NEXT
PROTECTING THE NEXT GENERATION

Protecting the Next Generation in Malawi

NEW EVIDENCE ON ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH NEEDS

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This report is part of a larger project, conducted in Burkina Faso, Ghana, Malawi and Uganda, titled Protecting the Next Generation: Understanding HIV Risk Among Youth. The project was designed to contribute to the global fight against the growing HIV/AIDS epidemic among adolescents by documenting and analyzing young people's sexual and reproductive health needs; communicating the new research findings to a broad audience to raise awareness; and stimulating the development of improved policies and programs to serve youth.

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Table of Contents

Executive Summary 4

Chapter 1: Introduction 6

Chapter 2: Young People Have Complex Lives and Wide-Ranging Needs 10

Chapter 3: Youth Get Information from Many Sources 15

Chapter 4: Young People's Knowledge Is Broad but Not Deep 21

Chapter 5: The Formal Health Care Sector Can Do More 24

Chapter 6: Barriers Are Especially High Among Vulnerable Youth 27

Chapter 7: We Can Protect the Next Generation 30

Appendix Tables 34

References 46

Executive Summary

In recent decades, the AIDS epidemic has added a deadly new dimension to Malawi's already numerous and complex public health challenges. The spread of HIV/AIDS is inextricably linked to other sexual and reproductive health problems, as the behaviors that expose people to HIV are the same behaviors that put them at risk for other STIs and unintended pregnancy. The youth of Malawi bear the brunt of these intersecting problems. Unintended pregnancy among adolescent women can lead to social stigmatization, loss of educational opportunities and physical harm, either from attempting an unsafe abortion or from giving birth before reaching physical maturity. Youth are also at high risk for STIs, including HIV, since many do not have the information they need to avoid unsafe behaviors, the willingness to risk embarrassment to obtain contraceptives or the knowledge to identify STI symptoms. Yet there is cause for optimism: Adolescents want to learn more about sexual and reproductive health matters, and many have already adopted protective sexual behaviors. New research findings on 12–19-year-olds, presented in this report, make it possible to fill many gaps in our understanding of adolescents' lives and identify avenues for government agencies and other key stakeholders to help youth protect their health.

For many, adolescence marks the onset of sexual activity and its concomitant health risks

- Among 15–19-year-olds, 26% of females and 49% of males are unmarried and sexually active; 26% of females and 3% of males have ever been married.

- Among 20–24-year-olds, 16% of females and 9% of males had had sexual intercourse by age 15, and by age 20, 79% and 74%, respectively, had done so.

- Condoms are the most commonly used contraceptive method. Among those who have used a method, 40% of females and nearly all males have used a condom; 13% of females have used the injectable.

- The majority of adolescent males did not use a condom the last time they had sex. Among 12–19-year-old males who had sex in the past year, 57% had one partner and did not use a condom at last sex; 8% had two or more partners and did not use a condom at last sex.

- Among sexually active 12–19-year-olds, 38% of females and 7% of males were not at all willing to have sex the first time. Ten percent of 15–19-year-old women have at some point in their lives been physically forced or threatened into having sexual intercourse.

- Transactional sex is a common part of dating: Among young people who have had sexual intercourse with someone other than a spouse during the past year, 80% of females and 9% of males have received something in exchange.

- Sixty-three percent of women aged 20 have had their first birth; among them, 18% wanted the child later and 15% did not want to have a child at all.

Young people get sexual and reproductive health information from many sources

- More young people (71%) receive information on sexual and reproductive health from the media than from any other source, and the radio is the most cited form of mass media.

- Among 12–19-year-olds, 67% of females and 73% of males say that it is important for sex education to be taught in schools.

- Young people prefer health care providers over any other source for information on sexual and reproductive health. Yet the proportion who receive information from health care providers (57%) is lower than the proportion who say they prefer them as a source (66%).

Young people's knowledge is broad but not deep

- More than 90% of young people are aware of HIV/AIDS. However, only 51% of females and 65% of males know that abstinence, being faithful and using a condom are three ways to avoid HIV infection.
- Misinformation about how pregnancy occurs is common: More than 40% of 12–19-year-olds believe that a woman cannot get pregnant the first time she has sex or if she has sex while standing up.
- Most adolescents know of at least one modern contraceptive method, but only 15% of young women and 24% of young men who have heard of the condom have witnessed a formal condom demonstration.
- Young people hold misperceptions about condoms: For example, among 12–19-year-olds, 44% of females and 32% of males believe that a condom can be used more than once.
- Although roughly two-thirds of young people know about STIs other than HIV/AIDS, knowledge about most STI symptoms is low.

Adolescents prefer to obtain reproductive health care from public sources

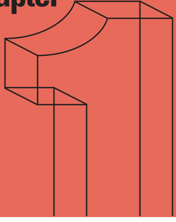
- Government hospitals and clinics are the most well-known and preferred source for contraceptive and STI services. However, nearly 40% of young people do not know of any place to obtain contraceptive methods, and 23–31% do not know of any sources for STI treatment.
- Among those who do know where to obtain such services, 51–63% of adolescents cite personal reasons, such as fear and embarrassment, as barriers to seeking sexual and reproductive health care.
- More than 70% of young people who have not had an HIV test express a desire to get tested, and most know of and prefer to go to government facilities. Still, only 7% of sexually experienced young people have been tested.
- Most adolescents who forgo being tested for HIV do so because they believe they are not at risk.

Outreach efforts must be tailored to the diverse needs of young people

- Early marriage and childbearing may isolate young women by leading to school attrition and reduced independence. Among out-of-school women aged 15–19, 11% say they discontinued their schooling because of a pregnancy.
- Females and rural youth tend to receive less education—and thus less school-based sex education—than their male and urban counterparts. For instance, 55% of rural females aged 15–19 are in school, compared with 78% of urban males of the same age.
- Rural youth are less likely than their urban peers to have obtained information on contraception from a reliable source. Fifty-eight percent of rural youth, for example, obtain such information from health care providers or teachers, compared with 82% of urban youth.
- Malawi's one million orphans, especially those whose parents are casualties of the HIV/AIDS epidemic, face a host of disadvantages that make it difficult for them to obtain information and services and thus place them at great risk of negative reproductive health outcomes.
- Poverty is associated with risk-taking behaviors among youth. Only 16% of females and 30% of males from households in the lowest wealth quintile used a contraceptive method at last sex, compared with 40% of females and 53% of males from households in the highest wealth quintile.

Action is needed on many fronts to meet the sexual and reproductive health needs of adolescents

- It is vital that accurate information on sexual and reproductive health be made available to all youth. Comprehensive school-based sex education taught by trained educators in all schools should be a top priority.
- Community-based and mass media education campaigns should provide accurate information and dispel myths about pregnancy and HIV; such efforts should target disadvantaged and hard-to-reach youth.
- To make sure sexual and reproductive health services are accessible and inviting to adolescents, service providers should be trained to offer youth-friendly care and information; young people should also be informed about where they can obtain services, including HIV testing.
- Stakeholders should address social and cultural barriers that increase adolescents' vulnerability to sexual risk by addressing stigma surrounding female sexuality, discouraging early marriage and encouraging responsible behaviors, especially among males.
- The Government of Malawi, in conjunction with the international donor community, should provide sufficient funding to fully implement its national programs and policies that support adolescent sexual and reproductive health.



Introduction

In the quarter century since the first case of AIDS was diagnosed, few parts of the world have been spared from its toll. Nowhere, however, has been hit harder than Sub-Saharan Africa, where the disease has decimated families and communities, crippled national economies and slowed the pace of efforts to alleviate poverty. Almost two-thirds of HIV-infected individuals live in Sub-Saharan Africa, where—as in other regions—young people are becoming infected at alarming rates. Worldwide, an estimated 40% of new infections are among those aged 15–24.[1(p.4)] Addressing the needs of youth, therefore, will be critical to stemming the epidemic.

Malawi has been especially hard hit by HIV. Fully 14% of 15–49-year-olds are HIV positive.[1] The current population structure is skewed toward the young: About 6.3 million (48%[2]) of Malawi's 13 million people are younger than 15;[3] 91,000 of this group are suspected to be infected with HIV.[1] The comparatively low incidence of HIV among this group presents a window of opportunity to reach young people with the information and tools they need in time to help them avoid infection.

The same behaviors that expose adolescents to HIV also endanger their health and well-being by putting them at risk for unintended pregnancy. Unintended pregnancy may harm young women if they are not physically or psychologically ready to carry a pregnancy to term, or if they try to terminate the pregnancy by means of an unsafe abortion. In addition, the stigma attached to unwed motherhood can cause young women to drop out of school, endangering their future economic prospects. Controlling the spread of HIV and preventing unintended pregnancy among Malawi's next generation will depend largely on equipping young people with the knowledge and skills to engage in healthy sexual behavior and increasing their access to sexual and reproductive health services.

New evidence provides insights into how to protect young people

This report presents key findings from a new body of research that describes the sexual and reproductive health needs of Malawi's youth. The information was gathered from young Malawians themselves through focus group discussions, in-depth interviews and a nationally representative survey on sex, relationships, marriage, HIV/AIDS and pregnancy among young women and men aged 12–19 (for more details on data sources, see box on page 8). Particularly noteworthy is the inclusion of data on very young adolescents (those aged 12–14), a group whose views and needs have not been extensively examined in prior research.

The report investigates how adolescents interact—and how they would prefer to interact—with schools, the health care system, mass media, community members and family to obtain sexual and reproductive health information and services. Investigating young people's knowledge about and attitudes toward these institutions provides key insights into what strategies will help foster sexual and reproductive health among youth. Drawing from this wealth of new information, the report provides policymakers and program managers in Malawi with specific recommendations to help them design and implement interventions that address the needs and preferences of young people—as expressed in their own words—regarding where to get the tools they need for healthy sexual development.

Young people's circumstances dictate their needs

Although HIV/AIDS and unintended pregnancy affect adolescents from every segment of Malawian society, young people's needs for information and services, and

their risk for negative outcomes, vary depending on many factors. Gender, poverty status, family structure, school status, marital status and place of residence all influence young people's sexual and reproductive health knowledge, attitudes and behaviors.[4–9] Thus, programs and policies must be targeted to address the diversity of adolescents' life circumstances.

Young women are particularly vulnerable to negative sexual and reproductive health outcomes. As in many other countries in the region, young Malawian women are at much greater risk than their male counterparts for HIV infection: Some 9.6% of young women aged 15–24 are HIV positive, compared with only 3.4% of young men.[1] This heightened risk is related in part to biological factors, but also to social and cultural norms, for instance, the tendency of adolescent women to marry men who are older and thus more likely than their wives to be HIV positive.[10,11]

HIV/AIDS has a disproportionate impact on the poorest members of society. People living in poverty have limited access to the resources needed to avoid HIV/AIDS, including education and health care.[10–12] Fifty percent of Malawians, including millions of children and adolescents, live below the poverty line.[13(p.11)] AIDS frequently perpetuates and deepens poverty by killing the most productive and economically important members of society, leaving their dependents vulnerable. Current estimates of the prevalence of orphanhood* suggest that 6% of Malawians younger than age 15 have lost their father to AIDS, 1% have lost their mother and 3% have lost both of their natural parents.[2(p.12)] Altogether, approximately one million children have lost at least one parent, making them especially vulnerable to malnutrition, school dropout and sexual abuse, among other risks.[14–16]

Culture and religion are important in young people's lives

Protecting the health of adolescents also means understanding the cultural factors that shape their attitudes and perceptions about sexuality and intimate relationships. Although Malawi has a rich and diverse cultural heritage, many prevailing norms and practices leave adolescents poorly equipped to protect their sexual and reproductive health.[17–19] Taboos against young people engaging in sexual activity are perpetuated by the authority figures to whom adolescents look for information and guidance, including parents and clergy. While disapproval of teenage sex may act as a disincentive to engage in sexual intercourse, it can also prevent the spread of vital knowledge and isolate sexually active youth, thus placing adolescents at risk for HIV/AIDS and other negative sexual health outcomes. Efforts to promote sexual and reproductive health among young Malawians must work within traditional cultural practices to support improved communication about sexual behavior and access to needed services.

Religious institutions are major cultural influences in Malawi. Nearly all young people belong to a religious group—the most dominant being Protestant, Catholic, Pentecostal and Islamic—and most of them say that religion is very important to them and report that they attend religious services at least once a week.[20(p.40)] In addition, about a quarter of adolescents belong to a church-based social group. Yet the church is not generally a good source for complete and accurate information on sexual and reproductive matters: Few adolescents report having learned about contraception and HIV/AIDS from their church, and even fewer express a desire to learn about such matters from this source.[20(pp.122&136)] Nevertheless, the large role that religion plays in young people's lives demonstrates the opportunity churches have for reaching young people with information on sexual health matters.

HIV/AIDS and unintended pregnancy are interconnected issues

HIV/AIDS cannot be addressed in isolation from other sexual and reproductive health risks. Unprotected sexual intercourse may lead not only to HIV infection, but to unintended pregnancy and early childbearing. Young women experience high rates of pregnancy in Malawi: There are 162 live births for every 1,000 women aged 15–19.[2] Many teenage pregnancies are unintended, signaling a high level of unmet need for family planning services among youth. Condom education and distribution are examples of strategies that help reduce the prevalence of both HIV and unintended pregnancy.

There is widespread consensus in Malawi—including at the governmental level—about the need to reduce HIV prevalence and early and unintended childbearing. Most important, though, is the fact that young women and men themselves express a strong desire to delay childbirth for three or more years,[2] and a substantial proportion of sexually active youth who have used a condom say that they were motivated to do so out of a joint concern for avoiding pregnancy and HIV/AIDS.[20(p.81)]

The government is taking positive steps to meet the sexual and reproductive needs of youth

Since the advent of HIV/AIDS, the Government of Malawi has coordinated a national response to the challenges posed by the epidemic. As early as the 1990s, the government began establishing youth-focused subcommittees of the District AIDS Coordinating Committee in every district of the country.[21] These Youth Technical Subcommittees are intended to provide services that benefit young people; they train headmasters and peer educators to provide HIV prevention education and distribute youth-friendly public education messages and materials on AIDS.

*In this report, orphans are defined as individuals younger than 18 who have lost one or both parents.

Data Sources

QUANTITATIVE DATA

This report is based largely on data from the 2004 Malawi National Survey of Adolescents, which was designed to investigate a wide range of issues related to sexual and reproductive health (especially the prevention of HIV) among adolescents aged 12–19. This nationally representative household survey was organized by the National Statistical Office, Zomba, Malawi, in collaboration with ORC Macro, the Centre for Social Research at the University of Malawi and the Guttmacher Institute; it took place between March and August 2004. The survey used a two-stage stratified sample design based on the sample frame used by the Malawi National Statistical Office for the Malawi Demographic and Health Surveys. The first stage involved the selection of enumeration areas from urban and rural strata. In the second stage, households were selected from the chosen clusters, and all 12–19-year-olds who had spent the night prior to the survey in each household (de facto residents) were eligible to be interviewed. A total of 4,031 adolescents aged 12–19 were interviewed (1,979 females and 2,052 males); the overall response rate was 90%. Further details about the survey and its findings are available elsewhere.[1–3]

QUALITATIVE DATA

This report also draws on qualitative data collected by the Guttmacher Institute and the Centre for Social Research at the University of Malawi. Eleven focus group discussions with 14–19-year-olds were conducted in 2003 to examine how young people in Malawi view sexual and reproductive health issues—including abstinence, condom use and STIs—and to determine their preferred and actual sources of sexual and reproductive health information and services. Participants were selected from both urban and rural areas and comprised a mixture of male and female and in-school and out-of-school adolescents. Urban focus group discussions were conducted in four townships in Blantyre City, one of the oldest urban areas in the country; rural focus group discussions were conducted in Mchinji, a remote area with a high fertility rate where a number of sexual and reproductive health programs have been implemented. Each discussion had 8–12 participants and lasted an average of two hours. The discussions were recorded, transcribed and translated from the local languages into English. Results from these discussions, along with findings from similar focus groups in Burkina Faso, Ghana and Uganda, have been published.[4]

In addition, 102 in-depth interviews were conducted in 2003 with 12–19-year-olds of both sexes to examine the context of and motivations behind adolescents' sexual and reproductive health behaviors—issues that are difficult to research using large-scale quantitative surveys that rely on closed-ended questions. Equal numbers of interviews were conducted in urban and rural areas. The total includes 15 interviews with adolescents from high-risk groups: those who worked or lived on the streets, worked as petty traders or resided in an orphanage. The discussions were recorded, transcribed and translated from the local languages into English. Further details about the study methodology and findings are available elsewhere.[5]

The government has also implemented various forms of sex education (often called life skills education in Malawi) as a way to promote sexual and reproductive health among adolescents. HIV/AIDS information was first introduced into school curricula in 1989.[22] On the basis of evidence showing the effectiveness of sex education in other countries, a more comprehensive curriculum was introduced in upper grades in 1998.[23] Because most pupils were dropping out of school after Standard 4, life skills classes were subsequently added in that grade to increase the proportion of young people who received positive sexual and reproductive health messages and to attempt to keep young women in school by providing them with information to prevent unintended pregnancies. In 2005, life skills education was introduced more broadly in both primary and secondary school classes.

Despite the government's commitment to life skills education, a number of problems are hampering implementation. These problems include a shortage of teachers, a lack of teaching materials, reluctance among teachers to address sexual and reproductive health issues, and a lack of training for teachers.[24] Furthermore, subjects in which standardized exams are required are often prioritized in school over subjects, such as life skills education, that currently require no exams. Finally, life skills education in Malawi is only mandatory in public schools; therefore, it is not known what life skills education, if any, private school students are receiving.[20(p.38)] Evaluations are being conducted to determine whether life skills curricula achieve their intended goals and to explore how the program could be improved.

In addition to life skills education, the Ministry of Education—with the support of the United Nations Children's Fund—launched anti-AIDS clubs, popularly known as Edzi Toto ("AIDS is not for me") in 1999.[25] The clubs, which are for both students and out-of-school youth, seek to provide interactive ways for young people to identify and change risky behaviors.

The current national response to HIV is guided by the National HIV/AIDS Action Framework for 2005–2009. This framework has a strong focus on youth. In addition, the National Population Policy and the National Family Planning Policy and Contraceptive Guidelines recognize the right of adolescents to receive family planning services, thereby paving the way for programs targeting their reproductive health needs.[26] The National Reproductive Health Program, for example, supports maternal health care, family planning services, and STI prevention and management services, including for adolescents. The National AIDS Policy is intended to mobilize resources to fund HIV prevention and AIDS treatment programs, including those focusing on youth, with special emphasis on orphans and other vulnerable subgroups.[27] The policy recognizes young women's vulnerability and asserts the government's commitment to protecting their health and rights by calling for gender-sensitive HIV prevention services.[27(p.20)]

These policies and programs are important steps in the effort to protect the health of the younger generation of Malawians. However, much more progress and financial and human resource investment are needed to halt the spread of HIV/AIDS and reduce early unintended child-bearing.

A guide to this report

This report discusses in detail some of the challenges in and opportunities for improving the sexual and reproductive health of adolescents in Malawi. Chapter 2 places HIV/AIDS and unintended pregnancy in context by providing an overview of the sexual behavior and relationships of young people in Malawi. Chapters 3 and 4 focus on young people's preferred sources of information and levels of knowledge about HIV/AIDS and unintended pregnancy. The potential of the formal health care sector to meet young people's sexual and reproductive health needs is the focus of Chapter 5, and Chapter 6 discusses the particular needs of specific groups of young people.

The challenge to improve the sexual and reproductive health of young people in Malawi is great but also achievable. Protecting the next generation will require the efforts of many stakeholders, including the Malawian government, nongovernmental organizations, community and religious leaders, families and young people themselves. Program and policy implications of this research are presented in the final chapter.

Laws and Policies

Below are laws and policies that affect the sexual and reproductive health of adolescents in Malawi. Not all have been fully implemented or enforced.

CONTRACEPTION

"Family planning services shall be provided to all women of reproductive age regardless of parity and marital status . . . . All women, men and young people shall have the fundamental right to determine the type of contraceptive to use, how many children to have and when to have them based on informed consent."[1]

STI TESTING

- "Legislation shall provide for 13 as the age of consent to voluntary HIV testing and 16 for other medical tests and treatment without parental consent."[2(Section 3.2.5.2)]
- The government shall "ensure that STI services are appropriate for and accessible to women, young people and other vulnerable groups."[2(Section A.2.4.1)]

SEX EDUCATION

- The government shall "ensure that children and young people have access to youth-friendly sexual and reproductive health information and education, including HIV/AIDS and STI information, appropriate to their age and needs, to equip them with knowledge and skills to protect themselves, in particular from HIV and other STIs. Peer education will be one of the possible modes of teaching."[2(Section 5.5.1)]
- The government shall "incorporate life skills education, including reproductive and sexual health education, into the school curricula as a subject in which students are regularly assessed."
- Similar programs shall be "made accessible to out-of-school youth to [enable them to] protect themselves, in particular, from HIV and other STIs."

PREGNANCY AND SCHOOLING

Young women must stop attending school during pregnancy and lactation, but they may reenroll in school afterward.[3,4] Young men who make someone pregnant must leave school for one year to help raise the child.

STATUTORY RAPE

"The Penal Code shall be revised to provide that sexual intercourse by an adult person with a child below the age of 16, whether or not there was consent, shall be a criminal offence."[2(Section A.2.3.2)]

ABORTION

Abortion is permitted only to save a woman's life, and then only with spousal approval and a doctor's authorization.[5,6] In all other cases, a woman who attempts to abort her fetus is subject to a seven-year prison sentence. Although adolescents are not specifically mentioned, abortion restrictions apply to all women.

FEMALE GENITAL CUTTING

"The Penal Code shall be revised to criminalize female genital mutilation."[2(Section A.2.3.3)]

PARENTHOOD

"Women have the right to full and equal protection by the law, and have the right not to be discriminated against on the basis of their gender or marital status which includes the right . . . to be accorded the same rights as men in civil law, including equal capacity . . . to acquire and retain custody, guardianship and care of children and to have an equal right in the making of decisions that affect their upbringing."[7]

Young People Have Complex Lives and Wide-Ranging Needs

Adolescents are a diverse group attempting to negotiate gender roles that they are assuming for the first time. Transitions commonly experienced during this time include sexual debut and, for young women, marriage and pregnancy. Gender, age and marital status all contribute to shaping the sexual and reproductive health needs of young people.

The majority of youth are sexually inexperienced

Health experts believe it is crucial to arm adolescents with information about their sexual and reproductive health *before* they become sexually active, so that when they do begin to have sex, they do so safely.[28(p.60)] Thus, it is promising that most Malawian adolescents aged 12–19—nearly four in five young women and three in five young men—report that they have never had sex.[20(p.61)] A far greater proportion of those aged 12–14 than of those aged 15–19 are sexually inexperienced.[29,30]

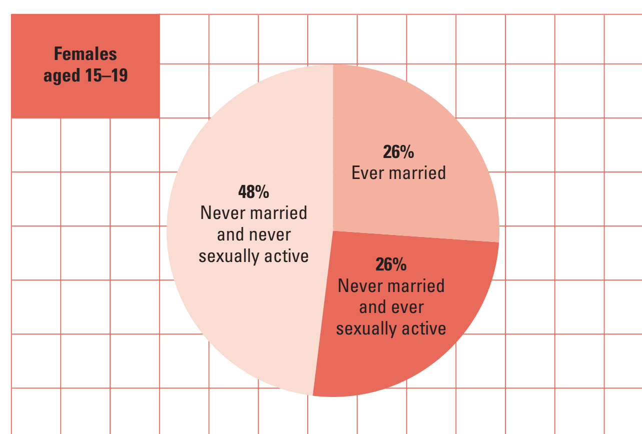
The desire to avoid HIV and other STIs—cited by more than 70% of sexually inexperienced youth—is the most common reason for abstaining from sex.[20(p.60)] In addition, about two-thirds of abstinent young women and nearly one-third of abstinent young men say that avoiding pregnancy is one of the reasons they have never had sex.

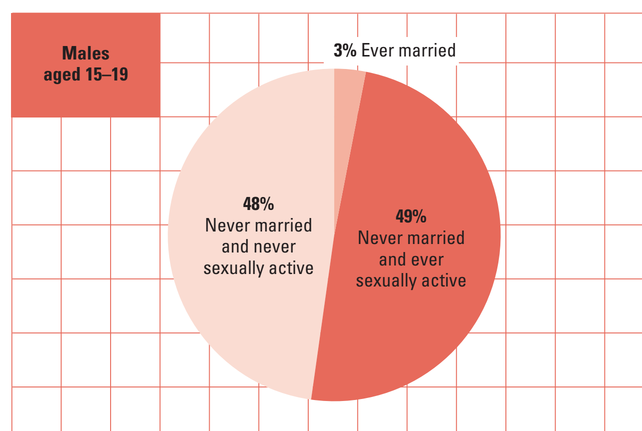
Sexual activity begins during adolescence

While many young people, especially 12–14-year-olds, have not yet begun to have sex, slightly more than half of 15–19-year-olds (52% of both females and males) are sexually active.[2(pp.103&104)] A much larger proportion of females than males experience sex within the context of marriage: Some 26% of young women are married, compared with 3% of young men (Figure 2.1). Females are about half as likely as males to be sexually active outside

FIGURE 2.1

One-quarter of female adolescents are sexually active outside of marriage, compared with one-half of male adolescents.





Source Reference 2 (pp. 103 & 104)

of marriage: Twenty-six percent of females have never been married and are sexually active, compared with 49% of males.

Young women tend to become sexually active earlier than young men. Among females aged 20–24, 16% initiated sexual activity by age 15, 57% by age 18 and 79% by age 20 (Figure 2.2).[2(p.99)] By contrast, among 20–24-year-old males, 9% first had sexual intercourse by age 15, 48% by age 18 and 74% by age 20.[2(p.97)]

For most young people, first sex occurs within the context of a relationship. More than 70% of sexually active adolescents—both males and females—report that their first partner was a girlfriend or boyfriend.[20(p.63)] Among the remaining 30% of young women, a husband or live-in partner is their first sex partner. Seventeen percent of adolescent men report a casual acquaintance as their first sex partner; only 2% first had sex with a wife or live-in partner.

The majority of adolescents have had no more than one recent sex partner.[20(p.65)] Among sexually experienced adolescent females, 23% did not have sex in the last 12 months, while 71% had sex with one partner and only 6% had sex with two or more partners. Among adolescent males who have ever had sex, 35% did not have sex in the last 12 months, 55% had sex with one partner and 9% had sex with two or more partners.

Condoms account for the majority of contraceptive use among adolescents: Forty percent of females aged 12–19 who have ever had sexual intercourse have used a condom; among similar males, that proportion is nearly 100%.[20(p.78)] The only other method that accounts for a sizable proportion of modern contraceptive use among adolescents is the injectable, which is used by 13% of females who have ever used a method.

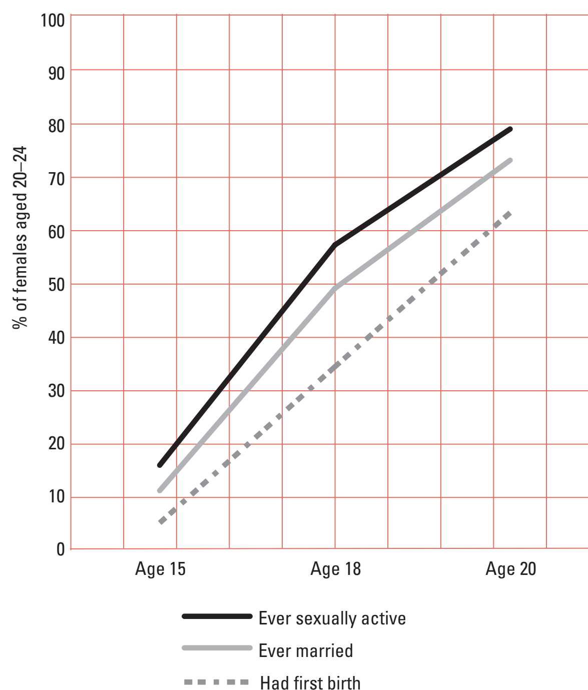
Despite having used a condom at one time or another, the majority of sexually active adolescent males do not use condoms consistently. Among males aged 12–19 who have had sex in the past year, 57% had one sex partner and 8% had two or more—all without using a condom the last time they had sex; 28% with one partner and 7% with two or more did use a condom at last sex (Figure 2.3, page 12).[20(p.111)] In other words, a greater relative proportion of those with two or more partners are using condoms than those with only one partner, yet a full 65% of sexually active young men last had sex without a condom.

Sexual coercion is a major public health concern

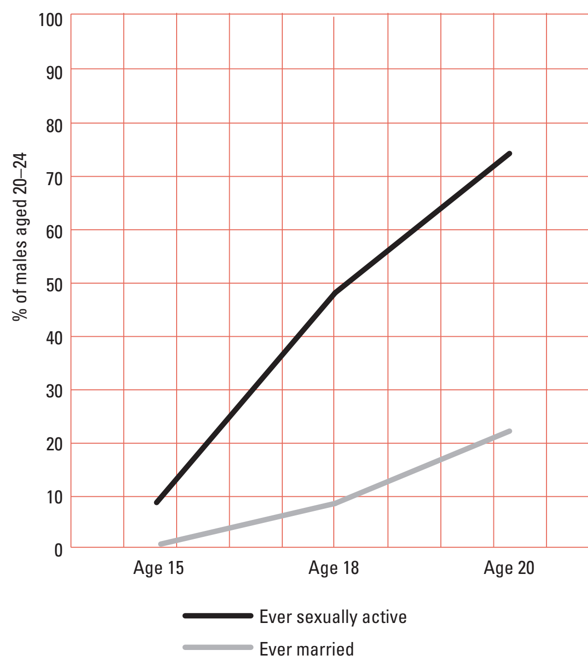
First sex is often consensual among Malawian youth. Seventy-one percent of men and 41% of women aged 12–19 who have ever had sexual intercourse report that they were "very willing" to have sex for the first time.[20(p.64)] An additional one-fifth of both females and males were "somewhat willing." However, 38% of sexually active young women and 7% of similar men report having been "not willing at all" the first time they had sex. Some

FIGURE 2.2

Sexual initiation occurs earlier among females than among males.



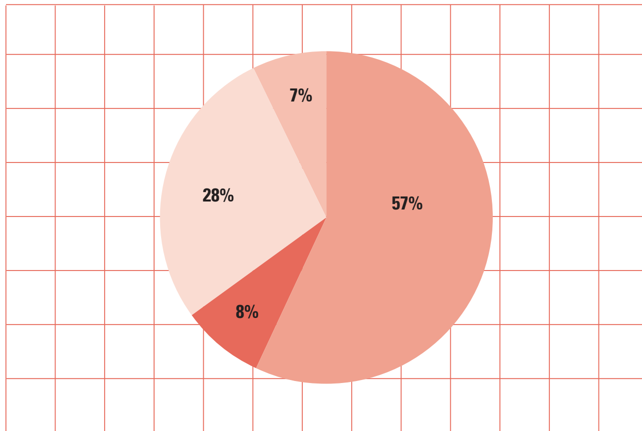
Source Reference 2 (pp. 65, 97 & 99).



Source Reference 2 (pp. 97 & 99).

FIGURE 2.3

The majority of males aged 12–19 did not use a condom the last time they had sex.



1 partner in past 12 months, no condom

≥2 partners in past 12 months, no condom

1 partner in past 12 months, used condom

≥2 partners in past 12 months, used condom

Source Reference 20 (p. 111).

of these young people experienced extreme forms of coercion: Nearly one in 10 young women aged 15–19 have been physically forced, hurt or threatened into having sexual intercourse, most commonly by a stranger, friend or schoolmate.[20(p.69)] Countless others have experienced less violent forms of pressure to have sex.

Sexual coercion and unwanted sex can have negative consequences for the reproductive health and psychological well-being of those who experience these events. The reproductive health risks include HIV and other STIs, unintended pregnancy (which may lead to unsafe abortion and concomitant injury), and the onset of risky sexual behaviors, including having unprotected sex and acquiring multiple sex partners.[31–34] Psychological consequences can include guilt, anxiety, substance abuse, depression and, in some cases, suicide or attempted suicide.[35]

Interviews with young people show that social stigma regarding premarital sexual activity may cause young women to feel too inhibited to say "no" to unwanted sex. In the following quote, the young woman was more willing to subject herself to unwanted sex than to "create a scene" by revealing to her parents that her boyfriend was in her bedroom.

> *He told me that . . . he couldn't let me get dressed. Then he told me that he wanted to have sex with me and he went on to say that he cannot control himself. Then I was dumbfounded because to scream would create a scene; then I just let him do what he wanted not realizing that I will end up being pregnant.*[36(p.39)]
>
> *—Female, aged 18, urban, in school*

Social norms dictating that men should initiate sex and that women should acquiesce make it difficult to identify coercion from young people's narratives.[36(p.39)] One 17-year-old female not in school described her sexual debut as follows: "When he suggested we have sex, I resisted but later accepted."[37] Such accounts may actually describe situations in which both adolescents want to have intercourse, but because it is socially inappropriate for young women to express sexual interest or desire, respondents' narratives do not distinguish between sex that is truly unwanted and sex that is stigmatized but wanted.

Interviews with young men indicate that they, too, experience pressure from their partners to have sex. The pressures that they most often identify are related to attempts by female partners to initiate sex—a reversal of traditional power dynamics.

> *Respondent (R): She forced me but I did not want.*
>
> *Interviewer (I): Did you want it or not?*
>
> *R: I wanted but for fear.*
>
> *I: So did she draw you into it or she just offered what you wanted?*
>
> *R: She just forced me.*
>
> *I: Why do you say it like that?*
>
> *R: Because I tried to resist by saying that that's all but she insisted that we should do it.*[37]
>
> *—Male, aged 14, urban, out of school*

Exchanging money and gifts for sex is common within relationships

In Malawi, it is common for young people, especially young women, to receive money or gifts in return for sex. Four in five young women and approximately one in 10 young men who have had sex in the past year with someone other than a spouse report having received something in exchange.[20(p.67)]

These transactions appear to be a routine part of dating.[38]

> *I: What was [your boyfriend's friends'] reaction when they heard that the two of you are going out?*
>
> *R: At first they told him that he should be giving me things or money.*
>
> *I: And what things did he give you?*
>
> *R: Clothes, shoes and soap…underwear like half-slips and pants.…*
>
> *I: What were the things you did together with this boyfriend?*
>
> *R: Playing, asking me to have sex. Sometimes I used to say yes, sometimes no.*[37]
>
> *—Female, aged 18, urban, out of school*

…cultural norms and economic necessity often push women into marriage at a young age.

Such cases cannot necessarily be attributed to the widely publicized "sugar daddy" phenomenon, in which much older partners exchange money or other items for sex with adolescent women, because most young women are close in age to their partners.[20(p.67),36(p.42)] Among young women who have received gifts for sex, nearly all (96%) were given money and more than half (52%) received clothing.[20(p.67)] Other gifts included food, soap, school fees and jewelry. Among young men who have received something in exchange for sex, the distribution of items received was somewhat different: Food was the most common gift (40%), followed by money (39%), clothes (28%) and jewelry (17%). The exact relationship between risk-taking behaviors and receiving gifts in return for sex requires further investigation, since analysis of these findings on transactional sex suggests that gifts are not necessarily coercive.[38]

Early marriage poses health risks

The Malawi constitution allows marriage—with parental consent—as early as age 15.[39] It is uncommon for adolescent men to be married, but cultural norms and economic necessity often push women into marriage at a young age. Families may view early marriage as a way to protect their daughters from the threat of sexual assault or to alleviate economic hardship.[40] For example, in the matrilineal tribes of Malawi, marriage involves bringing the husband to the wife's village to support her extended family. For some young women, however, early marriage leads to HIV infection or to pregnancy before they are physically or psychologically prepared for motherhood.

As would be expected, the proportion who get married before age 20 is much higher among females than males. Seventy-three percent of women are married before that age, compared with 22% of men (Figure 2.2, p. 11).[2(pp.97&99)] The median time span between sexual debut and marriage is relatively short for females—less than a year—whereas for males, it is five years. Among females, childbearing follows shortly after marriage: The first birth usually occurs after 0.9 years of marriage.

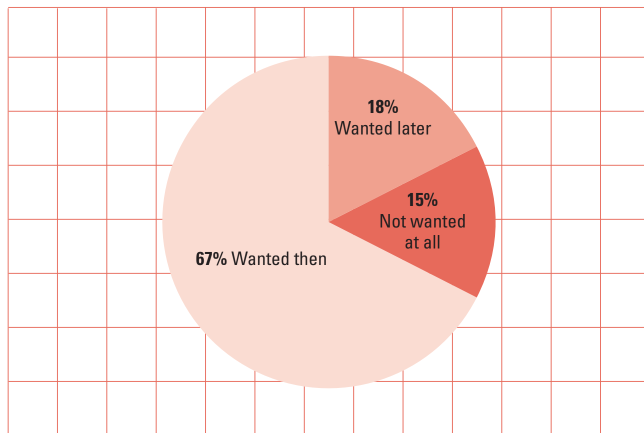
Global health experts increasingly point to a link between early marriage and HIV risk, particularly in countries, like Malawi, with a high prevalence of HIV/AIDS.[41,42] Young married women usually have frequent sexual intercourse. Since childbearing is integral to marriage in Malawi, marital sex is more likely to be unprotected than sex among unmarried adolescents. For instance, only 11% of married 15–19-year-old women used a condom the last time they had sex, compared with 38% of unmarried women that age who were having sex with a boyfriend.[20(p.103)] Married women are usually younger than their husbands, and such age disparities increase their risk of contracting HIV and other STIs because older partners are likelier than younger ones to be infected.

Early childbearing and unintended pregnancy are common

For young women, childbearing may occur before their bodies are developed enough to safely carry a pregnancy to term. This poses risks of obstetric injury and even death from obstructed labor or hemorrhage. Yet 63% of women have had their first birth by age 20.[2] One-third of these births are either mistimed or unwanted: Eighteen percent of young mothers wanted to delay their last birth, and 15% did not want their last pregnancy at all (Figure 2.4).[2(p.120)] Early parenthood is markedly less common among men: Only 1% of males aged 15–19 say they have ever made someone pregnant.[20(p.87)]

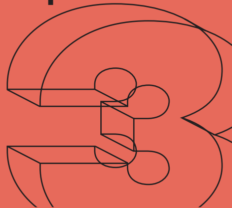
FIGURE 2.4

One-third of births to women younger than 20 are unintended.



Source Reference 2 (p. 120).

Some adolescents faced with an unintended pregnancy turn to abortion. Adolescents are more likely than adult women to delay seeking care once they know they are pregnant, and they are also more likely to use unskilled providers and dangerous methods if they attempt to induce an abortion.[43] Young women also tend to delay seeking care when abortion complications ensue, which can lead to serious medical consequences and death. One study to date has assessed abortion among adolescents in Malawi; the data come from a hospital-based sample of young women who were seeking treatment for abortion complications and do not offer insight into the prevalence of abortion in Malawi.[44] Because abortion is illegal and highly stigmatized, it is extremely difficult to get accurate information on its prevalence. Asking young people about their friends' experiences with trying to end a pregnancy may provide the most accurate picture of how many young Malawians attempt abortion. Nineteen percent of 12–14-year-old females and 40% of 15–19-year-old females say that they have had close friends who have tried to end a pregnancy.[20(p.89)] The methods of inducing abortion named by respondents include drinking herbal preparations and bitter medicines and taking unspecified tablets or pills—methods that may be harmful, as well as ineffective.



Youth Get Information From Many Sources

Adolescents in Malawi obtain sexual and reproductive health information (i.e., information on contraception, HIV and other STIs) from a variety of sources, including family members, the mass media, friends, teachers and health care providers. An understanding of the advantages and disadvantages of the various information sources that adolescents use and prefer can inform efforts to improve young people's knowledge of sexual and reproductive health issues. Educating younger adolescents, in particular, is key to ensuring that youth enter their sexual lives with accurate information (see box, page 16). Evaluations of programs that have been implemented to reach adolescents suggest promising avenues for further outreach.

Parents and other family members are not preferred sources of information

Educating Malawian youth about sexual matters has traditionally been the role of extended family members, including aunts, uncles and grandparents; it is not considered appropriate in Malawi for parents to speak to their children about sexual matters.[45(p.34)] Yet urbanization has reduced adolescents' access to sexual health information from family members by breaking up the extended family network.

> *Moderator: Now what are problems the youth face when they are seeking information concerning pregnancy?*
>
> *Participant: Sometimes parents do not feel free to advise their children.…A child feels free [to talk] with her grandparents, but our grandparents live in the village and we only meet them once in a while. As a result of this, we seem to lack information.*[45(p.34)]
>
> —*Females, focus group, urban, in school*

Very few young people prefer to receive information on contraceptive methods and STIs, including HIV, from family members; instead, they strongly prefer health providers and, to a lesser degree, teachers and mass media sources (Figure 3.1, page 17).[46] Adolescents express concern that parents are not able to address sexual and reproductive health issues without being judgmental, closed-minded or uncomfortable.[36] Nevertheless, some adolescents, females in particular, say they prefer to get information on HIV/AIDS and pregnancy prevention from their parents and grandmothers—relatives they consider to be trustworthy because of their life experiences and willingness to talk.[36]

The relatively low proportions of young people who receive—and want to receive—sexual and reproductive health information from their family do not reveal the full extent to which parents affect the sexual and reproductive health and behaviors of their children. Although direct communication with parents about sex-related matters may be limited, parental monitoring and other implicit forms of communication can nevertheless influence adolescents to adopt protective behaviors.[47] Unfortunately, 25% of adolescents do not live with a parent or guardian (Table 3.2, page 17).[46] This means that a substantial proportion of young people are not benefiting from this influence.

Mass media is an important informal source of information

Radio, television and other mass media play an important role in disseminating health information throughout the country. In fact, Malawian adolescents get much of their information on HIV prevention, treatment and testing, and other sexual and reproductive health issues, from mass media sources.[20] Indeed, among 12–19-year-olds, 60% of

females and 73% of males report having received information about HIV/AIDS from the mass media; however, only 22% and 27%, respectively, consider the media their preferred source.[20(p.136)]

Radio is the most accessible mass media source for young people: Among those aged 12–19, 42% of young women and 54% of young men listen to the radio almost daily; 20% and 17%, respectively, listen at least once a week (Figure 3.2, page 18).[20(p.119)] This medium is among the most frequently cited sources for information on contraception, STIs and HIV/AIDS among youth who know of any source, and is the most preferred media source for information on these topics.[20(pp.122,129&136)] Young Malawians who favor the radio as a source for health information say they like it because the radio allows information to travel quickly.[48]

What Do Younger Adolescents Need and Want?

New research on younger adolescents (those aged 12–14) points to ways of reaching this important but often overlooked group. Many 12–14-year-olds still live at home with at least one parent or guardian, and many are still in school, which makes them easier to reach with information than older adolescents. In addition, the vast majority of these young people have yet to initiate sex, which provides an opportunity to arm them with information on preventing HIV and unintended pregnancy before they are at risk. Understanding the needs and preferences of these young Malawians is key to designing interventions that promote healthy behaviors.[1]

YOUNGER ADOLESCENTS ARE NOT NAÏVE

Younger adolescents are aware of sexuality and intimate relationships. Although fewer than one in 20 females and one in five males aged 12–14 have had sex, 37% and 53%, respectively, know close friends who have become sexually active (Table 3.1);[2,3(pp.59)] even higher proportions have friends who have engaged in kissing and fondling.[3(p.59),4] Sexual intercourse among younger adolescents is not always voluntary: Four percent of females and 2% of males have ever been physically forced, hurt or threatened into having sex. Therefore, even though some adults may believe that younger adolescents are not ready for information about sex, many of these youth are already exposed to sex, including through first-hand experience.

THIS GROUP LACKS ESSENTIAL INFORMATION ABOUT HIV

While four in five 12–14-year-olds know that abstaining from sex is a means of preventing HIV transmission, only about half know all three tenets of the ABC method: abstaining from sex, being faithful (i.e., having one partner who is not infected and who has no other partners) and using a condom. Even fewer possess a full complement of basic information about HIV: Only 18% of females and 24% of males can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about the disease.

YOUNGER ADOLESCENTS WANT AND NEED SEX EDUCATION

Younger adolescents want to know how to protect their health: The majority of 12–14-year-olds (65% of females and 70% of males) believe it is important for sex education to be taught in schools.[3(p.121)] Nearly three in four females and more than two in three males in this age-group believe that 12–14-year-olds should be taught about how to avoid HIV/AIDS; two-thirds believe that they should be taught about using condoms to avoid infection.

TABLE 3.1

Percentage of 12–14-year-olds by measure of sexual activity and knowledge of HIV and other STIs, according to gender, 2004

Measure	Females	Males
SEXUAL ACTIVITY		
Ever had sex	3	19
Know close friends who have had sexual intercourse*	37	53
Ever been physically forced, hurt or threatened into having sex†	4	2
KNOW WAYS TO PREVENT HIV TRANSMISSION		
Abstain from sex	79	80
Have just one uninfected, monogamous partner	58	68
Use a condom correctly at every sexual intercourse	63	72
KNOW OF THE ABC METHOD OF AVOIDING HIV‡	44	55
HAVE ADEQUATE KNOWLEDGE OF HIV TRANSMISSION§	18	24
KNOW OF AN STI OTHER THAN HIV	48	50

Notes *Among unmarried respondents only. †Respondents were asked about forced sex only if no one older than three was present or within hearing range. Only one eligible adolescent per household was asked about forced sex. ‡ABC=abstain, be faithful and use condoms. §Know that HIV transmission can be reduced by having sex with only one, faithful, uninfected partner and also by using condoms; that a healthy-looking person can have HIV; that a person cannot get HIV from mosquito bites; and that a person cannot get HIV from sharing food with someone who is infected.
Sources References 2 and 3 (pp. 59 & 96).

These findings show that younger adolescents are an ideal target for outreach campaigns and educational programs. As more than nine in 10 adolescents aged 12–14 attend school,[3(p.36)] efforts to improve school-based sex education are likely to have a widespread effect. In a country where the overall HIV/AIDS prevalence is 14% and 41% of pregnancies are unintended, policymakers must not miss out on the opportunity to empower youth with the information and skills they will need when they become sexually active.[5,6]

Although the majority of youth have at least occasional opportunities to listen to the radio, many adolescents have very limited access to this and other types of media. More than two in 10 young women and one in 10 young men do not listen to the radio at all; 72% of young women and 49% of young men never watch television; and among young people who have ever been in school, 60% of women and 55% of men never read newspapers or magazines.[20(p.119)] Sixteen percent of young women and 9% of young men report that they are not exposed to any media sources.

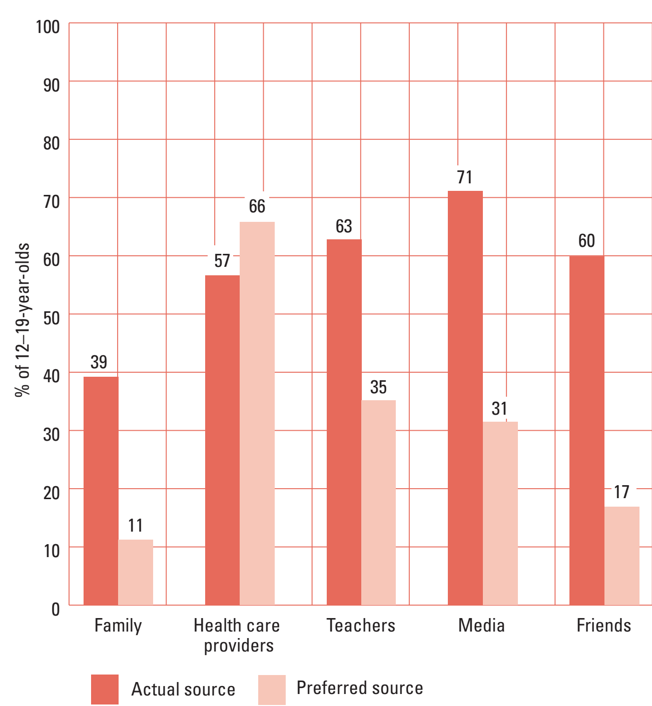
The Internet is a medium through which adolescents could potentially gather information about sexual and reproductive health matters while maintaining their privacy and avoiding embarrassment. However, it is not currently a source of information for adolescents in Malawi. Fewer than 1% of both males and females have ever used the Internet.[20(p.119)] Even though exposure has increased quite rapidly in other parts of the world, the situation in Malawi has changed little since data were collected in 2004. Internet access remains extremely limited in the country as a whole, and Internet cafes are too expensive for most Malawians to afford.[49]

Adolescents who have access to the media note certain drawbacks to using it as a source for sexual and reproductive health information. Some believe that journalists, radio hosts and television hosts do not always provide accurate information. Others feel dissatisfied with such sources because they are impersonal and not interactive.

> *It is good to hear things from the radio, but the problem we have concerning this source is that when something is not clear and you want to ask a question, that opportunity is not there.*[45(p.32)]
>
> *—Males, focus group, rural, out of school*

FIGURE 3.1

Young people prefer to receive sexual and reproductive health information from health care providers, but most commonly get it from the media and teachers.



Source Reference 46.

TABLE 3.2

Percentage distribution of adolescents by their living arrangements, according to gender and age, 2004

Living arrangement	Females 12–14	Females 15–19	Males 12–14	Males 15–19	Total
Does not live with a parent or guardian	24	33	19	24	25
Lives with one or both parents	69	60	72	67	67
Lives with a guardian only	7	8	9	9	8
Total	100	100	100	100	100

Source Reference 46.

Information from peers is plentiful, but seldom preferred and often inaccurate

While 60% of young people receive sexual and reproductive health information from friends, only 17% cite friends as a preferred source of information (Figure 3.1).[46] Friends are not viewed as credible, particularly when it comes to HIV prevention information, and indeed they often transmit false or incomplete information. For example, a 14-year-old male not in school reported having been told by a friend that HIV/AIDS enters the fingernails and causes the fingers to become longer.[36(p.25)]

Respondents trust their friends more when it comes to discussing pregnancy prevention, and they feel free to speak openly with their friends on this sensitive subject.[36(p.29)] Although some adolescents say they get information from peers that helps them abstain from sex and use condoms, information from friends is, in fact, frequently inaccurate. Sometimes the adolescents know the information to be false, other times they do not.

> *Interviewer (I): Has anyone ever talked with you about preventing pregnancy?*
>
> *Respondent (R): Yes.*
>
> *I: Who?*
>
> *R: [Friend's name].*

I: What did you talk about?

R: She said she learnt at school if a man asked you to meet him on a particular day, you should suspend it to a later date, you count on the days.

I: What do you count on?

R: She said if you have already had your menstruation that month you cannot become pregnant if you had sex with a man, but I take it to be false.[37]

—Female, aged 13, urban, in school

Peer education is a popular strategy for teaching young people about sexual and reproductive health matters, and it is important to recognize that adolescents' ambivalent or negative attitudes toward receiving such information from friends does not reflect on these strategies. Although some of the friends referred to above may have been peer educators, respondents were not given the opportunity to distinguish between trained peer educators and untrained friends.

Until recently, most adolescents had not received sex education

Given the large proportion of young people who are in school (74% of females and 81% of males aged 12–19[20(p.36)])—as well as the drawbacks associated with other common sources of sexual and reproductive health information—schools may be the best forum for conveying this information to Malawian youth. Yet, until recently, most adolescents did not receive sex education in schools. Among 12–14-year-olds, only 13% of females and 19% of males reported receiving sex education in school; the proportions are 14% and 31%, respectively, among 15–19-year-olds (Figure 3.3).[*20(p.141)] Two in three adolescents who had attended school reported that their schools did not offer classes or talks on sex education. Even among those who said that their school did offer such opportunities, many had not attended classes or lectures.

Although sex education is now mandatory in all public schools, implementation remains somewhat problematic. For one, the introduction of sex education met with resistance from some teachers.[50] Although their reluctance to teach the subject is said to be waning, facilitated in part by teacher training, some teachers continue to skip certain topics because of embarrassment or personal beliefs. Young people's accounts of sex education classes and lectures show that there can be great variation in what is taught under the rubric of sex education.

I: Who taught you?

R: A teacher, Mr. K.

I: …And he talked about condoms?

R: Yes.

I: What did he say about condoms?

R: He said if one does not want to contract HIV/AIDS [she or he] must use a condom during intercourse.

I: What did he say on abstinence?

R: [Silent]

I: Was abstinence talked about?

R: No.

I: How about staying a virgin until marriage. Was that tackled?

R: No.

I: How about the importance of being faithful for those married?

R: No, it was not talked about.[37]

—Female, aged 12, urban, in school

I: When you were still in school were you told anything?

R: Concerning AIDS?

I: Yes.

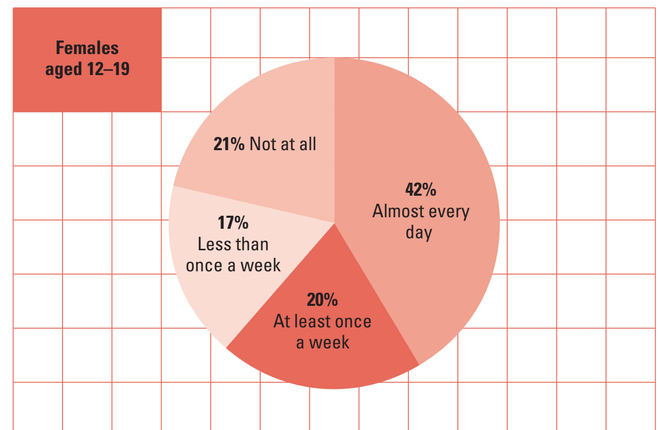
R: Yes.

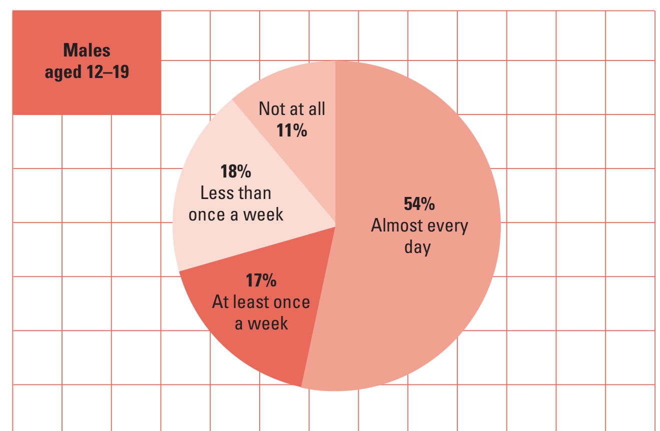
I: What were you told?

*These data were collected in 2004, the year before the broadest life skills policy to date was introduced (see Chapter 1). If these data were to be collected today, it is likely that higher proportions of young people—but not all in-school adolescents—would report receiving sex education. The curriculum's implementation remains uneven and its quality is inconsistent.

FIGURE 3.2

Most adolescents have some exposure to the radio.





Source Reference 20 (p. 119).

R: We were told about abstinence to prevent HIV/AIDS because a lot of youths today are not trustworthy.

I: Why are they not trustworthy?

R: They can have more than one sexual partner and having sex with them all, they may not tell who has the disease, and they end up contracting HIV or pregnancy. While you have contracted HIV/AIDS you can be told to drop out of school, ruining your future.

I: Did you find your talks useful?

R: Yes.

I: How?

R: I learnt about abstinence because it would not be welcome for me to be HIV positive.[37]

—Male, aged 13, urban, living on the streets, out of school

A second barrier to sex education is that it is not currently a subject that is tested or graded in Malawi. By the time young people enter secondary school, strong emphasis is placed on preparing pupils for standardized exams. Scores on these exams play an important role in determining whether a young person will be eligible for further educational opportunities, including university. Far less classroom time is spent on subjects that are not tested, including sexual and reproductive health. These subjects are sometimes taught at the end of the school day; that way, they can be cut short if higher-priority classes last longer than expected. Furthermore, when there is a shortage of teachers, sex education may not be taught at all.[50] These challenges make it difficult to ensure that young Malawians are exposed to a standardized curriculum, such as the life skills syllabus developed by the Ministry of Education.[51]

At the same time, young people express a strong desire for sex education in schools: More than two-thirds of young Malawians who have attended school feel that it is important for sex education to be taught in this setting (Figure 3.4).[20(p.121)] In addition, fewer than one-third of both females and males who have attended school believe that sex education encourages sex. Fully 79% of females and 75% of males believe youth aged 12–14 should be taught about how to avoid AIDS. Furthermore, one-third of adolescents say they prefer teachers as sources of information on contraception and STIs, including HIV/AIDS.[20(p.129&136)]

Health providers are adolescents' most preferred source of information

Although young people express a greater preference for getting information on sex-related matters from school, rather than from parents, friends or mass media, health care providers are by far the most preferred source for such information. In fact, health care providers stand as the lone source for which adolescents' preference (66%) is higher than their actual use (57%; Figure 3.1).[46] Among adolescents who know of at least one contraceptive method, 52% of young women and 35% of young men have received information on contraception from health care workers.[20(p.122)] An even greater proportion (65% of young women and 47% of young men) prefer health care providers as their source for this information.

In qualitative interviews, youth often expressed beliefs that health workers are knowledgeable, give good advice and provide accurate information.

I: Are there people you feel you can go to for information about [HIV/AIDS]?

R: Yes, there are.

I: Who?

R: I can go to a nurse.

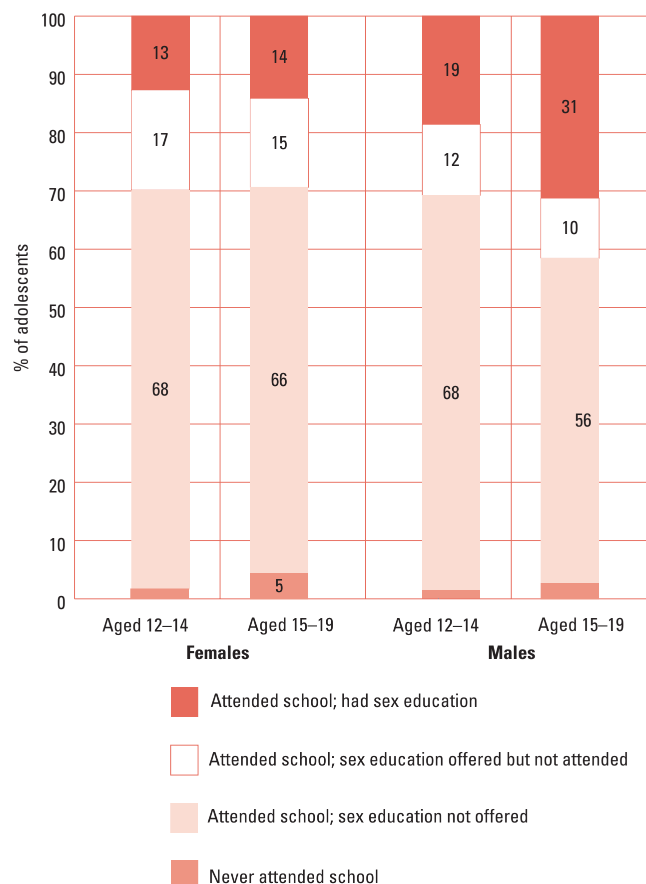
I: Why do you think you can go to a nurse?

R: I can go to a nurse because I am assured of getting reliable information.[36(p.26)]

—Mother, aged 18, urban, out of school

FIGURE 3.3

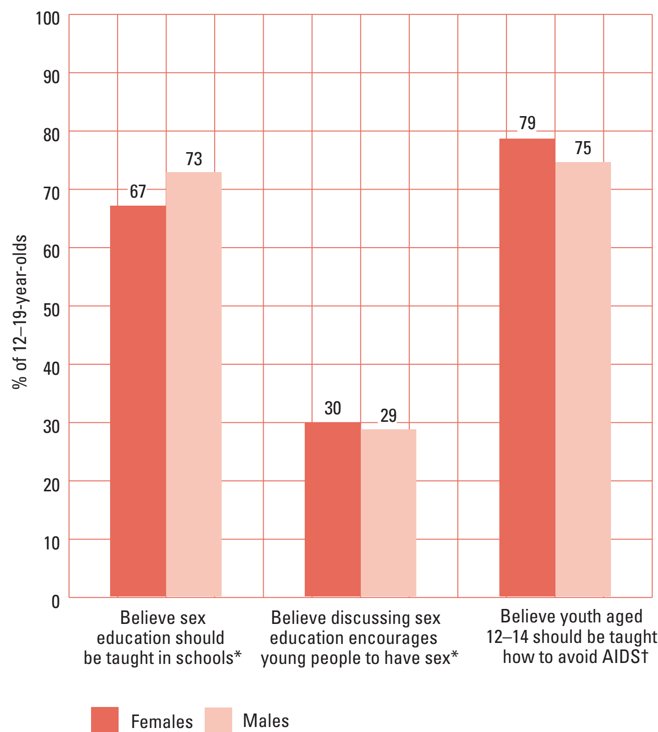
Before 2005, few adolescents received sex education.



Source Reference 20 (p. 141).

FIGURE 3.4

Most young people have positive opinions about school-based sex education.



Note *Asked of those who ever attended school.
†Asked of those who have heard of AIDS.

Source Reference 20 (p. 121).

Programs use a variety of strategies to reach youth with sexual and reproductive health information

Community-level and national program designs draw on research and experiential evidence to determine how best to communicate with young people about sexual and reproductive health matters. Unfortunately, it is often difficult to determine which approaches work best because programs intended to improve sexual and reproductive knowledge and outcomes among adolescents are rarely reviewed in published evaluations—a problem that exists not only in Malawi, but throughout the region. Rigorous evaluations of program impact would help to determine which programs effectively impart information to youth and are worth scaling up.

A few useful international and Malawi-specific reviews do exist. For instance, recent reviews have found that education that includes information about both abstinence and contraception is more effective in decreasing risky behavior among youth than education focused solely on abstinence.[52,53]

A review published in 2004 evaluated 11 school-based HIV/AIDS risk-reduction programs for youth, including programs in Tanzania, Uganda and Malawi. The Malawi program, an after-school program for secondary school students that used an educational board game, was not considered successful.[54] Programs deemed effective at targeting primary and lower-secondary school pupils had strong program and evaluation designs, as well as the following "promising components": They built on theoretical frameworks, such as cognitive theories of behavior, theories of learning and pedagogy, and theories of community influence and power; they targeted a young (primary school–age) audience before they became sexually active; they anticipated and proactively addressed resistance from teachers and communities toward condom education; they ensured adequate material and human resources; and they provided proper training for teachers and encouraged their commitment to the program.

Another useful evaluation is a review of two components—anti-AIDS clubs and media campaigns—of Going to Scale: Sustained Risk Reduction Behaviour for Youth, a three-year program (1997–2000) in Malawi set up to implement a series of school-based extracurricular activities.[55,56] Unfortunately, evidence that Going to Scale had improved young people's knowledge of HIV/AIDS was weak.[57] This assessment underscores the importance of using measurement and evaluation to document the successes and challenges of programs aimed at reducing HIV/AIDS. The review also recommends focusing resources on interventions that acknowledge and deal with HIV/AIDS as a multifaceted issue affected by numerous social and economic factors, rather than through health sector–based epidemiologic interventions alone.

An evaluation of Malawi's Fourth Country Program, conducted in 2002 by the United Nations Development Programme and the United Nations Population Fund, found this program to be promising. The program's life skills curriculum was deemed an effective channel for introducing sexual and reproductive health information in primary and secondary schools, and its peer education, community-based distribution services and interactive communication approaches were found to have positive effects on behavioral change among young people.[58] In addition, during the program's four years, the number of primary health care facilities offering reproductive health services grew, as did the number of community-based personnel providing such services, including condom distribution, to youth. However, the assessment also revealed that, despite strong demand for life skills curricula among parents and students, teaching of sexual and reproductive health in schools encountered considerable resistance from religious leaders and some policymakers.

Young People's Knowledge Is Broad but Not Deep

Complete, accurate information about health and health care empowers youth to make choices that promote their well-being, allowing them to lead healthy, productive lives. Yet many young men and women in Malawi lack information that would enable them to prevent negative sexual and reproductive health outcomes. Although the overwhelming majority of youth have heard of HIV/AIDS, many adolescents have incomplete or inaccurate knowledge about how the disease is transmitted. Similarly, many youth are misinformed about how pregnancy occurs, and although most have heard about methods of contraception, large proportions of adolescents have not received the practical instruction needed to use them effectively. Young people also know very little about STIs other than HIV.

Many young people have heard of HIV/AIDS but are lacking critical information

The vast majority of young Malawians—more than 90% of young men and women in both rural and urban areas—have heard about HIV/AIDS.[20(p.94)] Encouragingly, awareness is as high among 12–14-year-olds, most of whom are still sexually inexperienced, as it is among adolescents as a whole.

Awareness of HIV/AIDS is an important first step toward prevention, but without knowledge about how HIV is transmitted and prevented, young people are unprepared to take effective action to protect themselves and their partners. An analysis of young people's awareness of HIV shows that only 51% of females and 65% of males in Malawi know about abstinence, being faithful and using a condom—the three main ways to avoid HIV infection.[20(p.94)] Even among wealthier, older and in-school youth, knowledge is incomplete: For instance, among 15–19-year-olds from the wealthiest households (those in the top 20% of the wealth index), 67% of females and 83% of males know the three main ways to avoid HIV. Young women in the Central Region of the country are less knowledgeable than those in the Northern and Southern Regions, while young men in the Northern Region are less knowledgeable than those in the Central and Southern Regions.*

Dangerous misperceptions about HIV/AIDS continue to circulate, yet their prevalence is low. Five to six percent of teenagers believe that a man infected with HIV can be cured if he has unprotected sex with a virgin.[20(p.94)] Although it is alarming that anyone believes this myth, it is encouraging that the proportions are low, possibly because of a high level of media coverage on this topic.

Misinformation about pregnancy prevention is common

Adolescents' understanding of how pregnancy occurs informs their decisions regarding contraceptive use. Thus, addressing young Malawians' misperceptions on this subject is integral to preventing unintended pregnancies. The most prevalent myth about pregnancy prevention is that a girl cannot get pregnant the first time she has sexual intercourse: Nearly half of all 12–14-year-olds and more than a third of older adolescents believe this to be true.[20(p.86)] In addition, more than four in 10 young women and young men believe that a woman cannot conceive if she has sex standing up. Substantial portions of adolescents also believe that a woman cannot get preg-

*The Northern Region includes the districts of Chitipa, Karonga, Rumphi, Mzimba and Nkhata-Bay. The Central Region includes the districts of Nkhotakota, Kasungu, Ntchisi, Dowa, Salima, Mchinji, Lilongwe, Dedza and Ntcheu. The Southern Region includes the districts of Mangochi, Machinga, Zomba, Phalombe, Chiradzulu, Blantyre, Balaka, Mwanza, Chikwawa, Thyolo, Mulanje and Nsanje.

Adolescents' understanding of how pregnancy occurs informs their decisions regarding contraceptive use. Thus, addressing young Malawians' misperceptions on this subject is integral to preventing unintended pregnancies.

nant if she washes herself immediately after sex or if her partner withdraws before ejaculating. One rural, out-of-school 12-year-old explained that, rather than using condoms, his partner would urinate after intercourse to avoid pregnancy: "She urinates after sex. Then we are sure that she has prevented it because she has spat the things that would have made her pregnant."[36] These widespread misconceptions are cause for alarm, considering that many sexually active adolescents do not want to experience or cause an unintended pregnancy and may be unknowingly putting themselves at risk.

Awareness of contraception is high, yet knowledge on effective use is lacking

Most 12–19-year-olds are aware of contraception: Fully 82% of young women and 90% of young men know of at least one method; proportions are even higher among the 15–19-year-old subset.[20(p.74)] The contraceptive method that young people are most likely to know is the male condom, followed by female sterilization, the injectable, the pill and male sterilization.

Awareness of modern methods of contraception means little, however, if adolescents are not equipped to use these methods correctly. Only 15% of young women and 24% of young men who have heard of the male condom have actually seen a formal condom demonstration (Table 4.1).[20(p.106)] Moreover, incorrect knowledge is prevalent: Twenty-one percent of young women and 15% of young men disagree with the statement that a "condom should always be put on before sexual intercourse starts." Even larger proportions (32% of females and 16% of males) disagree with the statement that a "condom should be put on only if the penis is fully erect or stiff." Finally, more than

TABLE 4.1

Percentage distribution of 12–19-year-olds who have heard of the male condom, by measure of condom knowledge, according to gender, 2004

Measure	Females	Males
HAVE SEEN A FORMAL CONDOM DEMONSTRATION		
Yes	15	24
No	85	76
Don't know	0	0
CONDOM SHOULD ALWAYS BE PUT ON BEFORE SEXUAL INTERCOURSE STARTS		
Agree	76	83
Disagree	21	15
Don't know	2	2
CONDOM SHOULD ONLY BE PUT ON IF THE PENIS IS FULLY ERECT OR STIFF		
Agree	57	80
Disagree	32	16
Don't know	11	4
CONDOM CAN BE USED MORE THAN ONCE		
Agree	44	32
Disagree	51	65
Don't know	4	3
Total	100	100

Source Reference 20 (p. 106).

four in 10 young women and three in 10 young men agree that a condom can be used more than once.

Certain common notions—including that condoms have small holes through which HIV can pass and that they are prone to bursting during intercourse—are impeding condom promotion efforts. Although condom breakage may indeed occur during sex on rare occasions, the expectation that this will happen far outweighs the actual probability. Interviews suggest that fear-based misconceptions are sometimes perpetuated by authority figures, including teachers.

> *Interviewer (I): Was there anything mentioned about condoms in the talks [by teachers]?*
>
> *Respondent (R): Yes.*
>
> *I: What was said about condoms?*
>
> *R: They said that people will persuade you to have sex with them saying they are going to use condoms, but condoms do not provide 100% protection because they are prone to bursting and sometimes they have pores, hence they cannot be trusted.*[36(p.25)]
>
> *—Female, aged 13, urban, in school*

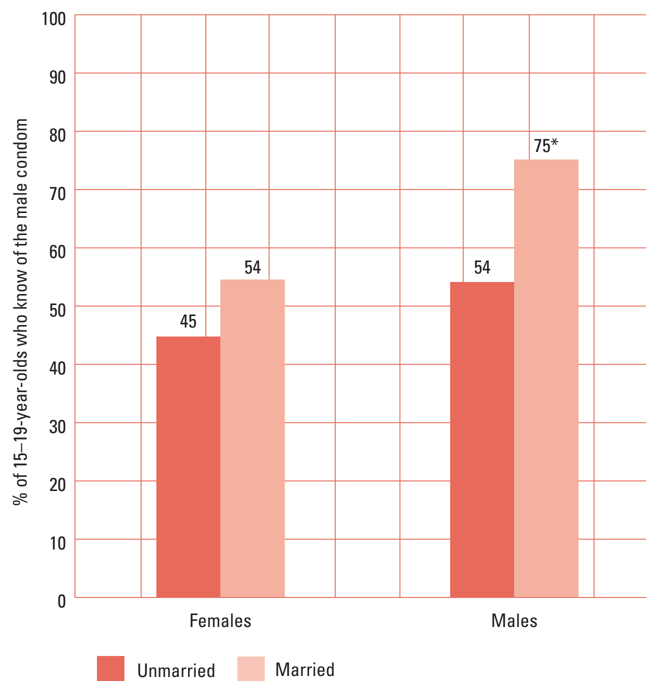
Furthermore, among young people who know of the male condom, more than half of married women and of both married and unmarried men feel that using a condom is a sign of not trusting one's partner (Figure 4.1).[46] In addition, approximately two in five young women aged 15–19 say that they are not at all confident about getting a male partner to use a condom.[20(p.107)]

Knowledge of STI symptoms is incomplete

Although about two out of three Malawian adolescents have heard of STIs other than HIV, much smaller proportions of young people are aware of the symptoms that accompany these infections.[20(p.96)] When asked which types of STI symptoms they know, adolescents who have heard of an STI besides HIV most often named genital ulcers and sores, followed by discharge, warts and growths on the genitalia, and burning pain during urination. Only one in 10 knew that tenderness in the lower abdomen and genital itching could indicate an STI. Low awareness of common STI symptoms can result in negative health consequences: Untreated STIs can develop into serious conditions, such as pelvic inflammatory disease, and several STIs (including syphilis, herpes and gonorrhea) increase the risk of HIV transmission.[59]

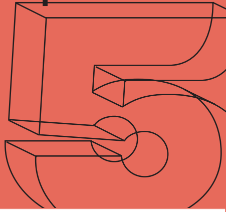
FIGURE 4.1

Many young people feel that using a condom is a sign of not trusting one's partner.



Note *N=16.

Source Reference 46.



The Formal Health Care Sector Can Do More

When adolescents know where to get services and have the confidence and resources necessary to obtain care, they are better able to protect their own health and the health of their sex partners. Unfortunately, a substantial proportion of Malawian teenagers do not know where to find contraceptive and STI services. Most of those who do know of a source for sexual and reproductive health care are aware of public clinics and hospitals, and they tend to prefer these government facilities to private providers and nongovernmental organizations (NGOs). Yet even when young people know where services can be attained, various personal and logistical barriers may prevent them from using these providers when they need them.

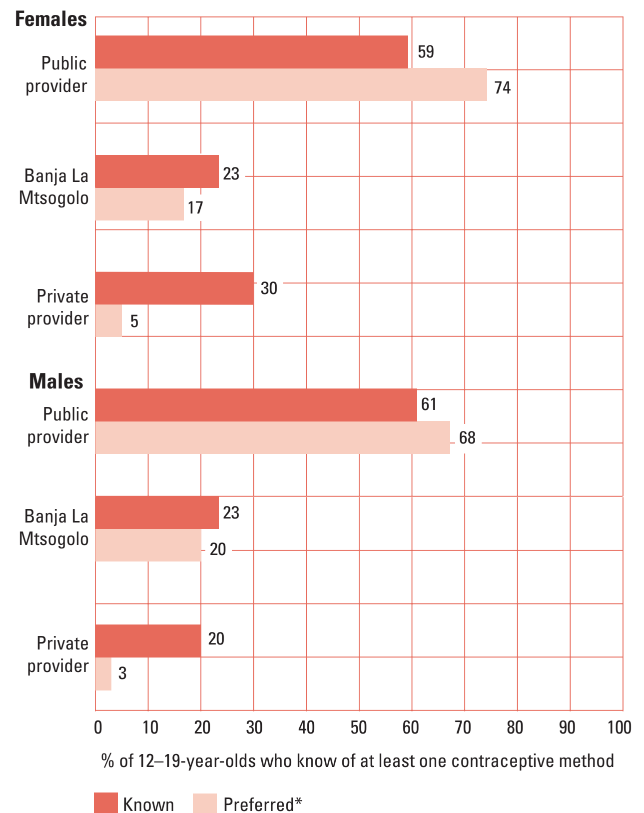
Public clinics are the most well-known and preferred source for contraceptive and STI services

Although nearly all adolescents know of at least one modern contraceptive and have heard of HIV, and the majority have heard of other STIs, many do not know where to obtain related health services: Almost 40% of young men and women do not know any source for obtaining contraceptive methods, while 31% of young women and 23% of young men do not know any source for the treatment of STIs.[20(pp.124&132)]

Government clinics are well known and heavily favored as a source for contraceptive services: Among adolescents who know of at least one contraceptive method, three-fifths of both males and females know of public facilities and the majority (three-quarters of females and two-thirds of males) prefer them over other sources (Figure 5.1).[20(p.124)] A sizable proportion—17% of young women and 20% of young men—name Banja La Mtsogolo, an NGO that runs clinics throughout the country, as their

FIGURE 5.1

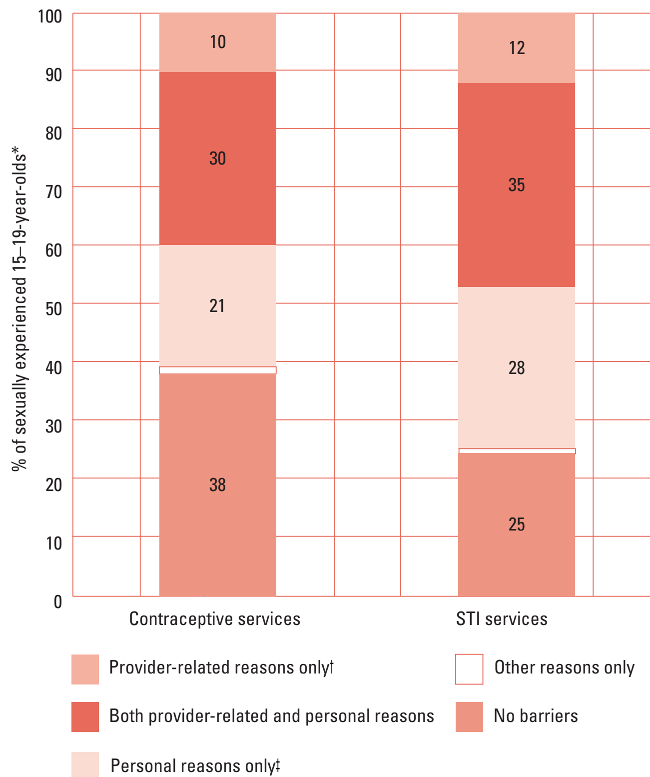
Adolescents know and prefer public clinics as a source for contraceptive services.



Note *Among those who know of a source.
Source Reference 20 (p. 124)

FIGURE 5.2

Both personal and provider-related barriers prevent adolescents from obtaining sexual and reproductive health services.



Note *Among those who know of at least one source for each service. †Provider-related reasons include inconvenient hours/days, lack of privacy, high cost, lack of same-sex providers, and that adolescents do not know where to go, do not know how to get there, cannot go alone and think they will not be treated nicely; for STI treatment only, treatment not effective. ‡Personal reasons include fear, embarrassment, shyness and being too young.

Source Reference 46.

most preferred source. No more than 5% of females and males who have heard of a contraceptive method and a source for obtaining contraceptives express a preference for private providers.

Public clinics and hospitals are also preferred for STI treatment. Approximately 80% of adolescents who know a source for STI care prefer government clinics, compared with 5% who prefer private facilities and 12% who prefer NGOs (primarily Banja La Mtsogolo).[20(p.132)]

Fear and embarrassment are the major barriers to seeking care

One of the keys to improving young people's sexual and reproductive health is understanding the challenges this group faces in getting the services they need. When it comes to obtaining contraceptive methods and STI diagnosis and treatment, young people perceive a number of barriers, both personal (such as feeling afraid) and provider related (such as not being able to locate, travel to or afford services; Figure 5.2).[46]

Feeling too afraid, embarrassed or shy to seek services may be the result of strong social stigma against premarital sex—particularly for young women. Such stigma could prevent people of either sex from seeking contraceptives, as doing so would require them to acknowledge being sexually active. In addition, young people's perception that parents are unwilling to talk about sex-related issues (see Chapter 3) may stand in the way of their obtaining health care, as many rely on parents to pay for medicine and care and to provide transportation to health clinics.[36(p.32)]

Adolescents' lack of trust in health care providers—manifested in fears that providers will not respect their privacy or treat them nicely—is also a major barrier that adolescents say inhibits them from obtaining contraceptives. Other prevalent provider-related barriers include the cost of services and not knowing of a provider or how to get there.

Young people face similar barriers to obtaining STI treatment. Like obtaining contraceptives, seeking treatment for STIs means acknowledging sexual activity; however, additional stigma is associated with STIs. Many of those who have forgone treatment when they experienced symptoms, particularly young women, cite embarrassment as their reason for not seeking care.[20(p.131)] One 16-year-old male who had experienced genital sores explained why he neglected to seek care for this symptom: "I was shy because if you are telling people about your problems it's like you are exposing yourself."[36(p.32)]

Embarrassment is at times compounded by the treatment adolescents receive or observe at health clinics.

> *Participant (P) 1: They [adolescents] even go to private clinics because at hospital they just shout, "Those having STIs should go there," so the person feels embarrassed.*
>
> *P 2: When you stay for a while like this, [the] consult medical officer saying "Eh! Those having gonorrhea whatever, there!" The way you know, so you stand amongst many people, so you feel embarrassed.*[45(p.37)]
>
> —*Females, focus group, urban, out of school*

HIV testing is widely known and in demand, but most adolescents have not been tested

As is the case in many countries where HIV prevalence is high, the mantra of "know your status" has become a critical part of Malawi's HIV prevention campaign. In addition to giving young people important information about their own health status, confidential HIV testing can play a central role in preventing the spread of the disease and in connecting people with other prevention and treatment services, such as antiretroviral therapy and programs to prevent mother-to-child transmission.

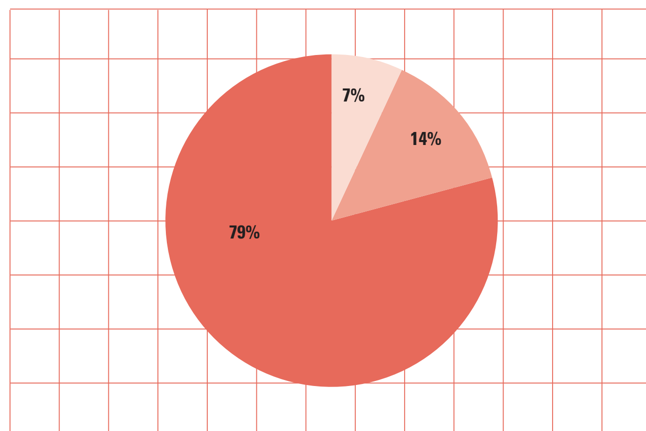
Although the majority of Malawian youth know that there is a test to diagnose HIV and where to get the test, use of testing services by young people is low. Only 7% of sexually experienced adolescents have been tested (Figure 5.3).[46] Low levels of testing are seen across the country, but the proportions of young men and women who have been tested are far lower in the Central and Southern Regions than in the Northern Region.[60,61]

Adolescents' behaviors indicate a preference for certain testing locations: Most of the young people who have been tested received their last test in a government hospital or clinic (57% of women and 48% of men); much smaller proportions were tested at a site of the Malawi Counselling and Resource Organisation or at a private clinic or hospital.

Of those adolescents who know about the HIV test but have never been tested, most (71% of females and 79% of males) say that they want to be tested.[20(p.140)] The majority (61%) say they have forgone testing because they are not sexually active or believe they are otherwise not at risk (Figure 5.4).[46] However, earlier findings show that many adolescents in Sub-Saharan Africa underestimate their HIV risk. According to a study of rural Tanzanians, for example, adolescents feel that an acquaintance or steady friendship lasting one month was adequate to ensure that one's partner does not have HIV.[62] Other reasons for not getting tested include not wanting to know one's status, the cost of obtaining a test and not knowing where to get tested.

FIGURE 5.3

Most sexually experienced 12–19-year-olds know about the HIV test, but few have been tested.



Have been tested

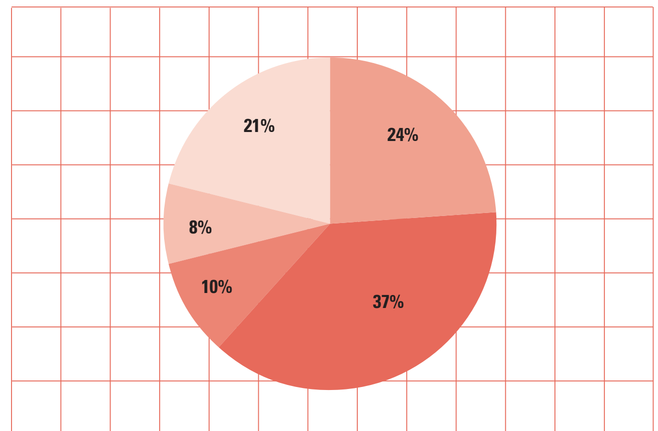
Do not know about the HIV test, or know about it but not where to get it

Know about the test and where to get it, but have never been tested

Source Reference 46.

FIGURE 5.4

Adolescents who know about the HIV test and want to be tested cite many reasons for not getting tested.



Not sexually active

Not at risk for other reasons

Not wanting to know status

Costs too much/no money for test

Other (e.g., logistical reasons and believing that one can get infected from the test)

Source Reference 46.

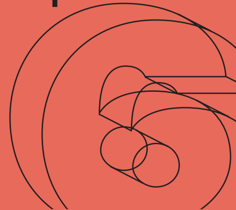
Youth indicate that logistical difficulties, including not knowing a testing facility or being able to travel long distances to reach one, hinder them from getting tested for HIV.

> *Moderator (M): Where do the youth go for a blood test?*
>
> *P 2: District headquarters.*
>
> *M: Oho, so how do they travel to get there?*
>
> *P 2: Transport is a major problem and hence the majority doesn't go there.*[45]
>
> *—Males, focus group, rural, in school*

Whereas some youth articulate the benefits of testing, others describe a range of negative feelings toward getting tested, including the possibility that a positive test will drive them to commit suicide or take revenge by intentionally spreading the disease.[*45(p.39)] Some also note that HIV-positive parents may neglect their children.

As policymakers and program managers seek to reach more young people with HIV testing services, it is important to bear in mind that the biggest hurdle has already been crossed: Most young people want to be tested. To take maximum advantage of this willingness, however, stakeholders must supplement health services with education that addresses the stigma attached to testing and the perceived social ramifications of knowing one's status.

*The idea that HIV-positive people in Malawi have intentionally infected others may be a myth. Ethnographic work conducted by the Malawi Diffusion and Ideation Change Project (based at the University of Pennsylvania) has yielded no evidence of this supposed phenomenon (source: Watkins S, University of California, Los Angeles, California, USA, personal communication, May 18, 2007).



Barriers Are Especially High Among Vulnerable Youth

All young Malawians need information and services to protect their sexual and reproductive health, yet access to these resources is unequal. An adolescent's gender, school status and area of residence, for instance, are likely to affect his or her ability to obtain information and services. Therefore, it is important to tailor policy and program actions to the unique circumstances of different groups of Malawian youth.

Young women face unique and overlapping challenges

Young women in Malawi face a number of disadvantages in obtaining sexual and reproductive health care, many of which are connected to their roles within relationships and in society.[63] Marriage and childbearing during adolescence lead women to leave school, isolating them from an important source of sexual and reproductive health information. Furthermore, a young married woman's access to the financial resources necessary to seek sexual and reproductive health care is often controlled by her husband.[2(p.283)] Such concerns are not pertinent to male adolescents, who tend to have more independence and do not get married as young.

Education is another area in which females are at a marked disadvantage when compared with their male peers. Although the introduction of free primary education in 1994 has dramatically increased young women's access to education,[64] schooling beyond the primary grades is still out of reach for many: In early adolescence, more than 90% of females attend school, but the proportion is only 58% among those aged 15–19; in contrast, 71% of 15–19-year-old males are in school.[20(p.36)]

Among young people who attend school, determination to excel in the classroom is a disincentive to engage in risky behaviors.[36(p.35)] Previous research shows that students in Sub-Saharan Africa are more likely than their out-of-school peers to delay sex and to use protection if they do have sex.[65] Many adolescents—even those who are not currently in school—believe that education is the key to a better life. The desire to become independent through continuing their education is a common theme among young women; some who have not had sex say that having a boyfriend is too time-consuming and express fear that being in a relationship will result in their dropping out of school.[36(p.35)] One female gave the following description of when she would be willing to start a romantic relationship:

> *I will have completed my school and, God willing, I will have been employed. That means I could manage independently, be it in a family with my husband or divorced.*[36]
>
> *—Female, aged 15, urban, out of school*

Among young women who have stopped schooling, 11% cite becoming pregnant as the main reason for stopping.[20(p.37)] National policy explicitly states that young women who become pregnant are allowed to continue their education after delivery,[66(p.8)] but many pregnant students feel pressure to drop out nonetheless because they are viewed as bad role models for their peers or as having behaved shamefully.[45(p.22)] By contrast, parallel stigma is not attached to young men who impregnate someone, and they are rarely held accountable.

Another group of young people (primarily women) who face especially high health risks and have little access to information and services are those who engage in commercial sex work. There is evidence of a flourishing sex industry in Malawi, particularly in the main cities of Blantyre, Lilongwe and Mzuzu, and some females begin sex work as early as age 13.[67] Some clients insist on sex

without a condom, and others offer to pay premiums to avoid the use of condoms, a proposition that may be difficult for commercial sex workers to turn down.[68] The socioeconomic circumstances that often cause them to enter into prostitution, as well as the stigma against sex work, combine to limit sex workers' access to education and sexual and reproductive health care.

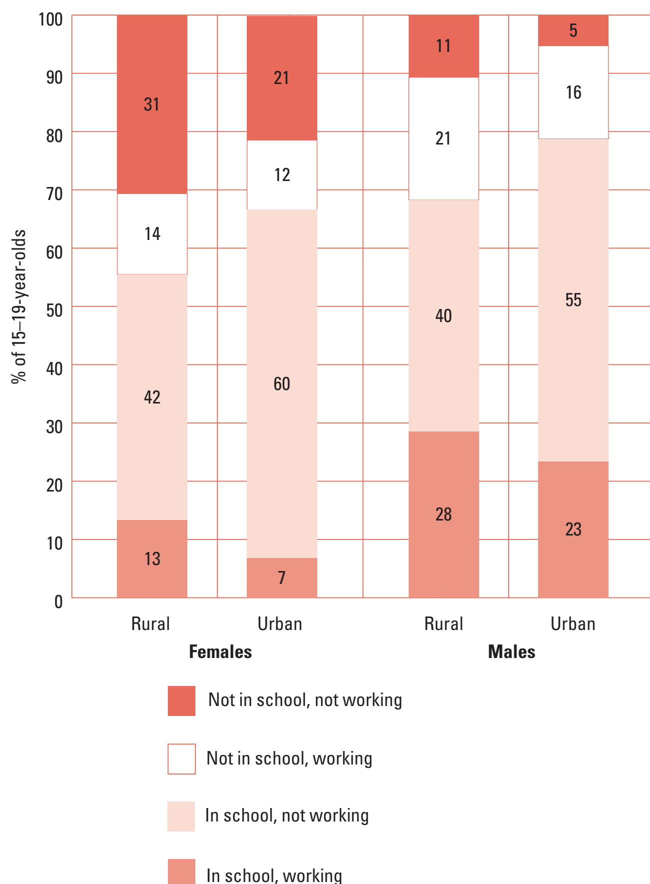
Rural youth are at risk because of gaps in access to education and health care services

Adolescents who live in rural areas constitute the majority of the country's youth population and are more than twice as likely as urban youth to live in poverty.[2] Without the means to afford school fees, many rural youth attain only a primary school education. Among those aged 15–19, 45% of females and 32% of males living in rural areas are not in school, compared with 33% and 21%, respectively, in urban areas (Figure 6.1).[46] Predictably, lower proportions of rural youth than urban youth are exposed to school-based sex education and understand how HIV is transmitted.[60,61] Likewise, comparatively small proportions of young people living in rural areas report obtaining information on contraceptive methods from most sources (Figure 6.2).[46]

Lack of information is only one of the disadvantages faced by rural youth: They also have less access to modern health care. According to a World Health Organization measure of optimal health care availability, Malawi has far fewer facilities than needed to serve its population well.[69] In rural areas, visiting health clinics and hospitals often requires traveling long distances, a considerable barrier for young people, who may not have the time or money to make the trip. This may contribute to lower proportions of rural than urban youth having been tested for HIV.[2(p.203)]

FIGURE 6.1

Almost one-half of rural females and one-third of rural males are not in school.



Source Reference 46.

Orphans and street children experience compounded disadvantages

One of the tragic results of the AIDS epidemic in Malawi has been the sharp increase in recent years in the number of orphans. It is estimated that there are now more than one million orphans living in Malawi, nearly double the number in 1998—and this number is expected to increase in the next 10 years.[70] About half of orphans have lost one or both parents to AIDS. As is the case in other Sub-Saharan African countries,[14,15] young women in Malawi seem to be more negatively affected by orphanhood than young men, making them more vulnerable to malnutrition, school dropout and sexual abuse, among other risks.[14–16] Some orphans wind up living on the street; this population is particularly vulnerable to abuse and prostitution.[52] The intersecting disadvantages faced by orphans and young people living on the streets make it difficult for these adolescents to meet their basic needs, including obtaining sexual and reproductive health information and services.

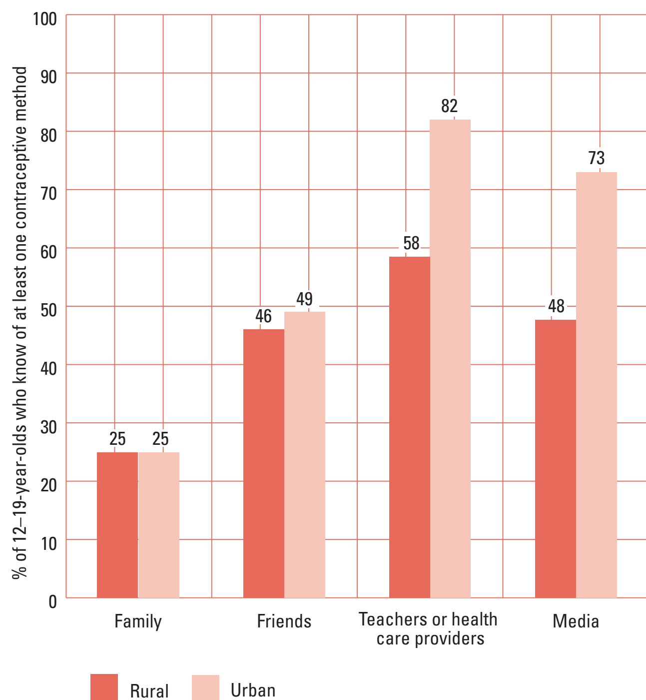
Poverty is correlated with less sexual knowledge and more sexual risk-taking

Poor adolescents have less access to sexual and reproductive health information and services than their better-off counterparts—a disparity that is apparent in their comparatively low level of knowledge and high level of risky behavior. Among the poorest 15–19-year-olds (those whose households fall into the lowest wealth quintile), 13% of females and 16% of males have adequate knowledge of pregnancy prevention—meaning that they know at least one modern method of contraception; that there are certain days in her cycle when a woman is more likely to get pregnant; that a woman can conceive the very first time she has sex; and that a woman can get pregnant if she has sex standing up. By comparison, in the highest quintile of wealth, 47% of females and 46% of males aged 15–19 possess this knowledge.[60,61]

A similar pattern holds true for contraceptive use at last sex among 15–19-year-olds. Sixteen percent of females and 30% of males in the lowest wealth quintile used a con-

FIGURE 6.2

Lower proportions of rural than urban youth get information about contraceptives from nearly every source.



Source Reference 46.

FIGURE 6.3

Lower proportions of poor adolescents than of their wealthier counterparts practice contraception.

Source Reference 46.

traceptive method the last time they had sex, compared with 31% of females and 41% of males in the same age-range in the middle three quintiles, and 40% and 53%, respectively, among the wealthiest adolescents (Figure 6.3).[46] However, barriers to care among poor adolescents are often structural, rather than personal. Compared with young people in the highest quintile, smaller proportions of 15–19-year-olds in the lower wealth quintiles cite cost, fear, shame or embarrassment as barriers to obtaining contraceptive services.[60,61]

Chapter 7

We Can Protect the Next Generation

This research sheds light on a complex mix of structural, socioeconomic and cultural factors that hinder young people in Malawi as they strive to protect themselves from STIs and unintended pregnancy. Yet adolescents' desire to take control of their sexual and reproductive health bodes well for their future, as well as for slowing the HIV/AIDS epidemic. At the 2001 United Nations Special Assembly on HIV/AIDS, then–Vice President of Malawi Justin Malewezi stated:

> *Empowering young people with information about HIV/AIDS is helping to reduce transmission. Young people are the most effective voice in promoting responsible sexual behaviour among the youth. This is why the Malawi Government is involving young people themselves in advocacy for change.*[71]

The special assembly declaration, ratified by Malawi and 188 other nations, stated that "by 2010, 95% of young people…[will] have access to the information, skills and services that they need to decrease their vulnerability to HIV." However, Malawi is not yet on track to fulfill this commitment. Furthermore, while HIV continues to garner the majority of international attention, reducing early and unintended childbearing remains an equally challenging goal.

An array of challenges face adolescents and stakeholders

A host of structural challenges stand between the next generation of Malawians and a healthy future. "Brain drain" has taken its toll on the health care sector, as Malawian medical professionals are lured abroad by the promise of better wages.[72,73] In addition, the education sector has suffered from the AIDS-related deaths of many teachers, further restricting the impact of schools that are already lacking adequate resources.[74] Some nongovernmental organizations (NGOs) have initiated programs to provide information and services to young people, but only a few have been implemented and the majority have not been adequately evaluated to determine their effectiveness.

In addition to broader structural problems, widespread risky sexual behavior is a major obstacle to addressing the sexual and reproductive health needs of young Malawians. By age 20, 79% of young women and 74% of young men are sexually active.[2] Most sex among young people occurs without a barrier method: Sixty-five percent of sexually active 12–19-year-old males did not use a condom at last sex.[20(p.111)] Young women are particularly vulnerable to the consequences of unprotected sex. By age 20, 73% of women are married and 63% have given birth.[2] Thirty-eight percent of sexually active young women say they were "not willing at all" the first time they had sex.[20(p.64)]

Young people also face barriers to obtaining the sexual and reproductive health information they need to protect themselves from unintended pregnancy and disease. Only about one-fifth of them possess adequate knowledge regarding how to prevent pregnancy, and approximately one-quarter possess adequate knowledge to protect themselves from HIV/AIDS.*[60,61]

*This includes knowing that HIV transmission can be reduced by having sex with only one faithful, uninfected partner and also by using condoms; that a healthy-looking person can have HIV; that a person cannot get HIV from mosquito bites; and that a person cannot get HIV from sharing food with someone who is infected.

Finally, young people face a number of personal and practical obstacles to obtaining sexual and reproductive health care. Fear, shyness and embarrassment are the most significant barriers to seeking contraceptive services or obtaining treatment for STIs.[20(pp.123&131)]

These challenges must all be addressed in order to effectively meet young people's sexual and reproductive health needs.

Policies and programs hold promise for better adolescent sexual and reproductive health

Despite the many challenges inherent in improving the sexual and reproductive health of Malawi's adolescents, there are also successes to be celebrated. Young people in Africa have been at the forefront of the effort to prevent HIV. The recently published *African Youth HIV/AIDS Best Practices Handbook* profiled 95 government, civil society and community projects from across Africa; young people initiated, obtained funding for, implemented and evaluated 75 of these projects.[75] Young people's innovative strategies to effectively engage other youth in preventing AIDS in their communities constitute some of the best practices. A number of initiatives carried out by the government and NGOs, including the religious community, have also made positive contributions to the national fight against HIV and promoted the sexual and reproductive health and rights of young people.

■ *The Government of Malawi, with the support of international NGOs, has taken many steps to improve the health and well-being of the nation's youth.* Key government policies on sexual and reproductive health issues have highlighted adolescents as a group requiring special focus for HIV/AIDS and pregnancy prevention. Important policies include the National AIDS Policy of 2003, the National Population Policy, and the National Family Planning Policy and Contraceptive Guidelines, as well as the establishment of the Youth Technical Subcommittees. In addition, the government has put forth a National Plan of Action for Orphans and Vulnerable Children, which includes specific strategies for reaching Malawi's most neglected populations.

Beginning with the Fourth Country Program (1997–2001), Malawi's national population policy has included the goal of promoting safer sexual and reproductive health and HIV prevention practices—especially among young people.[57] To achieve this, the program supports the development of family life education materials; training on HIV/AIDS and family life education at the country's two secondary school teachers' colleges; and the formation of youth groups and out-of-school youth programming aimed at expanding the network of community-based peer educators in Malawi. In addition, in 1998, the Ministry of Education piloted a life skills syllabus. This curriculum has been extended—with the assistance of NGOs—to out-of-school youth.

International NGOs have been working in collaboration with the government and large international donors to fund adolescent sexual and reproductive health programs in Malawi. One outstanding example of this collaboration is the United Kingdom–based International AIDS Alliance's Regional Youth Program.[76] This program trains members of the community to be counselors and to use experiential learning activities to equip youth with comprehensive sexual and reproductive health knowledge and life skills. Other interventions funded by international NGOs include outreach programs to increase the number of people obtaining HIV counseling and testing services, and a successful National HIV Testing Week in 2006, during which 90,000 Malawians were tested for the virus.[77]

■ *Malawian NGOs, civil society and faith-based organizations are also on the front lines in protecting the next generation.* Important initiatives and services provided by Malawian NGOs, civil society and faith-based organizations include peer education, life skills education, and awareness and sensitization campaigns; advocacy for community and political action; health centers and youth drop-in centers; and radio and television programs. Many of these efforts are supported by international donors. Some of Malawi's most influential NGOs include Counseling Adolescents and Youth Organization, Youth Net and Counselling, Salima Aids Support Organization and Active Youth Initiative for Enhancement. Banja La Mtsogolo (BLM), a local NGO set up in 1987 with funding and technical support from Marie Stopes International, is the largest reproductive health services provider in Malawi. BLM runs innovative contraceptive marketing campaigns, extensive outreach services and a comprehensive health program for young people that covers almost 70% of the country geographically.

The religious community has been particularly engaged in fighting HIV with health and education services. Hospitals run by the Christian Health Association of Malawi provide low-cost health care, including sexual and reproductive health services, throughout the country. These hospitals, including St. Luke's Hospital in Zomba, Malamulo Hospital in Blantyre, St. John's Hospital in Mzuzu and Likuni Mission Hospital in Lilongwe, perform community outreach targeting adolescent sexual and reproductive health issues.

Faith-based organizations also target young people's health through a number of religious radio stations, magazines and schools; however, family life education provided through these avenues may not always be comprehensive or evidence based, and is therefore unlikely to have a lasting impact on young people's lives. On the prevention side, the faith-based community has relied heavily on abstinence-only messages. For example, the Evangelical Lutheran Development Program teaches HIV/AIDS awareness and produces youth dramas that promote monogamy and abstinence until marriage. Although most programs have had weak or no measures

in place to document and evaluate their own impact, one evaluation of these programs in other Sub-Saharan African countries was not positive. The 2005 Faith in Action study carried out by the Global Health Council examined the role of faith-based organizations in addressing HIV/AIDS in six developing countries, including three in Sub-Saharan Africa.[78] The study found that although these organizations provide valuable medical services via clinics and home-based care, there are clear limitations to their behavior-change messages focusing solely on abstinence and faithfulness. The report concludes that these programs are tailored to be consistent with moral beliefs that frequently dilute the accuracy of the messages they teach.

Recommendations

Increased investment in Malawians' sexual and reproductive health is integral to reaching the long-term goals of reducing the national incidence of HIV and unintended pregnancy. A considerable national and international investment in Malawi's adolescent population, in particular, is necessary, as adolescence presents a window of opportunity for establishing healthy behaviors. Given the evidence laid out in this report, we believe the following recommended actions have the potential to turn the tide on the HIV/AIDS epidemic and improve general sexual and reproductive health among young people.

■ *Continue to bolster life skills education.* School-based life skills education needs to be supported to ensure that all students are reached effectively. This can be done through training teachers and providing adequate teaching materials to all schools, including private ones that are currently not required to teach the curriculum. To ensure that the subject is not sidelined in classrooms, exams should be required on life skills topics. Reaching out-of-school youth with life skills education should also be prioritized.

■ *Support teacher training.* To impart accurate and comprehensive sexual and reproductive health information, and to feel confident in making themselves available to answer young people's questions, teachers need training in life skills education, ongoing support and access to up-to-date information on STIs, HIV testing, contraceptive methods and antiretroviral therapies.

■ *Increase the health information reaching youth.* Although schools may be the ideal source for sexual and reproductive health information, the reality is that adolescents (especially those who are not in school) obtain their information from a variety of sources. To reach the greatest possible number of young people, resources should be directed toward ensuring that media, peers, relatives and health care providers pass on accurate information. For example, the information in this report should be used to shape mass media programming by specifically addressing myths about how pregnancy occurs and how HIV is spread, lack of knowledge about where to obtain contraceptive and HIV information and services, ignorance of STIs other than HIV, and fears about approaching parents and medical staff for help with sexual matters.

■ *Deepen young people's knowledge of HIV/AIDS and pregnancy risk.* Although impressively high proportions of young people have heard about HIV/AIDS and are aware of the risk of pregnancy from sexual intercourse, many young people do not have in-depth knowledge about either of these subjects. Intervention programs need to impart detailed and practical information, such as how to use condoms and when in a woman's menstrual cycle she is most likely to conceive.

■ *Reach young people before they start having sex.* Although most 12–14-year-olds have not had sexual intercourse, they are not sexually naïve. As many as 11% of the females and 23% of the males in this age-group have either experienced some form of intimate activity (kissing, fondling or sexual intercourse) or have had a boyfriend or girlfriend.[20(p.59)] This underscores the need to start providing information to adolescents at young ages, so they know how to protect themselves and their partners when they become sexually active.

■ *Discourage early marriages to protect the next generation of women.* About three-quarters of women in Malawi marry by the time they turn 20. These young women may become pregnant before their bodies are ready for childbearing. In addition, if they do not use condoms, they are at risk of contracting HIV and other STIs from what are likely to be older and more sexually experienced husbands. Programs to keep young women in school through adolescence should be implemented, and the minimum age at marriage should be increased and enforced.

■ *Invest in youth-friendly services.* Fear of stigma, discrimination and lack of confidentiality prevents many young people from accessing the health services they need. To counter such concerns, medical providers require training and supervision that emphasize sensitivity toward an adolescent clientele. Simultaneously, efforts must be made to encourage adolescents to trust health care providers and have confidence in their professionalism.

■ *Increase knowledge of HIV risk and access to voluntary testing and counseling.* Although many young people express a desire to be tested for HIV, very few of them actually get tested, primarily because they feel they are not at risk. Interventions are needed to help young people understand and address their HIV risk. One way of addressing the low levels of testing and of integrating services is to implement routine voluntary testing for pregnant women, as has been done in Botswana.[79] Another alternative is to offer testing in the privacy of people's homes or in other unobtrusive ways to minimize people's fear of stigmatization associated with seeking out an HIV test.

■ *Address the many ways that adolescent females are vulnerable to unwanted sex.* Young women are particularly at risk of becoming infected with HIV because of social and cultural factors that put them at a disadvantage compared with men. The high proportion (38%) of young women who report that they were "not willing at all" when they had sex for the first time demonstrates the lack of control that many have over their sexual experiences. Addressing societal norms that make it difficult for young women to exercise healthy sexuality—including by supporting their right to say no to unwanted sexual activity—and the stigma that keeps young women from seeking or receiving sexual and reproductive health care are ways to reduce females' vulnerability.

■ *Investigate transactional sex.* More than 80% of females report that they have received money or gifts in exchange for sex. These gifts are most often received from peers, not from older "sugar daddies," and a connection between such transactions and risky sexual behavior has not been established. However, researchers should investigate further the threshold at which gifts exert a coercive influence over young women's willingness to engage in sexual intercourse, as well as men's expectations attached to the giving of gifts, so as to more fully understand and address the role that gifts and money play in risk-taking behavior.

■ *Hold young men accountable for their sexual behavior.* Male sexual behavior is not stigmatized the way female sexual behavior is, and some young men respond by acting irresponsibly. Male adolescents' resistance to condom use puts them and their partners at risk of both unintended pregnancy and STIs, including HIV. Interventions are needed to hold young men to a higher standard of sexual responsibility by helping them to take proactive measures to protect their and their partners' health.

■ *Scale up condom distribution and education.* Social stigma, combined with myths, fears and misperceptions about condoms among young people, has likely undermined adolescents' commitment to consistent condom use. The fact that close to half of all unmarried adolescents and more than half of their married counterparts think using a condom is a sign of not trusting one's partner indicates that intervention programs can do more to instill positive views about condoms, including the view that using a condom is the mature and responsible thing to do for oneself and one's partner.

■ *Integrate HIV and pregnancy prevention efforts.* Evidence shows that young people are as concerned about preventing early and unwanted pregnancy as they are about protecting themselves from HIV/AIDS. Both problems have remarkably similar solutions, and strategies to address them should be integrated to make the most of Malawi's limited resources. Sex education and condom promotion should cover both topics. Providers should capitalize on any clinic visit by young people by talking to them about the full range of sexual and reproductive health issues affecting their lives.

■ *Implement existing policies and evaluate what works.* Malawi has a number of progressive laws on the books, including the National HIV/AIDS Action Framework and the National Plan of Action for Orphans and Vulnerable Children. To be effective, these programs need better funding, stronger support and rigorous systems of evaluation.

Malawi must make the most of its limited resources to protect adolescent health

Malawi is a young democracy facing enormous obstacles with limited resources. As one of the poorest countries in the world with one of the highest HIV prevalence rates, the fight to protect the next generation remains a hard battle. Yet inaction will have far-reaching effects across the socioeconomic and political spectrum. Therefore, protecting young people's health should be a cornerstone of all economic development efforts taking place in Malawi.

In 2006, Malawi, along with many other countries, set ambitious targets for achieving universal access to HIV prevention services, treatment and care by 2010. As Malawi's resources are scarce, reaching these goals and others will require government and civil society leaders to successfully capitalize on the global commitment to confronting the HIV/AIDS epidemic and the issue of unintended pregnancy.

The evidence presented in this report demonstrates the need to design and implement comprehensive, targeted prevention strategies that will fit young people's diverse circumstances and experiences. We can and must protect the next generation.

APPENDIX TABLE 1A	Selected social and demographic characteristics of 12–19-year-old females, by age-group, 2004 Malawi National Survey of Adolescents						
Characteristic	All		% distribution by residence with biological parents				% whose parents/ guardians always know where they are at night*
	N	% (weighted)	Both	Mother	Father	Neither	
FEMALES AGED 12–19	**1,979**	**100.0**	**41.5**	**18.7**	**3.9**	**35.9**	**57.6**
RESIDENCE							
Rural	1,480	77.3	43.2	19.7	3.3	33.7	55.3
Urban	499	22.7	35.6	15.1	5.6	43.7	65.6
ATTENDING SCHOOL							
No	503	26.2	27.0	18.6	1.7	52.7	52.3
Yes	1,475	73.8	46.6	18.7	4.6	30.0	59.5
MARITAL STATUS							
Not married	1,830	92.9	43.9	19.4	4.0	32.7	58.5
Married	145	7.1	10.6	8.5	2.1	78.9	43.7
HOUSEHOLD WEALTH							
Lowest quintile	379	21.0	28.9	28.2	2.1	40.8	49.0
Middle three	1,182	57.0	46.2	18.4	4.5	30.9	56.8
Highest quintile	414	22.0	40.9	10.3	3.9	44.8	68.3
REGION							
Central	722	44.1	45.0	17.2	4.0	33.9	45.7
Northern	381	10.4	44.9	16.4	3.4	35.3	75.4
Southern	876	45.6	37.4	20.7	3.8	38.1	65.2
FEMALES AGED 12–14	**944**	**100.0**	**45.4**	**19.6**	**3.9**	**31.1**	**57.9**
RESIDENCE							
Rural	726	78.3	48.0	20.3	3.4	28.3	56.4
Urban	218	21.7	35.5	17.2	5.9	41.4	63.4
ATTENDING SCHOOL							
No	74	8.6	29.6	16.0	2.5	51.9	46.9
Yes	870	91.4	46.8	20.0	4.1	29.2	58.9
HOUSEHOLD WEALTH							
Lowest quintile	189	21.7	31.4	29.9	0.5	38.2	51.0
Middle three	564	56.2	52.0	18.1	5.3	24.6	57.3
Highest quintile	191	22.1	42.0	13.2	3.9	41.0	66.3
REGION							
Central	361	44.7	51.2	17.9	3.1	27.8	44.3
Northern	184	10.8	49.5	15.8	4.0	30.7	77.7
Southern	399	44.4	38.7	22.0	4.8	34.6	66.8
FEMALES AGED 15–19	**1,035**	**100.0**	**38.1**	**17.9**	**3.8**	**40.3**	**57.3**
RESIDENCE							
Rural	754	76.4	38.7	19.2	3.3	38.7	54.2
Urban	281	23.6	35.8	13.4	5.3	45.5	67.1
ATTENDING SCHOOL							
No	429	41.9	26.5	19.0	1.6	52.8	53.3
Yes	605	58.1	46.4	17.0	5.4	31.2	60.3
MARITAL STATUS							
Not married	890	86.7	42.3	19.3	3.9	34.4	59.5
Married	144	13.3	10.7	8.6	2.1	78.6	42.9
HOUSEHOLD WEALTH							
Lowest quintile	190	20.4	26.5	26.5	3.7	43.3	47.0
Middle three	618	57.7	41.2	18.5	3.8	36.4	56.4
Highest quintile	223	21.9	40.0	7.8	3.5	48.7	69.7
REGION							
Central	361	43.5	39.5	16.2	4.8	39.5	46.9
Northern	197	10.0	40.6	17.0	2.8	39.6	72.4
Southern	477	46.6	36.3	19.6	3.1	41.1	63.7

*For married adolescents, the question refers to parental knowledge before respondent got married. **Source:** Reference 46.

% who attend religious services ≥weekly	% distribution by school and work status				% who have worked or done something for money in past year	% worried about getting pregnant	% worried about getting HIV/AIDS
	In school		Not in school				
	Working	Not working	Working	Not working			
95.1	**14.3**	**59.5**	**7.8**	**18.4**	**20.3**	**37.9**	**51.0**
94.0	15.9	56.3	8.2	19.6	20.4	36.7	50.6
98.9	8.4	70.5	6.8	14.3	19.9	41.9	52.4
94.7	0.0	0.0	29.8	70.2	30.4	36.7	54.2
95.3	19.3	80.7	0.0	0.0	16.7	38.3	49.9
95.0	15.3	64.0	6.3	14.4	20.1	39.0	51.1
96.5	0.7	1.4	28.2	69.7	23.9	24.6	50.3
92.4	14.0	52.4	12.4	21.2	21.2	32.7	48.4
94.7	16.7	56.1	7.4	19.8	21.0	38.7	52.7
98.6	7.8	75.6	4.6	12.1	17.5	40.5	49.2
92.7	14.3	58.9	9.1	17.6	19.7	36.4	52.6
98.6	27.7	56.8	10.2	5.3	29.0	69.6	86.5
96.6	11.1	60.9	6.0	22.0	18.9	32.0	41.4
93.6	**17.1**	**74.3**	**1.4**	**7.2**	**15.6**	**33.8**	**46.6**
92.4	18.9	71.7	1.8	7.6	16.5	33.8	48.0
98.0	10.2	83.9	0.0	5.9	12.7	33.7	41.5
86.4	0.0	0.0	16.0	84.0	32.1	17.3	35.8
94.3	18.7	81.3	0.0	0.0	14.1	35.3	47.6
90.7	17.1	70.2	2.0	10.7	18.1	29.9	44.1
92.8	20.5	71.2	1.9	6.4	15.8	36.0	50.2
98.6	8.2	86.1	0.0	5.8	12.5	31.7	39.9
90.0	17.7	72.3	1.2	8.7	15.2	31.0	47.9
98.0	33.3	64.7	1.0	1.0	25.5	74.5	86.3
96.2	12.4	78.7	1.7	7.2	13.6	26.7	35.6
96.4	**11.7**	**46.3**	**13.5**	**28.4**	**24.5**	**41.5**	**55.0**
95.4	13.3	42.2	13.9	30.6	23.9	39.3	53.0
99.6	6.8	59.8	12.0	21.3	25.8	48.6	61.4
96.4	0.0	0.0	32.3	67.7	30.1	40.2	57.6
96.6	20.2	79.8	0.0	0.0	20.3	42.5	53.1
96.4	13.5	53.3	11.2	22.0	24.5	44.1	55.5
96.5	0.7	1.4	28.6	69.3	24.3	25.0	51.1
94.4	11.2	35.3	22.3	31.2	24.2	35.3	52.6
96.4	13.4	42.8	12.2	31.6	25.6	40.9	55.0
98.7	7.4	66.1	8.7	17.8	22.1	48.5	57.4
95.2	11.3	46.4	16.3	25.9	23.7	41.5	57.0
99.0	22.1	49.0	19.2	9.6	33.0	65.1	85.8
96.9	10.0	45.7	9.6	34.8	23.2	36.5	46.4

APPENDIX TABLE 1B Selected social and demographic characteristics of 12–19-year-old males, by age-group, 2004 Malawi National Survey of Adolescents

Characteristic	All		% distribution by residence with biological parents				% whose parents/ guardians always know where they are at night*
	N	% (weighted)	Both	Mother	Father	Neither	
MALES AGED 12–19	**2,052**	**100.0**	**47.6**	**17.7**	**4.2**	**30.6**	**50.6**
RESIDENCE							
Rural	1,541	76.8	47.3	19.9	3.7	29.1	46.5
Urban	511	23.2	48.2	10.1	6.1	35.5	63.8
ATTENDING SCHOOL							
No	387	19.4	33.8	21.1	4.3	40.9	37.2
Yes	1,663	80.6	50.9	16.8	4.2	28.0	53.7
HOUSEHOLD WEALTH							
Lowest quintile	363	17.8	37.6	32.3	2.2	27.9	44.0
Middle three	1,297	60.8	49.6	17.0	4.3	29.1	47.1
Highest quintile	388	21.3	50.6	7.2	5.8	36.4	66.2
REGION							
Central	725	40.4	50.2	16.6	3.7	29.6	48.3
Northern	357	8.8	50.6	18.5	6.2	24.7	50.0
Southern	970	50.8	45.0	18.3	4.3	32.4	52.4
MALES AGED 12–14	**905**	**100.0**	**50.9**	**17.4**	**3.9**	**27.9**	**58.4**
RESIDENCE							
Rural	678	77.8	50.6	19.0	3.5	26.9	54.7
Urban	227	22.2	51.7	11.9	5.0	31.3	71.6
ATTENDING SCHOOL							
No	62	7.3	26.9	23.9	6.0	43.3	40.9
Yes	842	92.7	52.7	16.8	3.8	26.7	59.9
HOUSEHOLD WEALTH							
Lowest quintile	182	20.6	40.9	31.7	3.2	24.2	54.8
Middle three	554	60.0	51.8	15.7	4.1	28.5	54.3
Highest quintile	165	19.4	60.0	8.0	4.0	28.0	76.6
REGION							
Central	299	38.6	55.8	16.0	4.0	24.2	56.9
Northern	150	8.6	44.9	23.1	9.0	23.1	57.7
Southern	456	52.7	48.2	17.5	2.9	31.3	59.7
MALES AGED 15–19	**1,147**	**100.0**	**44.9**	**17.9**	**4.4**	**32.8**	**44.2**
RESIDENCE							
Rural	863	75.9	44.6	20.7	3.7	30.9	39.8
Urban	284	24.1	45.6	8.8	7.0	38.6	58.3
ATTENDING SCHOOL							
No	325	29.2	35.1	20.4	4.0	40.5	36.6
Yes	821	70.8	49.1	16.8	4.6	29.5	47.2
HOUSEHOLD WEALTH							
Lowest quintile	181	15.6	33.7	33.1	1.1	32.0	33.0
Middle three	743	61.6	47.9	18.0	4.5	29.6	41.6
Highest quintile	223	22.8	44.1	6.6	7.0	42.2	59.1
REGION							
Central	426	41.9	45.7	17.1	3.6	33.6	41.9
Northern	207	8.9	54.5	15.8	4.0	25.7	44.0
Southern	514	49.2	42.2	19.0	5.4	33.4	46.0

*For married adolescents, the question refers to parental knowledge before respondent got married. **Source:** Reference 46.

% who attend religious services ≥weekly	% distribution by school and work status				% who have worked or done something for money in past year	% worried about getting someone pregnant	% worried about getting HIV/AIDS
	In school		Not in school				
	Working	Not working	Working	Not working			
95.6	**27.4**	**53.2**	**12.8**	**6.7**	**45.1**	**31.0**	**44.3**
94.7	29.2	49.7	13.6	7.6	47.3	30.0	44.8
98.3	21.4	64.8	10.0	3.8	37.7	34.1	42.7
90.1	0.0	0.0	65.7	34.3	65.0	34.4	52.8
96.9	34.0	66.0	0.0	0.0	40.3	30.2	42.4
95.0	27.9	51.1	14.6	6.4	49.0	23.3	38.0
94.6	30.2	48.8	13.1	7.9	47.4	31.9	47.2
98.8	18.1	67.8	10.4	3.7	35.0	34.5	41.4
93.2	23.8	53.8	13.5	8.9	45.4	35.4	47.3
97.2	39.3	49.4	7.3	3.9	52.5	39.7	58.1
97.2	28.2	53.4	13.1	5.3	43.6	26.0	39.5
95.1	**27.5**	**65.2**	**4.0**	**3.3**	**34.8**	**22.1**	**32.6**
94.2	29.9	61.7	4.5	3.8	37.3	21.4	33.4
98.5	18.9	77.6	2.0	1.5	26.4	24.8	29.9
78.8	0.0	0.0	54.5	45.5	55.2	14.9	29.9
96.4	29.6	70.4	0.0	0.0	33.2	22.7	33.0
93.0	25.9	61.6	8.6	3.8	37.8	17.7	26.9
94.3	32.0	61.1	2.8	4.1	36.7	22.6	36.5
100.0	13.1	83.4	2.9	0.6	24.6	24.6	26.9
92.6	24.6	65.1	5.4	4.9	37.9	27.6	33.4
94.9	32.1	65.4	1.3	1.3	44.9	25.6	43.6
97.1	28.9	65.2	3.4	2.5	31.1	17.5	30.3
95.9	**27.3**	**43.5**	**19.8**	**9.3**	**53.4**	**38.1**	**53.7**
95.2	28.5	39.8	21.1	10.7	55.7	37.1	54.2
98.2	23.4	55.4	16.0	5.2	46.1	41.3	52.2
92.7	0.0	0.0	68.0	32.0	66.8	38.4	57.4
97.2	38.6	61.4	0.0	0.0	47.9	38.1	52.3
96.6	30.1	40.3	21.0	8.5	60.8	29.1	50.0
94.8	28.8	39.2	21.2	10.8	55.7	39.2	55.6
98.1	21.4	57.6	15.2	5.8	42.0	41.2	51.4
93.6	23.1	45.3	19.5	12.1	51.0	41.1	57.6
99.0	45.5	37.4	12.1	5.1	59.0	50.5	70.0
97.3	27.5	43.2	21.5	7.8	54.3	33.3	47.5

APPENDIX TABLE 2A Sexual activity and risk and protective behaviors among 12–19-year-old females, by age-group, 2004 Malawi National Survey of Adolescents

Characteristic	All		% distribution by sexual activity				% who have ever been touched, kissed, grabbed or fondled in an unwanted sexual way*
	N	% (weighted)	Never had sex	Have had sex but not in past 12 months	Have had sex in past 12 months with spouse/ cohabiting partner	Have had sex in past 12 months with noncohabiting partner	
FEMALES AGED 12–19	**1,979**	**100.0**	**79.4**	**4.7**	**7.3**	**8.6**	**17.7**
RESIDENCE							
Rural	1,480	77.3	79.6	4.6	7.8	8.0	17.6
Urban	499	22.7	78.8	4.9	5.6	10.7	17.9
ATTENDING SCHOOL							
No	503	26.2	47.5	9.9	27.5	15.1	22.9
Yes	1,475	73.8	90.7	2.8	0.2	6.3	15.8
MARITAL STATUS							
Not married	1,830	92.9	85.6	4.5	1.0	8.8	16.9
Married	145	7.1	0.0	4.9	89.4	5.6	27.2
HOUSEHOLD WEALTH							
Lowest quintile	379	21.0	81.8	4.1	7.2	7.0	15.2
Middle three	1,182	57.0	77.9	4.6	8.5	9.0	17.6
Highest quintile	414	22.0	81.3	5.3	4.4	9.0	20.3
REGION							
Central	722	44.1	85.7	3.7	6.2	4.4	14.4
Northern	381	10.4	86.3	3.9	5.4	4.4	6.4
Southern	876	45.6	71.9	5.7	8.8	13.5	23.1
FEMALES AGED 12–14	**944**	**100.0**	**96.9**	**0.7**	**0.2**	**2.1**	**12.1**
RESIDENCE							
Rural	726	78.3	96.5	0.9	0.0	2.6	13.9
Urban	218	21.7	98.5	0.0	1.0	0.5	5.5
ATTENDING SCHOOL							
No	74	8.6	93.8	1.2	2.5	2.5	8.2
Yes	870	91.4	97.2	0.7	0.0	2.1	12.6
HOUSEHOLD WEALTH							
Lowest quintile	189	21.7	96.6	1.5	0.0	2.0	16.4
Middle three	564	56.2	97.2	0.6	0.0	2.3	12.7
Highest quintile	191	22.1	97.1	0.5	1.0	1.4	6.7
REGION							
Central	361	44.7	97.6	1.2	0.5	0.7	10.4
Northern	184	10.8	100.0	0.0	0.0	0.0	1.5
Southern	399	44.4	95.7	0.5	0.0	3.8	16.7
FEMALES AGED 15–19	**1,035**	**100.0**	**63.5**	**8.2**	**13.8**	**14.5**	**22.5**
RESIDENCE							
Rural	754	76.4	63.8	7.9	15.1	13.1	20.8
Urban	281	23.6	62.4	9.1	9.1	19.4	27.8
ATTENDING SCHOOL							
No	429	41.9	39.0	11.5	32.1	17.4	26.3
Yes	605	58.1	81.3	5.8	0.5	12.4	19.9
MARITAL STATUS							
Not married	890	86.7	73.4	8.6	2.0	16.0	21.6
Married	144	13.3	0.0	5.0	89.3	5.7	28.1
HOUSEHOLD WEALTH							
Lowest quintile	190	20.4	67.1	7.0	14.1	11.7	13.8
Middle three	618	57.7	60.7	8.2	16.1	14.9	21.4
Highest quintile	223	21.9	66.8	9.4	7.6	16.1	33.1
REGION							
Central	361	43.5	74.4	6.1	11.4	8.1	18.0
Northern	197	10.0	72.8	7.8	10.7	8.7	13.3
Southern	477	46.6	51.4	10.3	16.5	21.8	28.4

*Questions asked of only one eligible adolescent per household and only if no one older than three was present or within hearing range. †Among those who had ever had sex. ‡Respondent answered yes to a direct question about ever having had an STI or answered yes to having had a specific symptom. §Among respondents who had had sex in the past 12 months. **Excludes the response "Partner is older, but don't know age."

% who have ever been physically forced, hurt or threatened into having sexual intercourse*	% who have ever been pregnant†	% who have ever had an STI†,‡	% who used a contraceptive at last sex§	% distribution by number of recent sex partners and male condom use§				% whose last sex partner was ≥5 years older**	% who have had sex in exchange for money or gifts††
				One partner		≥2 partners			
				Used	Did not use	Used	Did not use		
7.2	**52.9**	**6.4**	**29.2**	**21.2**	**71.2**	**2.2**	**5.4**	**16.3**	**80.3**
6.9	54.0	7.0	29.7	20.2	71.9	2.5	5.4	14.6	83.8
8.4	50.0	4.2	27.8	24.7	68.5	1.4	5.5	22.2	73.0
13.3	73.4	8.5	22.2	14.1	79.1	2.3	4.5	19.8	83.3
5.0	12.4	2.2	44.3	36.8	53.7	2.1	7.4	8.2	77.1
6.8	34.8	4.9	35.9	30.4	61.9	2.2	5.5	10.3	80.5
13.2	86.0	9.2	20.0	9.0	83.6	2.2	5.2	24.3	87.5
6.0	61.8	0.0	16.9	11.9	72.9	0.0	15.3	13.3	95.2
7.6	53.8	9.2	29.6	20.3	73.6	3.0	3.0	14.0	78.3
7.6	42.0	3.7	39.0	32.8	62.1	1.7	3.4	26.7	78.1
6.8	57.3	5.6	29.3	21.7	67.4	2.2	8.7	18.3	61.5
7.2	55.2	0.0	35.0	19.0	81.0	0.0	0.0	38.1	80.0
7.6	50.6	7.5	28.6	21.3	71.8	2.5	4.5	13.1	84.9
4.1	**6.9‡‡**	**3.4‡‡**	**27.3‡‡**	**13.6‡‡**	**68.2‡‡**	**4.5‡‡**	**13.6‡‡**	**14.3‡‡**	**80.0‡‡**
4.8	0.0‡‡	3.8‡‡	26.3‡‡	15.8‡‡	63.2‡‡	5.3‡‡	15.8‡‡	0.0‡‡	78.6‡‡
1.6	66.7‡‡	0.0‡‡	0.0‡‡	0.0‡‡	100.0‡‡	0.0‡‡	0.0‡‡	100.0‡‡	0.0‡‡
9.8	40.0‡‡	0.0‡‡	25.0‡‡	0.0‡‡	75.0‡‡	25.0‡‡	0.0‡‡	50.0‡‡	100.0‡‡
3.4	0.0‡‡	4.3‡‡	27.8‡‡	16.7‡‡	66.7‡‡	0.0‡‡	16.7‡‡	5.9‡‡	76.9‡‡
4.7	0.0‡‡	0.0‡‡	50.0‡‡	0.0‡‡	100.0‡‡	0.0‡‡	0.0‡‡	0.0‡‡	100.0‡‡
4.3	0.0‡‡	6.7‡‡	16.7‡‡	15.4‡‡	61.5‡‡	0.0‡‡	23.1‡‡	8.3‡‡	72.7‡‡
3.0	28.6‡‡	0.0‡‡	33.3‡‡	16.7‡‡	66.7‡‡	16.7‡‡	0.0‡‡	40.0‡‡	100.0‡‡
3.6	20.0‡‡	0.0‡‡	20.0‡‡	0.0‡‡	80.0‡‡	20.0‡‡	0.0‡‡	60.0‡‡	100.0‡‡
1.5	0.0‡‡	0.0‡‡	0.0‡‡	0.0‡‡	0.0‡‡	0.0‡‡	0.0‡‡	0.0‡‡	0.0‡‡
5.7	0.0‡‡	5.6‡‡	25.0‡‡	17.6‡‡	64.7‡‡	0.0‡‡	17.6‡‡	0.0‡‡	76.9‡‡
9.8	**56.5**	**6.6**	**29.4**	**21.8**	**71.4**	**2.0**	**4.8**	**16.4**	**80.3**
8.5	58.9	7.3	29.8	20.6	72.6	2.2	4.5	15.4	84.5
14.0	48.9	4.3	27.5	25.4	67.6	1.4	5.6	18.8	73.0
14.1	74.1	8.6	22.1	14.4	79.1	1.9	4.7	19.3	83.1
6.9	15.0	1.8	48.8	42.3	50.0	2.6	5.1	8.8	77.2
9.2	38.8	5.0	36.6	32.3	61.5	1.9	4.3	10.9	80.5
13.5	85.8	9.3	20.3	9.1	83.3	2.3	5.3	23.1	87.5
7.3	67.1	0.0	16.4	12.7	70.9	0.0	16.4	12.7	95.0
10.1	57.4	9.4	30.5	21.1	74.1	3.2	1.6	14.4	79.2
12.0	43.2	4.1	39.6	34.6	61.5	0.0	3.8	24.5	75.9
9.7	60.5	6.1	29.9	23.0	66.7	1.1	9.2	16.1	60.0
13.6	57.1	0.0	31.6	20.0	80.0	0.0	0.0	35.0	80.0
9.1	54.7	7.6	28.6	21.5	72.6	2.7	3.2	14.2	86.0

††Question not asked if most recent partner was the first sex partner ever and had sex only once, or if partner was a spouse or cohabiting partner. ‡‡N is 25–49.
Source: Reference 46.

APPENDIX TABLE 2B Sexual activity and risk and protective behaviors among 12–19-year-old males, by age-group, 2004 Malawi National Survey of Adolescents

Characteristic	All		% distribution by sexual activity				% who have ever been touched, kissed, grabbed or fondled in an unwanted sexual way*
	N	% (weighted)	Never had sex	Have had sex but not in past 12 months	Have had sex in past 12 months with spouse/ cohabiting partner	Have had sex in past 12 months with noncohabiting partner	
MALES AGED 12–19	**2,052**	**100.0**	**58.5**	**14.8**	**1.1**	**25.6**	**17.5**
RESIDENCE							
Rural	1,541	76.8	55.8	14.8	1.3	28.1	16.7
Urban	511	23.2	67.4	14.5	0.4	17.7	20.1
ATTENDING SCHOOL							
No	387	19.4	33.8	19.1	5.7	41.5	20.7
Yes	1,663	80.6	64.4	13.7	0.1	21.8	16.8
HOUSEHOLD WEALTH							
Lowest quintile	363	17.8	60.0	12.4	1.1	26.5	19.0
Middle three	1,297	60.8	56.0	15.0	1.3	27.7	16.8
Highest quintile	388	21.3	64.3	16.3	0.5	18.9	18.3
REGION							
Central	725	40.4	60.7	13.7	2.1	23.6	17.7
Northern	357	8.8	72.5	12.4	0.0	15.2	6.5
Southern	970	50.8	54.4	16.1	0.5	29.0	19.2
MALES AGED 12–14	**905**	**100.0**	**80.8**	**5.8**	**0.0**	**13.4**	**15.5**
RESIDENCE							
Rural	678	77.8	78.0	6.7	0.0	15.3	14.2
Urban	227	22.2	90.0	3.5	0.0	6.5	19.9
ATTENDING SCHOOL							
No	62	7.3	66.7	7.6	0.0	25.8	16.7
Yes	842	92.7	81.9	5.8	0.0	12.3	15.3
HOUSEHOLD WEALTH							
Lowest quintile	182	20.6	75.8	7.0	0.0	17.2	15.3
Middle three	554	60.0	79.5	6.5	0.0	14.0	15.2
Highest quintile	165	19.4	89.7	3.4	0.0	6.9	16.9
REGION							
Central	299	38.6	83.1	4.0	0.0	12.9	12.4
Northern	150	8.6	93.7	2.5	0.0	3.8	2.4
Southern	456	52.7	76.8	7.7	0.0	15.5	19.2
MALES AGED 15–19	**1,147**	**100.0**	**40.3**	**22.0**	**2.0**	**35.7**	**19.3**
RESIDENCE							
Rural	863	75.9	37.0	21.7	2.4	38.8	18.8
Urban	284	24.1	50.6	23.0	0.7	25.7	20.8
ATTENDING SCHOOL							
No	325	29.2	26.9	21.7	6.8	44.6	21.3
Yes	821	70.8	45.6	22.2	0.1	32.1	18.4
HOUSEHOLD WEALTH							
Lowest quintile	181	15.6	42.4	18.8	2.4	36.5	23.5
Middle three	743	61.6	37.4	21.6	2.3	38.6	18.1
Highest quintile	223	22.8	46.9	25.2	0.8	27.2	19.4
REGION							
Central	426	41.9	43.7	20.9	3.7	31.7	21.8
Northern	207	8.9	55.0	20.0	0.0	25.0	9.0
Southern	514	49.2	34.7	23.4	0.9	41.0	19.3

*Questions asked of only one eligible adolescent per household and only if no one older than three was present or within hearing range. †Among respondents who have ever had sex. ‡Respondent answered yes to a direct question about ever having had an STI or answered yes to having had a specific symptom. §Among respondents who had had sex in the past 12 months.

% who have ever been physically forced, hurt or threatened into having sexual intercourse*	% who have ever gotten someone pregnant†	% who have ever had an STI†,‡	% who used a contraceptive at last sex§	% distribution by number of recent sex partners and male condom use§				% whose last sex partner was ≥5 years older**	% who have had sex in exchange for money or gifts††
				One partner		≥2 partners			
				Used	Did not use	Used	Did not use		
3.2	**2.9**	**9.6**	**36.6**	**28.3**	**56.9**	**7.0**	**7.9**	**0.7**	**8.9**
3.0	2.8	10.2	34.4	26.4	59.0	5.7	8.9	0.9	7.1
3.6	3.9	7.8	48.2	38.1	45.2	14.3	2.4	0.0	18.6
3.4	6.5	11.5	43.5	31.4	52.1	7.4	9.0	0.5	6.8
3.2	1.2	8.8	33.1	26.6	59.1	7.0	7.3	0.8	10.0
2.2	0.7	14.6	27.6	20.4	64.3	5.1	10.2	0.0	8.5
3.7	3.1	8.5	36.0	27.5	59.4	5.6	7.5	1.1	7.2
2.3	3.9	9.7	50.6	41.0	36.1	15.7	7.2	0.0	15.7
2.8	4.3	12.7	31.6	23.7	63.5	6.6	6.2	1.9	3.1
5.5	4.1	8.2	42.9	32.1	46.4	10.7	10.7	0.0	45.0
3.1	1.7	7.7	39.3	30.8	53.1	7.2	8.9	0.0	9.1
2.4	**0.0**	**1.7**	**19.7**	**16.4**	**77.9**	**1.6**	**4.1**	**3.3**	**8.2**
2.2	0.0	1.9	17.6	13.9	79.6	1.9	4.6	3.7	7.8
2.9	0.0	0.0	30.8	30.8	69.2	0.0	0.0	0.0	20.0
4.1	0.0	0.0	5.9	5.9	88.2	0.0	5.9	5.9	18.2
2.3	0.0	2.0	22.1	17.5	76.7	1.9	3.9	2.9	7.9
2.4	0.0	0.0	21.9	15.6	81.3	0.0	3.1	0.0	10.0
3.0	0.0	2.7	17.1	13.3	80.0	2.7	4.0	5.3	7.1
0.0	0.0	0.0	33.3	33.3	58.3	0.0	8.3	0.0	0.0
3.1	0.0	5.1	13.3	13.3	82.2	0.0	4.4	8.9	9.1
2.4	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0
1.9	0.0	0.0	24.3	18.7	73.3	2.7	5.3	0.0	7.8
4.0	**3.6**	**11.7**	**41.5**	**31.7**	**50.8**	**8.5**	**9.0**	**0.0**	**9.1**
3.9	3.4	12.4	39.5	30.2	52.7	6.8	10.3	0.0	7.3
4.2	4.5	8.3	51.4	39.4	40.8	16.9	2.8	0.0	18.3
3.3	7.1	12.6	47.3	33.7	49.1	8.3	8.9	0.0	6.6
4.3	1.6	11.2	37.5	30.2	52.4	8.7	8.7	0.0	11.2
2.9	1.0	21.2	30.3	22.7	56.1	7.6	13.6	0.0	7.8
4.3	3.9	9.7	41.1	31.0	54.2	6.3	8.5	0.0	7.1
4.5	4.4	11.1	53.4	43.1	31.9	18.1	6.9	0.0	18.6
2.6	5.0	14.4	36.6	26.9	58.1	7.8	7.2	0.0	1.9
6.1	4.5	8.9	48.0	34.6	42.3	11.5	11.5	0.0	47.4
4.7	2.2	10.0	44.3	34.5	46.6	8.6	10.3	0.0	9.4

Excludes the response "Partner is older, but don't know age." ††Question not asked if most recent partner was the first sex partner ever and had sex only once, or if partner was a spouse or cohabiting partner. **Source: Reference 46.

APPENDIX TABLE 3A	Knowledge and use of sexual and reproductive health information and services among 12–19-year-old females, by age-group, 2004 Malawi National Survey of Adolescents						
Characteristic	N	% distribution (weighted)	% who know there are certain days when a woman is more likely to get pregnant	% with adequate knowledge of pregnancy prevention*	% who know three main ways to avoid HIV†	% with adequate knowledge of HIV/AIDS‡	% who know someone who has HIV or who has died from AIDS
FEMALES AGED 12–19	**1,979**	**100.0**	**47.5**	**21.8**	**51.2**	**22.7**	**66.3**
RESIDENCE							
Rural	1,480	77.3	43.3	16.8	48.0	20.5	67.5
Urban	499	22.7	61.9	39.0	62.3	30.2	62.6
ATTENDING SCHOOL							
No	503	26.2	63.3	24.0	50.9	20.2	69.4
Yes	1,475	73.8	41.9	21.0	51.4	23.6	65.3
MARITAL STATUS							
Not married	1,830	92.9	44.9	20.8	50.5	21.9	65.7
Married	145	7.1	81.8	34.5	60.6	33.1	76.1
HOUSEHOLD WEALTH							
Lowest quintile	379	21.0	35.7	11.2	37.4	14.3	68.7
Middle three	1,182	57.0	47.6	19.5	52.4	21.5	65.5
Highest quintile	414	22.0	58.8	38.4	61.4	34.0	66.0
REGION							
Central	722	44.1	38.5	15.5	41.1	17.5	66.5
Northern	381	10.4	46.9	29.3	81.3	31.4	88.9
Southern	876	45.6	56.4	26.3	54.1	25.7	61.1
FEMALES AGED 12–14	**944**	**100.0**	**30.8**	**14.6**	**44.0**	**18.2**	**59.0**
RESIDENCE							
Rural	726	78.3	27.3	10.7	41.3	17.3	60.3
Urban	218	21.7	42.6	28.9	54.1	21.6	54.4
ATTENDING SCHOOL							
No	74	8.6	33.3	9.9	29.6	8.6	50.0
Yes	870	91.4	30.5	15.1	45.4	19.1	59.9
HOUSEHOLD WEALTH							
Lowest quintile	189	21.7	24.9	9.3	32.4	12.7	60.5
Middle three	564	56.2	27.2	11.1	44.2	17.4	58.3
Highest quintile	191	22.1	45.5	28.8	55.0	26.0	59.3
REGION							
Central	361	44.7	24.6	10.4	35.8	14.0	56.9
Northern	184	10.8	25.2	13.7	75.5	33.3	86.3
Southern	399	44.4	38.2	19.1	44.6	18.9	54.7
FEMALES AGED 15–19	**1,035**	**100.0**	**62.6**	**28.2**	**57.6**	**26.7**	**72.9**
RESIDENCE							
Rural	754	76.4	57.8	22.3	54.1	23.4	74.1
Urban	281	23.6	77.9	47.2	69.1	37.3	69.1
ATTENDING SCHOOL							
No	429	41.9	68.8	26.5	54.8	22.3	72.9
Yes	605	58.1	58.0	29.4	59.8	29.9	72.9
MARITAL STATUS							
Not married	890	86.7	59.6	27.3	57.2	25.7	72.4
Married	144	13.3	81.6	33.6	60.0	33.6	75.7
HOUSEHOLD WEALTH							
Lowest quintile	190	20.4	46.3	12.6	41.9	16.3	76.3
Middle three	618	57.7	65.3	26.7	59.6	24.9	71.9
Highest quintile	223	21.9	70.9	47.0	67.4	41.3	72.2
REGION							
Central	361	43.5	51.3	20.0	46.1	20.7	75.4
Northern	197	10.0	67.6	43.8	86.7	29.5	91.4
Southern	477	46.6	72.0	32.4	62.2	31.7	66.6

*Know of at least one modern method of contraception and also know all of the following: that there are certain days when a woman is more likely to get pregnant; that a woman can get pregnant the very first time she has sex; and that a woman can get pregnant if she has sex standing up. †Abstain, be faithful and use a condom. ‡Know that HIV transmission can be reduced by having sex with only one, faithful, uninfected partner and also by using condoms; that a healthy-looking person can have HIV; that a person cannot get HIV from mosquito bites; and that a

	% who know of any STI other than HIV	% who have ever talked with a family member about sex-related matters	% who have attended sex education classes or talks in school	% who know a source for contraceptives	% who say cost is a barrier to obtaining contraceptives	% who say feeling shy, embarrassed or fearful is barrier to obtaining contraceptives	% who know a place to get an HIV test	% who have ever been tested for HIV§
	63.3	**31.9**	**13.5**	**50.2**	**5.8**	**36.8**	**71.9**	**11.0**
	58.1	28.6	12.6	43.4	3.6	31.6	67.2	7.0
	81.1	42.9	16.6	73.3	13.2	54.7	88.1	24.2
	71.5	30.2	8.0	60.1	5.4	45.0	75.2	12.5
	60.4	32.5	15.4	46.6	6.0	33.9	70.7	8.0
	61.8	32.3	14.0	48.3	5.9	36.5	71.0	8.7
	82.4	27.5	5.6	74.8	4.9	40.8	85.2	14.1
	53.3	21.2	9.0	36.7	3.8	27.4	60.5	1.3
	60.3	30.2	13.3	46.7	4.3	34.7	69.7	9.6
	80.4	46.6	18.0	72.4	11.6	51.7	88.4	25.0
	55.5	25.5	12.5	36.3	7.2	23.9	59.0	12.9
	46.4	29.3	17.8	44.7	1.4	30.9	70.5	24.1
	74.6	38.5	13.4	64.8	5.5	50.7	84.7	8.7
	48.3	**23.3**	**12.7**	**35.5**	**3.7**	**27.7**	**62.2**	**6.9****
	43.2	22.4	12.6	30.3	2.3	23.0	56.5	0.0**
	66.3	26.5	13.2	54.6	8.3	44.4	82.8	66.7**
	46.9	13.4	2.5	32.9	2.5	28.4	51.9	40.0**
	48.4	24.2	13.6	35.8	3.8	27.6	63.1	0.0**
	41.2	15.2	9.3	27.3	3.9	15.2	49.8	0.0**
	43.6	22.3	12.5	32.1	2.5	25.7	58.9	0.0**
	67.3	33.7	16.7	52.6	6.7	44.7	83.2	28.6**
	41.5	20.1	14.2	22.7	3.8	15.2	48.1	20.0**
	24.5	22.5	13.7	27.5	0.0	17.6	60.2	0.0**
	61.1	26.7	11.0	50.6	4.5	42.6	76.8	0.0**
	76.7	**39.5**	**14.1**	**63.2**	**7.7**	**45.0**	**80.6**	**11.3**
	71.6	34.4	12.5	55.3	4.7	39.5	76.9	7.7
	93.2	56.3	19.3	88.8	17.3	63.3	92.4	22.8
	76.0	33.3	8.8	65.2	6.1	48.1	79.5	12.0
	77.2	44.0	17.8	61.8	9.0	42.8	81.4	9.7
	75.8	41.3	15.4	61.2	8.1	45.5	79.8	9.7
	82.1	27.9	5.7	75.9	5.0	41.4	85.0	12.9
	64.7	27.0	8.8	45.6	3.7	38.8	70.7	1.4
	75.1	37.0	14.0	59.5	5.9	42.6	79.0	10.2
	92.2	58.3	19.5	90.0	16.0	58.0	93.1	24.3
	68.6	30.6	11.1	48.8	10.3	31.9	69.0	12.3
	67.6	36.2	21.0	61.9	2.9	43.8	80.0	24.1
	86.2	48.6	15.5	77.0	6.3	57.6	91.4	9.3

person cannot get HIV from sharing food with someone who is infected. §Among respondents who have ever had sex. **N is 25–49.
Source: Reference 46.

APPENDIX TABLE 3B Knowledge and use of sexual and reproductive health information and services among 12–19-year-old males, by age-group, 2004 Malawi National Survey of Adolescents

Characteristic	N	% distribution (weighted)	% who know there are certain days when a woman is more likely to get pregnant	% with adequate knowledge of pregnancy prevention*	% who know three main ways to avoid HIV†	% with adequate knowledge of HIV/AIDS‡	% who know someone who has HIV or who has died from AIDS
MALES AGED 12–19	**2,052**	**100.0**	**41.5**	**20.5**	**64.9**	**31.8**	**71.7**
RESIDENCE							
Rural	1,541	76.8	39.1	16.0	61.6	28.5	71.7
Urban	511	23.2	49.3	35.5	75.9	42.8	71.9
ATTENDING SCHOOL							
No	387	19.4	48.4	26.3	65.3	25.1	75.6
Yes	1,663	80.6	39.9	19.0	64.8	33.4	70.7
HOUSEHOLD WEALTH							
Lowest quintile	363	17.8	34.3	9.4	53.6	22.9	68.0
Middle three	1,297	60.8	40.8	19.1	64.0	29.3	72.5
Highest quintile	388	21.3	50.0	34.0	76.9	46.3	72.5
REGION							
Central	725	40.4	42.2	20.8	60.7	32.2	70.8
Northern	357	8.8	25.7	14.6	52.2	19.6	78.1
Southern	970	50.8	43.7	21.3	70.5	33.6	71.4
MALES AGED 12–14	**905**	**100.0**	**22.1**	**7.7**	**54.6**	**24.1**	**59.5**
RESIDENCE							
Rural	678	77.8	22.1	5.8	52.0	21.7	61.0
Urban	227	22.2	21.8	14.4	63.7	32.8	54.0
ATTENDING SCHOOL							
No	62	7.3	15.2	4.5	43.3	12.1	47.8
Yes	842	92.7	22.6	8.0	55.4	25.1	60.4
HOUSEHOLD WEALTH							
Lowest quintile	182	20.6	16.7	2.7	42.5	18.3	59.1
Middle three	554	60.0	22.2	6.7	54.3	21.7	59.4
Highest quintile	165	19.4	27.3	16.0	67.4	37.7	59.4
REGION							
Central	299	38.6	23.1	8.3	45.0	22.3	57.7
Northern	150	8.6	7.6	3.8	39.2	16.5	65.4
Southern	456	52.7	23.6	7.9	64.1	26.8	59.8
MALES AGED 15–19	**1,147**	**100.0**	**57.2**	**30.8**	**73.3**	**38.0**	**81.6**
RESIDENCE							
Rural	863	75.9	53.2	24.4	69.5	34.1	80.5
Urban	284	24.1	69.7	50.9	85.2	50.2	85.2
ATTENDING SCHOOL							
No	325	29.2	55.2	30.8	69.8	27.7	81.4
Yes	821	70.8	58.0	30.7	74.7	42.1	81.7
HOUSEHOLD WEALTH							
Lowest quintile	181	15.6	52.8	15.9	65.3	27.8	77.3
Middle three	743	61.6	55.3	28.9	71.6	35.2	82.7
Highest quintile	223	22.8	65.4	46.3	83.3	52.1	81.7
REGION							
Central	426	41.9	56.4	30.1	72.2	39.4	80.5
Northern	207	8.9	40.0	23.0	62.4	22.0	88.0
Southern	514	49.2	61.0	32.9	76.0	39.5	81.4

*Know of at least one modern method of contraception and also know all of the following: that there are certain days when a woman is more likely to get pregnant; that a woman can get pregnant the very first time she has sex; and that a woman can get pregnant if she has sex standing up. †Abstain, be faithful and use a condom. ‡Know that HIV transmission can be reduced by having sex with only one, faithful, uninfected partner and also by using condoms; that a healthy-looking person can have HIV; that a person cannot get HIV from mosquito bites; and that a

% who know of any STI other than HIV	% who have ever talked with a family member about sex-related matters	% who have attended sex education classes or talks in school	% who know a source for contraceptives	% who say cost is a barrier to obtaining contraceptives	% who say feeling shy, embarrassed or fearful is barrier to obtaining contraceptives	% who know a place to get an HIV test	% who have ever been tested for HIV§
67.8	**31.9**	**25.6**	**57.8**	**5.4**	**29.3**	**75.5**	**5.1**
63.9	27.2	19.6	51.9	5.4	26.9	70.9	3.8
80.5	47.4	45.6	77.5	5.1	37.1	90.9	10.5
73.2	28.9	14.7	55.8	7.1	29.9	75.7	5.0
66.4	32.6	28.4	58.3	5.0	29.0	75.4	5.0
58.6	20.7	17.7	45.7	5.5	21.6	65.4	5.6
64.7	27.7	20.0	53.2	4.8	28.3	72.5	3.1
84.7	53.2	48.8	80.6	6.9	37.5	92.6	11.1
61.7	20.7	18.1	44.9	4.9	14.8	65.7	5.0
49.4	19.6	16.9	35.8	1.1	45.3	65.2	10.2
75.9	42.8	33.1	72.0	6.5	38.0	85.0	4.5
49.9	**23.8**	**18.6**	**42.8**	**3.0**	**19.0**	**62.8**	**1.1**
45.9	20.5	14.2	37.5	2.8	16.7	56.2	0.0
64.2	35.1	34.3	60.9	3.5	26.9	86.1	10.0
37.9	20.9	0.0	28.4	7.6	7.6	45.5	0.0
50.8	24.0	20.1	43.8	2.6	19.8	64.2	1.3
38.9	15.6	9.2	30.6	3.8	14.5	48.9	0.0
47.5	21.3	16.1	39.6	2.4	18.1	59.8	0.0
69.1	40.6	37.1	63.4	4.0	24.6	87.4	11.1
40.0	12.6	13.7	24.8	2.6	8.3	47.7	0.0
27.8	11.5	10.3	16.5	1.3	34.2	48.7	0.0
60.8	34.0	23.6	60.3	3.6	24.4	76.4	1.8
82.2	**38.4**	**31.3**	**70.0**	**7.3**	**37.6**	**85.7**	**6.1**
78.8	32.6	24.1	63.6	7.5	35.3	82.9	4.9
92.6	56.5	53.9	90.0	6.6	44.6	94.5	11.2
80.2	30.5	17.7	61.6	7.0	34.3	81.7	5.4
82.9	41.6	37.1	73.4	7.4	38.7	87.2	6.3
79.4	26.1	26.7	61.9	7.4	29.5	82.4	8.1
78.1	32.8	23.1	63.8	6.6	36.3	82.4	3.9
95.3	61.9	56.8	92.2	8.9	46.3	96.5	11.8
77.8	26.7	21.4	59.7	6.6	19.7	79.2	6.1
66.0	26.0	22.0	51.0	1.0	54.0	78.0	11.1
88.8	50.5	41.3	82.1	9.0	49.8	92.6	5.6

person cannot get HIV from sharing food with someone who is infected. §Among respondents who have ever had sex.
Source: Reference 46.

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Box: Data Sources

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2. Appendix Table 1A.

3. Appendix Table 1B.

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