Adolescent Sexual and Reproductive Health in Malawi: A Synthesis of Research Evidence

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Table of Contents

Executive Summary

This report is part of a larger, five-year study of adolescent sexual and reproductive health issues called *Protecting the Next Generation: Understanding HIV Risk Among Youth* (PNG). The project, which is being carried out in Burkina Faso, Ghana, Malawi and Uganda, seeks to contribute to the global fight against the HIV/AIDS epidemic among adolescents by raising awareness of young people's sexual and reproductive health needs with regard to HIV/AIDS, other sexually transmitted infections (STIs) and unwanted pregnancy; communicating new knowledge to a broader audience, including policymakers, healthcare providers and the media, in each country, regionally and internationally; and stimulating the development of improved policies and programs that serve young people. The research involves focus group discussions and qualitative interviews with adolescents, teachers and health workers, as well as national surveys of adolescents. This synthesis is the first publication of the PNG project in Malawi. It identifies important knowledge gaps and informs the project's communication and advocacy initiatives by providing an overview of current policies and interventions for youth.

The primary goal of this report is to summarize what is known about adolescent sexual and reproductive health in Malawi and to identify knowledge and program gaps requiring further research and program action. Drawing from a wide range of studies carried out in the country since 1990, the synthesis reviews the social, cultural and economic context in which adolescents live; their sexual and reproductive health experiences; sources of information and services related to sexual and reproductive health; knowledge and attitudes about HIV/AIDS and personal risk assessment; and policies and programs on adolescent sexual and reproductive health in the country. The studies reviewed include the Demographic and Health Surveys (DHS) conducted in Malawi in 1992, 1996 and 2000, and other small-scale studies carried out in different parts of Malawi to inform the development of specific programs.

Past studies highlight various cultural practices that influence young people's behaviors, attitudes and motivations related to sexual and reproductive health issues. The socialization process, which involves various forms of initiation ceremonies, has a strong influence on how adolescents understand their sexual and reproductive health. Although Malawian culture values virginity and condemns premarital childbearing, there is a general understanding that initiation ceremonies, which are meant to groom young people to be responsible sexual beings, sometimes achieve the undesired outcome of encouraging young boys and girls to initiate sexual relationships prematurely because they feel that the initiation ceremonies mark their transition to maturity. The socialization process also reinforces the dominance of men and boys and the subordination of women in sexual relationships. This social orientation is likely to weaken women's autonomy and latitude to negotiate for safer sex. It is also evident that the traditional socialization system's role in adolescent sexuality and reproductive health has been waning as a result of the increasing influence of religion, schooling, exposure to media and other sources of information on these issues. While sexual abuse appears to be a major problem in Malawi, the actual magnitude of this problem is not known.

Indeed, although premarital sexual intercourse is disapproved of in many Malawian communities, studies have shown that many adolescents initiate sex at an early age. For example the 2000 DHS revealed that 61% of males and 57% of females aged 15–19 had ever had sex at the time of the survey. Factors associated with early initiation of intercourse include low levels of schooling, peer pressure to experiment with sex and poor economic wellbeing. Between 1992 and 2000, age at first marriage increased slightly for women aged 20–24 (from 17.7 to 18.2) but decreased for men aged 25–29 (from 24 to 22.7).

The major problem with early initiation of sexual relations is that many young boys and girls are not aware

of protective measures; they feel vulnerable and lack the confidence to demand use of protection against STIs and unplanned pregnancies. According to the 1992 DHS, 35% of females aged 15–19 were either pregnant or mothers at the time of the survey, a figure that remained unchanged even in the 2000 DHS. The consequences of early initiation of sex and lack of control are more acute for girls, who usually have to leave school when they get pregnant. Some girls risk their lives through illegal abortions and are more vulnerable to STIs, including HIV, because they typically have sexual relations with men who are more experienced and older.

Although the proportion of married adolescents using contraceptives increased from 7% to 15% between 1992 and 2000, it is still quite low, especially given that knowledge of at least one family planning method is almost universal. Barriers to the use of contraceptives among adolescents include unavailability of contraceptives, fear of real and misconceived side effects, unfriendly service providers and opposition from sexual partners.

Many young people engage in risky sexual behaviors, as demonstrated by the high proportion of boys who have multiple sexual partners. According to the 2000 DHS, 16% and 2% of sexually experienced males and females age 15–19, respectively, had had two or more sexual partners in the 12 months preceding the survey. Furthermore, 13% of males aged 15–19 had had some type of STI during the 12 months prior to the survey. The majority of adolescents indicate that they would go to the hospital for treatment of STIs, although some would prefer traditional healers because of privacy issues, lack of medicines in hospitals and the belief that traditional medicine cures better because it completely kills germs that may cause infertility.

Use of condoms for family planning is quite low, though it increased slightly from 10% in 1992 to 15% in 2000 for males and from 1% to 3% for females over the same period. Use of condoms at last intercourse is somewhat higher once use is broadened to include use for preventing STIs. Nonuse of condoms is due to a number of factors, including ignorance of condoms, unavailability of condoms, sex not feeling good with condoms, trusting the partner and the belief that lubricant in condoms causes other diseases such as AIDS. Both young men and women generally believe that it is men's responsibility to make decisions on condom use, and that women who possess or insist on condom use are perceived to be "loose."

The major sources of sexual and reproductive health information for adolescents are youth clubs, the radio, government health workers and friends. Parents are not a major source of information because they do not normally talk to their children about sexual and reproductive health issues; this responsibility is left to other relatives, such as aunts, grandparents and other people within the community such as *anankhungwi* (traditional initiators). Barriers to access to information on sexual and reproductive health include ignorance about the existence of the services, fear of teachers and parents and poor attitudes of health workers toward adolescents.

Knowledge of HIV/AIDS among Malawian adolescents is almost universal. The vast majority know that HIV is mainly transmitted through sexual intercourse and that abstinence and proper use of condoms are ways of preventing the transmission of HIV. There is also increasing awareness of voluntary counseling and testing (VCT), although very few people have gone for VCT services; in 2000, only 7% of adolescent men aged 15–19 had ever had an HIV test. Low utilization of VCT is due a number of factors, including lack of VCT services in the community and being afraid of living a stressful life if found HIV positive.

A number of policies in Malawi address adolescent sexual and reproductive health issues: the National Youth Policy, National Population Policy, National Gender Policy, Reproductive Health Policy and the National HIV/AIDS Policy. In addition to these policies, there are also specific programs that address adolescent sexual and reproductive health; for example, life skills education in schools and Edsi Toto ("AIDS is not for me") Clubs are involved in different activities aimed at creating awareness about AIDS among adolescents.

Based on the findings from this synthesis, the following gaps in evidence have been identified:

(i) There are a number of regional variations in Malawi regarding key indicators such as age at first sex and age at first marriage. These patterns call for more in-depth studies to understand the underlying causes of regional differences and whether such factors could also have a role in shaping sexual and reproductive health attitudes and practices among adolescents.

(ii) Given the paucity of data on sexual abuse, there is need to find out the magnitude of the problem in Malawi.

(iii) Abortion is legally restricted in Malawi, yet it is an important medical and social problem: Hospital records show that many women, particularly young girls, resort to dangerous and unorthodox means of abortion that put their health and lives in danger. There is need to determine the magnitude

of this problem at the community level and also to improve collection of abortion data in hospitals and clinics through routine health management and information systems.

(iv) There are a number of cultural practices that put adolescents at risk of contracting HIV and other STIs. While these practices have been identified, further studies should attempt to determine the extent to which these cultural practices are being carried out, and their actual impact on STI/HIV/AIDS transmission and other sexual and reproductive health problems.

(v) A range of sexual and reproductive health services are offered to adolescents, but some adolescents are not even aware of the existence of such services. Further studies on adolescent sexual and reproductive health services need to document and map the range of services available to adolescents in various communities to determine underserved areas. Further studies should also seek to develop ways to improve adolescents' awareness of services that are available to them.

(vi) Voluntary counseling and testing is now a key component of HIV/AIDS prevention and treatment. Yet the percentage of adolescents in Malawi who have gone for VCT is still very low. Further studies need to be done in order to determine factors that would help promote the uptake of VCT services.

(vii) While the level of adolescent sexual and reproductive health program activity has expanded considerably over the last few years, there is a need to carry out comprehensive evaluations of the impact of programs in order to establish best practices to be scaled up. Indeed, many of the studies and programs reviewed in this study were implemented in localized areas and with limited monitoring and evaluation capacity. As a result, they have limited applicability to the wider national context. A major challenge, therefore, is to assess the wider applicability and occurrence of these findings and lessons on the national scale.

Introduction

Although the definition of adolescence varies across cultures and different studies use various age-groups, the common understanding of this concept is that it is a period in which children make the transition from childhood to adulthood. In Malawi, adolescence is typically defined to span the ages pf 10 to 19.[1] The 1998 census showed that adolescents comprise 23% of the total population of Malawi and the majority live in rural areas.[2] The population of adolescents is estimated to have increased from 1.86 million in 1987 to 3.01 million in 2002.[3]

The period of adolescence is characterized by a number of changes, including physical and emotional changes, the search for identity and greater maturity in reasoning. As adolescents go through these changes, they tend to experiment with such activities as sexual intercourse, alcohol consumption, drug use and smoking. Many adolescents adopt risky behaviors without having adequate or correct information on how to protect themselves from the adverse consequences of these behaviors. HIV/AIDS prevalence data show that 15–24-year-olds have the highest rates of new HIV infection, with adolescent girls considerably more likely to be infected than adolescent boys.[4] These figures have brought to the fore the unique vulnerability associated with adolescence.

Societies naturally make concerted efforts to ensure that adolescents grow into responsible and productive adults. Traditionally, adult men and women have the responsibility of molding male and female adolescents, respectively, into responsible and productive adults. While most communities in Malawi advise girls and boys against engaging in premarital sexual intercourse to avoid premarital pregnancy,[5] available data show that early sex and teenage pregnancies are common in Malawi.[6]

It should be acknowledged that traditional structures that help mold adolescents into adults are changing due to factors such as education, religion and urbanization. As a result, there seems to be a vacuum for young people's socialization, particularly on sexuality issues,[7] because traditional structures have largely disintegrated while the emerging ones are not fully meeting the socialization needs of adolescents.[8] In these changing times, elders lament that young people do not listen to advice, and this is perceived as a major explanation for the high prevalence of diseases among young people, including HIV/AIDS.[9]

Schools are another key institution where adolescents learn about sexual and reproductive health matters. However, levels of school attendance are quite low in the country, as suggested by the fact that most people in Malawi are illiterate. Only 52% of males and 31% of females can read or write either in English or in their native language.[10] The introduction of free primary education in 1994 saw the increase in gross enrolment rates from 95 and 85 in 1993–1994 to 142 and 131 per 1000 boys and girls, respectively.[11] These figures should, however, be interpreted with caution. Kadzamira and colleagues have stated that between 1990 and 2000 over 70% of the children who entered school dropped out before completing the full cycle, which implies that less than 30% of those who entered school each year completed the eight-year primary cycle. This explains why the estimated net enrolment rate for both girls and boys (76 per 1000) is much lower than the gross enrolment rate.[12] In the eight-four-four school system, children ordinarily enroll in primary school at age six, and the vast majority of young people should have attended school for at least 10 years by age 15. However, only 33% of women and 34% of men aged 15–19 had completed at least seven years of schooling in 2000 (Appendix Tables 1 and 2, line 1). As one would expect, the levels of school attendance are higher in urban than in rural areas, and in line with many other social indicators, they are also higher in the Northern than in the Central and Southern regions. The socioeconomic environment in which adolescents live

also affects their lives and sexual and reproductive health outcomes. The limited access to land, low education, poor health status, limited off-farm employment and lack of access to credit have generally been identified in the Malawi Poverty Reduction Strategy Paper as the major causes of poverty in Malawi.[13] As the HIV/AIDS pandemic continues to claim economically productive young men and women and leave behind the elderly and orphans, poverty seems to be worsening. The lack of economic resources to meet adolescents' basic needs may influence young people to adopt risky sexual behaviors as a survival strategy.[14]

A number of studies on adolescent sexual and reproductive health have been done over the years in Malawi. Additionally, various intervention programs addressing the sexual and reproductive health needs of adolescents have also been implemented in different parts of the country. This report provides a comprehensive overview of current knowledge on adolescent sexual and reproductive health issues in Malawi, with a focus on HIV prevention. It draws upon the existing body of social science research and includes both quantitative and qualitative studies. Its goal is to communicate key findings from existing research to a wide audience within the country. The specific objectives are:

- to synthesize key findings from the studies that have been done on adolescent sexual and reproductive health in Malawi;
- to identify information gaps in order to inform the development of future research in this area; and
- to highlight implications and priority areas to inform programs and policies and to improve the sexual and reproductive health of youth.

The core issues reviewed are sexual behavior, marriage and childbearing, sexual coercion, abortion, contraceptive use (including condom use), knowledge related to HIV/AIDS and other sexually transmitted infections (STIs), attitudes and protective practices among young people, and health information and services.

This report synthesizes findings from a wide range of qualitative and quantitative studies carried out since 1990 on adolescent sexual and reproductive health issues in Malawi. Most studies on adolescents have been conducted in localized areas; many of them are meant to provide baseline data to guide formulation and facilitate evaluation of sexual and reproductive health programs in those areas. None of these localized studies have nationally representative samples, and as such they provide limited evidence of adolescent sexual and reproductive health behavioral patterns. However, taken together the studies give a comprehensive picture of adolescent issues, especially because most of them cover the entire adolescent age span (10–19) and some include young people as old as 24.

The only surveys that provide national-level data are the three Demographic and Health Surveys (DHS) conducted in 1992, 1996 and 2000. DHS surveys collect information on respondents' background characteristics, knowledge and use of family planning, childbearing history and attitudes, and knowledge and attitudes related to HIV/AIDS. The 1996 survey, which focused on knowledge, attitudes and practices, did not have detailed questions on childbearing history. DHS surveys target women and men of all reproductive ages (15–49), and their use in adolescent research is limited because they can only provide indicators of sexual and reproductive health status and outcomes among adolescents aged 15–19. However, being the only source of nationally representative data, DHS surveys are extensively cited throughout this report. A set of key indicators of young people's sexual and reproductive health knowledge and behaviors from the 2000 DHS is included in two appendix tables for all females and males aged 15–19 and by specific subgroups.

With the exception of these DHS surveys, where some attempts were made to generate various indicators from the primary data set wherever necessary, the review for the other studies solely relied on study reports that were collected from various libraries and program institutions in Malawi. Therefore, the quality of the data collected in the studies could not be verified. Most of the reports were collected from different libraries and resource centers in Lilongwe, Zomba and Blantyre. The United Nations Resource Centre and the library at the Ministry of Health and Population in Lilongwe were particularly useful in providing reports on studies on adolescent sexual and reproductive health. Library staff were particularly helpful in locating appropriate literature on adolescent sexual and reproductive health. The data box on page 10 describes major data sources utilized and studies reviewed, specifically when and where studies were conducted, the sample size, types of respondents and who conducted the study.

This report is part of a larger, five-year study of adolescent sexual and reproductive health issues called *Protecting the Next Generation: Understanding HIV Risk Among Youth* (PNG). The project, which is being carried out in Burkina Faso, Ghana, Malawi and Uganda, seeks to contribute to the global fight against the HIV/AIDS epidemic among adolescents by raising awareness of young people's sexual and reproductive

health needs with regard to HIV/AIDS, other STIs and unwanted pregnancy; communicating new knowledge to a broader audience, including policymakers, health-care providers and the media, in each country, regionally and internationally; and stimulating the development of improved policies and programs that serve young people. The research involves focus group discussions and qualitative interviews with adolescents, teachers and health workers as well as national surveys of adolescents. This synthesis is the first publication from the PNG project in Malawi: It identifies important knowledge gaps and informs the project's communication and advocacy initiatives by providing an overview of current policies and interventions for youth.

Commonly Cited Data Sources

Government of Malawi., *Demographic and Health Survey 1992,* Zomba, Malawi and Calverton, MD, USA: National Statistical Office (NSO) and ORC Macro, 1994: This was a nationally representative sample survey that covered 5,323 households where 4,849 women aged 15–49 and 1,151 men aged 20–54 were interviewed. Approximately 22% of female respondents were aged 15–19, while one-quarter of male respondents were aged 20–24. The study provided information on a number of issues, including levels and trends in fertility, child and maternal health, knowledge and use of family planning, knowledge about HIV/AIDS, and availability of health services. This survey was implemented by the NSO between September and November 1992.

Government of Malawi, *Knowledge, Attitudes and Practices in Health 1996,* Zomba, Malawi and Calverton, MD, USA: NSO and Macro International, 1997: This Demographic and Health Survey interviewed a representative sample of 2,683 women aged 15–49 and 2,658 men aged 15–54 on health issues. A total of 618 adolescent females and 572 adolescent males were interviewed. The survey, which was implemented by the NSO between June and October 1996, looked at a number of health issues, such as fertility regulation, child health (including vaccination and Vitamin A coverage), knowledge about malaria and its management and prevention, and knowledge about HIV/AIDS and other STIs.

Government of Malawi, *Demographic and Health Survey 2000,* Zomba, Malawi and Calverton, MD, USA: NSO and ORC Macro, 2001: This survey was implemented by the NSO between July and November 2000. It covered 14,213 households where 13,220 women aged 15–49 and 3,092 men aged 15–54 were interviewed. Of these respondents, 2,867 were adolescent females and 660 were adolescent males (aged 15–19). This study provided information on fertility regulation, levels, trends and preferences; infant and child mortality and maternal and child health; infant feeding (including nutritional practices and nutritional status); HIV/AIDS and other STIs; adult and maternal mortality; and malaria management.

Maluwa-Banda D and Lunguzi J, *Baseline Survey Report on Meeting Development and Participation Rights of Adolescent Girls in Malawi,* Lilongwe, Malawi: United Nations Population Fund, United Nations Children's Fund and Department of Youth and National Youth Council of Malawi, 2002: The major objective of this study was to identify the factors that affect the participation of girls in the development process in their communities. This study, which was both qualitative and quantitative, was done in five districts, namely Thyolo, Mwanza, Lilongwe, Mchinji and Nkhata Bay. A questionnaire was administered to a total of 345 adolescent boys and girls, and focus group discussions were done with both in- and out-of-school adolescent girls. The report discusses the participation of girls in community activities and schooling, including reasons for dropping out of school, sources of sexual and reproductive health information, availability of sexual and reproductive health services, sexual activity and use of contraception and condoms.

McAuliffe E, *AIDS: The Barriers to Behavioural Change,* Zomba, Malawi: Centre for Social Research, 1994: This qualitative study was conducted in Mzimba, Lilongwe and Blantyre in September 2003; it was aimed at finding out people's attitudes about sexual behavior, relationships and cultural norms; knowledge and attitudes about HIV prevention; knowledge and attitudes about condom use and barriers to behavior change in the face of AIDS; and potential communication channels for dissemination of AIDS education materials. Focus group discussions were conducted with 88 youth aged 15–19, 83 women aged 20–56, 76 men aged 22–66 and 61 people in high-risk groups (STI clinic attendees and bargirls).

Bisika T and Ntata P, *Youth and AIDS Follow-up Mini-KAPB Survey in Blantyre, Lilongwe and Mzuzu,* Zomba, Malawi: Centre for Social Research, 1996: The major objective of this study was to evaluate a three-year United Nations Children's Fund (UNICEF) Youth and AIDS project, which was aimed at educating and empowering youth in the fight against AIDS. A total of 1,544 men and women aged 10–20 were interviewed. Some of the major findings from this study are that friends are the most common source of information on sex-related issues; that more than half of the respondents had had penetrative sex at the time of the survey; and that curiosity, enjoyment and pressure from friends were

cited as reasons for engaging in premarital sex. Knowledge about HIV/AIDS was almost universal, and the most common sources of information were health talks and the radio. Most respondents reported having changed their sexual behavior since the advent of HIV/AIDS: They have started using condoms and reduced the number of sexual partners, and some are abstaining from sexual intercourse. The study also found low levels of condom use among the youth, though most of them said they had not used condoms because they had never engaged in sex. While young people knew where they could get condoms, a substantial percentage said that it was not all that easy to get condoms. The youth in this study suggested that for them to sustain risk-free behaviors, they needed to be provided with condoms.

Maluwa-Banda D, *Baseline Survey Report on the Sexual and Reproductive Health Programme for Out-of-School Young People,* Lilongwe, Malawi: Department of Youth, National Youth Council of Malawi and United Nations Population Fund, 2001: The Department of Youth in the Ministry of Gender and Community Services has been implementing the Family Life Education for Out of School Youth project on a pilot scale since 1996. The project, piloted in Chitipa, Kasungu, Nkhota Kota, Zomba and Thyolo, was aimed at addressing factors influencing the quality of life of the individual, family and community by empowering youth with decision-making and communication skills. The project, now renamed *Sexual and Reproductive Health Programme for Young People,* has been extended to five more districts (Nkhata Bay, Mchinji, Dedza, Mwanza and Mulanje). Before this expansion, there was need for a baseline survey to determine young people's knowledge, attitudes, beliefs and practices on sexual and reproductive health and contextual factors that influence adolescent behavior. The baseline survey was conducted in four districts (Zomba, Mulanje, Nkhota Kota and Nkhata Bay). Three hundred three youths aged 12–25 responded to the individual questionnaire for young people, 96 people responded to the questionnaire for adults, and there were also questionnaires for nongovernmental organizations and staff in the Department of Youth. A total of 16 focus group discussions were conducted with the youth and eight were conducted with adults. The baseline survey showed that the radio is the main source of information on HIV/AIDS and that despite high levels of knowledge of HIV/AIDS, misconceptions still exist. More than 75% of the youth respondents had had sex; for those who abstained, it was mainly because of fear and not being ready for sex. Just over 5% of respondents reported having ever had sex against their will. Condom use at first penetrative sex was found to be low, with nearly 70% of respondents reporting having ever had sex without condoms. Adults were concerned that messages on sexual and reproductive health were focused on condoms and not abstinence and were also aware of the cultural practices that enhance the spread of HIV/AIDS. The study recommends, due to the complex relationship between sex and such contextual factors as individual desires, culture and socioeconomic factors, that there is need for a comprehensive strategy that will focus on key factors that contribute to HIV infection among young people.

McAuliffe E and Ntata P, *Baseline Survey in Lilongwe and Blantyre Districts? Youth and AIDS,* Zomba, Malawi: Centre for Social Research, 1994: In 1993, UNICEF Malawi and UNICEF Australia were planning to implement a three-year study in two pilot districts, Lilongwe and Blantyre. A baseline survey was conducted in these two districts to assess young people's knowledge, attitudes, practices and behaviors. Phase one of the study—the survey—had a sample size of 1,000; in phase two, 48 focus group discussions were conducted. This study found that generally the youth discuss sex with their friends; more than 50% of the sample had had sex; and youth engage in sex for enjoyment, to obtain money and out of curiosity. Young people recognize AIDS as a major public health problem and knowledge about this disease (including modes of transmission and prevention) is quite high, though there are also misconceptions. Although respondents were concerned about contracting HIV/AIDS, they did not feel at risk of getting the disease. The majority of respondents said that they had first heard about the condom from the radio and explained that the condom is used for prevention of AIDS and other STIs and prevention of pregnancy, among other uses. Condom use was reportedly low (28%), and reasons such as less enjoyable sex, encouraging promiscuity, scarcity of condoms and the condom lodging in the vagina were given as reasons for not using condoms. The study recommends that although increasing condom use might be a solution, the success of the project would depend on finding alternative means of meeting the social and financial needs that force the youth to engage in risky sexual behavior.

The Social Context, Cultural Values and Beliefs

The prevailing cultural and socioeconomic contexts have a strong impact on patterns of adolescent sexual and reproductive behavior. The socialization process that young people undergo is influenced largely by the existence of opinion leaders, including village headmen, traditional initiators (*anankungw*i or *nkhoswe*), traditional birth attendants, churches and mosques, local political leaders and teachers. Some cultural practices, such as initiation ceremonies, early sex, early marriage and funerary cleansing rites have a strong role in shaping the behaviors of young people in Malawi.[15]

During the initiation ceremonies, instructors (the *nankungwi/akunjira*) tell young people the "*dos* and *don'ts*" of behavior. Often there are more *don'ts* than *dos* for young females compared with their male counterparts. Among other things, girls are told to avoid men and boys, not to enter their parents' bedroom, not to put salt in food during monthly periods and to respect and be obedient to men. While initiation rites are for character-building,[16] they are also known to encourage early initiation of sex. Indeed, while boys are also taught to avoid girls, many initiates come out feeling that the initiation actually certifies them to experiment with sex since they are now considered "adults."[17] For example, in some communities in Malawi, especially in the Central Region, initiates are literally encouraged to experiment with sexual intercourse through the kuchotsa fumbi ("removing dust") tradition as noted from the following excerpt from a focus group discussion carried out in Lilongwe:

> *"When young people come out from the initiation rites, they are like mad dogs hunting for women whom they can have sex with….They are not even told to wear condoms. These are young people who have unprotected sex…."*[18]

Among some Chewa communities (e.g., Dedza), girls who are initiated get to sleep with a man termed a *fisi* ("hyena") whose role is to initiate girls into sexual intercourse. The serious problem with the practice is that the *fisi* can sleep with several girls on the same night and without any protection, thereby increasing the vulnerability of girls to sexually transmitted infections (STIs) and HIV.

The paradox is that, in general, Malawian culture does not condone interactions among boys and girls. As a result, boys and girls grow up with poor socialization and communication skills on sexuality and other issues. Spousal communication about sex is also difficult because young females are brought up to view male partners as superior on sexual issues.[19] Indeed, the counseling sessions and the whole process of socialization are entrenched in cultural values that tend to emphasize and strengthen the dominance of men and boys and the subordination of women and girls in sexual relationships.[20] Cultural norms are widely held that women should be inexperienced and naive in sexual matters and that pleasing men is the primary goal of sex.[21] Indeed, from very young ages, girls are treated as sexual beings whose primary objective is to please mean, while boys are never taught what it takes to please a woman sexually.[22]

Sexual activity is male dominated and controlled, as studies have shown that males initiate sex in 92% of the relationships and girls often feel powerless to refuse sex or negotiate safer sex.[23] In fact, if a girl initiates sex, she is labeled a "loose" person. In a study conducted by McAuliffe,[24] when girls were asked how they would feel if their boyfriends did not ask them for sex, the majority of girls (over 50%) reported that they would feel loved and respected; 22% would think their boyfriends did not love them; 18% would think their boyfriends did not trust them; and 13% would think that 'he was no man'. While parents and the society at large exercise strict controls and closely monitor girls' sexual behavior, boys are often left alone to explore relationships. For instance, a study in Mchinji District in central Malawi, found that young men date as many girls as they like before deciding on marriage, but girls

who have more than two boyfriends before getting married are labeled "loose."[25] The strong disapproval of premarital pregnancies is shown by many reports of unmarried, pregnant girls being beaten or even disowned by their parents. Until 1994, when a multiparty system of government was established and free primary education introduced, school girls who got pregnant were expelled from school and not easily allowed to return to school, but the boys who made the girls pregnant continued to attend school.

Parents also play a key role in shaping adolescent behavior. However, because it is considered taboo for children to discuss sexual matters with their parents, many parents have traditionally left this responsibility to grandparents, aunts and traditional initiators. Although the custom of arranged marriages does not exist in Malawi, young people are sometimes pressured into early marriages and transactional sex by family members.[26] Boys and girls often talk to their friends and peers about their choice of partner but sometimes seek advice from grandmothers, aunts and fathers.[27]

In addition to sex and family life education obtained from traditional initiation ceremonies and counselors, young people receive considerable counseling from faith-based institutions on sex and sexuality, with a focus on abstinence. Most religious groups oppose contraception, including condom use, on the basis that encouraging these methods promotes irresponsible sexual behavior among young people. The faith-based institutions also tend to disapprove of traditional initiation ceremonies because of the belief that the sexuality instruction that adolescents are given there encourage them to initiate sexual intercourse prematurely. Paradoxically, the same female individuals who are counselors in faith-based institutions are sometimes former traditional advisors.

Besides traditional initiation ceremonies and the counseling provided by faith-based institutions, peer sex education also shapes adolescent attitudes and beliefs regarding sex, whether formally through peer educators or informally among friends. As a result, most young people are misinformed about sexuality and reproduction,[28] because they often get wrong information from friends (e.g., that a girl will not get pregnant if she has sex while standing).[29] The youth indicate that there is pressure on both males and females to have sexual relationships from other youth who have already started sexual relations.[30] Adolescents also learn about sexual and reproductive health matters from schools, either through biology lessons or through family life education seminars or lessons. However, a relatively small proportion of school-aged adolescents complete their seventh year of schooling, which is when these classes would usually be offered.

In summary, adolescents in Malawi grow up in a social and cultural context that appears to reinforce the contradictions and confusions that adolescents face as they grow into adulthood. While the traditional as well as modern societies discourage premarital sex and boy-girl relationships, the sex and family life education that boys and girls receive promotes gender imbalances that put girls in a particularly vulnerable and submissive position on sexuality matters. Girls are taught to avoid premarital sex, yet their sex education revolves around lessons on how they should please men sexually. Additionally, communities closely monitor and control girls' sexual behavior, but not much, if anything, is done to control boys' sexual behavior. As a result, boys grow up with a distorted sense of fidelity in sexual relationships, a factor that continues to increase women's vulnerability to STIs, even within marriage. Considering the significance of these issues in adolescent sexual and reproductive health, there is need for further studies to establish the extent of adherence to these practices and beliefs and ways in which to change them throughout Malawi.

Adolescent Sexual and Reproductive Experiences

Age at first sexual intercourse

Despite the societal disapproval and stigma associated with premarital sex, various studies show that most young people in Malawi initiate sex at young ages and before they get married. Some young people initiate sexual activity as early as age 10, and many report having sexual intercourse by age 17. A number of studies have shown that over 50% of adolescents initiated sexual intercourse before age 15.[31] Other studies whose samples included adolescents as young as eight found that the median age at sexual initiation ranged from 15[32] to 18.9.[33]

The 2000 Demographic and Health Survey (DHS) data also point to relatively early initiation of sex among Malawian youth; 61% males and 57% females aged 15–19 had ever had sexual intercourse (Appendix Tables 1 and 2, line 5).[34] The median ages at first sexual intercourse for 20–24-year-olds were 17.7 for males and 17.0 for females (Appendix Tables 1 and 2, line 6). The majority of sexually experienced adolescents (67% of women and 62% of men) had had sexual intercourse in the last three months (Appendix Tables 1 and 2, line 8). The data also show that more boys have premarital sex than girls; 72% of men and 38% of women aged 20–24 reported having had premarital sex before age 20 (Appendix Tables 1 and 2, line 7).

More years of schooling are associated with relatively late initiation of sex (especially for women) and less premarital and recent sexual intercourse for women. For instance, girls with seven or more years of schooling initiate sex two years later than their counterparts with less than seven years of schooling (16.5 vs. 18.3 years, respectively; Appendix Table 1, line 6). For boys, there is no difference in median age at first sex between those with at least seven years of schooling and those with less schooling, although current sexual activity and multiple partnerships are less common among the more educated subgroup (Appendix Table 2, lines 8 and 9).

A rural-urban difference in sexual initiation is evident and portrays an interesting gender dimension. Although urban teenage girls start having sexual intercourse later than their male counterparts, boys have penetrative sex later than girls in the rural areas. Median age at sexual initiation for rural females is 16.9, while that for males is 17.9 among 20–24-year-olds (Appendix Tables 1 and 2, line 6). The gender variation in sexual initiation between rural and urban areas is probably a reflection of differences in contextual and social factors that influence adolescents to engage in sexual intercourse.[35]

Adolescents in the Southern region initiate sexual activity earlier than their counterparts n the Center and the North. According to the 2000 DHS, the median age at first sex for men aged 20–24 was 17.1 years in the North, 18.4 in the Center and 16.9 in the South (Appendix Table 2, line 6). For women, the median ages at first sex were 17.1, 17.6 and 16.6, in the North, Center and South, respectively (Appendix Table 1, line 6). These results are corroborated by a recent study carried out in the three regions that showed that 3% in the North (Rumphi district), 11% in the Central (Mchinji District) and 29% of women in the South (Balaka District) had initiated sex by age 14; among men, 8%, 9% and 19% had had sex by age 14 in the three regions, respectively.[36] These differences appear to be a reflection of differences in traditional practices in socialization of children in the three regions. In the Southern region, most children undergo elaborate initiation ceremonies that are widely interpreted to permit the initiated youth to start having sex.[37]

There is evidence that age at first intercourse is declining in Malawi.[38] This is further supported by the 2000 DHS, which shows that median ages at first sexual intercourse for men aged 20–24 and 50–54 are 17.7 and 19.6, respectively.[39] These changes suggest that sexual relations are increasingly becoming a source of individual pleasure and gratification, as opposed to fulfillment of marriage and procreation obligations, as was the case in the past.[40] Some adolescents argue that sex be-

fore marriage is essential because 'practice makes perfect', and it demonstrates one's progression to manhood or womanhood.[41] Other factors possibly responsible for this trend include the increase in the level of poverty because, as noted above, poverty increases young people's (especially girls') susceptibility to sexual advances by older men, and some poor parents also encourage their young daughters to provide sexual favors so that they can make money to support the family.[42]

Age at first marriage

While age at first sex for women has been declining, age at first marriage has been increasing, which extends the period during which adolescent girls may have sex out of wedlock (Appendix Figure 1). The median age at first marriage for adolescent females aged 20–24 slightly increased from 17.7 in 1992 to 18.2 in 2000. In 1992, 36% of female adolescents aged 15–19 were in marital union whereas only 33% of the same age group were married in 2000.[43] For males aged 25–29, however, the median age at first marriage declined from 24.0 to 22.7 years over the same period. While 73% of men aged 25–29 were married by age 20 in 2000, only 59% were married in 1992.[44]

The relatively low median age at first marriage indicates that many girls marry before they are physically and psychologically ready for marriage and pregnancy, especially since childbearing routinely follows within a year or so after marriage. Marrying at such young ages also limits young women's capacity to negotiate for sexual and reproductive health outcomes with their relatively older husbands. Traditionally, early marriages have been used as a form of protecting of young girls from engaging in premarital sex and pregnancy. Early marriages have also been a result of low levels of school attendance and high incidence of premarital pregnancies.[45] Economically and socially underprivileged youth are the most vulnerable and disempowered groups in protecting themselves against unwanted pregnancies, sexually transmitted infections (STIs) and HIV/AIDS, due to their limited education and lack of access to accurate information on sexuality.[46]

The 2000 DHS shows minor regional differences in the median age at first marriage. The median age at first marriage among 20–24-year-old women was 17.8 in the North and 17.9 in the South (Appendix Table 1, line 11). The survey further shows that in the same age group, women in the Centre married at an older age of 18.7. This differs from the 1992 DHS, which showed that the median ages at first marriage for women aged 20–24 were 17.9, 17.9 and 17.3 in the North, Center and the South, respectively. However, data collected in Rumphi, Mchinji and Chiradzulu districts in 1988 showed some striking regional differences in age at first marriage. By age 16, about one-quarter of all women in the Chiradzulu (South) had married for the first time, while less than 15% had done so in the other two regions. By age 20, the percentages of ever married women were 80%, 70% and 65% in the South, the Center and the North, respectively.[47] Similar patterns are observed from data collected in 2001 by the same research group: The median ages at first marriage for women were 17, 18.0 and 18.9 in the South, Center, and North, respectively.[48] These regional patterns call for more in-depth studies to understand the underlying causes of the differences and whether such factors could also have a bearing in shaping sexual and reproductive health attitudes and practices among adolescents.

Number of sexual partners

The 2000 DHS showed that among male respondents aged 15–19, 16% reported having had two or more sexual partners in the 12 months preceding the survey, while only 2% of the female respondents of the same age did so (Appendix Tables 1 and 2, line 9).[49] Young men who have less education, who live in urban areas, and who are not exposed to media at least once a week are more likely to engage in multiple sexual partnerships than those who are more educated, live in rural areas, and are regularly exposed to the media, respectively (Appendix Tables 1 and 2, line 9).

Other studies have also found that young men tend to have more sexual partners than young women, regardless of marital status.[50] Both boys and girls venture into having more partners in order to have more latitude in choosing one for marriage as they grow up. However, girls are more cautious than boys about having multiple sexual partners simultaneously, because this would lower their chances of getting married. The common occurrence of multiple sexual relationships among Malawian adolescents in the absence of consistent use of condoms (see below) exacerbates their vulnerability to HIV/AIDS and other STIs.

Sexual abuse

Most sexually active adolescent females report having had the first sexual intercourse with a man older than them; according to Pathfinder, 56% of female adolescents experienced forced sex and 66% reported that they accepted money or gifts in exchange for sex.[51] These social and economic forces put adolescent girls in particular in a situation where they have to bargain

their moral values just for survival. As a result, they often find themselves involved in nonconsensual relationships with more than one man.

The actual magnitude of the problem of sexual abuse in Malawi is unknown, although results from recent studies indicate that it is a serious problem. For example, a study by Maluwa-Banda and colleagues[52] reported that a quarter of adolescent girls had ever been forced to have sex against their will, and another study by Lema and Thole (1997) found that 42% of their respondents acknowledged that someone had tried to force them to have sex but they had been able to refuse the attempt.[53]

Reports of sexual abuse were fairly rare in Malawi until the advent of gender awareness and democracy, which suggests that there was considerable underreporting of incidents of sexual abuse during the one-party era that ended in 1994. Despite this change, there is still limited public awareness about sexual abuse and its consequences. In addition, there is insufficient capacity to provide necessary services to the victims of sexual abuse and to punish the assailants. Young girls may also be abused more because of the belief that they are least likely to be infected with HIV/AIDS. Although there have been beliefs that having sex with a young virgin girl may cure HIV/AIDS in some parts of Africa,[54] the prevalence of such beliefs in Malawi is not known. Further studies are therefore necessary to determine the extent of the problem of sexual abuse in Malawi and to evaluate how such cases are managed.

Unplanned pregnancies and early childbearing

Parenthood is highly valued in Malawian society and is viewed as an important rite of passage to adulthood for both young men and women.[55] At the same time, there is strong societal disapproval of premarital or out-of-wedlock childbearing. In 1992, 35% of Malawian females aged 15–19 were either pregnant or mothers,[56] while in 2000, 25% had ever had a child and 10% were currently pregnant (Appendix Table 1, line 12 and 13).

In a study conducted in Dowa District, 78% of the respondents indicated that teenage pregnancies were common in their areas.[57] According to this study, factors responsible for teenage pregnancies included poverty (39%), early sex (16%), ignorance of reproductive health (9%), nonuse of family planning (7%) and 'sugar daddy' relationships (5%). In the traditional setting, abortion is sometimes condoned when a pregnant girl is deemed too young to give birth or a married woman gets pregnant again too soon after giving birth.[58]

Early childbearing has a number of implications for the young mother and the baby. Teenage pregnancies are associated with greater possibility of miscarriage, still birth, premature birth and babies of low birth weight.[59] Women who enter into marriage in their teens are not only inclined to end their schooling prematurely but are also more likely to have more children by the end of their reproductive years than those who get married in their 20s.[60] For unmarried pregnant girls, the consequences are even more serious. Parents may get worried or shout at the girl, sometimes to the extent of disowning her, peers laugh at the girl and even encourage her to have an abortion, and service providers usually embarrass the girl once she visits the hospital or clinic.[61] Thus, the fear of stigma is likely to influence girls to terminate premarital pregnancies.

Unsafe abortion constitutes a major medical and social problem in Malawi, but the magnitude of the problem at the national level is not known, because no countrywide studies have been done. Lack of data on abortion is compounded by the fact that abortion is illegal except in cases where the pregnancy endangers the woman's life. However, hospital-based figures indicate that the most common reason for admission to the gynecological wards in Malawi's major hospitals is abortion complications. In 1994, abortion complications accounted for 68% of the admissions to the gynecological wards at Queen Elizabeth Central Hospital. The mean age of patients was 24.4 years, and adolescents aged 10–19 made up 21% of the total; half of these girls were students. Of the 15–19-year-olds, 61% were married.[62] According to this study, young women account for more than half of the deaths due to abortion complications.

It should be mentioned that the data presented here are from one central hospital located in the city of Blantyre. Because of the gaps in knowledge about the extent of the problem of abortion in Malawi, there is need to collect detailed data on abortion at the clinic level and within communities to determine the extent and impact of this problem. Within clinics, data collection can be enhanced by including abortion cases as one of the indicators that should be reported in the routine health management information systems.

STI and HIV infection: incidence and prevalence

HIV/AIDS prevalence data from a number of African countries show that young people aged 15–24 have the highest risk of infection. Most new infections occur among youth and prevalence rates among adolescent girls are higher than among adolescent boys.[63] Chendi[64] found 20% of Malawian young people aged 15–23 (with

five times as many young women than young men) were HIV positive. Girls are more vulnerable than boys not only because they have sex with older men, who tend to have more sexual partners and experience, but also because of physiological reasons. In another study in Malawi from 1990 through 1995, HIV incidence was highest among women under the age of 20 and declined steadily among older women.[65] There is a residential effect on the levels of HIV prevalence in Malawi: The prevalence of HIV among 15–49-year-olds is 12% in rural areas, compared with 23% in urban areas.[66]

In the past, contracting STIs was perceived as a sign of masculinity, but today people who contract STIs are labeled as promiscuous and as HIV/AIDS high-risk groups. As a result, people are reluctant to report having ever contracted an STI.[67] The 2000 DHS combined reports of ulcers, sores, discharge and STIs and found that 8% of women and 13% of men aged 15–19 had had some type of STI during the 12 months prior to the survey.[68] The presence of STIs increases the risk of contracting HIV. Young people are vulnerable to infection when they engage in unprotected sex, often as a result of peer pressure, poverty, influence of pornographic materials, drug and alcohol abuse, lack of parental guidance and lack of access to condoms.[69] Youth's high vulnerability is also linked to insufficient knowledge, skills and resources to protect against HIV infection.[70]

Because nothing is known about the practice of anal sex in prisons, it is important for future research to document the extent to which other sexual practices like anal sex are practiced outside as well as in prisons, and the implications of such practices on boys' vulnerability to HIV/AIDS.

Although child prostitution has received very little program attention, the commercial sex industry is flourishing among youth.[71] Prostitution among girls aged 13–18 is common in the main cities of Blantyre, Lilongwe and Mzuzu, where girls roam the streets at night and hang around hotels, inns and motels in search of men who will pay for sex. Some girls also work as bargirls without being paid wages, because they are expected to generate their income from sexual clients.[72] Some of the clients insist on sex without a condom and offer to pay higher premiums for sex without a condom, which bargirls may find tempting.[73]

Some cultural practices are also harmful and may expose adolescents to STIs, including HIV/AIDS. These practices include the engagement of older men to initiate a girl into sexual activity, wife inheritance (practiced among the Tumbuka), and the use of a male relative to cleanse a widow by having sex with her (practiced among the Sena in Nsanje).[74] Women in some communities use herbs to dry themselves during sexual intercourse; these herbs can damage the lining in the vagina, which may increase the risk of HIV infection for the women and their partners.[75] These practices need to be discouraged so as to control the transmission of HIV to young people.

It can be seen from the above discussion that cultural practices, poverty, prostitution and unprotected anal sex in prisons may contribute to the spread of STIs and HIV among Malawian adolescents. As shall be shown later, knowledge about HIV/AIDS and STIs, including how they are transmitted and how they can be prevented, is extremely high. Therefore, studies are urgently required to understand why there is continued engagement in risky sexual practices despite the high knowledge levels about HIV/AIDS and STIs.

Knowledge and use of contraception and condoms

Contraception

Nearly all adolescents aged 15–24 reported knowledge of at least one method of family planning in the 2000 DHS. Despite these impressive levels of knowledge, however, only 24% of sexually experienced women and 38% of men aged 15–19 had ever used a modern method of family planning, while 15% of sexually active women and 31% of sexually active men were using any method of contraception at the time of the survey (Appendix Tables 1 and 2, lines 15 and 17).[76] These rates represent some improvement from the 1992 DHS, which showed that 7% of married women aged 15–19 were using any method of contraception.[77] The same patterns are observed for sexually active men aged 15–19, among whom contraceptive prevalence rates increased from 15% in 1992 to 31% in 2000 (Appendix Table 2, line 17).

Another major change that took place during this period is a sizable increase in reliance on modern methods relative to traditional ones. Of all male contraceptive users aged 20–24, 78% and 90% were using modern methods in 1992 and 2000, respectively. Among women aged 15–19, the proportion of users of modern methods increased from 51% to 87% over the same period, while it increased from 44% to 88% among women aged 20–24.[78] In 2000, the most commonly used methods of contraception for adolescent women aged 15–19 were injectables (3%), followed by condoms (3%). For women aged 20–24, injectables led by a much bigger margin (15% vs. 3%). For adolescent men, condoms were by far the most popular method.[79] A study carried out by Maluwa-Banda and Lunguzi[80]

also showed that the most commonly used methods reported by adolescent girls were condoms, followed by injectables and pills.

Barriers to the use of family planning services among youth include social and cultural factors, such as religious and cultural beliefs; poor quality services such as negative attitudes of family planning providers toward young people and unavailability of contraceptives; misconceptions, rumors and fear of side effects, lack of money, fear of disclosure or exposure, difficulties in expressing need especially to adults, and the inability to negotiate contraceptive use.[81] Some girls do not use contraceptives because service providers are in general not youth friendly.[82] For instance, service providers feel uncomfortable providing contraceptives to adolescents and unmarried women because it contradicts their own cultural beliefs and because they feel that contraceptives promote sexual activity among young people.[83] Stigma is also a barrier because young people who seek contraceptives are labeled promiscuous.[84] The prevailing fears and misconceptions are associated with lack of adequate information regarding reproduction and sexuality in the community. According to a study by Chonzi,[85] young people fear that oral contraceptives and IUDs can cause cancer and other illnesses, contraceptive use before having a child can cause impotence or infertility, condoms and the loop get stuck inside the woman's body, and condom use connotes mistrust or unfaithfulness. Some young people do not use contraceptives because of ignorance and misconceptions, such as a girl cannot get pregnant if she washes her private parts soon after intercourse, if they have sex in water, if it is the first sexual intercourse, and if the woman is standing or the man is sitting during intercourse.[86]

While DHS data have generally shown that there is an increase in the use of contraceptives among adolescents and a number of studies have explained the barriers to use of contraceptives, there is need to further understand the most critical reasons for the low uptake of such services among adolescents and how to remedy these problems.

Condoms: knowledge, use and barriers to use

Knowledge of condoms

Condoms are a major component of the ABC approach (abstinence, be faithful and condoms) used to fight the HIV/AIDS epidemic and unplanned pregnancies among young people in Sub-Saharan Africa. Knowledge of condoms is very high in Malawi: In 1992, 84% and 94% of women aged 15–19 and 20–24 knew about condoms, respectively, while 95% and 99% of men in the same age groups knew about condoms.[87] In 2000, knowledge of condoms increased to almost universal levels (96–99% for women and 95–100% for men in the two age groups). However, only 69% of women and 83% of men aged 15–19 knew where to obtain a condom (Appendix Tables 1 and 2, line 14). Knowledge of where to get condoms also varies according to a number of population characteristics: It is relatively high among older boys and girls, those with seven or more years of schooling, those living in urban areas and those with greater media exposure (Appendix Tables 1 and 2, line 14).

Use of condoms

National surveys show that while levels of condom use are quite low, there has been some increase during the past decade, especially among adolescent men. The percentage of men aged 15–19 and 20–24 who were using condoms for family planning increased from 10% among both age groups in 1992 to 13% and 21% in 2000, respectively. For women, however, the reported rates were much lower; while no increase occurred among those aged 20–24 (3%), a sizable increase from 1% to 3% was recorded for those aged 15–19.[88]

Use of condoms at last sexual intercourse follows the same pattern as current use of condoms for family planning; 13% of women and 28% of sexually active men aged 15–19 had used a condom at last intercourse (Appendix Tables 1 and 2, line 19, and Appendix Figure 2). For both men and women, use of condoms is positively associated with years of schooling, urban residence and media exposure. Use of condoms is much lower among married men and women compared with their sexually active, single counterparts, probably because of the common belief that condoms are meant for unstable sexual relationships and using them within marriage brings tensions and suspicions about unfaithfulness.[89]

Rates of condom use for family planning and at last intercourse are similar for men, but markedly different for women; this suggests that men are more likely than women to use condoms for dual protection against STIs and pregnancy (Appendix Figure 2). The 2002 DHS shows that out of the sexually experienced adolescent women who had used condoms, 54%, 21% and 20% reported that they had used condoms to prevent pregnancy only, to avoid STIs/HIV only and for both reasons, respectively (Appendix Table 1, lines 30–32). For men, however, 21%, 44%, and 28% reported that they used condoms for the three respective reasons

(Appendix Table 2, lines 30–32). The elevated level of reported condom use for boys relative to girls suggests that many boys may be using condoms with irregular partners outside their own age range, or that girls underreport male condom use because they themselves do not use male condoms. A study in Lilongwe and Blantyre cities found that among male adolescents who had used condoms, 48% used condoms with girlfriends, 21% with girlfriends and casual partners and 21% with casual partners only. Of young women who had used condoms, 83% used condoms with boyfriends, only 3% had used them with boyfriends and casual partners and 6% with casual partners only.[90]

Other studies have also examined use of condoms in Malawi. For instance, a study conducted in 1997 among youth in Blantyre, Lilongwe and Mzuzu showed that between 21% and 36% of all sexually experienced youth had ever used condoms.[91] A study by the National Youth Council of Malawi in 2000 showed that 33% and 43% of male and female respondents respectively had used a condom during the first penetrative sexual intercourse. Another study by Maluwa-Banda (2001) found that about 30% of young people in Nkhata Bay had used a condom during their first sexual intercourse.[92]

Barriers to condom use

To ensure that adolescents are protected against HIV/AIDS, other STIs and unplanned pregnancies, there is need for proper and consistent use of condoms. In one study, approximately 70% of both male and female respondents who had ever used condoms reported that there were times when they had had sex without a condom.[93] Indeed, although most adolescents believe that condoms are effective in the prevention of HIV/AIDS and other STIs, studies in Malawi show that many do not use them all the time because of a number of reasons, including:

- not aware of condoms;[94]
- condoms not available;[95]
- condoms not trustworthy or 100% effective because they can burst, they expire or they are porous and penetrable by sperms and HIV;[96]
- sex does not feel as good with condoms (like "having a shower while wearing a raincoat");[97]
- adolescents trust the partner;[98]
- forced sex (rape);[99]
- lack of money to buy condoms;[100]
- the couple wants children;[101]
- some people want to spread AIDS deliberately;[102]
- lubricant in condoms can cause other diseases, such as tuberculosis, rashes and HIV/AIDS;[103] or the HIV virus is sometimes deliberately put in the condom.[104]
- when both boys and girls or just boys are drunk;[105]
- they already had unprotected sex in the past and it does not matter anymore since they may have already infected each other;[106]
- partners refuse to use condoms or partners (mostly boys) do not suggest condom use;[107] and
- service providers do not offer condoms to young people, particularly girls who do not have children.[108]

Adolescents also complain that they sometimes get confused because they receive conflicting messages from different sources regarding the most appropriate preventive strategy to follow. They are in general torn between using condoms and following church messages that tend to discourage the use of condoms and promote abstinence instead, mainly because of the belief that condoms might encourage sexual activity among adolescents.[109]

In order to address the numerous barriers to condom use described above, there is need for intensifying health education messages about the importance of the consistent and proper use of condoms and, as shall be explained later, the need to provide youth-friendly services. Additionally, there is need to identify the most critical program obstacles to condom use.

Decision making in condom use

Part of the sizable differences in reported levels of condom use between adolescent men and women is the underreporting of condom use by girls (or over reporting by boys). It is generally believed that condoms are a male method and that girls should not carry or insist on using condoms. In a study by Bisika and Ntata, one interesting reason for nonuse of condoms was that some girls wondered why their boyfriends had not suggested to them that they use condoms.[110] This suggests that girls think asking for condom use is not their responsibility but that of their sexual partners. In some cases, however, boys claim that girls do not like the use of condoms and argue that once the boys introduce the topic, girls become suspicious of their HIV status. In McAuliffe's study of barriers to behavioral change, many primary school and out-of-school males reported that it is the male's responsibility to suggest and provide condoms for use in a relationship. However, while many male secondary school students reported that either gender can suggest use of condoms, most of the fe-

male groups reported that it should be the female's responsibility to provide condoms because, as one respondent put it, "they are the victims of the aftermath of sex."[111]

There were feelings among males that females who provide condoms are perceived to be promiscuous.[112] Similar results were obtained in Maluwa-Banda and Lunguzi's study, in which girls reported that they find it difficult to negotiate the use of condoms because boys perceive girls as being "prostitutes" if they ask the boy to use a condom.[113] Those who said that males should suggest condom use in a sexual encounter reported that this is because he is the one who wears a condom, he is in charge or asks for sexual intercourse, and that he should protect himself against diseases.

These findings highlight the need to empower girls if condom use is to increase among adolescents in Malawi. This could be done through promotion of greater discussion about sexual partnerships between boys and girls. The perception that adolescent girls who suggest condom use are "prostitutes" is counterproductive because it bars girls from initiating condom use.

Information and Service Sources for Adolescent Sexual and Reproductive Health

Adolescents in Sub-Saharan Africa, especially adolescent girls, often lack basic sexual and reproductive health information, skills in negotiating sexual relationships and access to affordable and confidential sexual and reproductive health services in their communities. Concerns about privacy, ability to pay and perceived disapproval by service providers further limit access to services where they exist.[114] This section examines the range of sexual and reproductive health services and the different sources of information targeting adolescents in Malawi.

Sources of reproductive health services and information

The most popular sources of information about sexual and reproductive health for adolescents are the radio, youth clubs, health facilities, schools and friends. In one study done among adolescent girls, it was found that the three major sources of sexual and reproductive health information for young people were youth clubs (38%), the radio (29%) and government health facilities (23%). The other sources also mentioned by the adolescents were the print media (11%), Banja La Mtsogolo (7%), community-based distribution agents (5%), nongovernmental organizations (4%), parents (5%), friends (6%) and District Youth Offices (1%).[115] The small percentage of respondents who reported parents as sources of sexual and reproductive health information confirms earlier assertions that parents do not normally advise or talk to their children about sexual and reproductive health issues because it is considered taboo.

The most important sources of condom information for students and out-of-school adolescents were the radio and hospitals. Secondary school students added that their teachers were another important source of condom information.[116] Most adolescents who had used condoms reported that they got them from health facilities and commercial shops.[117] The radio and health facilities are the most important sources of information not only for condoms but also for other information on sexual and reproductive health issues.

Types of information and services available to adolescents

There are different types of sexual and reproductive health services that are offered to adolescents. According to an assessment of youth-friendly reproductive health services conducted by the National Youth Council of Malawi in Blantyre, Lilongwe, Mchinji, Kasungu and Mzimba Districts, the types of services that adolescents are supposed to be offered are wide-ranging:

- distribution of contraceptive services;
- contraceptive education;
- education on gender;
- education on sexuality and reproduction;
- HIV/AIDS education;
- HIV/AIDS counseling and testing;
- sexually transmitted infection (STI) counseling and education;
- STI treatment;
- pregnancy counseling services;
- marriage counseling;
- sexual abuse counseling;
- substance abuse counseling;
- life skills education; and
- recreational activity.

Most of the health facilities visited in this assessment mainly offered such services as contraceptives, treatment of STIs, STI counseling, HIV/AIDS and STI education, and pregnancy services. The study also found out that most adolescents were aware of these services. Another study done in Lilongwe city and other districts (namely Nkhata Bay, Mchinji, Thyolo and Mwanza) showed that approximately two-thirds of adolescent women acknowledged that various sexual and reproductive health services were available in their communities, but only about half of male adolescents mentioned that sexual and reproductive health services

were available in their communities.[118] Some studies show that most adolescents prefer services offered by the hospital, followed by friends and peers, who may give out condoms.[119]

Studies that have analyzed the composition of patients in hospitals show that adolescents make up a sizable proportion of people who seek sexual and reproductive health services. For instance, in Mchinji in 1999 the records at the district hospital showed that adolescents comprised 59% of all admissions in the maternity ward and 35% of patients in the STI clinic. In 1997, 53% of all admissions in the female ward were adolescents.[120] In the first quarter of 2001, clinic records showed that 64% of abortions in Nkhotakota involved girls younger than 25.[121] Because abortion is illegal in Malawi, women obtain unsafe abortions then visit clinics for medical attention after having developed abortion-related complications.[122]

It is evident, therefore, that while a wide range of sexual and reproductive health services can be offered by health facilities, only a limited number are actually offered; in some cases, the adolescents themselves are not even aware of most of the services that they can actually receive. Future studies on adolescent sexual and reproductive health services need to document and map the range of services available to adolescents in various communities throughout the country in order to define underserved areas.

Barriers to existing sexual and reproductive health services

While many adolescents visit reproductive health facilities, a significant percentage do not visit these facilities because of certain barriers. For example, Maluwa-Banda and Lunguzi[123] found that, on average, 43% of adolescent girls did not have access to sexual and reproductive health services, while 26% said that the reproductive health services provided in different facilities were not friendly to them. Most adolescent girls (64%) said that their parents or guardians would not allow them to obtain sexual and reproductive health services.[124] Adolescents sometimes fail to obtain services because of ignorance of the existence of the services, fear of teachers and parents, poor attitudes of the health workers and long waiting times at these facilities.[125] The provision of youth-friendly services is a relatively new concept in Malawi. In most cases, however, facilities provide services jointly to both adults and adolescents, and this generally puts adolescents at a disadvantage because they may not feel free to mix with adults.[126] Out of a total of 300 adolescents interviewed in Lilongwe, Mchinji and Kasungu Districts, 48%, 54% and 44% respectively had visited the facilities offering reproductive health services, and most of these claimed they had been well assisted. The report also found that among those who were treated well, the majority were male probably because the services males need are easy to get compared to those required by females.[127]

In order for sexual and reproductive health services to be youth friendly, the National Youth Council of Malawi suggests that they should aim at having respect for and understanding of clients, that waiting times should be short, that there should be short distances to the centers where these services are offered, that these services should involve adolescents and that the youth are attended to by providers of the same gender, among other factors.[128]

Adolescent Awareness, Knowledge and Attitudes About HIV/AIDS and STIs

Malawi is one of the countries that has been badly affected by the HIV/AIDS pandemic. According to 2003 national estimates, the prevalence of HIV among 15–49-year-olds is 14%,[129] with an estimated 900,000 infected adults and children. The prevalence of HIV in urban areas is almost twice that in rural areas: 23% and 12%, respectively. Adolescents have also been badly affected by the pandemic, and reports have shown that 18% of pregnant women aged 15–24 are infected with HIV. With such a high prevalence of HIV, it is important that adolescents know about AIDS and how they can protect themselves from contracting HIV. Close to two decades have passed since the first case of AIDS was diagnosed in Malawi, and it is now imperative to examine the adolescents' awareness, knowledge and attitudes about HIV/AIDS and other sexually transmitted infections (STIs).

Knowledge about HIV/AIDS

The Malawi government's efforts to fight HIV/AIDS have focused on information, education and communication campaigns aimed at creating awareness about the disease and its impact on households, communities and the nation as a whole. The assumption in this context is that people who are knowledgeable about HIV/AIDS will protect themselves. However, a number of studies have shown that despite the fact that people are aware of HIV/AIDS and how it is transmitted and can be prevented, they still engage in risky behaviors. For example, Munthali[130] found out in northern Malawi that people who suspect that they are HIV positive sometimes have unprotected sexual intercourse with the aim of spreading the infection. Additionally, there is still continued attribution of HIV/AIDS to witchcraft, and the cultural practice of wife inheritance is still prevalent in some parts of Malawi.[131]

While HIV/AIDS awareness levels were relatively low in the 1980s at the onset of the pandemic, knowledge of the disease is now almost universal among both adolescent men (99%) and adolescent women (98%) in Malawi (Appendix Tables 1 and 2, line 22). A number of other studies have also shown that knowledge levels are in excess of 90%.[132] A recent study in Dowa District revealed that over 90% of youth knew about HIV/AIDS, but a slightly lower percentage (80%) knew about gonorrhea and syphilis and an even lower percentage (40%) knew about *bubos*.[133]

A number of sources of information about HIV/AIDS have been identified. McAuliffe[134] showed that hospitals, radios and school teachers were the most frequently mentioned sources of information. Other sources of information included newspapers and magazines, posters, video and film, health talks, drama and songs, and friends and relatives. In more recent studies, the radio was the most frequently mentioned source in the four districts where the survey was conducted.[135] This was followed by the hospital (36%), friends (31%) and youth clubs (27%), the print media (10%), religious leaders (8%), teachers (7%), Banja La Mtsogolo (3%) and parents (3%).[136] At the national level, the 1996 Malawi Demographic and Health Survey (DHS) showed that the radio was the most commonly mentioned source of information on HIV/AIDS by both females (76%) and males (88%) aged 15–19.[137]

Knowledge about transmission and prevention of HIV/AIDS and STIs

Various studies conducted in Malawi show that adolescents recognize sexual intercourse as the major route of transmission for HIV.[138] The overwhelming recognition of sex as the primary mechanism for HIV transmission is reflected in the high percentage of adolescents who mentioned abstinence, condoms and faithfulness as ways of preventing the disease (Appendix Figure 3). Between 1996 and 2000, there was a huge increase in the percentage of both men and women aged 15–19 who mentioned abstinence and condom use as key means of HIV prevention. However, the proportion mentioning faithfulness or sticking to one partner declined by over 50% for both men and

women. This trend would be worrying for HIV/AIDS prevention efforts if it were to signal young people's increasing acceptance of multiple sexual partnerships. Knowledge about prevention methods is much higher among males than among females. For example in the 2004 Global Report on AIDS, the United Nations Programme on HIV/AIDS says that in Malawi 41% of males aged 15–24 are able to identify prevention methods and reject three misconceptions, while the corresponding proportion among females is 34%.[139]

Other studies have yielded similar findings. For instance a study conducted in 1990 showed that about half of respondents reported that HIV/AIDS is mainly spread by sexual promiscuity, while only 3% mentioned that the disease could be transmitted by contaminated blood.[140] Another study conducted in Mzimba in 1990 showed that 87% of teenagers attending school knew that HIV is transmitted through sexual intercourse, 86% by blood transfusion, 88% by sharing piercing instruments; 89% reported that people with multiple sexual partners can easily contract HIV/AIDS, while 72% knew that HIV can be transmitted from mother to child.[141] In a study conducted in 1997, 67% of the youth in Blantyre, 68% in Lilongwe and 58% in Mzuzu mentioned avoiding sexual intercourse as a method of preventing HIV transmission. Another study conducted in Salima in 1997 showed that only 50% of youth knew that HIV could also be transmitted from mother to child and through blood transfusions, while 88% reported that it can be transmitted through sharing toothbrushes or razor blades and through sexual intercourse.[142]

There are regional variations with regard to knowledge about modes of HIV and STI transmission and prevention strategies. The 2000 DHS showed that more females aged 15–19 in the South (71%) mentioned abstinence as a way of preventing the transmission of HIV when compared with those in the North (56%) and the Center (59%; Appendix Table 1, line 24). A similar pattern prevails for men, whereby 72%, 70% and 56% in the South, Center and North, respectively, mentioned abstinence as a way of preventing the transmission of HIV (Appendix Table 2, line 24). The survey also showed that urban residence, schooling and media exposure are positively associated with knowledge of the three key preventive strategies. Other studies have also shown that knowledge of HIV/AIDS and STIs is positively associated with levels of schooling,[143] and that knowledge is higher among in-school and youth club members than among the out-of-school and non–youth club members.[144]

The fact that the 2000 DHS reveals that approximately 33% of men and 36% of women aged 15–19 mentioned "avoiding sharing of razors" as a means of preventing HIV/AIDS points to widespread awareness of key factors other than sexual intercourse in the spread of HIV/AIDS in the country, which need to be investigated. The prominence of this factor may be a reflection of the efforts by program officials to dissuade Malawians from sharing razors during initiation ceremonies like circumcision and administration of traditional medicines.

Misconceptions and attitudes about HIV/AIDS

Misconceptions and negative attitudes about HIV/AIDS may have implications for behavior change initiatives, as shown by a number of studies. Msapato and colleagues[145] found that approximately 63% of teenagers in school in Mzimba thought that dying of AIDS was a punishment. This suggests that AIDS is associated with promiscuity, as evidenced by the following excerpt from one respondent: "I would not care for an AIDS victim because it was his fault to acquire the disease." The perception that AIDS is a punishment from God has come up in a number of other studies, including one done in Salima in which 42% of the adolescents believed that AIDS is a punishment from God to sinful people and that traditional healers can protect a person from AIDS through the use of traditional medicine.[146] Another misconception that seems to be widespread is the linking of HIV/AIDS to traditionally identified syndromes such as *kanyera* and *tsempho. Kanyera* and *tsempho* are believed, like AIDS, to be contracted when couples violate some taboos related to sexual intercourse.[147] Thus, a person with AIDS may be considered to be suffering from *tsempho* or *kanyera* and therefore may not be taken to the hospital to be treated for opportunistic infections, since *tsempho* and *kanyera* can be cured by the use of traditional medicine.[148] These diseases are likened to AIDS because the victims also lose weight, have pale skin and hair that has lost its texture.[149]

A number of other potentially dangerous misconceptions and gaps in knowledge about HIV/AIDS have been reported. For instance, a key piece of information that one needs to know about HIV/AIDS is that a person who looks perfectly healthy can carry and transmit the HIV virus to others. The percentage of adolescent women aged 15–19 who reported knowledge of this basic fact rose from 73% in 1996 to 82% in 2000; among adolescent men, it rose from 80% to 87% (Appendix Tables 1 and 2, line 26).[150] Despite this improvement, it should be a concern that close to one-fifth

of adolescent women and 13% of adolescent men did not know this fact in 2000.

Many youth also hold misconceptions that may negatively affect their preventive behavior and perceptions about people living with HIV/AIDS. For example, a study in Salima District found that 25% of youth believed that HIV could be transmitted through casual contact, such as drinking from the same glass, holding hands and kissing, or living with someone who has AIDS. Kissing was the most commonly mentioned mode of HIV transmission.[151] In the same study, 6% of the respondents (mostly in primary school) also mentioned that HIV could be transmitted through mosquito bites. Another study showed that 10% of adolescents in Blantyre and Lilongwe Districts reported that it is possible to contract HIV by sharing clothes or bedding. Sharing soap or eating and drinking utensils, coughing, bathing in the same water as the infected person and handshaking were also identified in many focus group discussions as routes for the transmission of HIV, as were kissing and mosquito bites.[152] Some of these misconceptions about AIDS, especially kissing, sharing of clothes and mosquito bites, were also mentioned by the youth in a study conducted in Blantyre, Lilongwe and Mzuzu among primary school pupils, secondary school students and out-of-school youth.[153]

There are some fatalistic perceptions about HIV/AIDS among youth that appear to discourage the uptake of HIV prevention strategies. There are statements such as AIDS is a disease targeting people and not animals ("Rabies for dogs, Newcastle for chicken and AIDS for people") and that we will all die sometime, so if it is through AIDS, that is what happens.[154] These perceptions may nullify the need to protect oneself against HIV. To the extent that many of these beliefs and misconceptions are likely to have a negative impact in the fight against HIV/AIDS, there is need for further research to establish their prevalence throughout the country and to evaluate their impact on HIV transmission.

Attitudes about HIV testing and counseling

Voluntary counseling and testing (VCT) involves people making their own decisions to seek counseling and HIV testing. VCT is likely to contribute to the prevention of the transmission of HIV because people who know their HIV status may change their sexual behavior. Many people whose partners have died of AIDS have developed apathy because they feel that their fate is already sealed, yet a negative test result may give them new hope for the future and motivate them to adopt preventive measures. For those who are HIV positive, the test gives the opportunity to plan their future, including living healthier lifestyles, protecting their sexual partners and adopting treatment if accessible. According to one study carried out in the country, the key advantage of VCT reported by respondents was that it can help people make decisions about their lives, especially decisions to lead healthier lives and avoid having sex to avoid getting infected further and infecting their partners.[155]

The 2000 DHS showed that 7% of adolescent men aged 15–19 who had ever heard about HIV had been tested for HIV, 86% wanted to be tested, 12% did not want to be tested and 2% said that they did not know if they wanted to be tested or not. Among female adolescents, the percentages were similar: 7%, 81% and 12%, respectively (Appendix Tables 1 and 2, lines 28 and 29).[156] Other studies have also shown similar levels of demand for VCT services. For instance, a study among young people in Lilongwe found that 72% of males and 65% of females had thought about VCT.[157] However, a study conducted in Mzimba, Kasungu, Blantyre and Mwanza showed that only 37% of respondents were willing to have an HIV test and that willingness to have a test was largely influenced by the cost, privacy, confidentiality and distance to testing centers.[158]

While demand for VCT is high in most studies, those who have not thought about it or who have thought about it but not gone for the test have given various reasons, including:[159]

- no need for the test because one is not promiscuous;
- not ready for VCT;
- VCT services are not available in the community;
- one trusts his or her partner;
- afraid of living a stressful life if found HIV positive;
- uses condoms consistently; and
- not sexually active.

The majority of participants in a qualitative study carried out in 1994 reported that they would change their behavior if they were diagnosed HIV positive in order to prevent the spread of HIV/AIDS.[160] There were others, however, who said that they would not change because they saw no need of changing if one is already HIV positive, and a few respondents said that they would not change because they would want to spread the disease further.[161] When this study was repeated some three years later, it was found that in both Blantyre and Lilongwe the majority of participants said that if found positive they would do nothing but repent their

sins. Others, however, mentioned that they would consult traditional healers, that they would stop having sexual intercourse and that they would feel sorry for themselves or even commit suicide. However, very few youth said that they would start educating others or tell their parents.[162] Some recent studies have suggested that some people do not want to use condoms when they suspect they are HIV positive because they would like to transmit it to as many sexual partners as possible.[163]

Another key issue about VCT relates to whether the person would inform sexual partners about the result so that the partner could also go for a test. In 1997, about 53% of male and 47% of female youth in Blantyre reported that they would want people to know if they tested positive. The fear of stigma or discrimination after disclosing that one is HIV positive is probably one of the major reasons many people would not want their HIV status to be known. In a study conducted among in-school and out-of-school youth, the majority of the male groups said that they would not inform their partners about a positive test result because the partners could spread the news, that the relationship could come to an end, that the partner could commit suicide, that he or she may want to spread HIV and that partners may refuse sexual intercourse. Some youth, however, said that they would inform partners if they were found HIV positive, mainly because they would want to prevent the spread of HIV by letting their partners know their status and that they should not have children.[164] One misconception that was mentioned during the study with primary school pupils was that having sexual intercourse frequently can reduce HIV in the body. If widespread, such a belief would have a negative impact in the fight against HIV/AIDS, because those who turn out to be HIV positive may be more inclined have multiple partners than they would have been otherwise.

Maclachlan and colleagues[165] also found that some people have not gone for the test because they think that HIV tests are not always accurate. While some adolescents are prepared to undergo an HIV test, there is need to create awareness about the need for and existence of VCT services and to establish adequate support structures, for example at the community level, to address the needs of those who test positive. In a study examining sources of information about VCT services, the radio was the commonest source of information on HIV testing. Nevertheless, most respondents (68%) wanted to receive their HIV/AIDS information from health workers.[166] The high demand for VCT also highlights the need to expand the infrastructure and services throughout Malawi. Further research is also required to determine the prevalence of the reasons for not adopting VCT and some of the key misconceptions, such as having sex with more partners helps to reduce the viral load in the person who is HIV positive.

Attitudes about STI treatment

A number of studies have shown that in general youth are knowledgeable about the signs and symptoms of STIs. A study conducted among young people in Blantyre and Lilongwe in 1994 showed that the most commonly mentioned STIs were AIDS, gonorrhea, syphilis and mabomu (bombs). At the time, AIDS was also recognized as the most dangerous STI by the majority of youth, and a majority also believed that AIDS could be prevented through avoiding sexual promiscuity and the use of condoms.[167] In a recent study, most adolescent girls reported that they can protect themselves from contracting STIs by using condoms, going for a test in order to rule out STIs before having sexual intercourse, abstinence and being faithful to one's partner, among other preventive measures.[168]

While the majority of youth mentioned that they would choose a hospital or clinic for the treatment of STIs, a substantial proportion said that they would seek a combination of treatments from both the hospital and traditional healers. The major reason given for seeking care from traditional healers is that youth are assured of privacy during the process of seeking care. At health facilities, youth also fear being humiliated by hospital or clinic staff.[169] Other studies have shown that girls especially would prefer to use traditional medicine because they believe it kills the causative agent. There is a widespread belief that if the causative agent is not killed, the girl may not be able to bear children in future.[170] Those who mentioned that they would go to the hospital for treatment of STIs argued that they would do so because the hospital knows about AIDS but traditional healers do not, as in some cases they would use a razor blade that had been used on someone with AIDS.[171] The consultation of traditional healers is also done because of the unavailability of medicines in hospitals.

Risk Assessment

One of the aims of a study conducted in Blantyre, Lilongwe and Mzuzu in 1997 was to find out what youth consider to be their major health concerns and whether HIV/AIDS is one of these concerns. A number of diseases were mentioned, including AIDS, gonorrhea, *bubos,* syphilis, malaria and diarrhea.[172] The study shows that 43% of the boys and 38% of the girls labeled AIDS as their primary health concern.

In another study conducted in 1994, focus group discussions with primary school pupils showed that the youth generally perceived themselves at risk of getting HIV because of borrowing razor blades, visiting barber shops, sexual intercourse, injections and nonuse of condoms. The same reasons were also given by secondary school students who believed that they were personally at risk of getting HIV. In addition to these reasons, secondary school students mentioned that there are many ways of getting HIV and that they do not trust their partners, especially if they do not use condoms. There were other primary school pupils who perceived themselves as not being at risk of HIV infection because they were not involved in sexual intercourse. Out-of-school youth shared similar views.[173] A study conducted three years later in 1997 showed that only 45% of the youth appeared to be concerned about getting AIDS, a drop from 79% in 1994 in Blantyre and Lilongwe. A number of reasons were given as to why the youth were not concerned, including the fact that they had never engaged in sexual intercourse or had stopped engaging in sex.[174] In the same survey youth were asked what should be done to help them sustain risk-free behavior. Most of the youth said they should be provided with condoms, they should avoid unsafe sexual intercourse and that more Anti–AIDS clubs should be established.[175]

Studies have also shown that there is a very close relationship between poverty and the spread of HIV/AIDS. Because of economic deprivation in their households, girls often engage in sexual intercourse for economic reasons.[176] In Malawi, there is a growing prevalence of 'sugar daddies' and 'sugar mummies', generally older men and women who obtain sexual favors from young girls and boys in exchange for money, clothes or other gifts. This situation puts girls increasingly at risk; from one study it seems that sugar daddies and mummies do not use condoms to protect themselves from HIV infection and that sugar daddies opt for girls because they are thought not to have the virus.[177]

Special Groups At Risk

Special groups of adolescents at high risk of sexually transmitted infections (STIs) and HIV infection include street children, commercial sex workers, refugees and illegal immigrants. In Malawi, not many HIV/AIDS–related studies have been carried out with street children, refugees and immigrants. However, there have been a number of studies on commercial sex workers, bargirls and orphans. As discussed earlier, adolescent girls aged 13–18 are found on the streets of Blantyre, Lilongwe and Mzuzu in search of men who will exchange sex for money, while others are employed as bargirls without pay because they are expected to get money from clients.[178] Although there are all these different types of special groups, the following discussion will center on orphanhood, which is a major problem created by the HIV/AIDS epidemic in Malawi.

Orphans

According to Malawian policy guidelines on the care of orphans, an orphan is a child younger than 18 who has at least one parent who died.[179] In recent years, there has been an unprecedented increase in the number of orphans in Malawi. According to 1998 census data, the population of orphans young than 20 was 567,526; of these, approximately 15% had lost both parents. The distribution by gender showed that 52% were boys and 48% were girls. By education status, most orphans (77%) in the survey had attended primary school, but only 14% had gone to secondary school and 7% had no formal schooling at all.[180]

In the past, families and communities have been effective sources of caring for orphans; this care was centered on the extended family system.[181] However, increasing AIDS–related deaths of many adults in the reproductive age group has raised orphanhood to a crisis level because traditional social support structures can hardly cope without external assistance. As a result, there are increasing numbers of child-headed households and cases of child labor.[182] Although communities prefer home-based care and support of orphans, there are an increasing number of orphanages. However, the Malawian government advocates that institutional care should be the last resort.

Before parents die from AIDS, family resources are often completely depleted during the period of illness, which leaves orphans with no resources. Property grabbing, neglect and deprivation of orphans are common, especially when the parent who has died is the father.[183] In addition to basic needs such as clothing, food, shelter and health care, orphans also need emotional and psychosocial support when parents die.[184]

Since orphans face a lot of problems, it becomes increasingly difficult for them to focus on schooling, which results in high dropout rates for these disadvantaged children. Sometimes school dropout leads adolescents to other means of sustaining themselves, including stealing, promiscuity and abuse of alcohol and drugs. The pursuit of promiscuity to realize their needs can place female orphans at risk of contracting HIV.[185]

Policies and Programs on Adolescent Sexual and Reproductive Health

Adolescent sexual and reproductive health policies

Malawi's policies that address adolescent sexual and reproductive health issues include the National Youth Policy (NYP), the National Population Policy (NPP), National Gender Policy (NGP), National HIV/AIDS Policy, Reproductive Health Policy (RHP), Family Planning Policy and Contraceptive Guidelines (FPPCG), National Health Policy (NHP) and the Malawi Poverty Reduction Strategy. In addition to services provided by various government institutions in line with these policies, there are a number of non-governmental organizations (NGOs) and private companies that are providing information and services for youth in Malawi. The NGOs and private companies are guided in their work by their own policies, which are in turn informed by relevant national policies. The following is a brief discussion of existing policies and programs for adolescents in Malawi.

The National Youth Policy

The NYP was developed in 1995 and targets young people aged 14–25. The policy provides broad guidelines for developing programs and services aimed at facilitating youth participation in national development efforts. These guidelines address the key issues facing youth today, namely high illiteracy rates, unemployment, lack of awareness of reproductive issues and the HIV/AIDS epidemic. The policy further identifies Malawian youth as a distinct sector in government policy.[186] More specifically, the policy recognizes the need to involve youth in decision making processes at both national and local levels. It further acknowledges that the current education system does not adequately prepare young people for life after school and is partly responsible for high unemployment and underemployment rates. The policy is now being reviewed to target the 10–24 age group.

Since NYP calls for the active participation of young people in national development, a number of motivated youths have come together and formed youth-run NGOs in different parts of the country to play a lead role in the functioning of the Youth Technical Sub-Committees at the district level throughout Malawi. An example of such a youth NGO is the Centre for Youth and Children Affairs, which was founded in August 1995 in order to promote and protect the rights of children based on the Convention on the Rights of the Child. It further empowers marginalized youth and children in the social, political and economic development of Malawi. Youth clubs have been formed in different parts of the country to teach young people about the transmission and prevention of HIV/AIDS. As of 1998, 22 out-of-school youth clubs had been established in their impact area of TA Tsabango in Lilongwe. The NGO's funders include the United Nations Children's Fund (UNICEF) and the United Nations Development Programme. A study conducted in Nkhata Bay, Lilongwe, Mchinji, Thyolo and Mwanza showed that 67% of the adolescent girls interviewed were members of youth clubs.[187]

Another example of local youth NGOs is the Youth Arm Organization (YAO), which was founded in 1995. The NGO aims at promoting the future of Malawian youth through participation in socioeconomic, health, human rights and environmental conservation issues. YAO has a multipurpose youth drop-in center located in Blantyre that offers such youth-friendly services as peer education, peer counseling, youth animation, an information resource center, indoor games, video shows, music and sports. The drop-in center seeks to impart life skills training to youth. Built into the project is a paper-making and recycling income-generating activity and other outreach fundraising activities, including drama and music shows, which act as incentives to youth and provide resources for sustaining some of the project activities. The project has been funded by the U.S. Agency for International Development, UNICEF, John Snow International (JSI) and Population Services International (PSI).[188]

The National Population Policy

The NPP was launched in 1994. The policy aims at curbing rapid population growth to a level compatible with Malawi's social and economic goals. Strategies to achieve this objective include improved family planning and health care programs, increased school enrolment, with emphasis on raising the proportion of female students to 50% of total enrolment, and more employment opportunities. The policy also advocates the provision of child spacing and family planning services to anybody who seeks them, regardless of age and marital status.[189]

Family Planning and Contraceptive Guidelines

Malawi's Family Planning Policy and Contraceptive Guidelines, revised in 1996, recognize the right of adolescents to receive reproductive health services. The guidelines further recognize that all persons of reproductive age, regardless of marital status, have the fundamental right to make informed decisions about how many children to have and when to have them. These guidelines also recognize the special risks of teenage pregnancy and advocate provision of family planning methods to adolescents without the consent of relatives, spouses or partners. In recognition of such problems as adolescent pregnancy, HIV/AIDS and other sexually transmitted infections (STIs) associated with adolescent sexuality, these policy guidelines also encourage the introduction of family life education within families, in primary schools and at all other levels of education, with special efforts being made to educate out-of-school youth.[190]

Reproductive Health Policy

In 2002, the government of Malawi adopted the RHP with the goal of providing accessible, affordable, convenient and comprehensive reproductive health services to all women, men and young people through informed choice in order to enable them to attain their reproductive health goals and rights. In this policy, youth reproductive health issues that are highlighted include family life education; provision of family planning services to all women, regardless of parity and marital status; ensuring that quality family planning services are accessible and convenient at all levels; ensuring reproductive rights of all individuals; ensuring that family planning and reproductive health services are male, youth and young adolescent (aged 8–14) friendly; and encouraging delay of the first pregnancy and condom use.[191]

The National AIDS Policy

The recently developed NAP provides the necessary legal and administrative framework for the implementation of a rights-based, expanded, multisector, national response to the HIV/AIDS epidemic. Specific objectives include ensuring multisector participation, provision of adequate resources for AIDS activities, observation of human rights (including gender and cultural sensitivity), provision for special needs and creation of an enabling environment for the implementation of HIV/AIDS and related programs.[192] Although the new policy outlined policy statements and implementation strategies focused on youth, it overlooked issues relating to youth in special vulnerable groups, such as youth in prison, boarding schools, training centers, army and police; yet these youth are possibly at high risk because they live away from their parents and guardians.

Adolescent sexual and reproductive health programs

A number of programs have been initiated in Malawi to address the sexual and reproductive health needs of adolescents. The following is a brief discussion of some of the key programs.

The National Reproductive Health Program

The National Reproductive Health Program (based in the Ministry of Health and Population) provides safe maternal health care, quality family planning and adolescent reproductive health services; prevention and management of unsafe abortion; prevention and management of STIs, including HIV/AIDS; reduction of levels of unwanted pregnancies; discouragement of harmful reproductive health practices; prevention and provision of support to victims of domestic violence and abuse; promotion of responsible sexuality; and equal access to information, education, supplies and services, regardless of age, gender and economic status.[193] The Ministry implements this program in collaboration with NGOs and other stakeholders.

Given the multidimensional nature of the reproductive health issues targeted by the program, there is a need for a multisectoral approach when addressing sexual and reproductive health issues. However, while it is recognized that several organizations deal with youth reproductive health issues, there seems to be little coordination and therefore no consensus on who does what, how, when and to whom, which makes it difficult to assess the provision of services to youth.[194] There is therefore an urgent need that these activities be properly coordinated so as to avoid duplication of efforts. In

this regard, the Centre for Reproductive Health at the College of Medicine has been established to fill some of these gaps (the Centre is funded by the Gates Foundation, through Johns Hopkins University).

The Youth Technical Sub-Committee and associated activities

The Youth Technical Sub-Committees (YTSC) were established in all districts in Malawi in the early 1990s. They draw membership from district offices of the Ministries of Education, Youth, Health and other ministries. Additionally, members are drawn from local and international NGOs. The government funds most of the activities that these committees are involved in, and in some cases the committees obtain support from the National AIDS Commission and other agencies. The YTSC are generally responsible for the following:

- coordination of youth health-related activities, such as HIV/AIDS–related activities for in- and out-of-school youths;
- training headmasters and patrons of the anti–AIDS clubs in schools;
- training peer educators;
- distribution of information, education and communication materials;
- counseling youth who have problems;
- establishment of Community AIDS Committees; and
- providing technical support to youth NGOs, and the monitoring, evaluation and registration of all youth NGOs and clubs.

The YTSC—like those for orphans, home based care and Behavior Change Communication (BCC)—is a subcommittee of the District AIDS Coordinating Committees (DACCs). In districts where DACCs are fully functional, all these subcommittees are also functional.

Life skills education

According to the World Health Organization, life skills are defined as abilities for adaptive and positive behavior that enable people to deal effectively with the demands and challenges of everyday life.[195] In September 1998, the Ministry of Education, through the Malawi Institute of Education, published the life skills syllabus to be used in primary schools.[196] The program seeks to address key challenges facing youth in Malawi today, such as HIV/AIDS, STIs, drug and substance abuse, growth and development, relationships, violence and delinquency, repressive cultural and traditional practices, dealing with peer pressure, resource management and access to services.

The Learning Skills Project was initially implemented on a pilot scale in 24 primary schools throughout the country in 1998–1999, and has since been scaled up to all grades in all primary schools in Malawi. The evaluation of the pilot life skills initiative showed that it had a positive impact on school pupils; for example, many young people feel empowered to say "no" if their friends pressure them to do something bad.[197] In order to secure out-of-school youth, some organizations, such as Scripture Union of Malawi (SUM), have also introduced the program and associated activities to out-of-school youths. The SUM program trained 112 primary school teachers and peer educators to promote positive behavior among adolescents, initiate the formation of SUM clubs in their schools and communities and form three rural youth clubs for out-of-school youths.

HIV/AIDS in the school curricula

In 1989, the National AIDS Control Program initiated a project to increase pupil awareness about transmission and prevention of HIV/AIDS. The project also sought to create positive attitudes among pupils toward AIDS patients by reducing misconceptions about the disease.[198] While HIV/AIDS education is taught in the majority of schools, teachers seem ill-equipped to teach because of the lack of proper training and incentives.[199]

The "Why Wait?" educational program

The "Why Wait?" curriculum and teaching methodology address HIV/AIDS prevention and life skills for youth that enable them to have a more fruitful future. This program is based on the book *Why Wait? What You Need to Know About the Teen Sexuality Crisis,* by Dick Day and Josh McDowell. Working with the Ministry of Education, Day introduced the "Why Wait?" educational program in some primary and secondary schools in Malawi. According to Kadzamira and colleagues, the "Why Wait?" educational program is based on Christian principles and has been particularly influential in both the formal curriculum and in anti–AIDS extracurricular activities. It is an abstinence-based program that emphasizes moral ethics in the formation of 'healthy' relationships among male and female students, the aim being to help young people make informed decisions regarding their future. The program has also been introduced in Kenya and Nigeria.

The "Why Wait?" program was introduced in secondary schools throughout Malawi toward the end of the 1990s, and in 2003 it was introduced in some pri-

mary schools in Blantyre on a pilot scale, with plans to scale up nationwide in 2004. An assessment of the program has shown that it has managed to bring some behavioral changes among young people; for example, some teachers mentioned the reduction in pregnancy cases and improved class discipline as changes resulting from this intervention.[200] However, teachers complained about the shortage of resource materials to teach the life skills lessons effectively. Many children cannot afford exercise books and the "Why Wait?" manuals. It was also evident that the training that teachers received was not sufficient or appropriate to enable them to teach life skills education.

Edzi Toto Clubs

Anti–AIDS clubs, popularly known as Edzi Toto ("AIDS is not for me") Clubs, have been established for girls and boys in many parts of Malawi. These clubs are designed to help members develop improved skills in critical thinking and communication. They use interactive, participatory methods to carry out various activities, including HIV/AIDS–related dramas, debates, quizzes, role plays and sports among members and nonmembers. Through these techniques, the clubs try to present HIV/AIDS and sexual health information in interactive ways that can help fellow students identify and change their risky behaviors.[201] A study set out to evaluate the impact of these clubs found that their performance depended on resources and staff and student commitment. For example, while most students were aware of the existence of clubs, very few of them participated in their activities, particularly in primary schools.[202] Participation of teachers in such clubs was also critical: Clubs where teachers attended HIV/AIDS orientation seminars were stronger and more successful than other clubs.[203]

In addition to the in-school Edzi Toto Clubs, there are out-of-school anti–AIDS clubs. These out-of-school clubs provide access points for peer education on HIV/AIDS prevention activities and income-generating activities.[204] According to Chendi's study, young people enrolled in these clubs generally possess a good knowledge of life skills. The in-school and out-of-school clubs complement life skills education and have had an impact on young people's lives, as some of the adolescents have reported changes in sexual behavior and adoption of the use of condoms during sexual intercourse. Furthermore, these clubs are helping to break the barriers of communication between the young and older members of the community, as parents also participate in the activities.[205]

The review above shows that there is a substantial amount of program activity to meet the reproductive health needs of adolescents in Malawi. However, a major limitation of the programs is that many of them are implemented with limited capacity for comprehensive monitoring and evaluation of their impact. Detailed evaluation studies are required for these programs to determine best practices that can be scaled up to significantly improve sexual and reproductive health services for young people in the country.

Conclusion

The primary objective of this report was to synthesize what is known (using previous studies) about the sociocultural and policy environment in which young people in Malawi live; their sexual and reproductive experiences; information and service needs for adolescents; and awareness, attitudes and knowledge about HIV/AIDS, other sexually transmitted infections (STIs), condoms and condom use. The review highlights knowledge and service gaps that future research and efforts to improve the delivery of sexual and reproductive health services to the youth should focus on.

From the studies that have been reviewed, it is evident that adolescents consider HIV/AIDS a major health problem. In the absence of a cure for AIDS, the Ministry of Health and Population and other stakeholders encourage abstinence, use of condoms and faithfulness to one's partner as key preventive measures against the transmission of HIV among youth. In addition to these strategies, there is increasing emphasis on voluntary counseling and testing (VCT) in order to help young people make informed decisions about their future on issues such as marriage, and to protect sexual partners if the young person is HIV positive. VCT can bring about the reduction or control of HIV/AIDS if it is widely adopted. Adolescents are particularly vulnerable to HIV/STI infection because of the tendency to experiment with sexual intercourse and the economic deprivation that forces them (particularly girls) to engage in risky sexual behaviors. It is therefore very important to empower youth and to equip them with the life skills needed to deal with problems; this is already being done by many adolescent sexual and reproductive health programs operating in Malawi.

Some cultural beliefs and practices in the country exacerbate young people's vulnerability to HIV/AIDS. For example, in some parts of the country, boys are encouraged to experiment having sexual intercourse in what is referred to as *kuchotsa fumbi* (removing dust) soon after initiation. This places young men at risk of contracting STIs, because in most cases sexual intercourse does not involve the use of condoms. The emphasis on male aggression and female meekness in young people's socialization puts young women at a disadvantage because it undermines women's power to negotiate safer sex or contraceptive use; at the same time, young men feel justified in having multiple partners and sometimes forcing young women to have sex with them. Although the National AIDS Commission and other stakeholders have attempted to educate people about the dangers of practicing some of the traditions that enhance the transmission of HIV, these efforts need to be strengthened.[209] The fight against HIV/AIDS should also place special emphasis on empowering women economically and socially since economic deprivation and the general lack of basic necessities are some of the factors that force young women to engage in risky sexual behaviors.

Adolescents' main sources of sexual and reproductive health information include health workers, the radio, traditional initiators, peers and friends. While having multiple sources of information is good, sometimes adolescents receive inaccurate and contradictory messages about sexual and reproductive health that can misguide them in the pursuit of better and safer sexual and reproductive health. This problem is compounded by the fact that sex education is still considered a taboo in many Malawian communities. Parents rarely talk to their children about sex, and persons such as traditional birth attendants, traditional initiators (*anankungwi*), aunts and grandparents are traditionally designated to discuss sex and related issues with young girls and boys. While these elders play a key role in educating children about their sexuality, there is need for the promotion of the discussion of sex between parents and their children, as some children indicate that it would be better if they received some of this information from their parents. Additionally, the *fisi* ("hyena") practice whereby a designated man has sex with girls being initiated in a given village increases young girls' vulnerability to STIs and HIV/AIDS. The existence of myths

and misconceptions regarding sexual and reproductive health (e.g., that a girl cannot get pregnant if she has sexual intercourse while standing) indicates that adolescents are sometimes misinformed. Identifying such myths and misconceptions and determining their prevalence are necessary steps, because they can inform the design and implementation of better educational programs.

Although the health services delivery system in Malawi is supposed to deliver a wide range of sexual and reproductive health services to adolescents, studies have shown that the range of services actually offered is very limited and that many adolescents are not aware of the range of services available. There is therefore need for adolescents to know the wide range of services that are offered so that they can make informed choices when they encounter sexual and reproductive health problems. A number of barriers to obtaining sexual and reproductive health services have been discussed in this report, among which is health providers' negative attitude toward adolescents. Contrary to reproductive health policies issued by the Ministry of Health and Population, some service providers do not provide contraceptives to unmarried young people. Although some teachers are simply reluctant to teach HIV/AIDS education to their students, many are trained poorly or not at all in sexual and reproductive health, which results in under-implementation of the official HIV/AIDS curriculum in schools. These shortcomings underscore the need to provide sexual and reproductive health services that are adolescent friendly. Additionally, to ensure effective implementation of various national policies that seek to promote the reproductive health needs of young people, there is need to intensify campaigns to reorient teachers and service providers on a regular and continuous basis. In order to achieve a significant improvement in adolescent sexual and reproductive health, there is need to determine—through rigorous monitoring and evaluation of programs—best practices that can be scaled up to the rest of the country.

Although a number of concerns about adolescent sexual and reproductive health have been raised, it is important to note that that there are many positive elements in the effort to safeguard the sexual and reproductive health of adolescents in Malawi. The main bright part of the picture is that interest in and concern about adolescent sexual and reproductive health are increasing. A number of policies, as discussed above, have been adopted and intervention programs initiated in different parts of Malawi to address adolescent sexual and reproductive health concerns. Young people are aware of the threat of AIDS and the means to prevent it and are involved in designing and implementing programs, including many youth-led NGOs and anti-AIDS clubs. As data reviewed in this report show, there is also some improvement in youths' adoption of such preventive strategies as use of condoms.

Based on the findings from this synthesis, the following gaps in evidence have been identified:

(i) There are a number of regional variations in Malawi regarding key indicators such as age at first sex and age at first marriage. These patterns call for more in-depth studies to understand the underlying causes of regional differences and whether such factors could also have a role in shaping sexual and reproductive health attitudes and practices among adolescents.

(ii) Given the paucity of data on sexual abuse, there is need to find out the magnitude of the problem in Malawi.

(iii) Abortion is legally restricted in Malawi, yet it is an important medical and social problem: Hospital records show that many women, particularly young girls, resort to dangerous and unorthodox means of abortion that put their health and lives in danger. There is need to determine the magnitude of this problem at the community level and also to improve collection of abortion data in hospitals and clinics through routine health management and information systems.

(iv) There are a number of cultural practices that put adolescents at risk of contracting HIV and other STIs. While these practices have been identified, further studies should attempt to determine the extent to which these cultural practices are being carried out, and their actual impact on STI/HIV/AIDS transmission and other sexual and reproductive health problems.

(v) A range of sexual and reproductive health services are offered to adolescents, but some adolescents are not even aware of the existence of such services. Further studies on adolescent sexual and reproductive health services need to document and map the range of services available to adolescents in various communities to determine underserved areas. Further studies should also seek to develop ways to improve adolescents' awareness of services that are available to them.

(vi) Voluntary counseling and testing is now a key component of HIV/AIDS prevention and treatment. Yet the percentage of adolescents in Malawi who have gone for VCT is still very low. Further

studies need to be done in order to determine factors that would help promote the uptake of VCT services.

(vii) While the level of adolescent sexual and reproductive health program activity has expanded considerably over the last few years, there is a need to carry out comprehensive evaluations of the impact of programs in order to establish best practices to be scaled up. Indeed, many of the studies and programs reviewed in this study were implemented in localized areas and with limited monitoring and evaluation capacity. As a result, they have limited applicability to the wider national context. A major challenge, therefore, is to assess the wider applicability and occurrence of these findings and lessons on the national scale.

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Figure 1: Median age at first sex, first marriage and first birth for women aged 20–24, Malawi Demographic and Health Survey, 1992 and 2000

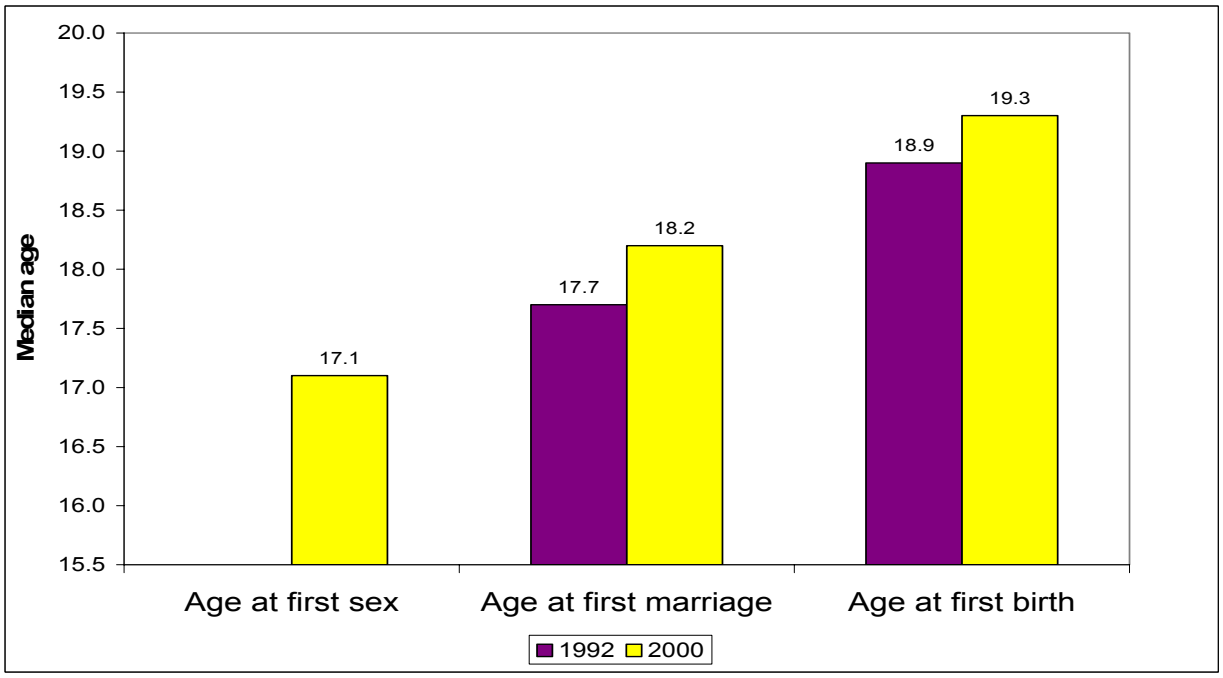


Figure 2: Percentage of adolescents (15–19) who were currently using condoms for family planning and who had used condoms at last intercourse, Malawi Demographic and Health Survey, 2000

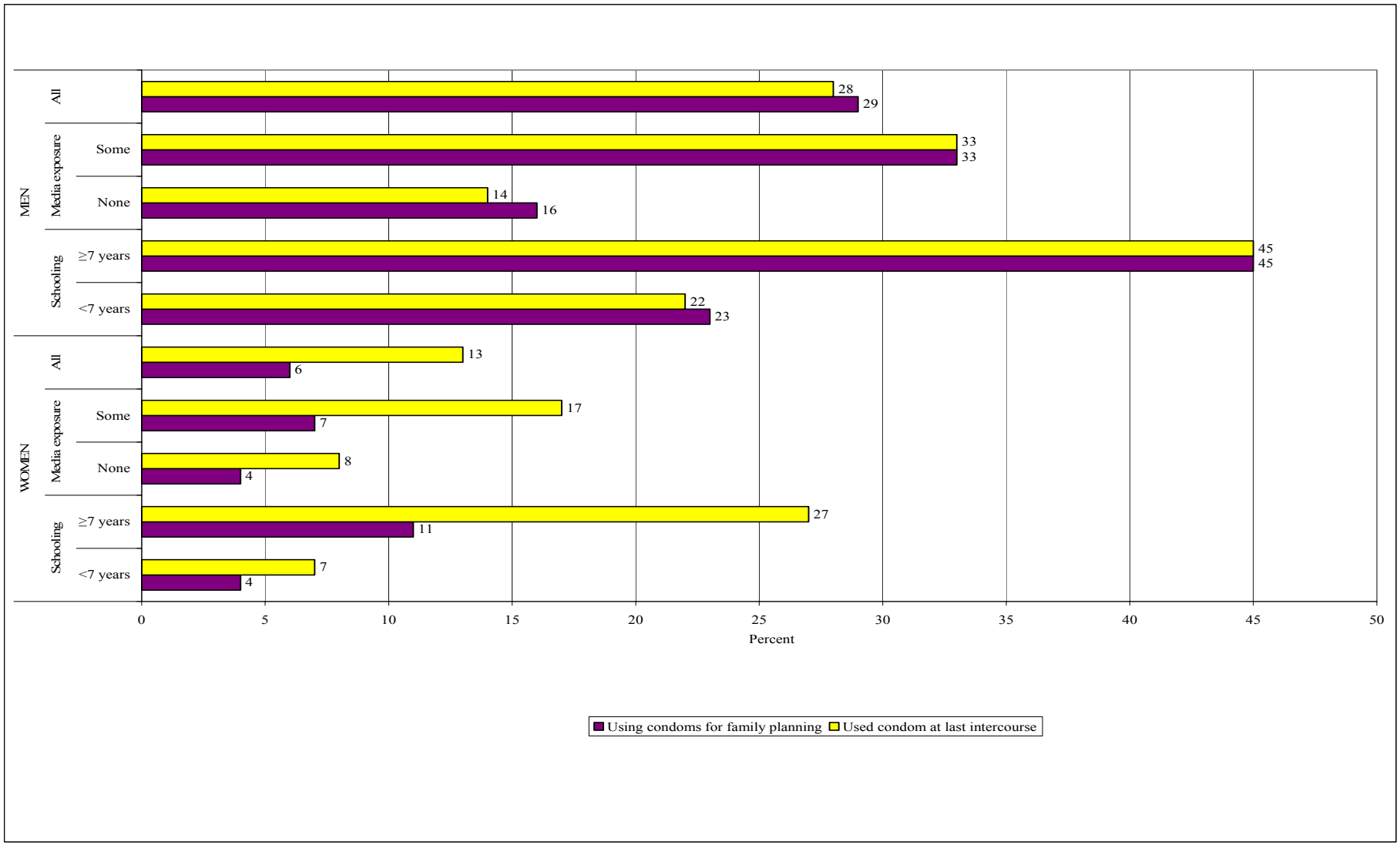
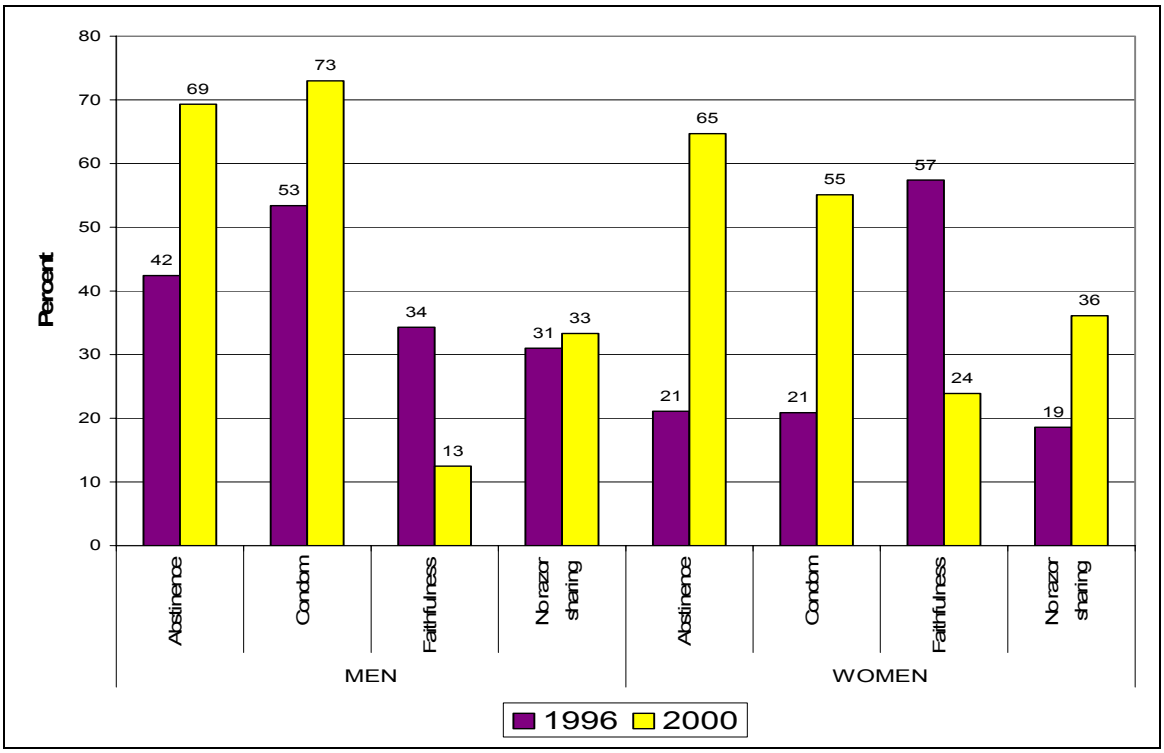


Figure 3: Percentage of adolescents (15–19) who mentioned ways of preventing HIV/AIDS, Malawi Demographic and Health Survey, 1996 and 2000



Appendix Table 1: Selected background characteristics and measures of sexual and reproductive behavior among adolescent women aged 15–19* in Malawi, Demographic and Health Survey 2000

		Age		Education		Residence		Region			Media exposure at least once a week	
Characteristics and measures	Total	15–17	18–19	<7 years	≥7 years	Rural	Urban	North	Central	South	No	Yes
Unweighted N	2914	1660	1254	1882	1032	2228	686	516	974	1424	1235	1679
A. Background characteristics												
1. Percent with ≥7 years of education	33	29	37	–	–	26	64	52	28	32	20	42
2. Percent currently working	40	37	44	44	30	44	19	48	40	38	45	36
3. Percent with some exposure to mass media (at least once a week)	56	57	55	48	73	51	81	63	52	57	–	–
4. Percent living in urban areas	17	17	17	9	34	–	–	20	13	19	7	25
B. Sexual behavior												
5. Percent ever had sexual intercourse	57	41	78	58	56	58	56	55	52	62	60	56
6. Median age at first sexual intercourse among 20–24-year-olds	17.0	–	–	16.5	18.3	16.9	17.7	17.1	17.6	16.6	16.9	17.1
7. Percent had premarital sex before age 20 among 20–24-years-olds‡	38	–	–	37	41	38	39	28	35	43	38	38
8. Among sexually experienced, percent had sex in last 3 months	67	62	70	70	60	67	67	66	66	68	67	67
9. Among sexually experienced, percent had≥2 partners in last 12 months	2	2	2	2	2	2	2	1	2	2	2	2
C. Union and fertility												
10. Percent ever in union†	37	19	60	41	27	38	30	44	31	40	41	33
11. Median age at first marriage among 20–24-year-olds	18.2	–	–	17.5	19.2§	18.0	19.6	17.8	18.7	17.9	18.0	18.4
12. Percent ever had a child	25	10	45	27	21	27	20	24	22	28	30	22
13. Percent currently pregnant	10	6	16	11	9	11	8	12	9	10	11	9
D. Contraceptive knowledge and use												
14. Among all, percent know where to obtain a condom	69	65	75	61	85	64	92	66	66	73	60	76
15–16. Among sexually experienced, percent ever used:												
15. Any modern method of contraception for family planning	24	19	26	19	34	21	38	31	22	23	19	28
16. The condom for any reason	18	22	15	11	32	16	30	22	18	17	13	23
17–18. Among sexually active, percent currently using:												
17. Any modern method of family planning	15	10	17	11	24	12	28	18	13	15	12	17
18. The condom for any reason	6	7	5	4	11	5	10	11	6	5	4	7
19. Among those who had sex in the last 12 months, percent used the condom at last intercourse	13	19	10	7	27	11	23	16	13	12	8	17
20. Among all, percent who approve of family planning	86	83	90	83	93	85	93	76	86	89	83	89
21. Among nonusers, percent who intend to use a method later	74	71	79	71	82	72	84	61	74	77	69	78
E. Knowledge and attitudes about HIV/AIDS												
22. Percent who have heard of HIV/AIDS	98	98	99	97	100	98	100	99	99	98	97	99
23–25. Among all, percent who correctly identified that one can prevent HIV/AIDS by:												
23. Using the condom	55	53	58	48	70	52	72	39	49	64	47	62
24. Abstaining from intercourse	65	66	64	62	71	63	73	56	59	71	60	68
25. Limiting sexual partner to one	19	16	23	19	19	18	25	20	22	17	16	21
26. Among all, percent who know that it is possible for a healthy looking person to have the AIDS virus	82	79	85	76	93	79	93	80	77	86	77	85
27. Among those who have ever heard of HIV/AIDS, percent who think that children aged 12–14 should be taught about using a condom to avoid AIDS	55	53	57	53	59	54	57	41	50	62	53	56
28. Among those who have ever heard of HIV/AIDS, percent who have ever been tested for HIV	7	5	9	5	10	5	12	7	5	8	5	8
29. Among those who have never been tested for HIV and among those who have ever heard of HIV/AIDS, percent who would want to be tested for HIV	81	78	85	77	89	80	86	84	78	83	78	83
F. Protective behavior												
30–32. Among those who used a condom at last intercourse, percent who use condoms at last intercourse:												
30. To prevent pregnancy only	54	59	46	51	56	52	59	52	54	53	48	55
31. To prevent STIs only	21	21	21	18	23	24	16	8	24	22	18	22
32. To prevent STIs and pregnancy	20	18	22	17	22	18	25	36	17	19	18	20

* Measure is among adolescents aged 15–19 unless otherwise stated.
† Ever in union includes currently married, formerly married and cohabitating.
‡ Premarital sex is the percent of all women aged 20–24 who had intercourse before age 20 and were never married at first intercourse.
§ Among 25–29-year-olds, as median not reached among 20–24-year-olds.

Appendix Table 2: Selected background characteristics and measures of sexual and reproductive behavior among men aged 15–19* in Malawi, Demographic and Health Survey 2000

		Age		Education		Residence		Region			Media exposure at least once a week	
Characteristics and measures	Total	15–17	18–19	<7 years	≥ 7 years	Rural	Urban	North	Central	South	No	Yes
Unweighted N	674	406	268	416	257	515	159	115	254	305	171	503
A. Background characteristics												
1. Percent with ≥7 years of education	34	28	43	–	–	27	66	65	29	31	18	39
2. Percent currently working	33	29	39	39	20	36	20	8	36	35	37	31
3. Percent with some exposure to mass media (at least once a week)	75	77	73	69	87	72	92	69	71	81	–	–
4. Percent living in urban areas	18	20	15	9	35	–	–	22	14	20	6	22
B. Sexual behavior												
5. Percent ever had sexual intercourse	61	50	77	62	58	63	49	42	58	69	61	61
6. Median age at first sexual intercourse among 20–24-year-olds	17.7	–	–	17.7	17.6	17.9	17.2	17.7	18.4	16.9	17.8	17.6
7. Percent had premarital sex before age 20 among 20–24-year-old§	72	–	–	68	75	69	82	63	66	79	69	73
8. Among sexually experienced, percent had sex in last 3 months	62	58	66	66	54	64	53	57	57	67	57	64
9. Among sexually experienced, percent had≥2 partners in last 12 months	16	16	15	18	11	14	22	7	16	16	20	14
C. Union and fertility												
10. Percent ever in union ‡	4	1	8	5	3	4	2	1	3	5	4	4
11. Median age at first marriage among 25–29-year-olds	22.7	–	–	22.1	23.8	22.4	24.4	22.3	22.8	22.7	22.6	22.8
12. Percent ever had a child	3	1	6	3	3	3	2	0	2	4	2	3
13. Among those currently in union, partner currently pregnant	30	†	†	†	†	†	†	†	†	†	†	†
D. Contraceptive knowledge and use												
14. Among all, percent know where to obtain a condom	83	78	90	78	93	80	99	73	81	88	79	85
15–16. Among sexually experienced, percent ever used:												
15. Any modern method of contraception for family planning	38	30	44	31	51	36	44	50	41	32	17	44
16. The condom for any reason	37	30	44	31	50	36	43	48	41	32	17	44
17–18. Among sexually active, percent currently using:												
17. Any modern method of family planning	31	25	35	24	48	28	50	41	33	27	16	35
18. The condom for any reason	29	24	34	23	45	27	42	41	31	26	16	33
19. Among those who had sex in the last 12 months, percent used the condom at last intercourse	28	22	34	22	45	27	39	39	30	25	14	33
20. Among all, percent who approve of family planning	87	86	90	86	91	86	92	72	87	92	82	89
21. Among nonusers, percent who intend to use a method in next 12 months	na	na	na	na	na	na	na	na	na	na	na	na
E. Knowledge and attitudes about HIV/AIDS												
22. Percent who have heard of HIV/AIDS	99	99	100	99	100	99	100	99	100	99	98	100
23–25. Among all, percent who correctly identified that one can prevent HIV/AIDS by:												
23. Using the condom	73	71	76	71	76	72	78	61	71	78	70	74
24. Abstaining from intercourse	69	67	73	67	74	67	79	56	70	72	67	70
25. Limiting sexual partner to one	11	8	14	9	14	11	9	13	10	12	10	11
26. Among all, percent who know that it is possible for a healthy looking person to have the AIDS virus	87	84	92	85	91	86	92	70	89	88	82	88
27. Among those who have ever heard of HIV/AIDS, percent who think that children aged 12–14 should be taught about using a condom to avoid AIDS	58	56	61	58	58	57	64	51	59	59	57	58
28. Among those who have ever heard of HIV, percent who have ever been tested for HIV	7	5	9	4	12	6	10	6	6	7	3	8
29. Among those who have never been tested for HIV and among those who have ever heard of HIV/AIDS, percent who would want to be tested for HIV	86	85	89	87	85	86	88	85	87	87	85	87
F. Protective behavior												
30–32. Among those who used a condom at last intercourse, percent who use condoms at last intercourse:												
30. To prevent pregnancy only	21	25	17	19	22	21	21	†	24	10	†	22
31. To prevent STIs only	44	41	46	43	46	43	50	†	38	51	†	41
32. To prevent STIs and pregnancy	28	34	25	28	30	29	21	†	30	31	†	30

* Measure is among adolescents 15–19 unless otherwise stated.
† Unweighted N less than 20.
‡ Ever in union includes currently married, formerly married and cohabitating.
§ Premarital sex is the percent of all men aged 20–24 who had intercourse before age 20 and were never married at first intercourse.

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