Republic of Malawi

Ministry of Health
(Reproductive Health Unit)

Youth Friendly Health Services Training Manual

Participants Handbook

2009
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>BLM</td>
<td>Banja La Mtsogolo</td>
</tr>
<tr>
<td>CBOs</td>
<td>Community Based Organisations</td>
</tr>
<tr>
<td>CHAM</td>
<td>Christian Health Association of Malawi</td>
</tr>
<tr>
<td>CHBC</td>
<td>Community Home Based Care</td>
</tr>
<tr>
<td>DM</td>
<td>Diabetes Mellitus</td>
</tr>
<tr>
<td>DMPA</td>
<td>Depo-medropogesterone acetate</td>
</tr>
<tr>
<td>DYO</td>
<td>District Youth Officer</td>
</tr>
<tr>
<td>FPAM</td>
<td>Family Planning Association of Malawi</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV Testing and Counselling</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IGA</td>
<td>Income Generating Activity</td>
</tr>
<tr>
<td>NAC</td>
<td>National AIDS Commission</td>
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<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>NYCOM</td>
<td>National Youth Council of Malawi</td>
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<tr>
<td>MAGGA</td>
<td>Malawi Girl Guides Association</td>
</tr>
<tr>
<td>MDHS</td>
<td>Malawi Demographic and Health Survey</td>
</tr>
<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
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<td>PLHIV</td>
<td>People living with HIV</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission of HIV</td>
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<tr>
<td>RHU</td>
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<tr>
<td>SDP</td>
<td>Service Delivery Point</td>
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<td>SRH</td>
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</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
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<tr>
<td>UNFPA</td>
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<td>United Nations Children Fund</td>
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<tr>
<td>VCT</td>
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<td>VIPP</td>
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<td>WHO</td>
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FOREWORD

The youth are regarded as 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. As young people grow and develop, they have various needs and problems, which affect their growth and development. However, the young people and adults around them are either not aware of the needs, or are unaware of what to do about those needs; and where they are aware, they usually have problems in accessing services that address their needs.

The Malawi Youth Friendly Health Service (YFHS) Training package aims to improve the way service providers respond to the needs of young people and improve their ability to communicate with other stakeholders to improve young people’s health.

The training package is intended for service providers who provide preventive, curative and promotive health services to the youth. Such service providers include trained registered health service providers e.g. doctors, clinical officers, nurses and other professionals such as psychologists, social workers, teachers, youth development workers and youth peer educators as well as young people themselves. It is envisaged that having such a broad target audience will ensure that the Training Programme benefits from different insights and perspectives from a broad range of stakeholders and service providers.

The Training Programme is expected to be implemented as a stand alone 5 days training workshop and that service providers who participate in the Training Programme will:

- Become more knowledgeable about the characteristics of young people and of different aspects of youth health and development;
- Become more sensitive to the needs of young people;
- 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 to young people that respond to their needs and are sensitive to their preferences;
- Have prepared a personal plan indicating the changes they will make in their work with and for young people.

However, the Training Programme is not intended to equip participants with specific clinical or counselling skills in youth health care. The assumption being that such skills are addressed in other capacity building programmes organised by the Ministry of Health and its partners. Where relevant such capacity building materials should be made available or be referred to during the training workshop. The Training Programme does not intend to duplicate other capacity building initiatives that are already implemented by the Ministry of Health. Facilitators should be flexible enough to gauge the level of capacity of their participants and tailor the materials in this Training Programme to complement such capacity building materials.
In practical terms, the Training Programme will provide participants with ideas and practical tips to two key questions:

- **What do I, as a health-service provider, need to know and do differently if the person who walks into my clinic is aged 16 years, rather than 6 or 36?**

- **How could I help other influential people in my community to understand and respond better to the needs and problems of young people?**

The Ministry of Health therefore, expects that, through this manual, service providers will be able to re-examine and re-orient their service delivery to address the needs and problems of the youth. This manual is intended to assist service providers, be it government, the Christian Health Association of Malawi (CHAM), non governmental organisations and all other stakeholders in re-designing, reviewing and developing programmes and policies that focus on the promotion of friendly health services for young people in Malawi.

C.V. Kang’ombe  
Secretary for Health
ACKNOWLEDGEMENTS

The Malawi Youth Friendly Health Services (MYFHS) training manual is a culmination of concerted efforts of many individuals who have been involved at various stages in the development of the Malawi Youth Friendly Health Service Standards and the adaptation of the WHO Orientation Programme on Youth Friendly Health Services which has significantly informed the content of the MYFHS Training Package.

The Reproductive Health Unit 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.

Special recognition and gratitude is extended to the following individuals for their special involvement and contributions in the development of the manual.

The development of the National HIV and AIDS Action Framework was a result of a combined effort and support of various organisations and individuals. It is difficult to acknowledge all, but some deserve special mention.

The Reproductive Health Unit (RHU) wishes to offer gratitude to the National Technical sub Committee on Youth Friendly Health Services for facilitating the development of the training materials. In particular, the following merit special mention: Dr Chisale Mhango, Director RHU, Fannie Kachale, Deputy Director, RHU; Julius Malewezi, Hans Katengeza, Jean Mwalabu, RHU; Joyce Mphaya and Grace Mlava from UNICEF, Juliana Lunguizi, UNFPA, Jean Mwandira, Chisomo Zileni and Cecelia Kphaizi from National Youth Council of Malawi; Assana Magombo, Brandina Kambala and Samson Semu from Banja la Mtsogolo.

The RHU is indebted to the World Health Organisation for financing the development of the training package. In particular special gratitude should go to the WHO Representative Dr Moeti and her team comprising of Mrs Theresa Mwale, Dr Richard Banda, and Dr Susan Kambale of the WHO country office and the external technical assistance of Dr Chandra Mouli of the Department of Child and Adolescent Health (Geneva) and Dr Kampatibe of the Department of Child and Adolescent Health WHO AFRO Office and local technical assistance of Dr Kenneth Maleta of the Division of Community Health, College of Medicine, University of Malawi.

Last but not least special recognition should be made of the following stakeholders for their input during the whole process: United Nations International Children’s Fund (UNICEF), United Nations Population Fund (UNFPA), and National Youth Council of Malawi (NYCOM).
Handout for

Unit 1

Introduction
This handout provides information to complement the material covered in the unit *Introduction to the Training Programme* (TP) on *Youth Friendly Health Services*. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts. References are included at the end.

**THIS HANDBOOK PROVIDES INFORMATION ON THE FOLLOWING:**

1. Overall aim of the Training Programme  
2. Expected outcomes of the Training Programme  
3. Intended participants  
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1. OVERALL AIM OF THE TRAINING PROGRAMME

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. This aim will be achieved through a series of 4 units.

2. EXPECTED OUTCOMES OF THE TRAINING PROGRAMME

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

- Be more knowledgeable about the characteristics of adolescence and adolescent development
- Be more sensitive to the needs of young people
- Be better-equipped with information and resources
- Be better able to provide youth-friendly health services
- Have prepared a personal plan indicating the changes they will make in their work with and for young people.

What does the training programme not do?

The Training Programme is not designed to develop improved clinical or counselling skills in youth health service provision.

3. INTENDED PARTICIPANTS

The Training Programme has been developed to address the needs of service providers, especially health care providers, in their work with young people. Adolescents can be participants in the Training Programme and their inclusion will ensure that their point of view is heard. Representatives from other relevant professional groups (e.g. Youth Development workers, social workers, psychologists, nutritionists and teachers) may also be invited to participate in the programme to give it a multisectoral perspective.

4. TRAINING PROGRAMME UNITS

Figure 1 show the units included in the training programme. All participants in the Training Programme must attend the all the units listed in the table below.
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<td>3</td>
<td>Sexual and reproductive health</td>
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<td>3C</td>
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<td>3G</td>
<td>HIV and AIDS and young people</td>
</tr>
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<td>Nutrition and young people</td>
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<td>5</td>
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5. METHODOLOGY

The teaching and learning methods used throughout the Training Programme are participatory and appropriate to working with adults who always bring a wealth of personal experience to any learning event. It is recognized that the main group of intended participants already have extensive clinical and/or other experience of working with adolescents and adolescent health issues.

A participatory approach enables the individual to draw on his/her own experience and learn in an active way. It also enables a more equal relationship between participants and facilitators than is possible in the more conventional trainer-learner or teacher-student approaches.

The Programme uses a range of methods and approaches, from direct input in the form of short mini lectures to problem-solving in small groups and role play sessions.

Ground rules for participatory learning

Experience has taught us that it is sometimes necessary to establish some ground rules when using participatory approaches. The following are some examples of such rules:

- Treating everyone with respect at all times, regardless of gender, age or cultural differences; Ensuring and respecting confidentiality so that facilitators and participants are able to discuss sensitive issues (such as those relating to sexual and reproductive health, mental health and substance use) without fear of repercussions;
- Agreeing to respect and observe time-keeping and to begin and end the sessions on time;
- Making sure that everyone has the opportunity to be heard;
- Willing to accept and give critical feedback;
• Drawing on the expertise of other facilitators and the participants in difficult situations.

Adherence to these rules will help to ensure an effective and enjoyable learning environment.

**Visualization in Participatory Programmes (VIPP) methods**

The Training Programme also uses Visualization in Participatory Programmes (VIPP) methods (1, 2). VIPP is a people-centred approach to planning, training, and other group events. It combines techniques of visualization with methods for interactive learning. Central to VIPP is the use of a large number of multi-coloured paper cards of different shapes and sizes on which you express your key ideas in letters or diagrams, large enough to be seen by the whole group. Using this method, everyone takes part in the process; even participants who are shy or hesitate can find a means of expression. Those who might normally dominate the group are required to let others have a say.

Some rules for card-writing so that VIPP will be successful:

- Write only one idea per card
- Write a maximum of three lines on each card
- Use key words
- Write large letters in both upper and lower case
- Write legibly
- Use different sizes, shapes and coloured cards to creatively structure the results of discussions
- Follow the colour code established by the facilitator for different categories of ideas.

VIPP cards can be used in plenary sessions or small groups for you to put down your responses to a question. The use of cards enables the responses to be organized in a logical way and to show areas of consensus and disagreement.

**6. REFERENCES**

Handout for

Unit 2

Meaning of adolescence and its implications for public health
This handout provides information to complement material covered in the unit *Meaning of adolescence and its implications for public health*. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

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Adolescence

Adolescence has been described as the period in life when an individual is no longer a child, but not yet an adult. It is a period in which an individual undergoes enormous physical and psychological changes. In addition, the adolescent experiences changes in social expectations and perceptions. Physical growth and development are accompanied by sexual maturation, often leading to intimate relationships. The individual’s capacity for abstract and critical thought also develops, along with a sense of self awareness when social expectations require emotional maturity. It is important to keep this in mind for a more complete understanding of the behaviours of adolescents.

Age groups

Who defines adolescents as individuals in the 10 -19 year age group and youth as the 15 to 24 year age group. These two overlapping age groups are combined in the group ‘young people’, covering the age range 10-24 years (1).

The Malawi national Youth Policy of 2004 defines young people as boys and girls of the age between 10 -25 years regardless of marital status, economic status and parity (2). In the health sector in Malawi, most of the services have been targeting adolescents i.e. ages between 10 and 19 years and mainly in sexual and reproductive health (SRH) services. This target group for SRH has recently been revised downwards to include ages between 8 and 25 years (3). The Ministry of Health has a strong underfive programme, which leaves out the young people of the ages between 6 and 9. As such the national Young people’s Health strategy of the Ministry of Health considers young people to be those between the ages 6 to 25 years.(4)

WHO clearly recognizes that “adolescence” is a phase rather than a fixed time period in an individual’s life. As indicated above, it is a phase of development on many fronts: from the appearance of secondary sex characteristics (puberty) to sexual and reproductive maturity; the development of mental processes and adult identity; and the transition from total socio-economic and emotional dependence to relative independence.

It is important to note that adolescents are not a homogeneous group. Their needs vary with their sex, stage of development, life circumstances and the socioeconomic conditions of their environment.
2. DEMOGRAPHIC AND SOCIOECONOMIC INFORMATION ON ADOLESCENTS

Population

There are more than 1.1 billion adolescents worldwide today – that is, one in every five people on the planet is aged between 10 and 19 years. Approximately 1.5 billion of today’s world populations are young people between 10 and 24 years old; 85% of them live in developing countries (5,6) (Table 1 shows the global and regional distribution of adolescent populations.

TABLE 1. DISTRIBUTION OF THE GLOBAL POPULATION IN THE YEAR 2000

<table>
<thead>
<tr>
<th>Region</th>
<th>Total population</th>
<th>Adolescent population</th>
<th>% adolescent pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td>World</td>
<td>6,055,049</td>
<td>1,153,822</td>
<td>19</td>
</tr>
<tr>
<td>More developed regions</td>
<td>1,187,980</td>
<td>159,849</td>
<td>13</td>
</tr>
<tr>
<td>Less developed regions</td>
<td>4,867,069</td>
<td>993,973</td>
<td>20</td>
</tr>
<tr>
<td>Least developed regions</td>
<td>644,678</td>
<td>152,562</td>
<td>24</td>
</tr>
<tr>
<td>Africa</td>
<td>784,445</td>
<td>184,611</td>
<td>24</td>
</tr>
<tr>
<td>Latin America &amp; Caribbean</td>
<td>519,143</td>
<td>105,821</td>
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<tr>
<td>North America</td>
<td>309,631</td>
<td>43,751</td>
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<td>Asia</td>
<td>3,682,550</td>
<td>715,862</td>
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<td>Europe</td>
<td>728,887</td>
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<td>Western Pacific</td>
<td>30,393</td>
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<tr>
<td>Malawi</td>
<td>11,200,000</td>
<td>2,688,000</td>
<td>24</td>
</tr>
</tbody>
</table>

Source: reference 2; for Malawi, MDHS 2004

EDUCATION.

Formal education is of great importance for the development of adolescents. Schools provide an environment for acquiring knowledge, and for building literacy, numeracy and thinking skills. Education is a vital tool for socio-economic development (through improved economic opportunities available to those who are educated) and also for its positive impact on health. Schools are a major source of education and guidance on specific health issues and, in addition, offer a setting for the provision of health screening and health services. National policies and the available resources determine whether schooling for adolescents is obligatory and accessible. Adolescents in developing countries have fewer opportunities for education than their counterparts in developed countries, and girls have even fewer opportunities for schooling than boys. In Malawi, only 11% of the secondary school aged children (defined as ages up to 24 years) are attending secondary education while up to 82% of children between 6 and 13 years old are attending primary school. However, more boys than girls attend school at all levels and there are obviously regional and urban rural differences (7).
EMPLOYMENT.

Many adolescents do not complete their secondary school education. A substantial proportion seeks work in the informal sector. Worldwide there are an estimated 73 million adolescents aged between 10 and 14 years who work under conditions that are detrimental to their health (addition, throughout the world many millions of adolescents live and work on the streets, putting them at high risk of sexual abuse and/or substance use(8) and injuries. In Malawi 37% of children aged between 5 to 15 years old are engaged in some form of work, 8% are doing some type of work for non relatives and often without pay. Older children are more likely to be working than younger children but girls are more likely to be working long hours on household chores compared to boys. However there in no significant difference in the percentage of boys and girls who are working which is estimated at 35 and 39% respectively (9).

It has been estimated that between 1970 and 2025 the urban adolescent population in developing countries will grow by 600%. The projected rapid growth in the number of adolescents living economically deprived urban areas poses considerable challenges to government and civil society.

POVERTY

Despite many development gains in the last century, both absolute and relative poverty continue to increase in many parts of the world. Although poverty affects all age groups, it brings particular risks to the health and development of adolescent. For instance, the pressure to earn a living at a young age could hinder their ability to stay in school and gain proper education, and could also expose them to exploitation and abuse by unscrupulous adults. This is especially important in Malawi with the very high prevalence of HIV which has led to increase in orphan hood (see unit on HIV and AIDS) which in turn has resulted in young people heading households and having to fend not only for themselves but also their siblings. This puts them at special risk. In Malawi, 12% of young people under the age of 18 years have lost their father, 6% have lost their mother and 4% have lost both their natural parents (10).
3. THE NATURE AND SEQUENCE OF CHANGES DURING ADOLESCENCE

Adolescence is characterized by a rapid rate of growth and development. During this period the body develops in size, strength and reproductive capabilities, and the mind becomes capable of more abstract thinking. Social relationships move from being centred on the family base to a wider horizon in which peers and other adults come to play significant roles in the adolescent’s life. It is also a time when new skills and knowledge are acquired and new attitudes are formed.

Although the decade of life from 10 to 19 years provides a time-bound definition of adolescence, it is important to realize that the changes occurring during this period may not correspond neatly with precise ages. This is because of variations in the onset and duration of changes between individuals. Moreover, this period of transition is perceived differently by different cultures; its perception is clearly mediated by social, economic and cultural factors. Hence, the experience of adolescence differs among individuals and by sex in any given society, and by varying conditions and circumstances such as disability, illness, socioeconomic status and poverty (11). Peak rates of growth and development during adolescence are exceeded only by those during foetal life and infancy. However as indicated above, in comparison with infancy and early childhood, there is much greater individual variation both in the timing of developmental milestones, and in the degree of changes in rates of growth (12).

Adolescence is sometimes divided into early, middle and late periods, which are respectively the 10-14, 15-17 and 18-19-year age groups. These periods roughly correspond with the phases in physical, social and psychological development in the transition from childhood to adulthood (Table 2). While these stages are not universally accepted, and vary as above, they provide a basic framework to understand adolescent development.

<table>
<thead>
<tr>
<th>Table 2: Stages of adolescence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category of change</td>
</tr>
<tr>
<td>Growth</td>
</tr>
<tr>
<td>Cognition</td>
</tr>
<tr>
<td>Psychosocial</td>
</tr>
<tr>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Family</td>
</tr>
<tr>
<td>Peer group</td>
</tr>
<tr>
<td>Sexuality</td>
</tr>
</tbody>
</table>

Reference 13
4. MAGNITUDE OF SELECTED PRIORITY HEALTH PROBLEMS AFFECTING ADOLESCENTS

Most adolescents are healthy – that is, they show lower levels of mortality and morbidity compared to children and adults. Most adolescents also believe that they are healthy. For instance, a study of almost 16,000 adolescents conducted in nine countries in the Caribbean found that 80% of the adolescents surveyed considered themselves healthy and 88% felt comfortable about their appearance. Two-thirds of them had not had sexual intercourse, and 89% did not use alcohol and other psychoactive substances. The majority liked school (94%) and got along with their teachers (96%), and felt that their parents and family members cared about them (14).

There is growing recognition, however, that some adolescents do in fact develop health problems, and in addition many more adopt unhealthy behaviours that lead to health problems in their adult lives. The health problems and problem behaviours affecting young people in developing countries have been classified by WHO as shown in the table below (Table 3).

<table>
<thead>
<tr>
<th>Diseases which are particular to young people</th>
<th>Diseases and unhealthy behaviours which affect young people disproportionately</th>
<th>Diseases which manifest themselves primarily in young people but originate in childhood</th>
<th>Diseases and unhealthy behaviours of young people whose major implications are on the young persons future health</th>
<th>Diseases which affect fewer young people than children, but more of them than adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases: Disorders of secondary sexual development</td>
<td>Diseases: Maternal morbidity and mortality STIs (including HIV) Tuberculosis Schistosomiasis Intestinal helminthes Mental disorders</td>
<td>Diseases: Rheumatic heart disease</td>
<td>Diseases: STIs (including HIV) Dental disease</td>
<td>Diseases: Malnutrition Malaria Gastroenteritis Acute respiratory infections</td>
</tr>
<tr>
<td>Difficulties with psychosocial development Suboptimal adolescent growth spurt</td>
<td>Alcohol use Other substance abuse Injuries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaviours:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Young people will contribute a substantial number of cases because they form a large proportion of the population in most developing countries.
Studies suggest that there are significant sex differences in adolescent morbidity and mortality rates. Boys worldwide have higher rates of morbidity and mortality from injuries due to interpersonal violence, accidents and suicide, while adolescent girls have higher rates of morbidity and mortality related to sexual behaviour (15).

Drawing upon data from around the world, a list of “priority” health problems affecting adolescents has been developed (Box 1). Each of the problems on the list meets the following three criteria. Firstly, they cause mortality or morbidity either during the adolescent period, or in later life as a result of behaviours initiated during this period. Secondly, they cause significant levels of mortality and morbidity. Thirdly, many of these health problems and problem behaviours are inter-related. For instance, substance use is associated with depressive states, and alcohol use is associated with road traffic accidents.

**Box 1 Health problems established during adolescence**

- Intentional and unintentional injuries
- Sexual and reproductive health problems including HIV/ AIDS
- Substance use and abuse (tobacco, alcohol, and other substances)
- Mental health problems
- Nutritional problems
- Endemic and chronic diseases

Each of these problems is described briefly below.

**Intentional and intentional injuries**

Unintentional injuries are the leading cause of death among young people, especially traffic accidents. Of the estimated 195,000 adolescents killed each year in traffic accidents, more than 60% are boys (WHO GPE 2000). Many of these traffic accidents are related to the use of alcohol and other psychoactive substances. For every young person killed in traffic accidents, an estimated 10 more are seriously injured or maimed for life.

Interpersonal violence is a form of intentional injury, which is increasing among young people, with girls especially being victimized (15). Although boys are far more likely than girls to be perpetrators of violence, research is now showing that boys are also victims of violence.

Data on the incidence of sexual violence and rape are not well-established. A review in 1994 confirmed that rape is not rare. Data from legal statistics and rape crisis centres show that a high proportion of rape victims in many developing countries are under 15 years of age and that most perpetrators are known to their victims (16). Sexual abuse of girls and boys is an even more widespread problem, with three times as many girls as boys being affected.
Sexual and reproductive health – consequences of unsafe sex

Adolescence is a time for sexual exploration and expression. For many adolescents sexual relations begin in adolescence, in or outside of marriage. The consequences of unprotected sex in adolescents include too early and unwanted pregnancy, and sexually transmitted infections, including HIV.

When adolescents become pregnant, especially in early adolescence, they are at risk of complications both during pregnancy and during delivery. Moreover, the risk of mortality and morbidity is higher in infants born to adolescent mothers, than for older women.

Lack of knowledge and skills, poor access to contraceptive methods including condoms, as well as vulnerability to coerced sex puts adolescents at high risk of unwanted pregnancies and infections. Further, a range of obstacles to their utilization of health services may make it difficult for them to obtain the advice and health services they need (17).

Unwanted pregnancy is often seen only as a problem for adolescent girls, but recent research shows that adolescent fathers face some of the same issues that young mothers face: too-early role transition from adolescent to parent; social isolation; unstable relationships; and social and family

In developing countries, maternal mortality in girls under 18 years of age is two to five times higher than in women aged 18-25 years (18, 19). Worldwide, more than 13% of all births are to women 15-19 years old. There are however considerable variations both between and within countries (20). Adolescent mothers in many developing countries face many health and social problems.

Unsafe abortions in adolescents are estimated at 2.5 million a year, representing 14% of all unsafe abortions. A further 4.8 million (or 26%) unsafe abortions take place in young women 20-24 years old (WHO, RHR, 2002).

Every year, more than one out of 20 adolescents will contract a curable sexually transmitted disease (STD), not including viral infections (22), and every year a third of the estimated 333 million new STDs occur in young people under 25 years (23).

HIV and AIDS

The HIV and AIDS pandemic is one of the most important and urgent public health challenges facing governments and civil societies around the world. Adolescents are at the centre of the pandemic both in terms of its spread, and in terms of the potential for changing the attitudes and behaviours that underlie this disease.

An estimated 30% of the 40 million people living with HIV and AIDS (i.e. 10.3 million) are young people aged 15-24, and half of all new infections – over 7000 daily – occur among young people (17). The vast majority of young people who are HIV-positive do not know that they are infected, and few young people who are engaging in sex know the HIV status of their partners.
In Malawi, the National adult HIV prevalence is estimated at 14% (NAC, 2005). In 2005, there were 1,120,000 people infected with HIV and 96,552 were new infections in Malawi (NAC, 2004). Half of the above new infections occurred in young people aged 15-24 years and 75% of these new infections in young people occur in girls of the same age category. In antenatal attendees, the prevalence of HIV in 2005 was 16.9% and most of the attendees were below 30 years (NAC, 2005). In general HIV prevalence is higher in the urban areas than in the rural (21.6% & 12.1% respectively). The High HIV prevalence has been attributed to high incidence (new infections) in the younger age group (15-19 years) (NAC, 2005).

Young people are vulnerable to HIV because of risky sexual behaviour, substance use, and their lack of access to HIV information and prevention services. Many young people do not believe that HIV is a threat to them, and many others do not know how to protect themselves from HIV. Not surprisingly therefore, only 6.8% and 17.2% of young males and females aged 15-19 respectively ever tested and received result by 2005 in Malawi.

**Substance use**

Harmful substance use (tobacco, alcohol and illicit substances) will increase the risk of cancers, cardiovascular diseases, and respiratory illnesses later in life (15). If tobacco use begins at all, it usually begins in adolescence; few people begin to smoke regularly after the age of 18 (3). Alcohol is the most common element in substance-use related deaths of young people. The earlier the age of onset of drinking the greater the chance of developing a clinical alcohol disorder later in life (24). More importantly, there is growing evidence of the “clustering” of behaviours risky to health. A recent review of evidence from around the world, carried out by WHO, showed that the use of substances by adolescents, is associated with a greater likelihood of early sexual initiation (26).

**Mental health**

Young people are often vulnerable to the kinds of stresses (including the challenges of growing up and exposure to risky behaviours) that contribute to mental ill health. It is during adolescence that some mental health problems first appear. Mood disorders such as depression, and psychotic disorders such as schizophrenia, are two types of mental illnesses for which early recognition and intervention are critical for a successful and long-lasting recovery (27).

Suicide is one of the three leading causes of death for young people. Suicide rates among adolescents are rising faster than among any other age group. There are 90,000 suicides committed by adolescents each year. For every completed attempt of suicide, there are at least 40 unsuccessful attempts (27). There appear to be clear gender patterns in the way in which young people respond to stressful and traumatic life events (12). Various studies have shown that in times of stress or trauma, boys are more likely than girls to respond to stress with aggression (either against others or against themselves), to seek diversion in physical activity, and to deny or ignore stress and problems. On the other hand, adolescent girls more frequently turn to friends and pay
attention to health needs resulting from stress. These gender patterns of coping with stress can also be seen in gender differences in suicide.

**Nutrition**

During adolescence, nutritional problems originating earlier in life can potentially be corrected, in addition to addressing those that begin during adolescence. Malnutrition is estimated to account for 16% of all disability-adjusted life years\(^1\) in the general population and is the largest single factor contributing to ill health. Among adolescents malnutrition is not one of the main causes of ill health as it is for instance in children under the age of 5. However, under- and over-nutrition, anaemia and lack of micronutrients, especially relevant for pregnancy, are increasing problems in both developing and developed countries\(^2\). The adolescent’s need for iron, increased by growth, development and menstruation, are hampered by malaria, hookworm infestation and Schistosomiasis, which affect young people disproportionately\(^2\).

**Chronic and endemic diseases**

Data show that malaria and tuberculosis (TB) are among the 10 major causes of death in adolescents (125,000 deaths each year from malaria and 75,000 due to TB)\(^3\). It is important to ensure that adolescents are addressed in programmes to combat these conditions, as well as others such as schistosomiasis and helminth infestations. Chronic conditions include noncommunicable diseases such as asthma, epilepsy, cystic fibrosis, juvenile diabetes and haemoglobinopathies such as sickle-cell disease. In general, the focus on chronic conditions has been greater in developed countries but there is growing awareness that they need to be addressed in developing countries as well. Chronic conditions could adversely affect adolescent development. Factors such as growing autonomy and sensitivity to peer pressure, characteristics of an emerging adolescent identity, could hinder compliance to diet and treatment regimens in individuals with chronic conditions. It can hence be a challenge to manage these conditions in adolescents within the context of all the other changes that are taking place. The management of these conditions requires comprehensive care and support addressing both biomedical and psychosocial issues in an ongoing manner, rather than the application of a “diagnose and treat” approach.

**Differences in perspectives**

The data provided above present information on the major problems facing adolescents as perceived by health planners and policy-makers. However, adolescents themselves often have very different perceptions of their health-related needs and problems. Their concerns often relate to issues such as body size, acne, and relationships with their peers and members of the other sex. Box 2 shows the different priorities given to young people’s health by two different stakeholders: health planners and young people themselves.

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\(^1\) The Disability Adjusted Life Year (DALY) is a measure used to quantify burden. It is a time based measure which captures impact of premature death (in years), and the time (in years) lived with disability. One DALY is one lost year of healthy life.
To be truly meaningful, programmes intended for adolescents must make every effort to understand and address their viewpoints and perspectives. Additionally, adults who interact with adolescents (e.g. parents and other family members, teachers, youth leaders and religious leaders) are important groups to be consulted and involved (29). This will make it possible for all the key stakeholders to make their own special contributions to the health and development of adolescents.
5. WHY INVEST IN ADOLESCENT HEALTH AND DEVELOPMENT

The behaviours and lifestyles learned or adopted during adolescence will influence health both in the present and in the future. Tobacco use is a good example of how a behaviour, almost always adopted during adolescence, leads to disease and death later in life. Further, the benefits of adolescent health and development accrue not only to the adults that emerge from the process, but also to future generations. The three main reasons for investing in the health and well-being of adolescents are shown in Box 3. It is estimated that every year about 1.4 million adolescents die – mostly from accidents, violence, pregnancy-related problems and illnesses that are either preventable or treatable. Many more develop behaviours that could destroy their chances for personal fulfillment and their ability to contribute to society. Investing in adolescent health and development will reduce the morbidity and mortality in this age group. It will maximise their opportunity to develop to their full potential and to contribute the best they can to society.

**BOX 3**

Three main reasons for investing in adolescent health

- Health benefits for the individual adolescent – in terms of his or her current and future health, and in terms of the intergenerational effects
- Economic benefits: improved productivity, return on investments, avert future health costs
- As a human right: adolescents (like other age groups) have a right to achieve the highest attainable health

*Reference 30*

Investing in adolescent health and development will also 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 children and to other children tomorrow.

Investing in Adolescent Health and Development (ADH) makes economical sense: 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 are being safeguarded by continuing attention to ADH. When adolescents develop suboptimally or die prematurely this means a waste of earlier investments. Investing in prevention and promotion during adolescence also averts future health costs: smoking prevention averts health costs much later in life.

Promoting and safeguarding adolescent health should not only be regarded as an investment, but also as a basic human right. The UN Convention on the Rights of the Child (CRC), 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*. The CRC also gives young people the right to preventive health
care and requires specific protection for those living in exceptionally difficult conditions or with disabilities. This means that governments have the responsibility to ensure that health and other basic services essential for good health are provided.

6. GUIDING PRINCIPLES AND A CONCEPTUAL FRAMEWORK FOR PROMOTING AND PROTECTING ADOLESCENT HEALTH AND DEVELOPMENT

Working in conjunction with UNFPA and UNICEF, WHO has developed a framework for country programming for adolescent health (29). The framework spells out the twin goals of programming – promoting healthy development in adolescents on the one hand, and preventing and responding to health problems if and when they arise, on the other. It lists the interventions that need to be delivered – as a package – to meet these goals: the creation of a safe and supportive environment, the provision of information, building life skills, and the provision of health and counseling services. It also lists the settings wherein these interventions could be delivered and the players who could deliver them (including both adults and adolescents themselves).

The framework is a truly comprehensive one, 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 4) that should underpin our work with adolescents as well as keys to success.

Box 4
Guiding concepts for planning for adolescent health and development

- Adolescence is a time of risk and opportunity
- Not all adolescents are equally vulnerable
- Adolescent development underlies prevention of health problems
- Problems have common roots and are interrelated
- The social environment influences adolescent behaviour
- Gender considerations are fundamental

Source (ref 29)

Adolescence is a time of risk and opportunity. Generally speaking, adolescence is a healthy period of life. However, some adolescence do lose their lives and many more develop health problems or problem behaviours that could lead to disease and premature death in adulthood. In that sense adolescence is in fact a time of risk; but it is also a time of opportunity 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 prevention of health problems: The two overlapping goals of promoting healthy adolescent development on the one hand, and preventing and responding to health problems on the other, cannot be viewed as

problems are closely linked to one another. The provision of preventive and curative health services for specific health problems is important. However, the prevention of health problems (and problem behaviours) 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) is even more important.

Problems have common roots and are interrelated: Research shows that the health problems of adolescents are interrelated. This is because the underlying behavioural causes of many of these health problems are the same. For example, studies from around the world – gathered and analyzed by WHO – point to the fact that adolescents who engage in other risk behaviours, such as using alcohol and other substances, are more likely to initiate sexual intercourse early (26) (Figure 1).

![Figure 1](early-sexual-initiation)

**Early sexual initiation**

<table>
<thead>
<tr>
<th>Risk or protective factors for adolescents</th>
<th>Africa</th>
<th>Asia</th>
<th>Caribbean</th>
<th>S. America</th>
<th>N America</th>
</tr>
</thead>
<tbody>
<tr>
<td>A positive relationship with parents</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>?</td>
</tr>
<tr>
<td>A positive relationship with teachers</td>
<td>+</td>
<td>+</td>
<td>?</td>
<td>+</td>
<td>Not significant</td>
</tr>
<tr>
<td>Friends who are sexually active</td>
<td>-</td>
<td>?</td>
<td>-</td>
<td>-</td>
<td>?</td>
</tr>
<tr>
<td>Engaging in other risky behaviours</td>
<td>-</td>
<td>?</td>
<td>-</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>Having spiritual beliefs</td>
<td>?</td>
<td>+</td>
<td>+</td>
<td>?</td>
<td>+</td>
</tr>
</tbody>
</table>

**Key**

+ Protective factor; - risk factor, ? not measured

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/her full potential, and for him/her to be healthy. For example, the synthesis of studies by WHO, referred to above, points to the fact that adolescents who have positive relationships with parents and with other adults in the community are less likely to experience depression (29). Unfortunately, many adolescents in today’s world are living, studying and working in unsafe and unsupportive environments, with negative effects on their health and development (Figure 2).

![Figure 2](depression)

**Depression**

<table>
<thead>
<tr>
<th>Risk or protective factors for adolescents</th>
<th>Africa</th>
<th>Asia</th>
<th>Caribbean</th>
<th>S. America</th>
<th>N America</th>
</tr>
</thead>
<tbody>
<tr>
<td>A positive relationship with parents</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Parents encourage self expression</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Conflict in the family</td>
<td>-</td>
<td>NS</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>A positive attitude towards school</td>
<td>NS</td>
<td>+</td>
<td>+</td>
<td>Not Significant</td>
<td>+</td>
</tr>
<tr>
<td>Positive relationship with adults in the community</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>Not Significant</td>
<td>Not Significant</td>
</tr>
<tr>
<td>Having spiritual beliefs</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>Not Significant</td>
<td>Not Significant</td>
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<td>Key</td>
<td>Significant</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Protective factor; - risk factor,</td>
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</table>

*Source (ref 25)*

**Gender considerations are fundamental**: A good understanding of the biological differences in the growth and development of males and females (through the years of adolescence), and of the different ways in which they are affected by health problems is important. Equally important is a good understanding of the different social and cultural influences on males and females, and how this affects the way in which adolescent males and females view themselves and relate with others.
What health care providers need to do when working with and for adolescents.

A fundamental principle in working with/serving adolescents is “putting them at the centre”, in other words, making their needs and problems, thoughts and feelings, viewpoints and perspectives central to your work with them. Some key issues are listed in the Box 5.

**Box 5 Putting adolescents at the centre**

- Regarding adolescent as an individual, not just a case of this or that problem
- Striving to understand the specific needs of each individual adolescent
- Acknowledging – and heeding- the viewpoints and perspectives of the adolescent in line with his or her evolving capacity
- Taking into primary consideration the best interests of the adolescent, when making decision or taking actions that affect him or her
- Respecting the rights of the adolescent (as laid out in the UN convention on the rights of the child) while at the same time taking into account the rights and responsibilities of parents
- Striving to prevent personal beliefs and attitudes, preferences and biases from influencing ones professional assessment and actions

All these issues will be touched on and developed further in all the Orientation Programme modules. One concrete method which health workers could use to understand the adolescent they are working with is to use the HEADS approach (31) (Box 6). This approach consists of a checklist of questions to carry out a rapid assessment to provide information on the psychological and social dimensions of the adolescent’s life. It could be used in combination with a medical history to provide information on Box 6.

**Box 6**

**Areas addressed by the HEADS approach to assess the psychological situation and the social circumstances of adolescent patients**

- Home: about the family
- Education: about their interest and performance
- Eating: about their habits
- Ambition: about their hopes for the future
- Activities: about their social and recreational activities
- Drug use: whether they smoke or use psychoactive substances
- Sexuality: their thoughts and feelings about their sexual activity
- Suicide: how they feel and whether they have thought of hurting themselves

*Source reference 31*

A final point worth noting is that since many of the factors that affect adolescent health and development are interrelated, they cannot be completely addressed by the health
sector alone. Health-care providers can, however, work with other sectors including the education and social welfare sectors to address collectively the health issues of adolescents. Health staff can also become more aware of the role and responsibilities of the other sectors and be well informed of what services are available for adolescents outside the health sector. As you will see in the later units there are also many things that health care providers can do within the health sector to make the services more adolescent-friendly.
REFERENCES

4. *Young People’s Health Strategy and Implementation Framework.* Ministry of Health 2004


### Annex 1 SPOT CHECKS Session 1: (ACTIVITY 1-2)

<table>
<thead>
<tr>
<th>SPOT CHECK 1</th>
<th>What are the important changes that take place in the individual as they go through adolescence? Please provide three answers</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>SPOT CHECK 2</th>
<th>What are the most important actions to do when working with or for adolescence? Please provide three answers</th>
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<thead>
<tr>
<th>SPOT CHECK 3</th>
<th>What are the four most important health problems facing adolescents in your area? Please provide 4 answers.</th>
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<thead>
<tr>
<th>SPOT CHECK 4</th>
<th>We should invest in adolescents because- Please provide four answers</th>
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</table>

<table>
<thead>
<tr>
<th>SPOT CHECK 5</th>
<th>Do you agree that adolescents should be primarily involved in the development, planning, and evaluation of health programmes that serve them? Please mark your answer with a spot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>Possibly</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Nature and sequence of changes and events during adolescence

<table>
<thead>
<tr>
<th>Events / changes that occur</th>
<th>Early adolescence (10 – 13)</th>
<th>Middle adolescence (14 – 16)</th>
<th>Late adolescence (17 – 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td></td>
<td></td>
<td></td>
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Annex 4  Examples of letters  Session 5: Activity 5.1

These are typical examples of letters written by adolescents to an “Agony Aunt (Aunt Nasoko)” or to a personal column or health column in a newspaper or magazine, which illustrate the health-related predicaments of adolescents and their need for advice and help.

Dear Dr Banda

I am a 19 year old girl, still in school, and have a steady boyfriend who is also 19. Our love is very strong, but we never get involved in sexual acts. Recently he proposed to have sex with me. I refused because it is against my religion to have sex before marriage. He tells me that since we will get married anyway, it would be okay to have sex. I love him very much and do not want to lose him.

Dear Dr Phiri

I am a 16 year old orphan girl who is dating a man much older than me. He buys me books, clothes, and other things I need for school. We have had sex once but I am worried that I could become pregnant. I’m afraid that he might leave me because he already has a wife. How can I be sure that am not pregnant? Should I tell him? What if he leaves me? What should I do?

Dear Dr Manganya

I am a 16 year old girl in secondary school. I often have sex with my boyfriend. I recently read that failure to use a condom could lead to STIs or AIDS. I talked to him about using a condom. He threatened to leave me and go back to his old girlfriend if I open the subject again. I do not want to lose him by insisting that he should use a condom. My friend, Tsala, told me that if I washed immediately after having sex, I would not get an STI or AIDS. This is what I am doing now. Is this the right thigh to do? Can this help?

Dear Aunt Nabanda,

I am so scared that am writing to you to ask for help. Last school term when we were opening school, our neighbour who is also our landlord offered to give me a ride to school as he was going to the same town as my school. My parents were very happy for me and greed that he should pick me up. On the way to school he was very nice to me and bought me food and told me that I had turned into a beautiful young woman. He then took back roads as he said they were shorter and nicer. He drove through a forest and started kissing me and undressed me. I begged him to stop but he was much too strong for me. He hurt me and raped me. He then gave me K5000 and told me not to tell anyone. He said that if I mentioned this to anyone he would evict us from our home. Last month he came to our school and brought me lots of food and groceries. He then asked that he should collect me when we close for the term. Last week we had a talk about AIDS and I think I may have got the disease. My parents are so poor but they work very hard. I feel so guilty and am in pain. I do not know what to do. Can you help me?
Handout for

Unit 3A

Introduction to sexual and reproductive health and young people
This handout presents background information, which is the foundation for the subunits on sexual and reproductive health.

**THIS HANDOUT PROVIDES INFORMATION ON THE FOLLOWING:**

<p>| | |</p>
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<td>Initiation of sexual relations in young people</td>
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<td>Consequences of unprotected sexual relations</td>
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<td>Promoting the sexual and reproductive health of young people</td>
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<td>8.</td>
<td>What can health-care providers do to improve adolescents’ access to sexual and reproductive health information and services?</td>
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Annex 2. Case studies | Session 5 – Activity 5-1 | 54 |
1. DEFINITIONS OF SEXUAL AND REPRODUCTIVE HEALTH

Sexual health

The term sexual health is used to describe the absence of illness and injury associated with sexual behaviour, and a sense of sexual well-being. It has been defined as follows: “... 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.” (1)

Reproductive health

WHO defines reproductive health as “...a state of complete physical, mental and social wellbeing, 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 to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right to access appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.” (2)

2. PUBERTY

Adolescence is a period of transition from childhood into adulthood. It is marked by dramatic physical, psychological and social changes. The onset of puberty “announces” an important step on the road to adulthood. 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 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 in boys, there is the appearance of “man-like” musculature.

These changes are accompanied by others such as the appearance of the axillary and pubic hair in both boys and girls, and the change 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.

In many traditional cultures, elaborate rituals are carried out to commemorate the onset of puberty, to “announce” sexual readiness and to celebrate the “arrival” of an adult into the community. Even in modern times, the onset of puberty is a defining moment in an individual’s life, and in the way in which his/her place and role in the family and community are perceived. In Malawi, various rites of passage are performed to mark the transition and these vary according to the culture and tribe.

In both developed and developing countries, puberty is occurring at an earlier age than it did in previous generations. This is attributed to improved nutrition and health status (3). The changes generally occur over a 5-year period, but range from 8 years to 14 years. In general, girls start puberty about 18 months earlier than boys. Girls today enter puberty between the ages of 8 and 13, and boys between 9 and 14 years (4).

In many parts of the world, both in developed and developing countries, girls are reaching puberty at earlier ages. Most of the change is attributed to improved health and nutrition status. Declining trends in the age of onset of puberty are accompanied in many countries by increasing age at marriage. This has important implications for sexual and reproductive health of adolescents.

3. INITIATION OF SEXUAL RELATIONS IN YOUNG PEOPLE

As their bodies change and mature, many young people will develop an interest in sex. A recent synthesis of behavioural case studies in 20 developing countries in Africa, Asia and Latin America points to the fact that adolescence is the period during which sexual activity is initiated in a substantial proportion of individuals (5). The report goes on to say that “much of this activity is risky; the practice of contraception and condom use is often erratic and unwanted pregnancies and unsafe abortions are observed in many settings. Sexual relations are not always consensual: force and coercion are far from unknown. While young people tend to be generally well informed, they have only patchy in-depth knowledge of issues related to sexuality. Moreover expressed norms often conflict with behaviour. Lastly, there are wide gender-based differences in sexual conduct and in the ability to negotiate sexual activity and contraceptive use”. (6) Studies from around the world confirm that a larger percentage of boys report being sexually active than do girls of the same age. Further, boys report that they begin sexual activity earlier (Figure 1).

Demographic and Health Surveys (DHS) data indicate that the reported ages of sexual debut for boys are generally decreasing in nearly all countries for which DHS data are available, while the reported ages at first sexual experience for girls has decreased in only a fifth of these countries (7). The earlier age of puberty, combined with the delayed age of marriage and the declining age of first sexual experience (for some groups of adolescents) means that many more adolescents are having sexual relations before marriage.
Age at first sexual intercourse in Malawi

The 2004 Malawi Demographic and Health Survey (MDHS) data point to relatively early initiation of sex among Malawian youth; 64% and 78% of male and female young people under age 20 years respectively had ever had sexual intercourse. The median ages at first sexual intercourse for the 20-24 years age group were 18.1 years for males and 17.4 years for females.

Adolescents in the Southern region initiate sexual activity earlier than their counterparts in the Center and the North. According to the 2004 MDHS, the median age at first sex for boys aged 20-24 was 18.3 years in the North, 18.5 in the Central and 17.4 in the South. For girls, the median ages at first sex were 17.6, 18.2 and 16.7, in the North, Central and South, respectively. These differences appear to be a reflection of differences in traditional practices in socialization of children in the three regions. In the Southern region most children undergo elaborate initiation ceremonies that are widely interpreted to permit the initiated youth to start having sex (8).

Average age at first sexual experience in Malawi.

<table>
<thead>
<tr>
<th>Age</th>
<th>Proportion</th>
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<tr>
<td>5</td>
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<tr>
<td>6</td>
<td>0.05</td>
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<td>7</td>
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<td>8</td>
<td>0.15</td>
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<td>9</td>
<td>0.20</td>
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<td>15</td>
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Sexual expression

Sexual relations are often seen to be only those which involve penetrative sexual intercourse. However, there are many other ways of expressing sexual feelings that do not involve penetration and that are safe in terms of preventing pregnancy and infection from STIs and HIV. These behaviours include holding hands, hugging, kissing, body rubbing, masturbation and mutual masturbation.
4. 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, type and number of sexual partners, and the use of any form of contraception). These factors include characteristics of the youth themselves, those of their families, friends and communities, as well as the relationships of the youth to these entities. Some of these factors are protective for youth sexual behaviour and others are not.

Table 1 presents results from studies carried out around the world, of factors that influence the early initiation of sexual activity (9). They suggest that protective and risk factors can explain differences in adolescent behaviour, even after accounting for variables such as age, sex, ethnic group and socioeconomic status.

<table>
<thead>
<tr>
<th>Risk or protective factors for adolescents</th>
<th>Africa</th>
<th>Asia</th>
<th>Caribbean</th>
<th>S. America</th>
<th>N America</th>
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<tbody>
<tr>
<td>A positive relationship with parents</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>?</td>
</tr>
<tr>
<td>A positive relationship with teachers</td>
<td>+</td>
<td>+</td>
<td>?</td>
<td>+</td>
<td>Not significant</td>
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<td>Friends who are sexually active</td>
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<td>?</td>
<td>-</td>
<td>-</td>
<td>?</td>
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<tr>
<td>Engaging in other risky behaviours</td>
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<td>?</td>
</tr>
<tr>
<td>Having spiritual beliefs</td>
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<td>+</td>
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Key
+ Protective factor; - risk factor, ? not measured

From the table we can conclude that:

- Families matter: Adolescents who have a positive relationship with parents are less likely to start sexual intercourse early.
- Schools matter: Adolescents who have a positive relationship with teachers are less likely to start sexual intercourse early.
- Friends matter: Adolescents who believe that their friends are sexually active are more likely to start sexual intercourse early.
- Beliefs matter: Adolescents who have spiritual beliefs are less likely to start sexual intercourse early.
- Risk behaviours are linked: adolescents who engage in other risk behaviours, such as using alcohol and drugs, are more likely to start sexual intercourse early.

Clearly, an individual’s experience of sexual relations is mediated by biological factors (such as the age of puberty), cultural norms (such as the age of marriage) and social factors (such as power relations between men and women). Perhaps the most profound societal influence on an individual’s sexuality comes from prescribed gender roles – the
social norms that shape the relative power, responsibilities, and behaviour of women and men (10). Young men often believe that sexual initiation affirms their identity as men and provides them status in the male peer group. For many adolescent boys worldwide, sexual experience is seen as a rite of passage to manhood and an accomplishment or an achievement. In some cultures, sexual “conquests” are often shared with pride within the male peer group, while doubts or inexperience are frequently hidden from the group (11). On the other hand, the prescribed role of girls and women in sexual relations is often to be passive. They are not encouraged, or given support, to make decisions regarding their choice of sexual partners, to negotiate with their partners the timing and nature of sexual activity, to protect themselves from unwanted pregnancy and disease, and least of all to acknowledge their own sexual desire (10).

5. SEXUAL ABUSE AND COMMERCIAL SEXUAL EXPLOITATION

Young girls often lack the power, confidence and skills to refuse to have sex or to negotiate safer sex. Gender norms can place them at high risk of sexual violence including coerced or forced sex (12).

Sexual abuse, coercion and rape are tragic realities that affect young people in developing and developed countries alike. They can and do result in problems such as unwanted pregnancy and sexually transmitted infections, including HIV, in addition to having long-lasting psychological consequences. The extent to which young people worldwide fall victim to non-consensual sex and sexual coercion is difficult to measure because surveys vary greatly in the way in which they define involuntary sex.

Economic hardships can force young girls and boys to leave home and seek a livelihood and support elsewhere. Commercial sexual exploitation and prostitution are sometimes consequences of this. In other instances, the adolescent may leave home because of abuse by family members and end up living on the street, or in sexually exploitative relationships.

6. CONSEQUENCES OF UNPROTECTED SEXUAL RELATIONS

Whether they are married or unmarried, and engage in heterosexual or homosexual acts, adolescents can face potentially serious physical, social and economic consequences from unprotected sex. Some of these consequences are described below (13, 14).

Health risks to both young males and females

Sexually transmitted infections

At the time of first sexual contact, young people often lack knowledge about sexuality and reproduction. Indeed first sex is often experimentation and young people generally do not prepare for it by obtaining and using condoms or contraception, even if they know where to and can get them. Young girls may lack the power, confidence and skills to
refuse to have sex. The gender roles of the submissive female and the dominant male make it more difficult for the girl to say no. In some places, gender norms condone early initiation of sexual activity by young boys (by older women including sex workers) and encourage sex with multiple partners. Some youth are subject to sexual abuse of varying degrees, including incest or rape.

If contraceptives, particularly condoms, are not readily available, or are not used, young people of both sexes risk getting sexually transmitted infections and girls risk having an unwanted pregnancy. Many young women do not even know they have contracted a sexually transmitted infection because they have no symptoms or because they are unaware of them. Undiagnosed and untreated, the disease continues to plague them into adult life and may lead to pelvic inflammatory disease, ectopic pregnancy and eventually infertility, as well as damaging eyesight and general health of any children they may have. Another disease of women – cervical cancer – shows itself only in later life but research shows that a woman’s risk of this disease is doubled if her first sexual activity was in early adolescence.

Health risks to the adolescent mother

Too early pregnancy

Many adolescents have healthy pregnancies and healthy babies. They give birth without complications and enjoy their role as mothers. But all too many do not. Although their bodies may be mature enough to become pregnant, some adolescents are not sufficiently physically developed to have a safe pregnancy and delivery.

Pregnant adolescents are more likely to suffer eclampsia and obstructed labour than women who become pregnant in their early twenties. In the early adolescent years, a girl is still growing and her pelvis has not reached its full adult size. Pregnancy increases the body’s nutritional needs and can slow down the girl’s growth. Obstructed labour is far more likely if a girl’s pelvis is not full size at childbirth.

A particularly devastating complication of obstructed labour is obstetric fistula, a hole between the vagina and the bladder or rectum. The woman constantly leaks urine or faeces, smells offensive and is often ostracized both by her family and by the community. Studies in Asia and Africa show that adolescents having their first baby are much more likely to suffer obstetric fistula than older women giving birth for the first time (13).

Girls who become pregnant in their adolescent years are less likely to seek prenatal care than older women. Yet pregnant adolescents are more likely to have health problems than women over 20. Studies in several countries have shown that the risk of death during childbirth is higher among adolescents than among older women (15). Even if a pregnant adolescent is physically developed, she may lack the social and emotional maturity to cope with the experience of becoming a mother and the changes it means to her life. Her male partner, if he is an adolescent, is also not likely to be ready to shoulder the responsibilities of fatherhood.
Unsafe abortion

In cultures where early marriage is common, adolescent pregnancy is generally welcomed by the family, if not always by the adolescent girl. If the pregnancy occurs outside marriage, social sanctions may be severe and induced abortion often seems the only way of avoiding public shame and rejection. Adolescents account for a very high proportion of abortion complications, primarily because they are likely to obtain clandestine illegal abortions, or delay seeking abortion until late in the pregnancy.

Health risks to the baby

Babies born to young adolescent mothers also face more health risks than babies of older women. Babies of adolescent mothers are more likely to have low birth weight, run a higher risk of being premature and have a higher rate of perinatal mortality. A major problem arises from “children having children”. A young adolescent mother, barely out of childhood herself and certainly not an adult may not have the parenting skills needed to raise a child.

Social costs of pregnancy to the adolescent mother

Unmarried pregnant young women run the risk of being rejected by family and community. One problem is often linked to others. Adolescents who have babies are often unable to continue their schooling. A young woman with a baby often has less chance of finding employment, and if she has not completed her education, she will be at an added disadvantage. Her income is likely to be low in comparison to most others. Poverty and poor health often go hand in hand, rendering the mother even less able to cope and setting the child back in its development.

The cost to the community

Early pregnancy has negative consequences not only for the mother and baby, but also for the community. The poor unmarried mother with little education is not only unable to contribute to the development of the community, but she and her family may become a burden on it. It is in the community’s interest for all families – whether two-parent or single-parent – to be economically viable, and early pregnancy certainly does not help that to happen.
7. PROMOTING THE SEXUAL AND REPRODUCTIVE HEALTH OF YOUNG PEOPLE

The UNFPA, UNICEF, WHO common agenda for action in adolescent health and development (16) calls for the implementation of a package of actions, tailored to meet the special needs and problems of adolescents and includes the provision of information and skills, health and counseling services, and the creation of a safe and supportive environment (16). Promoting the sexual and reproductive health of adolescents involves the implementation of the same set of actions.

- 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 to negotiate safer sex, if they wish to. If they are sexually active, they also need physical skills such as how to use condoms.
- Counselling can help adolescents make informed choices, giving them more 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 change and development, a safe and supportive environment in their families and communities can enable them to undergo these changes in safety, with confidence and with the best prospects for healthy and productive adulthood.

It is worth stressing that adolescents are a diverse group. For example, a boy of 12 is at a very different stage of personal development than a boy of 18. Similarly, he is different in psychological and social terms from a girl of 12, in addition to obvious physical differences. Social circumstances can influence personal development; for example, the health and development of a boy of 12 who is part of a caring middle-class family is likely to be very different from those of a boy of the same age who is fending for himself on the street. Finally, even two boys of the same age, growing up in very similar circumstances, may proceed through adolescence in different ways, and at different “speeds”. The sexual and reproductive health service needs of adolescents are correspondingly heterogeneous. Adolescents who are not yet sexually active have different needs from those who are; sexually active adolescents in stable, monogamous relationships may have different needs from those in more casual relationships. Quite different needs characterize those faced with unwanted pregnancies or infection, or those who have been coerced into sex. It is important therefore to be aware of the diversity of sexual and reproductive health needs of adolescents, and to tailor our responses to their specific needs.
8. WHAT CAN HEALTH-CARE PROVIDERS DO TO IMPROVE YOUNG PEOPLE’S ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH INFORMATION AND SERVICES?

Adolescents seek information and clues about sexual life from a variety of sources – parents, siblings, peers, magazines, books, the mass media, etc. Whilst 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, their implications, and how to take care of themselves. This is often because the subject of sexuality is a sensitive one in many societies. As a health-care provider, 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 also work with your colleagues to make your services more sensitive and responsive to the needs of the adolescents you serve. For more information on this, please refer to Unit 4.

In many societies, parents and other community members are concerned that the provision of information on sexuality can do more harm than good. As a health-care provider, it is important that you are very well aware that this is not true. A review of scientific studies from around the world, conducted by UNAIDS in 1997, evaluated the impact of sex education programmes on adolescent knowledge and behaviour and found half of the studies that evaluated sexual health education and HIV/AIDS education initiatives neither increased nor decreased sexual activity and attendant rates of pregnancy and STIs. Moreover, 41% of the studies reported that HIV/AIDS and/or sexual health education either delayed the onset of sexual activity, reduced the number of sexual partners, or reduced unplanned pregnancy and STI rates. Little evidence was found to support the contention that sexual health and HIV education promote sexual activity. If any effect is observed, almost without exception, it is in the direction of postponed initiation of sexual intercourse and/or effective use of contraception. Failure to provide adolescents with appropriate and timely information represents a missed opportunity for reducing the incidence of unwanted pregnancy and STIs, HIV and their negative consequences (17). It is because of this that the school curriculum in Malawi includes life skills education which among other things aims to equip young people with SRH information.

In conclusion, it would be useful to recall a statement made by Dr Gro Harlem Bruntland, the former Director-General of WHO, at a ministerial conference on Population and Development (The Hague, Netherlands, 1999): “Young people need adult assistance to deal with thoughts, feelings and experiences that accompany physical maturity. By providing this help, we are encouraging responsible life styles. Evidence from around the world has clearly shown that providing information and skills on human sexuality and human relationships helps avert health problems, and creates more mature and responsible attitudes.” She then went on to stress that health-care providers and other adults have a major role to play in promoting adolescent sexual and reproductive health: “Think of the costs of failing to ensure that young people – our common future – have the knowledge, skills and services they need to help them make healthy choices in their sexual and reproductive health lives.”
9. REFERENCES

7. Green C. Young men, the forgotten factor in reproductive health. Washington, DC. Focus on Young Adults. 1997.
### ANNEX 3A-1 SPOT CHECKS

#### SPOT CHECK 2
What percentage of your male adolescent patients do you think are sexually active by the age of...?

|   |   |   |   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|---|---|
| 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |

#### SPOT CHECK 2
What percentage of your female adolescent patients do you think are sexually active by the age of...?

|   |   |   |   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|---|---|
| 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |

#### SPOT CHECK 3
Adolescents engage in sex because (fill in the blanks)

- They are encouraged to do this from the films they watch
  - ______________________________
  - ______________________________
  - ______________________________
  - ______________________________

#### SPOT CHECK 4
Adolescents can get information and health services they need. *Please answer with a spot and give reasons for your answer*

- Yes because ______________________________________________________________
- No, because ______________________________________________________________
- Don’t know _______________________________________________________________
- Not sure _________________________________________________________________

#### SPOT CHECK 5
The problems that too early sexual activity in young people can result in are... *Please fill in the blank spaces*

- ______________________________________________________________
- ______________________________________________________________
- ______________________________________________________________
- ______________________________________________________________
CASE STUDY 1

Chimwemwe, a 14-year old in Lilongwe, attended a girl's boarding school and was the top pupil in her class. Her closest friend, Maria, was in the same class and they were the two star students in their class. Chimwemwe came from a rural village in Mchinji. Maria was the daughter of a prosperous businessman in Lilongwe. The two girls shared many secrets. They were both virgins and members of SCOM. One weekend in their fourth year in secondary school, while attending a student camp, they became friends with two boys from a nearby school. They ended up having sex, their first time. This was one month before the school holidays. The following month they both missed their menstrual periods. They were on vacation and did not share this secret until the school opened. Could they be pregnant? As the school was in Lilongwe, Maria’s mother used to visit her every month. On her next visit Maria disclosed to her mother the problem. The mother immediately understood what was going on. She asked for permission for Maria to attend a family emergency, took her home and arranged for an immediate termination of pregnancy by her gynaecologist. Maria was back in school that Monday. Chimwemwe remained in school and soon the teachers started suspecting that she might be pregnant. She had been frequently unwell and moody, her performance in class deteriorated, and the school nurse was summoned to examine her. Chimwemwe had to miss class in order to get to the clinic during working hours. 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 kill her if they heard 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 as all the adult patients and workers kept staring at her. There she was told that 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. She had to leave. Maria gave her some money and Chimwemwe left school and travelled to Mtandire to see her uncle, a construction worker who lived in one of the slums. 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 sympathized with her but could not raise any money. He therefore sent a letter by post to Chimwemwe’s parents, asking them to send the money.

Chimwemwe was now four months pregnant and it 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 their neighbourhood. Two months later Chimwemwe delivered a premature baby boy at a nearby health centre. 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 could accept her. A businesswoman selling gin in the slum area 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 was liked by her teachers and her classmates.

One day, when Malita was in class, she noticed that her underpants were feeling wet and uncomfortable. When she looked down at her dress, she noticed that it was splotched with blood. The girl sitting beside her noticed this too and went 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 did not know what had happened to her or what to do. She was in shock.

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 class, 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 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.
Handout for

Unit 3B

Sexually transmitted infections in young people
This handout presents background information to complement the material in unit 3B entitled *Sexually transmitted infections in young people*. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

**THIS HANDBOOK PROVIDES INFORMATION ON THE FOLLOWING:**

1. What are sexually transmitted infections (STIs)? 58
2. Global estimates of STIs in young people 58
3. What are the factors contributing to STIs in young people? 59
4. What are the consequences of STIs among young people? 60
5. What are the main factors that hinder getting a prompt and correct diagnosis of STIs in young people? 61
6. What are the main factors that could hinder the effective management of STIs in young people? 61
7. What can health-care providers do to overcome the reluctance of young people to seek STI treatment? 62
8. What do health-care providers need to know about STI management in adolescents? 62
9. What are the key aspects of diagnosis and good management practice of STIs in young people? 63
10. Linkages with community or outreach programmes 67
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Annex 3B-3. Role plays Session 7 – Activity 7-2 71
1. WHAT ARE SEXUALLY TRANSMITTED INFECTIONS (STIs)?

Sexually transmitted infections (STIs) refer to 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.

STIs are among the most common illnesses in the world, and have far-reaching health, social and economic consequences for millions of men, women and infants.

In addition to their sheer magnitude, the incidence and prevalence of STIs among adolescents is increasing in both developed and developing countries. This is a major public health problem for two reasons:

- STIs result in serious negative medical and psycho-social effects in the infected individual. In case of infected females, there is the added risk of infection and illness in the unborn child.
- STIs, especially those with 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.

The four most prevalent STIs are chlamydial infection, gonorrhoea, syphilis and trichomoniasis. These STIs can be prevented and cured provided that adequate antibiotics are available and standardized treatment protocols are employed.

2. GLOBAL ESTIMATES OF STIs IN ADOLESCENTS

The available epidemiological data indicate that sexually transmitted infections are a major health risk to all sexually active adolescents (Box 1 and 2). Epidemiological data show that there are notable differences in the incidence and prevalence of STIs between different groups within a population. These differences reflect a number of social, cultural and economic factors. STIs tend to be higher in urban residents, among unmarried individuals and in young adults, and they tend to occur at a younger age in females than males.

<table>
<thead>
<tr>
<th>BOX 1</th>
<th>Global data on STIs in adolescents and young people</th>
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<tr>
<td>- Every year more than one out of 20 adolescents contracts a curable STI, not including viral infections.</td>
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<tr>
<td>- The age at which STIs are acquired is becoming younger.</td>
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<td>- Of the estimated 333 million new STIs that occur in the world every year, at least one third occur in young people under the age of 25.</td>
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<tr>
<td>- Globally, more than half of all new HIV infections (over 6,500 each day) are among young people aged 10-24 years. (Source: Reference (1,2,3))</td>
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</table>

Box 2. National data on self reported STIs among young people in Malawi (MDHS 2004)

- 7.7% and 8.6% of young females and males respectively aged 15-19 years old report having symptoms of STIs.
- 9.5% and 5.6% of young females and males respectively aged 20-24 years old report having symptoms of STIs.
- The prevalence is higher in rural areas compared to urban areas.
- Within regions, the prevalence of STIs is higher in the southern region especially in the districts of Zomba, Mulanje, Thyolo and Blantyre.
- Females are more likely to seek treatment for their infections compared to males.

The differences in the epidemiology of STIs in young people compared to adults have not always been apparent. This is due to the common practice of reporting data on adolescents (aged 10-19 years) in the same category as “youth” (15-24 years) or together with “women of reproductive age” (15-49 years) (4).

The high prevalence of STIs in young people presents a real challenge to health-care providers, many of whom feel uncomfortable dealing with adolescent sexual health needs. As the size of the problem becomes more evident, health professionals are being called upon to provide an effective and confidential clinical service for them (5).

There is a dearth of representative age- and sex- specific STI data from developing countries, especially for adolescent males. This largely reflects the recognition that the burden of morbidity associated with STIs is far higher for women than for men (6) and that men are more likely to seek treatment for STIs.

### 3. WHAT ARE THE FACTORS CONTRIBUTING TO STIs IN YOUNG PEOPLE?

In today’s world, young people face heightened risks of exposure to STIs. In many societies, sexual activity begins during adolescence, either within the context of marriage or – increasingly – before marriage occurs.

Sexual relations during adolescence are often unplanned and sporadic, and sometimes the result of pressure, coercion or force (7). Adolescents start sexual activity typically before they have:
- Experience and skills in self-protection
- Adequate information about STIs and how to avoid contracting these infections
- Access to preventive services and protective supplies (such as condoms).

Adolescent girls are thought to be more susceptible to STIs than adult women because of both biological and social reasons:
• Protective, hormonally-driven mechanisms have not yet had time to develop fully (8). The inadequate mucosal defence mechanism and the immature lining of the cervix in adolescence (especially in early adolescence) provide a poor barrier against infection. Further, the thin lining and the relatively low level of acidity in the vagina render it more susceptible to infection (9).

• Because of financial pressures, young women – and even girls – are forced to sell sex for favours or for cash to pay for school fees or to support their families (10).

Adolescent boys in many cultures feel they have to prove themselves sexually; and in some cultures they may even regard STIs as “warrior marks” to indicate the transition to adulthood. Studies in various parts of the world confirm that adolescent boys and young men often have high rates of STIs, and that they frequently ignore such infections, or rely on self-treatment (11).

In addition to increasing the risk of STIs, unprotected sexual activity increases the risk of other reproductive health problems such as too early, unwanted pregnancy and unsafe abortion.

4. WHAT ARE THE CONSEQUENCES OF STIs AMONG ADOLESCENTS?

The consequences of STIs contracted during adolescence are more severe than in adults. This is especially true in the case of female adolescents (Box 3).

**BOX 3 Consequences of STIs for adolescents**

- Pelvic inflammatory disease (PID): Chlamydia infection during adolescence is more likely to result in (PID) and its sequelae (such as infertility);
- Cancer of the cervix: exposure to infection (such as Chlamydia and Human Papilloma virus) during adolescence is more likely to result in cancer of the cervix;
- Tertiary Syphilis: Heart and brain damage as a long-term consequence of an untreated Syphilis infection;
- Stigma and embarrassment associated with STIs can impair psychological development and attitudes towards sexuality later in life.

*Source: Reference (12).*
5. WHAT ARE THE MAIN FACTORS THAT HINDER A PROMPT AND CORRECT DIAGNOSIS OF STIs IN YOUNG PEOPLE?

Young people often lack information about the services that are available. For example, they may not know of existing services, where and when they are provided or how much they cost. Even if they have this information, they are often reluctant to seek help for diagnosis and treatment because of embarrassment, because they do not want to be seen by people they may know, and because of fear of negative reactions from health-care workers (13).

In Malawi adolescents with STIs go to traditional healers or buy remedies from street vendors. This is likely to result in improperly and inadequately treated infections. The symptoms and signs of some STIs disappear without treatment; in these situations, young people may believe that the disease has resolved spontaneously when in fact it has not done so.

STIs may be asymptomatic, especially in young women. Young people may not be aware of the differences between normal and abnormal conditions (such as normal and abnormal genital discharges), and hence do not seek help. Asymptomatic and mildly symptomatic STIs are likely to be missed when health-care providers apply the syndromic approach for diagnosis and management. Symptomatic STIs may also be missed if health-care providers do not have adequate skills to undertake a clinical examination or to elicit the needed information from young people who are not fully knowledgeable about their bodies.

6. WHAT ARE THE MAIN FACTORS THAT COULD HINDER THE EFFECTIVE MANAGEMENT OF STIs IN YOUNG PEOPLE?

As indicated above, young people may be reluctant to use services due to factors such as inadequate information, difficulties in accessing services, and lack of money to pay for them. They often tend to self-medicate when they believe that they have exposed themselves to the risk of an STI (14).

Young people often have difficulty in complying with treatment because it may be lengthy (e.g. in the case of chlamydia) or painful (e.g. in the case of venereal warts), and sometimes they need to conceal medication so that the STI is not revealed to others. In many places, medicines for the treatment of STIs can be bought at pharmacies, without a prescription, they can also be bought from vendors in a market. It is therefore important for the health-care worker to ascertain if the adolescent has tried/taken any medication for the STI, before coming for help.
7. WHAT CAN HEALTH-CARE PROVIDERS DO TO OVERCOME THE RELUCTANCE OF YOUNG PEOPLE TO SEEK STI TREATMENT?

Health-care providers have important roles to play in relation to this, both as service-providers and as change-agents in the community. These issues are discussed in detail in unit 4 titled `providing young people with the health services they need’.

8. WHAT DO HEALTH-CARE PROVIDERS NEED TO KNOW ABOUT STI MANAGEMENT IN YOUNG PEOPLE?

Currently young people with STIs are managed in the same way as adults. However, young people have special needs and STIs in young people may be more difficult to diagnose and to manage than in adults. The challenge is to identify and treat infected individuals, in order to ensure cure and to prevent them from passing on the infection to others. Ideally, this should be done using a risk assessment approach, and selecting screening tests and treatments most appropriate to the local context (16). To do this well for young people requires a good understanding of the social, economic and cultural context (including the gender context) in which young people live (15, 16). For these reasons, the World Health Organization is developing reference materials and job-aids for healthcare providers.

WHO recommends the use of the *Syndromic approach* to the management of STI. This approach is especially appropriate where human resources and laboratory facilities are not available for etiological diagnosis to be made in resource-poor settings since etiological diagnosis, requiring laboratory facilities, is costly (17). Seven syndromes have been identified which enable health-care workers at the primary level to treat infections using signs, symptoms and a risk assessment. Flow charts and accompanying guidelines and training materials for the management of the seven syndromes have been widely disseminated and are currently in use in many countries including Malawi (Box 4) (*Management of STI Using Syndromic Management Approach: A Trainers handbook. Second Edition V0.03 2004; Management of STI Using Syndromic Management Approach: Guidelines for Service Providers. Second Edition V0.03 2004*).

The syndromic approach can be used for STI assessment in young people because the presentation of symptoms is similar irrespective of age. However, health-care providers must be aware of the factors discussed earlier, which could hinder prompt and correct diagnosis and effective management of STI in adolescents. Some STIs are asymptomatic or mildly symptomatic in young people. The syndromic approach – which is based on symptomatic individuals presenting for help – will have little impact on them.
BOX 3 Flow charts are available for seven syndromes

- Vaginal discharge (in women)
- Urethral discharge (in men)
- Genital ulcer disease (in men and women)
- Swollen scrotum (in men)
- Lower abdominal pain (in women)
- Inguinal bubo (swelling) (in men)
- Eye discharge (in babies)

9. WHAT ARE THE KEY ASPECTS OF DIAGNOSIS AND GOOD MANAGEMENT PRACTICE OF STIs IN YOUNG PEOPLE?

Respect for their youth patients, acknowledgement of their rights to health information and services, and concern for their well-being should guide the words and actions of health-care providers.

In some countries, adolescents have the right to ask for and receive the health services they need. In others, the prevailing laws prohibit the provision of some sexual and reproductive health services to individuals below a certain age. Specifically, the consent of parents/guardians or spouses may be needed before STI treatment can be provided. In dealing with such situations, health-care providers must do everything in their power to safeguard the health and well-being of their young patients. In Malawi, however, there is no specific law barring young people’s access to sexual and reproductive health services and that should always be born in mind.

Health-care providers may find themselves in the situation of trying to find a balance between the rights of parents to know about the problems of their offspring who are still minors, and the rights of a young patient to privacy and confidentiality. As discussed earlier, they should deal with such situations in a balanced and responsible manner.

There are some things that health-care providers need to be aware of and do differently when they are dealing with young patients. These are listed in Box 4 and are described in more detail below. Some of the points are specific to young people, others are not. Only some of them are “new”, but following them faithfully will enable health-care providers to deal with their young patients more effectively and with greater sensitivity.
BOX 4 Factors to consider when treating a young person with a STI

- Being aware of the help-seeking and care-seeking practices of young people;
- Establishing a good rapport;
- Eliciting information about the nature of the problem by taking a good history;
- Carrying out a physical examination;
- Arriving at a diagnosis;
- Communicating the diagnosis and its implications, discussing treatment options, and providing treatment;
- Responding to the psychological needs and helping the individual deal with any social implications;
- Preventing recurrence of the problem and other STIs;
- Tracing and contacting other infected persons.

Being aware of the care-seeking practices of young people

Health-care providers need to be aware of what adolescents do when they have an STI – in other words, where they seek help and why.

Establishing a good rapport

Health-care providers can help young patients to overcome their anxiety by using kind words and gestures and, where appropriate, the adolescents’ special vocabulary. Non-communicative, and sometimes even abrasive, behaviour from the youth may be due to anxiety. Health-care providers should keep this in mind and handle such situations calmly, without being offended or intimidated by their young patients.

Eliciting information about the nature of the problem

With an open and non-threatening manner, health-care providers could make it easier for their young patients to relax and be forthcoming about their problems. History-taking can be intimidating and threatening to the youth. Therefore the health-care provider should gently explain that the series of questions being posed are important to reach the right diagnosis and provide the right treatment. The adolescent should also be informed that the information provided would be treated as confidential.

Health-care providers may not approve of a young person’s sexual or other activities, but it is important for them to be non-judgemental in their dealings with the youth. Demonstrating irritation and anger can contribute to a breakdown in communication, and make the youth reluctant to return for help.

Health-care providers must also refrain from making instinctive assumptions (for instance, that a young woman with a vaginal discharge has an infection that has been contracted sexually).
Carrying out a physical examination

Both male and female young people are likely to be anxious about their genitalia being examined by a health-care provider. In addition, females are likely to be particularly anxious about undergoing a pelvic examination. The health-care provider should make every effort to ensure that the experience is not a traumatic one—physically or psychologically.

The presence of a chaperone should be offered to all patients having intimate examinations, irrespective of the sex of the health-care provider. Some patients prefer to have a person of the same sex examine their private parts; health-care workers need to be sensitive to cultural norms and social taboos in this respect.

It is also important for health-care providers to have a proper understanding of the physical—and psychological—changes that occur at puberty.

Arriving at a diagnosis.

Risk assessment for syndromic diagnosis and management in developing countries is different from the approach to diagnosis in developed countries. In the latter context, a detailed sexual history would be taken and, based on the behavioural risks; the clinician would select appropriate screening tests, whether or not the patient is symptomatic.

Syndromic management for urethral discharge in men and genital ulcers in men and women has proved to be both valid and feasible. It has resulted in adequate treatment of large numbers of infected people and is inexpensive, simple and cost-effective. However, there have been some problems with the algorithms for the syndromic management of women with symptoms of vaginal discharge and/or lower abdominal pain. The notable problem is in the management of cervical (gonococcal and chlamydia) infections. Endogenous vaginitis is the main cause of vaginal discharge rather than STIs in general, especially in low-prevalence settings and in adolescent females.

Experience has shown that risk assessment questions based on demographics, such as age and marital status, tend to incorrectly classify too many young people as being at risk of cervical infection. Therefore, there is a need to identify the main STI risk factors for young people in the local population and to tailor the risk assessment accordingly. For young people as for adults, it is important to tailor the risk assessment appropriately, to match the reality of the country—or district—in order to improve the sensitivity and specificity of the behavioural risk assessment.

Communicating the diagnosis and its implications, discussing treatment options, and providing treatment

It is important for young people to understand the diagnosis and its implications. They will also need to know what services are available to them at the health facility, and what exactly they should—and should not do—to ensure that they can take the full course of treatment and are cured of the problem.
An important issue is ensuring treatment compliance. The factors that may hinder compliance in young people have been discussed earlier. The health-care provider needs to raise this issue and to tailor the treatment regimen (as and when possible) to make it easier for adolescents to complete their treatment.

**Responding to psychological needs and helping the individual deal with any social implications**

The STI should be correctly diagnosed and managed. At the same time health-care providers need to assess the psychological state of the youth and his/her social circumstances so that appropriate advice or referral to other services can be made. This is especially important in cases where the STI has been the result of rape or sexual abuse.

Counselling aims to assist individuals to deal with problems and situations by enabling them to understand their situation, examine the available options, deal with the problem, and help them make sound decisions accordingly. Counsellors are trained to help clients make decisions about life situations, including how to avoid STIs.

There is a need to arrange for the youth to return to the health facility in order to assess the effectiveness of the treatment. The purpose of such a visit must therefore be explained clearly. Health-care providers should use the opportunity presented by the youth’s presence at the health facility to determine his/her need for other services that could be provided by the health centre (e.g. contraceptive services). Information should be provided on other forms of assistance that are available, such as referral to other agencies or organizations providing social support.

**Preventing a recurrence of the problem and infection with other 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:

- Information that builds on existing knowledge and experience, and relevant to the individual’s stage of development and circumstances;
- Skills that will enable them to cope with the realities of their everyday lives;
- Supplies, such as condoms and contraceptives.

Health-care providers should make every effort to provide their young patients with this assistance, or to refer them to other organizations when necessary. Young patients should be encouraged to inform their partner(s) about their infection, and to encourage them to seek treatment.

**NOTE**

It is impossible in practice to force people to identify or even notify their partner(s). People may not know/remember their partners. Even if they do so, they may be unwilling to identify or notify them.
10. LINKAGES WITH COMMUNITY OR OUTREACH PROGRAMMES

Many health-care providers operate independently of projects and programmes reaching out to or working with young people in the community. Not surprisingly, they are generally used only by a small number of young people. In order to reach larger numbers of youth, more active means need to be used to reach out with services. Also, staff with a special interest in working with young people should be identified and encouraged to work with outside agencies in order to establish referral mechanisms and communication channels that will raise awareness of the availability of the service, and its utilization by young people.

In addition, easy access to condoms in the community is essential, especially for those young males who are less likely to go to a clinic. This can be achieved through social marketing programmes which help to ensure that condoms are available in public places – either free or at a low cost.

SUMMARY

Sexually transmitted infections are an important public health problem. Health-care providers should give special consideration to STIs in young people because:

- Young people run special risks of exposure to STIs, with young girls being especially vulnerable;
- The consequences of infection and disease contracted during youth are more severe than those in adults;
- Diagnosis of STIs in young people can be more problematic;
- Effective treatment of STIs in young people faces a number of constraints.

Given the above, health-care providers should make every effort to manage their young patients more effectively and with greater sensitivity, as outlined in this handout.
12. REFERENCES

## SPOT CHECKS (Session 1: Activity 1-2)

### SPOT CHECK 1
What percentage of all new STI infections in the world each year are among young people under age 25?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
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### SPOT CHECK 2
What should health care providers do with regard to STI prevention among young people *(please tick the three most important reasons)*

- Stress to all young people that they should abstain from sex until marriage
- Stress faithfulness to sexually active young people
- Give condoms and information on how to use them to those who have more than one partner
- Make STI services adolescent friendly
- Ensure that all young people know about STIs and all the ways of avoiding them
- Make condoms and information available to all adolescents

### SPOT CHECK 3
Are boys more vulnerable to STIs than girls in your country?

<table>
<thead>
<tr>
<th>Vulnerability</th>
<th>Boys are much more vulnerable</th>
<th>About the same</th>
<th>Girls are more vulnerable</th>
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### SPOT CHECK 4
Why are adolescent girls much more susceptible to STIs than adult women?

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### SPOT CHECK 5
Factors that hinder adolescents from seeking prompt STI treatment *(Please three of the most important factors)*

- STIs are often asymptomatic
- They do not have information about existing services
- They do not have money to pay for services
- Fear of stigma and embarrassment
- Scared of being scolded by health workers
ANNEX 3B-2          CASE SCENARIOS          (Session 6: Activity 6-2)

SCENARIO 1
A 16-year old boy in the city of Lilongwe is brought to a clinic by his mother. She says that he told her that he had been injured in his groin, playing football with his friends. When taking the history, the doctor notices that the boy is silent, and does not interrupt his mother, or add to anything that she says. The doctor listens to her for a while, and then leads the boy to the examination room. After shutting the door and settling the boy on the table for examination, the doctor asks him to say what the problem is, in his own words. The boy is silent. After a few minutes, the doctor gently probes once again. He replies in a low voice and asks the doctor to promise not to repeat anything he says to his mother....

Question to pose: How would you deal with this situation?

SCENARIO 2
A 16-year old young 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 by the duty nurse who has briefly examined the young girl and asked her a few questions. She then calls in a junior female doctor who has recently joined the hospital. The doctor is appalled by the nurse's brusque manner and harsh words to the young woman. 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 takes her aside, completes the examination, gives her the appropriate medication, and asks her to come back for review in a week. She is gentle and courteous with the young woman which appears to inflame the nurse further.

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

SCENARIO 3
A 19-year old man presents at a rural health centre with a urethral discharge. He tells the duty doctor that he has been suffering from this, on and off, for a year. He knows that this is an STI, but does not seem very concerned about it. He says that he has had similar episodes in the past after visits to prostitutes in the nearby town. He is rather open about this and says that all his friends do the same. On enquiry, the doctor learns that the young man is married and has a wife who is 16 years old. The doctor explains that it would be important for both partners to be treated. The young man shakes his head, saying that it would be out of the question....

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

SCENARIO 4
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 could be obtained from the mother or from the child on how and when the sores started. The girl was examined behind a screen while her mother sat in the same room. Examination revealed that the child had florid vulval condylomata strongly suggestive of syphilis. The nurse in charge, a mature and experienced woman, took the child into another room and probed the matter gently. After several minutes of gentle but persistent probing, the girl told the nurse that her uncle had been “playing” with her, and had 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 3B-3 ROLE PLAYS (Session 7: Activity 7-2)

<table>
<thead>
<tr>
<th>ROLE PLAY 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are a doctor working in a busy municipal clinic, in an urban area. You have had a demanding morning, running the outpatient clinic. The 18-year old young man, who is seated in front of you, is your 40th &quot;new patient&quot;, today. You have diagnosed him with gonorrhea, and handed him a prescription to take to the pharmacy in the clinic. He thanks you and rises to leave. You realise that you have not discussed STIs prevention with him, and tell him to sit down...</td>
</tr>
<tr>
<td><strong>Roles:</strong> Doctor and 18-year old male patient.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ROLE PLAY 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are a woman in your mid 40s. You are a nurse at a private clinic in Kawale. The clinic is well established and you are very well known in the community. The young woman seated in front of you is someone whom you have known over 10 years and she is a daughter to your neighbour. She is 17 years old and had just finished secondary education. She came to the clinic to seek help for her pimples and she is about to leave. You realise that you have not kept the promise you made to your neighbour some time ago about the risks and consequences of unsafe sexual activity. You try to do so now</td>
</tr>
<tr>
<td><strong>Roles:</strong> Nurse and 17-year old female patient.</td>
</tr>
</tbody>
</table>
Handout for

Unit 3C

Pregnancy prevention and fertility regulation in young people
This handout presents background information to complement the material in unit 3C entitled *Pregnancy prevention and fertility regulation in young people*. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

**THIS HANDOUT PROVIDES INFORMATION ON THE FOLLOWING:**

1. Why adolescents need pregnancy prevention methods 74
2. Providing adolescents with information and education on sexuality and contraception 75
3. Providing adolescents with contraceptive services 76
4. References 88

Annex 3C- 1. Spot checks Session 1 – Activity 1-2 89
Annex 3C- 2. Role plays. Session 6 – Activity 6-2 90
1. WHY ADOLESCENTS NEED PREGNANCY PREVENTION METHODS

Use of contraceptives among adolescents

Millions of individuals around the world begin their sexual activity during their adolescent years. They do so often without adequate knowledge about sexuality, and without using modern contraceptives or protection against STIs including HIV. For example, Demographic and Health Survey (DHS) data from sub-Saharan Africa reveal that, in a number of countries, 80% of women have had sexual intercourse before age 20 (1). While these women may know of one or more contraceptive methods, in many sub-Saharan African countries fewer than 30% of sexually active women have ever used a contraceptive method (1).

Few unmarried adolescents use contraception during their first sexual experience. For example, only 4% of sexually active women aged 15 to 24 in Ecuador reported using contraceptives, and the corresponding figure in Uganda was only 6%. In the developing world, with some notable exceptions – such as in Latin America – few young women use contraception between marriage and first pregnancy. Most women who marry young have at least one child before age 20 (1). Sexually active young people are less likely to use contraception than adults even within marriage. Unmarried adolescents, who face additional barriers to obtaining contraceptives, are even less likely to use contraception than married adolescents.

Studies in the USA suggest that there tends to be a delay of one year, on average, between the initiation of sexual activity and the first use of modern contraceptives (1). Thus premarital sexual activity often results in unintended pregnancy. In Mexico City, nearly two-thirds of women aged 18 to 19 with premarital sexual experience reported that they had been pregnant at least once. In Zimbabwe, 46% of women aged between 11 and 19 who had been sexually active before marriage had been pregnant (1). Many unintended pregnancies occur within a year of first sexual intercourse.

Whether they are married or unmarried, adolescents can face potentially serious physical, psychological and social consequences from unprotected sexual relations. These include too-early and unwanted pregnancy and childbirth, unsafe abortion, and STIs including HIV and AIDS. These events can also limit educational and job opportunities and negatively affect social and cultural development, especially of adolescent girls (2).

Barriers to contraceptive use among adolescents

Adolescents in general – and unmarried adolescents in particular – often find it difficult to obtain the contraceptives they need. The most important reasons that adolescents cite, in a variety of different settings, for not using contraceptive methods when they are sexually active are (3):

- The unexpected and unplanned nature of sexual activity
- Lack of information and knowledge about contraceptives and where to get them
- Embarrassment and fear of lack of confidentiality
- Fear of medical procedures
- Fear of judgemental attitudes and resistance from providers
- Inability to pay for services and transport
- Displacement – refugees, or political strife
- Fear of violence from partner or parents
- Pressure to have children.

There is much that can and must be done to address these and other barriers.

In many parts of the world, laws and policies prohibit the provision of contraceptive information and services to adolescents. Restrictive societal norms add to this by hindering both their provision to and their utilization by adolescents. Working to reform these restrictive laws and policies and to overcome societal resistance will help improve the availability and accessibility of contraceptive services to adolescents.

In many places, adolescents lack information about sexuality, and specifically about contraception. To add to this, health-care providers are often unaware of the special needs of adolescents, and further, contraceptive services are not geared to meeting the needs of adolescents. There is a pressing need to provide adolescents with the information they need. Alongside this, concerted efforts are required to help health-care providers understand and respond to the special needs of adolescents, and to reorient health services to meet those needs and preferences. In addition to the biomedical issues, it is important for health-care providers to be aware of the wider social issues, such as inequitable gender norms, that affect the adolescent’s ability to obtain and use contraceptive services. Broader issues (such as gender norms and violence) often influence an adolescent’s ability to access and effectively use contraception. Further, violence, either as a result of domestic abuse or political strife, can disproportionately affect the ability of women to access and use contraceptive services. In addition to their role as service providers, health-care workers should, where they can, contribute as change-agents, to the actions that are needed at the community and societal levels, to address these issues. These initiatives will help prevent the consequences of too-early and unprotected sexual activity in this important population group.

2. PROVIDING ADOLESCENTS WITH INFORMATION AND EDUCATION ON SEXUALITY AND CONTRACEPTION

For decades, education on sexuality and reproductive health for adolescents has been a controversial issue in developed and developing countries alike, because of concerns that knowledge would lead to earlier or increased sexual activity among unmarried adolescents. However, a review of studies from around the world which examined the impact of sex education programmes on adolescent knowledge and behaviour, found no support for this contention (4). If any effect is observed, almost without exception, it is in the direction of postponed initiation of sexual intercourse and/or effective use of contraception. The report stated that failure to provide adolescents with appropriate and timely information represents a missed opportunity for reducing the incidence of unwanted pregnancy and STIs and their negative consequences (4).
Sexual and reproductive health education programmes need to tailor their messages to suit the needs of adolescents who have not begun sexual activity, and those who are already sexually active. Also, because some adolescents begin sexual activity during early adolescence, formal sex education programmes need to begin during this stage (4).

Research into the sexual and reproductive health of young people clearly points to the fact that information provision and education alone do not necessarily lead to behaviour change\(^2\). Increasing awareness and understanding is only the first step in preventing unwanted pregnancy and STI/HIV. In addition, adolescents must know where to find services and be comfortable in using them. This important issue is addressed in this handout.

### 3. PROVIDING ADOLESCENTS WITH CONTRACEPTIVE SERVICES

#### Dual protection provided by available contraceptive methods

Some adolescents may have temporary sexual relationships and multiple partners, which puts them at a high risk of STIs/HIV. Sexually active adolescents need to be aware of the importance of protection against both pregnancy and STIs/HIV. When used correctly and consistently, male condoms are the most effective method of preventing STIs including HIV and AIDS and can be highly effective in protecting against pregnancy as well. Another approach for simultaneous protection against pregnancy and STIs is the “dual use method”, that is to use condoms in conjunction with another method that has more contraceptive typical-use failure rates such as combined oral contraceptives or injectables.

The following Table 1 lists the effectiveness of the available contraceptive methods in preventing pregnancy and in providing protection from STIs including HIV (5).

<table>
<thead>
<tr>
<th>Method</th>
<th>Effectiveness Against pregnancy</th>
<th>Protection Against STI/HIV</th>
<th>Comments and consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence and non-penetrative sex</td>
<td>Not effective</td>
<td>Protective</td>
<td>Most effective method for dual protection. Only provides dual</td>
</tr>
<tr>
<td></td>
<td>Very effective</td>
<td>against STI/HIV</td>
<td>protection when used correctly and consistently</td>
</tr>
</tbody>
</table>

---

\(^2\) A discussion on other issues that contribute to changes in behaviour, e.g. social norms, are beyond the scope of this paper.
<table>
<thead>
<tr>
<th>Method</th>
<th>Efficacy</th>
<th>Protection</th>
<th>Advantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Condom</td>
<td>Somewhat effective</td>
<td>Effective against STI/HIV</td>
<td>Only provides dual protection when used correctly and consistently.</td>
</tr>
<tr>
<td>Female Condom</td>
<td>Somewhat effective</td>
<td>Effective against STI/HIV</td>
<td>Only provides dual protection when used correctly and consistently.</td>
</tr>
<tr>
<td>Spermicide</td>
<td>Somewhat effective</td>
<td>Effective</td>
<td>May protect against gonorrhoea and Chlamydia, no protection against HIV. Only provides limited dual protection when used correctly and consistently. Not recommended for use alone. Not recommended for frequent use (may cause genital lesions).</td>
</tr>
<tr>
<td>Diaphragm with spermicide</td>
<td>Somewhat effective</td>
<td>Effective</td>
<td>May protect against gonorrhoea and Chlamydia, no protection against HIV. It is not clear to what degree the diaphragm, when used with a spermicide provides protection against STIs. Only provides limited dual protection when used correctly and consistently. Spermicide not recommended for frequent use (may cause genital lesions).</td>
</tr>
<tr>
<td>Combined Oral contraceptives (COCs)</td>
<td>Effective</td>
<td>Very effective</td>
<td>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.</td>
</tr>
<tr>
<td>Progestin-Only pills (POPs)</td>
<td>Very effective (during breastfeeding)</td>
<td>Not protective</td>
<td></td>
</tr>
<tr>
<td>Long-Acting Hormonals: Injectables or Implants</td>
<td>Very effective</td>
<td>Not protective</td>
<td>If at risk of STI/HIV, recommend switching to condoms or using condoms along with this method.</td>
</tr>
</tbody>
</table>
Copper Intra-Uterine Device (IUD) | Very effective | Not protective | Insertion of an IUD in a woman with an STI increases the risk of PID | Use of IUDs among women at risk of STI/HIV is generally not recommended (unless other, more appropriate methods are not available). If and IUD user becomes at risk of STI/HIV, 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 | 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.

Male and female sterilization | Very effective | Not protective | If at risk of STI/HIV recommend using condoms along with this method.

**Medical eligibility for available contraceptive methods**

WHO places a high priority on ensuring that adolescents and young people worldwide have access to safe and high-quality reproductive health and family planning services. The publication *Improving access to quality care in family planning: Medical eligibility criteria for contraceptive use* (6), provides recommendations of an expert scientific working group for appropriate contraceptive use in the presence of various medical conditions. It provides essential information for the provision of contraceptives safely to adolescents, while at the same time ensuring that they are not denied access to contraception based on unfounded “contraindications”.

A brief review of method-specific medical, service delivery and counselling considerations for adolescents is provided below in Table 2. This table covers issues that are most important when providing contraceptive methods to adolescents. For a more thorough discussion of the medical eligibility criteria, please refer to *Improving access to quality care in family planning: Medical eligibility criteria for contraceptive use*. For more information on methods, such as mechanism of action, correct use, management of problems and side effects, and contraceptive benefits, see *The essentials of contraceptive technology: A handbook for clinic staff* (7).
Healthy adolescents are medically eligible to use any of the methods of contraception that are currently available. Age alone does not constitute a medical reason for denying any method to adolescents. However, age is an important social factor to take into account when considering irreversible contraceptive methods, such as male or female sterilization. It is also true that some concerns exist regarding the use of certain other methods by adolescents (for example, progesterone-only pills), but this must be balanced with the advantages of avoiding pregnancy. Many of the method-specific eligibility criteria that apply to older clients also apply to young people. Some conditions such as circulatory system diseases, that may limit use of some methods in older women, will not often apply to young people, since these conditions are rare in this age group.

1. At present, dual protection applies only to condoms. The evidence for the effectiveness of condoms for STIs/HIV prevention is substantially greater for male condoms than it is for female condoms.
2. Spermicides containing nor oxynol-2 do not appear to protect against chlamydia infection or gonorrhea.
**TABLE 2  Medical, service delivery and counselling considerations for adolescents**

<table>
<thead>
<tr>
<th>Method</th>
<th>Dual protection</th>
<th>Age restriction</th>
<th>Availability/ accessibility</th>
<th>Side effects</th>
<th>Other important counselling points for adolescents</th>
<th>Comments/ considerations</th>
</tr>
</thead>
</table>
| 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 STI/HIV also avoid anal and oral sex  
- Examples of sexual activity: hand holding, hugging, massaging, kissing, mutual masturbation.  
- Emphasize 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 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 provides dual protection |
<table>
<thead>
<tr>
<th>Method</th>
<th>Availability</th>
<th>Access</th>
<th>Protection</th>
<th>Side Effects</th>
<th>Correct Use</th>
<th>Recommendations</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spermicides</td>
<td>Yes (protective against some STIs, not HIV)</td>
<td>No age restriction</td>
<td>Easily available in many places</td>
<td>Usually no side effects (local irritation possible)</td>
<td>-Explain and demonstrate correct use -Recommend use with condom or diaphragm -Requires supplies at home (fear of discovery may be an issue)</td>
<td>-Not recommended for use alone -Not recommended for frequent use (may cause genital lesions)</td>
<td></td>
</tr>
<tr>
<td>Diaphragm with spermicide</td>
<td>Yes (protective against some STIs, not HIV)</td>
<td>No age restriction</td>
<td>Requires clinic visit for fitting Availability limited in many places</td>
<td>Usually no side effects (local irritation possible)</td>
<td>-Explain and demonstrate correct use -Requires supplies at home (fear of discovery may be an issue)</td>
<td>-It is not clear to what degree the diaphragm, when used with a spermicide provides protection against STIs. Spermicides not recommended for frequent use (may cause genital lesions)</td>
<td></td>
</tr>
<tr>
<td>Low dose Combined Oral Contraceptives (COCs)</td>
<td>No</td>
<td>No age restriction</td>
<td>Requires clinic visit in many places May be available through CBDAs</td>
<td>May include nausea and headache</td>
<td>-Explain and demonstrate correct use -Recommend also using condom if at risk of STI/HIV -Requires daily regimen -Requires supplies at home (fear of discovery may be an issue)</td>
<td>-A widely used method among adolescents although correct and consistent use may be an issue</td>
<td></td>
</tr>
<tr>
<td>Progestin only pills (POPs)</td>
<td>No</td>
<td>No age restriction</td>
<td>Requires clinic visit in many places May be available through CBDAs</td>
<td>Fewer side effects than COCs or long acting hormonals (injectables and implants)</td>
<td>-Explain and demonstrate correct use -Recommend also using condom if at risk of STI/HIV -Requires strict daily regimen -Requires supplies at home (fear of discovery may be an issue)</td>
<td>-Stricter regimen than COCs Good option for breastfeeding women after first 6 weeks postpartum</td>
<td></td>
</tr>
<tr>
<td>Method</td>
<td>Age Restriction</td>
<td>Required Action</td>
<td>Side Effects</td>
<td>Important Notes</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Emergency contraceptive pills (POPs or COCs)</td>
<td>No age restriction</td>
<td>Requires clinic visit in many places</td>
<td>May include nausea vomiting (much less likely with POP regimen)</td>
<td>Not meant for repeated use. Discuss initiation of a regular method. Important method when intercourse may be unplanned, unprotected.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Injectables: Depo medroxy progesterone acetate (DMPA) and Norethisterone Enanthate (NET-EN)</td>
<td>No first method of choice for those under 18</td>
<td>Requires clinic visit every 2 or 3 months</td>
<td>Irregular bleeding, amenorrhoea or weight gain</td>
<td>Recommend also using condom if at risk of STI/HIV. 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 may not be quickly discontinued.</td>
<td></td>
<td></td>
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<tr>
<td>Combined injectables: Cyclofem and Mesigyna</td>
<td>No age restriction</td>
<td>Requires clinic visit every month</td>
<td>Nausea or headache</td>
<td>Recommend also using condom if at risk of STI/HIV. 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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norplant implants</td>
<td>No age restriction</td>
<td>Requires clinic visit for insertion and removal</td>
<td>Irregular bleeding or amenorrhoea</td>
<td>Recommend also using condom if at risk of STI/HIV. No delay in return 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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copper Intrauterine Device (IUD)</td>
<td>Not first method of choice for</td>
<td>Clinic visit required for insertion and removal</td>
<td>Sides effects may include excessive</td>
<td>Recommend also using condoms if at risk of STI/HIV. No delay in return to fertility. Not a good choice for those at risk of STI/HIV (more than one sexual partner).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Method</td>
<td>Age restriction</td>
<td>No age restriction</td>
<td>Availability</td>
<td>Side effects</td>
<td>Communication</td>
<td></td>
<td></td>
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<td>--------------------------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Fertility Awareness-Based methods</td>
<td>No</td>
<td>Available anytime to anyone</td>
<td>No side effects</td>
<td>-Explain correct use - Recommended also using condoms if at risk of STI/HIV requires partner communication</td>
<td>Important for adolescent to understand their 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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lactational Amenorrhoea (LAM)</td>
<td>No</td>
<td>Can be used during 6 months postpartum when exclusively breastfeeding and amenorrhoeic</td>
<td>No side effects</td>
<td>Explain and demonstrate correct use. Recommend also using condoms if at risk of STI/HIV</td>
<td>Important method option for breastfeeding women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawal</td>
<td>No</td>
<td>Available anytime to anyone</td>
<td>No side effects</td>
<td>Explain correct use required partner communication /negotiation important</td>
<td>Important method to discuss, as may be only method available in some places</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male and female sterilization</td>
<td>No</td>
<td>Clinic visit required for procedure</td>
<td>Minimal side effects, local infection possible</td>
<td>-Recommended also using condom if at risk of STI/HIV. -Permanent method. -No daily regimen required. -No supplies needed at home (can be private)</td>
<td>Consider only in special circumstances after thorough counselling</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Those under 20, as risk of expulsion may be great in younger, nulliparous women. Removal of bleeding or pain during menses to fertility. No daily regimen required. No supplies needed at home (can be private). Nulliparous women may be at higher risk of expulsion.
| regret for both women and men |  |  |  |
Counselling on sexuality

Adolescence is a period when individuals may test limits set for them by adults, experiment with new behaviours, and struggle with issues of independence, acceptance, and peer group pressure. Thus, a supportive, encouraging, non-judgemental environment, where confidentiality is ensured, is essential when counselling adolescents. Health-care providers and others may benefit from special training in sexuality and in counselling skills, to enable them to deal with the needs, concerns and problems of adolescents.

Developing a good rapport with adolescents is important, as is using language that they can understand and be comfortable with. Due to inexperience and possibly embarrassment, adolescents may be hesitant in expressing their needs. Providers need to be patient and take the necessary time when working with them.

Adolescents may have special information needs, such as a desire to understand the changes that are happening in their bodies as they mature, whether they are “normal” or not, and other information regarding sexuality and sexual function. Service providers who are not comfortable discussing these issues with adults, should refer them to those who are. Also, parents should be encouraged – and given the necessary support – to communicate with their children/adolescents on sexuality.

Counselling should cover responsible sexual behaviour and needs to be directed at both males and females. Male adolescents should be encouraged to share the responsibility for contraception and STI/HIV prevention with their female partners.

Counselling for contraceptive method choice

While adolescents may choose to use any one of the contraceptive methods available to them, some methods may be more appropriate for adolescents for a variety of social and behavioural reasons. Many of the needs and concerns of adolescents that affect their choice of a contraceptive method are similar to those of adults seeking contraception. For example, using a method that does not require a daily regimen, such as oral contraceptive pills do, may be a more appropriate choice for an individual.

In helping an adolescent make a choice of which method to use, health-care providers must provide them with information about the methods, and help them consider their merits and demerits. In this way, they could guide their adolescent clients to make well-informed and voluntary choices of the method that is most suitable to their needs and circumstances (taking eligibility, practicality and legality into consideration). The information provided should address the following issues:

- The effectiveness of the method
- Information on protection against STIs including HIV
- The common side-effects of the method
- The potential health risks and benefits of the method
- Information on return to fertility after discontinuing use of the method
- Where the method can be obtained and how much it costs.
After a method is chosen, it is also important to discuss correct use of the method and follow-up information, such as signs and symptoms which would necessitate a return to the clinic. Proper education and counselling at the time of method selection can help adolescents address their specific problems and make well-informed, voluntary decisions. Further, expanding the number of method choices offered can lead to improved satisfaction, increased acceptance and higher contraceptive prevalence.

**Special considerations**

**Married adolescents**

It is important to remember that many adolescents 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. Those desiring a quick return to fertility may prefer to avoid injectables such as Depo Medroxy Progesterone Acetate (DMPA), which can delay return to fertility. Young married women may in some cases feel a pressure to have children, and thus may want to keep their contraceptive use private from their spouse or in-laws. They also may knowingly or unknowingly be in a relationship where they are at risk for STIs including HIV/AIDS. This is an important, yet often difficult issue to discuss, and must be done with sensitivity.

**Unmarried adolescents**

Unmarried adolescents may be less likely to seek contraceptive services at health facilities because of embarrassment at needing or wanting reproductive health services, and because of fears that the staff may be hostile or judgemental 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.

For unmarried adolescents who do seek contraceptive services, it is important to discuss abstinence or non-penetrative sexual activity as options, even with those who have already had sexual intercourse. With support, individuals can delay sexual activity until they are older, and thus be better able to deal with its social, psychological and physical implications. This requires commitment, high motivation and self-control. Adolescents need support and encouragement to abstain from and/or delay the initiation or continuation of sexual intercourse. For unmarried adolescents who want to have sexual intercourse, condoms – or condoms in combination with another method – are the best recommendation. For adolescents who are not in monogamous relationships, sexual activity may be sporadic and unplanned. In these circumstances, condoms are a good choice because they are widely available and can be used when needed.

Adolescents, especially those in monogamous relationships, may also desire to use other, longer acting methods. Providers of contraceptives must support this decision. For these adolescents as well, the risk of STIs including HIV/AIDS must be discussed. Some
of them may be at risk for STIs/HIV when they do not consider themselves to be, if their partner has other sexual partners.

**Adolescents who have been coerced into having sex**

In designing and providing services, it is crucial not to assume that clients are engaged in mutually consensual sexual relations. 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. Health-care providers need to be sensitive to these issues. They must also be well aware of how to access the health and social services that these adolescents may need.

<table>
<thead>
<tr>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>• In many parts of the world, adolescents are entering their reproductive years ill-prepared to protect and safeguard their sexual and reproductive health.</td>
</tr>
<tr>
<td>• For all adolescents, but especially for those who are sexually active outside the context of marriage, access to appropriate information and services – and the assurance of confidentiality – are particularly important.</td>
</tr>
<tr>
<td>• To help ensure contraceptive use among sexually active adolescents, contraceptive information and services must be made readily available through a variety of delivery points, including community based points and outreach services.</td>
</tr>
<tr>
<td>• 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 their adolescent clients and to their communities and societies.</td>
</tr>
</tbody>
</table>
4. REFERENCES

## ANNEX 3C-1 SPOT CHECKS (Session 1: Activity 1-2)

### SPOT CHECK 1
Which contraceptive methods should be used by adolescents? *Please tick all unsuitable methods*
- Abstinence.
- Male condom
- Female condom
- Spermicide
- Diaphragm with spermicide
- Combined oral pill
- Progestin only pill
- Combined injectable
- Progestin only injectable
- Progestin only implant
- Intra uterine device
- Fertility awareness base methods
- Lactational amenorrhea
- Withdrawal
- Sterilisation

### SPOT CHECK 2
Which contraceptive methods are protective against HIV / STI? *Please write down two examples of each.*

**Protective**

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**Not protective**

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### SPOT CHECK 3
Which contraceptive methods are available in your local clinic? *Please write down two examples*

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### SPOT CHECK 4
Which contraceptive methods do not require the cooperation of male partners? *Give 3 answers*

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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 an antenatal outpatient clinic, everyday. One Friday morning, as you walk into your clinic, you see two young women, in their late teens, 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 - yet another possible unintended, unwanted pregnancy... When it is their turn, your suspicions are proved right. The two young women are aged 15 and 16. They are students in a nearby secondary school. The one in tears tells you that her periods are 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 adolescent girls 15 and 16 years old

Role play 2
You are a female clinical officer in your mid 40s. You run a clinic in Zingwangwa township which has been well established over the past 10 years. One evening your nurse ushers in a young woman whom 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 which is almost a whisper. She says that she is 19 years old, just married and has moved into the neighborhood to live with her husband and his extended family. She smiles when you congratulate her, and she says that she is happy with her husband but she 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 has just also started a new job which promises to send her for further studies abroad and 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
Handout for

Unit 3D

Care of adolescent pregnancy and child birth
This handout presents background information to complement the material in unit 3D entitled *Care of adolescent pregnancy and childbirth*. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

**THIS HANDOUT PROVIDES INFORMATION ON THE FOLLOWING:**

1. The scope of adolescent pregnancy, childbirth and maternal mortality  
2. Factors that influence adolescent pregnancy and childbirth  
3. Risks associated with pregnancy and childbirth in adolescence and how they differ from those in adults  
4. Care of adolescents during pregnancy, childbirth and the postnatal period  
5. References

| Annex 3D-1. Spot checks | Session 1 – Activity 1-2 | 104 |
| Annex 3D-2. Case study | Session 2 – Activity 6-1 | 105 |
| Annex 3D-3. Role plays | Session 3 – Activity 6-2 | 106 |
1. THE SCOPE OF ADOLESCENT PREGNANCY, CHILDBIRTH AND MATERNAL MORTALITY

It is estimated that 15 million births occur every year to adolescents. This represents about 11% of all births each year (1). The global average rate of births per 1000 females aged 15-19 years is 65. There are however wide regional variations – see Table 1.

<table>
<thead>
<tr>
<th>Region</th>
<th>Rate of births per 1000 females aged 15 to 24</th>
<th>Source: References (2, 3, 4)</th>
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<tbody>
<tr>
<td>Africa</td>
<td>143/1000</td>
<td>Range from 45 in Mauritius to 229 in Ghana</td>
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<tr>
<td>Middle east</td>
<td>56/1000</td>
<td>Range from 18 in Tunisia to 122 in Oman</td>
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<tr>
<td>South East Asia</td>
<td>56/1000</td>
<td>Range from 4 in Japan to 115 in Bangladesh</td>
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<tr>
<td>Latin America</td>
<td>78/1000</td>
<td>Range from 56 in Chile to 149 in Nicaragua</td>
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<tr>
<td>Europe</td>
<td>25/1000</td>
<td>Range from 4 in Switzerland to 57 in Bulgaria</td>
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<tr>
<td>Malawi (15-19 yrs)</td>
<td>162/1000</td>
<td></td>
</tr>
<tr>
<td>Malawi (20-24 yrs)</td>
<td>293/1000</td>
<td></td>
</tr>
<tr>
<td>Malawi (15-19 yrs) rural</td>
<td>175/1000</td>
<td></td>
</tr>
<tr>
<td>Malawi (15-19 yrs) urban</td>
<td>109/1000</td>
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<tr>
<td>Malawi (20-24) rural</td>
<td>308/1000</td>
<td></td>
</tr>
<tr>
<td>Malawi (20-24) urban</td>
<td>237/1000</td>
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</table>

Declines in adolescent pregnancy and birth rates have occurred in most developed countries and also in a wide range of developing ones (5). Significant delays in the age of first marriage and accompanying declines in early childbearing have occurred in North Africa and Asia. However, the proportion of women who give birth as adolescents is still very high in Sub-Saharan Africa. Further, the proportion of adolescent births to unmarried women is increasing in some countries, and can be expected to continue to do so if contraceptive use among unmarried, sexually active young women does not increase rapidly (6).

For those adolescents who do give birth every effort is required to make motherhood safe. The statistics show that this is not currently the case. Pregnancy-related complications are the main cause of deaths for 15-19-year old girls worldwide (7). In some developing countries, maternal mortality among adolescent girls under 18 years is 2-5 times higher than in those aged 18-25 years (8).

Children born to adolescent mothers often experience higher risks of death during the first five years of life. A comparative study of Demographic and Health Surveys data from 20 countries showed that the risk of death by age five was 28% higher for children born to adolescent mothers than those born to women aged 20-29 years. (9)

An important contributory factor to maternal morbidity and mortality among adolescents is their higher recourse to unsafe abortion. In countries with reliable statistics, 40-60% of adolescent pregnancies end in induced abortion (10). Another contributory factor of growing importance, both to maternal mortality and to childhood mortality, is HIV/AIDS (11).
2. FACTORS THAT INFLUENCE ADOLESCENT PREGNANCY AND CHILDBIRTH

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 1.

**BOX 1 Factors contributing to adolescent pregnancy and childbirth**

Declining age of menarche – The age of menarche has declined in developed countries and in the urban areas of many developing countries from +/- 15 years to +/- 12.5 years.

Longer periods of education and delayed marriage for some adolescents, and early marriage and pressure to have children for others – A growing number of adolescent girls stay on in school for longer periods and marry late as a result. For many other adolescent girls, female status is equated with marriage and motherhood. They are required to marry early, and face immediate pressure to prove that they are fertile.

Initiation of sexual activity during adolescence – In many parts of the world, adolescents become sexually active whether or not they are married. Sexual activity among unmarried adolescents is increasing in many parts of the world. However, it must be noted that the age of first sexual debut has increased or remained unchanged in a number of countries, notably in Asia and Latin America.

Sexual coercion and rape – Adolescent girls may be coerced into having sex, often by adults and peers in their social circle. Pregnancies can result from such assaults. Girls who are subject to sexual abuse and rape can suffer serious, life-long physical and psychological consequences.

Education levels – This strongly influences adolescent childbearing as seen in many countries in which women with no education give birth before the age of 20 years, whereas women with even some secondary schooling are less likely to do so.

Socio-economic factors – Economic hardships can force young girls to leave home and seek a living elsewhere. Sexual exploitation and prostitution are sometimes the consequences of this. Through ignorance of contraception, inability to access contraceptive services, and inability to insist on condom use, the young girl may soon find herself pregnant.

Other risk behaviours – The use of alcohol and other substances may be associated with unprotected sexual activity, leading to unwanted pregnancies.

Lack of knowledge – Sexual and reproductive health information and education programmes are underway in many places. This has contributed to increases in knowledge and understanding. However, adolescents in many places continue to have significant knowledge gaps and misconceptions about sexuality and reproduction.

Lack of access to services – In many places, a range of barriers hinder the abilities of adolescents to obtain the contraceptive services they need3. Further, termination of pregnancy is illegal in many parts of the world. Even where it is legal, it is often inaccessible to adolescents.

*Source: References (12,13,14,15,16)*

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3 Adolescent pregnancies tend to be highest in regions with the lowest contraceptive prevalence. Moreover in many developing countries recent gains in contraceptive prevalence have been almost exclusively among older, married women and not adolescents.
3. RISKS ASSOCIATED WITH PREGNANCY AND CHILDBIRTH IN ADOLESCENCE, AND HOW THEY DIFFER FROM THOSE IN ADULTS

Pregnancy and childbirth in adolescence carry a greater risk to the health of both mother and baby, than in adult women. This is attributable to both biology and the social environment. A young maternal age, when combined with low social status and inadequate access to health care, contribute to the high maternal mortality in adolescents reported in many developing countries. The risks are high during the antenatal period, during labour and in the postpartum period (Box 2). Babies born to adolescent mothers also have a higher risk of being of low birth weight, and of higher rates of mortality and morbidity.

| BOX 2 Pregnancy complications occurring more commonly in adolescents than in adults |
|---------------------------------|---------------------------------|
| Pregnancy-induced hypertension  | Anaemia during antenatal period  |
| STIs/HIV                        | Higher severity of malaria      |
| Pre-term birth                  | Obstructed labour               |
| Anaemia during postpartum period| Pre-eclampsia                   |
| Postpartum depression           | Too early repeat pregnancies    |
| Low birth weight                | Perinatal and neonatal mortality|
| Inadequate child care and breastfeeding practices |

Problems in the antenatal period (17)

Pregnancy-induced hypertension

There are conflicting reports on the incidence of hypertensive diseases of pregnancy in adolescents. However, studies report an increased incidence of the condition in young adolescents, when compared with women aged 30-34 years.

Anaemia

Results from a meta-analysis of studies show an increased risk of anaemia in adolescents from developing countries, compared with women over 20 years of age. Anaemia in pregnancy is often caused by nutritional deficiencies, especially of iron and folic acid, and by malaria and intestinal parasites. Vitamin A deficiency and HIV infection may also play a role in its causation.
STIs/HIV

Sexually active adolescents are at an increased risk of contracting STIs, including HIV infection, owing to their biological and social vulnerability. There is also the increased risk of mother-to-child transmission of HIV in adolescents, because the HIV infection is more likely to be recent, and therefore associated with higher viral loads. The presence of other STIs (syphilis, gonorrhoea and chlamydia) with local inflammation may increase viral shedding, thereby increasing the risk of transmission during labour.

Higher severity of malaria

Malaria is one of the most important causes of anaemia during pregnancy. First-time pregnant women (which include many adolescents) are more likely to be infected with malaria than women who have been pregnant before. They are also more likely to suffer its more severe forms. This puts them at risk. It also puts their fetuses at risk of intrauterine death or low birth weight.

Problems during labour and delivery

Pre-term birth

A meta-analysis using data from developed and developing countries showed that, compared to women over twenty years of age, adolescents are at increased risk for pre-term delivery. A likely cause of this is the immaturity of the genital organs of young women. However, social factors such as poverty, behavioural factors such as psychoactive substance abuse, and lack of optimal antenatal care also have a negative influence on pregnancy outcome.

Obstructed labour

In young girls (below 15 years of age), cephalo-pelvic disproportion is more likely to occur than in older adolescents, and in adult women. This is due to the immaturity of the pelvic bones, and the small size of the birth canal. In such circumstances, lack of access to medical – and surgical – care can result in obstructed labour with all the attendant implications. Prolonged obstructed labour can result in vesico-vaginal and recto-vaginal fistulae, which if left untreated can have serious social repercussions for the young woman.

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4 Gynaecological age is defined as the chronological age less the age at menarche. A value of less than two years is associated with a higher risk of pre-term labour, and possibly cephalo-pelvic disproportion and consequent obstructed labour.
Problems in the postpartum period

Anaemia

Adolescents are more at risk of anaemia in the postpartum period due to pre-existing anaemia during pregnancy. This may be further aggravated by blood loss during labour and delivery and may increase the risk of puerperal infection.

Pre-eclampsia

Several studies report that pre-eclampsia occurs more often in young adolescents. The symptoms may become worse during the first postpartum days, and occasionally the first symptoms are recognized postpartum.

Postpartum depression

Adolescent women are also more likely to suffer from postpartum depression, or other mental health problems.

Too early repeat pregnancies

In many countries unmarried adolescents face considerable barriers in obtaining reliable contraception, because of barriers to the provision of services to them. Unprotected intercourse and repeat pregnancy have been found to occur in as many as 50% of these young women, within 24 months of delivery.

Problems affecting the baby

Low birthweight

A number of clinical studies in developing countries, and some from developed countries, have showed a higher incidence of low birthweight (weight <2500 grams) among infants of adolescent mothers.

Perinatal and neonatal mortality

Clinical studies in both developing and developed countries have found increased perinatal and neonatal mortality rates in infants of adolescent mothers, compared with infants of older mothers.

Inadequate child care and breastfeeding practices

Young mothers, especially those who are single and in difficult socio-economic situations, may find it hard to provide their children with the care they need. This is reflected in their poor child feeding, including breastfeeding, practices.
Why are these complications worse in adolescents than in adults?

The complications described above are by no means limited to adolescents. Older women also suffer from similar complications. Also, the situation of adolescents varies depending on their marital status and the support available for them during pregnancy and childbirth. Social and cultural norms may hinder the ability of adolescents (married and unmarried) to obtain information and access antenatal, delivery, and postnatal services. There are, however, several reasons why the complications have a worse outcome in adolescents.

1. Biologically, young adolescents are not mature enough for the strain imposed on them by pregnancy. Firstly, in physical terms, their pelvic bones are not fully mature, and as a result, cephalo-pelvic disproportion could potentially occur. Secondly, 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. If the adolescent’s growth and development have been hindered by under-nutrition during childhood, she would then be entering pregnancy with nutritional deficiencies as well as impaired growth and development, further increasing the risk of negative outcomes. Thirdly, young adolescents may also not be psychologically prepared for motherhood. This could result in mental health problems such as depression.

2. Compared to older women, adolescents 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 his young wife. If single, the shame of the pre-marital pregnancy may leave her voiceless and even as a family outcast. In some cultures, single pregnant adolescents are sent away to distant relatives until after delivery. In such circumstances, the adolescent is unlikely to get the psychological and practical support that she needs.

3. Adolescents are more likely to enrol later and to make fewer health-facility visits for antenatal care. Clearly, socio-economic factors have a major influence on antenatal care utilization. The stigma associated with premarital pregnancy is another critical factor contributing to this. In many places, unmarried adolescents hide their pregnancies for as long as they can. On the other hand, married adolescents may not even know of the value of antenatal care, and even if they do, may be unable to obtain it. What this means is that adolescents are deprived of a service that has been shown to contribute to positive pregnancy outcomes.

4. In many places, adolescents deliver at home. They come to - or are brought to - hospital only as a last resort, often with serious complications. The factors that contribute to this include:
   - 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 for the cost of private transport to get there.

What this means is that a problem that could be prevented or promptly managed in a hospital could potentially get out of hand during delivery at home.

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. Further, many healthcare workers are not conversant with the issues that need to be borne in mind when providing care during pregnancy to adolescents. As a result, antenatal visits and the delivery experience can be unpleasant for the young person, and in addition inadequate in terms of technical quality.

4. CARE OF ADOLESCENTS DURING PREGNANCY, CHILDBIRTH AND THE POSTNATAL PERIOD

There is much that can be done to reduce the occurrence of problems, and to improve the health of the mother and the (unborn) baby. This includes early diagnosis of pregnancy, effective antenatal care, effective care in labour and delivery, and effective postpartum care.

Early diagnosis of pregnancy

The early diagnosis of pregnancy is an important first step in drawing the adolescent into antenatal care. Health-care providers and other adults in more regular contact with the adolescent, including family members, have the shared responsibility of creating a supportive environment in which she feels able to share information about her situation. Health-care providers need to be aware that a young adolescent may not know that 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. Another issue to be aware of is that if the adolescent is unmarried, she may want to hide her pregnancy or even to terminate it. Being aware of these issues, and being on the lookout for telltale signs of early pregnancy (such as nausea) will help ensure that an early diagnosis of pregnancy is made and that the adolescent receives the care and support she needs.

Antenatal care

Repeated contacts with the health-care system provide a useful opportunity for the detection and treatment of problems that commonly affect pregnant adolescents. Pregnancy-induced hypertension can easily be detected. Uncomplicated hypertension can be managed on an outpatient basis. In case of complications (such as pre-eclampsia, eclampsia, and abruption placentae), referral to a hospital is indicated. Anaemia and malaria too can be detected and treated during routine antenatal care. Antenatal visits also provide a valuable opportunity to screen for STIs such as syphilis and to provide the required treatment, when needed. They also provide an opportunity for the provision of food supplements, in case under-nutrition is detected. It is worth noting that there is only limited evidence of the value of food supplementation on
increasing birthweight. Finally, antenatal visits could help identify those adolescents – especially very young adolescents – at risk of preterm labour, though interventions to address this are limited (17).

Antenatal care should go much further than the detection and treatment of problems. It provides a valuable opportunity for the provision of information and counselling support that adolescents need. WHO recommends a minimum of four antenatal visits for all pregnant women (18). This is especially important in the case of adolescents – especially unmarried ones – because of their greater need for support.

Antenatal care also provides an entry-point for the identification and provision of social support services. The waiver of user-fees, and the provision of medicines such as antimalarials, and food supplements free-of-charge will help ensure that they do in fact benefit from antenatal care. In this regard the signing of service agreements between the Ministry of Health and private hospitals in Malawi should improve access to these services.

**Counselling during pregnancy**

As indicated above, health-care providers should seek to understand the situation that their adolescent patients are in, and to provide them with the information and counselling support that meet their needs (listed below). In addition, pregnant adolescents may have questions and concerns of their own. They must be given an opportunity to raise and discuss these issues.

- The life situation of the adolescent including her marital status and socio-economic situation,
- and the support available to her from her husband/partner, family members, friends and others;
- The options available to her in terms of the pregnancy (e.g. in some places discreet arrangements are available for handing the child over for adoption soon after birth);
- The support that she needs, and the social support services for which she is eligible;
- Her access to health services for routine antenatal care and in case of emergency;
- Her plans for the delivery;
- Her plans for the care of the baby;
- Her plans for continuing with her education or work after the delivery.

Counselling should also include health issues that are relevant to the person. These include good nutrition, malaria prevention and smoking (and other psychoactive substance use) cessation. Another important issue is HIV/AIDS. As indicated above, adolescents are at an increased risk of contracting HIV infection, and of transmitting the infection to their infants. In a growing number of countries, voluntary counselling and testing services, as well as anti-retroviral therapies to prevent mother-to-child
transmission, and to safeguard the health of the mother, are becoming available. Adolescents should be encouraged to obtain HIV counselling and testing.

In addition to opening the door to anti-retroviral therapy to prevent mother-to-child transmission, and to prevent/ reduce viral multiplication in her body, the knowledge of her HIV status will enable the HIV infected adolescent to take the necessary steps to prevent transmission to others. For those who test HIV-negative, this 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, labour starts at term, and the infant is in cephalic presentation, labour is not at increased risk. However, if the adolescent is severely anemic, postpartum haemorrhage can be dangerous. In very young adolescents, pre-term labour as well as obstructed labour are more likely to occur. What this means is that although in general, labour is not necessarily more risky in adolescents than it is in adults, some adolescents clearly are a high risk for specific reasons. As a general rule, 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 who are likely to require institutional delivery do not find themselves stranded at home because there is no one around to accompany them to the hospital, or because transportation is not available/affordable.

Guidelines for the provision of care during normal labour have been developed by WHO (19). Besides observing and monitoring, supporting the woman and her partner (or companion) is very important, especially in adolescents. Studies have shown that continuous empathetic support during labour, provided by a nurse or midwife results in many benefits both to the mother and the baby (17).

Postpartum care

Postpartum care includes the prevention, early diagnosis and treatment of postnatal complications in the mother and the infant. It also includes the provision of information and counselling on breastfeeding, nutrition, contraception and care of the baby (20). The adolescent mother will require support on how to care for herself and her baby. Since many adolescents – especially those in difficult social situations - do not receive adequate antenatal care, or the support of their partners/families, postpartum care is even more important for them.

Contraception

Many too-early repeat pregnancies are unplanned and as a result of absent or inadequate contraceptive efforts (17). The postpartum period presents a good opportunity for taking concrete steps towards pregnancy prevention and for promoting dual protection by using condoms.
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.

Breastfeeding

WHO has made recommendations concerning breastfeeding (20). A young adolescent – especially one who is single – would require extra support in achieving breastfeeding successfully.

Between 5-20% of infants born to HIV-positive mothers may acquire HIV through breastfeeding depending on a range of factors. Every HIV-infected mother should receive counselling, which includes information about the risks and benefits of different infant feeding options, and specific guidance in selecting 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-infected mothers is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life, and should be discontinued when an alternative form of feeding becomes feasible (21).

The first weeks and months as a young mother

Many adolescents return with their babies to the love and support of their families. Many others are less fortunate. Their social circumstances are often distressing. If the adolescent mother is unmarried or without a partner, she may face problems with her family and community because they 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 for planning her future. Responding to this can be both rewarding and challenging.

SUMMARY

- Pregnancy in adolescents is not uncommon.
- Many factors contribute to adolescent pregnancy.
- Adolescents have higher maternal mortality than adults.
- Babies born to adolescents have a higher mortality too.
- Many of the complications arising during pregnancy and delivery have worse outcomes in adolescents.
- There are important issues for health-care 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 concerted actions beyond the health sector. Three key actions in relation to this are increasing girls’ access to education and job opportunities, enhancing their status of women and girls in society, and improving their nutritional status.
5. REFERENCES

SPOT CHECK 1

In developing countries, how does the rate of maternal mortality of girls under 18 years old compare with adults? *Please mark with a circle your answer*

- Rates are about the same
- About twice as much for adults
- About three times as much
- About four times as much
- About five times as much

SPOT CHECK 2

Which factors could contribute to antenatal complications in pregnant young adolescents?

- Married
- Unmarried

SPOT CHECK 3

What are the commonest antenatal complications in young adolescents?

- .................................................................................................................................
- .................................................................................................................................
- .................................................................................................................................
- .................................................................................................................................

SPOT CHECK 4

In your opinion what are the most important issues to raise in counselling session with pregnant adolescents?

- .................................................................................................................................
- .................................................................................................................................
- .................................................................................................................................

SPOT CHECK 5

What are the critical factors in caring for the pregnant adolescent in the post partum period?

- .................................................................................................................................
- .................................................................................................................................
- .................................................................................................................................
CASE STUDY 1

Sabina, a 15-year old adolescent girl was brought to the casualty department of a government hospital located in the southern region of Malawi. The accompanying relatives told the doctor on duty that she had been in labour for three days, and was being cared for at home, by a Traditional Birth Attendant (TBA).

This was Sabina's first pregnancy. She had not attended any antenatal clinic for the entire duration of her pregnancy (which was at term). According to her relatives, labour had started three days earlier. The TBA who had been attending to her, gave her herbal potions to speed up the labour, to no avail. Sabina had complained of unbearable abdominal pain, had started bleeding from her vagina and had grown progressively weaker. That is why her relatives decided to bring her to hospital. Further enquiry revealed that Sabina had been married a year ago to a man in his late thirties. She was his second wife. The man was a migrant worker in South Africa.

Examination revealed a young woman with pregnancy at term. She was pale and dehydrated. Her abdomen was tender and firm. Foetal heart sounds could not be heard. There was moderate vaginal bleeding. Vaginal examination revealed a fully dilated cervix with marked caput. The foetal head was 3/5 and fixed. A diagnosis of obstructed labour with intrauterine foetal death was made. Arrangements were made for emergency caesarean section.

At caesarean section, the foetus was found lodged in the abdominal cavity. It was evident that the uterus had ruptured at the fundus, extending to the left lateral side. There had been severe bleeding. The doctors considered uterine repair but decided against it. A sub-total hysterectomy was performed and the abdomen closed.

Sabina had a stormy post-operation period. Her temperature remained high despite antibiotics and on day 5 she started to have urinary incontinence although a Foley’s catheter had been left in place. Her fever settled after 10 days but the urinary incontinence continued. At the examination under anaesthesia three weeks later, the presence of a Vesico-Vaginal Fistula was confirmed. She was discharged and advised to return after three months for surgical repair of the fistula.
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 7gm/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

An 18 year old girl has come in to the antenatal clinic in a municipal health centre with a 30 week pregnancy. The nurse elicits information and carries out an examination. She notices on examination that she has quite aggressive condylomata. While eliciting information she had learnt that this was her second pregnancy and that her first pregnancy had ended as a still birth some 2 years ago. The girl also explains that she is widowed as her husband who was a cross border truck driver died the previous month. She sets about explaining the diagnosis and its implications for the health of the mother and her unborn baby, and what remedial action needs to be taken…

Roles: Nurse, 18-year old pregnant girl (30 weeks).

ROLE PLAY 3

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 from teachers at school by binding her abdomen tightly. The girl is in labour. Her cervix is 4 cms. 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.

ROLE PLAY 4

A 15-year old girl who delivered a baby boy three days ago at a maternity hospital in a city, is now ready to go home. The nurse responsible for this is filling in the discharge slip and then turns to speak with her about follow-up care.

Roles: 15-year old girl, 3-day old baby (doll), nurse
Handout for

Unit 3E

Unsafe abortion and young people
This handout presents background information to complement the material in unit 3E entitled *Unsafe abortion and young people*. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

**THIS HANDOUT PROVIDES INFORMATION ON THE FOLLOWING:**

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2. Factors contributing to unsafe abortion in young people .......... 110
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1. THE NATURE AND SCOPE OF UNSAFE ABORTIONS

WHO estimates that about 25% of all pregnancies worldwide end in an induced abortion. Table 1 that follows presents global estimates relating to abortions for women of all ages (1). The vast majority of unsafe abortions take place in developing countries, and as can be expected, in countries in which abortion is restricted by law.

<table>
<thead>
<tr>
<th>Estimated annual figure</th>
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<tr>
<td>Abortions performed globally</td>
<td>50 million</td>
</tr>
<tr>
<td>Abortions performed in developing countries</td>
<td>30 million</td>
</tr>
<tr>
<td>Unsafe abortions</td>
<td>20 million</td>
</tr>
<tr>
<td>Death from unsafe abortions</td>
<td>80,000</td>
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</table>

Source: Reference (1).

Unsafe abortion accounts for up to 13% of all maternal deaths (1). Some 80,000 women are estimated to die every year as a result of unsafe abortion. Many more women survive the experience only to suffer throughout the rest of their lives from chronic health problems, and in many cases infertility.

In many parts of the world, more young girls than adult women will resort to abortion as a way of solving an unwanted pregnancy. A conservative estimate of the total number of abortions among young women in developing countries ranges from 2 million to 4.4 million annually. In many developing countries, hospital records of women treated for complications of abortion suggest that between 38% and 68% are less than 20 years old. A recent review of unmarried women aged 15-19 years who gave birth in the preceding five years showed that 32-93% of the births were unwanted or mistimed. Even among the married young people, up to 61% of the last births were unwanted or mistimed (2,3).

The choice to have an abortion is not an easy one. Adolescents often state a number of reasons for resorting to abortion (4):

- **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:** Since 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 in adults.
- **Failed contraception:** Contraceptive use among young women is often low. Where they are used, this is often done so inconsistently and incorrectly. Also, less effective methods tend to be used.
• **Coerced sex (including rape and incest):** Cross-cultural data point to the fact that a larger percentage of rape and sex abuse incidents are perpetrated against young women than among adults.

Early studies on unsafe abortion, especially in developing countries, reported a higher prevalence in the urban and educated than in the rural areas. This may be as a consequence of greater access to information and wider availability of services in urban areas. 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. On the other hand, the poor are forced to seek the services of clandestine, unqualified providers with all the attendant implications.

### 2. FACTORS CONTRIBUTING TO UNSAFE ABORTION IN ADOLESCENTS

There are several factors which determine the magnitude and severity of unsafe abortion:

- Delays in seeking care
- Resorting to unskilled providers
- Use of dangerous methods
- Legal obstacles
- Service-delivery factors.

Delay in seeking abortion is the largest single factor in determining the risk of complications and death due to unsafe abortion among young women (5). Young women, like some adults, may delay seeking help even after complications develop. Young women may delay seeking care because they may not know that they are pregnant, or may not want to admit it even if they are aware of their pregnancy. They may not know where to obtain help. Even if they do so, they may not be able to obtain help because factors such as cost may prevent them from doing so. Finally, even if they can obtain help, they may be unwilling to do so because of the attitudes and behaviours of health-care workers.

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 non-medical person. Young women are more likely than adults to use dangerous methods for abortion, such as inserting objects into the cervix, placing herbal preparations into the vagina, or taking various preparations from modern and traditional systems of medicine – orally or through injection.

Varying forms of legal barriers to the provision of abortion services exist in many countries. Even in countries where these laws are relatively liberal, various requirements that have been created make it harder for adolescents to have access to safe abortion. For example, in some countries the consent of the husband, parent or guardian is needed for the abortion if the woman is below a certain age. Generally speaking, abortion-related mortality is highest in countries where abortion is legally restricted and
The way in which service-delivery is organised affects the extent to which young people have access to sexual and reproductive health information and services, including safe abortion when needed. Later in this handout, we will describe what actions need to be taken in order to improve the diagnosis and management of unsafe abortion in young women. For information on how to overcome barriers to the provision and utilisation of health services to adolescents, please refer to the unit 4. Providing young people with the health services they need

The magnitude and severity of problems related to unsafe abortion among the youth vary from country to country, and within communities in the same country.

Factors determining magnitude and severity include the extent to which:
- Reproductive health information and services are available and accessible to the youth;
- Safe abortion services are available and accessible;
- Health-care providers are helpful and non-judgemental in their dealing with young people;
- Community norms permit open and frank discussion about sexuality in young people;
- National laws and policies facilitate the provision of reproductive health information and services that young people need.

3. THE CONSEQUENCES OF UNSAFE ABORTION

While the risks of mortality and morbidity from unsafe abortion are high for women of all ages, they are especially high for young people. The consequences are multiple, and can be conveniently categorized as medical, psychological, social and economic.

Mortality

Information on mortality due to unsafe abortion for women of all ages was presented earlier in this handout. The available data clearly points to the fact that three groups of women run a heightened risk of mortality from unsafe abortion. These are women of young age, those who have not yet had children, and women of lower socio-economic status. The risk of mortality is clearly far greater for young women than for adult women.

Medical consequences

The major short-term complications are cervical or vaginal lacerations, sepsis, haemorrhage, perforation of the uterus or bowel, tetanus, pelvic infection or abscess, and intrauterine blood clots. Post-abortal sepsis can rapidly develop into septicemia; haemorrhage is a common complication that leads to or aggravates pre-existing anaemia. Both septicaemia and anaemia are common causes of death, especially in
developing countries where life-saving antibiotics and safe blood transfusion services are less available. Physical injuries may vary from small genital lacerations to major perforations involving not only the reproductive organs but also urinary and gastrointestinal systems.

In order to save the lives of these young women, major emergency surgical interventions are needed. Paradoxically such interventions are least available in developing countries, where young people are least able to prevent pregnancy. Where they are available, they are least accessible to those who require them most: poor adolescents in rural areas. Thus, young people who resort to unsafe abortion often pay with their lives.

The major long-term medical complications (more than a month after the procedure) include secondary infertility (a particularly heavy life-long burden, in societies where a woman’s status depends on her ability to have children), spontaneous abortion in a subsequent pregnancy, and an increased likelihood of both ectopic pregnancy and pre-term labour.

**Psychological consequences**

These are less well-documented than physical consequences but are by no means insignificant. Long-term abortion-related psychological problems have been frequently reported, especially in young women pregnant for the first time. These include a sense of loss and reactions of grief. Some have also expressed guilt that extends beyond the abortion itself to guilt for having engaged in sexual relations, and for failing as a “real” woman by opting for abortion (7).

**Social and economic consequences**

The social and economic consequences of unsafe abortion are borne by the girl herself, her family, community and the society as a whole. The girls who survive may face a range of social problems. If it becomes known that they have undergone an unsafe abortion, they may have to leave school and face disapproving attitudes, even ostracism, from their community. Furthermore, they risk being thrown out by their families. Girls who drop out of school, or are thrown out by the family, often marry early, get poorly paid jobs and are tempted or forced into prostitution. In short, the spiral of events stemming from their obtaining an unsafe abortion greatly reduces their life chances.

In some countries where abortion is illegal such as in Malawi, women – including adolescents – who have undergone an abortion illegally, may face imprisonment.

Throughout the developing world, the economic consequences of unsafe abortion are immense for both the community and the country. Treatment for the complications of unsafe abortion drains precious resources – often already in short supply – such as safe blood, other intravenous fluids, and antibiotics. Women recovering from unsafe abortion tend to stay in hospital three or four times longer than those recovering from safe abortion. Also, the long-term morbidity resulting from unsafe abortion incurs future health care and other costs. In addition, there are other significant costs. Investments made in
education and training young women are lost. Human resources which could have contributed to the nation’s development are lost. Unsafe abortion thus results in costs not only to individuals and families but to communities and societies.

4. DIAGNOSING UNSAFE ABORTION

In theory the diagnosis 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, by oneself, with the assistance of a friend or a 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 given an accurate history. This is especially so when they are accompanied by their parents, relatives or other persons because of fear and embarrassment at having had sexual relations.

Compared with adults, young women with an unsafe abortion are more likely to (4):
- Be unmarried and outside a stable relationship
- Be primi gravida
- Have a longer gestation up to the time of abortion
- Have used dangerous methods to terminate pregnancy
- Have resorted to illegal providers
- Delay seeking help
- Come to the health facility alone or with a friend, rather than with the partner
- Have ingested substances that interfere with treatment
- Have more entrenched complications.

It is important for health-care providers to bear in mind that unwanted pregnancy may be the real presenting problem, though other symptoms may be reported, and to observe the young person’s demeanor and behaviour carefully. This will assist in ensuring that the diagnosis of unsafe abortion is not missed. It would be important to employ a gentle, reassuring manner, and to tactfully ask the girl’s parents or guardians to wait outside the consulting/examining room. This will enable the health-care provider to have a private and confidential conversation with the girl.

5. MANAGING UNSAFE ABORTION

The clinical presentation will obviously depend on the condition of the patient. In case infection has set in, the young woman is likely to be feverish and dehydrated. The other likely clinical signs are: a swollen, tender abdomen, bleeding and foul-smelling discharge from the vagina, with some products of conception still in the uterus, tender adnexae, and fullness in the pouch of Douglas. In case treatment has been delayed, the young woman is likely to be in shock with impending respiratory and circulatory failure.
The management of the patient will depend on the history and the findings of the examination. It should be based on the following principles (8):

- *Emergency resuscitation* may be necessary as many young women present in shock. In primary level facilities, health-care workers will need to be prepared to make referrals and arrange for transport to a referral facility with effective treatment.
- *Evacuation of the uterus* is necessary to remove all the products of conception.

For inevitable or incomplete abortion, uterine evacuation is necessary. The technique chosen will depend on the length of gestation, stage of the abortion, uterine size and availability of skilled staff and supplies. If there are signs of infection, abdominal injury, cervical or uterine perforation, evacuation should be carried out only after broad-spectrum antibiotics effective against gram-negative, gram-positive and anaerobic organisms, as well as chlamydia, have been started.

In the first trimester, vacuum aspiration is the surgical procedure of choice. In the second trimester, the risk of complications is higher. Because delay is so characteristic of young abortion patients, many second trimester abortions are carried out in this age group. Early second trimester (12-14 weeks) procedures can be done by vacuum aspiration using larger cannulae. Curettage is also sometimes required. The treatment of incomplete abortion in the late second trimester (more than 14 weeks), by dilation and curettage or by uterotonics should be done by experienced health-care workers. In addition, intravenous fluids and oxytocics, blood transfusion and facilities to perform abdominal surgery must be available as a back-up.

- *Management and prevention of complications* such as infection and injury. It is unfortunately true that complications are more frequent and more severe in environments where self-induced or otherwise unsafe abortions are common and where reproductive health services in general are lacking.

- *Arrangements for post-abortion care* must be put in place because young people are more easily “lost to follow-up” than are adults. Establishing a good rapport with the young patient will facilitate follow-up. In any case, patients must be given information on danger signs to look out for, such as fever and chills, nausea and vomiting, abdominal pain and backache, tenderness to pressure in the abdomen, heavy bleeding and foul-smelling vaginal discharge. They must also be provided with information on sexuality and contraception for well-informed decision-making.

6. PREVENTING UNSAFE ABORTION

In many parts of the world, young and adult women with unwanted pregnancies continue to resort to abortion, whether or not it is legal and safe. Prevention of such pregnancies must therefore be one of the key objectives in efforts to eliminate unsafe abortion. Communities, governments and health-care workers should endeavour to:

- *Improve access to reproductive health information and services*
The need to improve young people’s access to reproductive health information and services has been discussed in unit 3A. *Sexual and reproductive health in young people.* Specifically, there is an urgent need to expand the availability of a wide range of contraceptive methods to enable sexually active adolescents to choose the method that best suits their needs. The contribution that emergency contraception could make in preventing unsafe abortion needs to be clearly articulated. Adolescents need to know that this method is available, and where it could be obtained when needed. Information on ways and means of improving the accessibility and acceptability of health services is provided in unit 4. *Providing young people with the health services they need.* Further information on contraception is provided in unit 3C. *Pregnancy prevention and fertility regulation in young people.*

- **Train health-care providers in comprehensive abortion care.**

Health-care providers – both modern and traditional – need to be trained in comprehensive abortion care so that they can recognize the signs and symptoms of abortion-related complications and how to manage them effectively. They also need to be trained in post abortion counselling. In this way, they can help young people deal with the many health and social issues that arise. In addition to building the knowledge and skills of health-care providers, it is important to help them examine their attitudes and beliefs, in order to prevent these factors from hindering the provision of care.

The dilemma for service providers is often a complex one. On the one hand there are laws concerning the provision of abortion services, and on the other hand there are laws governing the treatment of minors. Both of these sets of laws can come together to pose barriers to the health and well-being of young people, especially young adolescents. The issuance of clear standard operating procedures and guidelines for the management of unsafe abortion, within the context of the prevailing laws and policies, will assist health-care providers in dealing with the legal and ethical dilemmas that they encounter.

- **Involve communities in protecting and safe-guarding adolescents**

In addition to their role as service-providers, health-care workers have to play the important role as change-agents in their communities. They must work to involve communities in discussions on unwanted pregnancy, unsafe abortion and its consequences, and the contribution they could make to protecting and safe-guarding adolescents in the community (9).
SUMMARY

- Unsafe abortion is common among young women in many countries.
- By definition, it implies interference of pregnancy by persons without the necessary knowledge and skills, or in conditions that are not conducive to good health. It can be within or outside of the law.
- Young people obtain abortions for a broad range of reasons related to social, economic and cultural reasons.
- Young people undergoing unsafe abortions tend to be single, pregnant for the first time, and tend to obtain 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 for post treatment follow-up.
- The management of unsafe abortion should include post-abortion counselling, addressing contraception in addition to other issues.
7. REFERENCES

<table>
<thead>
<tr>
<th>SPOT CHECK 1</th>
<th>In Malawi roughly what percentage of all maternal deaths are caused by unsafe abortion</th>
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</thead>
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<tr>
<td></td>
<td>10%  20%  30%  40%  50%</td>
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<tr>
<th>SPOT CHECK 2</th>
<th>In Malawi, roughly what percentage of women hospitalised with abortion complications are under 20 years old</th>
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<th>SPOT CHECK 3</th>
<th>Some people say that if safe abortion services are made available and accessible to adolescents, it will encourage promiscuity. Do you agree with this</th>
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<th>How confident do you feel working with adolescents on the issue of abortion</th>
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<tr>
<th>SPOT CHECK 5</th>
<th>A school girl presents with complications due to unsafe abortion, which of the following best describes how you would feel about the situation? Please answer with three spots</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• I feel angry with her  • I feel angry with the boy or man who is responsible  • I feel pity for her  • I feel angry with the politicians for the restrictions on safe abortion  • I feel we have failed because she resorted to unsafe abortion  • I feel pity for the life that has been aborted  • I feel angry with the person who did the abortion</td>
</tr>
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<th>SPOT CHECK 6</th>
<th>As health care providers what should we focus on to prevent unsafe abortion among adolescents? Please answer with three spots</th>
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<tbody>
<tr>
<td></td>
<td>• Train modern and traditional health care providers in abortion care  • Support efforts to change the law to expand access to safe abortion  • Improve provision of contraceptives to all adolescents  • Encourage authorities to stop untrained people carrying out abortions  • Emphasize abstinence from sex before marriage</td>
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<td>SPOT CHECK 7</td>
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<td>Realistically is there more you could do with respect to unsafe abortions among adolescents</td>
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<td>Please mark your answer below</td>
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<tr>
<td>No</td>
<td>perhaps</td>
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</table>
CASE STUDY 1

Maria, a 14-year old school-girl, attended a boarding school on the outskirts of Blantyre. One evening, she was admitted to Queen Elizabeth Hospital with complaints of high fever and severe lower abdominal pain. Maria was brought to the hospital by one of her teachers. She had been found huddled up in bed and shivering in the school dormitory.

They were received by a nurse in casualty who asked Maria a few questions about what had happened but did not get much information. Maria was clearly very upset and mumbled or answered in monosyllables. The teacher, who appeared sympathetic to Maria, told the nurse that another pupil had found Maria very unwell in bed and that she had been terribly sick. She wondered if Maria had eaten something and had a stomach upset.

The nurse thanked the teacher and asked her to wait while she took Maria for an examination. Maria was weeping while undressing and the nurse comforted her and asked if she would like to tell her a little bit about what had happened. Maria confided that she had got pregnant, had had an abortion which had gone all wrong and, indicating the lower abdomen, said that her tummy hurt terribly.

The nurse called the doctor on duty and reported what Maria had told her. On examination, the doctor found that her abdomen was tender with marked guarding. The uterus was bulky and there was a foul-smelling purulent discharge due to infected products of conception.

On further questioning, Maria told the doctor that, seven days before, her best friend had taken her to an abortionist in a slum area of Kampala, who had inserted a rubber pipe deep into her vagina and instructed her to go to hospital when heavy bleeding started. The doctor asked her about the date of her last period and how sure she was that she was pregnant.

Maria told him that her periods had started about two years ago but had always been irregular. She was having a love affair with a boy from a neighbouring school and they had started to have sex three months before. She was seven weeks late with her period and suspected she was pregnant. She did not do any test.

Following the abortion, bleeding had not, in fact been heavy but intermittent, with steadily increasing lower abdominal pain. The pipe dropped out after two days. Maria had endured the pain and tried to keep going as best she could at school until that afternoon, when she could bear it no longer.

Despite the pain which was by then excruciating, the main concern Maria expressed was that neither the school nor her parents should know about the pregnancy. She begged the doctor not to tell them. She also asked if she was going to die. The nurse reassured her, while the doctor went out to tell the teacher who had accompanied Maria that she needed to be admitted to hospital for investigations.

She was admitted to the gynaecology ward with a diagnosis of septic incomplete abortion. She was started on parenteral antibiotics and taken to theatre for evacuation 12 hours later. Her temperature settled and she was put on haematinics. She was discharged after five days and given a return appointment to the gynaecology clinic a week later.

At the return visit she was given a cursory examination. She had apparently recovered completely; she was also extremely grateful to the doctor and nurse for not informing either the
QUESTIONS FOR GROUP DISCUSSION

1. Who do adolescents turn to for advice and help when they have an unwanted pregnancy?
   • In the case of a “botched” illegal abortion, with serious consequences, where do they go?
   • How promptly do they seek help when problems arise?

2. How are adolescents treated if/when they go to a government health facility, a private practitioner or an illegal abortionist?
   • From an adolescent’s point of view, what are the pros and cons of going to each of these places?

3. When seeing an adolescent in such circumstances, how can you make her feel at ease and encourage her to confide in you?

4. What are the things you need to be aware of when carrying out a physical examination of a young woman in such a situation?

5. What is the best way to communicate facts about abortion, its possible consequences and its implications, to adolescents?
   • Which of the adolescents’ concerns must you address?
   • In this situation, what are the rights of minors to privacy and confidentiality?
   • What are the rights of parents to be informed and make decisions?

6. Do health-care workers deal with the social and psychological aspects of abortion effectively?
   • What do they need to consider in order to deal more sensitively with these aspects?

7. What follow-up actions need to be undertaken following unsafe abortion?
   • How to coordinate with related services for contraception and STI prevention?
   • How can vital education and information on prevention best be provided?
CASE STUDY 2

Alefa, an 18-year old girl had just completed her secondary school education. She went to the outpatient department of the district hospital in the town in which she lived, because she suspected that she was pregnant. After waiting for several hours in a long queue, she was seen by a middle-aged male doctor. She told the doctor that she suspected that she was pregnant and wanted to have the pregnancy terminated. The doctor sent her for a pregnancy test at the hospital laboratory and told her to come back in two days.

The test confirmed that she was pregnant. On the next visit, she was examined and found to have a bulky uterus and to be 8-10 weeks pregnant. Yolanda again stated that she wanted the pregnancy terminated.

The doctor asked her to explain why she could not continue with the pregnancy. She explained that she had just completed her secondary school leaving certificate the year before and was due to go to nursing school in four months. She was the first-born in a family of six, both parents were school teachers and the father was a lay preacher at the local church. She pleaded with the doctor to help her. She felt very ashamed about the pregnancy and could not bear the thought of giving up or postponing her nursing training, which would ruin her own employment opportunities and let her family down.

The doctor told her that termination of pregnancy was illegal under any circumstances. However, he offered to assist her at his private clinic. Yolanda saw the doctor privately and was told that the termination of pregnancy could be performed the following day for a heavy fee – to be paid before the operation. She had no way of doing this and left very frustrated.

Two months later, she was brought to casualty. By chance the same doctor was on duty at that time. She was wheeled in on a stretcher by her parents. They told him that she had been behaving strangely for the past several weeks. She had gone to visit an aunt up country 10 days before and stayed away one week. She had been extremely unwell for the past three days. Her parents suspected malaria. Yolanda herself was too unwell to provide any further information.

Physical examination revealed a very sick girl with marked pallor, jaundice, temperature of 36 degrees, rapid and weak pulse, and blood pressure 80/50 mm; the abdomen was tender and distended. There was foul smelling discharge from the vagina. The diagnosis of septic incomplete abortion with a foreign body in the vagina, causing septicaemic shock was made.

Resuscitation was started and the patient was admitted to the surgical ward. Broad spectrum antibiotics were prescribed but were out of stock. Only penicillin was available. The parents rushed out to buy the prescription that they were given. A blood transfusion was ordered; and the drip started.

Six hours later, there was no improvement; a surgical evacuation under anaesthetic (EUA) was planned. At EUA, a stick was found in the vagina, perforating through the pouch of Douglas into the abdominal cavity. There appeared to be leakage of faecal matter into the abdomen. The doctors decided to do a laparotomy and an evacuation. At laparotomy, they found uterine perforation, partial necrosis of the posterior wall of the uterus and perforation of the gut. They also found fulminating peritonitis and a pelvic abscess. Gut resection, colostomy, and subtotal hysterectomy were performed. The patient was taken to the intensive care ward where her condition steadily worsened. She died five days later.
QUESTIONS FOR GROUP DISCUSSION

1. What important issues pertaining to health services (availability and accessibility) are highlighted by this case study?
2. In your experience and practice, how often does this sort of event occur?
3. What do we need to do (as health-care providers) to prevent such tragedies from occurring?
4. What do you need to be aware of when carrying out a physical examination on a young woman in such a situation?
5. How frequently do basic supplies and other resources for resuscitation run out in your experience?
6. What could have been done differently to save the young woman’s life after she presented at the hospital?
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 depends 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.

ROLE PLAY 2

A young woman (18 years) has died in hospital from septic incomplete abortion in the care of a certain middle-aged male doctor. 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 in his office both her parents and her sister.

The sister breaks down sobbing and in anger 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 affair makes this very difficult. He feels torn between his own guilt, genuine sympathy for the family and his real concerns about safeguarding his position . . .

Roles: Doctor, young woman's parents and 21-year old sister.

ROLE PLAY 3

A manual vacuum aspiration (MVA) programme has recently been introduced in the gynaecology ward of a district hospital. This means that evacuations can now be performed in the treatment room rather than in the operating theatre.

The value of post-abortion counselling and contraception has been stressed during staff training.

Three girls of secondary-school age who have just undergone medical termination of pregnancy are in the office of the nurse in charge, waiting to be discharged. The nurse has only a few minutes to devote to them.

As she begins talking to them about preventing future pregnancy, one of the girls says that she does not want to take contraceptive pills as she is sure that her parents will find them. She and her family live in small 2-roomed quarters and she has no privacy. The other girls immediately nod in agreement.

Roles: Nurse, three girls of secondary-school age.
Handout for

Unit 3F

Sexual abuse and young people

This handout is a reproduction of the Guidelines for the Management of Sexual Assault and Rape in Malawi and provides information to complement the material covered in unit 3F.

Participants should be referred to the document mentioned above.
Handout for

Unit 3G

Young people and HIV & AIDS
This Handout for participants provides information that complements the material on “Young People and HIV and AIDS”. The facilitator will ask you to refer to this Handout during the sessions.

1. Situation of HIV in Malawi 128
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1. SITUATION OF HIV IN MALAWI

The HIV situation in young people is presented in Box 1 below.

<table>
<thead>
<tr>
<th>BOX 1 HIV SITUATION IN MALAWI</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The National adult HIV prevalence is 12%.</td>
</tr>
<tr>
<td>• In 2005, there were 1,120,000 people infected with HIV and 96,552 were new infections in Malawi.</td>
</tr>
<tr>
<td>• Half of the above new infections occurred in young people aged 15-24 years and 75% of these new infections in young people occur in girls of the same age category.</td>
</tr>
<tr>
<td>• The prevalence of HIV in antenatal attendees in 2005 was 16.9% and most of the attendees were below 30 years.</td>
</tr>
<tr>
<td>• HIV prevalence higher in the urban areas than in the rural (21.6% &amp; 12.1% respectively). In 2005, the prevalence of HIV in the southern, central and Northern regions was 21.7%, 14.3% and 14% respectively.</td>
</tr>
<tr>
<td>• High HIV prevalence has been attributed to high incidence (new infections) in the younger age group (15-19 years).</td>
</tr>
<tr>
<td>• Most studies in Malawi indicate low comprehensive knowledge of methods of protection against HIV among young people and low condom use.</td>
</tr>
<tr>
<td>• Only 6.8% and 17.2% of young males and females aged 15-19 respectively ever tested and received result by 2005</td>
</tr>
</tbody>
</table>

Source 1, 2 and 3

2. FACTORS THAT IMPACT ON YOUNG PEOPLE’S RISK OF ACQUIRING HIV

RISK FACTORS AND PROTECTIVE FACTORS

There are factors in every society that have an effect on how people behave. Some of these factors relate to the person as an individual (e.g. age, sex, knowledge, attitude, behaviour and practice (KABP)). Other factors, known as contextual factors, relate to the social and environmental context or situation in which the individual lives. Contextual influences include peers, teachers, family and community, as well as poverty, civil unrest, the legal system, and the values and norms in the broader society. Most risk and protective factors are a mix of individual and contextual influences.

Risk factors include 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 include individual and contextual influences that discourage one or more behaviours leading to negative health outcomes or that encourage behaviours that prevent negative health outcomes. Protective factors can also lessen the likelihood of negative consequences from risk factors.
Scientific studies in young people show that the following risk factors are associated with an increase in the risk of becoming infected with HIV: (4)

- Increased age
- Commercial sex work
- Early age at becoming a commercial sex worker
- Commercial sex work in a brothel
- High numbers of sexual partners
- Current or past history of genital ulcer
- Unprotected anal sex
- Current or past history of STI
- Early age of sexual debut.

Protective factors that are statistically significant in avoiding HIV infection are:

- Regular use of condoms
- Usual partner circumcised
- Reduced number of sexual partners.

Other studies have identified protective factors that help young people avoid behaviours that put them at risk of HIV (5). These include:

- 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.

The term "risk groups" is no longer used because it can give the impression that these groups are to blame for HIV. Also "risk groups" often do not have a clear identity.

VULNERABILITY TO HIV

**BOX 2**

For most young people, the important messages that will protect them from the risk of HIV are: delaying sexual debut, reducing the number of sexual partners, and using condoms correctly and consistently. Vulnerability is a measure of an individual’s or community’s inability to control their risk of HIV infection. Vulnerability recognizes that they may not have a choice as to whether they engage in behaviour that puts them at risk of acquiring HIV.

Vulnerability increases the likelihood of negative health outcomes. There are social and contextual risk factors that make many young people vulnerable to HIV infection. These include: gender norms, relations between different age groups, race and other social and cultural norms and value systems, location, and economic status.

Even when HIV infection rates are generalized in a country as is the case in Malawi, some groups within the population remain highly vulnerable. The concept of vulnerability
recognizes that they may not have a choice as to whether they engage in behaviour that puts them at risk of acquiring HIV.

Behaviour or situations that put young people at risk of HIV include:

- Having sex with older men
- Being sexually violated
- Working in the sex trade
- Living on the street
- Being a migrant worker
- Living without parental support
- Being orphaned as a child or affected by HIV
- Being caught in armed conflict.

Young people represent a large proportion of these highly vulnerable people and they may need special HIV strategies to be reached.

Studies show that many young people do not believe that HIV is a threat to them, and many others do not know how to protect themselves from HIV. They are vulnerable because they often do not know how HIV is transmitted or what they can do to protect themselves. Surveys from 40 countries indicate that more than 50% of young people have serious misconceptions about how HIV is transmitted. Many adolescents do not go to school, and do not have access to information about AIDS, or do not have the opportunities to develop the life skills that they need to turn this information into action. Frequently they do not have access to prevention services that take their specific needs into consideration. (5).

There is need to pay particular attention to preventing HIV infection of girls and young women, who, in some regions, are almost three times more likely to be infected than young men of the same age. The difference in infection levels between men and women is even greater among young people.

**BOX 3. GENDER AND HIV**

Gender can be understood as the social construct of masculinity and femininity. In many societies, what is considered masculine is more valued than feminine; so, opportunities are connected to each sex and a relation in which more power is given to men than women may be established.

When the primary mode of HIV infection is heterosexual, young women are the worst affected. Globally, approximately as many women as men suffer from HIV; however, there is a difference in the implications of the disease for men and women. Some of these result from biological differences in sex between men and women, but more result from socially defined gender differences.

In some societies, gender norms allow men and boys to have more sexual partners than women and girls. Society may also accept or encourage older men to have sexual relations with younger women. In combination with the biological factors, where heterosexual sex is the main mode of HIV transmission, infection rates are much higher among young women than among young men. Gender power imbalances, patterns of sexual networking, and age mixing are all important
Young women may remain ignorant of the facts of sexuality and HIV because they are not “supposed” to be sexually knowledgeable, while young men may remain ignorant because they are “supposed” to be sexually all-knowing.

Young women may want their partners to use condoms (or to abstain from sex altogether), but often lack the power to make them do so. 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). Healthcare workers have a role in developing programmes that empower women and girls and reduce their vulnerability and risks for HIV. These should be within comprehensive sexual and reproductive health strategies.

Societies also need to address issues that affect the vulnerability of boys and young men (e.g. sex workers, poverty, injecting drug use, negative attitudes to sexuality).

These factors of inequality are not easily altered but until they are, efforts to contain and reverse the HIV epidemic are unlikely to achieve sustained success.

Adapted from: [http://www.who.int/gender/hiv_aids/en/](http://www.who.int/gender/hiv_aids/en/)

### BIOLOGICAL SUSCEPTIBILITY

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

Young women may be especially susceptible to infection. A young girl of 14 years may have a higher risk of acquiring HIV than a woman of 30 years (even when exposed to the same situation and viral load) for the following reasons.

**a) Immature genital tract in young girls**

In young girls, inadequate mucosal defence mechanisms and the immature lining of the cervix provide a poor barrier against infection. Once exposed to the virus, girls and young women are more susceptible than young men or adults due to the anatomy of the developing cervix and vagina. Also in young girls, the thin lining and relatively low acidity in the vagina facilitate transmission.

**b) Undeveloped genitilia more easily damaged during forced sex**

Non-consensual sex with undeveloped genitalia can lead to trauma and therefore increase the chance of transmission if exposed to HIV. In some settings there is a high rate of coerced sex among young girls. In studies, many young women report that they were unwilling or coerced into their first sexual experience. Forced sex is always very traumatic. This is even more traumatic on developing genitalia, allowing for increased risk of infection through skin tears.
c) **STIs in sexually active young people**

STIs among sexually active people also increase their chance of contracting and transmitting HIV. The infected partner has heightened infectivity due to the shedding of more viral RNA in vaginal/seminal fluid. Herpes simplex virus (HSV) and genital ulcer disease (GUD) are STIs known to encourage the spread of HIV. Prevention of STIs and early, correct treatment are important components in HIV prevention strategy. The presence of 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%. (From: WHO 2001: *STIs Overview and Estimates*).

d) **Female genital mutilation**

Female genital mutilation can cause lasting damage to the genital area and can increase the risk of HIV transmission during intercourse. Use of the same instrument to carry out genital mutilation on several girls or circumcision on several boys without sterilization may also cause the spread of HIV.

3. **HIV PREVENTION STRATEGIES AMONG YOUNG PEOPLE**

HIV prevention is the key to reducing infection rates and slowing the epidemic. Young people between the ages of 15 and 24 are at the centre of HIV epidemics for transmission and impact. They are both the most threatened and the greatest hope for turning the tide against HIV, by changing attitudes and behaviours that contribute to the epidemics.

There is an urgent need for HIV prevention strategies that work for young people because:

- Nearly half of the global population is less than 25 years old.
- Of the new HIV infections annually, about 40% are among young people (aged 15-25 years).
- HIV prevalence among young people is rising rapidly in some countries.
- The future epidemic will be shaped by the action and behaviour of young people.
- A variety of factors place young people at the centre of HIV vulnerability.

It has been shown that young people can protect themselves and others if they receive support. The 2006 Report on the Global Aids Epidemic documents behaviour changes, including delays in first sexual experience, increasing use of condoms by young people, and resulting decreases in HIV prevalence in young people in some sub-Saharan countries.(6)

Health workers can use HIV prevention as an entry point for developing a broader youth health and development agenda because many other problems are linked to HIV in terms of cause and effect, e.g. too early pregnancy, alcohol, drugs and domestic violence.
Aims of HIV prevention

- To prevent transmission of HIV for all people who are HIV-negative or HIV-positive (whether they know their status or not) in order to reduce the number of new infections.
- To help people who are HIV-negative (whether they know their status or not) to stay negative.
- To promote testing and counselling for people who do not know their HIV status.

Young people need the information and the 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, safer sex, negotiation and correct use of condoms, and the importance of sterile needles and syringes) to be able to opt for healthy 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 situation and circumstances.

Young people everywhere report that the education they receive about HIV and sexual reproductive health is too little and too late. Adults are often hesitant to provide young people with the facts about HIV prevention and sexual health, often because they fear this will encourage sexual activity. But there is compelling evidence from studies conducted around the world and in many different cultures that, in fact, sex education encourages responsibility. Knowledgeable young people tend to postpone intercourse or, if they do have sex, to use condoms.

Studies show that sex education does not lead to increases in sexual activity, pregnancy rates or rates of STI. Some studies show that HIV sexual education can delay the onset of sexual activity, reduces the number of sexual partners, or reduces unplanned pregnancy and STI rates. (7)

The most significant services for the prevention and care of HIV among young people are those that:

- Strengthen the ability of young people to avoid infection, including information and counselling interventions.
- Reduce risks by providing condoms for those who sexually active
- Provide diagnosis, treatment and care for sexually transmitted infections and for HIV and AIDS. (8)
4. WHO HAS A ROLE IN HIV PREVENTION?

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

1. Young People

HIV prevention must focus on young people because they have an essential role in slowing the epidemic. Many young people listen to and believe their peers, so that peer educators and counsellors have an essential role in HIV prevention among young people. Young people can be trained to spread messages and promote responsible behaviour among their friends and colleagues.

2. Parents and Other Adults in the Community

All adults have a role to play in their personal capacity as parents, members of extended families and as adult role models. They may also have a professional role as teachers, sports coaches and religious leaders. Studies have identified that having a positive relationship with parents, teachers and other adults in the community and having spiritual beliefs help adolescents to avoid behaviour that puts them at risk of HIV.

Health workers in all departments of the health service have a critical role in developing and providing HIV prevention services to ensure that effective health strategies are available for all young people.

There are some young people who have a higher risk of HIV exposure. People in the community need to be trained, given support and provided with the tools to work with young people who are most at-risk. Targeted strategies must be available that focus on their needs. (E.g. information on safer sex and free condoms for young sex workers, and outreach information programmes for out-of-school youth).

3. Public Idols who are Role Models for Young People

Musicians, film stars and sports figures provide role models for young people through their personal lives and through their performances. The images and messages they portray should encourage young people to adopt and maintain healthy behaviours.

4. Government Leaders and the Media

Politicians, journalists and bureaucrats can influence the social, economic, political and normative factors that determine the HIV risk in the environments where young people live and work. There are policies and strategies (e.g. free schooling for boys and girls) that can reduce the vulnerability of young people to HIV. The public image of sexuality and HIV in the media also influences young people. There is a need for codes of practice, regulations and education of the media to ensure that they carry out responsible advertising and programming.
5. People Living with HIV (PLHIV)

PLHIV 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 to have a role as a supporter or an activist for other PLHIV, as an educator or speaker on living with HIV, as an advocate for the rights of PLHIV or other public or community roles. People living with HIV are frequently subject to discrimination and human rights abuses. A strong movement of PLHIV can develop a network that provides mutual support and a voice at local and national levels and can be a particularly effective method of tackling HIV stigma.

5. KEY HIV PREVENTION STRATEGIES FOR YOUNG PEOPLE THROUGH HEALTH SERVICES

HIV prevention services must be offered to young people when they attend every department of the health services (tuberculosis clinics, STI clinics, ante-natal clinic, family planning clinic, and sexual and reproductive health clinics 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 but need to be adapted to the different needs of many young people (e.g. boys and girls, children in and out of school, younger and older adolescents, and married and unmarried young people).

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 the 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, they do not only want to hear 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 at all health services and in the community. In some settings, health workers have held group counselling sessions with young people – PLHIV, HIV-negative or unknown status – to discuss difficult situations in living with HIV and HIV prevention. This method creates a good dynamic because the group looks for solutions to situations, taking the focus away from the individual. This method has been used both for giving information on sexuality and HIV and also for opening the discussion on many sensitive issues faced by young people (e.g. peer pressure, condom negotiation, unwanted pregnancy, decision-making, how to be an adult, disclosure of HIV status).
3. **Access to male and female condoms**

The use of latex condoms to prevent the exchange of body fluids during sex is an essential element of all HIV prevention. Safer sex depends on the correct and consistent use of condoms, so condom provision must be accompanied by clear instructions on condom use for every act of penetrative sex. Female condoms offer women an option that may give them more control but they also require more counselling and assistance with respect to their proper use; they are also more expensive and less available. Condom promotion also supports dual protection, i.e. the simultaneous protection against unwanted pregnancy and the possible transmission of STIs/HIV by either the consistent use of condoms or the consistent use of condoms with another method of contraception.

4. **STI management**

STIs greatly facilitate HIV transmission and acquisition 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 3B. Sexually Transmitted Infections and Young People*
6. 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 what is happening in your community, the risk and protective factors in their lives, where transmission may be occurring, and what they identify as their needs 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?

Look for what you could do. Start small. Learn from what has been done elsewhere. Look for support from young people, other professionals and community members. You can begin 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?

HIV and young people raise many sensitive issues around sexuality and sex. Health workers, young people and community members often feel uncomfortable discussing and addressing these sensitive issues. If health workers are to work successfully with HIV and young people, it is important for them to examine their attitudes and practices and reflect on the material in the Orientation Programme. There is discrimination towards PLHIV 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, attitudes of personnel, lack of confidentiality or privacy, etc.).

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 life styles of the affected young people. All health workers have a responsibility to act with respect, professionalism and proper procedures towards all people, including PLHIV. Talk with others about what you have learnt 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. Who else do I need to work with?

Contact people who are already working with HIV and young people in your community or region and learn from their experiences (youth groups, nongovernmental organizations, health professionals, teachers, peer support groups, community leaders, etc.). Identify difficult areas of 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 with these issues for support and for sharing
information. Plan together, so that the strategies and HIV prevention messages that youth hear and see are consistent and complementary.

7. HIV TESTING AND COUNSELLING FOR YOUNG PEOPLE

The current concept of HIV testing and counselling has been broadened from making these available to those who ask for it at, for example, Voluntary Counselling and Testing (VCT) sites, to provider-initiated HIV testing and counselling (PITC). In all testing and counselling situations the patient always retains the right to refuse.

In the PITC approach, each encounter between a client/patient and a health worker is seen as an opportunity for:

- people who have never been tested (or were previously negative) to know their current status;
- people to discuss options and make choices according to their status;
- Health workers to provide the best care and prevention according to the patient’s HIV status.

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

HIV testing must only be offered with the 4 Cs: Confidentiality, informed Consent, Counselling and Condoms.

Importance of HIV testing and counselling for young people

Knowing one’s HIV status

1. Knowing their HIV status and receiving counselling and support can enable individuals to:

(a) **Initiate or maintain behaviours to prevent acquiring or transmitting HIV**

Learning about one’s HIV serostatus, with counselling support, can be a time when young people are open to making changes in their risk behaviour. This empowers those who are not infected to remain so, and those with HIV to access care and prevent further transmission. Correct and consistent condom use must be actively promoted by all testing and counselling services. Group counselling of young people can be a way of discussing difficult situations with HIV and the benefits of testing, and taking the focus away from the individual.

(b) **Gain early access to specific HIV-positive prevention, support, care and treatment**

Young PLHIV will probably remain asymptomatic for a long period after a positive-HIV test result. They can benefit from the scaling up of antiretroviral therapy only if they know their HIV status. The earlier they know that they are HIV-positive, the sooner they can receive counselling and support and reduce the risk of transmitting HIV, thus protecting themselves, their partners and their loved ones.
(c) Access strategies to prevent transmission from mothers to their infants

In some settings, mother and child health (MCH) clinics can offer HIV testing and counselling and antiretroviral drug regimens to prevent mother-to-child transmission (PMTCT). However, globally only a small proportion of pregnant women have access to these services.

2. Knowing their HIV status and receiving counselling and support can help communities to:

(d) Reduce the denial, stigma and discrimination that surround HIV

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

(e) Mobilize support and appropriate responses

Community mobilization 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. However, we may only reach this level in high prevalence settings.

All people, including young people, have a right to know their HIV status. However, any coercion to get tested must be strictly avoided.

Special considerations in HIV testing and counselling among young people

(a) Do not discount the potential for HIV in young people

It is important that health workers look for the possibility of HIV infection among young people because a large number of them are particularly vulnerable. Health workers should therefore encourage them to consider being tested. Even if they don’t want the test immediately, they must be invited to come back when they are ready and meanwhile be provided with links to other support services in the community. Young PLHIV will have a long asymptomatic period when early diagnosis is rare without an HIV test, and to assume there is an infection is difficult.

(b) Understand the issues of consent and confidentiality in HIV testing and counselling of minors

As with any patient, consent and confidentiality are important considerations with underage young people (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/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 the 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 their consent.

In some cases, allowances are made for groups of adolescents who are designated “mature” or “emancipated” minors (e.g. those who are married, sexually active or are pregnant) to provide consent for themselves for some services.

Each situation is different and an assessment should be made of the young person’s risk for HIV and the possibility that he/she will not return for testing. HIV testing and counselling without parental consent should be considered, if appropriate; this should be documented in writing and possibly shared between two members of staff. There may be legal restrictions on performing an HIV test without the consent of a parent or guardian and this is a significant barrier in many settings to an adolescent being tested.

(c) Remember that your first meeting with a young person may be your only meeting

It is important to take advantage of the initial session with young persons, as it may be your only chance to communicate the importance of the reality of HIV and of living ‘safe’. Because they may not come back, make sure that they have educational materials and links to community services and peer support, where they can access further information and support at a later date.

Community links and referrals need to be checked out in advance, to ensure that they are legitimate. Keep the information in a resource file which you can access easily when you wish to refer young people. If possible, you can offer to accompany them to the support service. Also encourage them to return to see you. If support services do not exist, you can consider starting a support group.

(d) Promote beneficial disclosure

All PLHIV need support to cope with living positively. Support from family and close friends can be particularly important, but they can only access this support 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 to share their concerns and experiences, and counselling can help them as regards whom to tell and how to go about it.

However, health workers need to be aware that there is a risk in disclosing HIV status in an unsupportive setting, particularly for young women who may be at risk of domestic violence. Young people need a lot of support around issues of stigma and disclosure of HIV status, which may involve disclosing their sexual activity and injecting drug use. The final decision on disclosure stays with the young person.

(e) Take the opportunity given by a negative HIV test

An HIV negative test result provides 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 include distribution of condoms, as appropriate.
(f) Promote future counselling of client together with their sexual partner

Couple counselling can help to avoid the situation where 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), couple counselling can provide support to each partner to help them cope with the situation. However, there are situations where couple counselling is not possible.

(g) 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.

(h) 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.

Circumstances in which young people may present for HIV testing and counselling

There are different reasons and situations why a young person may come for testing and counselling.

(a) Choice: the young person makes the decision to come for testing

Young persons may have recently experienced a situation which makes them think they could have been at risk for acquiring HIV (e.g. rape, condom breakage, unprotected sex, first experience with injecting drug use). They may have a marker disease (e.g. tuberculosis) or an STI, or be on the brink of something new in their lives (e.g. marriage).

(b) Recommendation: another person advises, the young person decides

Provider-initiated HIV testing and counselling recommends that health workers offer this service during all routine contacts with patients in healthcare settings. The health worker may be following the health centre’s policy or guidelines. All people should be informed and give their consent and the patient always retains the right to refuse the test.

A health worker may have some reason to suspect that a young person could be HIV-positive, e.g. presence of a marker disease like tuberculosis. Having an STI increases the risk of acquiring and transmitting HIV, so a young person who has an STI or TB should be advised to be tested for HIV. Young people who are vulnerable to HIV (e.g. sex workers) should be counselled to be tested for HIV. Peer counsellors, outreach workers or youth counsellors may have to recommend that the young person comes for HIV testing.
(c) **Mandatory**: other persons/people make the decision to test the young person

Mandatory screening of donors is required prior to all procedures involving transfer of body fluids or body parts. There may be other reasons for HIV tests in various situations, e.g. entering the military, before marriage, and applying for a job, visa or scholarship. HIV tests may be carried out in healthcare settings without the patient knowing. Testing without counselling has little impact on behaviour and is a significant lost opportunity for assisting people to avoid acquiring or transmitting HIV.

**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.**

**For young people who refuse HIV testing, the health worker should:**

- counsel them on the benefits of testing;
- identify and discuss their barriers to testing;
- provide emotional support and refer them to peer counselling;
- re-assess their intention to test at a later date;
- offer a follow up appointment.
8. YOUNG PEOPLE LIVING WITH HIV

Management of HIV in young people includes a range of services that provide
a) care
b) treatment
c) support
d) positive prevention for young people living with HIV, and
e) Counselling, which is an integral part of all these services.

The aim of services is to help young PLHIV to:

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

2. Adhere to care and treatment
Young PLHIV may need to take medication for a range of infections and illnesses. Adolescents infected through perinatal transmission may have begun antiretroviral therapy (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), close friends
PLHIV may be hesitant to reveal their HIV status to others for fear of stigma and discrimination. In order to receive the support of family and friends, young PLHIV will need to face the difficult task of telling them of their HIV status. Adolescents who were 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 assisting young PLHIV to cope with how it can affect them, their families and their loved ones. Unfortunately, health centres are still a place where there is HIV stigma and discrimination against PLHIV. Young PLHIV should be involved in developing and planning of HIV support services. This can lead to improved utilization and ownership of services, as well as reduce the stigma and present a positive role model to healthcare workers and patients.
Young People and HIV Stigma and Discrimination

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

HIV-related discrimination results when actions differentiate between people based on stigma (e.g. a confirmed or suspected HIV serostatus). Persons associated in the public mind with HIV or AIDS (e.g. homosexuals, prostitutes, drug addicts, haemophiliacs, family members and associates of HIV-positive people) may also face discrimination.

HIV-related stigma, discrimination and human rights violations are serious barriers to progress in understanding HIV infection, to providing care, support and treatment, and to 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. This can be through actions or omissions to act and result in a violation 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—which are at the root of HIV-related stigma.

Factors which contribute to HIV-related stigma:

- HIV is a life-threatening disease.
- People are scared of contracting HIV.
- The disease is associated with behaviours (such as having many sexual partners), which are already stigmatized in many societies.
- People living with HIV are often thought of as having been responsible for becoming infected.
- 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 infected with HIV from obtaining needed services because this may reveal their HIV status.

5. Psychosocial issues especially pertinent to young people living with HIV

For most people, sexual activity begins during adolescence and, in general, sex is an important part of the lives of young people. Young PLHIV 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.

People who work with young PLHIV say that in general the following questions identify the young people’s 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 responses can help health workers to talk with young people about these issues.

**a. 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 PLHIV has sex without a condom. Always use a barrier to prevent contact with blood or sexual fluid. Condoms are the most common barrier 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. Using a condom will reduce the risk. Use condoms correctly and consistently every time you have sex. Although it is not easy, it is important to tell your partner you are HIV-positive before there is any risk of HIV transmission. Counselling and support from other young PLHIV can help you to understand your options for enjoying a healthy sexual life as a PLHIV.

**b. 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. You need to have access to sexual and reproductive services, including counselling to make you aware of your reproductive choices and the health risks for your unborn child, in order to make informed decisions. Couple counselling should be encouraged but an individual's situation may make this impossible and the health worker needs to support the young person's decision.

**c. 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 PLHIV will die earlier than they would without HIV.

Emotional and spiritual support can help 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 formal and informal individuals and settings. 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 PLHIV.

**d. I am too young to have a chronic disease**

Adolescence is a special time in peoples' lives. All people have dreams for the future and to learn that you must live with HIV is shocking news at any age. For young people it can be hard to imagine how they are going to live their whole lives with a chronic disease, when they feel that they have only just begun to live. All 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 in helping him/her to develop the perception that life can continue – and be meaningful – even in the presence of HIV infection. Health workers can also provide referral to peer support.
e. 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 their support to help them cope with living positively. They can also benefit from sharing their fears and concerns with other young PLHIV. However, young people will need encouragement and support to tell, and all concerned must be aware that there may be a risk in disclosing HIV status in unsupportive settings.

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

f. 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 people living with HIV 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 the 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 their future opportunities.

Young PLHIV 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 member, school officials, etc.) due to the possibility that disclosure may ruin their image, plaguing them with the stigma associated with HIV. 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.

g. Can I still smoke, drink, go out and have fun like my friends?

Young PLHIV 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 jeopardize their health.

Health workers should ask for permission before giving young persons 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 ARV drug 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 their medication.

Young PLHIV will need support on deciding whom (among their friends) to tell and how to tell about their HIV status.
6. Positive prevention

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

Improving the self-esteem and confidence of young PLHIV has many benefits at the individual, family and community level. Positive prevention recognizes the rights and needs of PLHIV and can empower them and help them to take charge of their lives and encourage them to take responsibility for preventing HIV transmission. Positive prevention is focused 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, impregnated bed nets, screening and chemoprophylaxis (e.g. co-trimoxazole and INH) for tuberculosis.

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

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

Positive prevention requires the meaningful involvement of young PLHIV in the planning and implementing of HIV strategies. Young PLHIV can work with service providers to make strategies relevant and useful to young people. They give a perspective that is unique and provide credibility and relevance to the local context. They also give a face to HIV. When programmes enlist young PLHIV and their organisations (where they exist), they become emissaries to the general community which can lead to increased awareness, decrease in stigma and discrimination, and an increase in the use of services.

CONCLUSION

Successful Approaches to working with Young People and 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.
- Youth-friendly health services offering HIV testing and counselling, and services for the diagnosis and treatment of sexually transmitted infections.
- Community-based programmes for young men and education of young women to tackle sexual coercion and other forms of violence.
- Sustained media campaigns using communications channels that young people find credible and acceptable to promote gender equitable norms and HIV prevention education.

Adapted from ref 9, 10
9. REFERENCES

4. Risk and Protective Factors Affecting Adolescent Reproductive Health in Developing Countries. WHO, 2004
### Spot check 1
Globally, what percentage of all new HIV infections per year is among young people? Please mark your estimate on the line below.

0%_________ 25% _________ 50%________ 75% _________100%

### Spot check 2
Risk factors that contribute to acquiring HIV among young people
Why are young people more likely to be exposed to HIV? List three reasons. Please write your answers in the lines below.

1. _______________________________________________________
2. _______________________________________________________
3. _______________________________________________________

### Spot check 3
HIV prevention measures among young people
Young people can prevent HIV by using the following strategies: Please fill in your answers in the spaces provided below.

1. _______________________________________________________
2. _______________________________________________________
3. _______________________________________________________
4. _______________________________________________________

### Spot check 4
Why are girls and young women biologically or culturally/socially vulnerable to HIV infection upon exposure? List five reasons.

1. _______________________________________________________
2. _______________________________________________________
3. _______________________________________________________
4. _______________________________________________________
5. _______________________________________________________

### Spot check 5
Importance of HIV testing and counseling for young people
Why is HIV testing and counseling important for young people? Mention four reasons.

1. _______________________________________________________
2. _______________________________________________________
3. _______________________________________________________
4. _______________________________________________________

### Spot check 6
What can be done to reduce HIV transmission among young people in service delivery point and in the community?

1. _______________________________________________________
2. _______________________________________________________
3. _______________________________________________________
4. _______________________________________________________
### Spot check 7  PMTCT
How confident do you feel about working with young people on the issues of HIV?

Uncomfortable  
Not very confident  
Confident  
Very confident

---

### Spot check 8  Circumstances for HIV testing
Mention three circumstances that would make a young person go for an HIV test

1. ___________________________________________________________
2. ___________________________________________________________
3. ___________________________________________________________
4. ___________________________________________________________

---

### Spot check 9  Positive living among young people
What constitutes HIV positive living?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

---

### Spot check 10  Interventions to prevent the HIV transmission in young people
Mention four HIV prevention strategies for young people. Write your responses in the spaces provided below.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
ANNEX 3G-2  CASE STUDIES

**CASE STUDY 1  SEXUALITY**

An 18-year-old HIV-positive man says he believes he was infected with HIV after engaging in unprotected sex with a female sex worker. It was his first sexual experience. He says he was pressured into doing it by his peers who said that he would gain experience and enter manhood through his first sexual encounter. Now he is interested in pursuing a relationship with a particular girl. He wants to have sex with her but is afraid because of his HIV status. What can you, as his health worker, suggest to him in this situation?

**CASE STUDY 2  FERTILITY**

A young woman of 16 years has been diagnosed as HIV-positive. She recently married a man who frequently travels to neighbouring towns for work. She never had sex prior to her marriage. In her culture, it is expected that she should bear many children for her family. She believes that her husband unknowingly acquired HIV after unprotected intercourse with sex workers in the neighbouring town. The health worker at the antenatal clinic told her that she should not get pregnant but she is distressed because she wants to have children. She comes to you for advice and help. What can you, as the health worker, do for her?
Handout for

Unit 4

Nutrition and young people
This handout provides information to complement the material on *Nutrition and Young People* which is covered in this unit. The facilitator may refer to this text and may also ask participants to refer to this section.

**THIS HANDBOOK PROVIDES INFORMATION ON THE FOLLOWING:**

1. Definition of the term `good nutrition` and its importance 154
2. Groups of food necessary for good nutrition 154
3. Linkage between nutrition and HIV 156
4. Consequences of poor nutrition among adolescents and young people 157
5. Promoting nutrition among young people 158
6. Summary 159
7. References 160

Annex 4-1 Spot Checks 161
1. DEFINITION AND IMPORTANCE OF GOOD NUTRITION

Nutrition is generally defined as how any living organism changes and uses food for life [1]. Food is anything that a person eats or drinks. This means that the first thing a person has to do is to have food, and then have the appetite to eat it. It is from this food and drink that we get nutrients, the part of the food that an organism, individual must have for life and health. Hence Good Nutrition means that the foods and drinks you are eating are providing you with the nutrients you need for life and health [1].

It is important to ask ourselves, how can we make young people eat better and achieve good nutrition? This question should drive us in coming up with responses as to what is the importance of good nutrition. There are two most important reasons as to why we need good nutrition among young people.

Maintaining good health

Healthy eating or good nutrition contributes to overall growth and development. This includes healthy bones, skin, and lowered risk of dental caries, eating disorders, constipation, malnutrition and also iron deficiency. Good nutrition maintains energy levels, immunity, good development of body cells and keeps people in good shape. Poor nutrition in young people has resulted in obesity (overweight). This problem is more common among adolescents aged 12-19.

Prevention from infections

Body immunity of most adolescents and young people is still fragile. Poor nutrition facilitates risk to development of infections that will take advantage of the body being weak due to inadequate nutrition.

According to the 2004 MDHS, 48% of children under 5 years were stunted, too short for their age, 5% are wasted or too thin, and 22% are underweight. Worse still 22% of children are severely stunted. Stunted growth of children is an indicator of under nutrition and is typical of poor nutrition [2]. Poor nutrition makes children, adolescent susceptible to infections. However, with good nutrition the trend is reversed. Good nutrition is a protective factor against infections.

2. GROUPS OF FOOD NECESSARY FOR GOOD NUTRITION

It is very important that young people maintains a balanced diet in their everyday dietary intake. In a balanced diet each food group has got a specific role it plays and as such maintains good health.

According to the ministry of health and department of nutrition, Malawi has 6 groups of food that are essential to maintain good health. These groups of food should be encouraged among young people regardless of their socioeconomic status. The core principle to ensure that every young person in Malawi maintains the balanced diet is to promote cheap locally available foods in each group so that people do not strain to maintain a balanced diet.
The figure below summarizes the six groups of food that constitute a balanced diet and what role each group plays in the body.

<table>
<thead>
<tr>
<th>Group</th>
<th>Main Nutrient</th>
<th>Examples of foods</th>
<th>Their role in the body</th>
</tr>
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</table>
| Vegetables             | Vitamins and Minerals                   | Greens: Bonongwe, Chisoso, luni  
Fruits: Pumpkin, Tomatoes, peppers  
Roots: onion, garlic  
Mushrooms  
Flowers: Pumpkin flowers | Fights infections                                              |
| Fruits                 | Carbohydrates and Vitamins (water and fiber) | Sweet or tangy fruits that are often eaten raw  
Fruits: (Except for ones in the fat group or the vegetable group)  
Papaya, Guava, Lemon, Tangerine, Banana, Mchisu, Grenadilla  
Honey and Sugar Cane  
(These provide vitamins and carbohydrates) | Aids in food digestion                                      |
| Legumes and Nuts       | Protein and Carbohydrates (Minerals, Vitamins, Fiber, Fat) | Legumes are seeds in a pod:  
Beans and Peas: Hyacinth bean (khungudzu), groundbeans (Nzama), Soybeans, pigeon pea (Nandolo), Peas (Nsawawa), Mucuna (kalongonda), Nuts: Mtedza | Body maintenance  
Muscle and tissue development |
| From food animals      | Protein and Fat (Minerals and Vitamins) | Flesh, Blood: Mice, Chicken, Pigeon, Pig, Goat, Fish, Ngumbi (termites), 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 seed, | Energy giving foods                                |
**sesame seed, Sunflower seeds, Cooking Oils Fruits: Avocado pear, Coconut flesh Animal Fats: Butter, Lard**

| 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 |

### 3. LINKAGE BETWEEN NUTRITION AND HIV AND AIDS

Research has shown that there is an important link between improved HIV and AIDS outcomes and nutrition. Adequate nutrition is necessary to maintain the immune system, manage opportunistic infections, optimize response to medical treatment, sustain health levels of physical activity, and support optimal quality of life for People Living with HIV (PLHIV) and Young people living with HIV (YPLHIV), [3]. HIV weakens the body’s immune system considerably. However the food we eat contributes to production of antibodies, energy that help to keep us strong. As such we are able to withstand and have better health outcomes when we are HIV positive with good nutrition.

It is reported that good nutrition may contribute to slowing of the progression of the HIV disease [4]. This is why it is very important to ensure that PLHIV have got enough food if we are to improve their health outcomes.

Again the broader relationship and interactions between HIV, AIDS, food security and nutrition are also complex. Food insecurity and poverty may lead to high-risk sexual behaviors thus increasing the risk of acquiring HIV. With high poverty levels among young people in Malawi and with over 85% of them living in the rural areas, poor nutrition in YPLHIV is a major concern. YPLHIV are at a greater risk of food insecurity due to muscle weakness that makes them unable to work in their gardens. It is particularly important to emphasize the importance of good nutrition in adolescents and especially YPLHIV. Postponing interventions until PLHIV or their families become malnourished or food insecure can be counterproductive and costly. Thus, maintaining adequate nutrition and food security can be instrumental in mitigating the impact of HIV and caring for PLHIVs, their affected households, and communities [5].

The emergence of HIV and AIDS has made people to refocus once more on the role of nutrition in maintaining a healthy life in relation to the impact of HIV and AIDS on nutrition. Young people living with HIV (YPLHIV), needs to pay special attention on their diet. In promoting positive living among YPLHIV, good nutrition is at the centre of this puzzle.
4. CONSEQUENCES OF POOR NUTRITION

Poor food intake that is not balanced has got over arching effects among young people in Malawi. The consequences of unbalanced diet and poor nutrition has been highly observed from childhood, early adolescence and adulthood. These consequences include:

**Obesity**

Refers to more than 20% above the height and weight standards [6]. Some of the predisposing factors to obesity include high intake of fatty foods, unregulated intake of carbohydrates.

**Increased risk of diabetes**

Diabetes Mellitus (DM) is a complex chronic disease involving disorders in carbohydrate, protein and fat metabolism and the development of macrovascular, microvascular and neurologic complications [6]. Common signs and symptoms of DM include dehydration, flushed face, nausea and vomiting, fruity breath odor, lethargy among others.

**High blood pressure**

High blood pressure or hypertension can be defined as a consistent systolic blood pressure of more than 140mmHg and or a consistent diastolic blood pressure of more than 90mmHg. One of the risk factors in developing hypertension is high salt diet, obesity, alcohol intake and also emotional stress [6].

**Joint problems (Gout)**

Gout is a metabolic disorder that causes extreme pain, swelling and erythema of the involved joints. Prolonged hyperuricaemia (elevated uric acid) caused by either in synthesizing purines or by poor renal excretion of uric acid [6]. Unregulated intake of excess proteins is a risk factor.

**Other consequences include:**

- Poor health status
- Underdevelopment (Malnutrition)
- High risk of progression of HIV to disease
- Poor wound healing
- Increased prone to infections
- Poor cognitive development
- Bone malformation
- Dental problems
- Skin problems
5. PROMOTION OF GOOD NUTRITION

It is very important that young people and the general public know what basic guidelines they can use to promote good nutrition. Malawi as a country do not have standardized institution that people can go to and get advice on good nutrition. Hospitals, health centers are probably the only place young people can access counseling on good nutrition. However YFH centers and service providers need to know the basic strategies they can reach out to young people and the general public to counsel them on good nutrition. These guidelines [6] could provide the basic elements important to maintain good nutrition.

**Eat a variety of foods**

In eating a variety of foods, one is more likely to have taken all the necessary nutrients important to maintain a balanced diet. These foods include carbohydrates, proteins, minerals, vitamins, fat and water [6]. In Malawi, eating the 6 groups of food, one is rest assured that he or she is taking a balanced diet and thus promoting good nutrition and preventing disorders arising from poor nutrition.

**Maintain ideal weight**

Increased weight more than necessary as in the case of obesity has been shown that it is a risk factor to nutrition disorders such as hypertension. Under nutrition will entail that the person is less than the required weight in relation to his height, age and weight. Under nutrition predisposes people to infections as the body’s immune system is also compromised. It is easier in Malawi for young people to maintain their ideal weights if they eat locally cheap available foods containing all the 6 groups.

**Avoid too much fat, saturated fats and cholesterol**

Research has demonstrated that there is an association between dietary fat and the incidence of breast cancers, colon, rectum and prostate [7]. However we need fat in our bodies to keep us healthy and have energy. Regulation of how much fat we take could help in reducing incidence of these fatal cancers.

**Eat food with adequate starch and fiber**

Our bodies need adequate starch as starch is a good source of carbohydrate which is very important for energy giving. Fiber is important as it contains cellulose which aids in stimulating peristalsis. Dietary fiber is therefore very important in promoting normal bowel elimination and to decrease dietary cholesterol absorption [6]. Again high intake of dietary fiber has an inverse effect on the risk of colon cancer [7].

**Avoid too much sugar**

Young people and the general public need to avoid intake of too much sugars. Too much intake of sugars is a risk factor to dental caries. Again excess supply of sugars add to calorie intake without supplying nutrients.
Avoid too much sodium

High intake of sodium major electrolyte in the body can affect blood pressure levels. Decreased intake of sodium is associated with decreased blood pressure in people with hypertension.

Reduce intake of alcohol (do so in moderation)

Alcohol is high in calories but less in nutrients. It is very common that young people and the public who drink a lot of alcohol they most of the times do not eat balanced diets as such they are prone to malnutrition and other health risks. Again there is evidence that increased alcohol intake is associated with road traffic accidents.

SUMMARY

- **Good Nutrition** means that the foods and drinks you are eating are providing you with the nutrients you need for life and health
- Nutrition has got a direct link with HIV and AIDS. Adequate nutrition is necessary to maintain the immune system, manage opportunistic infections, optimize response to medical treatment, sustain health levels of physical activity, and support optimal quality of life for People Living with HIV (PLHIV) and Young people living with HIV (YPLHIV).
- Poor nutrition will lead to negative health consequences that will include malnutrition, hypertension, diabetes and more.
- A recommended dietary guideline include: eating a variety of foods, avoid too much sugar, eat foods with adequate starch and fiber, avoid too much sodium, reduce alcohol intake, maintain ideal weight and avoid too much fat, saturated fats and cholesterol.
REFERENCES

### ANNEX 4-1: NUTRITION AND YOUNG PEOPLE - SPOT CHECKS

<table>
<thead>
<tr>
<th>Spot Check 1: Importance of good nutrition</th>
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<tbody>
<tr>
<td>What is the definition and importance of good nutrition among young people in Malawi?</td>
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<tr>
<th>Spot Check 2: Consequences of good nutrition</th>
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<td>What effects would you see among young people with poor nutrition?</td>
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<th>Spot Check 3: Linkage of Nutrition and HIV</th>
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<tbody>
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<td>Discuss that the link that is there between HIV and nutrition</td>
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<th>Spot Check 4: Promotion of nutrition</th>
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<td>How would you advise a young person on how they can promote their nutrition?</td>
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Handout for

Unit 5

Substance abuse and young people
This handout provides information to complement the material on *substance abuse among young people*. The facilitator may refer to this session and ask participants to pre-read and refer to the handouts for additional information.

**THIS HANDOUT PROVIDES INFORMATION ON THE FOLLOWING:**

1. Definition of substance abuse  
   164  
2. Why young people abuse substances in Malawi  
   164  
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1. DEFINITION OF SUBSTANCE ABUSE

Most young people in Malawi mislead themselves by saying that they need drugs and alcohol to be a winner, to enjoy, to study and also to remove shyness. In Malawi, like the whole world, the most commonly abused substance is alcohol.

- Substance abuse has been defined differently in different literature. However the following definitions apply:
  - Drug - Substance used as medicine. Substance that stimulates the nervous system especially one that is addictive
  - Abuse - A maladaptive pattern of substance use leading to problems in psychosocial, biologic, cognitive/perceptual or spiritual/belief dimensions of life [1]. It is the excess use or wrong use of something.
  - Substance abuse - It is the excessive use of chemical substance to alter or modify behavior

2. WHY YOUNG PEOPLE MISUSE DRUGS IN MALAWI

Most young people in Malawi misuse drugs for various reasons. Some of the reasons as to why young people misuse and use drugs include:

- Peer pressure
- Easy to get
- To seek peer approval
- Rapid social changes
- Stress and anxiety
- To deaden pain
- To help stay awake when studying
- Emotionally deprived and lonely
- Frustrations
- Rejection by parents
- Easy availability of the drugs
- Idleness - boredom
- Lack of knowledge about the dangers of drug use
- Poverty
- Over- indulged - have too much cash
- Curiosity - experiment with drugs
- Some religious beliefs such as Rastafarian movement extol the virtues of cannabis
- Exercise of their democratic rights
- Breakdown of cultural values
- To take away shyness
3. MYTHS AND MISCONCEPTIONS ON SUBSTANCE ABUSE

There are a lot of myths and misconceptions about substance abuse in Malawi commonly circulating among adolescents and young people. These myths and misconceptions have perpetuated substance abuse among young people. See Table below:

<table>
<thead>
<tr>
<th>Item</th>
<th>Myth</th>
<th>Fact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Alcoholism is a disease that is difficult to cure</td>
<td>Alcoholism is a disease that responds to treatment, which includes eliminating all alcohol consumption and psychosocial counseling</td>
</tr>
<tr>
<td>2</td>
<td>Alcohol and chamba are the only drugs used by young people</td>
<td>Alcohol and chamba are not the only abused drugs in Malawi. Other drugs include tobacco, mandrax, glue, cocaine, heroin, petrol</td>
</tr>
<tr>
<td>3</td>
<td>Alcohol is not a drug. It is just an addictive substance</td>
<td>Alcohol is both a drug and an addictive substance. It affects the mind and body</td>
</tr>
<tr>
<td>4</td>
<td>Drinking alcohol among young people is hereditary</td>
<td>Most young people are initiated into drug and alcohol use by their peers</td>
</tr>
<tr>
<td>5</td>
<td>Driving after using chamba is as dangerous as drinking after drinking alcohol</td>
<td>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.</td>
</tr>
<tr>
<td>6</td>
<td>It is rare for a teenager to be alcoholic</td>
<td>Many youth abuse alcohol and many of them are addicted</td>
</tr>
<tr>
<td>7</td>
<td>Cigarette smoking is fashionable and not addictive</td>
<td>Cigarettes contain nicotine which is addictive. Cigarette smoking is harmful to your health. It has been found that smoking is associated with lung cancer. It is especially more dangerous for pregnant women to smoke because it affects the lungs and breathing of the fetus as well as the development of the brain.</td>
</tr>
<tr>
<td>8</td>
<td>Alcohol and drugs help young people handle their problems better</td>
<td>Alcohol and drugs make young people temporarily forget about their problem. Their problems do not however go away</td>
</tr>
<tr>
<td>9</td>
<td>Substances like glue (inhalants) are basically harmless even though adults make a big deal about them</td>
<td>Substances like glue or petrol can be extremely dangerous. Unlike most drugs, inhalants can cause permanent damage to organs like the liver or brain.</td>
</tr>
<tr>
<td>10</td>
<td>A cup of coffee and a cold</td>
<td>Drinking coffee and a cold shower will not hold you sleepy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Alcohol is a sexual stimulant</td>
<td>Alcohol like cocaine and other drugs, can actually depress a person's sexual response. The drug may lessen inhibition with a sexual partner but it causes problems such as inability to have erection, loss of sexual feeling or inability to have an orgasm.</td>
</tr>
<tr>
<td>12</td>
<td>When people stop smoking cigarettes, they cannot reverse some of the damage to the body.</td>
<td>If there is no permanent heart or lung damage, the body begins to heal itself when a person stops smoking.</td>
</tr>
<tr>
<td>13</td>
<td>Cigarette smoking every now and then is not harmful i.e. once a week</td>
<td>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 quick. People who smoke for any period of time have a greater risk of cancer and other lung diseases, cancer of tongue and throat and heart diseases.</td>
</tr>
<tr>
<td>14</td>
<td>Chamba is not harmful it helps adolescents and young people to study, to remove shyness, to be strong/powerful and become intelligent</td>
<td>Chamba has long-term effects such as decrease in motivation, memory loss, damage in coordination, impaired judgment, damage to the reproductive system and throat and lung irritation.</td>
</tr>
</tbody>
</table>

*Ref: Drug and alcohol abuse prevention among young people leaflet (FORUT and MAGGA)*
4. MOST COMMONLY ABUSED SUBSTANCES AMONG YOUNG PEOPLE IN MALAWI

The most commonly abused substances by young people in Malawi and their effects are:

<table>
<thead>
<tr>
<th>Drug and substance</th>
<th>Explanatory notes</th>
<th>Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Alcohol is a depressant drug with the potential to destroy health if taken in excess. Commonly abused substance among adolescents and young people in Malawi.</td>
<td>Euphoria (exaggerated feeling of wellbeing) Intoxication. Ataxia (staggering gait). Over consumption causes death, beat ups in homes, unplanned sexual encounters. Causes inflammation of the liver (liver cirrhosis). It drains more money from the individual and family. Speech is slurred. The mind tends to be clouded i.e ones ability to perform tasks is reduced. Could lead to head trauma. Nutritional deficiency.</td>
</tr>
<tr>
<td>Cigarettes</td>
<td>Mostly used by young people. Tobacco contains nicotine, a drug that is more addictive. Nicotine is a tranquilizer and is found in cigarettes.</td>
<td>If used over a long period of time it causes lung cancer and heart attacks.</td>
</tr>
<tr>
<td>Chamba (Marijuana, fodya wamkulu, Malawi Gold, Ganja, Jah, Kanundu, Nanzi, Weed).</td>
<td>It is a dried plant material from a plant called cannabis sativa. It is known with different names among young people in various parts of the country as shown.</td>
<td>Irritation of throat. Dryness of the mouth. Blood shot eyes. Increased appetite for food. Drowsiness. Disruption of thought and speech. Addictions. Untidiness. Knee jerk reflex.</td>
</tr>
<tr>
<td><strong>Sedatives</strong> (sleeping drugs)</td>
<td>Commonly referred to as sleeping tablets that are manufactured for medical use. Meant to reduce tension and anxiety.</td>
<td>Ability to trigger suicidal thoughts. Increase in dosage would result in overdependence.</td>
</tr>
</tbody>
</table>
and induce sleep  
Mostly sold at the black market

*Adapted from the Life Planning Skills Manual for Malawi*

Other commonly used drugs and substances in other countries (USA, UK, South Africa and elsewhere):

<table>
<thead>
<tr>
<th>Drug and substance</th>
<th>Explanatory notes</th>
<th>Effects</th>
</tr>
</thead>
</table>
| **Opium**          | Extract of poppy plant  
It is either smoked or pounded into powdered | Drowsiness  
It lowers rate of breathing and action of the heart |
| **Heroin** (popularly known as the killer drug) | An extraction from opium | Deep long sleep after injection  
Very addictive and produces psychological and physical breakdown  
Easy contracting of HIV through sharing of needles  
Leads to theft, violence and prostitution  
Overdose leads to death |
| **Cocaine**        | Expensive white powder extract from Coca shrub  
It is either sniffed or smoked as crack.  
Powerful drug producing exhilaration and indifference to pain or fatigue | Fatigue  
Depression  
Psychological dependence |
| **Glue Sniffing**  | Commonly used glue solvents and aerosol propellents  
When inhaled, it produces similar effect to short lived alcoholic drunkenness. | Gases squirted directly can cause suffocation and heart failure  
Hangover and loss of concentration |
| **Steroids**       | Anabolic steroids increase muscle size and male aggression  
They are a temptation to those heavily committed to perform sports  
Easily obtained in many private gymnasiums | Can restrict normal development in young people and women  
Reduces sex drive |
| **Barbiturates**   | Common painkillers found in homes i.e ibuprofen  
Overdose lead to death and | Physical dependence is common and sudden withdrawal is fatal |
| commonly used for suicide | Used to reduce stress and in some cases taken in suicide attempts |
5. PREVENTION OF SUBSTANCE ABUSE

Realizing how common abuse of substances among young people has become, the risks associated with it are enormous. Using evidence based strategies to prevent substance abuse is a key element in the fight against substance abuse.

**Role of young people**

Young people need to understand that they are at the centre of substance abuse and that they need to take responsibility to minimize the abuse of the harmful substances. Young people need to be given adequate information on the consequences of drug and substance abuse and the far reaching effects it has on their physical, mental and physiological wellbeing. Training peer educators to train their colleagues on substance abuse will facilitate knowledge uptake as their peers are a preferred source of information. It is very important that young people realizes that they need to take a leading role in discussing use of harmful substances with their peers. Again training them in life skills to withstand pressure from peers and make their own decisions is very critical.

**Role of guardians and parent**

Available literature in Malawi indicates that parents are also a preferred source of information and young people prefers to get information from them. They trust what parents and guardians tell them on issues affecting them. Parents and guardians need to utilize this comparative advantage to reach out to young people with understanding and empathetically.

**Information, Education and Communication**

Information on the harmful substances being abused need to be made available as much as possible. Young people need to understand the dangers of the substances they are abusing if they are to make decisions to change their behaviors. Communication through leaflets, brochures, print and electronic media need to stress the dangers of these harmful substances. There is need to make sure that service providers have adequate knowledge of substances that are frequently abused by young people and their consequences so that they can provide correct messages to them.

**Community mobilization**

The community needs to be mobilized and educated to strengthen their role in challenging young peoples abuse of harmful substances. The community is also supposed to report to relevant authorities i.e police, of people that are promoting use of harmful substances among young people. Providing correct information on the available harmful substances in each community, their consequences if they are abused by young people, will ensure that the community takes a leading role in safeguarding and preventing young people to use these harmful substances.
Life Skills Education

Life skills education in schools is an available opportunity in reaching to young people with information on substance abuse. Since life skills education is taught in all schools and substance abuse is one of the topics, there is need to emphasize this opportunity to young people who are still in and out of school. Again life skills will strengthen capacity of adolescents and young people in learning how best to stand peer pressure, be assertive, make informed choices so that they are not easily coerced to in using harmful substances.

Guidance and Counseling

Provision of guidance and counseling to young people at risk of substance abuse is very important. This will help them to know what are the pros and cons if young people abuse drugs. It will also help them to get important information that will help them make informed choices for what they are about to do. Counseling will also help young people who are using and abusing drugs to get over this bad behavior.

Policy advocacy and strengthening of ban of young people (especially under aged in clubs and bars) in purchasing drugs i.e alcohol, beer, cigarettes, chamba

Parents, organizations, young people, have got a role to play in advocating for a ban on young people purchasing drugs that could lead to mental illness and other negative consequences. The government of Malawi need to reinforce the law that do not allow young people less than 18years to enter clubs and bars. Club owners have got a responsibility to report and bar under aged in such places. Strengthening this policy would help to keep under aged young people away from drugs thereby aid in reduction of substance abuse among young people.

SUMMARY

- Alcohol and substance abuse are very prevalent in Malawi
- Alcohol is the most commonly abused substance in Malawi. This is partly due to weak reinforcements of laws prohibiting young adolescents to take alcohol
- Most young people and adolescents abuse alcohol and drugs i.e chamba because of peer pressure, lack of parental guidance, frustrations, to remove shyness among others
- There is need to strongly refute and dispel myths surrounding alcohol and abuse of other drugs by young people
- Substance abuse among young people could lead to mental illness i.e depression, anxiety and stress, psychosis, drop out in school, unsafe sex due to intoxication among others
- Life skill education, role of parents, young people themselves is very important to successfully reduce abuse of drugs and alcohol
REFERENCES

### ANNEX 5-1: SUBSTANCE ABUSE AND YOUNG PEOPLE

#### Spot Check 1: Definition of Substance Abuse

What do you understand by substance abuse?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

#### Spot Check 2: Why do young people misuse drugs in Malawi

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

#### Spot Check 3: Most commonly abused substances in Malawi

Brainstorm the most commonest abused substances in Malawi and their effects.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

#### Spot Check 4: Myths and misconceptions on substance abuse

From the common myths that you can brainstorm, what would you tell young people about the truths of those myths?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

#### Spot Check 5: Prevention of substance abuse

Elube, a 19 year old girl has got two friends who wants to try out alcohol and chamba, how would you help Elube to prevent her friends from using the drugs?

________________________________________________________________________
________________________________________________________________________
Annex 5-2: Role Play

Two participants should come in front and do a role play. One character should be a young person by the name of Fredrick, who has come to your health centre, youth centre or clinic. He tells you he has been taking alcohol and cigarettes for 3 years now and he wants to quit. The other character is you the service provider. Discuss a workable strategy with Fredrick.
Handout for

Unit 6

Mental health and young people
This handout has got information to complement the material on *mental health and young people*. The facilitator will refer to this material now and again and you may also be asked to refer to this text during training.

**THIS HANDBOOK PROVIDES INFORMATION ON THE FOLLOWING:**

1. Definition of mental health 177  
2. Why is mental health of particular importance among young people 177  
3. Consequences of poor mental health 179  
4. Promoting mental health among young people 181  
5. Summary 184  
6. References 185  

Annex 6-1: Spot Checks 186
1. DEFINITION OF MENTAL HEALTH

Mental health is an essential dimension in the definition of health according to WHO. Mental health can be conceptualized as a state of well being in which the individual realizes his or her own abilities, can cope with normal stresses of life, can work fruitfully and is able to make a contribution to his or her community. It also relates to a person’s ability to manage and cope with feelings that may arise as a result of their understanding or experience of social, physical or psychological events [1]. Young people are dynamic and energetic as such their mental health is very important.

2. IMPORTANCE OF MENTAL HEALTH TO YOUNG PEOPLE

Malawi has over 72.4% of total population below 30 years [2]. This means that Malawi is a youthful country. Keeping this population health at all times will translate to a vibrant nation contributing towards development of the nation. It will mean that less young people in juvenile jails, less cases of mental illness and disorders, less violence and vice versa more young people finishing school, more young people managing their own businesses, reduction in HIV incidence associated with abuse of drugs and substances.

Young people are very sensitive to ill health and keeping them health all the times could be really challenging. Ill health can occur anytime and could range from physical, social and psychological illness. Keeping young people mentally health is of public health importance and it is the duty of young people themselves, parents and guardians, teachers, health workers, peers, friends to make sure that mental health of young people is maintained at all times.

In discussing the importance of keeping young people health, we need to look at possible negative outcomes that could result from failure to maintain the mental health of young people. As we shall see in the preceding handout on the consequences of poor mental health, it is very difficult for a young person to contribute positively to the development of the country if they are not mentally well. We need young people mentally health for important reason- to help in the development of the country at all levels.

WHAT INFLUENCES MENTAL HEALTH

Physical factors

There are some physical conditions that can affect a persons physical capacity to manage everyday life. These conditions would lead to a young person being unable to act as normal persons. The conditions include brain injury or trauma, accident, birth injury or developmental disorders. Any physical damage directly to the head that will affect the brain could constitute a physical factor that could affect our mental health.

Psychological factors

Young people in their lifetime will experience difficult life events that leaves them less resilient and psychologically defeated. The events are so traumatic that they feel they are incapable of handling the events and they become compromised. As such the
consequences of these events causes a negative thought pattern that leaves them with distressing thoughts and feelings leading to mental ill health.

Social factors

Social problems especially those that cause stress, are recognized as a cause of mental ill health. Poverty, failure in schools, abuse, unemployment, violence, high incidence of HIV, substance abuse are among some social problems that can negatively affect peoples emotional well-being. These are socio-economical factors related to mental health. These conditions are with us everyday, however our ability to manage or not manage them is the biggest determinant in maintaining good mental health.
3. CONSEQUENCES OF POOR MENTAL HEALTH

Poor mental health will likely lead to mental illness and disorder among young people. There are a number of mental illness and disorders that could come about due to poor mental health.

Anxiety and Stress

Most young people experience stress due to everyday challenges they meet. These challenges include coping up with adolescent growth, physical, psychological and social challenges they meet everyday. Signs of anxiety and stress includes, feeling of sad and low, loss of appetite, difficult in sleeping, being fearful, tense or panicky. Others will experience frequent urination.

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

Depression

This is a common phenomenon among young people. It leaves young people to lacking in confidence. Depression usually sets in after a young person experiences loss and may struggle to keep hold of positive thoughts and instead see the negative aspects of the world and themselves. They may feel as though no one will ever understand them if they were to talk about their feelings. As such these feelings are locked inside them and building up negative thoughts about life. Depression can progress to clinical illness if five or more of the following symptoms is seen in a person for at least two weeks [3]:

- 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 or tiredness
- Feelings of worthlessness or guilt
- Difficulties in concentrating or thinking
- Recurrent thoughts of death

Therapeutic support and milieu (environment) i.e talking issues over with the involved person, parents, health worker or someone they trust can be of strong help in mild to moderate cases. However for severe cases, antidepressants are used.

Deliberate self Harm

In Malawi today suicide attempts among young people are often reported. Deliberate self harm among young people sets in when they feel completely lost and see no any meaning of life or to live due to a challenge they feel they cant manage. They fail to

7
Imagine how best they can move out of the negative or unpleasant situation they are. They feel completely abandoned, ashamed, guilty or bad. Most will start contemplating self harm that could be in form of excessively abusing drugs and alcohol, contemplating suicide, cut, slash or burn their skin.

Deliberate self harm would build from negative experiences due to failure to cope. These would result also due to issues of relationships, failure to cope with too much poverty, an HIV positive result, impregnating or getting an unexpected pregnancy, drug and substance abuse, loss of parents or relative, loss of job, stigma and discrimination among others.

It is important that young people who attempts self harm get therapeutic support. Counseling and guidance services available to young people and adolescents will go a long way to provide support and help young people positively challenge negative social events they meet everyday.

**Eating disorders**

Eating less than required or eating too much is what is referred to eating disorders in simple terms. This is usually a sign of an unpleasant situation that has just happened to a young person. Eating less could result from a stressful event. This could be that the young person is not pleased with a situation such as an HIV positive result, failure in class or being bullied by parents. This would result in withdrawal and could manifest in part in not eating or eating very little hence projecting the anger on food. Eating too much could also be due to the same unpleasant experience. Eating too much would result in obesity, excessive weight gain in relation to age.

Other eating disorders are Anorexia Nervosa or Bulimia Nervosa. These are serious conditions that could result in death of a person, cessation of menstrual periods due to inadequate intake of proteins. Both of these conditions are very common in adolescents.

**Obsessive Compulsive Disorders**

Obsessive Compulsive Disorders (OCD) results when a person has got thoughts that keep coming in his mind resulting in compelling that person to keep on doing something. These thoughts could feel scary or silly [3]. The person might want to be washing hands now and again just by greeting someone, checking and rechecking that doors are closed, checking and rechecking that a bedroom light switch is switched off.

There is usually a situation that triggers such behaviors and will keep on intruding into the persons thoughts. Management of OCD requires a psychiatrist to establish the cause of the disorder and it is when he is able to work out ways with the person on how to manage their thoughts at every stage.
Psychosis

To best describe what can happen to people with psychosis, imagine a person talking to you or having a conversation with you. The clarity with which you can hear that person’s voice is exactly what people with psychosis can often experience, except no one is actually talking to them - the voices are in their head. Such a symptom is known as an ‘auditory hallucination’. Psychosis can cause other symptoms, such as ‘visual’ hallucinations. This can result in people ‘seeing’ things that are not really there. These hallucinations can lead to a person responding to the voices they hear or visual images they see. Unsurprisingly, psychosis can leave a person feeling confused, anxious or suspicious of those around them, agitated and restless [3 ].

4. PROMOTING MENTAL HEALTH

The reason for promoting mental health is to prevent mental illness. The Adolescent Mental Health Guide provides 8 critical elements on how young people and adolescents mental health can be promoted.

Power of Communication

Communication is a very powerful tool in maintain health and promoting good mental health among adolescents and young people. Young people are very sensitive on how we communicate with them and if they notice that our tone is not supportive, it’s very easy for them to deviate and look for support elsewhere. Parents, professionals, peers working with young people need to make sure that how they communicate to young people should always bring them closer to them hence the concept of youth friendly health services is strongly borne on communication.

Body language, behavior, tone of voice and what someone actually say are what mental health professionals such as therapists and counselors listen and look out for. It is very important for parents, professionals (health workers, counselors, DYO:s), to look at what a young person is communicating through their body language and behavior and listen to their tone of voice, needs, and establish how they may be feeling at any given time. This is very important for anyone working with young people to mind how they communicate with them and so too how young people communicate to others.

Holding Boundaries

Everything that people do has got limits and boundaries. Limits and boundaries are often erected to prevent consequences that could follow if a person moves over those limits. The consequences are often bad. For example if one takes a lot of alcohol that advised by a doctor, the effects could result in liver damage and eventually death.

Adolescents and young people often break rules and boundaries. Sometimes with full awareness of the consequences, sometimes not. If young people knows what risks they are taking i.e having unprotected sex, abusing drugs, having multiple sex partners, it becomes far easier for them to recognize that they are ultimately responsible for their actions, decisions and choices. However this is often what is lacking in Malawi among
adolescents and young people. Often we do not propagate comprehensive and truthful information to young people for them to make informed choices as such the boundaries and limits are often broken due to limited information.

Parents, peers, professionals can help to promote positive mental in young people simply by communicating the limits, consequences of breaking them and communicating risks that could follow.

**Asking Questions**

Asking questions is an art and it needs to be done with utmost care. How people, parents and other professionals ask questions can make young people feel threatened or secure. Open ended questions versus closed ended questions will provide different responses. Often closed ended questions do not provide a chance for young people to explain themselves in relation to open ended questions.

It is important to communicate back empathy to young people so that it can leave the young person feeling as if someone is seeking to understand them. The more empathy a person can have and share with young people the easier it can be to walk in their shoes and be beside them as they attempt to resolve in their life.

For instance, the ‘why’....[did you do this?] question is not appropriate for young people as they feel you want to blame them as such they become defensive, feel insecure and believe you are empathetic. By contrast however, questions such ‘how’... [did this happen?] will make them feel you need an explanation and are assured of a possible discussion to follow.

**Emotional Literacy**

It is very important that we understand why we feel the way we do. This helps us to know who we are and this can help us manage our life situations easily. Often young people know how they are feeling but often are not sure what has made them feel that way. This is often what makes young people to struggle with managing certain situations and difficulties when they arise.

It is important for parents and professionals to be aware that not only do young people often let us know if we get something wrong, they will also only disclose information about themselves that feels safe enough. Parents in Malawi need to improve their communication with their children so that they help them appreciate who they are hence they could be able to manage their emotions.

**Exploring Options Vs Giving Advice**

Giving advice and exploring options together with the young person are critical elements in empowering young people to make their own decisions. Often parents, guardians feel that they need to give advice so that they can help the young person to make a decisions. However, exploring the issue at hand together between parents and their children and helping the young person make the decision is critical. It is though not
wrong to give advice to young people, however helping them to explore and give rational decisions over the decision they have made will help the young person make future decisions with confidence and often right ones. As such young people will need support of the guardians that is translated to love and empathy hence are likely to make better choices about life than lack of support.

**Challenging**

Young people often find themselves in situations that they feel they are not important and looks down at themselves. It is very important to know the views of young people are very important and need not to look down upon themselves. Positively challenging young people on their views or beliefs, using empathy and open questions will enable them to have a clearer picture of a particular situation and think life positively. For example:

“You say you are a failure because you have not been picked for the interview for the second time. No you are not a failure but consider yourself doing very well. The fact that you were shortlisted means that you are capable of doing the job but most importantly you learnt something also during the interview as such you have done very well.”

**Knowing Your Limitations**

Communicating to young people the limitation of the support they can give them, encourages them to take their own responsibility. The realization that it's not their parents, guardians, who have to make decision for them all the times, helps them to be on the guard. However they are encouraged also knowing that their parents, relatives, peers will provide the support they need all the time. As such when they have a difficult situation they are able to move forward on their own rationally knowing they have support hence minimizing the occurrence of poor mental health.

**Giving Constructive Criticism**

Criticisms are very important as it puts people and even young people on guard on what they say to others. Positive criticisms makes young people grow and will take the criticisms positively if they are meant on good purpose.

Constant criticism to young people without praise makes them feel unwanted, low self esteem, and self confident in what they do. Constructive criticisms are therefore important to held young people maintain an awareness of what they do well and what they don’t do so well. Parents and professionals (health workers, counselors), should praise young people for what they have done well and provide constructive criticisms that young people themselves should be part of providing solutions.
SUMMARY

- Mental health is the state of well being in which the individual realizes his or her own abilities, can cope with 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 is very important to prevent mental illness
- Mental health of young people is affected by physical factors (i.e. being bullied now and again), psychological factors (i.e. death of parents) and social economic factors (i.e. poverty).
- Counseling and guidance is very paramount at all levels and this should be part of the comprehensive youth friendly health services
- Consequences of poor mental health could be difficult to manage and could take time, however professionals, parents and peers needs to support young people so that we reduce incidence of mental illness
- Health workers, social workers, parents should help young people realize who they are, be empathetic to them and offer constructive criticisms
REFERENCES

1. World Health Organization (WHO).
### ANNEX 6-1: MENTAL HEALTH AND YOUNG PEOPLE- SPOT CHECKS

<table>
<thead>
<tr>
<th>Spot Check 1: Definition of mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the definition of mental health?</td>
</tr>
<tr>
<td>________________________________________________________________________________</td>
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<table>
<thead>
<tr>
<th>Spot Check 2: Causes of mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>What factors causes mental health?</td>
</tr>
<tr>
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<td>What can be done in your community to promote mental health of young people?</td>
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Providing young people with the health services they need
This handout provides information to complement the material covered in Unit 7 providing young people with the health services they need. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

**THIS HANDBOOK PROVIDES INFORMATION ON THE FOLLOWING:**

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1. AN AGENDA FOR CHANGE

Young people complete their physical, emotional and psychological journey to adulthood in a changing world that contains both opportunities and dangers. Most young people are full of optimism and represent a positive force in society, an asset now and for the future as they grow and develop into adults. When supported, they can be resilient in absorbing setbacks and overcoming problems. However, young people are exposed to risks and pressures on a scale that their parents did not face. Globalization has accelerated change while the structures that protected previous generations of young people are being eroded. They receive contradictory messages on how to address the daily choices which have lifelong consequences for healthy development. Millions are denied the essential support they need to become knowledgeable, confident and skilled adults. They miss out on schooling for economic reasons or because their communities are displaced or disrupted by war or conflict. While most young people have loving families who protect and care for them, many grow up with no adults committed to their welfare or where the ability of caring adults to support them has been damaged.

Young people are at risk of early and unwanted pregnancy, of sexually transmitted infections (STIs) including HIV and AIDS, and vulnerable to the dangers of tobacco use, alcohol and other drugs. Many are exposed to violence and fear on a daily basis. Some of the pressures young people are under, or the choices they make, can change the course of their young lives, or even end them. These outcomes represent personal tragedies for young people and their families. They are also unacceptable losses that put the health and prosperity of society at risk. Addressing the needs of young people is a challenge that goes well beyond the role of health services alone. The legal framework, social policy, the safety of communities and opportunities for education, employment and recreation are just some of the factors of civil society that are key to youth development.

However, within an integrated approach, health services can play an important role in helping young to stay healthy and to complete their journey to adulthood; supporting young people who are looking for a route to good health, treating those who are ill, injured or troubled and reaching out to those who are at risk. Effective health services reach young people who are growing up in difficult circumstances as well as those who are well protected by their communities. Health services need to link with the other key services for the youth, so that they become part of a supportive structure that protects young people against dangers, and helps them to build knowledge, skills and confidence. This is far from being the case in many countries. Health services often regard young people as a healthy group who do not need priority action, and so provide a minimum subset of adult or paediatric services with no adjustments for their special needs.

There is evidence that many young people regard such health services as irrelevant to their needs and distrust them. They avoid such services altogether, or seek help from them only when they are desperate.

“Youth-friendly” health services meet the needs of young people sensitively and effectively and are inclusive of all young people. Such services deliver on the rights of
young people and represent an efficient use of precious health resources. Their characteristics are further spelled out in this handout.

### SUMMARY

- Youth represent a positive force in society, now and for the future
- They face dangers more complex than previous generations faced, and often with less support
- The development needs of young people are a matter for the whole of civil society
- Health services play a specific role in preventing health problems and responding to them

Many changes are needed in order for health services to become youth-friendly.

### 2. WHAT HEALTH SERVICES DO YOUNG PEOPLE NEED?

Young people have in many surveys expressed their views about what they want from health services. They want a welcoming facility, where they can “drop in” and be attended to quickly. They insist on privacy and confidentiality, and do not want to have to seek parental permission to attend. They want a service in a convenient place at a convenient time that is free or at least affordable. They want staff to treat them with respect, not judge them. They want a range of services, and not to be asked to come back or referred elsewhere. Of course, those who plan and provide services cannot only think about the wishes of young people – services must be appropriate and effective, and they must be affordable and acceptable for the community.

However, services for this age group must demonstrate relevance to the needs and wishes of young people. Health services play a critical role in the development of young people when they:

- 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 adolescents.

Young people in crisis need counselling and community support beyond what health services alone can offer. This support comes from parents, families, teachers, trained counsellors, religious or youth leaders and other adults and from their own peers. However, if these links break down, early signs of crisis may become apparent during contact with health services.

Health-care staff needs to be sensitive to signs of anxiety, and know how to deal with young people in crisis, or where to refer them. Services also need to include information and education to help adolescents to become active participants in their own health.
Programmes monitoring growth and development should provide a golden opportunity for youth to request help and for health-care staff to give them information. However, such programmes are rarely provided at school and even when health checks do take place; they seldom give young people this kind of opening.

**Essential services**

A WHO consultation in Africa in October 2000 agreed that “adolescents have a right to access health services that can protect them from HIV/AIDS and from other threats to their health and well-being, and that these services should be made adolescent-friendly”. The consultation recognized that health and development needs cannot be met by health services alone, but outlined an essential list of clinical services:

- General health services for tuberculosis, malaria, endemic diseases, injuries, accidents and dental care;
- Reproductive health including contraceptives, STI treatment, pregnancy care and post-abortion management;
- Counselling and testing for HIV, which should be voluntary and confidential;
- Management of sexual violence;
- Mental health services, including services to address the use of tobacco, alcohol and drugs;
- Information and counselling on development during adolescence, including reproductive health, nutrition, hygiene, sexuality and substance use.

However, an appropriate range of essential services must be decided by each country, based on local needs assessments and resource availability.

The Global Consultation on Adolescent-Friendly Health Services, held by WHO in Geneva in March 2001, concluded that a core package could not be a “fixed menu”. Instead, the Global Consultation suggested that each country must develop its own package, negotiating its way through economic, epidemiological and social constraints, including cultural sensitivities. It declared: “What is needed is a process by which government ministries can make decisions about what is most appropriate for their situation, taking into account cost, epidemiological factors and adolescent development priorities.”

In Malawi such a package of essential services ahs been developed and is informed by the Malawi Youth Friendly Health Standards which is described further in later sections of this handout. The minimum package of health services for Malawi is presented in the next section.
3. THE MINIMUM PACKAGE FOR THE DELIVERY OF YOUTH FRIENDLY HEALTH SERVICES

The minimum Youth friendly Health Service (YFHS) package [1] is a combination of clinical services and health promotion interventions provided for addressing the health needs of young people. There are three areas of emphasis in the minimum package:

- **Health promotion**
- **Delivery of Health Services**
- **Referral and follow up**

All interventions in line with the three areas of focus are delivered within the framework of the national health care delivery system of the Ministry of Health (MOH) with support from its private and NGO partners.

Health services provided to young people are provided within the normal clinical standards and procedures as 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 as outlined in the Essential Health Package (EHP) of Malawi.

**Clinical service delivery at the community level**

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

**Clinical Service Delivery Package at Health Centre level**

Contraceptive services including condoms
Prevention, Diagnosis and Management of Sexually Transmitted Infections
Ante-natal, delivery and post natal care services
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

**Clinical Service Delivery Package at Hospital level**

Post Abortion Care
Contraceptive services including condoms
Prevention, Diagnosis and Management of Sexually Transmitted Infections
Ante-natal, delivery and post natal care services
Prevention of Mother to Child Transmission of HIV (PMTCT)
HIV testing and counselling
Provision of ARVs.
Treatment of sexual abuse victims (including PEP)
Referral to other service delivery points

**Health promotion and counselling during service delivery and at all levels**

Sexually transmitted infections (STI's)
Family planning
Psychosocial support
Nutrition
HIV and AIDS
Sexual Abuse
Maternal health care
Adolescent growth and development

**SUMMARY**

- Health services can help to meet youth needs, only if they are part of a comprehensive programme. Young people need:
  - 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 their health problems and deal with personal difficulties.
  - Health-care providers cannot meet all these needs alone. They can join or create networks that act together and maximize resources.
  - A package of basic health services must be tailored to local needs, including growth and development monitoring and immunization.
  - Reproductive health services, counselling and voluntary testing for HIV and other sexually transmitted infections are a high priority in most places.
  - Mental health services and counselling are important elements to support adolescents.
4. DO EXISTING SERVICES MEET THE NEEDS OF ADOLESCENTS?

Surveys in many countries suggest that when young people are looking for urgent treatment for what they consider to be sensitive conditions, health services are often their last resort. Healthcare providers are often dismayed by these findings, as they want to be a resource for young people – but they do not know how. Yet young people can be excluded by poor service delivery, their own lack of awareness or a combination of legal, physical, economic and psychological barriers.

- **Lack of knowledge on the part of the adolescent**

Most young people do not have the knowledge or experience to distinguish between conditions that go away of their own accord and those that need treatment. They do not understand their symptoms or the degree of risk they may be taking. They do not know what health services exist to help them, or how to access them.

- **Legal or cultural restrictions**

Reproductive health services, such as family planning clinics or post abortion services are often restricted. Abortions may be illegal, although the health system deals with the consequences of unsafe abortions. Even if condoms are available, health-care workers may withhold them from young people. In some cases young people may need consent from their parents for medical treatment.

- **Physical or logistical restrictions**

Services may be a long way from where the young person lives, studies or works, or available only at inconvenient hours. Additionally other physical barriers such as rivers, poor roads may hinder access to services.

- **Poor quality of clinical services**

Quality may be poor because health-care providers are poorly trained or motivated, or because a health facility has run out of medicines or supplies.

- **Unwelcoming services**

Of special concern is the way in which services are delivered. Young people are very sensitive to privacy and confidentiality, and do not want their dignity to be stripped away. Young people are more likely than older people to be deterred by long waiting times and administrative procedures, especially if they are made to feel unwelcome. Unfriendly health-care providers who do not listen or are judgemental, make it difficult for young people to reveal concerns. They may not return for follow-up care.
• **High cost**

Young people usually cannot afford to pay for health services but must ask an adult to support them. When desperate, young people will “beg, borrow or steal” money for treatment, but may then seek help in the private sector so as to protect their privacy, even if this treatment is more expensive and less effective.

• **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 sexual or reproductive health services.

It may also be difficult to seek help after 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 who feel vulnerable.

• **Gender barriers**

Some barriers are especially associated with the sex of the young person. Adolescent girls are very reluctant to be examined by males, while young men may find it difficult to discuss intimate symptoms with a female health-care provider. Sensitivities above may be especially cultural powerful disincentives for girls to use services. There are many cultural barriers associated with gender. It takes two to make a baby, but it is girls who become pregnant. It is very difficult for a 16-year old girl to attend a local clinic for a pregnancy test or for contraception, if she knows that she will be seen by a relative or neighbour. Girls who do not leave the house much may have less access to information and in some cultures have to seek consent from a parent or spouse before treatment. Girls may even be denied treatment by health-care workers, despite being legally entitled to them.

• **Peer pressure**

Young people often consult their friends about where they should seek treatment, and in this way, one person’s experience becomes the criteria by which a group of young people make their health-care decisions. Some may seek out useful sources of help such as trained pharmacists, but others turn to street vendors, traditional healers or unlicensed practitioners. Many seek no help at all with potentially catastrophic results. This reluctance to seek early help goes beyond reproductive and sexual health matters. Street children present late and usually do not complete their treatment, although they represent a significant source of hidden illness and infection. Young people in boarding schools or colleges also present late because they want to hide the diagnosis from their peers, the school authorities and their families. In both cases, the youth are protecting their privacy above their need for medical care.
These results in poor treatment, missed classes and an inability on the part of the hospital to provide effective contact tracing. When young people are confident that hospitals and clinics protect confidentiality, they ask for help sooner.

**SUMMARY**

- Young people lack knowledge about what services are available and how to access them
- There may be legal restrictions on the use of services or cultural reasons why young people do not wish to be seen there
- Youth give high priority to confidentiality
- They are put off if the services are a long way away or are expensive
- They will not use unfriendly services or those with poorly trained staff.
5. WHAT MAKES HEALTH SERVICES “YOUTH FRIENDLY”?

Youth friendly health services represent an approach which brings together the qualities that young people demand, with the high standards that have to be achieved in the best public services. Such services are accessible, acceptable and appropriate for adolescents. They are in the right place at the right time at the right price (free where necessary) and delivered in the right style to be acceptable to young people. They are equitable because they are inclusive and do not discriminate against any sector of this young clientele on grounds of gender, ethnicity, religion, disability, social status or any other reason. Indeed they reach out to those who are most vulnerable and those who lack services. The services are comprehensive in that they deliver an essential package of services to the whole target group.

They are effective because they are delivered by trained and motivated health-care providers who are technically competent, and who know how to communicate with young people without being patronizing or judgmental. These providers are backed up by adolescent-friendly support staff and have access to equipment, supplies and basic services. They also maintain a system of quality improvement so that staff are supported and re-motivated to keep up their high standards. Finally the services are efficient so that they do not waste money, and they record enough information to be able to monitor and improve performance.

The gold standard for youth friendly health services is that 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. Even if this ideal cannot be achieved immediately, improvements bring results.

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 by improving the competencies of health-care providers to deal effectively with adolescents.

The characteristics of youth friendly health services were discussed during the global consultation process initiated by WHO in 2000, and continued during the discussions by the expert group convened by WHO in Geneva in 2001. These characteristics are intended for application sensitively in each country and region bearing in mind the cultural, social, economic and political context and the need to support health-care providers to deliver the best possible service to the youth.

Technical competence

Service providers need a good knowledge of normal adolescent development and the skills to diagnose and treat common conditions, such as anaemia or menstrual disorders in adolescent girls, and to recognize signs of sexual or physical abuse. They need access to the correct drugs and supplies to treat common conditions and prevent health problems. They should know where to refer young people for specialist physical or
psychological treatment. Such referrals may be to people or services outside the health system for counseling or social support.

See the person, not the problem

Technical competence must be accompanied by respect and sensitivity to draw the young person out and to discover underlying problems that may not be the immediate cause of a visit. As well as conditions that only a clinician can understand, such as a “suboptimal adolescent growth spurt”, a service provider must be able to recognize a young person who is confused or frightened. Young people often lack confidence and may present with a “safe” symptom, to test the service before revealing their real concerns. By focusing on the person, rather than the symptom, providers can discover underlying concerns. Technical skills and a sympathetic professional approach should be combined with a non-judgmental approach. Health-care 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 to allow their own views to dominate the interaction.

Training and staff support

Technically competent and empathetic staff needs a system of ongoing support. A youth friendly approach should include repeated training sessions to refresh the skills of current staff as well as developing new skills for new staff. Training and peer-review sessions should cover everyone from doctors (who may believe they need no further training) to the receptionist and cleaner, who may be surprised that they are part of the team. These staff may be the first person a young person meets at a health facility. If they are unfriendly or indiscrete, a young person may never return. Management and supervision should be aimed at creating a supportive environment and at developing systems to maintain and improve quality. Health-care providers should be involved in drawing up protocols and guidelines covering key quality issues. They should also develop self assessment and peer review mechanisms which create a culture of openness. Monitoring systems should encourage adolescents to provide feedback on services.

Making the service physically accessible

Services need to be provided in places that young people can reach, at times that they can get there. This may involve holding special clinics in youth centres, or other places where youths go. Clinical staff can take turns to do late duty rotas so that a clinic can run in the evening or at weekends, when young people are not at school, college or working. Physical surroundings are important. Many places have no special youth centre, but still provide a welcoming health facility. Attention can be paid to the paintwork, posters on the walls, cleanliness and whether there are enough chairs where people wait. A general youth health clinic can advertise its name at the entrance, while an STI clinic may want a discrete entrance. Youth themselves may help to decide on a creative name that will be welcoming but not stigmatizing. A busy city hospital with little money for capital development can create a “youth health corner”, by putting up a partition, so that young people can be seen in privacy, or by using a rear door where they can enter without
stigma. Some clinics give young people numbers when they arrive so that they can be called to see the doctor or nurse without having to sit in a queue “on display” and without having their name called out. While waiting they should be able to look at health promotion literature, or even view a video.

**Confidentiality and privacy**

Young people need to be assured of privacy during a consultation and confidentiality afterwards. Young people should not be expected to undress or be examined where people can see them. Those waiting outside should not be able to hear a doctor giving a diagnosis. Patients must be confident that medical records will not be left on view and that receptionists will not gossip. In most countries there is a legal obligation for doctors to report sexual assault, a road traffic accident or gunshot wounds. There are also legal restrictions on treatment to young people below a certain age without parental consent. These and other legal constraints need to be explained as the only exceptions to a strict policy of confidentiality. This policy itself can be jointly developed with young people and health-care providers so that everyone understands and feels comfortable with the ground rules. The confidentiality policy, including exceptions, needs to be explained to all adolescent users and to parents or guardians, and needs to be clearly understood by referral agencies.

**Services that are acceptable to the local community**

Simply making services “youth friendly” will not increase usage, unless young people feel that it is acceptable to be seen to use them. Community support for the service must also be sought. The community should have an opportunity to understand why services are important for young people, and why these should include sexual and reproductive health services and confidential counselling. Local meetings may be held for parents, and community and religious leaders should be approached for support. Services may even be located in community settings. There are many examples of services being delivered in schools, community centres or on the street. Where public support is difficult to achieve (as is often the case for health services for sex workers or for injecting drug users) the services can be run in a low key way, or through community outreach workers.

**Involving adolescents**

Services that reach a high quality are those that closely involve the 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. The involvement of young people in planning and monitoring delivers on their right to have their views heard. It also increases the confidence that other young people place in those services.
SUMMARY
Youth friendly health services need to be accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient. These characteristics are based on the WHO Global Consultation in 2001 and discussions at a WHO advisory group meeting in Geneva in 2002. They require:

1. Youth friendly policies that
   - Fulfil the rights of young people as outlined in the UN Convention on the Rights of the Child and other instruments and declarations;
   - Take into account the special needs of different sectors of the population, including vulnerable and under-served groups, do not restrict the provision of health services on grounds of gender, disability, ethnic origin, religion or (unless strictly appropriate) age;
   - Pay special attention to gender factors;
   - Guarantee privacy and confidentiality and promote autonomy so that youth can consent to their own treatment and care;
   - Ensure that services are either free or affordable by young people.

2. Youth friendly procedures to facilitate
   - Easy and confidential registration of patients, and retrieval and storage of records;
   - Short waiting times and (where necessary) swift referral;
   - Consultation with or without an appointment.

3. Youth friendly health-care providers who
   - Are technically competent in adolescent-specific areas, and offer health promotion, prevention, treatment and care relevant to each client’s maturation and social circumstances;
   - Have interpersonal and communication skills;
   - Are motivated and supported;
   - Are non-judgmental and considerate, easy to relate to and trustworthy, devote adequate time to clients or patients;
   - Act in the best interests of their clients;
   - Treat all clients with equal care and respect;
   - Provide information and support to enable each adolescent to make the right free choices for his or her unique needs.

4. Youth friendly support staff who are
   - Understanding and considerate, treating each adolescent client with equal care and respect;
   - Competent, motivated and well supported.
5. **Youth friendly health facilities that**
   - Provide a safe environment at a convenient location with an appealing ambience;
   - Have convenient working hours;
   - Offer privacy and avoid stigma;
   - Provide information and education material

6. **Youth involvement, so that they are**
   - Well informed about services and their rights;
   - Encouraged to respect the rights of others;
   - Involved in service assessment and provision.

7. **Community involvement and dialogue to**
   - Promote the value of health services; and
   - Encourage parental and community support.

8. **Community based, outreach and peer-to-peer services to increase coverage and accessibility**

9. **Appropriate and comprehensive services that**
   - Address each adolescent’s physical, social and psychological health and development needs;
   - Provide a comprehensive package of health care and referral to other relevant services;
   - Do not carry out unnecessary procedures.

8. **Effective health services for young people**
   - That are guided by evidence-based protocols and guidelines;
   - Having equipment, supplies and basic services necessary to deliver the essential care package;
   - Having a process of quality improvement to create and maintain a culture of staff support.

9. **Efficient services which have**
   - A management information system including information on the cost of resources;
   - A system to make use of this information.
6. HOW ARE SERVICES BEST DELIVERED TO YOUNG PEOPLE?

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

Services at health centres or hospitals

Basic health services are usually delivered at ordinary health centres in local communities and there is no reason why this should not also meet the needs for many young people. One important task is to train and support staff in this setting, to improve skills and to develop an empathetic approach, so that young people are willing to attend. These skills can be sustained through regular post-qualification training, and through 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 normal opening hours, by creating a separate entrance for young people or by improving confidentiality once inside. A number of hospitals have developed specialist adolescent services or clinics in outhouses 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 centres of population, and may be constrained by competing demands for funds. There are also dedicated health centres which 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 they may be run by NGOs as “beacon” services that show what can be done. Such services can provide training and inspiration for other health-care providers, but they usually only have an impact in one area, and they cannot be replicated in mainstream services, because of the cost.

Services located at other kinds of centre

Because some young people are reluctant to visit health facilities, services can also be taken to places where young people already go. 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 such centres are already used by young people so that they do not have to make a special effort to go there. One drawback is that a particular centre may only attract part of the young population, being used mainly by boys or by girls or by 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. Increasingly in towns and cities services are being provided in shopping malls, as well as in...
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. Health-care 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 and immunization with a discrete follow-up appointment service for those who need further treatment or counselling. Visiting health-care providers can also provide health education talks and materials aimed at young people.

Outreach services are also needed for young people who slip through the net although they may be geographically close to an existing health facility. Young people living on the streets find it difficult to access mainstream services but will respond to services targeted on this vulnerable client group. Such outreach services may be run from health clinics or provided by NGOs. Once contact is made with young people who are outside 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. In the five years to 1996, it was estimated that the number of children enrolled in primary education increased by approximately 50 million, and the increase was most rapid amongst girls. Secondary school enrolment is also increasing. Schools are ideal places to screen for or treat a range of common illnesses, to provide vaccines such as booster tetanus shots, and for health and hygiene education. However, in practice this potential is seldom realized. Schools are short of resources and teachers have neither the training nor the equipment to deliver health education on top of their existing workload. To turn this 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 so that efforts are not duplicated.

It is also important to ensure that services provided at school have community support. Many head teachers are concerned that they will open themselves to criticism if they provide services for young people. Efforts among the school and community are required to ensure that such moves are supported. There is much evidence that parents welcome other responsible adults talking to their children about sensitive issues, as they 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, the 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 a general skills course for the large number of female workers.

## SUMMARY

- Youth-friendly health services can be delivered in health centres, in the community, through outreach services or at school;
- Hospital or clinic based services can become more youth-friendly;
- Community settings include services provided at community or youth centres, in shopping malls or even over the Internet;
- Outreach services are needed in cities to contact youth who do not attend clinics and those, like street children, who are marginalized;
- Outreach services in rural areas can be devised to reach young people living in isolated communities;
- Schools offer a critical entry point to bring services to young people who are in school;
- Young workers, including adolescents, can be reached with health education or screening services targeted on the workplace;
- Services can be located anywhere where young people go no single setting should become the only model.
7. YOUTH FRIENDLY HEALTH STANDARDS FOR MALAWI

GUIDING PRINCIPLES OF THE STANDARDS

The guiding principles of the Standards are based on the “Young People’s Health Strategy and Implementation Framework” developed by the Ministry of Health. Key principles include:

- Active participation of young people in the planning, implementation and monitoring of health services according to their level of capacity
- 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 worker and community volunteers
- Certification of all facilities providing YFHS

STANDARDS AND CRITERIA FOR YOUTH FRIENDLY HEALTH SERVICES

The sections below provide an overview of the main features of each of the standards. These are followed by a matrix of the standards, key actions needed to be taken at different levels of the health care delivery system, monitoring indicators and method of verification.

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

This section takes a holistic approach to the use of existing policies, procedures and guidelines with a view of making their implementation youth friendly. The standard emphasises on delivery of quality Youth Friendly Health Services within the framework of existing procedures, protocols and guidelines. It also focuses on capacity building for the provision of quality youth friendly health services in accordance with the 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 access, acceptability, availability and quality of health services provided to young people. It gives guidance to the different levels of the health care delivery services. Key partners expected to participate in the provision of services based on this standard include, Young People, NGOs and district health offices. The visibility of information on service availability at service delivery points, community and in places where young people meet is also highlighted as a major element. Treating young people with respect is also key attributes of this standard.

Standard 3: All young people are able to obtain health information (including SRH and HIV) relevant to their needs, circumstances and stage of development
This standard emphasises the availability and provision of appropriate information, education and communication in relation to the elements mentioned in the minimum package. Advocacy and community mobilization around SRH and health rights are also captured with emphasis on linkages and partnerships between stakeholders.

**Standard 4: Service providers in all delivery points have the required knowledge, skills and positive attitudes to effectively provide YFHS**

The training of service providers on making health services accessible, acceptable and friendly to young people is the basis for increasing their utilisation of services. This standard emphasises on training of service providers, orientation of support staff and other relevant stakeholders and monitoring of YFHS. Training is based on the national YFHS training package. The focus of the training is providing the service providers with knowledge, skills and positive attitudes in the provision of services to young people.

**Standard 5: Health information related to YP is collected, analysed and utilised in decision making at all levels**

Continually monitoring YFHS will ensure quality assurance. This standard emphasises on collection of disaggregated data in terms of sex and age and utilisation for planning purposes. Provision of feedback on information by the district and national levels and use of data for planning at the service delivery points are emphasised. Documentation of best practices and their dissemination is also emphasised.
8. REFERENCES

### ANNEX 7-1 SPOT CHECKS

#### SPOT CHECK 1
Adolescents often do not make use of available health services because........

*Please Tick Three most important reasons*

- They think that staff will inform their parents
- They do not like waiting or filling forms
- They are not interested
- They do not like the way staff treat them
- They do not want to draw attention to themselves
- They find it easier to talk to their friend that health workers
- They do not know where to go

#### SPOT CHECK 2
Health facilities should reach out to young people and become youth friendly because....

*Fill in the blank spaces*

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

#### SPOT CHECK 3
What are the most important characteristics of youth friendly health services....

*Fill in the blank spaces*

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

#### SPOT CHECK 4
How Youth friendly do you believe the health facility you come from is?

Not youth friendly Somewhat youth friendly very youth friendly
ANNEX 7-2   CASE STUDIES

Case study 1

Anita, a 15 year old girl comes to a health facility which is 8 Km from their village accompanied by a friend.

When the two girls reach the facility they go to the counter and ask to see a doctor. Anita is questioned about what her problem is and asked for her name and address (and that of her family) and her age. Anita explains that she feels weak and ill, and that she nearly fainted when carrying a bag of sweet potatoes home from the market, earlier in the day. She is asked to go and queue up with other patients.

When it is her turn to see the doctor, both girls enter the doctor's room. The doctor points to a bench and asks the girls why they have come.

The friend explains the problem but Anita keeps quiet. The doctor immediately asks Anita when she had her last period. Anita looks at the floor but does not reply to his question. The doctor walks to the bench and examines her eyes and tongue without a word, then asks her to lie down on the examination table and palpates her stomach and breasts. Anita starts crying. The friend is still seated at the bench. Neither girl knows what to say.

The doctor is pressed for time and walks back to his chair to write a note to the laboratory requesting a blood test for haemoglobin and a urine test for pregnancy. The doctor directs them to the laboratory, asks Anita to go there for the tests, and to return the following morning.

The following morning Anita returns to the facility alone and the doctor tells her that she is pregnant and also that she is suffering from anaemia. He prescribes iron tablets and explains the dosage to her. He explains to her the importance of antenatal care and asks her to come back the following month.

The doctor advises Anita to go home and talk to her parents about her pregnancy. She walks away confused and shocked.
Case study 2

Tawina, a 17 year old secondary school girl, has a boy friend (Jimmy) from the same school. Their relationship has lasted about 3 months and they started having sex one month ago. Both want to pursue further studies so they have been using condoms as a protection against unwanted pregnancy.

One evening when they had sex, the condom tore. Tawina is extremely scared of falling pregnant because it will prevent her from continuing her studies. She doesn't feel prepared for motherhood right now. Furthermore, she is afraid of her parent’s reaction. They are strongly religious and do not approve of sex before marriage.

Tawina decides to go and see Dr. Banda at the hospital in the capital city the very next day. She has heard from friends that he is a brilliant doctor who takes time to listen to his client’s complaints and worries and is willing to help them out of a difficult situation.

She arrives at the hospital and manages to get consultation with Dr Banda. The doctor could see the despair on her face and immediately tries to console her. He explains that he has half an hour at disposal. She explains what has happened, that she is scared of being pregnant and that under no circumstances is she willing to have a child at this point in time.

Dr. Banda explained to her that as “the accident” only happened a day earlier, there is no need for a pregnancy test or a physical examination. He questions her about her last menstrual period and tells her that she could have conceived.

He tells her that she should relax because he will be able to help her, and points out how important it is that she came for help. He explains to her the possibility of getting pregnant or not and tells her that he is going to give her contraceptive pills for emergency contraception. Dr Banda gives her Combined Oral Contraceptives and advises to take two pills that time and other two pills after 12 hours. He explains that it is good that she reported soon after the incident since this method is effective within 72 hours of the sexual contact. He however, explains that this method does not protect her form HIV or STIs. He asks her to come back after two weeks and encourages her to bring her boyfriend so that they can discuss more about pregnancy and pregnancy prevention.

Tawina and Jimmy return the following week while Tawina is having her menses. Dr. Banda talks to them about contraception in general and then about different methods appropriate for their age, and stresses that the condom is a very important method of protection, because not only does it protect against unwanted pregnancy but also against other sexually Transmitted diseases including HIV. He further elaborates that condoms can be used in a combined method for example with spermicide or with contraceptive pills for further protection.
CASE STUDY 3
Tawonga, a 14 year old girl has a boyfriend and they had unprotected sex with him a week ago. After the sexual act, Tawonga felt afraid that she might have contracted HIV from her boyfriend. She decides to go to a facility to have an HIV test. The facility is a few meters away from her home.

She goes to the health facility and does not know where to go exactly for HIV testing and she is afraid of asking anyone around about where to go for testing. She decides to go back home without getting a test. The next day, she goes to ask a friend who is a peer educator in their school about the exact place where she can get a test.

She returns to health facility with a friend who takes her to the VCT room. When she enters the room, she finds a counsellor who is a friend to her mother who welcomed her. She was asked why she came there and she explains that she wants to have an HIV test. The counsellor informs her that at her age, according to policy she is supposed to come with her parent to give consent. Tawonga refuses to involve her parents and indicates that after getting tested, she does not want her mother to know the results whether positive or negative.

What should the counsellor do in this scenario?

What are some of the barriers identified that would affect the young person’s access and utilization of the services she needs?
SESSION 8: ACTIVITY 8.2

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 making in the way you will work. The plan includes the following elements:

- The proposed changes you intend to make;
- The importance of the proposed 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.

General instructions

- Please use the tables entitled "Individual implementation plan", which appear on the following pages, to record five changes you intend making in the way you work with or for adolescents.
- Please review the example on the following page
- 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 and 5.
- In monitoring your own changes and application of this plan, it would be useful to set yourself target dates to review your progress and reassess your plans.

We wish you all success in your endeavours to improve your work with and for young people.
### SAMPLE OF INDIVIDUAL IMPLEMENTATION PLAN

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
<th>Column 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>The changes I plan to make in my everyday work with or for adolescents?</td>
<td>Why I believe this change is important: who or what will benefit and why?</td>
<td>How I will know whether or not I have been successful and when will I know this?</td>
<td>Any challenges or problems I anticipate in carrying out the changes</td>
<td>What help am I likely to need and who could provide me with this help?</td>
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</table>

**Example**

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<tr>
<td>Students in local schools.</td>
<td>They will find it easier to obtain the services they need</td>
<td>A steady increase in the number of students who come to the clinic to obtain services</td>
<td>Six months after making contact with the schools</td>
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<td>Friends of students, and family members of school staff who are in local schools.</td>
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<td>Support from the educational authorities</td>
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<td>Lack of interest from the school administration</td>
<td>A seminar to convince them of the value of this work</td>
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<td>Resistance from the teachers</td>
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