Empowering Young People

To manage sexual and reproductive health risks in the districts of Mangochi and Chikwawa

Background, results, lessons and recommendations from the project

Project background

Youth Net and Counseling (YONECO), Education Expertise Development Foundation (EEDF), Aidsfonds and Edukans with funding from DFID implemented the "Empowering young people" project in the districts of Mangochi and Chikwawa in Malawi targeting young people aged between 10 - 24 years.

The project was implemented to respond to increased HIV prevalence, teenage pregnancies and school drop outs among the youth due to limited access to sexual reproductive health services. The lack of access was due to social cultural barriers towards abstinence and safe sex among young people and unequitable gender norms in Chikwawa and Mangochi. These factors resulted into low contraceptive and condom use, high HIV prevalence, high teenage pregnancies and school drop outs.

The project was set out to reach out to 1,800 in primary level school learners, 3,600 out of school young people and 2,300 community members and other stakeholders between September 2016 and March 2018.

By the end of the project, 1810 (705 males and 1105 females) in school learners and 8,837 (5,301 females and 3,536 males) out of school learners participated in the project activities. 36 peer educators, 23 service providers and 22 teachers were trained to deliver comprehensive sexuality education and youth friendly health services. 7,590 parents (2,173 males and 5,417 females) and 246 (120 males and 126 females) religious and traditional leaders were engaged on providing supportive environment for SRHR for young people.

Key outputs for the program were:

a. **Institutionalized provision of youth friendly health services in target health facilities;**
b. **Improved access to youth friendly health services among adolescents and young people;**
c. **Improved knowledge of SRHR among in and out of school young people through comprehensive sexuality education;**
d. **Enhanced knowledge of community leaders, religious leaders, and parents on the need for adolescents and young people to access SRH services;**
e. **Attain positive shifts in cultural norms by integrating religious and traditional leaders and parents in advocating for SRHR of young people.**

The project was aligned to the Malawi government efforts to improve quality and availability of health services for young people. Thus, the project was relevant to the Malawi SRHR policy which aims at supporting safer SRH choices and ensure provision of quality, accessible reproductive health services as well as contributed to the implementation of the Malawi YFHS strategy (2016 - 2020).

Key lessons learnt

Engagement of the wider community in youth friendly health services initiatives, especially the gate keepers and power holders like traditional and religious leaders encourages intergenerational dialogue and wider discussion even on taboo subjects and help to break down stigma and discriminatory attitudes towards the youths. In Mangochi and Chikhwawa, while parents and traditional and religious leaders recognize that there is a need for youth and adolescent SRH education, they usually do not agree to extensive or intensive education on sex or sexuality. They think adolescents will be promiscuous if they learn about sexuality and contraceptives and do not understand the risk of not providing information. The targeting of key actors, especially at the beginning, is therefore a crucial phase in youth friendly health services interventions. Key to community engagement on youth friendly health services are:

- **Using culturally sensitive approach to community based youth friendly health services programming and using existing structures and systems can yield positive outcomes.**
- **Centering interventions on community power blockers and institutions of trust like traditional and religious leaders, as custodians of culture and agents of change is key to successful youth friendly health services initiatives. Such centering also ensures ownership.**

Partnerships among youth friendly health facility service providers and community level structures is critical for successful youth friendly health services initiatives. The Empowering young people project developed a referral protocol which basically linked community and school level structures like the youth clubs, parenting facilitators and circles and the my world my l ife patrons and matrons with the health facilities. Youths would get a referral letter from the community and school level structures to the health facility. Linkages between schools, communities and service providers has proved successful in getting the youths to access SRHR services. Critical to a successful referral system are:

- **Capacitating health facilities, for instance, infrastructure development encourages community members to seek services.**
- **Effective tracking of the referrals while ensuring confidentiality and trust among the youths.**
- **Using culturally sensitive approach and youth friendly systems and structures to accessing referrals e.g. the project used the matrons and patrons as referral actors for the in-school youths. The in-school youths shunned them as they were afraid that the teachers would know about the health status.**

Addressing issues of youth sexual and reproductive health requires an integrated approach that addresses the individual, relational, community and structural issues.

- **At the individual level, initiatives should empower the youths with knowledge and skills.**
- **At the relations level, initiatives promoting youths' access to SRHR should aim at build relationships that support and reinforce positive health behaviors of adolescents. This among others should include interventions that engage with close relationships which influence the sexual and reproductive behaviours and experiences of adolescents, such as parents, intimate and other sexual partners, and peers.**
- **At the community level, initiatives should target broader community members and institutions outside the family, for instance, schools and social gatherings.**
- **At the structural level, initiatives should aim at addressing the formal and informal rules, policies and procedures that restrict youths from accessing SRHR services.**

A 3-dimensional approach yields better results in youth-led SRH intervention. The 3-dimensional approach should focus on:

- **FOSTER URGENCY: Target boys and girls with SRH messages at tender age. Early awareness helps delay sexual debut among boys and girls. It increases self-awareness, making them highly likely to use condoms at both first and last sex. Delaying first sex and using condoms minimizes risks of early pregnancies, child marriages, and acquisition of HIV and other STIs.**
- **USING MIXED METHODS: Condoms remain a central product in the SRH service pack because of twin-purpose i.e. preventing pregnancies and STIs. But product diversifying is key to increasing contraceptive adoption rate among young persons. It also reduces reliance on natural means like withdraw, eventually cutting pregnancy risks.**
- **SOLIDIFY SUPPLY CHAINS: Apart from knowledge, young people require skills set that make them more self-aware and confident to access and use SRH services. Equally key are positive attitudes of service providers in creating a welcoming environment where young persons feel safer and more confident to engage. Decentralized supply chains such as youth clubs, peer educators, and parenting circles, and youth-friendly health service units are good starting points.**

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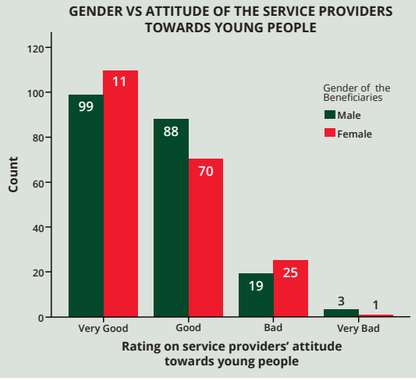
Project Approach/ Strategy

To achieve the results the project used a number of strategies and approaches and these are highlighted below:

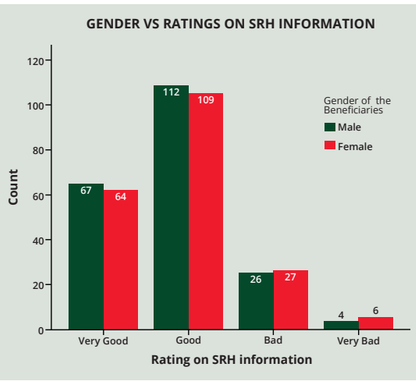
1. Capacity Building:
The project built the capacity of teachers and peer educators to deliver comprehensive sexuality education in school-based clubs and out of school youth clubs. Health care workers from health facilities were also trained to deliver youth friendly health services. Key result from these capacity building initiatives:

- **Improved attitudes among teachers, peer educators and youth friendly health service providers to deliver comprehensive sexuality education and youth friendly health services.**



2. Delivery of Comprehensive Sexuality Education:
Comprehensive sexuality education was delivered on ongoing basis in in school and out of school youth clubs to aid acquisition of SRHR knowledge and skills including referrals to services. Referral guide was produced and distributed to young people to encourage young people to seek services when needed. Key result from this approach:

- **Well informed young people who were able to access various youth friendly health services and took significant decisions concerning their lives.**



3. Creation of an Enabling Environment:
Parents, religious and traditional leaders were engaged through community theatre and parenting cycles to challenge SRH-related stereotypes, myths, and misconceptions and improve support for uptake and access of SRHR services among young people.

4. Service Provision:
The project supported provision of services through health facilities and outreach services. Services provided included HIV testing and counselling, STI screening and treatment, family planning methods and referral for other services. Results from this approach:

2,153 **Girls and young women received family planning**

1,448 **Young people**
(633 males, 815 females) got tested and know their results

414 **Young people**
(248 females, 166 males) referred for services

360 **Young people took significant decisions**

2,759 **Young people**
(2,206 males, 553 females) consistently accessed condoms

15,523 **Out of school youth**
(9,052 females, 6,471 males) and 3,282 in school youth (1,322 males, 1,960 females) reached with comprehensive sexuality education

1,457 **Young people**
(683 males and 774 females) reached through mobile outreach clinics which addressed long distances to health services

Photo: Marieke van der Velden

Project Impact

The project collected baseline and end line data before and after project interventions to assess progress in effecting the desired change by the project. Following the interventions, the following changes have been realised:

- **Enhanced community participation in and undertaking of collective action in support of youth's access to sexual and reproductive health services and educational outcomes. Through the project interventions, community members through the parenting facilitators and parenting circles have been participating in and undertaking collective action and have not only demanded youth friendly health services BUT also advocated for girls education in their communities.**

- **Improved assertiveness and self-efficacy of the adolescents especially girls. The project has been promoting comprehensive sexual education delivered through My World My Life Clubs and Youth Clubs. The youths from the impact areas have been empowered through their participation in the comprehensive sexuality education sessions as evidenced in their improved self-efficacy especially among the adolescent girls.**

- **Transformed attitudes, beliefs and practices which create barriers for the youths to access sexual and reproductive health services. Through the different interventions, especially the ones focusing on addressing harmful social cultural factors, the project has strengthened the capacity of the gate keepers and power holders like traditional and religious leaders on youths' sexual and reproductive health issues. Such capacity strengthening initiatives have resulted into the traditional leaders and religious leaders challenging some of the cultural and religious beliefs and taboos. They have also encouraged intergenerational dialogue and wider discussion even on taboo subjects and help to break down stigma and discriminatory attitudes towards the youths.**

- **Increased access to SRHR services. Through the project interventions especially on service provision, youths' access to sexual and reproductive health services has been increased as figures show.**

Increased use of family planning methods

	End line	Baseline
Condoms	45.5%	57%
Pills	8.1%	4%
Implants	16.2%	8%
Abstinence	1.3%	8%
Female condoms	0%	3%
Norplant	1.4%	
Female sterilization	0.9%	
Injectables	25.6%	16%
Withdraw	0.5%	3%
Male sterilization	0.5%	

Improved condom usage

% of young people to ever used a condom and who were currently using condoms

	End line	Baseline
Current	60.3%	56%
Ever	77.2%	69%

% of young people who used condoms at first sex and last sexual encounter

	End line	Baseline
First	58%	45%
Last	59.6%	51%

HIV testing

% of young people who tested for HIV and receive their results

	End line	Baseline
Tested	63.5%	43.4%
With results	97%	98%

Antenatal care

	End line	Baseline
Ever attended	75.8%	99%

Antenatal service provider

	End line	Baseline
Surveillance Assistant	4.2%	7%
Community Midwife	6.4%	4%
Doctor/Clinical Officer	53%	41%
Nurse/Midwife	34%	48%
Traditional Attendants	2.1%	