Qualitative Evidence of Adolescents' Sexual and Reproductive Health Experiences in Selected Districts of Malawi

Alister C. Munthali, Ann M. Moore,
Sidon Konyani, Bernie Zakeyo

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Executive Summary

This report provides an in-depth analysis of adolescent sexual and reproductive health issues in key districts of Malawi with a focus on prevention of HIV, other STIs and unplanned pregnancy. The data were collected by the Centre for Social Research of the University of Malawi in conjunction with the Guttmacher Institute. This report draws on in-depth interviews (IDIs) conducted with young people aged 12–19, with representation of in- and out-of-school adolescents (male and female), who live in Blantyre City and four rural districts: Rumphi in northern Malawi, Mchinji and Ntchisi in central Malawi, and Mangochi in southern Malawi. A total of 102 interviews were conducted—51 in Blantyre and 51 in the other four districts. Fifteen of the interviews were conducted with adolescents considered to be at higher-than-average risk of HIV and unplanned pregnancy, including adolescents who worked or lived on the streets, worked as petty traders or were residing in orphanages.

Adolescents' Experiences and Perceptions About Puberty

Knowledge about puberty is a measure of sexual environment in which adolescents are coming of age. While girls were told about menstruation and boys were told about growing pubic hair and experiencing wet dreams, adolescents did not have much information on pubertal changes in the opposite sex. Living in a rural environment increased adolescents' probability of having been spoken to about pubertal body changes. Since parents are not an important source of information and older relatives play an important role in transmitting this information to young people, when the nuclear family migrates, young people are no longer integrated into a social network that helps teach them about pubertal changes.

Adolescents' Perceptions of and Experiences with STIs, Including HIV/AIDS

How adolescents compare HIV to their other problems

Framing HIV in relation to other problems helps us understand HIV in the context of adolescents' lives. Poverty was adolescents' main problem. They said AIDS is not really comparable because it is deadly.

Risky and non-risky sexual behaviors

Having multiple sexual partners and having sex without condoms were considered risky sexual behaviors because these behaviors were perceived to expose one to HIV and pregnancy. Yet some believed that sex itself is risky, demonstrating adolescents' lack of confidence in contraception. Abstinence, monogamy and sex with condoms were considered protective sexual behaviors. Twelve and 13 year olds are not able to distinguish between risk and non-risky behaviors.

Knowing someone with AIDS

Respondents believed that one can visually perceive that someone has AIDS because they exhibit common symptoms. In settings such as Malawi where indirect diagnosis is the norm where there is high HIV prevalence and low ARV rates, adolescents may assume that they can identify people with AIDS. This assumption discounts the long incubation period and places the adolescent at risk of not accurately identifying who has AIDS. The fact that pity is the primary emotion shown towards HIV-positive individuals may be evidence for a low level of stigma among adolescents in the country.

Actual sources and preferred sources of information

While schools are teaching about HIV/AIDS, adolescents would prefer to get information from health workers and NGO staff. More information was requested by the adolescents on a number of topics including the incubation period of AIDS further rein-

forcing the point that this necessary information is lacking. Living in an urban area is again correlated with experiencing barriers to getting information.

Nonmarital Pregnancies and Childbearing

Perceptions about nonmarital pregnancy and childbearing

Adolescents feel sorry for girls who are pregnant or who already have children because of financial, social and possibly physical problems that could accompany the pregnancy or birth. These hardships were applied to boys involved in a nonmarital pregnancy.

Sources and preferred sources of information about pregnancy

Schools, youth centers and peers are important sources of information on pregnancy prevention, although the information is not necessarily correct. Parents were a major source of information for females. Female preferred parents and males preferred older relatives and friends as sources of information on pregnancy prevention. A minority of both sexes said they did not have anyone to talk to yet most respondents did not report having problems getting information on pregnancy prevention.

Sexual and Reproductive Health Problems

For non-sexual or reproductive health problems just as for sexual and reproductive health problems, the understanding of the etiology of the disease determined, in part, where respondents sought care. If it was an African illness, respondents were more likely to seek care from a traditional provider. Other reasons that determined where adolescents sought care included the availability of funds and the distance to the health facility. For those who sought care for a reproductive health problem, many first tried traditional medicine and then went to the hospital if the problem did not clear up. Barriers to seeking care included shyness, a lack of appropriate medicine at hospitals, long distances to a facility and a lack of money. When asked about what they would hypothetically do if they did experience a sexual or reproductive health care problem, most said they would tell a family member and seek care.

Adolescents' Intimate Relationships

Adolescents without relationship experience

Almost half of the adolescents reported not having had a relationship because relationships were equated with engaging in sex, putting the adolescent at risk of contracting STIs, including HIV, and, for females, becoming pregnant and consequently withdrawing from school. Even though condoms were known, many respondents voiced concerns that they could be punctured or burst. More females than males stated they would wait until they finished school, got married or became independent before having a relationship. Yet this equation of relationships with sex does not bear out in the data as a significant minority of adolescents had had a relationship and no sex.

Initiation of noncoital dating

Relationships were initiated by boys. The couples most frequently became acquainted at school. Most boys started relationships out of peer pressure or because they envied friends who had girlfriends. Females, for the most part, said they were pressured or coerced by males into a relationship they did not want. The relationships were covert, as adolescents feared being chastised and/or punished by their parents for being in a relationship. In their relationships, adolescents encouraged each other to work hard in school, chatted and watched soccer. Kissing was treated as leading to sex, so many female adolescents said they did not kiss their boyfriends. Most relationships ended because their partner had another girl/boyfriend or the relationship was interfering with school.

Sexually-active adolescents

Sexual intercourse took place within the context of a relationship. Males reported having initiated sexual intercourse by verbally or physically convincing the female to have sex, and many females described their sexual debut as pressured, coerced or forced; both males and females mentioned transactional sex. There was a high level of partner distrust in all of these relationships, but this did not translate into use of contraceptives either because contraceptives were expensive or not available, the respondent said the partner refused (many young men did not think they were capable causing a pregnancy) or the respondent did not know about contraceptives at that time. Boys said they did not think about HIV/AIDS; girls said they had thought about it but the sex they had had been unwanted so they had not been in a position to protect themselves.

Sources of Influence on Adolescents' Ability to Protect Their Own Sexual and Reproductive Health

Higher aspirations correlated with taking greater protective measures to avoid pregnancy and STIs.

What adolescents would do under pressure

In a hypothetical situation, most respondents felt confident that they could refuse sex if they did not want to have sex. Reasons given were being afraid of AIDS and, among males, that it is inappropriate for a girl to initiate sex. All adolescents were confident they could avoid drinking alcohol if they did not want to.

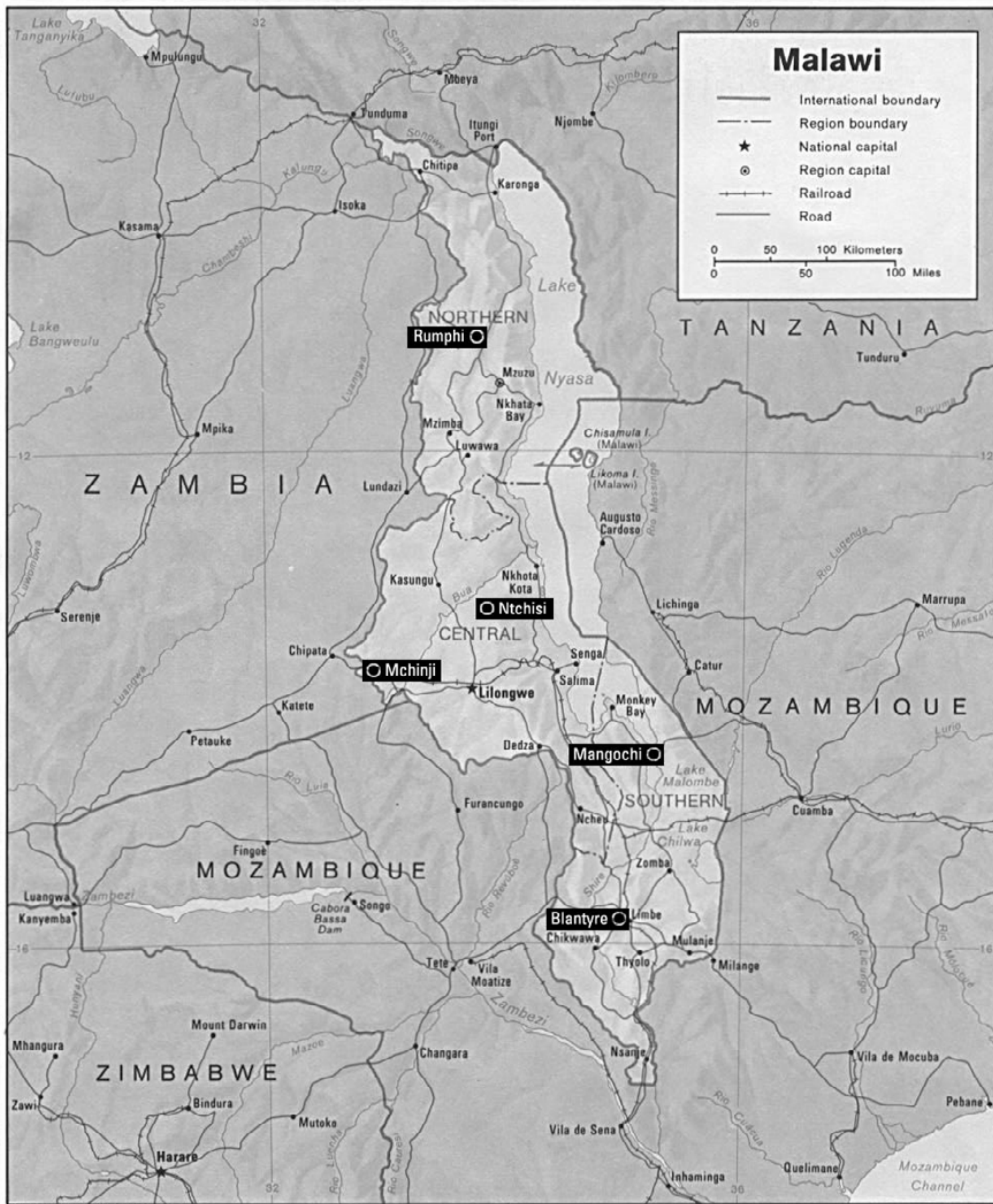
Initiation ceremonies and religious teachings

Some boys and girls were told to have sex during their initiation ceremonies yet it was more common to be told to abstain for sex. HIV was not discussed. Religious teachings encouraged abstinence and less commonly, condom use.

Policy and Program Implications

The lack of support from adults makes it difficult for youth to get information on sexual matters, to access contraception and to treat STIs. Dialogue between young people and adults to help adults accept that the onset of sexual behavior is a common and normal part of young people maturing into adults could lead to adolescents' improved ability to safeguard their sexual health. The most effective way to reach adolescents would be through their preferred channels: health workers and NGOs for information on HIV and parents and friends (e.g., through peer counselors) for information on nonmarital pregnancy. Myths about condom failure or ineffectiveness should be dispelled. Unequal power dynamics in adolescent relationships need to be challenged to improve girls' ability to advocate for themselves.

MAP OF MALAWI



Chapter 1

Introduction

HIV/AIDS is increasingly affecting youth worldwide: over 40% of new HIV infections occur among young people between the ages of 15 and 24.[1] Sub-Saharan African youth are particularly affected. Data from 2005 show that the median HIV prevalence rate in the region was 4.3% among young women (15–24 years old) and 1.5% among young men: prevalence rates well above those in all other regions of the world.[2]

When adolescents expose themselves to the risk of HIV, they are often placing themselves at risk of unintended pregnancy as well, a physical and social hardship that also has a much greater effect on the lives of young women than young men. Nonmarital pregnancy remains highly stigmatized in Sub-Saharan Africa, a fact that serves to isolate these young women and thereby increase the burden they experience as young, unwed mothers. Adolescent pregnancy often results in the young woman being forced out of school, and her chances of finding an eligible partner in the future become severely diminished.

Understanding the sexual and reproductive behaviors of young people—especially young women, who are particularly at risk—and the factors that protect or put them at risk of contracting HIV or other STIs or experiencing unplanned pregnancy is critical. Adolescence is a time when young people are beginning their sexual lives, and is therefore a logical entry point for influencing their sexual behavior. Youth aged 15–24 constitute one-fifth of the population of Sub-Saharan Africa and their state of health has significant implications for the future of individual countries and for the region as a whole.[3]

This report presents an in-depth analysis of adolescent sexual and reproductive health in five key districts in Malawi, with a focus on HIV, other STIs and unplanned pregnancy. The data were collected by the Centre for Social Research of the University of Malawi in conjunction with the Guttmacher Institute. It draws on 102 in-depth interviews conducted with young people of both sexes aged 12–19, who are both in and out of school, from urban and rural locations, and from at-risk groups (adolescents who work or live on the streets, work as petty traders or reside in orphanages). The main objectives of the study are:

- to learn about adolescents' experiences with and perceptions of HIV/AIDS;
- to better understand what adolescents' relationships with the opposite sex are like, including those where sexual intercourse has not occurred;
- to gauge how adolescents negotiate peer pressure to engage in risky or protective behaviors;
- to describe the different kinds of sexual and reproductive health problems that adolescents experience;
- to determine how prepared adolescents are to take appropriate action when they experience sexual or reproductive health problems;
- to depict the experiences and intentions of young people when they try to get help for a sexual or reproductive health problem; and
- to identify the important sources of influence, positive and negative, on adolescents' ability to protect their own sexual and reproductive health.

This report is part of a larger, five-year study of adolescent sexual and reproductive health 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 unplanned pregnancy; communicating new knowledge to a broader audience, including policymakers, health care providers and the media in each country, as well as regionally and internationally; and stimulating the development of improved policies and programs that serve young people.

In addition to the in-depth interviews analyzed on in this report, the larger study encompasses focus group discussions with 14–19-year-olds, in-depth interviews with key adults (teachers, parents and health workers) and a national survey of 12–19-year-old youth, all of which were conducted in each study country. A report comparing focus group data from all four study countries explores commonly held conceptions about sexual behavior and reproductive decision-making among adolescents.[4] Country-specific reports on the survey data are forthcoming, as are country-specific reports on the key adults. A comprehensive report on the four data sources for Malawi will be produced at the end of the project and the key findings from the comprehensive country-specific report will be included in a four-country comparative report. Due to the wealth of data that the in-depth interviews provide, they are analyzed here alone. Combined, these sources will provide a fuller understanding of how to best help youth to protect their health—information that can guide youth policy and programs.

The goal of the in-depth interviews was to examine the context and motivations that lie behind adolescents' behaviors—issues that do not fit well in a large scale quantitative survey that relies on close-ended questions. The findings contribute substantially to knowledge about adolescent sexual and reproductive health in three ways: First, evidence on adolescents' health-seeking behavior is scanty—we know very little about the sequence of steps that adolescents take in trying to get help for health problems, especially for problems such as STIs that are often stigmatized. Describing young people's attempts to seek health care (the kinds of sources, the sequence of steps, and supports and barriers faced along the way) facilitates a better understanding of health care utilization by this segment of the population and thereby better equips both clinic-based health providers and informal sector health providers (e.g., pharmacists and traditional healers) to meet the sexual and reproductive health needs of adolescents.

Second, much of what we know about adolescents' intimate relationships is limited to a few specific indicators. This study adds to existing knowledge by providing information about the range of experiences that adolescents have in romantic relationships, from their first interest in the opposite sex to life as a young, married person. By looking at relationships with the opposite sex—including those that did not involve sexual intercourse—these data elucidate relationship formation, relationship expectations and pressures that adolescents experience with respect to sexual intercourse. Emphasis is given to those aspects of intimate relationships that either expose adolescents to or protect or protect them from HIV, other STIs and unplanned pregnancy.

Finally, the in-depth interview methodology allows for detailed stories and often these stories include unanticipated links that help elucidate answers to the primary research questions. Young people's stories about their health problems and relationships provide details which allow for the surrounding circumstances of young people's lives to be more clearly described and understood. Ultimately, this improves our understanding of why some young people are at possible risk of HIV, other STIs or unplanned pregnancy while others are able to avoid those risks.

Chapter 2

Country Background

For the reader to have a better sense of the Malawian context, we present a very brief political and economic history of the country and discuss how the HIV epidemic as played out against that backdrop.

History, Population Growth and Economy

Located in southeastern Africa, Malawi is a small, land-locked country covering an area of 118,464 square kilometers. It shares boundary with Tanzania in the north; Mozambique in the east, south and southwest; and Zambia in the west. Malawi was a British colony from 1891 until it became independent in 1964. It became a republic in 1966 and thereafter adopted a one-party state. Dr. Hastings Banda, who was Malawi's first president, ruled Malawi for more than 30 years and during his reign, presidential directives formed the bulk of public policy. During his autocratic rule, anyone who opposed his rule was dealt with ruthlessly.

The Catholic Bishops published a pastoral letter in 1992 in which they called for introduction of multiparty politics and the rule of law. Pressure groups, notably the United Democratic Front (UDF) and Alliance for Democracy, opposed to the one party system were formed, opposition leaders were arrested, the university was closed and there were numerous labor unrests. Nonhumanitarian aid to Malawi was frozen as a way of forcing Dr. Banda's government to introduce a multiparty system of government. At the same time, there was severe drought and these factors negatively affected Malawi's economy. As a result of pressure, Dr. Banda called for a referendum in 1993, during which Malawians voted for the introduction of multiparty politics. The pressure groups transformed into political parties. The first elections were held in 1994 and the UDF under the leadership of Dr. Bakili Muluzi won the elections. Dr. Muluzi won his second and last term of office in 1999. In 2004, the UDF, under the leadership of Dr. Bingu wa Mutharika won the elections. A few months later, Dr. Mutharika resigned from the UDF to form the Democratic Progressive party, while retaining his current role as President. Today, Malawi is a multiparty state with over thirty registered parties.

The population of Malawi was 9.9 million in 1998 when the last census was conducted. As of now, Malawi's population is estimated at 12.9 million.[5] Between 1966 (when Malawi became a republic) and 1998, Malawi's population more than doubled. Youth aged 10–19 comprise 23% of the total population.[6]

Malawi is ranked as one of the poorest countries in the world. According to the National Statistical Office, 65.3% of the Malawi population lives below the poverty line. Over 90% of the population is rural and lives on an annual per capita gross domestic product of $600 (as of 2005).[7] More persons in rural areas (66.5%) live below the poverty line, compared with people in urban areas (54.9%).[8] Corruption, limited access to land, low educational attainment, poor health status (which has been exacerbated by HIV/AIDS), limited manufacturing and lack of access to credit have been identified as the major causes of poverty in Malawi.[9] Since colonial rule, agriculture has been and will remain the backbone of Malawi's economy and is the major source of income for both the country and individual citizens, accounting for 63.7% of total income of the rural poor.[10] Between 1970 and 1979 the agricultural sector contributed 39.6% of the real gross national product and contributed 40.6% of formal employment. The share of the agricultural sector in formal employment has been increasing and it reached 51.2% for 1995–2001, thus demonstrating the importance of agriculture in Malawi's economy. While the current government of President Bingu wa Mutharika is working to combat corruption and improve educational levels by offering free universal primary education, the country has a long way to go before it will be able to guarantee a minimum standard of living for all its citizens.

HIV/AIDS in Malawi

The first case of AIDS was diagnosed in Malawi at Kamuzu Central Hospital in Lilongwe in 1985.[11] Epidemiological data have documented the increase in the number of cases of AIDS through, among other indicators, the prevalence of HIV among pregnant women attending antenatal clinics. The first HIV prevalence measures among pregnant women attending antenatal clinics at Queen Elizabeth Central Hospital in Blantyre found a prevalence of 2.6% in the late 1980s and this rose to an estimated 35% by 1998.[12] The prevalence of HIV among 15–49-year-olds in 1998 was estimated at 14%. Prevalence was higher in urban areas at 26%, compared with 12% in rural areas. HIV prevalence rose to a high of 16.4% by 1999, but has been declining since then.[13, 14] In 2001, the national prevalence of HIV among those aged 15–49 was 15%.[15] In 2005, the estimated HIV/AIDS prevalence was 14.1%, which translated into an estimated 840,000 15–49-year-olds and 91,000 children (0–14 years of age) living with HIV/AIDS.[16] Figure 1 shows the trends in HIV prevalence among 15–49-year-olds. This figure shows that HIV prevalence reached its peak in 1999, then declined and remained fairly stabile since 2000. The 2004 Demographic and Health Survey shows that the prevalence of HIV in Malawi among those aged 15-–49 is at 11.7%.[17]

Tuberculosis has long been a problem, and the advent of the HIV/AIDS epidemic has fuelled the tuberculosis epidemic in Malawi. The National Tuberculosis Control Programme reports that, in 1985, the number of registered cases of tuberculosis was 5,335. This increased to 24,396 cases by 1999.[18] A countrywide survey in 2000 of tuberculosis patients found an HIV prevalence rate of 77% and in 2004, the number of reported tuberculosis cases reached 27,000.[19]

In Malawi, as in other countries in Sub-Saharan Africa, HIV is mainly transmitted through heterosexual intercourse. Ninety percent of HIV transmission in Malawi is via heterosexual contact.[20] Other routes of transmission include mother-to-child-transmission and blood transfusions. HIV transmission through blood transfusions is minimal, as all blood is tested for HIV before transfusion. Intravenous drugs and homosexual intercourse, both illegal, also exist in Malawi, but their magnitude is unknown. Studies done on HIV prevalence among commercial sex workers are rare in Malawi. One study done in 1994 in Lilongwe District found that over 70% of commercial sex workers were HIV-positive.[21]

HIV/AIDS and Unplanned Pregnancy Among Young People in Malawi

According to the 1998 census conducted by the National Statistical Office, young people aged 15–24 years constitute 23% of Malawi's population. An estimated 9.5% of young women and 3.4% of young men 15–24 years of age are infected with HIV.[22] According to the National AIDS Commission, fewer than 2% of all children in the 0–14 age-group are infected with HIV; a reflection of low levels of sexual activity in this age-group.[23] Fifteen percent of 15–24-year-old pregnant females in Blantyre had HIV in 2001.[24]

Experiencing other types of STIs can increase the risk of HIV infection. The 2004 Demographic and Health Survey found that 7.7% of women aged 15–19 and 8.6% of men aged 15–19 reported having an STI or STI symptom during the 12 months prior to the survey.[25] Yet these self-reports are most likely underestimates, as people are often unwilling to reveal they had an STI or are unaware of having one.

In addition to STI infection, adolescents are also at risk of having unintended pregnancies. Out-of-wedlock and nonmarital childbearing are greatly disapproved of by Malawian society. Yet in spite of this disapproval, teenage pregnancy and child bearing are common in Malawi. In 1992, 34.7% of females aged 15–19 were either pregnant or mothers[26] while in 2000, 25% had ever had a child and 10% were pregnant at the time of the survey. Initiation of sex at an early age, poverty, lack of understanding of sexual and reproductive health issues and nonuse of family planning are some of the factors that result in teenage pregnancies.[27] Abortion is sometimes condoned when the pregnant girl is deemed too young to give birth, or when a married woman gets pregnant too soon after giving birth, yet it is illegal.[28] Approximately 68% of the admissions in a gynecological ward at Queen Elizabeth Central Hospital in Blantyre in 1997 were due to abortion-related complications and 21% of these patients were aged 10–24 years.[29]

There are a number of policies, for example the National Youth Policy, the National Population Policy, Reproductive Health Policy and National AIDS Policy, that guide the design and implementation of adolescent sexual and reproductive health programs. HIV/AIDS and life skills education[30,31]; the "Why Wait?" Educational Programme[32]; and the "Edzo Toto" ("Stop AIDS") clubs[33] are some of the major activities and programs that have been initiated in Malawi to equip adolescents with appropriate skills and knowledge on how to deal with key challenges facing them.

Yet one of the weaknesses of these programs is that they are largely targeted at in-school adolescents. These and other "information-education-communication" campaigns (for example Youth Alert Mix and the Straight Talk programs on Malawi's national radio station) that have been conducted in Malawi since the late 1980s can take at least partial credit for the fact that HIV/AIDS knowledge among adolescents is almost universal.[34]

Special Groups of At-Risk Adolescents

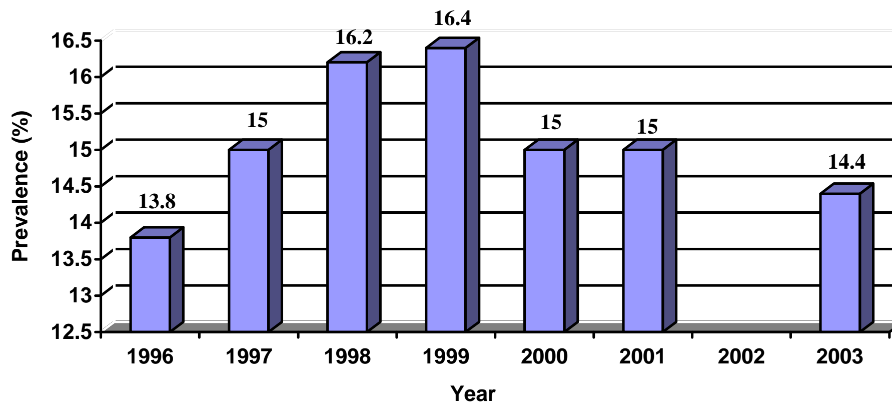
There are some special groups of adolescents in Malawi who are at higher risk than others of contracting HIV and other STIs. These adolescents include orphans, street children, commercial sex workers, girl children, adolescent mothers, children with disabilities and illegal immigrants. Yet not many HIV/AIDS studies have focused on these groups. In Malawi, some studies have, however, been done on street children and orphans.

The number of children on the street has been rising in the Malawian cities of Blantyre, Lilongwe and Mzuzu and more recently in the municipality of Zomba. A study done in 1987 identified a number of factors that lead children to street life; among them are poverty, disability, lack of parental control, family conflicts and witchcraft.[35] Witchcraft can cause homelessness either because children are accused of witchcraft and are chased away from home or parents are accused of witchcraft and their homes are destroyed. Alternatively, children themselves can be bewitched and can wander on the streets and not return home. A later study by the United Nations Children's Fund acknowledged the problems street children face in the main cities of Lilongwe, Blantyre and Mzuzu, including health problems such as malaria, scabies and abdominal pains. The report further identified child sexual abuse as one of the major problems that children on the streets experience.[36] One recent qualitative study found that girls aged 13–18 who live on the streets of Blantyre, Lilongwe and Mzuzu are in search of men who exchange sex for money, while others are employed as bargirls without pay since they get paid by sex clients.[37] These studies point to some of the vulnerabilities youths face while living on the street.

The 1998 national population and housing census revealed that there were 567,526 orphans younger than 20 and 15% of these had lost both parents.[38] Currently, it is estimated that there are just over one million orphans and half of these are due to the HIV/AIDS-related deaths of parents.[39] While overall, national HIV prevalence appears to have stabilized in the country in recent years, an increase in the number of orphans has continued because of the deaths of adults due to HIV/AIDS. The number is expected to increase to 1,150,000 by 2010, with the majority of the orphans being in the 10–18 year age-group.

Caring for orphans and other vulnerable children is a major crisis, as the traditional extended family system is having a hard time coping with the increase in orphans. As a consequence, there are increasing numbers of child-headed households and cases of child labour.[40] It is estimated that in 1998, 0.6% of the households were headed by individuals younger than 20 years of age.[41] Studies have shown that, in general, the death of parents deprives children not only of parental love, but of other basic needs, such as clothing, food, shelter and health care.[42] Since orphans face many problems, female orphans especially may adopt risky sexual behaviors or marry early, even though this puts them at increased risk of contracting HIV.[43]

Chart 2.1 Prevalence of HIV among 15–49-year-olds, 1996–2003



Sources: UNAIDS Secretariat, National AIDS Secretariat and UN Theme Group on HIV/AIDS, *The HIV/AIDS Epidemic in Malawi: The Situation and the Response*, Lilongwe, Malawi: UNAIDS Secretariat, no date; Tsoka MG et al., *Millennium Development Goals: Malawi 2002 Report,* Lilongwe, Malawi: Ministry of Economic Planning and Development, 2002; National AIDS Commission, *National HIV prevalence estimates report*. Lilongwe: Government of Malawi, 2001; and National AIDS Commission, *National HIV/AIDS Policy*, Lilongwe, Malawi: National AIDS Commission, 2003.

Chapter 3

Methodology

The data upon which this report is based were collected using semistructured in-depth interviews (IDIs) conducted in 2003 with adolescents aged 12–19 years. This methodology allowed ideas to emerge that may not have been accurately captured on close-ended questions. It also allowed for the construction of a fuller picture of adolescents' sexual environments. The results presented in this report should not be taken to be representative of the views of adolescents in Malawi, or even the areas that were visited. Furthermore, because the country is largely rural but the sample is evenly divided between rural and urban respondents, the responses overrepresent urban voices. The aim was actually not to have data that can be considered representative but that rather data that uncovered the practices, beliefs and attitudes of adolescents relating to sexual and reproductive health. The magnitude of these beliefs and practices are given in a forthcoming survey report.[44]

Research Team and Training

A pretest of the IDI guidelines was carried out by the research team in August 2003 in Zomba. The major problem encountered in the pretest was that it was difficult to find children aged 12–14 years who were not going to school at the time. Otherwise, no modifications were made to the in-depth guide after the field test. A research team was selected consisting of three males and three females. Their ages ranged from 17–25 years. Five were college graduates and one had a Malawi School Certificate of Education. All the research assistants had experience in conducting in-depth interviews. The interviewer training was held in September 2003 for one week. The training began with an overview of the *Protecting the Next Generation* project so the research assistants could understand how the IDIs fit into the overall research project. The activities included IDI selection criteria, the importance of getting consent, probing and role-playing.

Screening and Selection

Participants in the IDIs were selected based on the following characteristics:

- Age (12–14, 15–17 or 18–19 years of age)
- Place of residence (urban or rural)
- Schooling status (in or out of school)
- Gender (male or female)
- Parity (with or without a child)

A total of 102 interviews were conducted, 51 in Blantyre, an urban center, and 51 in four rural districts: Rumphi in the Northern Region (n=11), Ntchisi (n=14) and Mchinji (n=13) in the Central Region and Mangochi (n=13) in the Southern Region. Fifteen of the interviews (split between urban and rural areas), were conducted with special groups of adolescents (most of them out of school) considered to be at higher-than-average risk of HIV and unplanned pregnancy: adolescents who worked or lived on the streets, worked as petty traders or were residing in orphanages.

Data Collection

The major criterion for choosing these rural districts was to capture Malawi's main ethnic groups, (Chewa, Yao and Tumbuka) and compare them to urban Blantyre. The major ethnic group found in Rumphi are the Tumbuka, while the Yao and Chewa are found in Mangochi and Ntchisi, respectively. In Ntchisi, Rumphi, Mangochi and Mchinji, the IDIs were done in one traditional authority (an area that is controlled by a chief): Chikulamayembe in Rumphi, Nthondo in Ntchisi, Nkanda in Mchinji and Jalasi in Mangochi. In Blantyre, four residential areas were visited: Zingwangwa, Ndirande, Chilomoni and Bangwe.

Letters of introduction, signed by the director of the Centre for Social Research, were written to the chief executives or district commissioners of the selected districts with copies to district police officers and were carried by the research team. These letters were pre-

sented on the first day of the team's arrival in each district. In each enumeration area, permission was sought from the chiefs, village headmen or other appropriate representatives in urban Blantyre, while in the rural districts permission was sought from the traditional authority and village headmen.

The research team was familiar with the urban enumeration areas, so each interviewer travelled to a different area. In each area, the interviewer visited every sixth household and administered a screening form to determine whether there were eligible respondents in that household. Interviewers, the supervisor and the principle investigator met later to select respondents and return to their households to gain consent and carry out the interviews. For the rural district interviews, a social mapping approach was used for participant identification. Young men and women in each village assisted the field team to identify eligible respondents and the location of their households in the village. Respondents who were identified were purposively selected and interviewed. In each age and sex category, there were a specified number of respondents that were supposed to be interviewed.

In both rural and urban research sites, parents were asked to consent to the interview if the respondent was younger than 18 years of age. If the parent consented, further consent was sought from the adolescent. The interview took place only if consent was obtained from both. In almost all the cases for adolescents younger than 18, consent was obtained from parents. In addition to the household-based IDIs, 15 IDIs were carried out with orphans, petty traders and street children in the selected urban and rural areas. Consent to interview orphans in orphanages was obtained from the caretakers. For petty traders who worked close to their homes, consent was obtained from their parents or guardians. Some petty traders refused to leave the goods they were selling just to go back to their parents to get consent, and these respondents signed their own consent forms. For street children, it was difficult to get consent from their parents, hence in most cases, they gave sole consent.

The IDIs were conducted in September and October 2003 (see Appendix A). The interviews lasted between 45 and 120 minutes. Interviews with younger adolescents, especially those aged 12–14 years and those with no sexual experience lasted about 45 to 50 minutes. Table 1 shows number of interviews done according to category of interviewees.

Most interviews were conducted with same-sex interviewers. One-fifth of the interviews were conducted by members of the opposite sex because of language constraints (e.g., no female interviewers were available who spoke the language of the potential female respondent) or logistic constraints (e.g., the other female interviewers were busy and an interview with a female had to take place immediately). Reports from the fieldworkers indicated that interviews with respondents of the opposite sex went relatively well and did not substantially affect the adolescents' willingness to talk. The interviews were conducted in Chichewa, Yao and Tumbuka and then transcribed in the field in the same language. Immediately after each interview, a short report in English was written describing the interview setting and overall interaction with the respondent. The interviews were then translated into English by the interviewers themselves after being read and certified by the supervisor and the principle investigators.

Analysis approach

A coding scheme using 90 codes grouped into seven categories was developed to understand the main themes discussed: puberty, sexual relations, healthcare seeking, aspirations, perceptions of risks and social influences on young people. The 102 transcripts were coded by two of the co-authors using *QSR N6* (version 6) qualitative software. Each author was responsible for conducting analysis for a specific chapter. Text searches on relevant codes were read and each author prepared matrices of the substantive points by gender of the study participants. Each interview was treated as a unit of analysis and recorded in the relevant topical matrix. Summary text was then written based on common themes arising from the matrices. At least one other author read the summary text and compared it with the matrix of themes to ensure that one researcher's subjective biases did not determine the conclusions drawn.

As with all qualitative data, the views described and discussed in this report reflect those of the young people who participated in the interviews in Malawi. The IDIs were designed to capture the attitudes and experiences of males and females, young people in urban and rural areas, and young people in- and out-of-school in the areas where the IDIs were conducted. However, the findings reported here may not necessarily represent the views held by young people in general in Malawi or even of all young people in the communities where fieldwork was conducted.

Challenges During Data Collection

The research team encountered several challenges during the IDI fieldwork. The team attempted to visit every sixth house in the urban areas but could not find enough cases of out-of-school, 12–14-year-old adolescents with this method. The research team also had trouble locating enough male adolescents with children, either married or unmarried. As a result, the team informally asked members of the community if they knew adolescents with these characteristics. The research team was also not able to get consent from some parents in urban areas during screening activities because of parents' work schedules, and so the team had to make extra trips in the evenings to obtain consent. Another challenge was how to respond to some community members who asked how they specifically would benefit from participating in the study.

Study limitations

A key limitation of this study is the nature of the interview guidelines. In hindsight, the guidelines were lengthy and many of the questions encouraged short responses. As a consequence, the interviews tended to be abrupt in style and interviewers did not often ask questions apart from those on the guidelines. Opportunities were often missed to delve further into experiences adolescents mentioned, which can yield rich and detailed life stories, simply because there so many questions in the guidelines to ask. Interview guidelines with less direct questions and fewer questions in total, along with support for interviewers to follow-up on the personal experiences adolescents share, would have led to more nuanced data and a better understanding of adolescents' lives.

A second limitation is that the same set of questions was asked of all adolescents, regardless of their life situations and, as described above, there was little room for departing from the script. For adolescents in challenging circumstances, where one might suspect that risks of HIV and unintended pregnancy are especially high (such as in adolescents who live or work in the streets), the interview questions did little to draw out aspects of their lives (such as physical abuse) that might relate to this heightened risk.

Table 3.1. Descriptive statistics of the sample

	In-school adolescents	Out-of-school adolescents
Urban (Blantyre)		
Age		
12–14 years	9	10
15–17 years	8	4
18–19 years	7	13
Sex		
Female	15	13
Male	9	14
Marital status		
Unmarried	24	24
Married	0	3
Parity		
No children	22	23
Has children	2	4
Special group		
Petty trader	0	1
Street youth	0	3
Orphan	2	0
Rural		
District		
Mchinji	6	7
Mangochi	4	9
Ntchisi	6	8
Rumphi	6	5
Age		
12–14 years	9	8
15–17 years	5	12
18–19 years	8	9
Sex		
Female	11	15
Male	11	14
Marital status		
Not married	22	25
Married	0	4
Parity		
No children	22	23
Has children	0	6
Special group		
Petty trader	1	2
Street youth	0	3
Orphan	3	0
TOTAL	**51**	**51**

Chapter 4

Adolescents' Experiences and Perceptions of Puberty

Adolescents' knowledge about and preparedness to experience pubertal changes are one indication of the sexual and reproductive health information that young people are receiving. It is also an indirect measure of the sexual environment in which adolescents are coming of age and, in this context, relates to the resources and messages adolescents are accessing at the time in their lives when they are becoming sexually active. Understanding adolescent's sexual decision-making should be premised on the information with which they are working regarding sexual function and behavior.

This section explores the kinds of pubertal body changes adolescents are aware of, how they felt about or reacted to the changes that had happened to them, and their sources of information about these changes. Body changes mean pubic hair, menstruation and breasts for girls; and pubic hair, chest and facial hair, voice changes and having "wet dreams" for boys. A significant proportion of the respondents were knowledgeable about the body changes that happen to boys and girls during puberty: the growth of beards and pubic hair in males and the growth of breasts, the initiation of menstruation and the growth of pubic hair among females were mentioned more frequently than other body changes. The majority of the respondents had already experienced body changes at the time of the interview. Adolescents were more knowledgeable about body changes that occur in their sex than those occurring in the opposite sex. The majority, however, seemed not to be prepared for these body changes.

Body Changes in Males, According to Males

When asked about body changes in males, more than half of the male respondents mentioned the growth of beards and pubic hair, and nearly half of the respondents mentioned development of a deep voice and having wet dreams and/or producing semen. A minority of males mentioned the growth of armpit hair and developing an interest in girls. The development of pimples and the growth in size of genitalia were mentioned even less frequently. In some cases, adolescents were unable to properly describe the changes they were experiencing and sometimes even failed to attach a name to the changes; for example, one male adolescent called ejaculate "bostic [glue-like]" or "sticky things." Growth of beards, development of deep voices and growth of pubic hair were the most commonly known changes.

Body Changes in Females, According to Females

The most frequently named pubertal body change among girls was the growth of breasts. Fewer mentioned the onset of the menstrual cycle and the growth of pubic hair. A minority identified the growth of armpit hair and far fewer mentioned the softening of girls' voices, an interest in boys and growth of pimples. The growth of breast and the onset of menstruation were the most commonly mentioned changes.

Knowledge About Body Changes in the Opposite Sex

In addition to asking respondents about the body changes that occur in their own sex, interviewees were also asked about the body changes that occur in the opposite sex. The majority of males identified the development of breasts, while one in three mentioned menstruation. Half of the female respondents mentioned the development of deep voices and fewer than a third mentioned the growth of beards and public hair in males. Adolescents appear to be more knowledgeable (or more willing to talk) about the body changes that happen to their sex than the body changes that happen in the opposite sex. As one in-school, 16-year-old boy from Rumphi explained:

> *Interviewer: What changes take place in a girl's body when growing up?*
> *Respondent: When a girl is growing up what changes are the breasts.*
> *I: What else changes?*
> *R: There is not much that I know because I am a boy.*

It was more common for adolescents to mention body changes that are conspicuous; for example, male respondents mostly mentioned the development of breasts in females while females mentioned the development of deep voices and beards in males. Very few female respondents mentioned that boys have wet dreams when they reach puberty. Older females were more likely than younger females to mention the onset of wet dreams or sperm production.

Sources of Information About Body Changes

There are a number of people that adolescents had discussions with about pubertal body changes, including teachers, parents, uncles, aunts, friends, grandparents, siblings, counsellors and elderly relatives. Older sisters were a much more important source of information for females than older brothers were for males. More females than males mentioned that they discussed body changes with their grandparents and among females who mentioned grandparents, more were from rural areas. Very few respondents mentioned that they got the information from parents, and in most cases where this happened, it was mothers talking to their daughters. One female discussed body changes with her father. This respondent explained that her menstruation began when her mother and sisters were away and she thought that the blood flow was some form of sickness. Her father informed her that it was normal for girls to experience the blood flow and told her to buy cotton and advised her how to use it.

Regarding knowledge imparted by friends, one male 12-year-old out of school street kid from Blantyre explained how learning from friends commonly happened:

> *I: How did you come to know that a boy, when he is growing up, grows pubic hair?*
> *R: I have just known that.*
> *I: Who told you?*
> *R: One of the boys with whom I stay with has pubic hair and he shows me. He shows me when we are bathing.*

While school was mentioned by only a small proportion of respondents, more males (most of whom were aged 15 years or older and in school) than females named school as a source of information on body changes. Adolescents who reported having received information in school reported that teachers taught about body changes in science, social studies and health classes in primary school and in biology classes in secondary school. A few respondents learned about body changes through seeing older people bathing or reading books in the library. Only two respondents (one male and one female) said that they got information on body changes during initiation ceremonies. The radio and health facilities were not mentioned as sources of information on body changes.

One in three females and one in seven males reported that no one had ever talked to them about body changes that happen when a young person becomes an adult. Of the females who did not receive any information, half were from rural areas and the other half were from Blantyre; all of the males who did not receive any information were from Blantyre. In-school adolescents were just as likely not to have been spoken to as were out of school adolescents. In rural Malawi, relatives such as uncles, aunts and other elderly people play an important role in advising adolescents on sexual and reproductive health issues, and provide a network which may not be available to urban adolescents.

Content of Discussions on Body Changes

Adolescents who mentioned that they discussed body changes with other people were further asked about the content of these discussions. Two major issues that males reported discussing with other people were growing pubic hair and having wet dreams. A minority of the male respondents said that people discussed with them that they should propose (meaning asking somebody to be your girlfriend), have sex or develop an interest in girls, especially after experiencing wet dreams.

Young women talked to their mothers, sisters, counsellors and other elderly women after experiencing their first menstruation. They were told at the time that there was nothing strange about the onset of menstruation, as it was a sign of maturity that every woman experiences. Female respondents stated that during the discussions on menstruation, they were mainly advised on how to take care of themselves during menstruation. This care centered on the use of a piece of cloth or cotton to protect one's clothes from being soiled and the management of that cloth. An in-school, 18-year-old female adolescent in Blantyre explained:

> *I: What did she say you should do when [menstruation] happens again?*
> *R: She said if that happens again, I should take a piece of cloth and insert it here. If I want to remove it, I should wash it.*
> *I: And display it on a clothes line?*
> *R: No. [Laughs] Put it in a hidden place in my*

bedroom, maybe under the bed so that a child or boys should not see it.
I: Do you think that that was good advice?
R: Yes, it was good advice.
I: How was it good?
R: Because some people might get the cloth and use it for magical purposes. In that case one might die.

A number of girls and boys said that they were advised that during menstrual periods, no sex should take place because this can cause a man to suffer from abdominal complications that can lead to his death. Several adolescent girls also mentioned that during menstruation they were also forbidden to put salt in relish[45] because this can cause people who will eat the relish to fall sick. One in five girls said that they were told that they should not engage in sex with boys because they could become pregnant.

Reactions to Body Changes

Among females, the most common reactions to body changes, including menstruation, especially among those in rural areas, was surprise, puzzlement, wonderment and in some cases, fear of what was happening to them as nobody had told them what they could expect to experience. The respondents who expressed this sentiment related how they sought out other females for advice to address their concerns. Very few males, all from the rural districts, expressed similar sentiments about experiencing body changes. Among some males, the onset of body changes was the cause of unhappiness or dissatisfaction. An in-school, 14-year-old boy from Mchinji said that when his pubic hair started growing he reacted by shaving it; an urban, in-school, 18-year-old boy said that he felt restless after experiencing his first wet dream. A few adolescents misunderstood their body changes: One male respondent interpreted wet dreams as wetting one's bed and some females thought menstruation was a result of being injured, while another respondent thought she was suffering from bilharzia.

Other adolescents were happy to see body changes and said that they felt good about these changes. An in-school, 14 year old boy from Mchinji said that the growth of pubic hair afforded young boys an opportunity to chat with older boys, whereas before experiencing the changes they were castigated by older boys as being children not worth chatting with. Some female respondents said that they were happy when they grew breasts because they knew that they were growing up and they had envied friends with breasts who wore bras.

Chapter 5

Adolescents' Perceptions About HIV/AIDs and Other STIs

Locating HIV/AIDS in relation to the other problems/threats adolescents are facing helps us to understand adolescents' responses to HIV including whether and how they choose to take protective measures to avoid contracting the virus. This section explores what adolescents perceive to be the most critical problems that they face in their lives; how critical these problems are compared with HIV/AIDS; what sexual behaviors they think are risky and not risky; their perceptions of people with HIV/AIDS and whether they know people with AIDS; and actual and preferred sources of information on HIV/AIDS, including barriers to accessing information.

Adolescents' Most Critical Problem

The overriding problem named by adolescents, especially males, was poverty. Poverty resulted in a lack of basic necessities, such as food, clothes, school fees, shoes and school materials. Other problems less commonly named were illness and, for females, being harassed by males proposing to them. A few adolescents, primarily females, said they did not have any problems at all. In most cases, HIV/AIDS was only mentioned after probing.

The majority of the respondents said that the problems they cited were not comparable to HIV/AIDS. Most said that HIV/AIDS is a much bigger problem, since there are solutions for other problems they face while the illness has no cure. As an out-of-school, 15-year-old male who works as a petty trader in Blantyre related:

> *If I don't sell anything, I would not have something to eat on that day, but once you contract AIDS, it is final. You fail to do any tasks, you become weak, your hands are shaky. As such, it is better not to sell your wares but have a healthy body that would let you overcome any problems that you face in your life.*

In addition to HIV/AIDS being incurable, other reasons given for why HIV/AIDS is a major problem included that it creates many orphans, that critically ill HIV-positive people are unable to work, and that there is stigma and discrimination against those who have AIDS.

A few out-of-school adolescents, street kids and petty traders said that HIV/AIDS is not as critical as their problems because they needed immediate and urgent solutions to the problems they were facing, including a lack of food, clothes and employment. An out-of-school, 18-year-old male orphan in Mchinji explained:

> *R: All human beings need to eat to survive and when there is a shortage of food you cannot find the strength to be moving about to work for you to get the next meal.*
> *I: Why have you put the problem of AIDS in second position?*
> *R: Because firstly you need to have food.*

Risky and Non-risky Sexual Behaviors

Adolescents are aware of risky and non-risky sexual behaviors even though misperceptions still prevail.

Risky sexual behaviors

The majority of adolescents recognized at least one of the common risk behaviors that can lead to HIV and unintended pregnancy. A majority of the females and a minority of males said that engaging in sexual intercourse with multiple partners is risky because one cannot know the sexual behavior of one's partners; slightly fewer of the males and females said that engaging in sex itself is risky[46]; and a minority of the males and females said that having sex without condoms is risky. Other risk behaviors included buying each other gifts, kissing, drinking alcohol, having sex before marriage and having sex with prostitutes. Only a few adolescents, all of whom were aged 12 or 13 years, could not

name any risky behavior.

Some older adolescents, both males and females, said that condoms do not protect one from having risky sex because come with small holes that allow HIV to pass through, that condoms are not safe because people can deliberately make holes in them, that condoms can burst during sexual intercourse and that a lack of knowledge about how to put on a condom can put one at risk. One of the male respondents said that, in some cases, people put on two or more condoms because of the possibility of the condom bursting.

Non-risky sexual behavior

A minority of the respondents said that having sex with a condom is not risky, and fewer mentioned abstaining from sexual intercourse or just chatting with one's partner as not risky. Other non-risky sexual behaviors mentioned by a few respondents included having an HIV test before engaging in sexual intercourse, having one sexual partner and being faithful to that partner, buying each other gifts, being in a social group or club with one's partner, masturbating, remaining single, kissing and having a "non-dangerous partner."

Perceptions About People with HIV and AIDS

This section explores perceptions of adolescents about HIV/AIDS, particularly whether they can recognize someone with AIDS just by looking at her/him, whether they know someone who had AIDS and what they think about someone with AIDS.

Recognizing and knowing someone with AIDS

As it is rare for individuals in Malawi, especially in rural areas, to have had an AIDS test, other researchers have found most of the diagnoses take place through indirect means.[47] Consistent with those results, very few respondents reported that someone's HIV diagnosis was the result of their having gone for a test and either disclosing the results or someone else (relatives, doctors, etc.) disclosed the diagnosis. A large minority of adolescents said that they can recognize someone who has AIDS by just looking at her/him. The fact that individuals can have HIV/AIDS and not have any of the outwardly visible signs of the disease was not acknowledged by these respondents. The most commonly mentioned signs and symptoms of a person suffering from AIDS included weight loss; their hair turning white, curly and eventually falling out; the presence of shingles; and their falling ill easily. Some respondents did say that it is difficult to know that someone has AIDS without an HIV test.

The majority of the male respondents and a minority of the female respondents said they know or knew someone who has or had AIDS. Knowledge that a certain person had AIDS was established mainly through observation of perceived signs and symptoms. An out-of-school, 13-year-old male petty trader from Rumphi offered:

> *I: Do you personally know someone who has AIDS?*
> *R: I know one girl but she is not my age-mate.*
> *I: When did she contract AIDS and how did you come to know that she has got AIDS?*
> *R: I tend to compare how she was before and how she is looking nowadays and from that I see that she has lost too much body weight as she is thin now.*
> *I: Are you trying to say that she used to be fat?*
> *R: She was really fat and nice but now her body is wasted and she is too thin.*

What adolescents think about someone with HIV/AIDS

When respondents were asked what they thought of people with AIDS, the most common answer was that they felt sorry for them. An in-school, 19-year-old female from Mchinji explained:

> *I: What do you think about people who have AIDS?*
> *R: I cannot say that all people that have AIDS are stupid because some are innocent. It's unfortunate that they are infected by their partners and this makes me feel very sad.*

Respondents said they felt sorry for HIV-positive individuals because they are discriminated against, they are thin, they suffer for a long time, there is no hope and they could die anytime as the disease has no cure. A number of studies in Malawi found that community members questioned the rationale of going for an HIV test and getting the results if they were not going to have access to antiretroviral therapy, which was very expensive before 2005.[48] The introduction of free antiretroviral therapy in 2005 has offered new hope for people living with HIV in Malawi yet it will take a while for this access to influence peoples' perceptions of the disease condition.

Other responses included that people with AIDS should not be discriminated against and that they need care and support from their family, the community and

the government in order to live long. Some said that they chat with people with HIV/AIDS as a demonstration that they do not discriminate against them. Others believed that those who contracted AIDS very much enjoy having sexual intercourse, and some considered it important to pray for people with HIV (because prayer may chase away the virus and allow them to recover or because prayer is necessary to show these people love). Some respondents said they were afraid of people with AIDS. Some youths said that people living with AIDS should not have sex any longer and that AIDS is a shameful disease and a punishment from God.

Actual and Preferred Sources of Information on HIV/AIDS

Schools are an important source of information on HIV/AIDS. Most respondents would prefer getting this information from health workers and nongovernmental organizations (NGOs). Very few adolescents prefer getting information about HIV/AIDS from parents.

Who has talked to adolescents about HIV/AIDS

Schools were mentioned by the majority of the respondents as important sources of information on HIV/AIDS, not only from teachers but from guest speakers as well. Many respondents mentioned a wide range of nongovernmental organizations that visited schools and talked to pupils about AIDS. These included the National Initiative for Civic Education, Public Affairs Committee, Girls Attainment in Basic Literacy and Education, Malawi AIDS and Counselling Resource Organisation, Red Cross, World Vision, National Association of People Living with HIV/AIDS in Malawi, Population Services International, Youth Alert, students from the University of Malawi and representatives from the Ministry of Health. A few respondents said clubs at school, such as AIDS TOTO, were an important source of information. TOTO clubs are clubs for in-school and out-of-school youth and they are designed to help members develop improved skills in critical thinking and communication. Only a few respondents of both sexes said that friends or peers had talked to them about AIDS.

Other sources of information on AIDS mentioned by fewer respondents included the Ministry of Health, religious institutions and parents. The question on sources of information emphasized whether anyone had ever talked to adolescents about HIV and AIDS. This may explain why the radio, which the Demographic and Health Surveys and other national surveys have cited as the most common source of information on HIV/AIDS, was not mentioned.

A minority of the respondents, with a larger proportion being male and most of them 12–14 years old and/or out of school, said no one had spoken to them about AIDS. Most of these respondents said that they heard about AIDS on the radio (a response more commonly given in urban than rural areas). Other ways adolescents reported having learned about HIV/AIDS were by reading leaflets and posters and by overhearing other people talking about it. An out-of-school, 15-year-old male street child from Mangochi related:

> *I: Where then did you get information concerning AIDS?*
> *R: I heard it being discussed at the marketplace where I sold fish.*
> *I: What was said about it?*
> *R: That is, when having sex we should be using condoms to avoid transmitting AIDS.*

What was discussed and its usefulness

Discussions about HIV/AIDS mainly emphasized how a person contracts AIDS, how to prevent AIDS and that AIDS is a deadly disease. Issues of care and compassion and voluntary counseling and testing were mentioned by very few respondents.

Some of the information reported to have been given to respondents was factually wrong. Friends were described in some instances as having given false information. An out-of-school, 14-year-old male from Mchinji shared:

> *I: What did you discuss?*
> *R: He said HIV/AIDS destroys the body and the virus goes into the finger nails.*
> *I: Does it go like jigger fleas?*
> *R: No.*
> *I: How does it get into the finger nails?*
> *R: When it enters the human body it moves in the skin until it reaches finger nails.*
> *I: Then what happens?*
> *R: What happens is that fingers become longer.*

One of the most common inaccuracies passed along to adolescents was that condoms can frequently have holes. An in-school, 13 year old female in Blantyre said:

> *I: Was there anything mentioned about condoms in the talks [by teachers]?*
> *R: Yes.*

I: What was said about condoms?
R: They said that people will persuade you to have sex with them saying they are going to use condoms but condoms do not provide 100% protection because they are prone to bursting and sometimes they have pores hence they cannot be trusted.

The majority of adolescents who talked about the usefulness of discussions on HIV/AIDS said that the discussions were very useful because they were now knowledgeable and would use or are using the information in order to protect themselves from contracting HIV.

What adolescents would want to know about AIDS
Only a few adolescents said that they did not need any more information on HIV/AIDS, as they had had enough. There were some males who wanted to know about transmission and prevention of HIV/AIDS and other STIs. A few wanted to know about the origin of the disease itself, especially how the disease started, how it came to Malawi and who was the first person to have AIDS. Similar issues were raised by females but they also wanted to know how one knows s/he has the virus, where one can go for an HIV test, how razor blades and toothbrushes can transmit HIV, the time the disease takes from the time of infection to develop into full-blown AIDS and whether sharing a stone (used during bathing) with someone who has AIDS can lead to transmission of HIV. One female also wanted to know whether mosquitoes can transmit HIV.

Preferred sources of information
Adolescents were asked if there are people they feel they can go to for information on HIV/AIDS and whose information they would trust. A fifth of the respondents, primarily from rural areas, said they did not know where or to whom to turn for information. A 14-year-old out-of-school male petty trader from Mangochi said:

I: Is there anyone to whom you think you can go and ask about AIDS?
R: No, there isn't.
I: Then is there anywhere where you think you can go with questions?
R: No, people hide the issues.

Of the respondents who named someone or someplace they could go for information on HIV, most of them named one or two sources. A quarter of the respondents said that they would prefer to visit a hospital or health worker for information on HIV/AIDS because the health workers are knowledgeable about such issues, give good advice and seldom "lie." An 18-year-old out-of-school mother from Blantyre said:

I: Are there people you feel you can go to for information about these things?
R: Yes, there are.
I: Who?
R: I can go to a nurse.
I: Why do you think you can go to a nurse?
R: I can go to a nurse because I am assured of getting reliable information.

Most females preferred getting information from mothers or grandmothers. They believed information from elders to be trustworthy because they said these individuals are older so they know most things, they have experienced married life and they are free and open.

Some adolescents said that they preferred to talk to people at NGOs that deal with HIV/AIDS and other reproductive health issues, and among these organizations, Banja la Mtsogolo was most frequently mentioned. Adolescents gave a number of reasons for preferring NGOs, including that they communicate information through videos, they provide confidential services, they are trustworthy because they are also involved in research and they provide materials. Only a few respondents said that they would prefer getting information on HIV/AIDS from their friends or peers.

Teachers were mentioned infrequently as a preferred source of information on HIV/AIDS despite the fact that they are currently an important source of information on HIV/AIDS. Those who preferred teachers did so because teachers have access to information on AIDS from science books, are well educated and are the ones who teach pupils about morals and good conduct.

Barriers to Getting HIV/AIDS Information
Most of the respondents said that they did not have any problems accessing information on HIV/AIDS, but among those who said they did, more than half were from Blantyre, and were older (aged 15–18). Respondents gave a number of reasons including being afraid of being shouted at, being busy with household chores and funerals, and having no one available who would be able to give such information.

Chapter 6

Nonmarital Pregnancies and Childbearing

Malawi is a highly traditional society where marriage and childbearing within marriage is the norm. Pregnancy was equated by all the respondents with birth. No one mentioned abortion. The consequences of nonmarital pregnancy and the actual and preferred sources of information about pregnancy are treated below.

Perceptions About Nonmarital Pregnancy and Childbearing

Respondents generally felt pity for someone having a baby before marriage because both the mother and her child generally lack support in terms of clothes, food and other household necessities; men can deny responsibility because they are also too young to marry and care for the girl and child for many reasons including that they are still at school; girls are forced to drop out of school; and young girls who get pregnant may have pregnancy-related complications.

Social consequences for girls with nonmarital pregnancies are severe. Several respondents said that girls who have children outside of marriage are sometimes disowned by their parents and other relatives tend to marginalize them as well because their behavior is seen to bring shame and disgrace to their parents and family. Such girls are also considered "out of fashion" or "damaged goods" and less marriageable because prospective husbands are possibly not interested in assuming the burden of feeding a stepchild. An 18-year-old married, out-of-school mother from Blantyre offered the following example:

I: What comes to your mind when you hear about someone having a baby before marriage?
R: I get so concerned.
I: Why?
R: Because these people undergo different problems.
I: What kinds of problems do they face?
R: The baby needs a lot of care and support from one's husband.
I: What else?
R: After having this baby, these girls are neglected by other men. Even the person that impregnated them does not care any more.
I: What makes you think in this way?
R: There is a certain girl, my neighbor, who got impregnated by a certain boy. She got married to another man while pregnant. When this man discovered that he was going to be financially responsible for the other man's baby, he dumped her and now she lives with her mother but she needs care and support.

A minority of the male and female respondents mentioned that the reputation of young, unwed mothers may be tarnished by perceptions that she is promiscuous or a prostitute.

The negative depiction of unmarried young pregnant women was rarely or never applied to adolescent males.

I: How do you feel towards a boy who has impregnated a girl?
R: I don't feel in any way because as to him, all is well. After all, he is not the one who carries the pregnancy. The girl is the one who carries it, so he cannot get very embarrassed. He will be walking freely on the streets. I don't think I pity the boy. There is nothing to pity him for (in-school 16-year-old male in Blantyre).

Despite the negative feelings about nonmarital pregnancy and childbearing, some men admire their friends who had impregnated girls. An out of school, 13-year-old boy in Blantyre expressed envy of a boy who had impregnated a girl, as he also wanted to have a child.

For females who had become pregnant and had a child, they experienced this social stigma firsthand and, based on their own experiences, brought a different perspective to the experience of nonmarital pregnancy.

An in-school, 17-year-old mother from Blantyre explained:

I: Now, I want us to talk about pregnancy that a person gets premaritally. Before you got pregnant, what could you think of those people who are premaritally pregnant?
R: [Long pause] Such a person I could laugh at very much. "She is pregnant before her required time. She is a prostitute." I could think of her that she was a prostitute. Promiscuity gave her a child to make her calm so that she could be settled.
I: So when it happened to you, maybe we should say now, how do you look at such a person?
R: Such as person makes me feel sorry for because, one, she has ruined her future, and, two, she has given herself a job—to look after the child. So what about school? She has given herself a big job.
I: Do you still consider her as a prostitute?
R: No, right now, no.

Another female from Blantyre, 18 years old, in-school and with a child, expressed similar sentiments:

I: Before you became pregnant what came to your mind when you heard about someone having a baby before marriage?
R: I used to think that the girl had not been advised and that the boy had duped her into doing that. I used to think that there are things that if you stuck to your principles you cannot get pregnant.
I: After you got pregnant did your views about girls who have a child before marriage change?
R:They changed because there are some who lead men to have sex with them and there are others like myself who get pregnant accidentally so at that time I was able to distinguish between the two
I: What would you advise your younger sister if she got pregnant?
R: I would tell her that men are very cunning for you can agree to be doing this today but after some time he tries everything possible to lure you into doing the opposite. I would advise her to concentrate on school and write form four examinations before getting a boyfriend. However, before doing that I would encourage her to find out more about the background of the intended boyfriend by looking at the kind of friends he associates with. On the other hand, I would encourage her to not having sex with him even after they became engaged because that would give the man a chance to change his attitude. For instance, my boyfriend was telling his friends that he can only accept responsibility of my pregnancy out of pressure.

There were no men in the sample who said they had fathered a pregnancy.

Actual and Preferred Sources of Information About Pregnancy

Sources of information on pregnancy

When respondents were asked if anyone had ever talked to them about preventing pregnancy, a minority of the respondents, chiefly made up of out-of-school males, said that no one had ever talked to them about how pregnancy can be prevented.

The most common source of pregnancy prevention information was teachers, who taught about condoms, injections, pills and abstaining from sexual intercourse by, among other activities, spending time watching dramas, participating in sports and doing household chores. Respondents said that the information was useful because they learned about how to occupy themselves to avoid having sex and they learned about the dangers of early childbearing and how to prevent pregnancy through condom use. They said they were successful at adopting these measures suggested by their teachers and that that was why they were still in school at the time of the interview.

Another common source of information on pregnancy prevention for males was youth organizations such as youth centers. The main message from the youth organizations was that they should abstain from sex in order to prevent pregnancy.

Peers were a less important source of information. From their peers, adolescents learned to abstain from sexual intercourse and use condoms, and they obtained information on when in a woman's menstrual cycle she is most likely to conceive (although the information was frequently not accurate). For the most part, respondents said that information from peers was useful because they learned how they could prevent pregnancy.

Parents are an important source of information for girls. The major message from parents was that girls should abstain and avoid "playing" with boys because boys can make them pregnant. Girls said the information from mothers and grandmothers was useful because they adhered to the advice, it helped them prevent pregnancy and so they were able to remain in school.

Traditionally, initiation ceremonies have been im-

portant sources of information on sexual and reproductive health. However, only two males mentioned initiation ceremonies as sources of information. One of the respondents said that he learned at initiation ceremonies that if a girl urinates immediately after sex, she cannot get pregnant. Such information was deemed not useful by the respondent because he said that if the girl continued doing that she would become barren. The other respondent who named initiation ceremonies as a source of information on how to avoid pregnancies said that the information was not useful because he wanted to impregnate his girlfriend.

Preferred sources of pregnancy information

Respondents were asked if there were people they felt they could go to for information on pregnancy prevention. A minority of the females said that they would be free to ask their mothers and grandmothers about preventing pregnancy since parents are regarded as being knowledgeable, informative, trustworthy and secretive. Other female relatives such as sisters, sisters-in-law and aunts were also preferred because they were assumed to know a lot about pregnancy and so their information could be trusted. Unlike their female counterparts, only a few males mentioned parents as a source of information on pregnancy prevention. One of the respondents who preferred getting information from parents explained that his parents tell him a lot of things. One male respondent who did not name his parents as a source of information said that he would not go to his mother because he would feel shy. Some male respondents said that they would talk to other relatives, mostly uncles and elder brothers, about preventing pregnancy, the major reason being the freedom with which they felt they could express and discuss issues with them.

Friends and peers seem to be an important preferred source of information on pregnancy prevention, mainly among males. The major reason given was being free to express oneself to friends. A few females also preferred peers for the same reasons. Respondents said most of their friends were older and had some experience.

Very few respondents mentioned NGOs, but those who did said that they would go to these institutions because they are involved in such issues and hence are trustworthy. While teachers were mentioned by most respondents as people who had talked to them about pregnancy prevention, very few mentioned teachers as people they would go to for information on these issues. One respondent who did mention teachers as a preferred source of information said that this is mainly because teachers are educated and therefore knowledgeable about these issues.

A little over one-third of the males and one-fifth of the females said that there was no one that they would feel free to go to talk about preventing pregnancy. Some of the reasons given were shyness, being too young to discuss such issues and not being interested in sexual intercourse.

What adolescents would like to know about pregnancy

While adolescents may know that sexual intercourse can lead to pregnancy, they may not understand exactly what happens. Most male respondents wanted to understand pregnancy issues better, and asked about how pregnancy occurs in girls, how long it takes for a girl to get pregnant and where sperm go for one to impregnate a girl.

Most female respondents said that there is no information that they would like to have. Those few who said that they would like more information wanted to know how one gets pregnant and how pregnancy can be prevented, and about problems during delivery, including understanding why labor is so painful.

Barriers to getting information on nonmarital pregnancy

Very few respondents said that they had problems getting information on nonmarital pregnancy. A few younger adolescents aged 12 and 13 said that they were too shy to ask questions. Other barriers included not having anyone to ask, being too busy and having difficulty accessing distant service providers.

Chapter 7

Sexual and Reproductive Health Problems

Health care beliefs and health care-seeking behavior play a major role in determining the long-term impact of acquiring an STI, as STIs that are left untreated may be more likely to cause sterility and other health problems and spread to others than STIs that are treated promptly. This section discusses adolescents' general and sexual health-seeking behaviors and health-related beliefs that may affect whether respondents seek care from a modern health care provider. Respondents who said they had not experienced an STI were probed about what they would do if they were to get an STI.

General Health Problems

Malaria was the most common illness for which adolescents reported recently having sought care. Some of these respondents had initially bought medicine from shops and/or used traditional medicine, after which they usually went to the hospital for treatment.

Stomach aches were also a common problem for which adolescents recently sought care. Half of these had sought treatment from the hospital, while the remainder had used traditional medicine. Other health problems mentioned by few respondents included swelling, rashes, bilharzia, eye problems, diarrhea, injuries, wounds, flu, STIs (including herpes), cholera, general body pains and coughing.

The major sources of care were private and public hospitals, traditional healers and herbalists, and shops selling medicines. One respondent mentioned prayer. Adolescents' choice of health care provider depended on a number of factors, including availability of funds and distance to a health facility. The other determinant of provider choice was related to perceptions about the etiology of the disease: Illnesses which were perceived to be "African" in nature[49] did not require one to go to the hospital; traditional medicine was seen as the best in this context. Seeking care is also a matter of trial and error.

Sexual and Reproductive Health Problems

Respondents were asked if they had ever experienced a health problem, such as pains or sores on their "private parts" or any kind of reproductive health problem (sex- or pregnancy-related). There was a low prevalence of reported sexual and reproductive health problems among adolescents. Adolescents who had experienced a sexual health problem may not have felt comfortable revealing that in an interview because of the stigmatized nature of the illness or because of a lack of knowledge about the signs and symptoms of these illnesses.

Of the males who reported having experienced a sexual or reproductive health problem, adolescents consulted friends, grandparents and other such people when they have a sexual and reproductive health problem. Reasons given for consulting these individuals were that grandparents are old and are likely to have seen and experienced such things, grandfathers are open and in most cases they discuss such issues with adolescents hence adolescents feel free to discuss such issues with them, and friends are people in which one can confide. Parents are rarely consulted on issues surrounding sexual and reproductive health because, according to one 17-year-old male respondent from Mangochi, it is con-

Care-seeking for a sexual/reproductive health problem
A 17–year-old male respondent had sex with a young woman and later found that he had an infection which was strange to him. He told his friends about the sexual intercourse he had with the young woman and that he was feeling a lot of pain during urination. At his friends' bidding, he took some traditional medicine. There was no improvement, so he visited the hospital where he received treatment and was cured. The doctor, however, did not tell him what he was suffering from.

sidered disrespectful and adolescents feel shy.

Half experiencing a problem did not take any action. Among the remainder, most were first given traditional medicine by their friends, grandparents or traditional healers. Some of these adolescents reported having been healed, but those who did not get well either obtained other traditional medicines or visited the hospital for further treatment.

There are certain traditional beliefs about the causes of STIs and health problems resulting from sex. A stomach ache is in some cases perceived to be an STI, as was described by an in-school, 18-year-old male from Blantyre:

> *I: What did you say was the first thing to do after pains started in the stomach?*
> *R: I asked a person.*
> *I: Which person?*
> *R: A certain boy we call Tosh.*
> *I: Who is he to you?*
> *R: He is a friend to my elder brother, but I also like to chat with him. He told me to go to an African doctor who knows much about medicine. He said: "That means you had sex with a woman who has just aborted or someone who has just undergone monthly periods." So I refused that. Then I went to buy Tumbocid [an antacid]. Then I felt well. So I saw that this person was trying to cheat me by sending me to an African doctor [when I could cure myself].*

It is also believed that having sex with an older female can lead to sexual and reproductive health problems. An out-of-school, 17-year-old male from Ntchisi said that he had sex with his cousin who was older than him and he ended up with sores on his penis. His uncle explained to him that he had developed the sores on his penis because he had sex with an older woman—the woman was "stronger" than him, hence the development of the sores.

The reproductive health problems females experienced included sores on their genitalia, genital warts, itching of the genitalia, *libale* (itching of the genitalia and breast pains), extension of the birth canal during delivery and menstrual pains. Only a few sought care at the hospital. The young woman who said that she experienced a lengthening of her birth canal due to delivery said that although delivery was done at home, she sought care at the hospital because that was the only place where they could do a good job of stitching her up. The other woman who suffered from *masungwi* (candida) was advised by her sister that her problem could only be treated at the hospital. For *libale*, the respondent said that she sought traditional medicine. One respondent did not seek any treatment for her menstrual pains because she knew that every woman suffers from this problem, hence she felt that there was no need to seek care. Female respondents said that they discussed reproductive health problems with friends, mothers, aunts, sisters-in-law and grandmothers because they are older women and they are supposed to know about those problems affecting women.

Common Barriers to Getting Health Care and Reasons Why Care Is Not Sought

One of the barriers to seeking care for a reproductive health problem is shyness, as expressed in the following excerpt from an in-school, 16-year-old male respondent in Rumphi:

> *I: Have you ever experienced sores on your private parts?*
> *R: I did experience one at one time.*
> *I: Who did you first talk to about it?*
> *R: At first I told Happy when we were bathing at the river but he did not answer me. After that I didn't ask anyone.*
> *I: What did you think was the problem?*
> *R: I didn't know because the pain was coming from inside.*
> *I: Why were you not interested in finding out about the problem?*
> *R: I knew that if things were to become serious people will know about the problem but as it was I just didn't pursue the matter further.*
> *I: What happened to this illness? Did you take medicine or did it just heal on its own?*
> *R: The pain stopped on its own.*
> *I: This was after many days?*
> *R: Four days.*
> *I: What were the reasons you didn't seek care at all?*
> *R: I was shy because if you are telling people about your problem it's like you are exposing yourself.*

Decisions regarding where and when to seek health care are in some cases made by parents, relatives and other guardians. An out-of-school 14-year-old female from Mchinji related a case of how this typically happened:

I: What was your problem?
R: I had malaria
I: What did you do?
R: I had aspirin and penicillin
I: Who gave you the medicine?
R: I bought it myself
I: Who did you talk to about your condition?
R: My mother
I: What did she do?
R: She gave me three kwacha to buy medicine
I: Why didn't you go to the hospital?
R: She wanted to see if the condition would worsen.

It is important to note that parents and guardians are gatekeepers to health care, as they have the money for medicines and care; yet some adolescents said they were frequently uncomfortable with talking to parents and guardians about their sexual and reproductive health problems. The implication of this is that adolescents are less able to access health care for sexual and reproductive health problems than for other problems because they are less likely to broach the subject with their parents and as a consequence, not get the money for accessing treatment.

Western medicines are widely used in the developing world for off-label purposes. In this study, respondents reported having purchased antibiotics and antipyretics such as aspirin and Panadol, which they believed to be as universal cures, from local markets. For example, respondents reported purchasing painkillers when they suffered from malaria.

A number of reasons for not seeking care were mentioned by respondents, and these included the general lack of appropriate medicines in health facilities, long distances to health facilities, guardians being busy and a lack of money.

Other reasons respondents did not go for treatment included the perception that simple illnesses do not require going to hospitals. Some did not seek treatment because they felt they would get better with time.

Intentions to Seek Care for a Hypothetical Problem

The majority of the respondents said they had not experienced sexual and reproductive health problems. These respondents were asked some hypothetical questions about whether they thought they would seek health care if they did experience sexual and reproductive health problems. More than half of the respondents said that if they had problems such as sores on their genitals, they would go to the hospital for treatment. The major reason given was that medicines are available in the hospital, and once the disease is diagnosed, they would be given these medicines and they would be cured. One male respondent said that he would go to the hospital because the services offered there are free of charge. A few of the rural respondents said that they would buy drugs from the shops.

Many male respondents said if they had genital problems they would tell their parents because parents take care of them. Fathers were the most commonly identified person to whom they would disclose as fathers are men and should therefore be in a position to know the problem and how to deal with it. There was also a feeling that parents and friends needed to be told because if one has sores in one's private parts, people will easily know that you have a problem by observing how you walk. Brothers would be told because they are of the same sex and respondents felt that with brothers they could express themselves freely, or because brothers should help. Grandparents would be told because they are old and therefore should be knowledgeable.

A few female respondents said that they would tell their parents (especially their mothers and grandmothers) about their genital problems. One respondent said that parents have to be informed because they are the ones keeping her, but another said that she was afraid of telling her mother because her mother may shout at her. While most respondents said that they would seek care from the hospital or ask their parents, one respondent said that she would seek care herself. Only a few of the females talked about seeking traditional medicine.

Respondent's answers to the hypothetical sexual health problem should be viewed as hypothetical answers and not on equal terms as the actual reported behavior of adolescents who had experienced sexual health problems. The hypothetical response regarding hospitals having appropriate medicine is in direct contradiction to the reason given by adolescents for not seeking care—that hospitals do not have the appropriate medicine. This difference may simply be due to different individuals' perceptions, or it may be a reason that sounded plausible to the respondent for not seeking care when, in actuality, other issues kept him or her away but the adolescent may have been less willing to voice those reasons. On the other hand, the hypothetical reaction may be less realistic, as it is based on conjecture.

Chapter 8

Adolescents' Intimate Relationships

This section explores the details and sequences of adolescents' intimate relationships with the opposite sex which may or may not have involved sexual intercourse or not. It is important to examine how these relationships grew, what they were like for the respondent and what kinds of pressures the respondent felt while in the relationship.

Adolescents Who Had Never Had Sex

Fewer than half of the sample had not had a relationship at the time of the interview—distributed equally across genders and age ranges. There were more urban residents who were not yet romantically active, compared with rural respondents. While only a few young women related experiencing peer pressure to have a boyfriend, approximately a quarter of the young men (urban and rural and from every district except Mangochi) talked about experiencing peer pressure to get a girlfriend.

Reasons for not being sexually active

When asked why they had not yet had a boy/girlfriend, adolescents described having a boy/girlfriend as incompatible with school because relationships are time-consuming activities that would result in one dropping out of school, as narrated by a 12-year-old in-school male respondent:

> *I: Have you ever had a girlfriend?*
> *R: No.*
> *I: Why is it that you have never had a girlfriend?*
> *R: I'm still a child; issues of relationships can just disturb my education.*
> *I: In what ways can they disturb your education?*
> *R: I can stop school and start moving around with girls.*
> *I: Maybe there is somebody who stops you from having a girlfriend?*
> *R: No, I do avoid it myself.*
> *I: Have you ever had any desire to have a girlfriend?*
> *R: No.*
> *I: In your opinion, at what stage would you want to have a girlfriend?*
> *R: When I finish my education.*
> *I: Finishing your education up to what level?*
> *R: Till I reach college.*

Having a girl/boyfriend was equated by many with having sex. A few younger females from both urban and rural areas expressed fear that a boyfriend would ask for or force them to have sex and a few of them expressed fear of boys. Another reason that the respondents described relationships as incompatible with school was because the female would become pregnant and have to leave school, and the male would most likely have to leave school to support her. For most respondents, relationships also meant contracting unspecified diseases and other unknown but life-threatening conditions that were acquired through sex. A small proportion specifically identified AIDS and an even smaller proportion identified gonorrhoea and syphilis as consequences of being in a relationship.[50]

About half of the young women who had not had a relationship at the time of the interview said they wanted to wait until after they finished school to get their first boyfriend. An urban, out-of-school 15-year-old female said:

> *I: When are you planning to have a boyfriend?*
> *R: When I reach Form 4, if it is possible.*
> *I: Your answer is ambiguous. You are saying if you reach Form 4. Does it mean that you will have one as soon as you enter Form 4?*
> *R: No, after completing my Form 4.*
> *I: Why?*
> *R: Because by then I will have completed my school and, God willing, I will have been employed. That means I could manage independently be it in a family with my husband or divorced.*

The sentiment of wanting some kind of independence before having a boyfriend was a common theme among young women. A small proportion of young men said that they would have their first relationship when they finished school or became self-sufficient and a few said they would wait until they were ready to get married.

Fear of AIDS and pregnancy as reasons for not having had sexual intercourse

The majority of adolescents, some of whom had had a romantic relationship, had not had sexual intercourse at the time of the interview. Fear of AIDS was the primary reason given for not having had sex. Even though condoms were known by the vast majority of respondents, the fear that anyone could get AIDS—seemingly irrespective of protective measures—was prevalent.[51] Part of this perception may be understood by the distrust of condoms that was voiced by many respondents.[52] A rural, out-of-school 16-year-old male said:

> *Some puncture the condom and do sex. And some girls say "I will do it because this one will use the condom" not knowing that the boy has punctured the condom with the aim that he should transmit the disease AIDS to the girl so that they should both go [die].*

Yet males are not perceived to be the only ones making holes in condoms. The same respondent indicated later that condoms may come punctured so even males cannot trust in condoms they use:

> *R: I am afraid of the AIDS pandemic. If I try to attempt [sex], I could contract the disease.*
> *I: Why didn't you think of using a condom?*
> *R: I have to do what my mother advises me. She says condoms won't help me; I would just lose my life.*
> *I: Why does she say a condom won't help you?*
> *R: Because it may be a punctured condom.*

Another reason for condom distrust was that even if used correctly, condoms might fail. According to an urban, out-of-school 15-year-old female:

> *I: Why have you never had sex with anybody?*
> *R: I am afraid of being impregnated.*
> *I: I thought your partner could use a condom?*
> *R: They are not trustworthy.*
> *I: How are they not trustworthy?*
> *R: They work in minutes.*
> *I: What do you mean "working in minutes"?*
> *R: I thought condoms work in minutes.*
> *I: Elaborate on that point. What do you mean if you say "they only work in minutes"?*
> *R: When one uses it, it should not be more than 30 minutes.*
> *I: What if the minutes period expires?*
> *R: It bursts.*
> *I: So you are afraid that if he uses it, it maybe more than 30 minutes and it will burst?*
> *R: Yes.*

In addition to the condom distrust cited above, there appeared to be widespread misunderstanding among the respondents of sexual physiology and fecundity. There was common misidentification of a woman's fertile period as during her menstrual period, and some respondents identified post-coital urination as a contraceptive method.

More than half of the young women and one-quarter of the young men who had not had sex at the time of the study said it was because they were afraid of the young woman getting pregnant. Males added that they feared not being able to support a wife and child. Almost all the young men who gave this answer were aged 18 or 19 and from rural areas.

Opinions on sexual intercourse

There were a number of females, both urban and rural, in school and out of school, who had not yet had sex who saw sexual behavior as a negative, dangerous thing, primarily because of social sanctions brought to bear on an unmarried, sexually active female. They expressed that, if women have sex before marriage, their partners will not see any point in marrying them; people do not respect young women who have sex; young women who have boyfriends are hurting themselves; and people speak poorly of young women who have sex.

When sexually-inactive adolescents expect to initiate sexual intercourse

Congruent with what females said about having a relationship, one-third of the individuals who had not yet had sexual intercourse anticipated that they would have sex after they finished school. One-third anticipated that their first sexual relationship would take place in marriage. Demonstrating again the ubiquitous association of sex with disease, a rural, out-of-school 18-year-old male said that one should abstain from sexual

relationships until ages 22–25, since at that point it is more acceptable to appear with STIs than it is the age at which men get wives. The emotional reaction to not having had sex from the vast majority of females and a minority of the males was that they felt happy because they knew they were disease-free.

Initiation of relationships that did not involve intercourse

Among adolescents who had had a romantic relationship, one-third had not had sex. Among females who had not had sex, dating began between 10 and 18 years of age. Almost all relationships began after the boy initiated and encouraged the female to be in a relationship with him (see section below "Initiating romantic relationships" for how relationships begin). For boys who had had romantic relationships but had not had sex, dating began around age 14. Their girlfriends were either younger than themselves or the same age. Almost all met their girlfriends in school. Most started the relationships out of peer pressure or because they envied friends who had girlfriends.

The relationships were for the most part covert. In only one case did parents know about the girl's relationship and she was marrying her boyfriend. Some girls said they did not tell their parents for fear of getting beaten. In a few of the cases, friends and sometimes other relatives of the boy or girl knew about the relationship. None of the boys' parents knew about their relationships because the boys feared that their parents would be angry with them for being too young to be in a relationship (which could lead to sex) or for running the risk of impregnating a girl. Such perceptions indicate that parents conflate relationships with sex in the same way adolescents do.

The most common things these respondents said they did in their relationships were to encourage each other to work hard in school, chat and watch soccer games. Boys also named walking *shosholo* (hand in hand). Boys related that girls sometimes gave them gifts, including notebooks, cakes, mangos and maize. Kissing was treated as leading to sex, so many of the girls said they did not kiss their boyfriends.

None of the females who had had romantic relationships that did not involve sex had experienced pressure to have sex, while more than half had experienced pressure not to have sex. While some of these boys did relate experiencing pressure to have sex, more had experienced pressure not to have sex. One example of this came from a rural, in-school 15-year-old male who related: "[A friend] told me never to try doing [sex] because once I gave it a try and it feels good, I would not want to stop."

The longest relationship reported at the time of the interview was three years (and continuing). More than half of these relationships lasted a year. Most girls' relationships ended because she found out that her boyfriend had another girlfriend or she decided the relationship was interfering with school. Reasons given by males included that the girl moved away or she had another admirer, so the respondent withdrew. General relief was expressed at the end of a relationship that they did not "ruin each other's future" (i.e., the female did not get pregnant).

A romantic relationship that did not involve intercourse

A rural, in-school 15-year-old was 14 when he started dating a 13-year-old girl, whom he met at school. He envied his friends who had girlfriends, so he asked her to be his girlfriend. His friends and parents did not know about their relationship because the two of them were young and he was afraid they would be angry with him for being too young to be in a relationship. When they were together, they would chat but they did not talk about getting married because they were still young. They did talk about how sex was bad because it could lead them to contract HIV. He also had friends pressuring him not to have sex because these friends said once he had sex it would feel so good he would not want to stop. The relationship lasted two months.

Sexually Active Adolescents

Slightly fewer than half of the adolescents (both female and male) had had a sexual relationship. Most of the sexually active adolescents had had sex within the context of some kind of relationship. For the few respondents who had sex outside of a relationship, sex happened while playing "mother and father" when they were prepubescent or just entering puberty. Among the males who had sex within a relationship, some said that they were motivated to get a girlfriend because they started having wet dreams. A rural, in-school 14-year-old said that he proposed to a girl to be able to have sex with her. "[I] should be happy and get the things I want on her…to have sex with her *kumukwera* [to mount and have sex with a female]." Adolescents who had had sex-

ual relationships usually met those partners at school or in their community (they were neighbors or they encountered each other outside of the house but close to home). The youngest age at which a sexual relationship began was 9 years. Females were usually one or two years younger than the males in the relationships.

Initiating romantic relationships

Most relationships started with a boy sending a friend to deliver a letter to his female love interest telling her "I love you," or the boy approaching the girl outright and telling her that he loved her. (There was only one story of a girl proposing to a boy; it came from a 19-year-old out-of-school male from Blantyre.) Girls did not usually respond the same day to the proposal, but waited a few days to give their answer and they usually rejected the male a few times before eventually accepting his proposal since to accept a boy's first proposal was perceived to be "easy." An out-of-school, 17-year-old male from Ntchisi explained how he began a relationship with his first girlfriend:

> *I: After you met at the choir what happened next?*
> *R: I greeted her and asked where she stays, I also told her where I stay, then I told her what I wanted then she told me that a girl does not accept a proposal on the same day but days have got to pass to hear good result.*
> *I: Is it she who said that?*
> *R: Yes, this shows that she denied the proposal because it was the first time. When I went again some other time she denied the proposal but when I went there again she agreed and became my girlfriend. We were in a relationship until she went to [another town].*

Many females said they were pressured by their friends or coerced by the male into being in a relationship that they did not want to be in (at least in the beginning). An urban, in-school 14-year-old female related:

> *I: How did you feel about this relationship?*
> *R: At first I did not like it and I was not happy about it.*
> *I: But still more you were going to meet this boyfriend?*
> *R: Yes.*
> *I: What was it that was dragging you when you didn't like what was happening?*
> *R: I don't know.*
> *[…]*
> *I: How long did it take you to get out of that feeling?*
> *R: It was after a month or so because in the first month when invited to go and visit him at his home I used to refuse but afterwards I started visiting him and then I got used to him in the process.*
> *I: What influenced you to get used to him?*
> *R: Mainly it was because the affair had been going on for sometime.*

An urban, out-of-school 18–year-old explained:

> *I: Explain to me how you came to know each other.*
> *R: Oh! He told me that he loves me this other day when we met, and after some months we started the relationship after he insisted.*
> *I: He forced you into the relationship?*
> *R: Yes.*
> *I: So what did you do?*
> *R: I told him I loved him too [laughs].*

Confusing sentiments such as those expressed above are not uncommon among the young people interviewed. Their seemingly contradictory responses may be a product of not having the right words to express the emotions they were trying to describe, possibly a need to represent their behavior in a certain way (i.e., not appearing eager to be in a relationship with a male), or perhaps actually feeling these contradictory emotions. These contradictions emerge saliently again when females discuss their first sexual experiences.

Who knew about the romantic relationships

As was the case with romantic relationships that did not involve sexual intercourse, it was more common that friends knew about the relationship than parents. Within this sample, it was more common for the boys' parents to know about the relationship than the girls'—this pattern held in rural and urban areas and in different districts of the country. Only one mother knew of a girl's relationship; that case was in Blantyre and the couple had been together for a year. Grandparents were told about relationships about as frequently as parents were told. The reasons adolescents cited for not telling their parents were fear of being chastised and having been told the negative consequences of having a boyfriend/girlfriend (i.e., the girlfriend would become pregnant).

Both young men and young women perceived the

young men to make more decisions in the relationship. Types of decisions that males made in the relationships were about whether the girl could talk with boys, whether to have sexual intercourse, whether to buy gifts for each other and whether to be faithful to one another. An out-of-school, urban 15-year-old male petty trader explained:

I: What decisions were made by her?
R: Being female, she used to accept what I was telling her.

The fact that the respondents reported that males were more often the ones who decided to have sex helps contextualize the first sex experiences of the respondents.

The first sexual experience

The majority of males described how they were the ones to initiate their first sexual intercourse, which sometimes required verbally or physically convincing the female.

- An urban, out-of-school 18-year-old related that his partner first expressed resistance to sexual intercourse out of fear of her father because she said if he caught them having sex he would shout at her, but then she gave in.
- An urban, out-of-school 19-year-old said, "At first she was refusing but it was out of mere shyness but after that wore off, she accepted."
- A rural, in-school 14-year-old told how his first sexual experience happened after swimming at a dam when he chased and caught a girl who had been swimming and taunting him.
- A rural, out-of-school 12-year-old explained that sex happened when he told his partner what he wanted—"'I would like us to have sex' and she accepted."
- A rural, out-of-school 16-year-old related how he would say that he was tired and she would accept to have sexual intercourse with him.
- A rural, out-of-school, 14-year-old said:

R: When I wanted to have [sex] with her I could tell her.
I: Did she accept?
R: Yes, she accepted saying, "Let's go…."
I: What did you do to be aroused?
R: I did what I wanted....I had sex with her.

A smaller proportion of males reported that sex was initiated by females through, for example, a girl taking off her clothes or telling the boy that they should have sex. It is noteworthy that the ways that females initiated sex was different than the tactics used by males: asking for or demanding sex.

According to females, the sexual negotiation leading to sexual intercourse appeared to be dominated by the male's sexual interests and desires.

- An urban, out-of-school 17-year-old said, "[He told me:] 'You can't get pregnant in a single act.' After seeing that I loved the person, I asked myself why I was refusing."
- A rural, out-of-school 17-year-old related that, "When he suggested that we have sex, I resisted but later accepted."
- A rural, out-of-school 16-year-old said, "In order for us to do it, he coaxed me."
- An urban, in-school 14-year-old explained that "He told me what he wanted and I accepted."

It was shown earlier that girls have to wait to be "proposed" to by boys several times before they can agree to enter into a romantic relationship. Similar expectations likely apply to sexual debut: If girls accepted having sex the first time they are asked, then they will be considered "easy." Therefore, initially refusing and then acquiescing may a be a performative act that females are consciously or unconsciously engaging in, since to accept a male's sexual advances too readily may be socially stigmatized as only something a "loose" woman would do. Alternatively, it may be a strategy on the part of males to wear females down or coax them into having sex when in fact, she may not have wanted to.

In some situations, the pressure to have sex appears to have taken on a more coercive nature:

- An urban, in-school 18-year-old had told her boyfriend to wait until they were married and "he said that he cannot do that." "I just let him do what he wanted not realizing that I will end up being pregnant."
- "Then he said to me, 'I have come for that issue,' then I had no choice but to do it," said a rural, out-of-school 19-year-old.
- "What happened is that I wanted to satisfy him…. I didn't feel anything because he just

forced me," said an urban, in-school 18-year-old.

The most extreme case of coercion in the data was of an out-of-school 18-year-old girl in Blantyre:

I told him that I did not seek permission to sleep out from my parents, for when I was leaving home I just told them that I was visiting a friend, but he didn't take any of that and just locked me in and gave the keys to one of his friends through the window only to return with them the following morning. So during the time we were there I had sex with him.

Yet sometimes the language used to describe the situation does not substantiate the female's assessment that it was coerced. For example, another urban, out-of-school 18-year-old explained what happened at her sexual debut:

I: How did this come to happen?
R: He forced me.
I: How did it all start?
R: I have forgotten.

But then the respondent goes on to describe a non-forced situation where she spent the night with him in his bed.

He invited me to his place. While there he asked if I could spend a night there, at first I refused but I gave in after his sister supported the idea, and this was my first time to have sexual intercourse with him.

When asked how she felt about it, she said she felt it was "natural, we are supposed to do it." She said at first she was frustrated because she did not know how it was done but later on she was happy with it and now when she remembers, she's just surprised how it all happened. Therefore, even though females largely expressed their sexual debut as pressured, coerced or forced, these characterizations should be interpreted with caution.

Risk of pregnancy

When the young men were asked if they thought they were at risk for causing a pregnancy, the majority did not think they were at risk. The justifications they gave were that one or both partners were young, she had a "childish mentality," he didn't think he could make her pregnant (for unspecified reasons), he didn't know at that point that having sex could lead to pregnancy and he thought that they were using traditional contraceptive methods (avoiding sex during her menstrual period, having "spaced times of sexual intercourse" or having the female urinate after sex). One respondent said he didn't think about it and another said he did not care.

There was a high level of partner distrust in all of these relationships, as has also been documented within marital relationships.[53] Respondents mentioned frequently that they did not know what their partner was doing when the partners were out of sight and, therefore, they were always suspicious of their partner's fidelity and serostatus. Yet this suspicion did not translate into a high use of contraceptives: In the majority of sexual debut situations, no contraceptive was used. The reasons that contraceptives were not used varied from couple to couple:

- A rural, out-of-school 12-year-old said that he and his partner did not use condoms because he couldn't afford them, so she would urinate after sex to "spit out" the sperm.
- An urban, out-of-school 14-year-old said that he did not know about condoms at the time he began having sex.

A rural, in-school 17-year-old male said that his religion forbids people to do what they were doing, so they were discouraged to buy contraception.

R: We did not agree on using protective measures, such as using some preventive instruments available, which everybody refuses to [use], saying we are not going to have a good future if we did that.
I: What do you see that can spoil your future if you were using protective methods?
R: I would say we have religion and punishment. If one was to impregnate someone, it is the fair consequence of having sex, unlike collecting the sperms somewhere and throwing them away. That is regarded as killing and is prohibited by our religion.

Instead, this couple decided to limit their meetings to once a week or less to reduce their coital frequency. An urban, in-school 18-year-old said that he did not use condoms because "I didn't care about that."

Females' reasons for not using contraceptives also

varied and included the respondent not knowing she could get pregnant, the respondent having no access to condoms; the partner not wanting to use condoms; or the couple wanting to get pregnant. Others mentioned that they did think about getting pregnant, as the following quotation from a rural, out-of-school 18-year-old female shows:

I: You never thought about risking pregnancy?
R: Not at all, we never thought about it. We just thought we were first playing and that would not result in pregnancy.

Out of a total of 40 respondents who had had sex, five reported condom use at sexual debut. These five (three males and two females) were all urban residents and they were all 16 years of age or older at the time they had their sexual debuts. In some cases, the females had recommended using the condom and in others, the male had recommended using it. One case of condom use was particularly noteworthy because the female said that it had been a forced experience, yet she was able to recommend using condoms. Perhaps one reason why she was able to demand condom use was the existence of emotional commitment, as the couple was planning on getting married. While one female said she had not known that condoms could prevent pregnancy, a few males said they had been using it to prevent pregnancy and/or disease. An urban, out-of-school 18-year-old male explained why he and his partner had used condoms:

I: That time did it occur to you that you could contract AIDS or any sexually transmitted infection?
R: Yes, I knew.
I: Did you discuss it?
R: She refused.
I: What did she say?
R: She said that we should be using Chishango [a brand of condom].
I: Always?
R: Yes, always and I only slept with her twice and on both occasions I used Chishango.

Even though this respondent's partner refused to talk about AIDS or any other STIs, she demanded condoms and her partner agreed, perhaps because he, too, was aware of STIs, including HIV.

Partner distrust was a reason given by one urban, out-of-school 19-year-old female for having used a condom at sexual debut: "We were not staying [living] together and we had to take precautions because there was no guarantee about what happens behind closed curtains."

Risk of contracting STIs, including HIV

When asked about whether they thought they were at risk of contracting STIs, including AIDS, the most common response from the young men was that they were afraid of AIDS and other STIs.[54] To mitigate that fear, one respondent said that he used condoms, even though his partner refused to discuss diseases (see quote above); another respondent did not trust condoms to protect him; and a third related that he and his partner had agreed to be faithful. One rural, out-of-school 12-year-old said that he thought he might have already contracted AIDS from his current sexual partner. Only a few respondents said that they were not afraid. The most common reason males gave for not protecting themselves or their partners from STIs was that they did not think about it—primarily because she was young or they were both young, and so the possibility seemed slim to him that she might be infected.

When young women were questioned about whether they thought about the risk of STIs at the time of their sexual debuts, the most common response was that they had thought about STIs, and some couples had, as a result, agreed to be faithful. The second most common response was that female respondents were worried about STIs but had not been using anything because they had been unwilling or forced to have sex. An urban, out-of-school 18-year-old female said:

R: He told me just to trust him, he said he knows for sure that he is okay. But we did not go for testing, we trust that each one of us is okay.
I: How did you feel about it?
R: I feel bad and I hate it.
I: What did you do about it?
R: Nothing.

In this typical example, the male took control of the situation but that was disempowering for his partner who did not like the situation but did not or could not negotiate condom use.

Less frequently mentioned responses were that the young women had discussed the risk of STIs with their partners, that they did not think about it and that they were not worried about STIs because their boyfriends were not infected (although it was unclear if this had been medically confirmed).

Males' most common emotional reaction to having had sexual intercourse was happiness. One respondent

A female's relationship that included her sexual debut

An urban, in-school 18-year-old female had her sexual debut when she was 18 years old and her partner was 20 years old. They met when she was coming back from school. He started chatting with her and proposed to her during the same interaction but she did not accept that day. On another day, she did accept, saying "On this day I saw that the boy was so desperate and I accepted the proposal." She accepted because she felt pity for him, but she was also attracted to him.

No one knew about their relationship. When they were together, they discussed their future plan to get married. To avoid diseases, the respondent intended to wait to have sex until marriage because she was afraid of becoming pregnant, but her partner had been asking her to have sex. After they had been together one month, they had sex. She did it "to satisfy him" and because he said that she could not get pregnant. She did not know what his reason was; she did not ask. On the day they had sex, "we were chatting, so he started touching me here and there [...] so after he started touching me, I just realized that we had done it." She said, "I didn't feel anything because he just forced me." She said she had unwillingly exposed herself to unwanted pregnancy and STIs because the sexual experience had been forced. She said she had not thought about it again. She had thought that they would get married when she completed her education, but he got another girlfriend, which ended their relationship, leaving her very disappointed.

was happy in particular because his partner was beautiful. Another was happy because he could now boast to his friends. A few respondents who cited happiness said that they had also felt weak and worried. The second most common response was regret. The regret came primarily from fear that the respondent may have become infected with AIDS or infected his partner. Fewer respondents mentioned feeling they had fulfilled their curiosity or their desire.

The two most common emotional reactions among young women to having had sex were happiness and regret/remorse. Happiness was cited in cases where the respondent married her first partner, the partner gave her money for sex and the partner bought her clothes. Regret/remorse was expressed in cases where the respondent was concerned about having become pregnant. Less common reactions to having had sex were pain, disappointment because she did not marry her partner, worry because "she had been stupid," pity for herself and nothing/no reaction.

Transactional sex

Among the adolescents who had had sex, a few of the respondents or their partners had received gifts or money in the sexual relationship. Young women were always the recipients. Males related being asked for money by their partners but females did not relate asking for money. Some of girls were presented with the money and it is unclear if they were asking for it. Females related receiving money (five kwacha was the only amount specified in any of the interviews) specifically to buy herself food, soap or clothes. Males related giving money. A rural, out-of-school 16-year-old said that he knew that if he had no money his potential partner would refuse to have sex with him, so he spent all week assembling the money so that he could have sex with her once a week. "If I found the money in the morning, I gave her the money at school, then I would just go to have sex with her in the afternoon. But if I found the money in the afternoon or evening I took the money to give her at the time and have sex with her." Yet this is the only respondent who said that his partner would not have sex with him if he did not pay her. It is not always clear among the other respondents if the money and gifts were in direct response to having sexual intercourse or if they were just another activity that took place in the relationship. Offering money for sex might be a coercive tactic if the female was in dire need of the assistance. While it is possible that one respondents' partner expressed agency in avoiding sexual intercourse with her first sex partner when the partner did not bring her money, it does not seem as if that was a common strategy among females for avoiding sex. The exchange of gifts is further complicated by the fact that a giving of a gift might make the receiver feel obligated to repay the giver with sex.

Most recent sexual partners and things they did together

A minority of sexually active adolescents presented information on their current or most recent sexual partner. Some were in concurrent relationships and some of the recent relationships had only involved one act of intercourse. Activities that the couple did together, as related by the males, were chatting, inquiring about the girl's behavior with other men, encouraging one an-

other not to disobey parents and discussing the need to abstain from sex. One spoke about how his last sex partner would ask him for money to buy food at school. One of the males in a concurrent relationship described how he gave one girlfriend money, but did not give the other one money because she still had sex with him even if he did not bring her money. (This is not the same female as discussed above and so it is another example of a female agentically avoiding sexual intercourse when financial remuneration was not offered.)

One of the young women was in a violent relationship. The urban, out-of-school 18-year-old related that after sex, her male partner would lock her up and go out for the night. "Just to ask him where he had been he would be provoked to the point that he was beating me up."

One rural, out-of-school 17-year-old male, whose last intercourse experience was with his cousin, explained how the sexual interaction took place:

> *I was begging, "Who is better between a beggar and a thief?" Then she would say, "A beggar." Then I would ask her, "Could I touch your breasts?" (laugh). Then she said, "You can touch my breasts." Then I would touch her breasts. After touching her breasts, I would ask her that if she went for a visit and she was given* nsima*, would you take* nsima *without relish? Then she would answer, "No." Then I would tell that, "Why have you given me* nsima *without relish?" Then she would say, "No it's now daylight and we are not as free [parents are around]. You will eat relish in the evening."*

The sexual analogy here is that sexual intercourse was the relish on the sexual foreplay, the *nsima*. This particular female was able to reject sex at the point in time that her cousin wanted to have sex, demonstrating sexual agency.

The above example demonstrates adolescents' negotiations around when and where to have sex. While innuendo and indirect speech may be part of the flirtation, for some young people, they had a hard time speaking in clear language about sexual matters. A rural, out-of-school 16-year-old explained the way that sex came about with him and his partner:

> *R: We did not just say it in a straightforward language, it took some tricks to talk about it.*
> *I: What types of tricks?*
> *R: I said, "Let's go." So she [said], "To do what?" And I told her, "You know how people live. Let's go." Then when we arrive where we were going I would make her lie down.*

Ambiguous communication such as that presented above increases the probability of misunderstandings and thereby unpleasant or even unwanted sexual situations.

Contraceptive use at last sex

Few adolescents reported having used condoms the last time they had sex prior to being interviewed. The most common reasons for not having used condoms at last sex were that respondents said they did not think about pregnancy, they were not aware of how sexual intercourse can lead to pregnancy or the male perceived that he had "not yet started to pour the oil," meaning producing ejaculate with sperm in it. A few males said they had thought about the possibility of impregnating their partner. To hedge against that possibility, one strategy employed by a respondents was to meet his girlfriend less frequently or get married "if it came to that." Similar to what Schatz found in discussions with married couples, some males were fearful that if they introduced condoms, his partner she would think he was accusing her of having AIDS.[55] One respondent said he did not use condoms because sex without condoms was "sweet" [more pleasurable]. One respondent said that he had never spoken about condoms with his partner. Only two had used or tried to use condoms at last sex: One young man used condoms at last intercourse and one tried to use condoms but his penis was too small and the condom fell off (he was 11 at the time).

Half of the young men said they did not think about STIs the last time they had sex. Most said they did not think about them because they did not know about STIs. When one of these young men found out about STIs, he broke up with his girlfriend. Only one respondent said he thought about STIs and discussed them with his partner.

Among the young women who discussed their most recent sexual partner, half related that they had not felt at risk of pregnancy or diseases the last time they had sex. A rural, out-of-school 18-year-old said that she did not think about STIs because "all I knew was that I was still a child and my friend too and we could not have any infection." The other half had felt at risk of pregnancy and STIs. An urban, out-of-school 18-year-old related that she and her last sexual partner had discussed protecting themselves against STIs and she did think she was at risk of contracting AIDS or other

A male's last sex experience

A rural, out-of-school 16-year-old described his most recent sexual relationship, which happened when he was 11 years old and she was 12. The only person that knew about this relationship was a friend of his. It had been the respondent's idea to have sex. He wasn't using condoms because he said he was still a child and he had tried using it, but the condom was too big for him. They never discussed how to prevent a pregnancy or STIs because he said, "By then we were not aware." Regarding decisions that he and his partner made together, he said:

R: When I could tell her that we should have sex, she was saying, "No, we should have it another day." So I would just insist, then she would accept.
I: Insisting, what do you mean?
R: I would persuade her.

He did not provide further detail on how long they were together or why the relationship ended.

STIs—but immediately after sex she kept on thinking about those diseases and she thought that she had contracted a disease and that that was the end of her life. The urban, out-of-school 18-year-old involved in a violent relationship related that she felt she had been pressured to put herself at risk, since her partner had forced her to have sexual intercourse with him and he had other sexual partners. She said that her partner did not consent to using condoms. He "maintained that I was the one who was infected with diseases because of insisting to be using condoms."

Only three females gave their reasons for having had sex most recently: One was raped, one felt pressured because she had been taking money from a male for a long time and one had sex because she felt obligated. Contraceptives (condoms) were used in only one of the intercourse experiences that the three females related. It happened in the relationship where the female had been taking the male's money and felt pressured to have sex with him. A few of the respondents said that they were not using contraceptives because, as a couple, they had agreed not to have sex with other people because that could bring HIV into the relationship. A rural, out-of-school 18-year-old who had a child explained that although condoms protect one from disease, she and her partner used them only once. "He said you cannot eat the sweet with its wrapper; otherwise you cannot enjoy the taste [laughs]."

In order to measure power in the relationship, the respondents were asked who makes decisions in the relationship. Young men said the decisions they had made in the relationship were to have sex and for his girlfriend to give him gifts. None of the males said females decided anything. The one female who provided information on this question, a rural, out-of-school 17-year-old, said, "He used to make decisions and I could just accept it." Most recent relationships had ended because the young man had found out that his girlfriend had another boyfriend or because the young man was scared of impregnating his girlfriend.

Pressure to Have Sexual Intercourse

One in four young women in the entire sample had experienced pressure to have sex. Most had been pressured by their boyfriends or men they knew, while a few had been attacked by a stranger, pressured by their girlfriends or pressured by a teacher to have sex with him. The boyfriends pressured the girls by telling them that it was not possible to remain in a relationship without sex. The form of pressure one rural, in-school 19-year-old said she experienced was that she had been offered money. An urban, out-of-school 17-year-old mother was pressured in the face of prevailing taboos prohibiting her from engaging in intercourse. She explained, "Elderly people say that if a child is still young, you are not supposed to have sexual intercourse because it could "hot" the child and then the body [of the child] will have stunted growth, i.e. *'amanyentchela.'*" Culturally, having sex while menstruating and having sex soon after delivery is prohibited because there are some "chemicals" that remain in the womb which are dangerous for a man and if the child is still breastfeeding, the sexual act is believed to have the potential of making the child sick.[56]

Almost one in three males had experienced pressure to have sex. It was more common for boys to say they had been pressured by their girlfriends to have sex than for them to say they had been pressured by their male friends. One urban, in-school 18-year-old related experiencing pressure within a relationship from a girlfriend who was a regular sex partner. When she expressed desire to have sex, he interpreted that as pressure. He said to her, "To have sex should be my desire as a boy and not you telling me."

Other examples of pressure from females cited by males included walking enticingly, wearing skirts with slits, wearing sleeveless shirts so you could see their

breasts and by asking males to buy something for them. A rural, in-school 16-year-old said that he evaded pressure to have sex by not associating with girls because he feels if he did associate with girls he would want to have sex with them. Therefore, it is possible to see that the pressure experienced by young men is different than the pressure experienced by young women: The pressure from girls is primarily suggestive in nature. A few males gave specific reasons for not wanting to have sex, including because some girls have sores, because he had not sought consent from his and his partner's families and because he said he was not yet of age (answers from younger respondents).

Young women had been pressured, mostly by their mothers or grandmothers, to avoid sex. Some of the young women said the pressure took the form of threats about AIDS or vague warnings about getting a disease. One urban, out-of-school 19-year-old female was told by her mother, "[If you show him your nakedness], he will never marry you." Slightly fewer males than females had been pressured not to have sex. The pressure had come primarily from their parents and teachers. They were warned of the "sad consequences" of sex: pregnancy and diseases. A rural, in-school 15-year-old was warned by a peer that sex becomes addictive and was therefore advised to avoid it as long as possible. One rural, in-school 18-year-old was warned by his uncle with whom he lived that if his uncle saw him giving girls money he would be kicked out of the house.

One in four young women said they had been pressured to put themselves at risk of pregnancy because their boyfriends refused to use condoms. An urban, in-school 19-year-old believed that her boyfriend's friends tried to influence him to have unprotected sex by telling him that you can't suck candy with the wrapper on. Of the ten young women who were asked if they had been pressured to put themselves at risk of STIs, only one reported having felt pressured. No males felt that they had been pressured to impregnate a girl. Only one male felt he had been pressured to put himself at risk of STIs, which occurred when his friends tried to pressure him to leave his girlfriend to take up with another girlfriend.

Chapter 9

Sources of Influence on Adolescents' Ability to Protect Their Own Sexual and Reproductive Health

This section explores adolescents' hopes and plans for the future, as those with positive aspirations for the future may be more inclined to protect their sexual and reproductive health. In addition, the section explores the things that affect adolescents' hopes of achieving their aspirations. Young men and women were also presented with hypothetical situations about being pressured to have sex or drink alcohol understand their perceived of self-efficacy in dealing with such situations.

Aspirations

Respondents were asked what their lives would be like in the next five years and what would be the barriers to achieving their goals. The most common aspiration voiced was to complete their education. Respondents with this goal said that completing their education would enable them to get a good job, lead an independent life and support their parents and other relatives. Both urban and rural adolescents were among those who talked about education, and more than half of the respondents who wanted to complete their schooling were in school at the time of the interview. One of the major barriers to completing their education was the lack of financial resources to pay school fees and purchase other needs, such as clothes. There were some respondents who mentioned becoming pregnant or making a girl pregnant as one of the barriers to completing their education.

After finishing school, some respondents mentioned a wide range of jobs they wanted to have—doctors, professors, lawyers, members of parliament, pilots, drivers, teachers, soldiers and nurses—while others did not specify what they wanted to become. Two rural respondents, one male and one female, aspired to become president. There were two respondents aged 18 and 19 who said they wanted to become musicians, and they admired local musicians. The major barrier to achieving the skills for the job they wanted was a lack of financial resources.

Nearly one in five respondents said that they wanted to engage in farming and most of these were older adolescents who were rural and out of school. According to these respondents, one of the barriers they were facing was a lack of financial resources.

In sum, almost all of the respondents in Blantyre had expectations for themselves of finishing school and getting a good job that would allow them to support themselves and their families. In rural areas, it was more common for adolescents to have aspirations of working in farming and it was more common for them to have unprotected sex. Young women in rural areas with higher aspirations were abstaining and young men in rural areas were using condoms or abstaining.

Reactions to a Hypothetical Situation Where They Are Pressured to Have Sex

All respondents were presented with a hypothetical situation in which the respondent was pressured to have sexual intercourse. Most respondents, a high proportion of them male, felt confident that they could refuse sexual intercourse. A rural, in-school 18-year-old female said, "I can tell him not to force me. If it's 'no,' it's 'no' full stop." Reasons given by males for refusing sex in this exercise were being afraid of AIDS (urban and rural youths said that if a female is trying to have sex with them, it is because she has a disease she wants to spread); because being told to have sex by a female was enough of a reason to refuse sex, since they did not see it as appropriate to be told what to do by a female; and a few boys said they were more likely to refuse sex with beautiful girls, since they believed that a beautiful girl was more likely to have been more sexually active than other girls and would therefore be more likely to have a disease. A few other reasons mentioned by young men were that his mother and grandparents prohibited him from doing it, that they would not be married and that he could not support her should she become pregnant.

Another common response was to physically move away from someone who was pressuring them to have

sex, by either sneaking, walking or running away. A rural, in-school 17-year-old female said that if her male partner insisted, "Still more I will not accept because he doesn't have control of my body and I can walk away." A rural, out-of-school 18-year-old female said, "I cannot have sex with him when I don't want…because I don't want to be the HIV/AIDS victim."

Female respondents of all ages who were both in and out of school said they would end the relationship if a male tried to pressure them to have sex. An urban, out-of-school 18-year-old married female with a child said that she would end the relationship because having sex means that she could get pregnant again. Males said that they would end the relationship because if the female was pressuring them to have sex, it would mean that she is a harlot "because a normal woman cannot tell a man that 'Let us go and have sexual intercourse'" (rural, out-of-school 16-year-old male), or because the respondent could not condone that kind of behavior.

Of the full sample, one out of ten respondents (males and females) said that if confronted with pressure to have sex, they would appease their partner and have sex.

> *On such situations what makes you vulnerable is love. That's what makes a person do something. You start thinking that maybe if I say no he will go for another girlfriend. Then you just say,* "I should allow him." *It is how you find that you have done sexual intercourse (urban, out-of-school 18-year-old female).*

> *This is a very big problem and I think if he would like to have sex you cannot completely say "no" (urban, out-of-school 18-year-old female).*

> *I: Suppose you had a boyfriend who wanted to have sex with you? How would you deal with the situation?*
> *R: I would take it since I already said "yes" in the first place by going into relationship.*
> *I: Because you said yes to his proposal?*
> *R: Yes (rural, in-school 13-year-old female).*

> *I want to please him (rural, in-school 14-year-old female).*

One urban, out-of-school 18-year-old woman described having sex as part of the transactional negotiation:

> *I: What about if your boyfriend said you should go and have sex, what can you do?*
> *R: If he is not selfish that means you will also not be selfish. You will give him the things. If he also does not do good things then you too you become selfish.*
> *I: I should listen properly here, you are saying the man, money in hand, if he wants to taste you, will allow him?*
> *R: Yes.*
> *I: What about if the one who is selfish keeps on insisting, what can you do?*
> *R: Nothing. I can't help him.*
> *I: Will this relationship be okay?*
> *R: It can end. He should be selfish with his things, while mine should be easy to get? There will be nothing like that.*
> *I: Does it mean that you did not have sexual intercourse with your first two boyfriends because they were selfish?*
> *R: The first one was really selfish. But this second one was not selfish. I have some clothes which were bought by him.*
> *I: But why did you not allow him to taste?*
> *R: (Laughs) Because he was somebody who was patient. Should you force a person to taste? No, he would be surprised: "Why are you forcing me to taste?"*

This respondent described again the control that females can exercise regarding avoiding sexual intercourse if they are not being properly remunerated for it.

The hypothetical scenario of a girlfriend pressuring her boyfriend to have sex was viewed by the young men with skepticism, since it seemed unlikely to them that it was even a possibility. Some respondents assumed that a young woman would only insist on having sex if she wanted to pass on a disease such as HIV. An urban, in-school 13-year-old orphan went so far as to say he would beat a girl who tried to pressure him to have sex. Since the scenario was hard for many of the males to conceive of, their responses should be interpreted with caution since their difficulty in imagining the situation might have influenced their responses.

If I do not want to do it? I could tell her to wait until the day that I would like to have it. This is so because I don't want to do it at that time. But if she insists, I would accept it because…you know we boys think that that is right [to have sex] so if she insists so much and I am attracted to [her]...then it will be done according to her will (urban, in-school 16-year-old male).

I: What if your girlfriend suggests that you should have sex, what can you do?
R: I can accept that.
I: Why can you accept?
R: (pause for 15 seconds) Because she has offered me sex.
I: So you don't refuse offers?
R: Yes (rural, out-of-school 15-year-old male).

R: Since it's her who has told me, then I would do it.
I: What would make you do it, since you did not want to do it in the first place?
R: Because she has said it and to refuse she would think that I am a baby (rural, in-school 12-year-old).

A rural, in-school 18-year-old said that he would have sex within marriage if pressured and a rural, in-school 17-year-old said that if he did not have sex with her she would doubt the strength of his love towards her.

In the face of pressure to have sex, one in ten respondents of all ages said they would insist on condoms. Four said that they would have sex after both had had their blood tested.

Reactions to a Hypothetical Situation Where They Are Pressured to Drink Alcohol

Adolescents were also asked another hypothetical question: "If a very close friend wanted you to use alcohol and you did not want to, how would you deal with the situation? What if your friend insisted, what would you do?" Again, this question was asked to get a better understanding of how able adolescents felt to resist pressure to do something potentially risky.

Almost all the respondents said that they would either refuse or walk away, and if their friend insisted, they would either continue refusing or they would take specific measures such as severing the relationship. More female respondents than males said that they would sever relationships. A number of respondents said that if their friend insisted, they would inform their parents, his or her parents, or other people so that they could reprimand him or her. For example an 18-year-old boy from Rumphi said that he would tell his mother if the person insisted; this was also expressed by a 13-year-old out-of-school girl from Blantyre. On the same note, a 14-year-old girl from Mchinji said that if the person persisted in pressuring her, she would cry for help so that onlookers would make that person feel ashamed of what she was doing. There were a few respondents who said that they would refuse but if their friends insisted, they would go with them and drink Fanta or tea instead of beer; if this failed, they would leave the place. For example, a 17-year-old single mother from Blantyre said:

I: If a friend wants you to drink beer what can you do?
R: No I don't drink beer?
I: If s/he tells you "Let's go—you should taste brandy"?
R: I will tell him/her that s/he should better buy me a Coca Cola.
I: What about if he says he can't buy Coca Cola but beer?
R: I will let him/her to go and drink.
I: What else can you do if s/he insists that you must go to drink?
R: No, I will refuse because if I can drink, I will be drunk and men will take advantage.
I: What kind of advantage?
R: They can just be touching me.
I: What about if s/he insists?
R: If he or she insists that means s/he has a hidden agenda. Then I can refuse. Its better s/he should buy me Coca-Cola. If s/he says no then I will just leave.
I: So if you meet again; are you going to chat as usual?
R: Nothing, there will be no chatting because s/he had wronged me. S/he is no more my friend.

Some respondents said that they would refuse for religious reasons or that if a friend pressured them to drink it would be grounds for ending the relationship. Some said they would warn the person about the dangers of alcohol. Those adolescents who talked about refusing to drink because of the dangers associated with alcohol mentioned things like alcohol having bad effects, going after women when one is drunk and en-

gaging in bad behavior like swearing at people. Other adolescents said that they would be bold and firm in their decision not to drink, even if the other person insisted, because they feel that there is no way that some one can force them to do a thing that they do not do.

Initiation Ceremonies

There are two major types of initiation that boys and girls undergo, namely the traditional ceremonies and ceremonies at the church where they get advised. Half of the males said they underwent a traditional initiation ceremony. There were two major forms of traditional initiation ceremonies that males reported having undergone: One was circumcision which is practiced in Mangochi and the other is being initiated into the *gule wankulu* secret society,[57] as practiced in Mchinji and Ntchisi districts among the Chewa. Both signify that one is a grown-up. Of those who were initiated, the majority were initiated when they were aged 12 or younger. More females than males said that they had attended traditional initiation ceremonies.

What is communicated to initiates during initiation ceremonies

In districts such as Ntchisi and Mangochi, where initiation rites are practiced widely, after being initiated, some boys reported that they were advised to have sex with girls in a ceremony known as *kuchotsa fumbi* or *kusasa fumbi,* without which they were told that they would die or feel pain in the penis. Other boys reported that they were advised not to have sex with girls. They were also told about the need to respect their parents and other elders by kneeling in front of them, not going into their parents' bedrooms and obeying their parents. In addition to this, male initiates were told:

- not to use condoms so that the circumcised penis gets healed to the fullest (15-year-old, Mangochi),
- never to hit a woman, however cross one might be (12-year-old, Ntchisi),
- not to have sex while still young, but at age 20 (15-year-old, Ntchisi), and
- not to have sex with small girls, as one can be arrested (17-year-old, Ntchisi).

Girls are not circumcised in Malawi. Rather, initiation ceremonies are generally geared towards teaching girls about their bodies and how to behave respectfully. Female respondents mentioned that during the initiation ceremony, one of the major messages that is communicated to them is to avoid boys in order to prevent pregnancy and AIDS and so that one can complete one's education. Other advice that was communicated to girls during this period included:

- not to have sex for two or three weeks after a menstrual cycle to avoid pregnancy (18-year-old, Blantyre);
- not to have premarital pregnancy, as it is dangerous (14-year-old, Mchinji);
- to use condoms and other family planning methods to prevent pregnancy (18-year-old, Blantyre);
- to "clean the dust"—i.e., have sex (two females aged 18 and 19, Blantyre);
- "to pull the labia as men pull on them" (labia elongation is practiced as genital beautification by young women; their partners participate in the practice at times as well) (19-year-old, Blantyre); and
- not be rude to husbands (18-year-old, Blantyre).

A number of girls also mentioned that they were taught how to take care of themselves when they experienced menstruation (according to the respondents this is especially important, as it can be a cause of embarrassment if blood starts dripping and is seen by others) and prescriptions on social behaviour during this period: for example, that sex is not permitted because women can infect men with diseases and they can die, that they are not supposed to put salt in relish during this period, and, in some regions such as Rumphi, menstruating women are not supposed to cook.

In all the districts it seemed that girls were told that sex with boys is not condoned after initiation because of their potential to get pregnant; hence, after initiation girls are told not to interact with boys in order to avoid pregnancy and AIDS. While most female respondents said that sex is discouraged, those from Ntchisi and Mangochi talked of having been encouraged to have sex after initiation to "remove the dust," and a number of female respondents in these districts acknowledged having done so but that soon after initiation, they stopped having sex and interacting with members of the opposite sex, as they feared they would become pregnant.

These initiation ceremonies took place over the last few years when HIV/AIDS had already become a major problem, yet very few respondents reported that they were told to use condoms or to abstain from sex or about the dangers of HIV. The respondents who were encouraged to have sex soon after being initiated did

not receive advice about the dangers or risks involved in the ceremonial sex they were expected to perform.

Reasons for being or not being initiated

Those who were initiated or circumcised gave a number of reasons for having been initiated, including wanting to hear the advice given during such ceremonies, envying friends who have gone for initiation, believing that circumcision cleanses one from sins and needing to follow the example of Jesus, who was circumcised. Some adolescents did not know why they were circumcised and one even related that he did not want to but was forced to undergo initiation.

Even though some adolescent males came from areas where circumcision or elaborate initiation ceremonies are practiced, they were not circumcised for a number of reasons. One respondent pointed out that initiation ceremonies are conducted for a fee, and thus excludes those who are unable to pay. Some respondents pointed out that Christianity does not condone some of the traditional initiation ceremonies and people who have embraced Christian values may not attend these ceremonies. The rest of the respondents did not give reasons for not being initiated.

Like traditional ceremonies, the religious ceremonies also advised young men and women to respect their parents and elders. Yet, unlike some traditional ceremonies, the religious ceremonies unanimously discouraged individuals from having sex.

Those who attended initiation ceremonies were in most cases advised not to associate with those who have not been initiated. While association is not wholly prohibited, fear is inculcated in new initiates: If they reveal what happens during initiation ceremonies, they are warned that their parents will die suddenly, they will be bewitched or they will be punished and told to pay for a goat. This is why some informants said that they could not reveal what was said during the initiation ceremonies to the interviewers.

The Role of the Church and Religion

Almost all the respondents said that they belonged to a religious group. The predominant groups were Muslim, mainline Christian churches (Church of Central Africa Presbyterian, Catholic) and Pentecostal churches (Church of Christ). Some were members of their church's choir and drama groups.

According to respondents, religion itself and belonging to a certain religious group is important. Religious groups encourage them to grow up right in their spiritual life and embrace the moral values that constitute their faith, such as not to engaging in sexual intercourse until marriage, not committing adultery, engaging in steadfast prayer, not stealing, not killing and obeying one's parents. In most cases, respondents said that religious representatives, such as youth leaders, talked about reproductive health issues: encouraging adolescents not to have sex before marriage, encouraging them to practice abstinence in order to prevent AIDS and pregnancy, and teaching them that AIDS is a dangerous disease that is incurable. In some churches, sex is perceived as a sin, so people should avoid it. It was less common for rural respondents to say that the church talks about AIDS and pregnancy prevention.

The use of condoms was rarely mentioned in relationship to the church and respondents noted that talk about using condoms was absent from sermons. Yet there were different opinions about whether this should be happening. One respondent said that if the church did talk about condoms, people would be tempted to commit adultery. Another respondent said that it would be better if the church talked about condom use. Yet another respondent suggested that the church should allow youth to use condoms, as it is difficult for youth to remain abstinent.

Most of the respondents said that they agreed with the religious teachings they had received. In some cases, they expressed fear of the repercussions that may arise from doing things against these teachings: For instance, some adolescents feared that if they did not obey their God, they would be in trouble with Him. Several others disagreed with religious teachings for various reasons: One said he does not agree with the teaching that says no adultery because he says that "sex is life" for men. Another young woman talked about the hypocrisy in the church—the church elders are not abstaining, so why should she? And another young woman disagreed with the fact that her church, the Church of Central Africa Presbyterian, promotes the use of condoms. Adolescents did not mention the church addressing issues of care and compassion for people living with AIDS.

Chapter 10

Conclusion

These findings from the 102 in-depth interviews with adolescents highlight their knowledge, experiences and perceptions about important sexual and reproductive health issues, such as pubertal body changes; HIV and AIDS; sexual and reproductive health problems and seeking care; nonmarital pregnancies and childbearing; adolescent romantic relationships, including experiences with and reactions to the first sexual experience; and the sources of influence on adolescents' ability to protect their own sexual and reproductive health.

Provision of Sexual and Reproductive Health Information

While young people are talking to friends, teachers, grandparents, aunts, youth centers, health workers and NGO staff about sex-related matters, there seems to be a difference between knowing about body changes and being prepared for them. While the majority of adolescents knew about pubertal changes, they were not prepared for them. Overall, females had less information than males. Those most likely not to have any information were in urban areas. This may be because rural areas have stronger and more extended social networks than urban areas where traditional pathways of communication might be breaking down. If the nuclear family has migrated on its own, adolescents might not have the aunties, uncles and other extended family members to turn to for information. If adolescents have more information have about their bodies, in particular their sex organs, they may be in a stronger position to seek and find information and resources to take care of their sexual health.

Adolescents desire more information on HIV transmission and infection prevention and how pregnancy occurs. More could be done by adults to initiate discussions on sexual and reproductive health issues with adolescents before they become sexually mature and initiate their sex lives. The direct need for this information is evident in the low contraceptive use at first sex and the ubiquitous misinformation about when in a woman's menstrual cycle she is most likely to get pregnant. Perhaps the number of adolescents who said they simply did not think about contraception at first sex might also be reduced if adolescents had greater information about when someone is at risk of either becoming pregnant or causing a pregnancy.

Most respondents reported that they do not have any barriers to accessing information on HIV and AIDS and pregnancy prevention. Fear of being shouted at, shyness, being busy with household chores, having no one to talk to and having no access to service providers were the barriers that some adolescents reported. Because adolescents expressed a preference for getting sexual and reproductive health information through health workers and NGO staff, individuals in these positions should be encouraged to have more discussions with adolescents, as this study has shown that adolescents find such discussions are useful. There is, of course, a need for capacity building for the effective delivery of information and services—be that at health centers, NGOs, schools or communities. Traditional counselors who perform initiation rites should amend the information and prescribed behavior they promote in light of the HIV/AIDS epidemic, since some of the behavior encouraged at initiation places the adolescents at risk of HIV. These individuals would be the appropriate people to pass on this invaluable information to young people embarking on their sex lives.

Correct Misconceptions About HIV/AIDS and Pregnancy Prevention

Misconceptions about HIV and AIDS still persist among adolescents—for example, that one can visually identify someone with AIDS and that condoms often have small holes through which HIV can pass. In some quarters, AIDS is perceived as a punishment from God. Regarding pregnancy prevention, some adolescents believed that urinating post-sex and having sexual intercourse infrequently were contraceptive methods. Others misidentified the woman's fertile period as

occurring during her menstrual period. Sex education both for in-school and out-of-school adolescents should work towards replacing these misconceptions with accurate sexual and reproductive health information.

Improve Health Care for Sexual and Reproductive Health Problems

Most adolescents who had had a sexual or reproductive health problem sought care from traditional healers. Hospital treatment was only sought after drugs bought from shops or traditional medicines failed. Lowering the cost of health care for adolescents might increase adolescents' timely access to effective medical services. Additionally, training local health providers in the necessary knowledge and medicines to treat STIs would prevent teens from having to travel to hospitals. Traditional ways of communicating about sexual and reproductive health issues, such as through initiation ceremonies or conversation with elders, could be used to educate adolescents about when they need to seek health care and to encourage them to get health care when needed. Culturally-based discomfort regarding communication between youths and adults on sexual and reproductive health issues could be addressed by individuals in leadership positions role-modeling open communication with the young adults in their lives on sexual and reproductive health issues. While this goes against traditional models of communication in Malawian society, it is a change that can be justified because it can improve the well-being of Malawi's youth.

The provision of services in Malawian public health facilities is done free of charge with the exception of some paying wards in referral hospitals. Nevertheless, adolescents' lack of money is one of the major factors determining whether they seek care. Adolescents may not want to seek health care from public facilities because of lack of appropriate medicines in these facilities or because of the way providers treat them. The government should ensure that its facilities are well stocked with medicines and that the providers in these facilities are friendly to adolescents.

Support the Development of Positive Relationships Among Adolescents

The equation of relationships with sex that many adolescents without relationship experience voiced does not bear out in the data: Among the adolescents who had had relationships, one-third had had a relationship that did not include sexual intercourse. Other activities that adolescent couples did together were positive and risk free: encouraging each other to work hard in school, chatting and watching soccer games. Therefore, messages in schools and at home should encourage adolescents to form positive relationships that help them succeed including information on balancing relationships with school responsibilities.

Help Adolescents Stay Healthy

The vast majority of respondents do intend to have a romantic relationship before marriage. Nevertheless, adolescent sexual behavior is seen—even by adolescents themselves—as a negative, dangerous thing, and social sanctions are imposed on adolescents who are found to have been in a romantic relationship. Yet, relationship formation is widespread and this has implications for adolescents' sexual and reproductive health. Adolescents who choose to engage in relationships deserve the social support to equip themselves with the skills they need to be able to successfully negotiate these experiences in their lives. This includes helping adolescents master better communication skills around sexual intercourse, especially regarding condom use, so that they would be in a stronger position to advocate for condom use with their partners. As lack of trust was prevalent in the relationships, building communication skills should simultaneously build trust between partners.

Since females more frequently named their sexual debut as coerced than males acknowledged committing coercion, there is a need for greater couple communication and addressing unequal power according to gender in the relationship so that both members of the couple are clear about each other's feelings about engaging in sexual intercourse. Yet that may not fully address the high proportion of sexual debuts that females called forced, as some females may be describing consensual sex as forced as a result of a social taboo against females being sexually forward—a taboo that is underscored by the fact that only a minority of males and no females described any female-initiated sexual interactions. Messages targeted at males should take into account traditional conceptions of masculinity, and use these traditional conceptions to promote responsible sexual behaviour, for example equating masculinity with safeguarding the health of one's partner.

The secrecy surrounding many relationships puts some females at risk of unwanted sex since the secrecy may make them unwilling or unable to turn to parents for assistance in avoiding an unwanted sexual experience. If parents were more accepting of adolescent women's sexual activity, parents would be in a stronger position to protect their daughters and thus help reduce some of the sexual activity taking place—an outcome

that parents would undoubtedly support. Acknowledging females' sexual activity would also open the door to be able to provide females with the skills needed to cope with male pressure to engage in sexual intercourse, avoid sexual coercion and negotiate safer sex.

The lack of basic necessities is a reason why some young girls are engaging in sexual intercourse since having sex affords them an opportunity to get access to some goods. By having sex, they run the risk of having an unwanted pregnancy or contracting STIs, including HIV. Identifying the most vulnerable adolescents—for example, orphans—and targeting them with social safety nets that would help these girls meet their basic needs which might help protect them from engaging in risky sexual behaviors.

Promote the Use of Contraceptives Among Adolescents

The mistrust of condoms needs to be addressed in this high HIV setting. This is a challenge, especially considering Malawi's history of perceiving condoms as part of a large neoimperialist population control tactic. Even though most adolescents in this study were afraid of HIV/AIDS, the level of concern about STIs among females exceeded the actual use of barrier methods of protection against STIs. This difference is, in part, accounted for by a false sense of security that young women may have from agreeing to be faithful to their partners as well as by males' unwillingness to use condoms. Yet the information on trust is conflicting—while the vast majority of respondents say they do not trust their partners to be faithful when they are out of their partners' sight, the majority say they do not use contraceptives because they trust their partner (to be faithful or to be disease-free). Congruent with the concerns voiced about the lack of trust they have in their partner, a large proportion of adolescents regretted their sexual debut experience because it exposed them to the risk of pregnancy, HIV or both. Therefore, there is a disjuncture between the way adolescents conceive of the risk their partner represents and the reasons they give for not using contraceptives. Yet adolescents, who had aspirations for themselves to finish school and get good jobs were better contraceptive users than adolescents with lower aspirations. Since lack of access was not a primary reason for not using contraceptives, social expectations and roles need to be addressed more urgently than broader access. Improving access to education and career opportunities for youth might have the indirect effect of improving their contraceptive use habits, as well. Also, it is critical to educate individuals on accurate information about condoms that dispel myths prevalent in Malawian culture about condom ineffectiveness.

Support Pregnant Adolescents and Unwed Adolescent Mothers

Girls who become pregnant and have children before marriage are treated as social pariahs. In worst-case scenarios, they may be disowned by parents and other relatives because of the shame they purportedly bring to the family. Marriage prospects are also limited, as they are considered "out-of-fashion." They usually drop out of school and men responsible for the pregnancy frequently deny responsibility, thus leaving the girl to take care of herself and her child. Adolescent fathers are rarely stigmatized. Civic education to change social attitudes towards girls who are pregnant or have a child should focus on supporting them in the situation in which they find themselves. It also involves empowering girls so that they can have greater control over their reproductive experiences in the future.

In sum, more fact-based information about physiology and contraception, greater social acceptance of adolescent relationships and improved couple communication would be a positive step towards reducing sexual risk-taking in adolescent sexual relationships.

Appendix A
Adolescent Interview Guide

1. Brief background information

a. Family

- Who do you live with here?
- How long have you been living in this community?
- Are you married?
- Have you ever had/fathered a child?

b. Individual characteristics

- What is your age (at last birthday)?
- Are you a student in school?
- What do you usually do during the day?

2. Puberty and socialization

a. Body changes

- When a young person is growing into an adult, what are some of the changes in the body that happen?
- Have you experienced any changes in your body (pubic hair, voice breaking, menstruation, wet dreams, rapid growth, beards or breasts)?
  - o When did you first start experiencing body changes?
  - o How did you feel about these changes happening to you?

b. Information about puberty

- Has anyone ever talked to you about body changes that happen when a young person becomes an adult?
  - o Can you tell me about who talked to you and what you talked about?
  - o When were you first told about these changes?
  - o In what ways, if any, did you find these talks useful or not?

c. Initiation ceremonies

- Have you had an initiation ceremony?
  - o Can you tell me about your experience? (When? Where? What happened?) Who performed the ceremony? Why do you think the ceremony was done?
  - o What did you think about it? Would you recommend it for a younger family member or friend who has yet to go through it? Why or why not?
  - o In what ways, if any, did this change how you act towards (the opposite sex)? How about with (the same sex)?

3. Relationships

a. First boyfriend/girlfriend

- When did you have your first boyfriend/girlfriend, if ever?
  - o What is/was he/she like? (age, schooling).
  - o How did you come to know each other?
  - o Did anybody know about your relationship (Who? Who else? What were their reactions?)?
- What about your parents/guardians?
  - o What were the (sexual) things you did together?
  - o How did you feel about this relationship?
  - o What happened to this relationship?
  - o RELATIONSHIP ENDED: How long did this relationship last? What happened after that? Did you have other boyfriends/girlfriends?
- NEVER HAD A BOYFRIEND/GIRLFRIEND: [Optional question?] What are some of the reasons why you have never had a boyfriend/girlfriend?
- Have you ever wanted to have a boyfriend/girlfriend?
  - o What have you done, if anything, to try and get one? What was the outcome?
  - o When do you expect to have your first girlfriend/boyfriend?

b. *First sexual experience*
- When was the first time you had sexual intercourse (if ever)?
  - o How did this come to happen?
  - o How did you feel about it then (happy, curious, regrets)? How about now?
- NEVER HAD SEX: What are the reasons why you have not had sexual intercourse?
  - o Probe for fear of pregnancy, fear of sexually-transmitted diseases (like HIV/AIDS), religious reasons, no boyfriend/girlfriend, aspirations like staying in school.
  - o Has anyone pressured you to have sexual intercourse? Who? In what ways?
  - o Has anyone pressured you to not have sexual intercourse? Who? In what ways?
  - o How do you feel about not having had sexual intercourse? (happy, curious, regrets?)
  - o When do you expect/plan/anticipate to have sexual intercourse for the first time? Why then?

c. *EVER HAD SEX: Current or last sexual relationship*
- Let's talk about your relationship with the person you last had sexual intercourse with. What was he/she like? (age, schooling).
  - o What were the things you could talk about together?
  - o What were the things you could not talk about? Why couldn't you talk about these things?
  - What kind of decisions did you make? What kinds of decisions were made by him/her?
  - o How about decisions to prevent pregnancy? What did you decide to do? How did you reach that decision? Did you both agree/disagree?
  - o How about protecting against sexually-transmitted infections? What did you decide to do? How did you reach that decision?
- When you had sex with him/her, did you ever think you were at risk of pregnancy, HIV/AIDS or any other kind of sexually-transmitted infection? (It is important to note that each of these conditions should be probed on separately because they mean different things to different adolescents)
  - o IF YES: What happened? How did you feel about it?
  - o IF NO: Why not?
- Did you ever feel pressured by him/her to do something that you thought would put you at risk for pregnancy, HIV/AIDS or any other kind of sexually-transmitted infection?
  - o IF YES: What happened? How did you feel about it?

4. Healthcare seeking

a. *Health problems and steps in getting help*
- Let's talk about the last time you needed care for a health problem. What was the problem? What did you do? Where did you go?
- Have you ever experienced a health problem such as pains or sores on your private parts? [IF NONE, ASK: Have you had any kind of reproductive health problem—anything sex or pregnancy-related?]
  - o When did this last happen?
  - o What was the matter the last time this happened? What do you think was the cause?
  - o Who did you first talk to about it? Why? Were there others? Who? Why?
  - o What did you do first? (Who did you go to? Why? What happened?)
  - o What did you do next? (How long was it before you did this? Who did you go to? Why? What happened?) GO THROUGH ALL THE STEPS TO GET CARE.
  - o Was there something you thought about doing but you could not? (What was that? What were the reasons you could not do it?)
  - o What could you have done to prevent this problem, if anything?

b. *IF NO CARE SOUGHT*
- What were the reasons you didn't seek care at all?
- What were the problems you had in trying to get care?
- What would have made things easier for you?

c. *IF NO REPRODUCTIVE HEALTH PROBLEMS: Hypothetical health care situation*
- If you had a problem with your private parts, how would you deal with the situation? [If too sensitive a reaction from young girls, consider "If you had a menstrual problem"]
- How confident/sure are you that you could do that?
- What would make it easier for you to deal with such a problem?

5. Risk Assessment and Perceptions

a. *Risk assessment*

- What are some of the major problems facing you now?
  - o Which one of these is the most critical? Why?
  - o How much of a problem do you think AIDS is for you compared to (most critical problem named above, if not HIV)? What makes you feel this way?
- What things do you think are "risky sexual behaviors"? (probe on having sexual intercourse without a condom; having more than one sexual partner)
  - o Why do you think these are risky?
  - o What do you think may happen to someone who does these kinds of things?
- What kinds of sexual behaviors do you think are not risky?
  - o Why do you think these are not risky?

b. *Hypothetical risk situations*

- Let's talk about some of the situations young people your age find themselves in. Suppose your closest friend wanted you to use alcohol and you did not want to: How would you deal with that situation? What if your friend insisted, what would you do?
- Suppose you had a boyfriend/girlfriend who wanted to have sex with you when you did not want to: How would you deal with that situation? What if he/she insisted, what would you do?

c. *Perceptions*

- HIV/AIDS: What comes to your mind when you hear about AIDS?
  - o What makes you think that way?
  - o What do you think about people who have HIV/AIDS?
  - o Do you personally know someone who has HIV/AIDS?
  - o What do you think you can do to prevent HIV/AIDS?
- Premarital pregnancies: What comes to your mind when you hear about someone having a baby before marriage?
  - o What makes you think that way?
  - o What do you think a person can do to prevent having a baby before marriage?

6. Information and communication

a. *HIV/AIDS*

- Has anyone ever talked with you about HIV/AIDS?
  - o Can you tell me about who talked to you and what you talked about? (when first happened, when last happened, what talked about, with whom)
  - o In what ways, if any, did you find these talks useful or not?
  - o IF EVER IN SCHOOL: Have you gotten any information about HIV/AIDS at school? (What was talked about? Condom? Delaying sexual intercourse? Staying a virgin until marriage? The importance of being faithful?) Who talked about these issues (guest speakers, head teachers, guidance and counseling teachers, class teachers, etc).
- Are there people you feel you can go to for information about HIV/AIDS?
- Whose information do you trust about HIV/AIDS and how to prevent it? Why? Have you talked with (this person/these people)?
- Are there times when you tried to get information and could not do so? What kind of information were you trying to get?
- What type of information do you really want about HIV/AIDS?

c. *Pregnancy*

- Has anyone ever talked with you about preventing pregnancy?
  - o Can you tell me about who talked to you and what you talked about? (when first happened, when last happened, what talked about, with whom)
  - o In what ways, if any, did you finds these talks useful or not?
  - o IF EVER IN SCHOOL: Have you gotten any information about preventing pregnancy at school? (What was talked about? Contraceptive methods? Delaying sexual intercourse? Staying a virgin until marriage?) Who talked about these issues (guest speakers, head teachers, guidance and counseling teachers, class teachers, etc).
- Are there people you feel you can go to for talk about preventing pregnancy?
- Whose information do you trust about preventing pregnancy? Why? Have you talked

with (this person/these people)?
- What type of information do you really want about preventing pregnancy? Why?

d. Other information
- What other things do you want to know more about? (probe on relationships)

7. Religious groups
- Do you belong to a religious group?
  - o What group?
  - o How does this group help you make decisions in your everyday life?
  - o Has this group talked about or done any activities that have to do with HIV/AIDS or preventing pregnancy (or anything else health-related)? What did they do?
  - o What do you agree with from what your religious group teaches about these things? What do you disagree with?
  - o If not in a group – why not?

8. Perceptions of Self and Aspirations

a. Perceptions of Self
- How do other people think about you?
  - o What do your peers think?
  - o Your family?
  - o Other people in your community?

b. Aspirations
- What do you want your life to be like in the next five years? (What about your education or work?)
  - o What could make these things more or less likely to happen?
  - o How do you think you can overcome the obstacles?
- What things do you hold most dear in your life?
- Who do you most want to be like? What things make you want to be like this person?
- What are the things in your life that you feel happy about?
- What are some things that you hope to achieve in your life?

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