NECESSARY FOR GOOD NUTRITION

Young people need to maintain a daily balanced diet because each food group has a specific role in good health. A balanced diet covers six food groups, and young people in Malawi, regardless of their socioeconomic status, should be encouraged to consume foods in all of them. Cheap, locally available foods in each group should be promoted so people can maintain a balanced diet without straining to do so.

Table 15 summarises the six food groups that constitute a balanced diet and their functions in the body.

TABLE 15. Six food groups for a balanced diet, and their functions

GROUP	MAIN NUTRIENT	EXAMPLES OF FOODS	THEIR ROLE IN THE BODY
Vegetables	Vitamins and minerals	Greens: bononGwe, chisoso, luni, Chinese cabbage, mpiru Fruits: pumpkin, tomatoes, peppers Roots: onion, garlic Mushrooms Flowers: pumpkin flowers	Fight infections
Fruits	Carbohydrates and vitamins (water and fibre)	Sweet or tangy fruits, often eaten raw Fruits (except for ones in the fats or vegetables groups): papaya, guava, lemon, tangerine, banana, mchisu, granadilla Honey and sugar cane (these provide vitamins and carbohydrates)	Aid in food digestion and help form enzymes
Legumes and nuts	Protein and carbohydrates (minerals, vitamins, fibre, fats)	Legumes are seeds in a pod Beans and peas: hyacinth beans (khungudzu), ground beans (nzama), soybeans, pigeon peas (nandolo), peas (nsawawa), mucuna (kalongonda) Nuts: mtedza	Body maintenance Muscle and tissue development
Food from animals	Protein and fats (minerals and vitamins)	Flesh, blood: mice, chicken, pigeon, pig, goat, fish, cow, lamb, ngumbi (flying ants), caterpillars Eggs Milk and milk products: milk, chambiko, cheese	Energy-giving foods Body maintenance
Fats and oils	Fats (minerals, vitamins, proteins)	Foods that feel "fatty" in your mouth Oilseeds: pumpkin seeds, sesame seeds, sunflower seeds, cooking oils Fruits: avocado pears, coconut flesh Animal fats: butter, lard	Energy-giving foods
Staples	Carbohydrates (protein, minerals, vitamins)	Seeds without a pod and starchy roots Grains: rice, wheat, sorghum, millet, maize Starchy roots: yams (chilazi, viyao), sweet potatoes, Irish potatoes, cassava	Energy-giving foods

LINKAGES BETWEEN NUTRITION AND HIV AND AIDS

Adequate nutrition is necessary to maintain the immune system, protect against opportunistic infections, optimise response to medical treatment, sustain health levels of physical activity, and support optimal quality of life for PLHIV, including young people.

- HIV weakens the body's immune system. However, the food we eat contributes to production of antibodies and energy that help to keep us strong.
- Essentially, good nutrition slows the progression of HIV and facilitates effective response to treatment. Thus, it is important for PLHIV of all ages to have a balanced diet.

The broad relationships and interactions among HIV, AIDS, food security, and nutrition are complex. Young people living with HIV are at a greater risk of food insecurity than those who are HIV negative because muscle weakness hinders them from working in their gardens. Food insecurity and poverty may lead to high-risk sexual behaviours, thus increasing the risk of acquiring HIV and transmitting the virus.

For these reasons, it is particularly important for health workers to emphasise the need for good nutrition in adolescents, and especially young people living with HIV. Delaying interventions until they or their families become malnourished or food insecure can be counterproductive and costly. Maintaining adequate nutrition and food security can be instrumental in mitigating the impact of HIV and caring for young people living with HIV and their households and communities.

SIGNS AND SYMPTOMS OF MALNUTRITION

Malnutrition denotes impairment of health arising either from deficiency or excess, or an imbalance of nutrients in the body. An under-nourished person has inadequate amounts of essential nutrients in his or her body, which negatively affects body functioning. Signs of malnutrition are as follows:

- Feeling tired all the time and lacking energy
- Getting frequent infections
- Taking a long time to recover from infections
- Delayed wound healing
- Poor concentration
- Difficulty keeping warm
- Depression

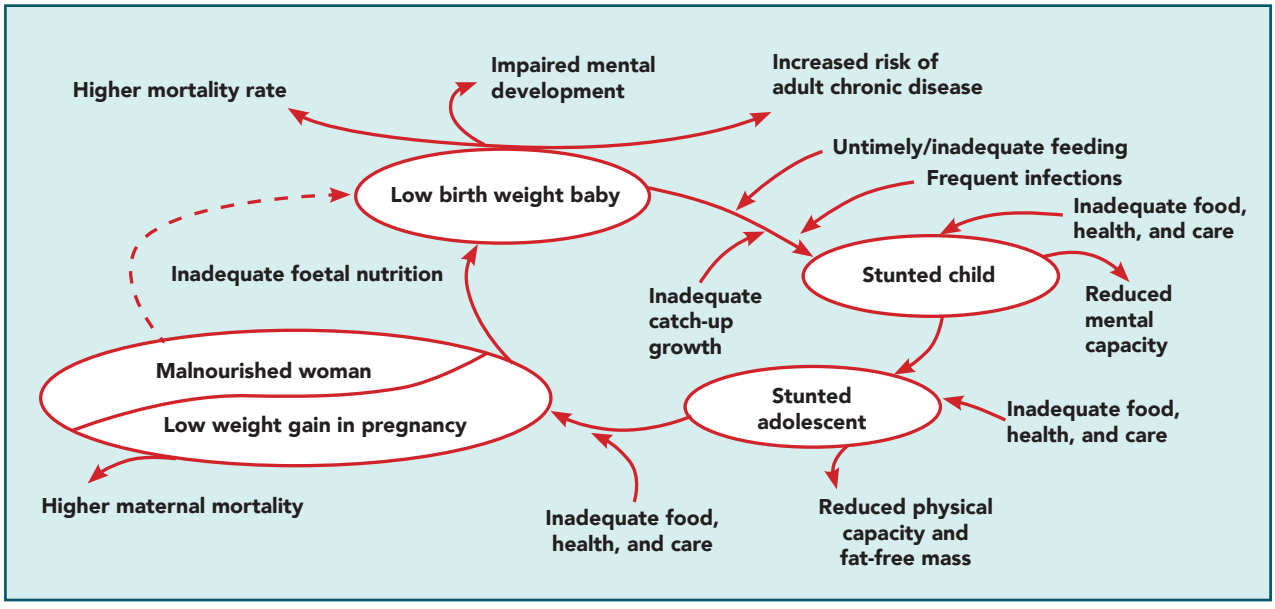
CONSEQUENCES OF POOR NUTRITION

Box 55. Consequences of poor nutrition

- Obesity (when a person's weight is 20% more than the standard weight for their height)
- Anaemia (in pregnancy, it can lead to such complications as maternal death, low birth weight, and foetal death)
- Risk of developing such conditions as diabetes, high blood pressure, and joint problems (gout)
- Growth retardation (stunting)/under-development
- Poor physical and mental development
- Poor wound healing
- Bone malformation
- Increased susceptibility to infections (due to weak immunity)

Poor nutrition has consequences throughout the life cycle. Chronic malnutrition from early childhood has effects in adolescence and adult life. Similarly, acute malnutrition at any stage of life has immediate consequences. Figure 5 illustrates the consequences of poor nutrition across the life cycle both for men and women.

FIGURE 5. Consequences of poor nutrition



SOURCE: Adapted from the Commission on the Nutrition Challenges of the 21st Century, 2000

PROMOTION OF GOOD NUTRITION

Health facilities are entry points for young people to access counselling, care, and support for good nutrition. However, YFHS providers need to know the basic elements of good nutrition in order to counsel young people correctly, as follows:

- **Eat a variety of foods.** In this way, one's diet is more likely to cover all six food groups and the nutrients necessary to maintain a balanced diet and prevent disorders arising from poor nutrition.
- **Eat locally available foods.** Locally available foods such as bonongwe, beans, ngumbi, therere, and chisoso are cheap and nutritious.
- **Avoid eating too many fats, saturated fats, and cholesterol.** Although fats are important for the production of energy, research has demonstrated an association between dietary fats and the incidence of cardiovascular disease and cancers of the breast, colon, rectum, and prostate. Thus the amount of fats should be regulated.
- **Eat food with adequate starch and fibre.** Starch is a good source of carbohydrates, which our bodies need for energy. Fibre contains cellulose, which aids in stimulating peristalsis, thus promoting good digestion and normal bowel elimination, in turn decreasing the absorption of dietary cholesterol. Dietary fibre is also known to have a protective effect against colon cancer. Consumption of foods high both in starch and fibre, such as apples, mgaiwa, oats, porridge, and brown bread, should be recommended to young people.
- **Avoid eating too much processed sugar.** Processed sugar is a risk factor for dental caries and obesity. In addition, such sugar increases calorie intake without supplying essential body nutrients.
- **Avoid eating too much sodium.** A high intake of sodium (salt) can affect blood pressure levels. Decreasing intake of sodium is associated with decreased blood pressure in people with hypertension. In particular, large amounts of added salt are a risk factor for hypertension, and hence should be avoided.
- **Reduce intake of alcohol.** Alcohol is high in calories but less so in nutrients. In most cases, young people who drink alcohol to excess do not eat balanced diets, making them prone to malnutrition and other health risks, such as kidney and liver failure. Moreover, excessive alcohol intake is associated with road traffic accidents and other risky behaviours such as unprotected sex and psychoactive substance use.

Summary

Good nutrition means that what you eat and drink provides you with the nutrients you need for good health.

There is a direct link between nutrition and HIV. For PLHIV of all ages, adequate nutrition is necessary to maintain the immune system, manage opportunistic infections, optimise response to medical treatment, sustain health levels, support physical activity, and support an optimal quality of life.

Poor nutrition leads to such negative health consequences as malnutrition (obesity and under-nutrition), hypertension, diabetes, and iron deficiency anaemia.

A recommended dietary intake entails eating a balanced, nutritious diet in adequate amounts. Such a diet also entails eating a variety of foods; avoiding too much sugar; eating foods with adequate starch and fibre; avoiding too much sodium; reducing alcohol intake; eating locally available cheap and nutritious foods; and avoiding too many fats, saturated fats, and cholesterol.

This unit provides information on the following:

1. Definition and magnitude of substance abuse
2. Why young people in Malawi misuse drugs
3. Myths and misconceptions about substance abuse
4. Most commonly abused substances among young people in Malawi
5. Prevention of substance abuse

UNIT 5.
SUBSTANCE ABUSE AND YOUNG PEOPLE

DEFINITION AND MAGNITUDE OF SUBSTANCE ABUSE

Substance abuse refers to excessive use of psychoactive substances—those that, when taken or administered into one's system, affect mental processes (cognition or emotional response), which in turn affect other social and biological dimensions of human life.

One household survey conducted in Malawi in 2012 estimated that 27.3 percent of males and 1.6 percent of females ages 18 and older reported using alcohol (Natvig et al., 2014). Another study found that there are three main drugs of abuse in Malawi; alcohol (traditional beverages such as chibuku, kachasu, and other beer), cannabis (locally known as chamba), and tobacco (SINTEF Health Research, 2008).

The use of alcohol sachets has been recognized as a problem among young people in Malawi. A qualitative study revealed that sachets are popular among young people because they are cheap, easily accessible, and quickly intoxicating owing to their high alcohol content (Soko and Chilapondwa, 2015). The government banned their manufacture in 2015.

Why young people misuse drugs in Malawi

Most young people in Malawi who misuse drugs do so for any of the following reasons:

- Peer pressure
- Ease of access to a drug
- Relief from pain, stress, and anxiety
- Stimulation to aid studying
- Relief from emotional deprivation, frustration, and loneliness
- Relief from shyness—a confidence boost
- Rejection by parents
- Boredom from idleness
- Lack of knowledge about the dangers of drug use
- Poverty
- Having too much disposable cash
- Curiosity about experimenting with drugs
- Religious beliefs, such as those of the Rastafarian movement, which extols the virtues of cannabis
- Exercise of their "democratic rights"
- Disorientation from rapid social changes
- Breakdown of cultural values

MYTHS AND MISCONCEPTIONS ABOUT SUBSTANCE ABUSE

There are several myths and misconceptions about substance abuse in Malawi that perpetuate it among young people. (See Table 16.)

TABLE 16. Myths and facts about psychoactive substance abuse

ITEM	MYTH	FACT
1	Alcoholism is a condition that is difficult to cure.	Alcoholism is a condition that responds to treatment, which includes eliminating all alcohol consumption and taking advantage of psychosocial counselling.
2	Alcohol and chamba are the only drugs used by young people.	Alcohol and chamba are not the only abused drugs in Malawi. Examples of other drugs are tobacco, mandrax, glue, cocaine, heroin, and petrol.
3	Alcohol is not a drug. It is just an addictive substance.	Alcohol is both a drug and an addictive substance. It affects the mind, body, and social relationships with others.
4	Drinking alcohol among young people is hereditary.	Most young people are initiated into drug and alcohol use by their peers.
5	Driving after using chamba is not as dangerous as driving after drinking alcohol.	Like alcohol, chamba affects motor coordination, slows reflexes, and affects perception (the way we see and interpret events around us). All of these changes increase the likelihood of an accident while driving.
6	It is rare for a teenager to be an alcoholic.	Many teenagers abuse alcohol, and many are addicted.
7	Cigarette smoking is fashionable and not addictive.	Cigarettes contain nicotine and other added substances that are addictive. Cigarette smoking is harmful to your health. Smoking is associated with lung cancer. Smoking is especially dangerous for pregnant women because it affects the lungs and breathing of the foetus as well as the development of its brain.
8	Alcohol and drugs help young people handle their problems better.	Alcohol and drugs make young people temporarily forget about their problems. Their problems do not go away, however. In essence, alcohol and drug abuse alters cognitive functioning, consequently compromising the capacity of the young person to effectively solve his/her problem.

TABLE 16. Myths and facts about psychoactive substance abuse *(continued)*

ITEM	MYTH	FACT
9	Substances such as glue (inhalants) are basically harmless, even though adults make a big deal about them.	Substances such as glue or petrol can be extremely dangerous. Unlike most drugs, inhalants can cause permanent damage to the liver, lungs, brain, or other organs.
10	A cup of coffee and a cold shower will sober a drunken person.	Drinking coffee and taking a cold shower will not sober a drunken person. One becomes sober only with the passage of time. It takes one hour for the liver to process one gram of pure alcohol.
11	Alcohol is a sexual stimulant.	Alcohol, like cocaine and other drugs, can actually depress a person's sexual desire and response. The drug may lessen inhibition with a sexual partner but it causes problems such as inability to have an erection, loss of sexual feeling, and inability to have an orgasm.
12	When people stop smoking cigarettes, they cannot reverse some of the damage to the body.	If there is no permanent heart or lung damage, the body begins to heal itself when a person stops smoking. Some cells can regenerate. The health-associated risks from smoking gradually decrease over time.
13	Cigarette smoking every now and then is not harmful.	As soon as people start smoking, they experience yellow staining of teeth, bad breath, and a shortness of breath that may affect their physical performance. Addiction to nicotine is very rapid. People who smoke for any period increase their risk of cancer and other lung diseases, cancer of the tongue and throat, and heart diseases. Every cigarette smoked damages the body.
14	Chamba is not harmful. It helps adolescents and young people study; become less shy; and be strong, powerful, and intelligent.	Chamba has long-term effects, such as a decrease in motivation, memory loss, damage in coordination, impaired judgment, damage to the reproductive system, and throat and lung irritation.

SOURCE: Adapted from FORUT and Malawi Girl Guides Association, n.d.

MOST COMMON ABUSED SUBSTANCES AMONG YOUNG PEOPLE IN MALAWI AND ELSEWHERE

Table 17 describes the substances most commonly abused by young people in Malawi, and their effects.

TABLE 17. Commonly abused substances by young people in Malawi, and their effects

DRUG/ SUBSTANCE	EXPLANATORY NOTES	SELECTED EFFECTS
Alcohol, especially spirits in sachets and small bottles	Alcohol is a depressant drug with adverse effects to one's health if taken in excess. It is the substance most commonly abused by adolescents and young people in Malawi.	Euphoria (exaggerated feeling of well-being) Intoxication Ataxia (staggering gait) Over-consumption leading to death, domestic violence, and unplanned sexual encounters Inflammation of the liver (liver cirrhosis) Drains money from the individual and family Slurred speech Diminished ability to perform tasks (mind is clouded) Could lead to head trauma Nutritional deficiency
Tobacco products, including cigarettes	Tobacco is mostly used by young people. Tobacco contains nicotine, a tranquilising drug that is addictive. Nicotine is found in cigarettes.	Smoking over a long period increases the smoker's risk of lung cancer and heart attacks. Other systemic effects are reduced libido, respiratory infections, and low birth weight or premature babies.

TABLE 17. Commonly abused substances by young people in Malawi, and their effects *(continued)*

DRUG/ SUBSTANCE	EXPLANATORY NOTES	SELECTED EFFECTS
Chamba	A dried plant called cannabis sativa. It is known by different names among young people in various parts of the country: marijuana, fodya wamkulu, Malawi gold, ganja, jah, kanundu, nanzi, weed.	Throat irritation Dry mouth Bloodshot eyes Increased appetite for food Drowsiness Disruption of thought and speech Addictions Untidiness Knee-jerk reflex
Sedatives	Commonly referred to as sleeping tablets, manufactured for medical use. Meant to reduce tension and anxiety, and induce sleep and calmness. Mostly sold on the black market.	Can trigger suicidal thoughts. An increased dosage can result in dependency. An increased dosage may be fatal because it depresses vital organs, such as the lungs and heart.

SOURCE: Adapted from Ministry of Youth, Sports, and Development, 1999

Table 18 describes the effects of substances commonly used in other countries.

TABLE 18. Drugs and other substances in common use outside of Malawi

DRUG/ SUBSTANCE	EXPLANATORY NOTES	SELECTED EFFECTS
Cocaine	Expensive white powder extracted from coca shrub. Either sniffed or smoked as crack. Powerful drug, producing exhilaration and indifference to pain or fatigue.	Fatigue Depression Psychological dependence
Steroids	Anabolic steroids increase muscle size and male aggression. Often used by those heavily committed to sports. Easily obtained in many private gymnasiums.	Can restrict normal development in young people and women Reduced sex drive

PREVENTION OF SUBSTANCE ABUSE

Information, education, and communication

Young people in Malawi need information, education, and communication (IEC) on the use, abuse, and harmful effects of psychoactive substances to help them understand their dangers. Communication may occur through leaflets, brochures, newspapers, radio, television, and social media posts. The IEC materials should be appropriately designed and made accessible to young people through youth clubs, schools, youth radio, television programmes, and social media. Service providers need an adequate knowledge of substances that are frequently abused by young people, and their consequences, so they can provide correct messages and information to their clients. The media can also stress the dangers of these harmful substances.

Community mobilisation

The community needs to be educated and mobilised to strengthen its role in challenging young people's abuse of harmful substances. The community should report those promoting use of harmful substances by young people to the relevant authorities, such as the police. Providing correct information on the harmful substances available in each community and the consequences of their abuse by young people will help the community take a leading role in prevention.

Life skills education

Life skills education should remain a priority in schools as a means to reach young people with information on substance abuse. Because all schools teach life skills education and substance abuse is one of the topics, authorities should emphasise this opportunity with in-school youth. The training can strengthen the capacity of adolescents and young people to withstand peer pressure, be assertive, make informed choices, and not be easily coerced into using harmful substances.

Counselling young people on the dangers of substance abuse

Counselling young people at risk of substance abuse will help them to understand its effects. During adolescence, some experience an identity crisis (i.e., difficulty reconciling their self-image with what people think of them); this may lead them to alcohol and substance abuse. Counselling is crucial to help them achieve psychological balance and get through this stage without resorting to substance abuse. Counselling will also help young people who are using and abusing drugs to reverse these poor choices.

Advocacy for the development and enforcement of legislation, policies, and other frameworks aimed at preventing substance abuse by young people

Parents, organisations, young people, and other stakeholders have a role to play in advocating new legislation and enforcing existing guidelines and policies to prevent the use and abuse of substances by young people and the general population. This advocacy may focus on enforcing the ban on the production of harmful products prone to abuse, such as the unlicensed cheap sachets of spirits with high alcohol content still available on the black market; enforcing stiffer penalties for people who sell drugs and other substances to young people; enacting and enforcing legislation that restricts operating hours of alcohol drinking places; and enforcing age restrictions in drinking places and on the purchase of cigarettes and other tobacco products.

BOX 56. Roles of stakeholders in substance abuse prevention

Role of young people. Solicit knowledge and understand the dangers of substance abuse; be peer educators and counsellors, helping other youths engaged in substance abuse; participate in designing and implementing programmes targeting control of substance abuse.

Role of parents and guardians. Provide information and advice because they are a source of information preferred by young people.

Role of policymakers and government. Enact evidence-based legislation that prevents substance abuse by young people and enforce this legislation: e.g., banning illicit alcohol sachets and setting and enforcing age restrictions in alcohol drinking places.

Role of public health and youth organisations. Use diverse platforms to provide information on the dangers of substance abuse; provide counselling, curative, and rehabilitation services for young people who abuse substances.

Psychosocial issues pertaining to drug and substance abuse

The effects and consequences of psychoactive substance abuse—especially on the psychological and social dimensions of young people's lives—have been widely discussed. Those who are using and abusing substances should be helped to quit and adopt behaviours that promote good health. This may require addressing the following questions.

CAN YOU BECOME ADDICTED IF YOU USE DRUGS FOR A SHORT TIME?

Young people exploring drug use may think they can take drugs for a short time and stop without becoming hooked. Each person is different, and there is no single correct answer to this question. Young people with this viewpoint should be informed that it is better not to start at all. Those who have already started should be informed that the earlier they stop, the more likely it is that they can avoid addiction and the harmful psychosocial changes that addiction leads to.

HOW CAN ONE AVOID DRUGS AND STILL BE "COOL" AT PARTIES?

Parties are the most common setting in which young people start using psychoactive substances. When alcohol and drugs are readily available at parties, young people feel peer pressure to use them as a way to fit in. Give young people the following tips to stay safe in such environments:

- Find friends who don't need drugs to party.
- Check out who will be at a party and what the plans for it are before you commit to what may turn out to be an awkward situation for you.
- Know the facts about drugs.
- Stop to think before you make decisions that you might regret.

These tips are also crucial to avoiding the use of drugs in general, whether at a party or in some other environment. "Cool" friends are the people who appreciate you for who you are, not for what you do or don't do.

CAN MY BODY BUILD TOLERANCE TO DRUGS?

People are becoming tolerant of a drug when they have to take more of it or take the same dose more frequently to get the effect they got at first. Tell them that developing tolerance does not mean they are addicted to the drug. However, it is important to seek help because the more they use, the greater the financial drain and the more aggravating the other consequences of drug use; they may be heading for addiction.

I AM USING ONLY ONE DRUG, SO I WON'T REALLY HAVE CONSEQUENCES, RIGHT?

Whether doing one drug will lead to doing another depends on each individual. In any case, the use of that one drug has its own consequences, which might not be different from those that follow the use of many drugs. Basically, being exposed to peers who use drugs, having greater access to drugs, and being in situations that led to initiating the use of any drug in the first place could combine to make other drug use more likely. It is important to get help as soon as possible.

I AM ADDICTED. I HAVE TRIED TO STOP AND I HAVE FAILED. SHOULD I JUST GIVE UP?

Some young people on drugs may want to stop but feel they do not have the will power to do so; or they may have tried to stop, failed, and given up. Providers, parents, and peers need to provide a positive environment to support young people's efforts to stop. Intensive counselling—available in religious and mental health institutions—should be offered to them so they appreciate the problem and start a journey of rehabilitation. Community integration efforts are crucial for positive psychosocial environments for young people who previously used drugs and were so-called delinquents. The more these young people are accepted as useful members of society who have abandoned substance abuse, the more likely it is that their psychosocial health will improve.

Summary

- Abuse of alcohol is prevalent in Malawi, especially spirits in sachets and small bottles, as is abuse of other psychoactive substances.
- Alcohol is the substance most commonly abused in Malawi. This is partly due to weak reinforcement of laws prohibiting adolescents from drinking alcohol.
- Most adolescents and young people who abuse alcohol and drugs such as chamba do so for such reasons as peer pressure, lack of parental guidance, frustration, or to feel self-confident.
- There is a need to strongly refute and dispel myths surrounding alcohol and substance abuse by young people.
- Substance abuse among young people can lead to such adverse consequences as mental illness (depression, anxiety and stress, psychosis), dropping out of school, and unsafe sex following intoxication.
- Life skills education, IEC, counselling, and community mobilisation are key strategies to prevent substance abuse among young people. Parents, young people, and policymakers can potentially play a crucial role in preventing alcohol and substance abuse.

This unit provides information on the following:

1. Definition of mental health
2. Importance of mental health to young people
3. Factors that influence mental health
4. Consequences of poor mental health
5. Strategies for promoting mental health among young people

UNIT 6.
MENTAL HEALTH AND YOUNG PEOPLE

DEFINITION OF MENTAL HEALTH

Mental health, as defined by WHO, is as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (WHO, 2014). It also relates to a person's ability to manage and cope with feelings that may arise as a result of perceptions of social, physical, or psychological events. Young people are dynamic and energetic and, in their transition to adulthood, they go through many life-changing experiences that require sound mental health to navigate.

IMPORTANCE OF MENTAL HEALTH TO YOUNG PEOPLE

According to global estimates by WHO, 10 to 20 percent of children and adolescents experience mental illness. About half of mental illnesses begin at age 14; three-quarters of them begin by the mid-20s (WHO, 2014).

Keeping young people healthy at all times will translate to a vibrant population that contributes to Malawi's development as a nation. It will mean fewer young people in juvenile jails, fewer cases of mental illness and disorders, and less violence. Furthermore, it will mean more young people finishing school and managing their own businesses, and a reduction in HIV incidence associated with abuse of drugs and substances.

It is the duty of young people themselves—parents and guardians, teachers, health workers, peers, and friends—to support the mental health of young people. Let us look at the potential negative outcomes of failure to do so.

FACTORS THAT INFLUENCE MENTAL HEALTH

Some determinants of mental health and mental disorders have to do with social, cultural, economic, political, and environmental factors. Let us begin, though, with physiological factors.

Physiological factors

Physiological factors may affect the brain and consequently an individual's capacity to perform physical and cognitive functions. A young person with these conditions may be unable to act in a capable way or manage everyday situations. Examples are brain injury or trauma at birth or later, developmental disorders, and convulsions resulting from illnesses such as malaria.

Psychological factors

Some young people will experience difficult life events that may leave them less resilient and psychologically defeated. For example, young people who have had difficult childhoods may have limited abilities to cope with stress. Painful events may lock them into negative thought patterns, contributing to poor mental health.

Social factors

Social problems such as poverty, school failure, sexual and physical abuse, unemployment, violence, and substance abuse can negatively affect young people's emotional well-being. These conditions are common; our ability to manage or not manage them is the biggest determinant in maintaining good mental health. A young person with low self-esteem is at higher risk than a peer with high self-esteem of developing mental illness, owing to his or her inability to cope with social challenges. The social environment plays a role in young people's growth and development, and thus is an important factor in promoting mental health.

TYPES AND CONSEQUENCES OF POOR MENTAL HEALTH

Anxiety and stress

Anxiety is a general term that refers to a mental disorder that causes apprehension, fear, nervousness, and worry, ultimately affecting how one behaves. These disorders may also exhibit physical symptoms. Stress refers to a state of mental or emotional tension resulting from adverse or very demanding circumstances. Most young people experience stress due to such everyday challenges as coping with adolescent growth and routine social challenges. Signs of anxiety and stress are feeling sad and low; loss of appetite; difficulty in sleeping; and being fearful, tense, or panicky. Physical manifestations may be frequent urination, diarrhoea, headaches, elevated blood pressure, and sweating.

Uncontrolled anxiety and stress may lead to more serious mental health disorders, such as schizophrenia.

Depression

Depression refers to a mental disorder characterised by low mood and a decrease in activity. It is a common phenomenon among young people, usually emerging after a young person experiences loss. The depressed young person becomes negative about the world and himself or herself, feels rejected, and loses confidence. Depression can progress to clinical illness if five or more of the following symptoms are seen in a person for at least two weeks:

- Low mood
- Loss of interest or pleasure
- Feeling sad or empty
- Experiencing a marked decrease or increase in appetite
- Difficulty in sleeping or oversleeping
- Loss of energy; tiredness
- Feelings of worthlessness or guilt
- Difficulties in concentrating or thinking
- Recurrent thoughts of death

In mild to moderate depression, a good support system (parents, peers, health workers, relations), including counselling, can help. In severe cases, antidepressants (drugs for depression) are used.

Eating disorders

Eating disorders can be loosely defined as eating less than required or eating too much. Eating disorders can follow a stressful event such as an HIV-positive result, failure in class, or being bullied by parents. The person tends to project anger on food, thus eating too much or too little. Extreme eating disorders common in adolescents are anorexia nervosa (where very little is consumed) and bulimia nervosa (where young people throw up after they eat). A consequence for girls is cessation of menstrual periods due to inadequate intake of protein. For either sex, these conditions ultimately can be fatal.

Obsessive compulsive disorders

Obsessive compulsive disorders (OCD) result when a person has thoughts that keep emerging in his or her mind, prompting the person to take some action such as frequent hand washing or checking repeatedly that doors are locked. Usually a particular situation triggers such intrusive thoughts and behaviours. The condition requires a psychiatrist to establish the cause of the disorder and map ways to manage it.

Schizophrenia

Schizophrenia is a mental disorder characterised by abnormal psychosocial behaviour and inability to recognize the environment/what is real. The causes of schizophrenia are not well-known, but genetics and psychological and social stressors are factors that contribute to its development. Schizophrenia can have the following symptoms:

- Disorganised thoughts and speech
- Hallucinations (having a sensation that is not real—a false perception; auditory hallucinations, in which one hears voices that are not present, are the most common)
- Delusions (false beliefs about oneself, such as the idea that one is God)
- Impaired social cognition (not recognizing the environment, such as people, places, and time)

Psychosis

Psychosis refers to an abnormal mental condition in which one loses contact with reality and exhibits personality changes and thought disorders. A psychotic may exhibit one or more of the following symptoms:

- Hallucinations (especially auditory ones)
- Delusions, especially persecutory delusions (believing that people intend to do one harm)
- Catatonia (a state of agitation resulting in detachment from reality)
  This condition commonly presents in two ways. First, the person is in a complete state of quietness and even when awake responds to nothing in the environment. Second, the person enters a state of extreme physical activity and mental fixation on something, with no attention to the environment (e.g., going around in circles repeatedly).
- Disordered thought and speech

Deliberate self-harm

Deliberate self-harm sets in among young people when they feel completely lost, abandoned, ashamed, and guilty, and see no meaning in life. It builds from failure to cope with such negative experiences as unexpected pregnancy, drug abuse, loss of loved ones, and stigma and discrimination. Most will contemplate self-harm in the form of abusing drugs and alcohol or committing suicide. Young people who attempt self-harm can get therapeutic support through counselling and guidance to help them positively challenge the negative social events they experience every day.

PROMOTING MENTAL HEALTH

The reason for promoting mental health is to prevent mental illness. The Adolescent Mental Health Guide describes eight elements of the promotion of mental health in adolescents and young people. These are as follows:

Power of communication

Communication is a powerful tool in promoting mental health. Young people are sensitive to how others communicate with them; any negative communication will drive them away, be stressful to them, and distort a relationship. Parents, professionals, and peers working with young people need to make sure that their communication with young people is positive, welcoming, and not dismissive.

Paying attention to young clients' tone of voice, body language, needs, and behaviour when communicating with them is key to identifying their situations correctly and supporting them. The concept of YFHS essentially rests on positive and effective communication.

Setting boundaries

Everything that people do involves limits and boundaries beyond which there can be negative consequences. For example, too much alcohol consumption is bad for the liver and substance abuse may lead to mental illness. Youth is the age of exploration; young people may cross these boundaries either in full knowledge or in ignorance.

Parents and service providers can help to promote positive mental health in young people by providing adequate and accurate information about the reasons for boundaries, and the consequences of crossing them. This helps young people to make informed decisions.

Asking questions

Asking questions is an art and needs to be done with the utmost care. In interactions with young people, parents and service providers need to ask questions in a way that communicates that they understand, are sympathetic, and want to help—not judge. This will create trust and young people will more likely open up, not be defensive, maintain a positive relationship, and be receptive to help—all attitudes promoting their mental health. Open-ended questions are preferred to closed-ended questions (those requiring only a yes or no answer) because they provide the young person with the opportunity to explain.

Emotional literacy and self-awareness

Understanding why we feel the way we do helps us to know who we are and to manage our life situations. Parents and service providers need to give young people positive feedback about their feelings and regularly acknowledge their abilities. Young people need support for emotions they cannot handle to minimise their risk of failing to cope with life situations.

Exploring options versus giving advice

Exploring options together with young people is a critical element in empowering them to make their own decisions. Helping young people to identify options and consider the advantages and disadvantages of each option rather than giving advice or telling them what to do will help them learn how to make thoughtful decisions, enabling confident decision making in the future.

Challenging

Young people often find themselves in situations in which they feel they are not important and look down on themselves. Positively challenging young people on their views or beliefs, showing empathy, and asking open-ended questions will lead them to a clearer picture of a particular situation, help them to see life positively, and ultimately build their self-confidence.

Knowing your limitations as a provider

Communicating to young people the limitations of the support that parents and guardians can give encourages young people to take responsibility for themselves. The realisation that they must make decisions for themselves helps them to be on their guard. Then, when they confront a difficult situation, they are able to trust their ability to move through it on their own, minimising dependence and the risk of lapsing into poor mental health.

Giving constructive criticism

Positive and constructive criticism constitutes feedback on the better course of action or behaviour than the prevailing one, and will help young people mature. Constant criticism with little or no praise makes young people feel unappreciated, resulting in low self-esteem and low self-confidence, and often limiting their inclination to test or nurture their abilities. Parents and service providers should praise young people when they have done well and provide constructive criticism where appropriate.

Summary

- Mental health is the state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work fruitfully, and is able to make a contribution to his or her community.
- Promoting mental health among young people helps prevent mental illness.
- The mental health of young people is affected by social factors (e.g., being bullied), psychological factors (e.g., the death of a parent), and economic factors (e.g., poverty).
- Counselling and guidance should be part of comprehensive YFHS.
- Consequences of poor mental health can be difficult to manage and can take time. Professionals, parents, and peers needs to support young people to reduce the incidence of mental illness.
- Health and social workers, parents, and other caregivers should help young people realise who they are, be empathetic with them, and offer constructive criticism.

This unit provides information on the following:

1. The concept of YFHS
2. Health services that young people need
3. The minimum package for the delivery of YFHS
4. Barriers to accessing YFHS
5. YFHS standards and accreditation process
6. How services are best delivered to young people
7. Empowering young people to demand health services
8. Initiating changes to improve provision of YFHS

UNIT 7.
PROVIDING YOUNG PEOPLE WITH THE HEALTH SERVICES THEY NEED

THE CONCEPT OF YFHS AND WHAT MAKES SERVICES "YOUTH FRIENDLY"

Malawi's MOH has established the following criteria for health services to be youth friendly: they must be effective, safe, affordable, and meet the individual needs of young people, who return when they need to and recommend the services to friends. Even if this ideal cannot be achieved immediately, improvements bring results in the health and well-being of clients.

Making services youth friendly is not primarily about setting up separate dedicated services, although the style of some facilities may change. The greatest benefit comes from improving generic health services in local communities and the competencies of healthcare providers to deal effectively with adolescents.

A broad perspective on the characteristics of what makes health services youth friendly is outlined in Box 57.

BOX 57. Characteristics of youth-friendly health services

Technical competence

Technically competent and empathetic staff needs a system of ongoing support. A youth-friendly approach requires repeated training sessions to refresh the skills of current staff and develop the skills of new staff. Monitoring systems should encourage adolescents to provide feedback on services.

Seeing the person, not the problem

Technical competence must be accompanied by respect and sensitivity to draw the young person out and discover underlying problems that may not be the immediate cause of a visit. Technical skills and an empathetic professional approach should be combined with a nonjudgmental attitude. Healthcare providers do not need to abandon their own belief systems or values, but they do need to understand a situation from a young person's point of view and not allow their own views to dominate the interaction.

Making the service physically accessible

Services need to be provided in places that young people can reach. This may involve holding special clinics in youth centres or other places where young people gather. Physical surroundings are important. Many health facilities have no special youth department but are welcoming in other ways. Attention should be paid to the paint, posters on the walls, cleanliness, and whether there are enough chairs where people wait.

Confidentiality and privacy

Young people need to be assured of privacy during a consultation and confidentiality afterwards. Young people should not have to undress or be examined where people can see them. Those waiting outside should not be able to hear a doctor giving a diagnosis.

Services that are acceptable to the local community

Young people must feel that the services being offered are acceptable and freely usable by them. Community support for the services must also be sought. The community should have an opportunity to understand why health services are important for young people, and why the services should address SRH and involve confidential counselling.

Involving young people

Services that achieve high quality are those that closely involve youth in their planning and monitoring. Through the involvement of young people, service providers can be confident that they are providing services in the right place, at the right time, and in the right style.

Health services that young people need

Access to care is an important determinant of health for all population groups, including young people. Indeed, most preventive, curative, and rehabilitative health services are offered within the realm of the health system and have a significant impact on population health, including that of young people.

Services need to include capacity building that teaches young people how to become empowered advocates on behalf of their own health and that of their peers.

According to WHO, an intermediate goal of any health system is to be responsive to people's expectations. These expectations usually capture the technical and user perceptions of what constitutes good-quality healthcare and are crucial to eliciting subsequent health service use. It follows that if healthcare systems are to be of any use in addressing the health needs of young people, they should be responsive to young people's health expectations. Youth-friendly health services aim to fulfil those expectations, as outlined in Box 58.

BOX 58. What young people want from health services

- A welcoming facility where they can drop in and receive care quickly
- Privacy and confidentiality, without the requirement of parental permission to attend
- A conveniently located place, with convenient times, that is free, or at least affordable
- Staff who treat them with respect and do not judge them
- A range of services broad enough, so they usually will not need to be asked to come back or be referred elsewhere
- Services that are appropriate, effective, affordable, and acceptable to the community

Services for this age group must demonstrate relevance to the needs and wishes of young people. Health services with the following characteristics can play a critical role in the development of these young people:

- Treat conditions that give rise to ill health or cause young people concern
- Prevent and respond to health problems that can end young lives or result in chronic ill health or disability
- Support young people who are looking for a route to good health by monitoring progress and addressing concerns
- Interact with young people at times of concern or crisis when they are looking for a way out of their problems
- Make links with other services, such as counselling services, which can support young people

Young people in crisis need counselling and community support beyond what health services alone can offer. This support can come from their own peers and from parents, families, teachers, trained counsellors, religious or youth leaders, and other adults. However, if these links break down, early signs of crisis may become apparent during their contact with health services. Healthcare staff need to be sensitive to signs of anxiety and know how to deal with young people in crisis or where to refer them.

Programmes monitoring growth and development should be a golden opportunity for youth to request help, and for healthcare staff to give them information. However, such programmes are rarely provided at school; even when health checks do take place, they seldom give young people this kind of opening.

The minimum package for the delivery of youth-friendly health services

The minimum YFHS package combines clinical services and health promotion interventions addressing the health needs of young people. This package has three areas of emphasis:

- Health promotion
- Delivery of health services
- Referral and follow-up

Health services should be provided to young people within the normal clinical standards and procedures approved by the MOH. The significant difference is that they will be provided in a youth-friendly manner. Types of services to be provided will also be in line with the minimum package outlined in the Essential Health Package of Malawi. These services can be provided using different modes of delivery, depending on capacity of the institution, either as a stand-alone or integrated service, as shown in Table 19.

TABLE 19. Sites and modes of delivery of youth-friendly health services

CLINICAL SERVICE	MODE OF DELIVERY
Community level	
• Contraceptive services, including condoms and HIV testing and counselling • Referral to health facility or other service delivery points • Youth outreach services • VMMC during outreach activities	• Stand-alone • Integrated • Outreach
Health centre level	
• Contraceptive services, including condoms • Prevention, diagnosis, and management of STIs • Antenatal, delivery, and postnatal care services • PMTCT • HIV testing and counselling • Treatment of sexual abuse victims • Referral to hospitals or other service delivery points • Postabortion care • Teen clubs for adolescents living with HIV • Cervical screening • VMMC • Provision of ART • Treatment for sexual abuse (including PEP)	• Stand-alone • Integrated • Outreach
Hospital level	
• Postabortion care • Contraceptive services, including condoms • Prevention, diagnosis, and management of STIs • Antenatal, delivery, and postnatal care services • PMTCT • HIV testing and counselling • Provision of ART • Treatment for sexual abuse (including PEP) • Referral to other service delivery points • Cervical screening • VMMC	• Stand-alone • Integrated
Health promotion and counselling during service delivery, and at all levels (cross-cutting)	
• STIs • Family planning • Psychosocial support • Nutrition • HIV and AIDS • Sexual abuse • Maternal healthcare • Adolescent growth and development	• Stand-alone • Integrated

BARRIERS TO ACCESSING YFHS

The 2014 Malawi YFHS evaluation study reported a number of barriers to young people's access to YFHS (E2A Project and University of Malawi, 2014). Most of these barriers had been reported before and persist today at many service delivery points. They can be addressed efficiently through a more collaborative approach by government, service providers, young people, and the community. Trained providers need to act as advocates of the solutions that emerge from such a collaborative effort and monitor the outcomes to make sure that barriers to access go away.

Long distance to the nearest health facility

Many young people in Malawi have reported difficulty in getting to health facilities owing to long distances. Most health facilities have catchment areas that extend beyond the five-kilometre radius recommended in the 2014 evaluation of YFHS.

Lack of knowledge on the part of the adolescent

Most young people do not know that YFHS exist in their communities, what health services are available to help them, or how to access these services. Thus, they fail to use even those services located nearby.

Cost of services

Young people usually cannot afford to pay for health services and must ask an adult to do so. This is especially problematic for health services accessed at CHAM institutions, where user fees are the norm. Indirect costs, such as charges for transportation and health passports (booklets issued to Malawi citizens to track their medical records), have been reported as barriers related to cost of service.

Low self-confidence or shyness

Young people sometimes feel too shy to access services from health facilities. Girls fail to ask for condoms and other contraceptives for fear of being judged adversely or even labelled as "sex workers."

Poor attitudes of health workers

Negative attitudes of providers are one of the biggest barriers to accessing YFHS. Managers of most health facilities report staff who are unable to provide a warm welcome and be nonjudgmental when providing services to adolescents and young people.

Long waiting times and inconvenient opening hours

Most health facilities in Malawi, especially those in rural communities, open late and close early. Even though public facilities are supposed to open by 7:30 a.m. and close at 5 p.m., most open at 9 a.m. and close by noon. No YFHS sites are open at night. This schedule is inconvenient for everyone, and especially for young people, who may be in school or working at those hours.

Unavailability or denial of services

Stockouts of some items, such as condoms and other contraceptives and HTC kits, and the unavailability of some services, discourage young people from coming to a health facility a second time. In some facilities, providers have refused certain contraceptives to those younger than age 18, saying to do so would promote promiscuity. This is misleading to young clients because it contradicts MOH policy, which is to make contraceptives available regardless of age.

Lack of privacy and confidentiality

Most health facilities in Malawi—especially health centres—do not have adequate infrastructure (separate rooms) to facilitate privacy. As a result, diagnosis and even counselling are never private. Knowing that other people can hear their conversations with providers puts young people off. Moreover, when providers give unsolicited advice, they sow distrust, leading young people to fear they will also share this information with parents.

HIV testing as a condition for other services

Malawi's VMMC policy requires people to be tested for HIV before having the procedure. This requirement scares young people away and leads them to believe that no service is available without an HIV test.

Religious and other beliefs

Some religious teachings, values, and beliefs discourage the use of modern contraceptives by their followers. In these communities, even young people with the greatest need have trouble asking for contraceptive services.

Lack of financial resources and infrastructure

Malawi's health system is struggling financially; as a result, many services that could incentivise young people to access YFHS are not readily available. For instance, most facilities cannot afford private examining and consultation rooms, recreation equipment, or even IEC materials, thus discouraging young people from accessing services.

Shortage of younger trained providers

Young people generally prefer to be served by providers close to them in age, but there are not enough healthcare providers at most service delivery points to facilitate peer-to-peer service delivery. Finding a provider of any age who has received YFHS training is also unlikely. The training is expensive; hence, few providers have had it.

Inadequate encouragement of young clients by health workers to access YFHS

Few facilities hold motivational community meetings to mobilise young people to access YFHS. Even facilities that provide YFHS rarely post signs in the community, or even within the facility, to advertise the service or distribute IEC materials.

Lack of youth participation

Young people are generally very willing to help plan YFHS in their community. Even so, most service delivery points do not involve young people in designing their YFHS; thus, potential clients feel no ownership of these services.

Legal or cultural restrictions

Reproductive health services such as family planning clinics or postabortion services are often restricted. Abortion currently is legal only to save the life of the mother, although the health system does deal with the consequences of unsafe abortions. In some cases, young people may need consent from their parents for medical treatment.

Cultural barriers

In many tribes, a culture of shame discourages adults and children from talking about their bodies or sexual activity. This can inhibit parents from discussing sensitive issues with their children and make a young person reluctant to use SRH services.

It may also be difficult for a young person to seek help after undergoing violence and sexual abuse. Not every young person has the same concerns, and not all services are equally sensitive, but these factors are widely applicable across cultures for both sexes, and especially among youth who have low self-esteem or feel vulnerable.

Gender barriers

Some barriers—many of them cultural—are associated with the gender of the young person. Adolescent girls are reluctant to be examined by male healthcare providers, and young men may find it difficult to discuss intimate symptoms with female healthcare providers. Such sensitivities may be especially powerful disincentives for girls to use services.

Peer pressure

Young people often consult their friends about where they should seek treatment; in this way, one person's experience becomes the criterion by which a group of young people make their healthcare decisions. Some may seek out useful sources of help, such as trained pharmacists, but others turn to street vendors, local shops, unlicensed practitioners such as traditional healers, or other sources of unproven treatment remedies, thereby separating themselves from YFHS.

MALAWI'S STANDARDS FOR YOUTH-FRIENDLY HEALTH SERVICES

The guiding principles of the standards are based on the *Young People's Health Strategy and Implementation Framework* (MOH, 2004). They are as follows:

- Active participation by young people, according to their capacity, in the planning, implementation, and monitoring of health services
- Provision of services based on the development and health needs of young people
- Community participation in activities and services availed
- Provision of YFHS by trained health workers and community volunteers
- Certification of all facilities providing YFHS

The sections below provide an overview of each standard.

STANDARD 1: Health services are provided to young people according to existing policies, procedures, and guidelines at all service delivery points.

This standard takes a holistic approach to the use of existing policies, procedures, and guidelines, with a view to making their implementation youth friendly. The standard emphasises delivery of quality YFHS within the framework of these policies, procedures, and guidelines. It also focuses on capacity building for the provision of quality YFHS in accordance with existing policy documents.

STANDARD 2: Young people are able to obtain health services that include preventive, promotive, curative, and rehabilitative health services appropriate to their needs.

This standard focuses on the access, acceptability, availability, and quality of health services provided to young people. It guides the different levels of healthcare delivery. Key partners expected to participate in the provision of services based on this standard are young people, NGOs, and district health offices. The visibility of information on the services available at delivery points, in the community, and in places where young people meet is a major element of this standard, as is treating young people with respect.

STANDARD 3: All young people are able to obtain health information (including on SRH and HIV) relevant to their needs, circumstances, and stage of development.

This standard emphasises the availability and provision of appropriate IEC materials in relation to the elements mentioned in the minimum YFHS package. It also captures advocacy and community mobilisation around SRHR and other health rights, with emphasis on linkages and partnerships among stakeholders.

STANDARD 4: Service providers at all delivery points have the required knowledge, skills, and positive attitudes to provide YFHS effectively.

Training service providers to make health services accessible, acceptable, and friendly to young people is intended to increase use of services by young people. This standard emphasises training service providers, orienting support staff and other relevant stakeholders, and monitoring YFHS. Training is based on the national YFHS training package. Its focus is to equip service providers with the knowledge, skills, and positive attitudes needed for their work with young people.

STANDARD 5: Health information related to young people is collected, analysed, and used in decision making at all levels.

Continually monitoring YFHS will assure their quality. This standard emphasises collection of data, disaggregated by sex and age, and its use for planning. It emphasises provision of feedback on information from the district and national levels and use of data for planning at service delivery points. It also emphasises documentation and dissemination of best practices.

THE YFHS ACCREDITATION PROCESS

In Malawi, a facility cannot be said to be providing YFHS without accreditation by the Reproductive Health Directorate (RHD) of the MOH. The process requires background work by a facility to ensure that it has the necessary qualities to provide YFHS. Accreditation takes into account some elements of the YFHS standards just described. The RHD uses a standard tool to assess the facility's implementation of the standards in its delivery of YFHS.

The components listed in Box 59 are taken into consideration for accreditation, but not all are required.

BOX 59. Essential YFHS components assessed in the accreditation process

- Availability on site of the National Youth Policy (Ministry of Youth and Sports, 2013), the SRH Policy (MOH, 2015), and the National HIV Prevention Strategy, 2015–2020 (National AIDS Commission, 2014)
- Guidelines for provision of quality YFHS (check the availability of the YFHS standards)
- Orientation on all of these youth policies, SRH policies, and standards
- Availability of the minimum package of YFHS (according to level of facility)
- Referrals to other service delivery points
- Adequate infrastructure to provide YFHS (check for room/space)
- A sign displayed that clearly shows the schedule and location of YFHS (check the sign)
- Provision of outreach services
- Availability of equipment, supplies, and medicines
- Availability of recreational materials (check that they are being used by young people)
- Availability of take-away IEC materials for young people
- Availability of posters being displayed that contain health information
- Community participation through meetings at least twice a year
- Youth participation at least twice a year
- Minimum of two service providers trained in YFHS
- Orientation of support staff
- Provision of young people's privacy during service delivery
- Service providers managing youth with respect
- Involvement of young people in service provision
- Availability of data about young people ages 10–24, disaggregated by age, sex, and marital status, and collected using the YFHS forms
- Data analysis and use by the facility
- Submission of quarterly reports to District Youth Officer/District Health Officer

HOW SERVICES ARE BEST DELIVERED TO YOUNG PEOPLE

YFHS can be delivered in hospitals, at health centres, in schools, or in community settings. They may be planned or started by groups of dedicated healthcare professionals who see that the needs of adolescents are not being met and believe services can be more effective. This section gives examples of different settings of YFHS delivery.

Services at health centres or hospitals

Basic health services are usually delivered at health centres in local communities; there is no reason why this arrangement should not also meet the needs of many young people. One important task is to train and support staff in this setting to improve their skills and develop an empathetic approach so that young people are willing to attend. These skills can be sustained through regular post-qualification training and a system of clinical protocols and guidelines, together with peer assessment and good-quality supervision and management. Privacy may be improved by holding special sessions outside of normal opening hours, creating a separate entrance for young people, or improving confidentiality once they are inside. A number of hospitals have developed specialist adolescent services or clinics in outbuildings or as part of the main building.

Hospital-based services have skilled specialists on site and can offer a full range of medical services. However, they are limited to urban areas and may be constrained by competing demands for funds. There are also dedicated health centres that provide a full range of services especially for young people. Such centres may be in large towns or cities, where they are relatively cost-effective, or be run by NGOs as "beacon" services that show what can be done. These centres can provide training and inspiration for other healthcare providers, but they usually only have an impact in one location and are too expensive to be replicated in mainstream services.

Services located at other kinds of centres

Considering that some young people are reluctant to visit health facilities, services can also be provided in places where young people already gather. In youth or community centres, a nurse or doctor may hold special clinics, and peer educators can put young people in touch with relevant health or social support services. One advantage is that young people already use these centres so they do not have to make a special effort to go to them. One drawback is that a particular centre may attract only part of the young population, being used mainly by boys or by girls or one age group.

Outreach services

In both urban and rural areas, there is a need to provide services away from hospitals and health centres to reach out to young people who are unlikely to attend otherwise. Increasingly in towns and cities, services are being provided in shopping malls and community or youth centres. Some countries have promoted services on the internet to catch the attention of young people who have access to computers. Youth in remote rural areas are often excluded from routine health services. Healthcare workers from local centres can take mobile services to visit villages to reach young people over a wide area. Services provided in village halls can include screening, health education talks and materials addressing young people, immunisation, and a discreet follow-up appointment service for those who need further treatment or counselling.

Outreach services are also needed for young people who may not have adequate access to health services even though they live near a health facility. For example, young people who are physically compromised and those living on the streets find it difficult to access mainstream services but will respond to services that address them. Once contact is made with young people who are outside of the system, it is important to find a way to create links between the outreach team and mainstream services.

Health services linked to schools

Schools provide a natural entry point for reaching young people with health education and services. With the introduction of free primary school education in 1994, enrolment has increased; secondary school enrolment is also increasing. School-based health service delivery strategies have proven successful in achieving high uptake of interventions in many countries, including uptake of the HPV vaccine in Malawi's HPV vaccine demonstration project. Schools are ideal places to screen for or treat a range of common illnesses, provide vaccines such as booster tetanus shots, and offer health and hygiene education. Inclusion of life skills education and SRHR topics in the primary curriculum has provided an opportunity to impart essential knowledge to inform young people's health decisions.

However, in practice, schools' potential is seldom realised. Schools are short of resources and teachers have neither the training nor the equipment to deliver health education in addition to their existing workload. To turn this situation around requires effective training to build the motivation and skills of staff, and may require outside support for sex education lessons. Some successful schemes train young people as peer educators in schools. As with outreach work, it is important to link school health services to local health services so that students who need follow-up care receive it, and to avoid duplication of efforts and service delivery.

It is also important to ensure that services provided at a school have community support. Many head teachers are concerned that they will open themselves to criticism if they provide health services for young people. Efforts by the school and community are required to ensure support for such moves. There is much evidence that parents welcome other responsible adults talking to their children about sensitive issues because parents often feel unable to deal with these issues at home.

Health services linked to workplaces

Employers and trade unions both have an interest in services that help to keep the workforce healthy, and many workers in workshops and factories are adolescents. Peer education on HIV and AIDS has been carried out in workplaces in some countries. In other countries, ministries of labour provide outreach programmes in boarding houses and factory-based education sessions to meet the reproductive health education needs of young women working in the factories. The ministries also conduct general skills courses for female workers (hair plaiting, cooking, etc.).

Community-level interventions

In Malawi, youth community-based distribution agents (YCBDAs) have been trained to reach out to their peers and the community at large to provide SRH services. Evidence indicates that most young people are more comfortable discussing sexual health issues with people their own age (MOH, 2013; E2A Project and University of Malawi, 2014). Older CBDAs also need to be trained in YFHS so they can improve their skills in communication and the efficiency of their service delivery.

YCBDAs and health surveillance assistants are a strategic resource because they bring services closer to communities and young people even in hard-to-reach areas.

Health services linked to religious institutions

Young people who belong to church groups can be excellent candidates for training to provide SRH services. Several recent projects have engaged young church members in this way by training them in YFHS, life skills, family planning, and other topics, and covering how they can communicate with peers about SRH issues without coming into conflict with church values and beliefs.

Church group members can be more engaged than others and elicit the confidence of parents who would otherwise be sceptical and suspicious of this kind of subject matter. Reaching out to young church members is emerging as a promising strategy for engaging parents and church leaders to consider youth-related SRH issues from a biblical perspective.

EMPOWERING YOUNG PEOPLE TO DEMAND HEALTH SERVICES

When young people face challenges in accessing health services, they tend either to steer clear of the service or to keep trying to access it because they have no choice. This is not acceptable. As people trained to provide good-quality services to young people, you need to make clear to them that they have a right to such services and that delivering these services is your job.

The following are some simple steps that you can take to empower young people to demand good-quality services.

- Choose one YFHS focal point person at a facility.
- Post a notice of this person's contact details and those of the facility's manager.
- Inform young people that they should channel their grievances to the YFHS focal point person and, if that person is not supportive, to the manager.
- Establish a YFHS committee comprising not only facility staff but also representatives of the community and of young people.
- Have the committee help plan YFHS activities, receive and handle complaints, and support overall implementation of YFHS at the facility.
- Provide a quarterly report to the young people in the community through its youth representatives as well as the committee as a whole.

Empowering young people should not be seen as a witch hunt directed at service providers, but rather as a process to support delivery of good-quality services. Young people should also be made aware that service providers and the community support the delivery of good-quality YFHS, and that their own advocacy will be key.

INITIATING YFHS

Initiating YFHS is a process, and planning is of paramount importance. The last unit in this manual offers a simple guide—in the form of activity sheets—to support this planning.

Summary

Health services can help to meet the needs of young people only if they are part of a comprehensive programme. Young people need the following:

- A safe and supportive environment that offers protection and opportunities for development
- Information and skills to understand and interact with the world
- Health services and counselling to address young people's health problems and deal with their personal difficulties
- A package of basic health services tailored to local needs, including growth and development monitoring and immunisation
- A high priority on reproductive health services, counselling, and voluntary testing for HIV and other STIs
- Mental health services and counselling to support adolescents
- More youth-friendly hospital- or clinic-based services
- The delivery of YFHS in health centres, in the community, through outreach services, or at school
- Access to services at such community settings as community or youth centres, shopping malls, or even over the Internet
- Urban outreach services to contact young people who do not attend clinics and those who are marginalised, such as street children
- Rural outreach services for young people living in isolated communities
- Use of schools as a critical entry point to bring services to young students

Healthcare providers cannot meet all of these needs alone. They can join or create networks to maximise resources.

UNIT 8.
ACTIVITY SHEETS

THE IMPROVEMENTS YOU PROPOSE TO MAKE IN YOUR WORK FOR AND WITH ADOLESCENTS

Purpose

The purpose of this exercise is to help you prepare the outline of a personal plan to improve your work for and with adolescents. In this plan, you will identify the changes you intend to make in the way you work. The plan has the following elements:

- The proposed changes you intend to make
- The importance of the proposed changes
- Resources required to make the changes
- How you will assess whether or not you are successful in making these changes
- The personal and professional challenges and problems you may face in making these changes
- The ways in which you are likely to address these challenges and problems, and the support you will need

We wish you all success in your endeavours to improve your work with and for young people.

Instructions

Please use Table 20—Individual Implementation Plan—to record five changes you intend to make in the way you work with or for adolescents.

Please review the example in the table.

Please designate one sheet for each change you intend to make. This way, you will have extra writing space.

For each change you propose in Column 1, complete Columns 2, 3, 4, 5, and 6.

In monitoring your own changes to and application of this plan, set target dates to review your progress and reassess your plans.

TABLE 20. Sample of individual implementation plan

COLUMN 1	COLUMN 2		COLUMN 3
The changes I plan to make in my everyday work with or for adolescents	Why I believe this change is important: who or what will benefit, and why		What will be required to make this change?
	Who/what will benefit?	Why?	
Example of implementation plan			
Contact the local schools to provide information on the new YFHS being provided by our clinic	Students in local schools Friends of students and family members of school staff who are in local schools	They will find it easier to obtain the services they need	Materials to share with schools Contact list of key people to reach at the schools

TABLE 20. Sample of individual implementation plan *(continued)*

COLUMN 4		COLUMN 5	COLUMN 6	
How I will know whether or not I have been successful, and when I will know this		Any challenges or problems I anticipate in carrying out the changes	What help I am likely to need and who could provide me with this help	
How?	When?		Help needed	Source
Example of implementation plan				
A steady increase in the number of students who come to the clinic to obtain services	Six months after making contact with the schools	Lack of interest from the school administration Resistance from the teachers	Support from the educational authorities A seminar to convince them of the value of this work	The District Health Officer could request this information Leaders of the parent-teachers association

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