

**Adolescent Sexual and
Reproductive Health in Malawi:
Results from the 2004
National Survey of Adolescents**

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Executive Summary

As part of the Protecting the Next Generation Project, a national survey of adolescents aged 12–19 was conducted in Malawi. The survey was aimed at producing national-level data on adolescents' knowledge, attitudes and practices that are either protective or put adolescents at risk of HIV infection and unwanted pregnancy. This survey was conducted between March and August 2004 by the National Statistical Office in collaboration with ORC Macro, the Centre for Social Research and the Guttmacher Institute. A total of 4,031 males and females were interviewed from urban and rural areas.

Characteristics of Respondents

More than 90% of respondents were not in a marital union and had not had a child. Nearly 25% of the respondents were orphans having lost at least one of their parents; 6% had lost both parents. Sixty-one percent of females and 64% of males had completed five years of schooling or less. The major reasons for dropping out of school included inability to pay school fees, lack of interest, illness and pregnancy. Most respondents were Christians and reported that religion was very important in their lives. Biological parents were less likely to have talked to adolescents about sex-related matters compared with other family members and nonrelatives. Thirty-eight percent of females and 32% of males had undergone initiation rites. Twenty percent of the males had undergone circumcision.

Sexual Activity and Relationships

Twenty-one percent of 12–19-year-old females had had sexual intercourse at the time of the survey: 3% of 12–14-year-olds and 37% of 15–19-year-olds. Among the sexually active females, slightly fewer than half were in union. Forty-two percent of males, almost all of whom were not in union, had had sexual intercourse: 19% of 12–14-year-olds and 60% of 15–19-year-olds. Fifty-five percent of females and 85% of males who ever had sex had their first sex because they felt like it.

Among all sexually active respondents, 16% of females reported having sex for the first time because they were married. Approximately 4% of the females said they were forced to have sex, while 6% said it was because they were expecting gifts or money for their partner. The majority of the females reported that their first sex partner was older than them. More than 70% of the respondents did not use any contraceptive at their first sex, with condom use being higher among unmarried adolescents than married ones. Seven percent of the females and 3% of the males said they had ever been physically forced, hurt or threatened into having sexual intercourse. Eighty-five percent of females and 67% of males aged 12–14 had never had sex, never had a boyfriend or girlfriend and had never (been) kissed or fondled. For adolescents aged 12–19 who had never had sex, the most popular reasons for not having had sex were to avoid STIs and AIDS (70%) and being afraid of pregnancy.

Contraception

Fifty-six percent of the sexually experienced females and 43% of the sexually experienced males had ever used a contraceptive method. The condom was the most commonly used method accounting for 81% of method use among females and 100% of method use among males. Twenty-eight percent of females and 15% of males reported having ever used traditional methods of contraception. Even though 80% of females and 57% of males had heard about the fertile period, only 20% of them had correct knowledge of the fertile period. Among females, use of contraception at last sex was 39% with boyfriends and 21% with spouses. Among males, use of contraception at last sex was 38% with a girlfriend and 29% with a casual acquaintance. For males and unmarried females, the condom was the most commonly used method, while injectables were the most common method among married women.

Pregnancy and Childbearing

Eighty-six percent of females in union had ever been pregnant, while 10% of those not in union had been. Sixty-four percent of females in union had ever given birth, while only 8% of those not in union had. Fewer than 2% of the males in the same age-group had ever made a girl pregnant or fathered a child. Nearly 25% of females in union were currently pregnant at the time of the survey and just over half of these wanted the current pregnancy, while 27% did not want the pregnancy. Herbal drinks and tablets/pills, relatively unsafe but widely available abortion methods, were the most commonly cited ways of terminating a pregnancy. Fewer than 1% of the adolescents aged 15–19 reported ever trying to end a pregnancy or had been involved in ending a pregnancy.

HIV/AIDS and Other STIs

More than 90% of the respondents reported having heard about HIV/AIDS. Adolescents were aware of ways of reducing HIV transmission with 88% of females and 91% of males citing abstinence, 68% of females and 79% of males citing having one monogamous partner, and 76% of females and 86% percent of males citing using condoms consistently and correctly. Yet misconceptions remained regarding HIV being transmittable through the sharing of food, mosquito bites and witchcraft. About 40% of the females and 44% males personally knew someone who had the AIDS virus. With regard to stigma, more females than males agreed with the statement that a teacher with AIDS should not teach; that they would not buy fresh vegetables from a vendor who had HIV; and that they would not be willing to care for a family member who had AIDS. Approximately two-thirds of respondents said they had heard about STIs other than HIV/AIDS, with fewer younger adolescents having heard about STIs than older adolescents. Eight percent of females and 12% of males reported having experienced an STI.

Profiles of Young Peoples' Risk and Protective Behaviors

More than a third of adolescents perceived themselves to be at great risk of contracting HIV. More females in union thought they had a great chance of getting HIV, compared to those not in union. Sixty percent of all respondents reported that sexual acts that took place in the three months prior to the survey were not protected at all and only 24% of the sex acts were protected 100% of the time. Among those who had had sex in the 12 months prior to the survey, condoms were not used

at last sex because respondents felt safe, did not have a condom available, had a partner who refused (5% for both males and females) and, for females in union, wanted to get pregnant. More males than females had correct knowledge of how condoms should be used; however, more males than females agreed with the statement that condoms reduce sexual pleasure and that condom use is a sign of not trusting your partner. The majority of respondents felt it was not embarrassing to buy condoms.

Sexual and Reproductive Health Information and Services

Only 14% of females and 26% of males had received some kind of sex education in school; for the most part, sex education occurred prior to intercourse. Topics covered included STIs, how pregnancy occurs, contraception and how to prevent pregnancy. The major sources of information on contraception, STIs and HIV/AIDS were teachers and health personals, followed by the mass media. Adolescents preferred the radio as their source of information on contraceptives, while health providers were the preferred sources of STI and HIV information. The major barriers faced by adolescents to obtaining contraceptives or getting advice or treatment for STIs were feeling embarrassed or shy (33% of females and 27% of males) and being afraid (32% of females and 16% of males).

Approximately 70% of the respondents had heard about voluntary counseling and testing and while the majority of them wanted to be tested, only 3% of the respondents had actually been tested. The majority of the respondents who had been tested received counseling and the results of the test. Most who had not been tested said it was because they were not at risk. Fewer than 20% of the respondents did not want to be tested because they did not want to know their status.

Conclusion

Knowledge about how HIV is transmitted and how it can be prevented is almost universal. There is a high level of sexual activity among young people, yet more than 60% of sexual acts in the three months prior to the survey were unprotected. Wanting to get pregnant/make someone pregnant was the primary reason for not using condoms only among 8% of females and 1% of males. The fact that the majority of the sexual acts were unprotected puts adolescents at risk of contracting HIV. Females, especially married females, are particularly at risk of contracting HIV, as use of condoms for those in union is very low (as expected). A nontrivial pro-

portion of adolescents also reported that they have been forced to have sex.

While there is a high level of knowledge about contraception, incorrect knowledge about the fertile period, low usage of contraception and lack of knowledge of methods other than condoms put adolescents at risk of unwanted pregnancy. Misperceptions also exist among adolescents about how pregnancy occurs, which may influence adolescents' use of contraceptives. Low overall school completion may be a contributing factor to the persistently high levels of misinformation. There is a need to address factors such as the inability to pay school fees to reduce school dropout.

With regard to information sources for contraceptive methods and HIV/AIDS, teachers, health providers and the radio were the major sources of information. Health workers were the most preferred source. The major barriers to accessing sexual and reproduction health information and services were being embarrassed and/or afraid, with females more affected by these barriers than males. While HIV testing services are offered at government health facilities, the Malawi AIDS Counselling and Resource Organisation and private clinics, only 3% of the respondents had been tested.

These data point to the need to teach adolescents about different contraceptive methods and women's fertile period to provide adolescents with information and services that will protect them from HIV and unwanted pregnancies. Adolescents' attitudes towards condoms are a greater obstacle to use than are barriers to buying condoms, demonstrating the need to reduce stigma surrounding condoms and provide more education on the benefits of condom use. There is also a need for teaching better negotiation skills to girls to help them both avoid unwanted sex and enforce condom use when they do have sex. Taking cues from the adolescents themselves on how they prefer to receive information, health workers should be the forum through which youth-friendly services are provided.

Chapter 1

Introduction

The Protecting the Next Generation Project

Adolescent sexual and reproductive health is a critically important policy and programmatic area in Sub-Saharan Africa. An estimated 7% of women and 2% of men aged 15–24 years in the region were living with HIV at the end of 2004.¹ Eighteen percent of 15–19-year-old females in eastern/southern Africa and 21% in western/middle Africa had had a child.² Between 1990–2000, 25% of 15–19-year-old females in eastern/southern Africa and 38% of females in western/middle Africa were married.³ Given the urgency and scope of addressing adolescents' sexual and reproductive health needs, it is important to assess their current knowledge, attitudes and behaviors that either put adolescents at risk for HIV transmission and unwanted pregnancy or that are protective; examine why some adolescents are at higher risk of HIV transmission and unwanted pregnancy than other adolescents; document adolescents' barriers to seeking sexual and reproductive health services and information; and provide new information about what very young adolescents (aged 12–14) know and do with respect to sexual and reproductive health.

In 2004 a nationally representative survey of adolescents aged 12–19 was conducted in Malawi to address these information and service needs. The survey data contain more detailed information than is available in other surveys on a range of issues such as adolescents' views of health information and service sources; sexual relationships and partner characteristics; the consistency and correctness of condom use; exposure to and content of sex education in schools; and family and peer influences. An important strength of the survey is that it contains information on very young adolescents (those aged 12–14 years), about whom very little has been known up to now. This age-group holds particular potential in slowing the pace of HIV transmission in the next generation. Moreover, the survey also provides information of comparable depth and for a large sample of male adolescents, a group often neglected.

The purpose of this report is to provide a comprehensive overview of the results of this survey on sexual and reproductive health of 12–19-year-old females and males in Malawi in 2004. Results are mainly descriptive of the knowledge, attitudes and behaviors of adolescents, with attention to differences and similarities according to gender and age. Relevant policy and programmatic implications are noted throughout the report.

The 2004 survey is part of a larger, multiyear study of adolescent sexual and reproductive health issues called Protecting the Next Generation: Understanding HIV Risk Among Youth (PNG). The project, which is being carried out in Burkina Faso, Ghana, Malawi and Uganda, seeks to contribute to the global fight against the HIV/AIDS epidemic among adolescents by raising awareness of young people's sexual and reproductive health needs with regard to HIV/AIDS, other STIs and unwanted pregnancy; communicating new knowledge to a broader audience, including policymakers, health care providers and the media in each country, regionally and internationally; and stimulating the development of improved policies and programs that serve young people; and ultimately improving the health of young people.

In addition to the national surveys conducted in the four participating countries, the project includes evidence from multiple perspectives and methods of data collection in order to provide comprehensive information on adolescent sexual and reproductive health knowledge, attitudes and behaviors. As part of this project, a review of studies done on adolescent sexual and reproductive health was conducted and synthesis reports have since been published for the four participating countries.⁴ Fifty-five focus group discussions were conducted in 2003 with adolescents in the four countries* to increase understanding of the perceptions

*In Malawi, a total of 11 focus group discussions with adolescents aged 14–19 were conducted in urban Blantyre and rural Mchinji.

and beliefs that influence adolescents' behaviors and their use of health information and services.⁵ Also in 2003, about 100 in-depth interviews* with adolescents were conducted in each country in order to understand the social context of young people's romantic and sexual relationships and their health-seeking behavior. Finally, about 60 in-depth interviews in each country were conducted in 2005 with health providers, teachers, and parents, guardians and adult community leaders in order to hear adults' perceptions of issues related to adolescent sexual and reproductive health; learn about adult-adolescent communication on issues related to sexual and reproductive health from adults' perspectives; and provide a better understanding of how adults perceive their role and responsibilities regarding adolescent sexual and reproductive health.

Malawi: Political and Historical Background

Malawi is a small landlocked country located in south-east Africa and shares its boundary with Mozambique, Zambia and Tanzania. The country was a British protectorate from 1891 until 1964, when it became independent under the leadership of Dr. Hastings Kamuzu Banda. In 1966, Malawi attained republic status and became a one-party state. In 1971, Dr. Banda was made Life President of Malawi. During his rule, presidential directives formed the bulk of Malawi's public policy. Any opponents of Dr. Banda's rule were dealt with ruthlessly. It was only after a pastoral letter was published by Malawi's Catholic Bishops in March 1992 calling for the introduction of multiparty politics and democratic governance that opposition groups emerged and challenged Dr. Banda. In 1993, Malawians voted overwhelmingly to adopt a multiparty, democratic system of governance. In the Presidential and parliamentary elections held in 1994, Kamuzu Banda was defeated and Bakili Muluzi elected President of Malawi.

During Banda's thirty-year rule, the flow of information was strictly controlled by the government and the private media were virtually nonexistent. In 1966, the government banned provision of family planning services in all public health facilities because of resistance to family limitation by political elites who regarded modern family planning as a foreign incursion.⁶ A family planning program was instituted in the country in 1982 following a combination of internal and external pressure. Until the 1990s, public or media discussion of issues relating to sexual and reproductive

health was very limited, and HIV/AIDS was never acknowledged publicly as a major health challenge by the top political establishment, resulting in a late start in addressing the epidemic. The advent of multiparty politics and end of Banda's reign brought about greater press freedom and public openness in discussing governance and related issues. The Muluzi administration put HIV/AIDS and reproductive health issues high on the development agenda and facilitated various international development partners to support the government in funding programs to improve sexual and reproductive health outcomes. Soon after becoming President, Muluzi led the first march by politicians aimed at increasing awareness and underscoring the importance of government-led action. He also presided over the establishment of National AIDS Commission in July 2001 which today has become the key coordinating agency for donors and stakeholders. Dr. Bingu wa Mutharika, who took over from Muluzi as president of Malawi in 2004, has continued to provide strong leadership in addressing HIV/AIDS and other reproductive health issues.

Malawi's Economic and Population Growth

With a per capita gross domestic product (GDP) of US\$156 in 2003, Malawi is ranked as one of the poorest countries in the world.⁷ According to the 2005 Welfare Monitoring Survey conducted by the Malawi National Statistical Office, 52% of the population of Malawi was below the poverty line in 2005,⁸ an improvement from 1998, when the Integrated Household Survey showed that 65% of the population of Malawi was living below the poverty line.⁹ It cannot be expressly concluded that poverty levels are going down in Malawi as, among other factors, the survey instruments and methods of calculating poverty rates were different.¹⁰ Between 1964, when Malawi became independent, and 1978, Malawi's economic growth was estimated at 6.0% annually. This was about double the average population growth rate of 2.9% over the same period. The rapid growth of the Malawian economy was attributed to the expansion of large-scale agriculture, high levels of gross domestic investment and favorable climatic conditions, among other factors.¹¹ However after 1979 the Malawian economy began to falter and by 1981, for the first time, the country experienced negative GDP growth (-5.2%). Even though Malawi started implementing World Bank and International Monetary Fund structural adjustment programs in 1981, the country's economy has not returned to achieving the growth it had before 1979.¹²

* A total of 102 in-depth interviews with adolescents were conducted in five districts: Blantyre, Mangochi, Mchinji, Ntchisi and Rumphu, representing the cultural diversity prevalent in Malawi.

According to the 1998 Population and Housing Census, approximately 86% of Malawi's population of 9.9 million live in rural areas and the remainder live in urban areas.¹³ The 2005 Welfare Monitoring Survey showed that poverty is more prevalent in rural areas than in urban areas. According to the study, 53% of the rural population lived in poverty, compared with 24% in the urban areas.¹⁴ The 2004-2005 Integrated Household Survey shows that 56% of the people in rural Malawi live in poverty, while only 25% of those living in urban areas live in poverty.¹⁵ While in aggregate, the proportion of people in urban areas living below the poverty line is lower than in the rural areas, there are pockets within the urban areas, particularly the informal settlements, which have higher proportions of people living below the poverty line than in the rural areas.¹⁶

Malawi has three administrative regions (provinces) namely the Central, Southern and Northern Regions. Slightly less than half of the Malawi population (47%) lives in the Southern region, while 41% and 12% live in the Central and Northern Regions of the country, respectively. The Southern and Central Regions are populated primarily by matrilineal societies, while the Northern Region is predominantly patrilineal. Although the Northern Region is least developed in terms of physical infrastructure, it generally exhibits higher levels of education and other social indicators than the Central and Southern Regions. Some 60% of people living in the Southern Region are in poverty and the corresponding rates for the Central and Northern Regions are 44% and 54%, respectively.¹⁷

Most Malawians are Christians: About 80% of the population belongs to various Christian denominations, including the Church of Central Africa Presbyterian (CCAP, Catholic). Thirteen percent are Muslims and the remainder belong to traditional African religions or do not belong to any religious group. It has been estimated that about 22% of the Christian population is CCAP and another 20% are Roman Catholics.¹⁸ There is, however, a growing membership among Pentecostal churches, which account for an estimated 32% of Malawian Christians.¹⁹

Adolescent Sexual and Reproductive Health

According to the 1998 census, adolescents aged 12–19 years old constituted 18.5% of Malawi's population. Since such a considerable proportion of Malawi's population is composed of adolescents, investments in ensuring that their sexual and reproductive health is safeguarded hold the potential of having a large impact on

Malawian health, well-being, productivity and economic growth.

The HIV prevalence rate in Malawi is one of the highest in the world with an estimated 14.4% of those aged 15–49 years old being infected in 2003. According to the National AIDS Commission, in 2003 HIV prevalence was 23% in urban areas, compared with 12% in the rural areas.²⁰ Among those aged 15–24, the prevalence rate is estimated at 18%, higher than the national rate.²¹ According to the National AIDS Commission, there were about 70,000 HIV-infected children aged 0–14 in 2003.²² This represents less than 2% of the total number of children in this age-group. The 2004 DHS also included HIV testing for women aged 15–49 and men aged 15–54. At the national level, the 2004 DHS reveals that 12% of the population aged 15–49 was HIV-positive; for those aged 15–19 years the prevalence was estimated at 2.1%. Prevalence of HIV among adolescents is 0.4% among males and 3.7% among females.²³ The prevalence of HIV increases with age and reaches its peak among 30–44-year-olds.

In addition to HIV and AIDS, there are also other sexual and reproductive health problems facing adolescents, such as unwanted or unplanned pregnancies, other STIs, sexual abuse and abortion complications. Demographic and Health Surveys conducted in Malawi between 1992 and 2004 have looked at some aspects of adolescent sexual and reproductive health, for example: knowledge about HIV/AIDS and other STIs, experience of STIs, early childbearing and contraceptive use. While the current study examines these and other issues covered in the Demographic and Health Surveys, it also provides more detailed information on issues such as perceptions about sexual and reproductive health services and information sources, sexual relationships and partner characteristics, correctness of condom use, sex education, the influence of family and peers, prevalence of abortion and anal sex. The study also provides data on 12–14-year-olds, as very little is known about their sexual and reproductive health.

Chapter 2

Methodology

A nationally representative household survey on adolescent sexual and reproductive health was carried out with 12–19-year-old females and males between March and August 2004. The National Statistical Office, in collaboration with ORC Macro, the Centre for Social Research of the University of Malawi and the Guttmacher Institute, conducted the survey.

Questionnaire Design and Content

A household screening form was used to list all usual members and visitors in each selected household. The age, sex, relationship to head of household and education characteristics were collected for each person listed. The purpose of the form was both to identify eligible 12–19-year-olds for individual interviews and to collect information on the household's access to water and sanitation facilities, environmental conditions, land ownership and possessions. All 12–19-year-old *de facto* residents (i.e., those having spent the prior night in the household) in a household were eligible and invited to participate.

The adolescent questionnaire collected information about many aspects of adolescents' lives, including their social environment, knowledge, attitudes, sexual and reproductive experiences, and key behavioral outcomes (e.g., condom use, current sexual activity). A conceptual framework of adolescent sexual and reproductive health (Chart 2.1) guided the content of the survey questionnaire. The adolescent survey questionnaire comprised the following sections:

- Respondent's background characteristics
- Family and social group information
- Reproductive experiences
- Pregnancy knowledge and sex education
- Contraceptive method knowledge, use, and information and service sources
- Marriage/union formation and sexual activity
- Sexual relationship history
- HIV/AIDS knowledge and experiences

- STI knowledge, experiences, and information and service sources
- Sociocultural practices
- Worries, substance use and childhood background
- Physical and sexual abuse and anal sex

Since the last section of the interview was the most sensitive, its application was treated differently than the rest of the questionnaire. Extra precautions were taken to ensure the privacy and confidentiality of responses to this section. If there was only one eligible respondent, that respondent was given the complete survey including the section on physical and sexual abuse. When there was more than one eligible 12–19-year-old in the household, a table at the end of the household screening form was used to randomly select one adolescent in the household to answer the section with sensitive questions. Only one adolescent per household was selected so that respondents could be assured that other adolescents in the same household would not know that the respondent had been asked these questions. Interviewers also had to complete a separate filter check for privacy before administering this final section: If anyone over three years of age was within listening distance, the interviewer did not administer the questions.

The Guttmacher Institute, in collaboration with the University of Cape Coast (Ghana), Institut Supérieur des Sciences de la Population (Burkina Faso), Makerere Institute of Social Research (Uganda), Centre for Social Research (Malawi) and the African Population and Health Research Center (Kenya) designed the content of the survey instruments. The household screening form and the adolescent questionnaire were developed with external input and pretested extensively. A review of 27 existing survey questionnaires used to measure different aspects of adolescent sexual and reproductive health was undertaken by staff from the Guttmacher Institute and most of the questionnaire items were drawn from these existing instruments.

Questions on standard measures of household amenities, contraceptive knowledge and sexual intercourse were drawn from recent Demographic and Health Surveys for the sake of comparability. Five questions about the correctness of condom use were based on items from Indiana University's Kinsey Institute for Research in Sex, Gender and Reproduction's Condom Use Errors Survey for Adolescent Males (August 26, 2001 version). To facilitate comparison of the findings across the four countries, the content of the questionnaires was the same, although an allowance was given for country-specific questions or categories of questions on issues that were of particular concern or importance to a specific country. A meeting with all research partners from the six institutions above in November 2002 provided input into the content areas and specific measures that should be obtained from national surveys of adolescents. ORC Macro provided a large amount of input on the structure of the survey instruments and also provided comments on the content.

Fifteen mock interviews were conducted in March 2003 in Zomba to estimate a range for the duration of the interview. Drafts of the survey instruments were then sent to 19 external reviewers for comment in April 2003. Further revisions were made in light of external reviewer input and low priority items were removed from the survey given the mock interview timing estimates (ranging between 60 and 118 minutes).

Preliminary findings from 55 exploratory focus group discussions (FGDs) conducted from January through March 2003 in the four study countries as part of the project were also used in revising the questionnaire. The FGDs indicated that young people in the four countries were generally comfortable talking about sexual activity and sexual relationships with the exception of 14–16-year-old females in Burkina Faso (these questions were not asked of 12–14-year-olds). Because of this, in Burkina Faso only, 14–16-year-old females were asked the set of questions asked of 12–14-year-olds about awareness of specific sexual activities. Questions about personal experiences were asked only if the participant indicated an awareness of the relevant sexual activity. In general, the FGD findings helped in the development of detailed questions about sexual behaviors and partner characteristics. Findings from the Uganda and Malawi FGD analyses, in particular, resulted in very specific survey questions that defined “sexual activities,” since this phrase covered behaviors ranging from talking together to visit-

ing with boyfriends or girlfriends to forced intercourse. Country-specific questions about how pregnancy occurs were also derived from the exploratory FGDs with adolescents.

A pretest of the survey instruments was conducted in September 2003 by the Institute of Statistical, Social and Economic Research in Legon, Ghana with 292 12–19-year-olds to obtain estimates of the average duration of the interview, examine the receptivity of 12–14-year-olds to sets of questions, and to check on instrument skip patterns and field protocols (including the random selection of one eligible adolescent per household for the last section of the questionnaire). Revisions to the instruments were based on feedback from the interviewers (which was taped so that other colleagues could listen to the comments), frequency distributions of variables and the timing estimates. The majority of the survey content is comparable across all four countries. Both survey instruments were translated into local languages. In Malawi, the questionnaires were translated into Chichewa, Yao and Tumbuka. The household and adolescent consent forms and questionnaires are available from the authors upon request.

Field Procedures

A pretest of the household screener and adolescent questionnaire of the 2004 Malawi National Survey of Adolescents (MNSA) was conducted in Chichewa and Tumbuka* in February 2004 by the National Statistical Office (Zomba, Malawi) and a representative of ORC Macro. The lessons learned from the pretest were used to finalize the survey instruments, field protocols and translations.

Training of field personnel was conducted at Chilima Lay Training Centre (Zomba, Malawi) the last two weeks of March 2004. Training was extensive and was based on standard Demographic and Health Survey training protocols for conducting an interview, making callbacks and completing survey questionnaires. The interviewer training manual was based on the core Demographic and Health Survey Interviewer's Manual and included an explanation of each question in the MNSA questionnaires. Interviewers were, in general, selected to be young (18–25 years old) and to have successfully completed and performed well in the training. A total of 28 male and female interviewers and 14 supervisors and field editors were selected to carry out the survey.

The field team was divided into seven teams. Each field team had four interviewers, a field supervisor and field editor. Field supervisors were responsible for all field logistics, from obtaining all sample maps and

* No surveys wound up being administered in Yao.

household listings to securing accommodation for the field team, and for managing the interviewer work load. Field editors were to observe at least one full interview every day (with the consent of the respondent), edit all completed questionnaires in the field, and conduct regular review sessions with each interviewer and advise them of any problems found in their questionnaires.

Data collection was conducted in two phases: March 29–June 5, 2004, and August 16–28, 2004. The number of adolescents interviewed in the first phase fell short of the minimum required, so additional households were systematically selected for interview. The shortfall was caused by a higher-than-expected number of dwelling units that could not be located or had been demolished since the sampling frame and mapping were put together in 2000. All adolescents aged 12–19 who were *de facto* residents in the selected households were eligible for interview. Interviewers made at least three attempts to contact households and eligible adolescents for interview, with each visit made at a different time of day and on different days (i.e., it was not permitted to make all three visits on the same day). Whenever possible, interviewers were assigned to interview adolescents of the same sex because of the sensitive nature of the topics covered. However, due to logistical complications in the field (such as scheduling difficulties and language barriers) 31 female respondents and 326 male respondents were interviewed by an interviewer of the opposite sex. While opposite sex interviewers may have affected the reporting of sexual behavior in a separate data collection effort with 12–19-year-olds in Malawi using in-depth interviews, this was not found to be the case.²⁴

Informed consent was sought from each eligible adolescent and, for adolescents younger than 18, consent from his or her parent or caretaker was obtained before the adolescent was approached to participate in the survey. Once the parent or caretaker gave consent, separate consent was still obtained from the eligible adolescent. Two different informed consent statements, one for the parent or caretaker and another for the eligible adolescent, were used.

Data entry and processing for the 2004 MNSA began shortly after interviewing started and was carried out at the National Statistical Office using the software package CSPro. CSPro is an interactive data entry system that can check for acceptable codes for questions, follow skips and filters in the questionnaire and check the consistency of data as they are entered. The questionnaires were entered by cluster, with each cluster being assigned to one data entry operator.

Consistency checks were developed and performed in two stages: simpler consistency checks were handled at the data entry stage and the majority of the more complex consistency checks were carried out during a secondary stage of machine editing. Guidelines were also developed on how to resolve inconsistencies detected during data entry and in the editing process, as well as the action to take if the inconsistencies could not be resolved through an examination of the responses to other pertinent questions in the questionnaire.

Data entry during the field period allowed field-check tables to be generated to examine data quality while interviews were still being conducted. Tables were produced every 2–3 weeks to measure the following:

- household and eligible adolescent response rates;
- age displacement (to determine whether interviewers were intentionally displacing the ages of young people from the eligible range (12–19 years) to an ineligible age (There was only motivation for interviewers to age people out of the sample and not into the sample because interviewers were responsible for a certain number of households, not interviews.);
- knowledge of male and female condoms (to ensure that interviewers were clearly distinguishing between the two methods);
- awareness of sources to get contraceptive methods or treatment for STIs (to check whether interviewers were intentionally coding respondents out of questions about service providers);
- having ever heard of sexual intercourse (among 12–14-year-old respondents) and experience of sexual intercourse (among 15–19-year-old respondents); and
- presence of others within hearing distance before the last section of questions was to be administered (Some interviewers might have been tempted to skip this section because of the nature of the questions, and one way to do this was to check the box that others were present or listening.).

Senior survey staff worked together with the data processing chief, the ORC Macro representative, Guttmacher Institute and National Statistical Office staff to interpret the tables and identify problems. If data collection problems were discovered at the team level, tabulations were produced by interviewers to determine whether problems were team-wide or restricted to one or two team members. Immediate action was taken to address the problems.

Table 2.1 shows the length of interview, privacy of interview and how well the interviewer thought the respondent understood the survey questions in general. The duration of the interview can indicate the burden on the adolescent respondent in answering questions: The survey aimed for a 45-minute interview on average. The results show that in general, males' interviews were longer than females' interviews by four minutes, due at least in part to their higher levels of sexual experience. Among respondents of each sex, the mean duration of interviews was longer for 15–19-year-olds.

Ensuring privacy of the interview was absolutely critical to fielding the survey, since the presence of particular people within hearing distance can influence the responses an adolescent is willing to give. Interviewers were trained to conduct interviews in places or ways that would assure privacy for adolescent respondents. Yet it was inevitable that, at times, people may have wandered by or been within hearing distance as they went about their daily activities. Interviewers were instructed at the end of the interview to note who was within hearing distance during any point of the interview. The results in Table 2.1 indicate that, overall, interview privacy was very high. About 97% of both male and female interviews were conducted with no person within the hearing range. Other people within hearing range were most often children.

Section 12, which contained especially sensitive questions, was not to be administered if anyone older than three years was within hearing distance of the interview. Separate information for this section on the presence of others was recorded by the interviewer. For these sensitive questions, interview privacy was slightly higher than for the overall interview: 97% for females and 98% for males (data not shown). It was higher among the 12–14-year-olds than among the 15–19-year-olds.

Finally, the interviewer assessment of the respondent's level of understanding provides a general indication of adolescent comprehension of survey questions. Table 2.1 shows that, in general, there was no variation between male and female respondents in their understanding of the questions. As expected, younger adolescents had a harder time understanding the survey questions compared with older adolescents.

Sample Design

The sample for the 2004 MNSA covered the population residing both in rural and urban areas in all parts of the country. A two-stage stratified sample design was used. The sample for the 2004 MNSA was select-

ed from the 560 enumeration areas listed in the 2000 MDHS sample frame. A total of 200 enumeration areas were systematically sampled from the 2000 MDHS sample: 161 in rural areas and 39 in urban areas. About 5,500 adolescents, including 1,500 each of males and females between ages of 15 and 19, were expected to be interviewed in this survey. After the data were collected through June 2004, only 3,448 adolescents were interviewed. Therefore, 15 additional enumeration areas totally approximately 750 households were added to the sample at that time. Thirteen of these were in the rural areas and two were in the urban areas. The 2004 MNSA presents estimates that are representative at the national and regional levels and by rural-urban residence.

Of the 4,879 adolescents aged 12–19 years listed in the household screener, 373 were usual members of the household but were not in the household the evening before the survey interview (i.e., they were *de jure* but not *de facto* household members). Among those absent, 26% were in boarding schools, 22% were staying in another household, 17% were on vacation, traveling or visiting and 27% were away for other reasons. The *de jure* household members did not make it into the sample.

Table 2.2 presents information on the number of households selected and interviewed and the number of eligible adolescents identified and interviewed by urban and rural residence and in total. It also provides the response rates for households and adolescents by urban and rural residence and in total. A total of 7,750 households were selected in the 2004 MNSA sample, of which 6,235 were rural and 1,515 were urban households. About 78% of the selected households had completed interviews (77% in rural areas and 80% in urban areas), while 21% of the selected households were vacant, destroyed or not found. The main reason that a selected address was found vacant, destroyed or not found was because of the outdated household listings which were used, as noted earlier. The total household response rate was 99.5% for rural and 98.4% for urban areas.

Within the interviewed households, there were a total of 4,506 eligible adolescents to be interviewed, of which 1,107 adolescents were urban and 3,399 adolescents were rural residents. Of the eligible *de facto* adolescents, 90% completed interviews for a total of 4031 interviews—89% in rural areas and 91% in urban areas. Six percent of the eligible *de facto* adolescents were reported not to be at home and 1% refused to be interviewed. The most common reason for adolescents not being at home was that they were away at boarding schools or away visiting someone for an extended period of time.

The overall response rate for the survey was 89%—89% in rural areas and 90% in urban areas. Being household-based, the MNSA survey design omits young people who are at boarding schools and those in institutions such as hospitals, prisons and the military.

Table 2.3 presents information on the number of eligible adolescents identified and interviewed by age-group and sex. The percentage of eligible respondents who refused to participate in the survey (or whose parents/caretakers refused their participation) and the percentage of eligible adolescents who were unable to be contacted after multiple attempts (i.e., those reported as being “not at home”) indicate the degree of difficulty in obtaining interviews with different groups of adolescents. Of the eligible adolescents identified, the response rate was slightly higher for females (91%) than males (89%), while within the age groups, the response rate was higher for 12–14-year-olds than for 15–19-year-olds. Males and 15–19-year-olds were more likely to be not at home than females and 12–14-year-olds. The refusal rates for both respondents and parents were similar across age-groups and for both sexes.

Comparisons of the 2004 data to external data sources are useful as a check on the ways that the 2004 survey sample population may differ from other surveys. Table 2.4 shows several key characteristics of 15–19-year-old females and males in the 2004 survey and the Malawi Demographic and Health Survey (2004 MDHS). While the proportions of male adolescents who had ever been in union (i.e., married or living with someone as if married) is consistent across the two surveys, the levels reported among female adolescents are very different: In the 2004 MNSA, 17% of sampled 15–19-year-olds reported that they had ever been in union, compared to 36% in the 2004 MDHS. Furthermore, 52% of 15–19-year-old females in the 2004 MDHS had had sex at the time of the survey; the corresponding percentage was 37% in the 2004 MNSA. The 2004 MDHS shows a higher proportion of 15–19-year-old females who reported having had a child (25%) than the 2004 MNSA (16%). Differences in the proportion ever having had sex and ever having had a child between the two surveys are very likely a product of the difference in proportion of females ever in union captured in each survey.

One possible reason for there being fewer adolescent females in union in the 2004 MNSA is because of age heaping: Young women may have been listed as age 20 instead of age 19 (and the eligible age range for the 2004 MNSA is 12–19 years). Since the average age for females entering union is 18 according to the 2004

MDHS, if age heaping was occurring, it would result in capturing fewer adolescents in union. The 19:20 age ratio (i.e., the number people age 19 in the household screener sample divided by the number of people age 20 in the household screener sample) should theoretically be around 1.0. While the data are not yet available for the 2004 MDHS as of this publication, a comparison of the age ratios of young women in the household screener samples from the 2000 MDHS and the 2004 MNSA show age heaping in both surveys (0.71 in the 2000 MDHS and 0.80 in the 2004 MNSA). This could have taken place if interviewers artificially “aged out” people from the eligible respondent range or respondents either were estimating their age or intentionally aging themselves out of the sample. However, there is no evidence that the observed discrepancies between the 2000 DHS data and the 2004 MNSA data in ever being in union and ever having sex for females 15–19 are explained by more 19-year-olds being “missed” by the 2004 MNSA.

Another possible reason for the discrepancy between these two surveys is that the response rates may have been different. Ten percent of the eligible female adolescents of the 2004 MNSA did not complete the interview—the bulk of them were not at home. This rendered an overall eligible adolescent response rate among 15–19-year-old females of 90%. The 2004 MDHS had a higher eligible female response rate of 96% across all age-groups. If adolescents in union were less likely to be home or to not complete the interview for other reasons, then this difference in response rates may be partially responsible for the discrepancies in the results.

The wording of questions was the same in both surveys for the union status and sexual intercourse questions for 15–19-year-olds, although the content of the questionnaires was different (the MNSA obtained much more detail on sexual activity and sexual and reproductive health-related information, services, sources and knowledge). While the organizations implementing the surveys were the same, younger interviewers were used in the 2004 MNSA than in the 2000 MDHS, with the expectation that this would lead to improved reporting of sexual behaviors (though perhaps this was, in the end, not the case). Lastly, the difference in the sampling frame may have had an effect: A fresh household listing was used for the 2004 MDHS while for the 2004 MNSA the 2000 household listing was used.

Differences in point prevalence estimates for measures of sexual behavior among adolescents have also been documented in the United States for surveys conducted in the same year.²⁵ Therefore, these differences

notwithstanding, as a national survey on aspects of sexual and reproductive health, the 2004 MNSA provides detailed information on sexual and reproductive health of adolescents, thus complementing results from the 2004 MDHS and the trends over time in behaviors that the MDHS documents.

TABLE 2.1. Percentage of adolescents duration of interview and others present during interview, and percentage distribution of adolescents by interview characteristics, all according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=936)	15–19 (N=1049)	Total (N=1985)	12–14 (N=901)	15–19 (N=1126)	Total (N=2027)
Mean duration of interview (minutes)	52.5	54.9	53.8	56.1	59.5	58.0
Presence of other people within hearing range during interview*						
No person within hearing range	97.2	97.0	97.1	95.6	98.3	97.1
Spouse/partner	0.1	0.7	0.4	0.1	0.2	0.1
Mother	0.5	0.2	0.4	0.0	0.4	0.2
Father	0.0	0.0	0.0	0.1	0.0	0.0
Brother/sister	0.1	0.1	0.1	1.0	0.3	0.6
Other adolescents	0.0	0.2	0.1	0.8	0.1	0.4
Other children	2.0	1.9	2.0	2.5	0.8	1.6
Other adults	0.0	0.3	0.2	0.2	0.3	0.2
Interviewer rating of respondent's understanding of survey questions						
Very well	54.7	71.7	63.7	53.6	72.6	64.1
Well	34.5	25.0	29.5	33.8	24.0	28.3
Not very well	10.8	3.2	6.8	12.6	3.4	7.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 2.2 Percentage distribution, numbers and response rates of households and respondents, according to residence, 2004 National Survey of Adolescents

Result	Residence		Total
	Urban	Rural	
Selected households			
Completed (C)	80.3	77.2	77.8
Household present but no competent respondent at home (HP)	0.9	0.4	0.5
Refused (R)	0.4	0.0	0.1
Household absent (HA)	1.1	1.0	1.1
Dwelling vacant, destroyed or not found (DV)	17.2	21.4	20.5
Other (O)	0.0	0.0	0.0
Total	100.0	100.1	100.0
Number of sampled households	1,515	6,235	7,750
Household response rate (HRR)*	98.4	99.5	99.3
Eligible de facto adolescents			
Completed (EAC)	91.4	89.1	89.7
Not at home (EANH)	5.9	6.6	6.4
Postponed (EAP)	0.1	0.1	0.1
Respondent refused (EAR)	1.5	0.9	1.1
Parent/caretaker refused (PEAR)	0.2	0.5	0.4
Partly completed (EAPC)	0.4	0.7	0.6
Incapacitated (EAI)	0.4	1.4	1.1
Other (EAO)	0.2	0.7	0.6
Total	100.0	100.0	100.0
Number of adolescents	1,107	3,399	4,506
Eligible adolescent response rate (EARR)†	91.4	89.1	89.7
Overall response rate (ORR)‡	89.9	88.7	89.0

*The household response rate is calculated as: $HRR = (100 \times C) / (C + HP + R)$

†The eligible adolescent response rate is calculated as: $EARR = (100 \times EAC) / (EAC + EANH + EAP + EAR + PEAR + EAPC + EAI + EAO)$

‡The overall response rate is calculated as: $ORR = (HRR \times EARR) / 100$

TABLE 2.3 Percentage distribution of adolescents, by interview characteristics, according to sex and age, 2004 National Survey of Adolescents

Result	Female			Male		
	12–14	15–19	Total	12–14	15–19	Total
Eligible de facto adolescents						
Completed (EAC)	91.2	90.1	90.6	89.6	88.2	88.8
Not at home (EANH)	4.8	6.2	5.5	6.2	8.1	7.3
Postponed (EAP)	0.1	0.1	0.1	0.2	0.2	0.2
Parent/caretaker refused (PEAR)	0.4	0.3	0.4	0.4	0.5	0.5
Respondent refused (EAR)	1.0	1.0	1.0	1.0	1.2	1.1
Partly completed (EAPC)	0.5	0.5	0.5	0.8	0.6	0.7
Incapacitated (EAI)	0.9	1.4	1.1	1.3	0.9	1.1
Other (EAO)	1.2	0.4	0.8	0.5	0.2	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of adolescents	1024	1167	2191	997	1318	2315
Eligible adolescent response rate (EARR)*	91.2	90.1	90.6	89.6	88.2	88.8

*The eligible adolescent response rate is calculated as: $EARR = (100 \times EAC) / (EAC + EANH + EAP + EAR + PEAR + EAPC + EAI + EAO)$

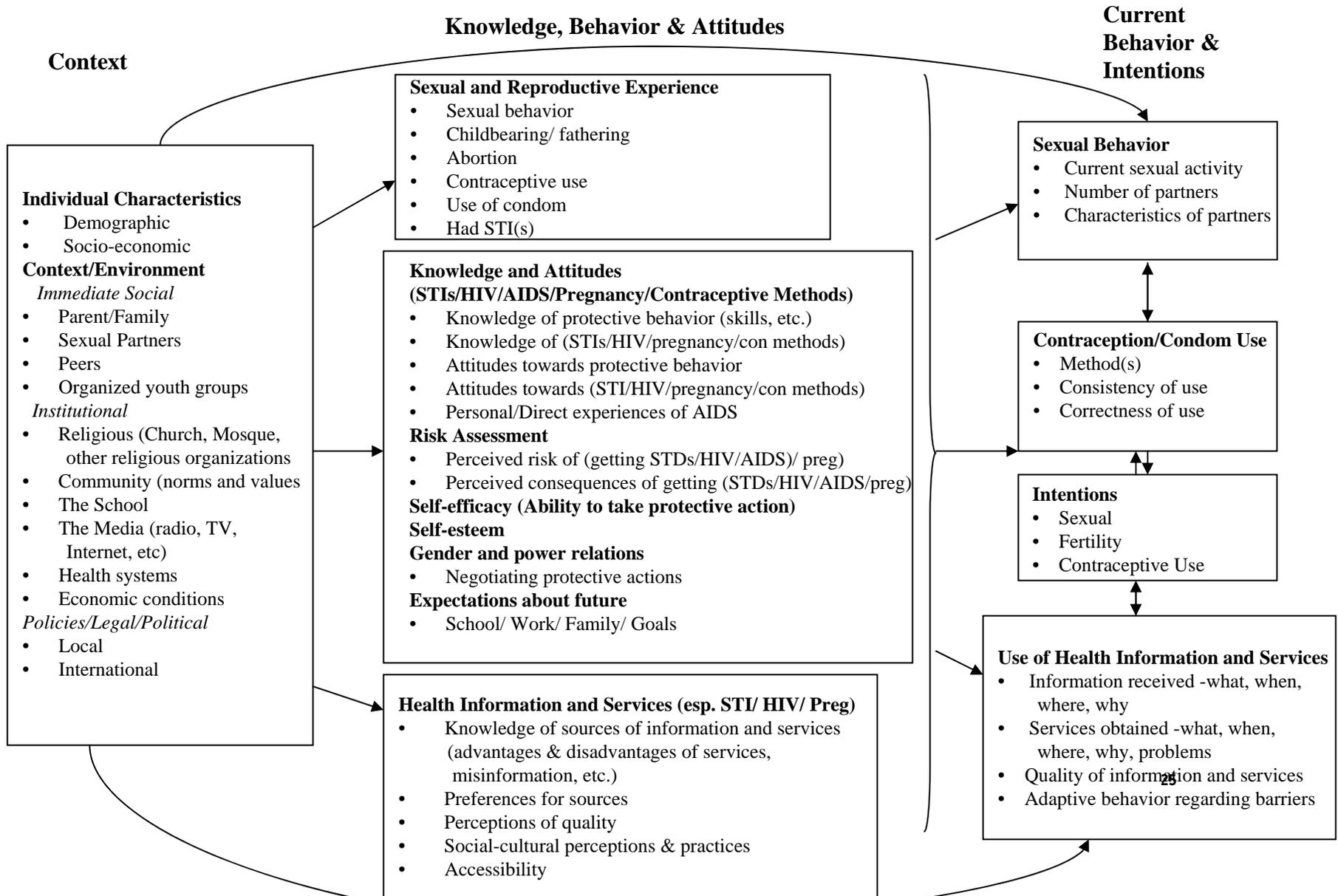
TABLE 2.4. Comparison of respondent characteristics of 15–19-year-olds across surveys: 2004 Malawi Demographic and Health Survey (MDHS) and 2004 National Survey of Adolescents (NSA)

Characteristic	Female		Male	
	2004 MDHS (N=2392)	2004 NSA (N=1055)	2004 MDHS (N=650)	2004 NSA (N=1126)
Ever in a union				
No	63.7	82.6	96.8	96.2
Yes	36.3	17.4	3.2	3.8
Ever had sexual intercourse				
No	47.8	63.4	47.7	40.1
Yes	52.2	36.6	52.3	59.9
Ever had a child				
No	74.7	84.3	--	--
Yes	25.3	15.7	--	--

Note: Ns are weighted for the 2004 MDHS and 2004 NSA.

Chart 2.1

Conceptual Framework of Adolescent Sexual and Reproductive Health



Chapter 3

Context of Adolescents' Lives

This chapter presents information on a range of important aspects of young people's lives—their education, work and family situations. This information will enable a better understanding of the social and economic reasons why young people are vulnerable to HIV and unwanted pregnancy. Family, peer pressure and other social aspects of adolescents' lives that have been shown to influence their protective and risk behaviors are also discussed in this chapter.

Characteristics of Survey Respondents

A description of the basic characteristics of the adolescents interviewed in the survey provides a background for interpreting findings on sexual and reproductive health presented later in the report.

Table 3.1 shows that most of the adolescents were not in union; only about 7% of women and 1% of men were in union at the time of the survey. Virtually none of those aged 12–14 were in unions and for those aged 15–19, 13% of women and 2% of men were in unions. As noted in Table 2.4, 83% of women and 96% of men aged 15–19 had never been in a marital union.

Slightly over three quarters of all respondents resided in rural areas and about a quarter in urban areas. About one-tenth of the respondents resided in the Northern Region; most respondents were Chewa, followed by Lomwe, Yao, Tumbuka and Ngoni, respectively.

Wealth quintiles were constructed adopting the protocol used in the Demographic Health Surveys (DHS) and based on analysis of household assets (wealth indicators)²⁶ in order to depict differences in household socioeconomic status for the adolescents.* Table 3.1 shows that female and male adolescents were similarly distributed across the five wealth quintiles.

* A number of indicators of possible of household wealth were used so as to create a distribution of cases. Based on principal components analysis, factor loadings were calculated for each selected variable, which were then used to derive a wealth index value for each household. If wealth were to be equally distributed, the proportion of households in each quintile would be 20%, as implied by the concept of quintile.

Family Formation and Living Arrangements

The sexual and reproductive health issues facing adolescents in union or those who have already given birth to a child are often quite different from those facing adolescents who are not in union or those who have not yet begun childbearing. Table 3.2 shows the distribution of adolescents by these key family formation characteristics. Eighty percent of females aged 15–19 and 98% of males were not in union and never had a child. Seven percent of the females aged 15–19 were not in union and had had a child; 9% of females aged 15–19 were in union and had had a child. Most (64%) of those females who were in union lived with their spouse or partner.

Living with a biological parent can have a positive effect on adolescents' sexual and reproductive health, due to the greater likelihood of receiving parental guidance and support, as well as to the monitoring by parents of their adolescent children. It also positively impacts young people's access to resources. Table 3.2 shows that while the majority of adolescents live with at least one parent, 30% of respondents were not in union and lived with neither of their biological parents. In cases where adolescents were not residing with their parents, the vast majority were living with a relative. Very small proportions of adolescents, irrespective of their sex, were adopted, fostered, residing with an employer as a house-helper or resided with other nonrelatives. Only 1% of 12–19-year-olds headed their own households.

At least one in four 12–17-year-old adolescents reported having been orphaned (one or both of their biological parents had died) (Table 3.3). About twice as many respondents had lost their father (14%) than had lost their mother (8% of the females and 7% of the males). Approximately 6% of the respondents reported that they had lost both biological parents.

Charts 3.1 and 3.2 summarize the frequency of contact between adolescents and their biological parents (among those with a living biological mother or father).

Adolescents had more contact with their mothers than their fathers: More lived with their biological mothers (73%) than with their biological fathers (62%) and fewer had no contact with their mothers (2%) than with their fathers (6%).

Schooling Experiences and Expectations

Sexual and reproductive health behavior is often strongly linked to adolescent educational attainment and school enrollment. Table 3.4 shows the enrollment in school, educational attainment and expectations for future educational attainment among adolescents by age-group and sex. Vocational training is included, since that too imparts skills that can impact adolescents' future.

The majority of females (97%) and males (98%) reported ever having attended school. School attendance was slightly higher for the younger age-group (12–14) than the older group (15–19), probably because more of the younger ones took advantage of the free primary education policy, which was introduced in Malawi in 1994. Total enrolment in primary school jumped from 1.9 million in 1994 to 2.9 million in 1995, and this was mainly due to the introduction of free primary school education. By 2001, total enrolment was at 3.2 million pupils.²⁷ Males are better off than females in school attendance, particularly among older adolescents, where 71% the males and 58% of the females were currently attending school. These low school attendance rates at the older ages indicate that many young people continue to drop out of school, even when free primary education is available. While the free primary education policy is credited with the large increase in enrollment between 1994 and 1995, the increase has been at the expense of educational quality, which has contributed to high dropout rates.²⁸ There is also a bottleneck problem whereby there are not enough places in Form 1 of secondary school for students completing primary education and eligible to continue.

The extent of unrealized potential in education is further demonstrated by the years of schooling completed by the adolescents. The official minimum age for starting primary school in Malawi is six years. By age 15, a typical adolescent should have completed at least eight years of schooling, yet 71% of females and 73% of males aged 15–19 had completed no more than seven. Only 23% of females and 22% of males aged 15–19 had attended secondary school at the time of the survey. Yet respondents' expectations for the highest level of schooling they would attain were highly optimistic: Some 71% of females and 79% of males ex-

pected to continue their schooling through at least secondary school with more than a third of the respondents expecting to reach higher education. The 12–14-year-olds were more optimistic than the 15–19-year-olds. Enhancement of skills through vocational training, such as apprenticeships and formal programs providing long-term courses in mechanics or secretarial work, are common. Thirty-five percent of 15–19-year-old females and 44% of similar males reported having received such training.

The reasons for dropping out of school demonstrate the challenges adolescents face in achieving their educational aspirations. Table 3.5 shows that the most common reason for leaving school was lack of school materials (46% of males and 30% of females gave this reason). Although the payment of school fees was abolished in primary school, parents still have to pay for school materials at primary level and secondary school students still have to pay school fees. Therefore, not surprisingly, 15–19-year-olds were much more likely than the younger group to cite school fees as the reason they left school (14% of females and 11% of males). With the high prevalence of poverty in Malawi, lacking other necessities such as books and pens can also prevent students from going further with their education. The other prevalent reasons for leaving school were lack of interest, cited especially among the younger females; illness (17% of younger males and females); and having to work at home (15% of the younger females and 26% of the younger males). Among females aged 15–19, the fourth most commonly mentioned reason (as reported by 13%) for leaving school was being pregnant. These findings are corroborated by the DHS Education Survey that found that the major reasons youths give for dropping out of school include lack of money, the need to work and lack of interest in going any further because they feel they have had enough education.²⁹

Chart 3.3 shows the proportion of adolescents still attending school among those who ever attended school by current age and sex. The percentages continuing in school decline sharply after age 14. Females consistently drop out of school in higher proportions than males across all ages. Another major drop for boys occurs after age 17.

Table 3.6 shows when adolescents began their schooling and some characteristics of their recent school environment to shed further light on their education experiences. Information is also included on whether those adolescents who are currently enrolled in school are repeating the same grade they were in the

prior school year. School characteristics include whether the school was single-sex or coed, school type (e.g., public or private, religious or not) and whether the adolescent was a day student or boarder. These characteristics may have some influence on the kind of monitoring by teachers that the student may have experienced in school.

Approximately 45% of females and 44% of males first attended school at age six (the official minimum age for starting primary school) or younger. Twenty-one percent of females and 22% of males started school when they were at least nine years old.

About 10% of female and 13% of male adolescents who were currently in school at the time of the survey had repeated the last grade. Repetition of the last grade was highest among the younger male adolescents (about 16%). Nearly all the respondents reported that the current or last school they attended was coed.

In Malawi, most of the schools are owned by the government. A minority are owned by religious organizations but they also receive assistance from the government. More than 70% of the respondents said that the last school they attended was government-aided and nonreligious. Nearly 20% of the females and 24% of the males said the last school they attended was a government-aided religious school. The advent of multiparty politics in Malawi also saw the establishment of many private schools, but tuition in these schools is high. Therefore, attendance at a private school, whether religious or not, was very low.

The vast majority of students were day students; only 3% of the females and 2% of the males were boarders.

Time Use and Work

Information about how adolescents spend their time, whether they earn income and what they do, where they work, and the degree to which they control that money is potentially helpful when thinking about the nature of programs to help adolescents meet their reproductive health needs. This information can also help us understand the broader context in which adolescents make decisions regarding their sexual and reproductive health.

Table 3.7 shows how adolescents typically spend their days and, for those who work, whether it is for money and if that work takes place at home or away from home. If the adolescent is earning money, the table also presents data on who has control over how those earnings are spent.

The table shows that almost all of the females (97%)

and 73% of males are engaged daily in household chores. A third of the males said they are engaged daily in family business including farm work, compared with 20% of females. A higher proportion of male respondents reported working to get money (12%), compared with 3% of females. It was more common that adolescents were in school and not working (60% of females and 53% of males) than that they were juggling both school and work (work being defined as helping with the family business/farm or working to get money—household chores are not counted here as working) (Chart 3.4). The proportion of females working with the family business/farm or for money was lower than their male counterparts, regardless of whether they were in school or not.

Table 3.7 further shows that males were at least two times more likely to have worked for money than females (45% versus 20%) during the 12 months prior to the survey.

Among those who were working for pay or in a family business, more males were working away from home (42% of males, compared with 24% of females). Although the younger adolescents (aged 12–14) are as likely to work outside the home as the older ones, the former are more likely not to be paid for their work than the latter. Of those earning money, many more males (60%) than females (37%) had the freedom to decide on how their money was to be spent. For 50% of the females and 34% of the males, their parents/guardians made the decisions on how the money was to be spent. These data suggest that families need the income earned by their children, both male and female. Although a smaller proportion of females than males work for cash, parents are more likely to decide how females' income is spent. Young adolescents are also engaged in work for cash income: About 17% of girls aged 12–14 and 24% of boys this age earned cash income.

Social Ties

Membership of social groups

Connections to a religious faith or to social groups offer an additional source of advice and guidance to adolescents and can help encourage adolescents to take fewer risks that might jeopardize their sexual and reproductive health. Table 3.8 shows the religious affiliations of adolescents and, for those who have a religious affiliation, how important religion is in their lives and how frequently they participate in religious services. This table also shows the percentage of adolescents who belong to a social group or club and, for those who do belong, the types of clubs they belong to

and whether they hold an office or position of leadership in the club.

The most common religious affiliation is Protestant, followed by Catholic, Pentecostal and Islam, respectively. Almost all adolescents who had a religious affiliation classified the importance of religion in their lives as “very important,” with over 95% of the adolescents reporting that they attend religious services at least once a week. Religious groups are also one of the primary social organizations that young people are involved in: Of the adolescents who belonged to a social group or club, 47% of females and 51% of males belonged to church-affiliated youth groups or choirs.

Twenty-eight percent of respondents reported belonging to a social group or club and of these, 28% of females and 24% of males said that they held an office or leadership position in these clubs. As would be expected, older adolescents were more likely to hold an office or leadership position. Approximately a quarter belonged to anti-AIDS clubs. The Wildlife Society and sports clubs were other major clubs to which young people belonged.

Parents’ and teachers’ monitoring of adolescents

An important role that parents can play in the sexual and reproductive health of their children is simply being aware of what their children are doing and who their friends are. Analyses show that the more monitoring parents do of their children’s lives, the better the outcomes for their children.³⁰ Table 3.9 shows adolescents’ perceptions of how aware their parents or guardians are about where they go at night, what they do with their free time and who their friends are. For adolescents who are married, the questions were asked with respect to before they were married, in order to better reflect the degree of involvement parents had when the adolescents were presumably still living with their parents. A question about the level of monitoring teachers do of their students was also asked of adolescents who had ever attended school and was with respect to teachers at the school they currently attend or last attended.

Fifty-six percent of the females and 49% of the males reported that their parents/guardians always knew how they spent their time. The patterns for knowledge of where adolescents go at night are similar: Some 58% of the females and 51% of the males reported that their parents/guardians always knew.

According to the adolescents, parents and guardians were considerably more likely to know their daughters’ friends (68%) than their sons’ friends (48%). When

these data are disaggregated according to rural and urban areas, more urban adolescents reported that their parents knew where they were going at night, knew what they were doing with their free time and also knew who their friends were, compared with rural adolescents (data not shown). The results in Table 3.9 indicate that adolescents think that teachers closely monitor them. Over 70% of adolescents who had ever attended school reported that teachers almost always kept an eye on students to make sure that they were not getting into trouble.

Interaction with friends

Friends often play an important role in adolescents’ lives. An important aspect of friendship networks is whether friends are the same sex or include both males and females. Table 3.10 provides information on adolescents’ close friends. The table shows that the majority of respondents had at least one close friend of the same sex with the large majority saying they had two or more close friends of the same sex. On average, females had 2.8 female friends while males had 3.6 male friends. Friendships with the opposite sex are much less frequent. More than half of females 12–19 said they had no close male friends and fewer than 40% of males said they had no close female friends. The table indicates that on average, females had 0.9 male friends, while males reported an average of 1.6 female friends.

Talking about sex-related matters

Table 3.11 shows the percentage of adolescents reporting different types of people who have talked to them about sex-related matters. The degree to which parents, other family members, friends and teachers are involved helps us better understand who, if anyone, is approaching adolescents about this sensitive topic. The responses to this question were not prompted. Findings show that fewer than a third (32%) of adolescents have talked with a family member about sex-related matters. While 29% of females have talked with nonfamily members on the issue, a considerably higher proportion of males (46%) reported that they had talked to non-family members.

Few parents/guardians discuss sex-related matters with their adolescent children. In 2004, slightly over three in four adolescents report that neither parent had ever spoken to them about sex-related matters (Chart 3.5). Sixteen percent of male adolescents reported their father and/or mother had talked to them about sex-related matters. Just under a quarter of the females had been spoken to by their mother compared with 8% who

had been spoken to by their father. Grandmothers were the next most commonly cited family members who talked to girls about sex-related matters (14%).

Adolescents also reported talking to friends and teachers about sex-related matters. Table 3.11 shows that 17% of the females indicated a female friend and 11% indicated teachers as the persons who ever talked to them about sex-related matters. For males, 32% indicated their male friend, while 19% indicated a teacher as having ever talked to them on such matters. It is noteworthy that initiation counselors are not named as an important source of information, considering the proportion of adolescents in the sample who were initiated (see Chapter 4). It is possible that adolescents named these individuals in another capacity and not as an initiation counselor—an aunt, grandmother, teacher or health care provider, for example.

Alcohol and Drug Use and Physical Abuse

The use of alcohol or drugs can impair one's sense of judgment and can make one more likely to indulge in risky behaviors and practices, such as having sex with someone they do not know very well or having sexual intercourse without using a condom or other contraceptive method. Table 3.12 shows the percentage of adolescents who have ever tried alcohol and, for those who have tried alcohol, the age at which they first tried it and whether they had been drunk in the 12 months prior to the survey. The table shows that 16% of the females and 20% of the males said they had ever tried alcohol. Eleven percent of those females and 15% of those males had their first alcoholic drink before the age of 11. Of those who had tried alcohol, 31% of females and 47% of males got drunk at least once in the past twelve months. Very few adolescents (1% of females and 3% of males) had ever tried any other type of drug. There is the possibility that alcohol or drug use might be underreported given the social inappropriateness of substance use.

Other studies have also shown that negative experiences in childhood, such as being physically or sexually abused, can increase the probability of engaging in risky behaviors later in life.³¹ In 2004, adolescents were asked whether several such negative experiences happened to them before age 10. Because of the special sensitivity of the experience, the question about physical abuse was asked only of one randomly selected adolescent per household so as to ensure the confidentiality of the information (see Methodology section). Eleven percent of females and 19% of males reported that someone in their household hit them hard enough

to leave marks or cause injury during their childhood. This violence occurred very or somewhat often in about 40% of the cases (data not shown).

Adolescents were asked whether their household suffered because someone drank too much alcohol. The data indicate that one-fifth of the adolescents' households suffered from this problem (data not shown).

Current Worries

Table 3.13 shows the level of worry that young people have about a number of important situations and needs that they face. Understanding the major overall concerns of young people provides a useful perspective on how sensitive adolescents are likely to be to HIV and sexual and reproductive health information and related interventions. Adolescents' responses on this topic also suggest other pathways through which programs and policies might channel prevention efforts. For example, if young people at risk of HIV/AIDS are most concerned with getting money or education, HIV/AIDS interventions might have a heightened impact if tied to livelihood or education programs.

This study has shown that worry about HIV/AIDS was of the greatest concern to adolescents. More than half of both males and females aged 15–19 were very worried about getting HIV/AIDS. Understandably, older adolescents were more likely to be worried about getting HIV/AIDS than younger adolescents. Such high levels of concern about HIV/AIDS among adolescents could be partly attributable to the extensive questions asked about HIV/AIDS earlier in the interview, as the questions about “worry” were asked of adolescents toward the end of the interview. At the same time, it might be a true reflection of the levels of worry about HIV/AIDS among adolescents. While just over 20% of the respondents were very worried about their health (21% of females and 23% of males) and about getting enough to eat (23% of females and 25% of males), somewhat higher proportions (31–44%) were very worried about getting money and about pregnancy (Table 3.13). As may be expected, females were more likely to be very worried about getting pregnant than males were about getting someone pregnant; older adolescents were more likely to be worried about this compared with younger adolescents.

Policy and Program Implications

- There is a need for the government to address factors (such as school materials and secondary school fees) that continue to cause adolescents to drop out of

school. In particular, there is need to address the low levels of transition from primary to secondary school.

- There is need for parents, community leaders and religious leaders to counsel young people regarding the importance of education, as many young people fail in school because of lack of motivation and guidance.
- High dropout rates (especially among older adolescents) indicate that many adolescents are unable to benefit from the information on sexual and reproductive health that is disseminated in schools. This underscores the need for interventions directed at out-of-school adolescents.
- The high proportion of adolescents who are members of youth groups and clubs (the majority of which are faith-based groups) highlights the potential value of these networks in reaching adolescents with sexual and reproductive health and livelihood interventions.

TABLE 3.1 Percentage distribution of adolescents, by basic sociodemographic characteristics, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=939)	15–19 (N=1053)	Total (N=1992)	12–14 (N=907)	15–19 (N=1124)	Total (N=2031)
Current union status						
Not in union	99.8	86.7	92.9	100.0	98.5	99.2
In union	0.2	13.3	7.1	0.0	1.5	0.8
Urban-rural residence						
Urban	21.7	23.6	22.7	22.2	24.1	23.2
Rural	78.3	76.4	77.3	77.8	75.9	76.8
Region						
Central	44.8	43.5	44.1	38.6	41.9	40.5
North	10.8	10.0	10.4	8.6	8.9	8.8
South	44.4	46.6	45.6	52.8	49.2	50.8
Ethnic group						
Chewa	41.5	40.4	40.9	34.2	34.3	34.2
Yao	15.0	11.9	13.3	15.3	14.7	15.0
Tumbuka	9.7	9.5	9.6	7.3	8.2	7.8
Tonga	1.4	1.2	1.3	1.1	1.2	1.2
Lomwe	12.3	14.8	13.6	18.4	17.4	17.9
Sena	5.1	4.3	4.7	6.6	5.9	6.2
Mang'anja	4.6	5.0	4.8	3.7	3.7	3.7
Ngoni	7.5	10.0	8.8	9.3	11.5	10.5
Nkhonde	0.8	0.9	0.9	0.8	0.8	0.8
Other Malawian	2.2	1.9	2.1	3.3	2.2	2.7
Non-Malawian	0.0	0.1	0.1	0.0	0.0	0.0
Household wealth quintile						
Lowest	21.7	20.5	21.1	20.6	15.6	17.9
Second	19.7	15.0	17.3	21.5	21.7	21.6
Third	18.2	19.0	18.7	19.5	21.0	20.3
Fourth	18.2	23.6	21.1	18.9	18.9	18.9
Highest	22.1	21.9	22.0	19.4	22.8	21.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 3.2 Percentage distribution of adolescents by union status, childbearing and living arrangements, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=939)	15–19 (N=1053)	Total (N=1992)	12–14 (N=907)	15–19 (N=1123)	Total (N=2030)
Union and childbearing status						
In union, ever had child	0.0	8.5	4.5	0.0	0.5	0.3
In union, never had a child	0.2	4.7	2.6	0.0	0.9	0.5
Not in union, ever had child	0.0	7.1	3.8	0.0	1.0	0.5
Not in union, never had a child	99.8	79.6	89.1	100.0	97.6	98.7
Lives with spouse/partner*						
No	--	36.4	35.9	--	--	--
Yes	--	63.6	64.1	--	--	--
Coresidence with biological parents						
Lives with both biological parents	45.4	38.1	41.5	50.9	44.9	47.6
Mother only	19.6	17.9	18.7	17.4	17.9	17.7
Father only	3.9	3.8	3.9	3.9	4.4	4.2
Neither biological parent, respondent in a union	0.2	10.4	5.6	0.0	0.8	0.4
Neither biological parent, respondent not in union	30.9	29.8	30.3	27.9	32.0	30.2
Relationship to head of household						
Head	0.0	1.7	0.9	0.2	2.2	1.3
Spouse	0.2	6.8	3.7	0.0	0.2	0.1
Son/daughter	66.4	57.7	61.8	70.6	64.1	67.0
Son/daughter-in-law	1.2	2.4	1.8	0.6	0.8	0.7
Grandchild	16.8	13.2	14.9	15.9	10.3	12.8
Parent-in-law	0.1	0.0	0.1	0.0	0.2	0.1
Brother/sister	1.7	5.0	3.5	4.7	6.3	5.6
Other relative	9.7	7.3	8.4	5.1	9.7	7.6
Adopted	0.5	0.7	0.6	0.4	0.1	0.2
Fostered	0.2	0.3	0.3	0.2	0.3	0.2
Stepchild	2.3	2.7	2.5	1.2	2.4	1.9
Househelp	0.4	1.6	1.1	0.8	2.0	1.4
Not related	0.5	0.7	0.6	0.2	1.6	1.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who are currently in union. Sample sizes: females 12–14 (N=2); females 15–19 (N=140); males 12–14 (N=0); males 15–19 (N=17). Notes: Ns are weighted. "--" = N is 24 or fewer.

TABLE 3.3 Percentage distribution of adolescents aged 12–17 years, by orphanhood characteristics, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=943)	15–17 (N=707)	Total (N=1650)	12–14 (N=907)	15–17 (N=721)	Total (N=1628)
Orphan status						
Both biological parents alive	75.2	67.9	72.1	73.5	73.4	73.5
Mother died, father alive	6.7	8.5	7.5	6.2	7.1	6.6
Father died, mother alive	13.7	15.0	14.2	14.1	14.6	14.3
Both biological parents died	4.5	8.6	6.2	6.2	5.0	5.7
Respondent's age when mother died*						
≤5	13.5	9.9	11.6	9.8	14.9	12.1
6–8	15.4	17.4	16.4	18.8	13.8	16.6
9–11	30.8	24.8	27.6	32.1	21.8	27.6
12–14	14.4	28.9	22.2	16.1	14.9	15.6
15–17	0.0	7.4	4.0	0.0	18.4	8.0
Don't know	26.0	11.6	18.2	23.2	16.1	20.1
Respondent's age when father died†						
≤5	12.4	9.0	10.7	12.6	9.2	11.1
6–8	15.3	6.0	10.7	19.7	11.3	16.0
9–11	31.2	30.5	30.9	31.1	22.0	27.2
12–14	16.5	28.7	22.6	12.6	22.0	16.7
15–17	0.0	10.2	5.0	0.0	19.1	8.3
Don't know	24.7	15.6	20.2	24.0	16.3	20.7
Coresidence with parent figures among adolescents with a deceased biological parent‡						
Lives with 2 parent figures	6.9	6.2	6.5	6.3	6.2	6.2
Mother figure only	5.2	5.8	5.4	7.5	5.7	6.7
Father figure only	0.9	3.5	2.2	3.3	1.6	2.5
Lives with biological mother	34.8	26.5	30.7	39.2	33.7	36.7
Lives with biological father	9.9	6.6	8.3	6.3	10.4	8.1
Lives with no biological parents or parent-figures	42.5	51.3	46.8	37.5	42.5	39.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to adolescents whose mother died. Sample sizes: females 12–14 (N=104); females 15–17 (N=121); males 12–14 (N=112); males 15–17 (N=87). †Limited to adolescents whose father died. Sample sizes: females 12–14 (N=170); females 15–17 (N=167); males 12–14 (N=183); males 15–17 (N=141). ‡Limited to adolescents with a deceased biological parent. Sample sizes: females 12–14 (N=233); females 15–17 (N=226); males 12–14 (N=240); males 15–17 (N=193). *Note:* Ns are weighted.

TABLE 3.4 Percentage distribution of adolescents, by schooling characteristics, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=943)	15–19 (N=1054)	Total (N=1997)	12–14 (N=907)	15–19 (N=1126)	Total (N=2033)
Ever attended school						
No	1.7	4.6	3.2	1.4	2.8	2.2
Yes	98.3	95.4	96.8	98.6	97.2	97.8
Currently attending school						
No	8.6	41.9	26.2	7.3	29.2	19.4
Yes	91.4	58.1	73.8	92.7	70.8	80.6
Schooling completed (in years)						
None	3.7	5.2	4.5	4.2	2.9	3.5
1–3	39.0	16.9	27.3	48.0	16.8	30.7
4–5	34.1	24.8	29.2	31.6	28.2	29.7
6	11.9	14.0	13.0	8.4	11.7	10.2
7	7.7	10.5	9.2	5.3	13.2	9.7
8	2.5	7.7	5.3	1.1	10.2	6.2
9+ years	1.1	20.9	11.5	1.4	16.9	10.0
Highest level of school attended						
None	1.7	4.5	3.2	1.4	2.8	2.2
Primary	95.9	72.1	83.3	97.0	75.0	84.8
Secondary	2.4	23.3	13.5	1.5	22.1	12.9
Higher	0.0	0.0	0.0	0.0	0.1	0.0
Expectations for highest level of schooling						
No expectation of further schooling	4.7	29.2	17.6	1.2	13.5	8.0
Primary	13.6	9.0	11.2	14.8	10.8	12.6
Secondary	45.9	28.9	36.9	43.4	33.8	38.1
Higher	35.8	32.9	34.3	40.6	41.9	41.3
Ever received vocational training						
No	66.5	65.3	65.9	66.2	56.4	60.8
Yes	33.5	34.7	34.1	33.8	43.6	39.2
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 3.5 Percentage distribution of adolescents who have stopped schooling, by main reason for stopping, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=65)	15–19 (N=389)	Total (N=454)	12–14 (N=54)	15–19 (N=292)	Total (N=346)
Main reason for leaving school						
Could not pay school fees	6.2	13.6	12.6	0.0	11.3	9.5
Lack of school materials	24.6	30.8	30.0	33.3	48.3	46.0
Completed schooling/had enough	0.0	3.6	3.1	0.0	4.5	3.8
Pregnant/made someone pregnant	0.0	12.9	11.0	0.0	0.0	0.0
Got married	0.0	4.1	3.5	0.0	0.0	0.0
Illness	16.9	7.5	8.8	16.7	7.9	9.2
Work at home	15.4	3.9	5.5	25.9	6.2	9.2
Not interested	23.1	15.9	17.0	9.3	9.2	9.2
Not a good student	4.6	1.5	2.0	0.0	2.7	2.3
Got a job	4.6	2.1	2.4	1.9	4.1	3.8
Parent sick/died	0.0	0.8	0.7	0.0	2.1	1.7
Other reason	4.6	3.1	3.3	5.6	3.4	3.8
Don't know	0.0	0.3	0.2	7.4	0.3	1.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 3.6 Percentage distribution of adolescents who ever attended school, by schooling characteristics, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=927)	15-19 (N=1007)	Total (N=1934)	12-14 (N=894)	15-19 (N=1091)	Total (N=1985)
Age first attended school						
≤ 6	44.0	46.7	45.4	45.9	41.5	43.5
7	16.6	14.9	15.7	13.2	16.8	15.2
8	11.9	8.8	10.3	9.6	10.3	10.0
≥9	19.8	21.3	20.6	21.7	23.0	22.4
Don't know	7.7	8.3	8.0	9.6	8.4	9.0
Repeated last grade*						
No	88.7	93.0	90.5	84.5	90.6	87.5
Yes	11.3	7.0	9.5	15.5	9.4	12.5
Current or last school was coed						
No	1.1	3.5	2.3	0.8	0.9	0.9
Yes	98.9	96.5	97.7	99.2	99.1	99.1
Current or last school type						
Government-aided, not religious	75.3	70.6	72.9	73.2	67.7	70.2
Government-aided, religious	20.9	18.9	19.9	22.9	24.9	24.0
Private, not religious	2.4	8.8	5.7	2.9	5.4	4.3
Private, religious	1.4	1.7	1.6	1.0	2.0	1.6
Living arrangement at current or last school						
Day student	99.6	95.4	97.4	99.0	97.0	97.9
Boarder	0.4	4.6	2.6	1.0	3.0	2.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those currently attending school. Samples size: females 12-14 (N=862); females 15-19 (N=612); males 12-14 (N=841); males 15-19 (N=798). *Note:* Ns are weighted.

TABLE 3.7 Percentage distribution of adolescents, by time use and work characteristics, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=943)	15–19 (N=1055)	Total (N=1998)	12–14 (N=907)	15–19 (N=1125)	Total (N=2032)
Usual daily activities outside of school*						
Studying	23.3	21.2	22.2	20.6	24.7	22.9
Household chores	96.4	97.5	97.0	76.5	70.5	73.2
Work on family business/farm	17.2	22.7	20.1	28.4	37.0	33.2
Work to get money	2.1	4.4	3.3	5.4	17.0	11.8
Playing with friends	49.8	42.6	46.0	49.6	46.4	47.9
Idling	1.3	2.2	1.8	6.6	3.0	4.6
Other	0.5	0.8	0.7	1.3	1.9	1.6
Work and school status						
In school, working	17.1	11.7	14.3	27.5	27.3	27.4
In school, not working	74.3	46.3	59.5	65.2	43.5	53.2
Not in school, working	1.4	13.5	7.8	4.0	19.8	12.8
Not in school, not working	7.2	28.4	18.4	3.3	9.3	6.7
Place of work†						
Home	77.3	75.7	76.3	60.1	57.7	58.5
Away from home	22.7	24.3	23.7	39.9	42.3	41.5
Remuneration‡						
Cash only	16.3	26.4	22.4	21.6	38.9	32.9
Cash and kind	1.2	2.6	2.1	2.1	3.2	2.8
In kind only	1.2	0.8	0.9	2.5	1.3	1.7
Not paid	81.4	70.2	74.6	73.8	56.6	62.6
Did anything for money in past 12 months						
No	84.4	75.5	79.7	65.2	46.6	54.9
Yes	15.6	24.5	20.3	34.8	53.4	45.1
Who decides how money will be spent‡						
Respondent	37.2	34.8	35.6	51.9	64.5	60.2
Spouse/partner	0.0	6.6	4.2	0.0	0.2	0.1
Respondent and spouse/partner jointly	2.0	7.0	5.2	2.5	2.7	2.6
Parents/guardians	54.1	48.0	50.2	41.5	29.8	33.8
Sibling	4.1	0.8	2.0	3.2	1.8	2.3
Someone else	2.7	2.7	2.7	0.9	1.0	1.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because multiple responses are possible. †Limited to those who are working or helping with family business/farm. Sample sizes: females 12–14 (N=172); females 15–19 (N=263); males 12–14 (N=281); males 15–19 (N=527). ‡Includes those who work for money or reported doing something for money in past 12 months. Sample sizes: females 12–14 (N=148); females 15–19 (N=256); males 12–14 (N=316); males 15–19 (N=600). *Note:* Ns are weighted.

TABLE 3.8 Percentage distribution of adolescents, by religious and social group participation, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=943)	15–19 (N=1055)	Total (N=1998)	12–14 (N=908)	15–19 (N=1126)	Total (N=2034)
Religion						
Catholic	26.1	26.6	26.4	24.0	25.9	25.1
Protestant	43.4	45.3	44.4	41.9	39.3	40.5
Pentecostal/Charismatic/Revivalist	12.4	12.8	12.6	16.3	18.7	17.6
Pentecostal/Charismatic	n/a	n/a	n/a	n/a	n/a	n/a
Other Christian	n/a	n/a	n/a	n/a	n/a	n/a
Muslim	13.3	11.1	12.1	12.2	12.4	12.3
Traditional religion	2.1	2.3	2.2	2.8	1.8	2.2
No religion	0.5	0.4	0.5	2.0	1.3	1.6
Other	2.2	1.5	1.9	0.9	0.4	0.6
Importance of religion*						
Very important	97.3	98.3	97.8	96.4	98.6	97.6
Somewhat important	1.7	1.2	1.5	2.6	1.0	1.7
Not important	1.0	0.5	0.7	1.0	0.5	0.7
Frequency of religious service attendance*						
More than once a week	24.0	28.4	26.3	23.8	28.7	26.5
Once a week	70.3	68.4	69.3	73.4	68.5	70.7
At least once a month	4.6	2.6	3.5	2.4	1.9	2.1
Less than once a month	0.7	0.4	0.6	0.0	0.5	0.3
Not at all	0.3	0.3	0.3	0.5	0.4	0.4
Belongs to any social group or club						
No	72.9	72.2	72.5	77.2	68.5	72.4
Yes	27.1	27.8	27.5	22.8	31.5	27.6
Holds an office or leadership position in club†						
No	81.0	64.5	72.2	80.2	73.9	76.2
Yes	19.0	35.5	27.8	19.8	26.1	23.8
Type of social club or group†						
Church/Muslim youth	23.5	21.2	22.3	30.4	22.6	25.5
Football/netball	13.3	19.5	16.6	22.3	32.3	28.6
Choir	24.3	25.3	24.8	27.2	24.6	25.5
Drama	8.2	3.4	5.7	1.0	4.0	2.9
Anti-AIDS	18.4	24.9	21.9	17.4	26.6	23.2
Red Cross	3.9	3.4	3.6	0.0	0.8	0.5
Girl/Boy Guide	5.9	2.7	4.2	1.9	0.0	0.7
Wildlife Society	13.3	13.3	13.3	9.7	10.8	10.4
Youth Brigade	2.7	0.7	1.6	1.9	0.8	1.2
Dancing group	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who have a religious affiliation. Sample sizes: females 12–14 (N=936); females 15–19 (N=1051); males 12–14 (N=888); males 15–19 (N=1111). †Limited to those in social groups or clubs. Sample sizes: females 12–14 (N=253); females 15–19 (N=293); males 12–14 (N=202); males 15–19 (N=348). Note: Ns are weighted. n/a=not applicable/available.

TABLE 3.9 Percentage distribution of adolescents, by parent and teacher monitoring, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=943)	15–19 (N=1054)	Total (N=1997)	12–14 (N=907)	15–19 (N=1125)	Total (N=2032)
Parents/guardians know where respondent goes out at night*						
Do not know	23.1	22.7	22.9	23.8	30.9	27.8
Sometimes know	19.0	19.9	19.5	17.8	24.8	21.7
Always know	57.9	57.4	57.6	58.4	44.3	50.6
Parents/guardians know what respondent does with free time*						
Do not know	19.8	20.1	20.0	18.2	20.0	19.2
Sometimes know	24.9	22.8	23.8	28.9	34.2	31.9
Always know	55.2	57.1	56.2	52.9	45.8	48.9
Parents/guardians know who respondent's friends are*						
Do not know	16.8	13.8	15.2	13.6	12.5	12.9
Sometimes know	17.6	16.9	17.2	35.1	42.1	38.9
Always know	65.6	69.4	67.6	51.4	45.5	48.1
Teachers keep eye on students to make sure they are not getting into trouble†						
Almost always	70.0	70.6	70.3	77.1	74.2	75.5
Sometimes	20.6	20.7	20.6	18.0	21.1	19.7
Almost never	8.8	8.0	8.4	3.9	4.1	4.0
Not at all	0.5	0.8	0.7	1.0	0.5	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

*For married adolescents, the question refers to parental knowledge before respondent got married. †Limited to those who ever attended school. Sample sizes: females 12–14 (N=927); females 15–19 (N=1006); males 12–14 (N=894); males 15–19 (N=1095). *Note:* Ns are weighted.

TABLE 3.10 Percentage distribution of adolescents, by characteristics of friendship networks, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=942)	15–19 (N=1054)	Total (N=1996)	12–14 (N=907)	15–19 (N=1124)	Total (N=2031)
Number of close female friends						
0	1.3	2.0	1.7	48.7	29.7	38.2
1	15.5	16.8	16.2	16.3	21.2	19.0
2	30.8	33.0	32.0	17.2	19.3	18.4
3	24.1	24.3	24.2	8.9	13.0	11.2
4	14.2	12.0	13.0	3.6	6.7	5.3
5+	13.9	12.0	12.9	4.9	10.1	7.7
Don't know	0.2	0.0	0.1	0.3	0.1	0.2
Average number of close female friends	2.9	2.7	2.8	1.3	1.9	1.6
Number of close male friends						
0	68.5	48.6	58.0	2.1	1.3	1.7
1	13.5	26.3	20.3	15.1	11.9	13.3
2	9.7	12.5	11.2	26.9	23.0	24.7
3	4.5	6.5	5.5	20.5	23.2	22.0
4	2.0	3.2	2.7	13.1	11.0	12.0
5+	1.8	2.9	2.4	22.3	29.4	26.2
Don't know	0.0	0.0	0.0	0.0	0.2	0.1
Average number of close male friends	0.7	1.0	0.9	3.4	3.8	3.6
Sex composition of friendship networks						
No close friends	1.6	1.5	1.6	1.3	1.3	1.3
Only male	0.1	0.6	0.4	47.7	28.4	37.0
Only female	67.0	47.1	56.5	1.2	0.2	0.6
Both male and female	31.3	50.8	41.6	49.7	70.1	61.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 3.11 Percentage of adolescents, by types of people who talked about sex-related matters with adolescents, according to sex and age, 2004 National Survey of Adolescents*

Characteristic	Female			Male		
	12–14 (N=943)	15–19 (N=1043)	Total (N=1996)	12–14 (N=907)	15–19 (N=1126)	Total (N=2033)
Persons who have ever talked to respondent about sex-related matters						
Any family member	23.3	39.5	31.9	23.8	38.4	31.9
Any nonfamily member	20.9	36.5	29.1	33.7	55.2	45.6
Spouse/cohabiting partner	0.0	0.9	0.5	0.0	0.0	0.0
Mother	17.6	28.2	23.2	12.1	18.7	15.7
Father	6.9	8.9	8.0	12.1	18.6	15.7
Brother	2.3	7.2	4.9	7.7	11.6	9.9
Sister	7.0	12.5	9.9	2.4	5.3	4.0
Aunt	4.9	9.7	7.4	1.2	2.6	2.0
Uncle	3.0	4.2	3.6	5.8	13.2	9.9
Cousin	0.7	2.9	1.9	0.4	1.3	0.9
Grandmother	10.4	18.0	14.4	3.1	5.7	4.5
Grandfather	0.4	0.9	0.7	3.4	6.8	5.3
Other family member	0.0	0.7	0.4	0.0	0.6	0.3
Girlfriend	2.0	4.2	3.2	0.6	2.2	1.5
Boyfriend	0.4	1.7	1.1	3.3	5.4	4.5
Male friend	2.1	5.1	3.7	22.7	38.8	31.6
Female friend	10.5	21.9	16.5	1.7	3.9	2.9
Teacher	10.1	11.0	10.6	14.0	22.8	18.9
Health care provider	1.2	4.1	2.7	2.8	5.3	4.1
Religious/church leader	2.7	5.3	4.1	2.3	3.8	3.2
Other nonfamily member	1.4	1.5	1.5	1.0	2.9	2.0

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 3.12 Percentage distribution of adolescents, by alcohol and drug use, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=941)	15-19 (N=1055)	Total (N=1996)	12-14 (N=904)	15-19 (N=1126)	Total (N=2030)
Ever tried alcohol						
No	85.4	82.9	84.1	86.1	75.8	80.4
Yes	14.6	17.1	15.9	13.9	24.2	19.6
Refused to answer	0.0	0.0	0.0	0.0	0.0	0.0
Age when had first alcoholic drink*						
≤11	[17.5]	6.1	11.0	34.9	5.9	15.1
12-14	[11.7]	13.3	12.6	35.7	18.8	24.1
15-19	[0.0]	17.8	10.1	0.0	58.8	40.2
Don't know age	[1.5]	0.6	0.9	8.7	0.7	3.3
Refused to answer	[69.3]	62.2	65.3	20.6	15.8	17.3
Has gotten "drunk" in last 12 months*						
No	[61.9]	73.1	68.8	65.0	48.1	53.2
Yes	[38.1]	26.9	31.2	35.0	51.9	46.8
Ever tried any other type of drug						
No	99.3	98.9	99.0	98.1	96.1	97.0
Yes	0.7	1.1	1.0	1.9	3.9	3.0
Refused to answer	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who ever had an alcoholic drink. Sample sizes: females 12-14 (N=42); females 15-19 (N=67); males 12-14 (N=100); males 15-19 (N=231). Notes: Ns are weighted. [] = N is 25-49.

TABLE 3.13 Percentage distribution of adolescents, by levels of worry about different issues, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=941)	15–19 (N=1056)	Total (N=1997)	12–14 (N=904)	15–19 (N=1126)	Total (N=2030)
Worry about own health						
Very worried	20.3	22.1	21.2	20.2	24.7	22.7
Somewhat worried	10.2	11.4	10.8	16.3	15.2	15.7
Not worried	69.1	66.3	67.6	62.8	59.9	61.2
Don't know	0.4	0.3	0.4	0.7	0.3	0.4
Worry about getting enough to eat						
Very worried	20.2	25.2	22.8	24.1	25.3	24.8
Somewhat worried	16.5	19.3	18.0	22.6	21.4	21.9
Not worried	63.1	55.2	58.9	52.7	53.3	53.0
Don't know	0.2	0.3	0.3	0.7	0.1	0.3
Worry about getting money						
Very worried	26.9	34.6	31.0	41.1	45.4	43.5
Somewhat worried	17.0	18.0	17.5	21.6	21.5	21.5
Not worried	56.0	47.4	51.5	36.7	33.1	34.7
Don't know	0.1	0.0	0.1	0.6	0.0	0.2
Worry about getting (someone) pregnant						
Very worried	33.9	41.5	37.9	22.2	38.1	31.0
Somewhat worried	11.9	12.6	12.3	10.8	11.1	11.0
Not worried	53.8	45.9	49.6	65.0	50.5	57.0
Don't know	0.4	0.0	0.2	1.9	0.3	1.0
Worry about getting HIV/AIDS						
Very worried	46.7	55.0	51.1	32.8	53.7	44.4
Somewhat worried	6.7	6.6	6.7	9.5	6.7	7.9
Not worried	45.6	37.9	41.6	56.3	39.4	46.9
Don't know	1.0	0.5	0.7	1.4	0.3	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

Chart 3.1 Frequency of contact with biological mother among adolescents with a living biological mother, 2004 National Survey of Adolescents

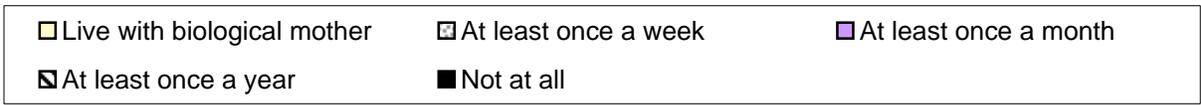
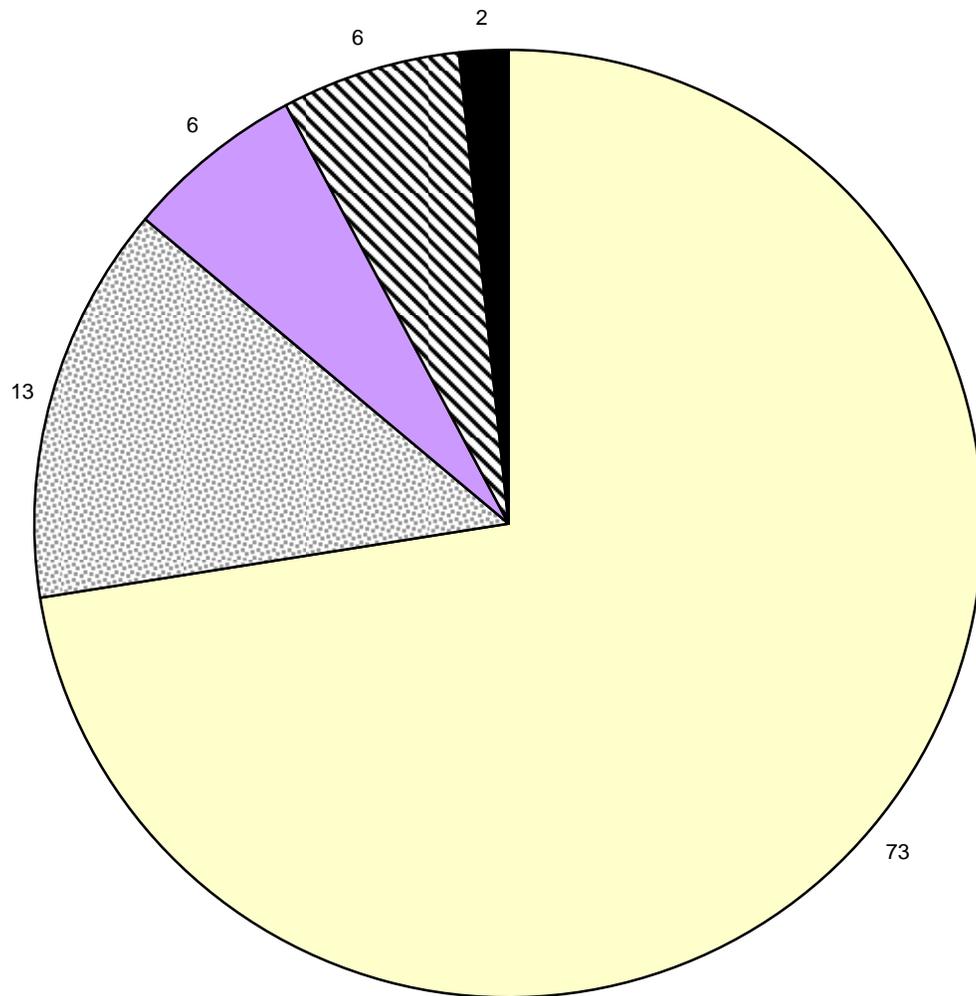


Chart 3.2 Frequency of contact with biological father among adolescents with a living biological father, 2004 National Survey of Adolescents

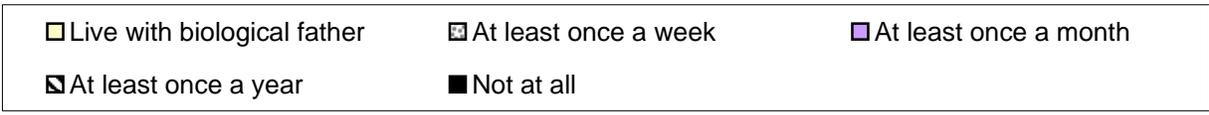
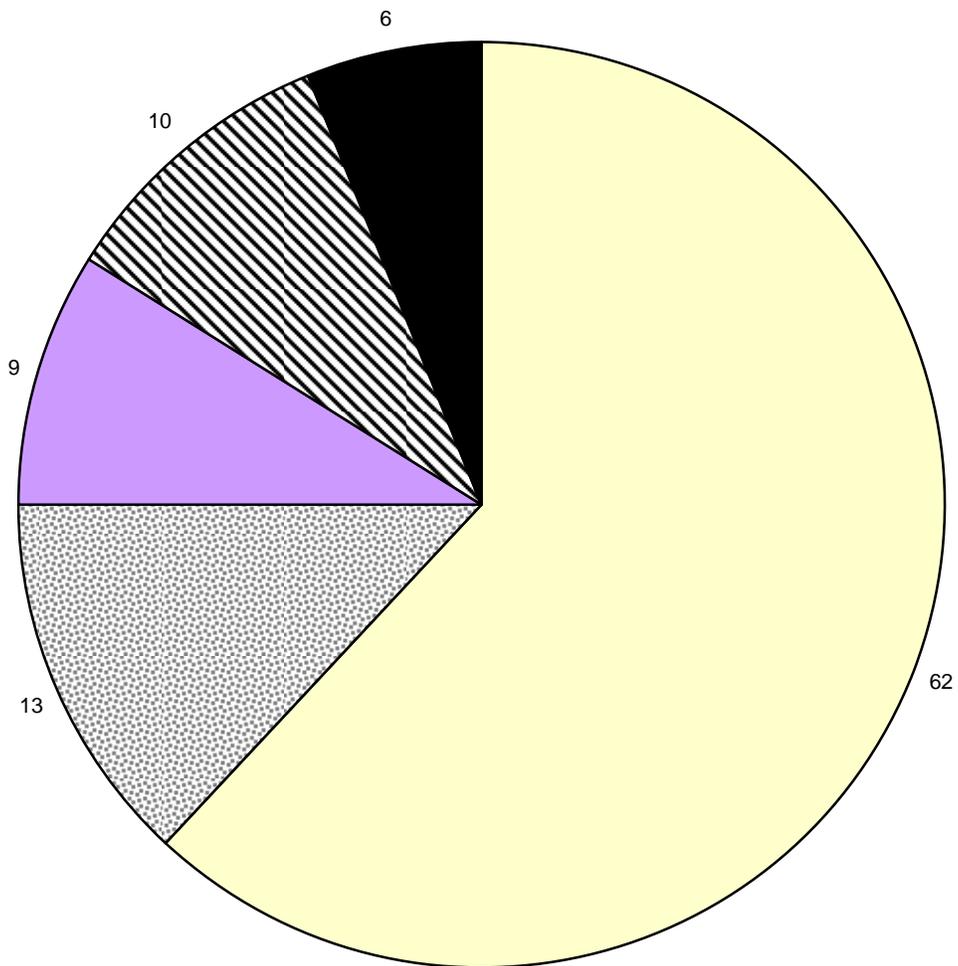


Chart 3.3 Percentage of adolescents currently attending school, among those who ever attended school, according to current age and sex, 2004 National Survey of Adolescents

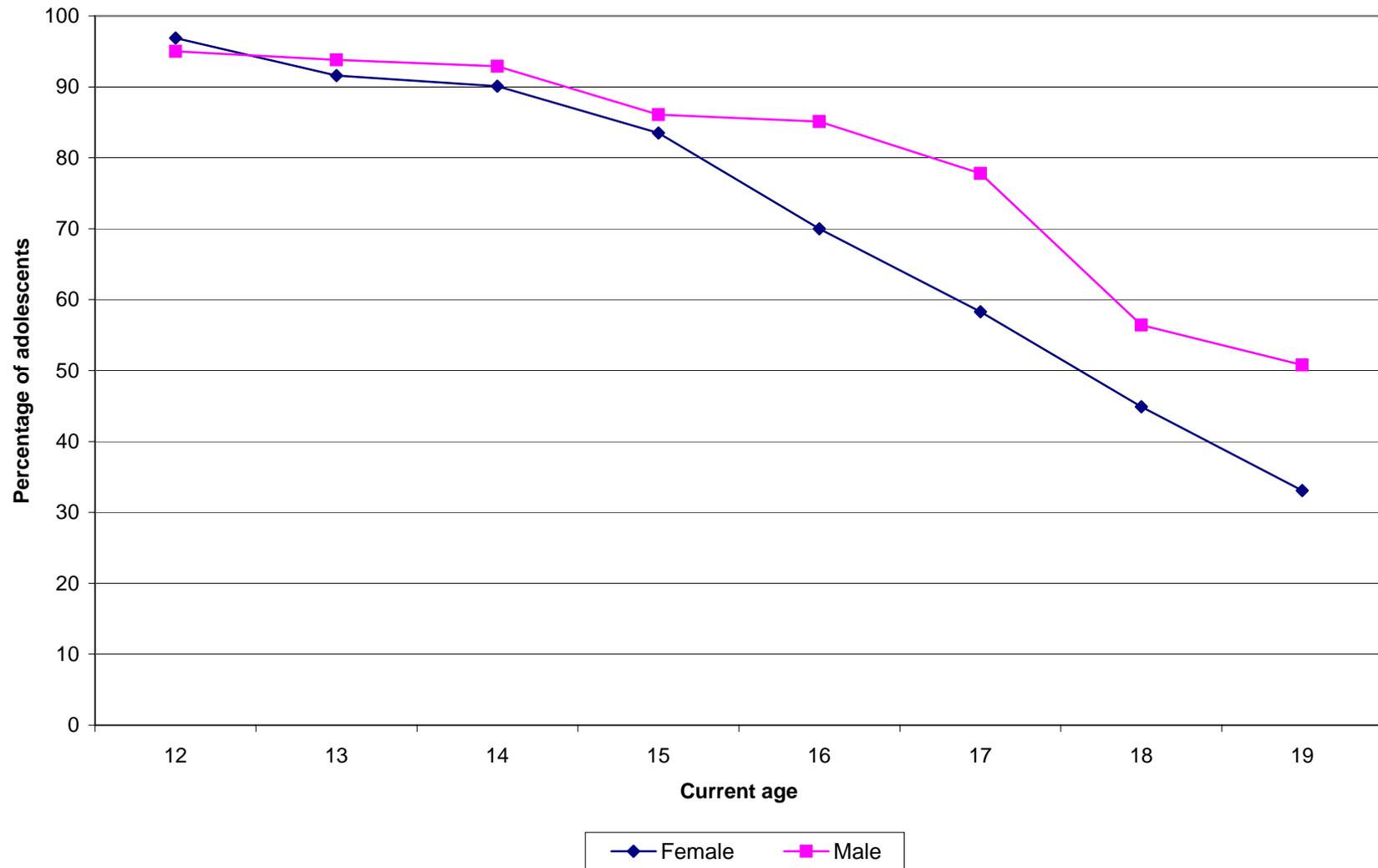


Chart 3.4 Work and school status of adolescents, according to sex, 2004 National Survey of Adolescents

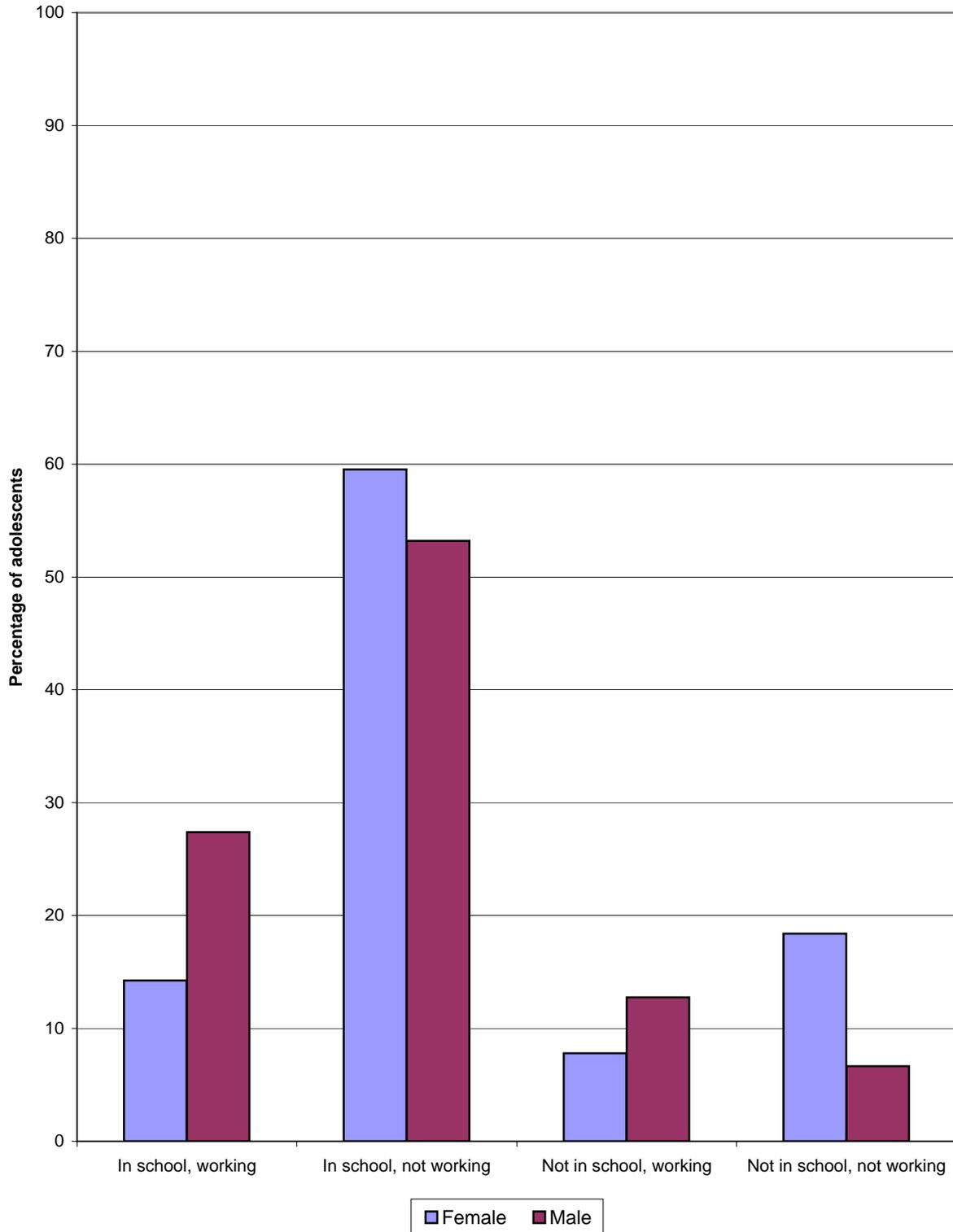
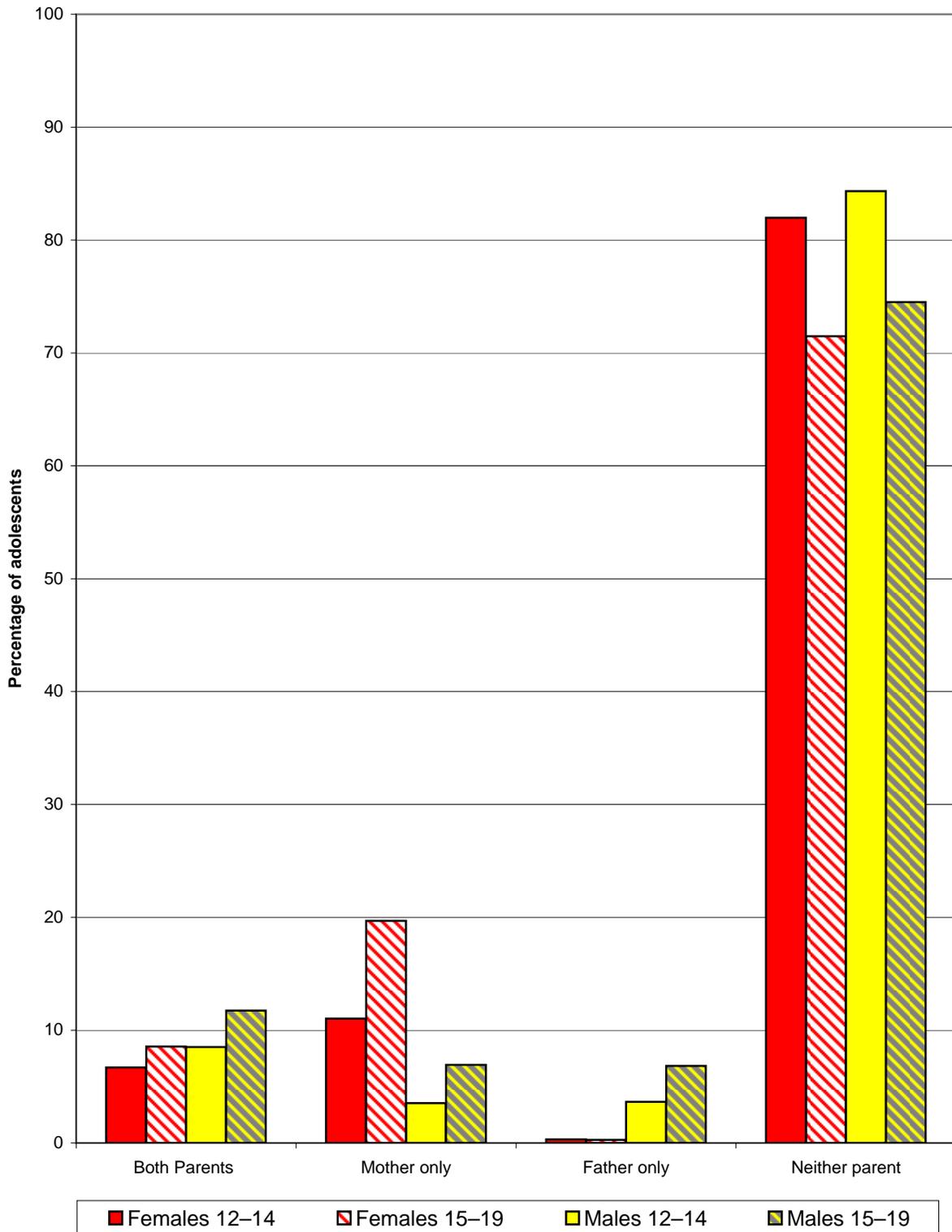


Chart 3.5 Communication with parents about sex-related matters among adolescents, according to sex and age, 2004 National Survey of Adolescents



Chapter 4

Sexual Activity and Relationships

This chapter presents information about adolescents' sexual maturation, sexual activity and intimate relationships. Adolescents' experience and timing of the first major sign of puberty, initiation rites and circumcision are described. Evidence is then presented on adolescents' awareness and experience of a range of sexual activities and relationships, including the timing of first sexual intercourse, characteristics of the first and most recent sex partners, and number of sex partners. The chapter also covers adolescents' experiences of sex in exchange for money or other goods, sexual abuse and coerced sex.

Puberty and Initiation Rites

Menstruation is, perhaps, a more significant and thus more memorable event among females than the more gradual pubertal changes experienced by males. The question wording for males was: "As boys grow into men, certain changes happen to their bodies, such as growing pubic hair, voices get deeper, or sometimes they have 'wet dreams.' At what age did you first notice any of these changes happening in your body, or have none happened yet?" For females, the question was: "As girls grow into women, changes happen in their bodies, such as the start of menstrual periods. At what age did you have your first menstrual period or have you not had one yet?" The median age at first pubertal change is calculated using a life table method since it includes years of exposure to the event (puberty) from those who have not yet experienced it.*³²

The results in Table 4.1 indicate that 87% of all females aged 15–19 and 23% of those aged 12–14 had started menstruation. The median age for start of menstruation was 15.1 years. Higher proportions of males than females (37% among 12–14 and 91% among 15–19-year-old males, compared with 23% among 12–14 and 87% among 15–19-year-old females) had started experiencing various puberty changes. The median age when boys started experiencing puberty related changes was 14.6 years. Since there is no single def-

inite sign of puberty for boys (as menstruation is for girls), these differences should not necessarily be interpreted as differences in timing of pubertal attainment between girls and boys.

Circumcision was performed on close to 20% of males. Most were circumcised between the ages of six and 11. Other types of initiation rites, such as *chinamwali* for girls[†], receiving advice from elders, being initiated in the *Nyau* secret society[‡] and undergoing Christian forms of initiation (where both boys and girls are advised as they grow into adulthood) were much more common. Approximately one-third of the adolescents had undergone initiation rites with a quarter of females and a third of males first experiencing initiation rites when they were 10 years or younger.

Sexual Activity and Awareness

Becoming sexually active and entering a union mark important transitions in the lives of adolescents. These transitions affect their exposure to the risk of pregnancy and STIs, as well as their immediate need for information and services to protect their sexual health. The transition into consensual union has especially broad effects on the lives of young women, as it shapes the

* Standard measures of calculating median age usually restrict the group to only those individuals who have already experienced the event, which can downward bias the median age calculation.

† An initiation rite in which young girls are advised by their elders on a number of things including sexual and reproductive matters, adulthood and marriage. Some of these initiation rites include encouragement to "clean the dust" (have sex). In districts such as Ntchisi and Mangochi, where initiation rites are practiced widely, some boys are advised to have sex with girls in a ceremony known as *kuchotsa fumbi* or *kusasa fumbi*. They are warned that noncompliance could lead to death or pain in their penis. Girls are also encouraged to have sex with men to "clean the dust" during certain initiation rites.

‡ *Gule Wankulu* (which literally means "the big dance") is both a secret cult and ritual dance practiced among the Chewa people living in Central Malawi. It is a sort of a secret society of initiated Chewa men. *Gule Wankulu* (otherwise known as *Nyau*) members are responsible for the initiation of young men into adulthood. Initiates become members of the secret society.

extent to which they can independently make decisions, including decisions regarding planning pregnancies and childbearing. Adolescents who had not yet become sexually active or entered a consensual union were asked whether they had ever had a boyfriend or girlfriend, as this is an indicator of who is likely to soon become sexually active.

To increase our understanding of the level of sexual development and awareness of young adolescents who are largely sexually inexperienced, separate questions were asked of single 12–14-year-olds about whether they had ever heard of certain behaviors, such as kissing, fondling and sexual intercourse. The question wording for awareness of each sexual activity was as follows:

- “Now I am going to ask you some questions about what young people might do together. Have you ever heard of kissing?”
- “Have you ever heard of fondling? By this I mean someone’s private parts, breasts or other parts of the body being touched in a sexual way.”
- “Have you ever heard of sexual intercourse? By this I mean a penis in a vagina.”

Follow-up questions asked whether they knew of any close friends who had engaged in these behaviors, and then whether they themselves had ever engaged in these behaviors. If the respondent had never heard of the sexual activity, she or he was not asked the two follow-up questions. Additional questions on relationship experience were also asked only to 12–14-year-olds. Results for sexual activity and relationship status are presented in Table 4.2.

Ever had intercourse and ever in union

The proportion of males who report having had sexual intercourse (42%) was twice as high as it was for females (21%) among the total sample of 12–19-year-olds. While very few young women (3%) report being sexually active in the early part of their adolescence, close to one in five of their male counterparts claim to have had sexual intercourse. Sixty percent of 15–19-year-old males report sexual initiation, compared to 37% of females in the same age-category. These differences may partially reflect variations in the levels of misreporting of sexual behavior by young people, whereby boys are more likely to overreport, while girls underreport sexual experience.³³

While almost no 12–14-year-olds had been in union, the percentage of female 15–19-year-olds (18%) who had ever been in a union was more than 4 times higher

than that among 15–19-year-old males (4%). A much greater proportion of males than females had had sexual intercourse and had never been in union. For males, one in five 12–14-year-olds and more than half of the 15–19-year-olds had never been in union and had had sex. Among females, the proportion who were sexually experienced (i.e., they have ever had sexual intercourse) outside of a union among 12–14-year-olds was negligible (3%), while one in five 15–19-year-olds who were never in union had had sexual intercourse. Among those who had never been in union and had never had sex, fewer than 10% of 12–14-year-old females and males had ever had a girlfriend or boyfriend, with fewer females having had this experience. Among 15–19-year-olds, females were more likely than males to have had a boyfriend but less likely to have had sex. Slightly fewer than half of females and about 30% of males aged 15–19 had never had sexual intercourse and had never had a boyfriend or girlfriend.

Sexual behavior and awareness among young adolescents

The questions on sexual activity and relationship status, which were only asked of 12–14-year-old adolescents, shows that although 42% of girls and 53% of boys had heard of kissing and knew of close friends who had kissed before, fewer than 10% said they had done it themselves. Kissing is not commonly a traditional part of courtship in Malawi and among some is seen as something more a part of Western culture than African culture.

Close to two-thirds had heard of fondling or knew close friends who had done it before. Fondling experience was more common among males than females: While more than one in four males who had heard of fondling report having experienced it, only one in ten females report experiencing it. More than seven in ten young adolescents had heard of sexual intercourse and over half of those adolescents knew of close friends who had had sex. Almost a quarter of young males who had heard of sexual intercourse claim they had experienced it, compared with only 4% of females. For all the three sexual activities covered in this section, both male and female adolescents were much more likely to report having known friends who had ever experienced these sexual practices than having experienced the activities themselves. This difference is suggestive of a high degree of underreporting of sexual activity, as young people who have indulged in sex are more likely to admit that their friends have done it than that they themselves have.

Sexual intercourse experience among 12–14-year-olds was significantly greater for males (19%) than for females (3%) but relationship formation did not look that different between the two sexes. Roughly equal proportions had never had sex but had had a girl/boyfriend and had never had sex or a girl/boyfriend but had (been) kissed or fondled.

Reasons and pressures to avoid sexual activity

Table 4.3 shows the reasons for never having had sexual intercourse and sources of pressure not to have sexual intercourse. The most popular reason for never having had sexual intercourse, given by more than 70% of the adolescents of both genders, was to avoid AIDS and other STIs. Close to two-thirds of females and a quarter of males had never had sexual intercourse because they were afraid of pregnancy. The proportion giving this response was higher for 15–19-year-olds of both sexes than 12–14-year-olds. Among the male adolescents, the 15–19-year-olds were about three times more likely than the 12–14-year-olds to avoid sexual intercourse for fear of getting a girl pregnant. Less common responses were desiring to wait to have sexual intercourse in marriage, lacking a partner and feeling too young. The reason given least frequently by both males and females was avoiding sex out of religious reasons.

Adolescents were also asked if they felt any pressure from others encouraging them not to have sexual intercourse. Generally, such pressure was more commonly experienced by females than males. About a third of 12–14-year-old females and one in four 15–19-year-olds felt a great deal of pressure from others not to have sexual intercourse. Three-fourths of these females felt pressure from their mothers, while 47% felt pressure from another female family member and 35% from their fathers). Fewer than one in five males felt “a great deal” of pressure to abstain from sex. Most males felt pressure not to engage in sex from their fathers (49%), followed by pressure from mothers (39%). A third of the boys experienced pressure from their male friends, while one in five felt pressured by their teachers. It seems that the religious establishment plays a very minor role in terms of pressuring boys and girls not to have sex, as only about 7% of the respondents reported pressure from their church or mosque. In fact, none of the female respondents and 2% of the male respondents who had not had sex in the 12 months prior to the survey mentioned religious reasons as a reason for not having sex (Table 4.4).

Sexual activity in the recent past

Table 4.4 presents sexual activity status and reasons for not having sex in the 12 months prior to the survey among adolescents by age and sex. These measures include adolescents both in and out of union.

The findings show that a considerable proportion of sexually experienced adolescents abstained from sex during the past year. About 15% of all males and 5% of all females (the figures translate to 35% and 23% of all sexually experienced males and females, respectively) abstained from sex in the 12 months prior to the survey. Another 6% of all females and 9% of all males had sex in the past 12 months but abstained in the last three months. More older and male adolescents than younger and female adolescents were sexually active in the past three months. Of all male adolescents aged 15–19, 26% had sex in the past three months, compared with 18% of female adolescents in the same age-group. Among all adolescents in the younger age-group (12–14 years), 2% of females and 9% of males had had sex in the past three months. The low level of recent sexual activity could be a reflection of some of the sexually experienced young people reverting to abstinence or it could reflect unwillingness to disclose recent sexual activity.

Reasons for no longer being sexually active

There were a number of reasons that sexually experienced adolescents gave for not having had sexual intercourse in the 12 months prior to the survey. These reasons mirrored the reasons in Table 4.3 that adolescents gave for not ever having had sexual intercourse: Over 73% of the respondents said that they did not have sex in order to avoid AIDS and other STIs, while slightly fewer than two-thirds of the females and nearly half of the males said that they were afraid of pregnancy. Roughly about one in ten males and females were no longer sexually active because they wanted to wait until marriage. A quarter of the females and one in ten males reported that they abstained from sex because they did not have a partner.

Attitudes about sexual activity

Table 4.5 indicates adolescents’ attitudes about sexual activity, according to their sex and age. On the question of whether or not young women or men should practice abstinence until they marry, the pattern of the responses among female and male adolescents in both age-groups are somewhat similar: About three in four male adolescents reported that both males and females should remain virgins until marriage, while 82% of female adolescents expressed this view. Close to half of

all female and male adolescents were of the opinion that usually people do not plan to have sex, a proportion that was higher among 15–19-year-olds and sexually active adolescents.

Interestingly, even among adolescents who had ever had sex, the majority of both genders indicated that young men and women should remain virgins until they marry. It is possible that the respondents are answering this question in a socially accepted manner, since this is the message they have most likely heard repeated.

First Sexual Intercourse

The timing of first intercourse is an important indicator of the onset and duration of exposure to the risk for both unplanned pregnancy and STIs. Younger female adolescents have higher biological risks both for complications of pregnancy and delivery and of STIs. Younger male and female teens are likely to be more exposed to the risk of sexual coercion. Age is also very likely to be related to knowledge of risks and means of protection, as well as to the ability to seek and obtain information and services: Older adolescents are likely to be better equipped in all respects.

Timing of first intercourse

Chart 4.1 shows age at first sexual intercourse. Since some of the adolescents had never had sex, we generated a profile of age at first sex using a life table method, which includes years of exposure to the event (first sex) from those who have not yet experienced their first sexual intercourse. Consistent with other results described above, male adolescents are consistently more likely to report being sexually experienced than their female counterparts. By age 12, about 6% of all male adolescents report having had sex, compared with only 1% of females. By age 15, about one in five males are sexually experienced, compared with close to one in 10 females. The magnitude of the difference narrows a bit by age 19, by which time 35% of males and 26% of females are sexually experienced.

Relationship with first sexual partner and main reason for first intercourse

The majority of all adolescents who ever had sex (more than 70%) had their sexual debut with a girlfriend or boyfriend. First sex with a spouse or live-in partner made up the rest of the experiences for females. For males, the only other significant category (about 17%) was those who had first sex with a casual acquaintance (see Table 4.6).

The vast majority of the males (85%) reported that they had sex the first time because they felt like it. For the females, slightly more than half gave this as the reason for having their sexual debut. Whereas about 16% of the females had had sex the first time because they were married, marriage as a reason for having one's first sexual encounter was virtually absent among the males. About 13% of the females said their partners insisted, which is a level two times higher than that for males. Approximately 4% of the females said they were forced to have sex with their first sex partner. Nearly 6% of the females reported that they had sex with the first partner because they were expecting gifts or money; with younger female adolescents aged 12–14 (11%) more likely to have sex because of this reason than older female adolescents aged 15–19 (5%). None of the males reported this reason. It is also noted that a slightly higher percentage of males (5%) than females (2%) said their friends influenced them to have sex with their first partner.

Characteristics of first sexual experience

Table 4.7 presents the characteristics of first sex (age of partner, willingness to have sex and use of contraceptives) among adolescents who ever had sexual intercourse by sex, age and union status.

Having sex with an older partner is likely to place one at greater risk of STIs, including HIV, since older partners are more likely to have more sexual experience than a sexual partner of the same age. More than half of the female adolescents' first sex partners (regardless of age or marital status) were older by 1–4 years. About one in four of the unmarried females had first sex partners who were their same age or younger. Overall, about 12% of females had sex partners who were 5–9 years older, with this proportion twice as high among those in a union compared to those not in a union. Among the male adolescents, the vast majority (82%) initiated sex with partners who were either the same age or younger. About 17% had partners who were older than them.

There is a striking difference between female and male adolescents willingness to have sex: About 71% of the males indicated that they were very willing to have sex the first time, while fewer than 10% were not willing at all. Among the females, 41% were very willing while 38% were not willing at all. The proportion who reported having been not willing at all was much lower for females in union (25%) compared with females not in union (44%). This may reflect that females feel that the socially desired response is to be willing to have sex with one's husband or, in fact, the sex may

have been more willing.

Contraceptive use at first sex is not common among young people. The majority of sexually experienced respondents (72% of females and 81% of males) did not use any contraceptive method at first sex. Females who were in union at the time of the survey were far less likely to have used a contraceptive method at first sex than those who were not in union. Condom use is higher among unmarried females (34%) aged 15–19, compared with those in union (6%) or even 15–19-year-old males (19%). Despite the fact that males report higher levels of sexual activity than females, males report lower levels of use of condoms and other contraceptives than females. This might be a reporting phenomenon and not an accurate reflection of behavior, as girls who are more willing to report sexual behavior may be more inclined to use condoms.³⁴

Sex Partners

The number of sexual partners over the period of a year and over an individual's lifetime is used as an indicator of the level of risk of exposure to HIV and other STIs. Table 4.8 shows that the majority of sexually experienced respondents have only had one sex partner and that females were considerably more likely to have had only one sexual partner than males. About 67% of sexually active females and 47% of their male counterparts had one lifetime sexual partner. For the 15–19-year-old males 57% had had more than one sex partner. For both sexually experienced males and females, about one in five has had only two sex partners. Another one in five 15–19-year-old males had had four or more sex partners in their lifetime. The numbers of females who had had more than two sex partners accounted for fewer than 10%, compared with 32% for males.

A higher proportion of sexually experienced males (35%) than females (23%) had not had a sex partner in the 12 months prior to the survey. In the 12 months prior to the survey, slightly over 70% of females and about 55% of males had had one sexual partner. These results show that a sizable proportion of adolescents who become sexually active are able to revert to long-term abstinence and that intervention programs can build on this to promote secondary abstinence among young people who have ever had sex.

Characteristics of last sexual relationship

Table 4.9 presents information on the last sexual relationship among adolescents who had sex in the 12 months prior to the survey.

The results are similar to those relating to the char-

acteristics of first sex presented in Table 4.7. Boyfriends or girlfriends constituted the bulk of partners of unmarried adolescents who had been sexually active in the 12 months before the survey. Among females who were in union, their last sex partner in the last 12 months was a spouse (68%) or live-in partner (32%). A higher proportion of 12–14-year-old males (19%) had their last sex with a casual acquaintance compared with 11% of the 15–19-year-olds. None of the female respondents, irrespective of age, reported having had sex with a casual acquaintance in the previous 12 months. Reported last sex with a commercial sex worker was very low for males (less than 1%). Female adolescents tended to have partners 1–9 years older, and females in unions were almost four times more likely to have partners 5–9 years older than those not in union. Male adolescents' last sex partners were generally either the same age or younger.

Singular sexual encounters and short-term relationships are generally more commonly reported among males than females, who were more likely to be in relationships that lasted four months or more. Most males (73%) were in relationships that lasted for three months or less. Among unmarried females, 38% had similarly short-term relationships. About 38% of females and 12% of males had relationships with their partners for one year or more. Except for about 4% of females whose last sex partner in the 12 months prior to the survey had drunk alcohol, alcohol use during last sex was close to nil for both males and females.

Sex in Exchange for Money or Gifts

How common is it for adolescents to receive money or gifts in exchange for sexual intercourse and what are the types of things exchanged? Questions about sex in exchange for money or gifts were asked of respondents in relation to up to three nonmarital sex partners in the last 12 months. The question was: "Have you received anything from this person, such as money, gifts or something else, so you would have sexual intercourse with (him/her)?" If yes, "What did you receive?"

Table 4.10 presents the prevalence of sex in exchange for money or other items. Four in five females and about one in ten males who had sex in the past 12 months with a nonmarital partner reported having received something in exchange for having sex. These very high proportions suggest that the behavior captured is a common feature of routine dating or courtship and that these types of exchanges are different from commercial sex or the "sugar daddy" phenomenon. Although the financial exchange has the po-

tential to reduce the receiver's autonomy and power in the relationship, the exchange taking place is may be more nuanced than paying for sex, as it also takes place in committed relationships and carries more meaning than simply an instrumental function.³⁵ With reference to particular items that one could receive in exchange for sex, almost all of the females who reported having received something in exchange for sex (96%) received money in exchange for sex, over half received clothes and one in five received jewelry or cosmetics.

Other Sexual Practices

While sexual intercourse remains one of the most important adolescent experiences to understand, given its direct link to unwanted pregnancy and STI transmission, several other sexual behaviors are linked to the transmission of HIV and other STIs as well. Table 4.11 contains information on awareness and practice of anal sex and use of chemicals for dry sex.

It has been argued (based on anecdotal evidence) that young women use anal sex as a substitute for vaginal sexual intercourse in order to avoid the risk of pregnancy and/or to preserve their virginity. Whereas anal sex can not result in pregnancy, it represents high risks for STIs, including HIV, if protection is not used. Survey questions about anal sex were especially sensitive and were asked only of one, randomly chosen eligible adolescent per household, and if only if no one over 3 years of age was within listening distance. Three questions were asked about anal sex: whether respondents had ever heard of anal sex, whether they knew of any close friends who had experienced anal sex and whether they themselves had ever experienced anal sex. If the respondent had never heard of anal sex, she or he was not asked the two follow-up questions. The question regarding awareness of anal sex was: "Young people sometimes have sex in different ways. Have you ever heard of anal intercourse? By this I mean where a man puts his penis in his partner's anus."

Anal sex was more commonly known among males (35%) than females (19%) and it was most known among 15–19-year-old males (47%) than any other group. About one in five of the 12–14-year-old males had heard of it. Of those who heard of it, 52% of the younger males knew close friends who had had anal sex before (compared with 28% of 15–19-year-olds), and one in ten had practiced it (compared to 4% of 15–19-year-olds). Whereas 28% of the 15–19-year-old females had heard of anal sex, 12–14-year-old females (9%) were the least likely to have heard of it. Of the 15–19-year-old females who had heard of anal sex, 34% had

close friends who had had anal sex and 7% said they had done it themselves. Overall, 6% of both males and females had experienced anal sex. It is evident here that females also experienced anal sex; hence anal sex is not only male-male sex but that some males are having anal sex with girls. The substantial proportions of adolescents who know about anal sex and those who know friends who have practiced it suggest that this practice might be more widely practiced than expected. Given the significance of this practice for STI transmission, further research is warranted to establish its prevalence and the context in which it occurs.

All the respondents in this survey were also asked if they had ever heard of herbs or chemicals women use to keep their vaginas dry during sexual intercourse. The practice of "dry sex" can make the vaginal tissues more prone to small tears and thus put a woman at greater risk of STI/HIV transmission. Fourteen percent of females and 17% of males had heard of the practice of dry sex. Most of those who had heard of it were 15–19-years-old (20% of females and 23% of males). Use of herbs or chemicals to keep the vagina dry among adolescents who had had sex before was also uncommon. Only 9% of sexually experienced females and 4% of males have ever used or had sex with someone who used herbs or chemicals to keep their vagina dry during sex.

Sexual Abuse and Coercion

Recent evidence has pointed to the relatively widespread occurrence of sexual coercion and its negative sexual and reproductive health consequences.³⁶ How common is sexual abuse and coercive sexual intercourse among adolescents and who perpetrates it? Survey questions were asked about how willing adolescents were at their first sexual intercourse (presented earlier in Tables 4.6 and 4.7), and, for one randomly selected eligible adolescent per household, whether they had ever experienced sexual abuse or sexual coercion. The question wording for sexual abuse was: "Sometimes people do things to us we do not want. Has anyone ever touched you in an unwanted sexual way, such as touching, kissing, grabbing or fondling?" The question wording for coercive sex was: "Has anyone physically forced, hurt or threatened you into having sexual intercourse?" Table 4.12 shows results for this analysis.

Almost one in five adolescents—both female and male—reported having been touched, kissed, grabbed or fondled in an unwanted sexual way, and 7% of females and 3% of males said they had ever been physically forced, hurt or threatened into having sexual intercourse. The highest proportion of respondents who

had experienced coerced sex was among 15–19-year-old females (10%). Close to half of the females that had been forced to have sex were coerced by a stranger, while one in five were coerced by a friend. About 15% of the females said that they had been forced into having sex by a schoolmate. Among the young men, a quarter had been coerced into sex by a friend, 18% by either a girlfriend or stranger and 15% a schoolmate.

Policy and Programmatic Implications

- The finding that a considerable proportion of adolescents (about 80% of females and 58% of males) were not sexually experienced shows that young people have a strong base of positive role models advocating sexual abstinence, a pattern that intervention programs can build on to promote abstinence. Additionally, the finding that the majority of adolescents believe that one should wait until marriage to have sexual intercourse presents an opportunity to encourage delaying the onset of sexual behavior. Yet this is complicated by the belief held by more than half of the respondents that sex is not planned.
- The finding that many adolescents who have had sex have not had recent sexual contact demonstrates that once adolescents initiate sexual intercourse, it is possible for them to revert to long-term abstinence and reduce the risk of unwanted pregnancies and STIs. Intervention programs can build on this to promote sexual abstinence.
- The findings that most adolescents who were sexually inexperienced or who had not had sex in the past year abstained because of fear of pregnancy and STIs/HIV infection demonstrates that prevention campaigns are having some effect. However, the fact that many of the young people who are sexually active indulge in unprotected sex points to the need for increased focus on how young people can effectively protect themselves.
- The finding that boys tend to indulge in riskier sexual behaviors than girls highlights the need to investigate and address the role of the socialization process and initiation ceremonies in propagating risk behaviors, which ultimately increase exposure to STIs, including HIV, among adolescents and their current and future sexual partners.
- Low levels of contraceptive use at first sex highlight the need to understand and address the reasons for not accessing or using contraceptives and for strengthening education on pregnancy and methods of prevent-

ing it even among adolescents who are not sexually experienced.

- The high proportion of female adolescents who reported that they received money or gifts in exchange for sex needs further investigation and should be a major concern for HIV/AIDS programs, since transactional sex may leave females particularly vulnerable to unprotected or unwanted sexual contact.
- Although not many young people reported that they personally engaged in anal sex nor did many use herbs or chemicals during sex, the high proportions of adolescents who reported that their friends have experienced these practices warrants further investigation to establish the prevalence of these behaviors, circumstances under which they performed and mechanisms for addressing them.

TABLE 4.1 Percentage distribution of adolescents, by experiences of and age at first menstruation or other pubertal changes, circumcision and initiation rites, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=943)	15–19 (N=1055)	Total (N=1998)	12–14 (N=908)	15–19 (N=1125)	Total (N=2033)
Experienced menstruation/male puberty changes						
No	77.2	13.1	43.3	63.1	9.0	33.2
Yes	22.8	86.9	56.7	36.9	91.0	66.8
Median age at first menstruation/male puberty changes (in years)						
	n/a	n/a	15.10	n/a	n/a	14.6
Age first experienced menstruation/male puberty changes*						
≤ 10	4.7	0.3	1.1	9.5	1.5	3.5
11	5.1	0.9	1.7	8.9	3.4	4.8
12	28.0	8.1	11.8	30.1	11.5	16.1
13	41.1	14.6	19.6	37.8	17.4	22.4
14	21.0	26.4	25.4	10.4	24.3	20.9
15	n/a	29.9	24.2	n/a	26.3	19.8
16	n/a	12.0	9.7	n/a	8.0	6.0
17 or older	n/a	5.9	4.8	n/a	5.1	3.8
Don't know	0.0	2.0	1.6	3.3	2.5	2.7
Experienced circumcision						
No	98.5	97.7	98.1	85.2	78.8	81.7
Yes	1.5	2.3	1.9	14.8	21.2	18.3
Age experienced circumcision†						
≤1	--	--	[0.0]	5.9	1.3	2.9
2–5	--	--	[2.6]	0.7	2.1	1.6
6–11	--	--	[36.8]	67.4	46.9	54.3
12–14	--	--	[28.9]	25.2	36.0	32.1
15–19	--	--	[31.6]	0.0	12.1	7.8
Don't know	--	--	[0.0]	0.7	1.7	1.3
Experienced initiation rites						
Yes	26.0	47.8	37.5	25.0	38.0	32.2
No	73.0	51.0	61.4	74.0	61.9	67.3
Don't know	1.1	1.1	1.1	1.0	0.1	0.5
Age first experienced initiation rites‡						
≤10	37.4	18.7	24.8	42.4	29.0	33.6
11	14.8	5.8	8.7	22.8	6.6	12.2
12	24.3	12.9	16.6	18.3	17.5	17.7
13	11.5	11.2	11.3	12.5	13.0	12.8
14	6.2	16.5	13.2	0.0	12.3	8.0
15	0.0	17.1	11.5	0.0	7.8	5.1
16	0.0	11.8	7.9	0.0	5.9	3.9
17+	0.0	5.0	3.4	0.0	6.4	4.2
Don't know	5.8	1.0	2.6	4.0	1.7	2.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who have experienced the event. Sample sizes: females 12–14 (N=214); females 15–19 (N=917); males 12–14 (N=336); males 15–19 (N=1025). †Limited to those who have been circumcised. Sample sizes: females 12–14 (N=14); females 15–19 (N=34); males 12–14 (N=135); males 15–19 (N=239). ‡Limited to those who have experienced initiation rite. Sample sizes: females 12–14 (N=243); females 15–19 (N=502); males 12–14 (N=224); males 15–19 (N=424). Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25–49.

TABLE 4.2 Percentage distribution of adolescents, by relationship status and sexual activity, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=943)	15–19 (N=1037)	Total (N=1980)	12–14 (N=907)	15–19 (N=1112)	Total (N=2019)
Ever had sexual intercourse						
No	96.9	63.4	79.3	80.7	40.1	58.3
Yes	3.1	36.6	20.7	19.3	59.9	41.7
Relationship status						
Ever in union	0.4	17.8	9.5	0.2	3.9	2.2
Never in union, ever had sex	2.8	19.1	11.4	19.2	55.9	39.5
Never in union, never had sex:						
Ever had a boyfriend/girlfriend	7.5	16.5	12.2	9.2	11.3	10.3
Never had a boyfriend/girlfriend	89.3	46.6	66.9	71.4	28.9	47.9
Sexual activity*						
Kissing:						
Heard of it	42.3	n/a	42.3	53.0	n/a	53.0
Know close friends who have done it†	49.5	n/a	49.5	44.8	n/a	44.8
Have done it†	7.4	n/a	7.4	9.9	n/a	9.9
Fondling:		n/a			n/a	
Heard of it	62.5	n/a	62.5	65.8	n/a	65.8
Know close friends who have done it†	55.2	n/a	55.2	64.3	n/a	64.3
Have done it†	10.6	n/a	10.6	26.8	n/a	26.8
Sexual intercourse:		n/a			n/a	
Heard of it	72.0	n/a	72.0	84.0	n/a	84.0
Know close friends who have done it†	52.9	n/a	52.9	64.6	n/a	64.6
Have done it†	3.9	n/a	3.9	23.1	n/a	23.1
Relationship status and sexual activity among 12–14-year-olds		n/a			n/a	
Ever had sex	3.1	n/a	3.1	19.3	n/a	19.3
Never had sex, but had boyfriend/girlfriend	7.4	n/a	7.4	9.2	n/a	9.2
Never had sex and never had boyfriend/girlfriend, but have (been) kissed or fondled	4.3	n/a	4.3	5.1	n/a	5.1
Never had sex, never had boyfriend/girlfriend, never (been) kissed or fondled	85.2	n/a	85.2	66.5	n/a	66.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Only unmarried 12–14-year-olds were asked these sexual activity questions. Sample size is (N=923). †Limited to those who have heard of the specific sexual activity. Note: Ns are weighted.

TABLE 4.3 Percentage distribution of adolescents who never had sexual intercourse, by reasons for never having had sexual intercourse and encouragement received, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=640)	15-19 (N=657)	Total (N=1297)	12-14 (N=576)	15-19 (N=446)	Total (N=1022)
Reasons for never having had sexual intercourse*						
Don't have a partner	8.0	10.8	9.4	8.3	4.9	6.8
Wait until marriage	12.1	16.0	14.0	20.0	16.1	18.3
Afraid to get pregnant/make someone pregnant	55.6	73.1	64.5	16.1	45.3	28.9
Avoid STIs/AIDS	76.4	69.4	72.9	67.3	76.7	71.4
Too young	8.8	2.6	5.6	6.9	2.0	4.8
Schooling reasons	2.5	2.1	2.3	1.7	2.9	2.3
Religious reasons	0.3	0.8	0.5	0.7	1.3	1.0
Because of parents	n/a	n/a	n/a	n/a	n/a	n/a
Not interested	n/a	n/a	n/a	n/a	n/a	n/a
No reason	n/a	n/a	n/a	n/a	n/a	n/a
Sex is bad/feel ashamed	n/a	n/a	n/a	n/a	n/a	n/a
Fear arrest/jailing	n/a	n/a	n/a	n/a	n/a	n/a
Other	3.6	2.9	3.2	6.4	5.8	6.2
Don't know	2.2	2.0	2.1	6.8	1.8	4.6
Level of encouragement from others not to have sexual intercourse						
A great deal	33.6	26.5	30.0	18.8	17.3	18.1
A little	6.4	7.5	6.9	3.5	4.9	4.1
None	59.8	65.9	62.9	77.8	77.8	77.8
Don't know	0.2	0.2	0.2	0.0	0.0	0.0
From whom adolescents receive encouragement* †						
Girlfriend/boyfriend	4.3	4.6	4.4	0.0	2.0	0.9
Mother	72.3	75.6	73.8	39.1	39.8	39.4
Father	35.4	35.5	35.4	45.3	53.1	48.7
Brother	9.8	18.3	13.7	13.3	11.2	12.4
Sister	16.0	15.7	15.9	7.8	5.1	6.6
Other female family member	43.8	51.2	47.1	8.6	9.2	8.8
Other male family member	8.6	11.5	9.9	11.7	17.3	14.2
Female friends	19.1	14.7	17.1	3.9	2.0	3.1
Male friends	0.8	0.0	0.4	36.7	30.6	34.1
Teacher	11.3	10.1	10.8	20.3	21.4	20.8
Church/mosque	5.8	7.8	6.7	5.5	8.2	6.7
Other	2.3	0.5	1.5	0.8	1.0	0.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because multiple responses are possible. †Limited to those who receive any encouragement from others not to have sexual intercourse. Sample sizes: females 12-14 (N=256); females 15-19 (N=218); males 12-14 (N=128); males 15-19 (N=98) Note: Ns are weighted. n/a=not available/applicable.

TABLE 4.4 Percentage distribution of adolescents, by sexual activity status and reasons for not having had sex in the last 12 months, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=942)	15–19 (N=1036)	Total (N=1978)	12–14 (N=906)	15–19 (N=1112)	Total (N=2018)
Sexual activity status						
Never had sex	97.0	63.4	79.4	80.8	40.1	58.4
Ever had sex, no sex in last 12 months	0.7	8.2	4.7	5.8	21.9	14.7
Had sex in last 12 months, not in last 3 months	0.4	10.0	5.5	4.3	12.2	8.7
Had sex in last 3 months	1.8	18.3	10.5	9.1	25.7	18.2
Reasons for not having had sex in last 12 months*						
Don't have a partner	--	25.0	23.1	13.7	8.3	9.3
Wait until marriage	--	7.2	10.1	13.7	9.5	10.3
Afraid to get pregnant/make someone pregnant	--	65.1	62.2	41.2	48.3	47.1
Avoid STIs/AIDS	--	72.6	73.6	56.9	77.5	73.9
Too young	--	0.0	0.0	0.0	0.8	0.7
Schooling reasons	--	2.4	2.2	2.0	1.7	1.7
Religious reasons	--	0.0	0.0	0.0	2.5	2.1
Because of parents	n/a	n/a	n/a	n/a	n/a	n/a
Not interested	n/a	n/a	n/a	n/a	n/a	n/a
No reason	n/a	n/a	n/a	n/a	n/a	n/a
Sex is bad/feel ashamed	n/a	n/a	n/a	n/a	n/a	n/a
Fear arrest/jail	n/a	n/a	n/a	n/a	n/a	n/a
Other	--	14.3	13.2	3.9	5.0	4.8
Don't know	--	1.2	1.1	3.9	2.1	2.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because multiple responses are possible. Limited to those who ever had sex but not in the last 12 months. Sample sizes: females 12–14 (N=7); females 15–19 (N=84); males 12–14 (N=51); males 15–19 (N=240). Notes: Ns are weighted. "--" = N is 24 or fewer. n/a=not available/applicable.

TABLE 4.5 Percentage distribution of adolescents, by attitudes about sexual activity, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=943)	15–19 (N=1053)	Total (N=1996)	12–14 (N=907)	15–19 (N=1125)	Total (N=2032)
Young women should remain virgins until they marry						
Agree	78.8	83.9	81.5	71.1	78.1	75.0
Disagree	19.6	15.9	17.6	24.0	21.7	22.7
Don't know	1.6	0.3	0.9	4.9	0.2	2.3
Young men should remain virgins until they marry						
Agree	78.7	85.0	82.0	72.2	77.2	75.0
Disagree	19.9	15.0	17.3	24.1	22.7	23.3
Don't know	1.4	0.0	0.7	3.6	0.1	1.7
Usually people do not plan to have sex, it just happens						
Agree	40.8	50.8	46.1	36.8	47.4	42.7
Disagree	47.4	46.2	46.8	52.1	50.7	51.3
Don't know	11.8	2.9	7.1	11.0	2.0	6.0
Among adolescents who ever had sex:						
Young women should remain virgins until they marry*						
Agree	[75.9]	81.1	80.7	68.6	74.9	73.6
Disagree	[24.1]	18.9	19.3	30.9	25.1	26.3
Don't know	0.0	0.0	0.0	0.6	0.0	0.1
Young men should remain virgins until they marry*						
Agree	[79.3]	82.3	82.1	68.6	73.2	72.3
Disagree	[20.7]	17.7	17.9	31.4	26.8	27.7
Don't know	[0.0]	0.0	0.0	0.0	0.0	0.0
Usually people do not plan to have sex, it just happens*						
Agree	[57.1]	63.2	62.7	51.1	56.8	55.7
Disagree	[42.9]	36.1	36.5	46.0	42.3	43.0
Don't know	[0.0]	0.8	0.7	2.9	0.9	1.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who ever had sex. Sample sizes: females 12–14 (N=29); females 15–19 (N=380); males 12–14 (N=175); males 15–19 (N=665). Notes: Ns are weighted. [] = N is 25–49.

TABLE 4.6 Percentage distribution of adolescents who ever had sexual intercourse, by relationship with first sex partner and main reason for having sex, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=27)	15–19 (N=379)	Total (N=406)	12–14 (N=175)	15–19 (N=677)	Total (N=852)
Relationship with first sex partner at time of first sex						
Spouse	[0.0]	18.5	17.2	0.0	0.6	0.5
Live-in partner	[7.4]	10.0	9.9	0.0	1.9	1.5
Boyfriend/girlfriend	[88.9]	69.9	71.2	77.1	78.3	78.1
Casual acquaintance	[0.0]	0.8	0.7	17.7	17.2	17.3
Commercial sex worker	[0.0]	0.0	0.0	0.0	0.1	0.1
Other	[3.7]	0.8	1.0	5.1	1.8	2.5
Main reason for sex with first partner						
Married	[7.4]	16.6	16.0	0.0	0.1	0.1
Felt like it	[55.6]	55.4	55.4	82.1	85.3	84.6
Partner insisted	[7.4]	12.9	12.6	7.5	5.5	6.0
Influence from friends	[0.0]	2.1	2.0	6.9	4.8	5.2
Expectation of gifts/money	[11.1]	5.3	5.7	0.0	0.0	0.0
Wanted to get pregnant	[0.0]	0.0	0.0	0.0	0.3	0.2
Was forced	[3.7]	3.7	3.7	0.0	1.2	1.0
Other	[7.4]	1.8	2.2	1.2	1.6	1.5
Don't know	[7.4]	2.1	2.5	2.3	1.0	1.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

Notes: Ns are weighted. [] = N is 25–49.

TABLE 4.7 Percentage distribution of adolescents who ever had sexual intercourse, by characteristics of first sex, according to sex, age and union status, 2004 National Survey of Adolescents

Characteristic	Female				Male		
	12–14 (N=27)	15–19 Not in union (N=270)	15–19 In union (N=109)	Total (N=405)	12–14 (N=170)	15–19 (N=664)	Total (N=834)
Age difference with first sex partner							
Partner is 10+ years older	[3.7]	1.9	4.6	2.7	1.8	0.6	0.8
Partner is 5–9 years older	[11.1]	9.3	19.3	12.1	0.0	0.5	0.4
Partner is 1–4 years older	[63.0]	50.0	56.0	52.3	14.7	11.9	12.5
Partner is older, don't know specific age	[0.0]	10.0	9.2	9.1	3.5	3.0	3.1
Partner is same age or younger	[22.2]	24.1	7.3	19.3	78.2	82.4	81.5
Don't know	[0.0]	4.8	3.7	4.4	1.8	1.7	1.7
Respondent's willingness to have first sex							
Very willing	[42.9]	33.7	60.2	40.8	62.3	73.5	71.2
Somewhat willing	[25.0]	22.5	14.8	20.9	29.1	19.4	21.5
Not willing at all	[32.1]	43.8	25.0	38.3	8.6	7.1	7.4
Contraceptive methods used at first sex							
Condom only	[10.7]	28.2	4.6	20.8	9.1	16.8	15.2
Condom and other method	[0.0]	5.5	0.9	4.0	0.6	2.3	1.9
Other method only	[7.1]	2.9	1.9	3.0	1.1	2.0	1.8
No method	[82.1]	63.4	92.6	72.3	89.1	79.0	81.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Notes: Ns are weighted. [] = N is 25–49.

TABLE 4.8 Percentage distribution of adolescents who had ever had sexual intercourse, by the number of lifetime and recent sex partners, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=28)	15–19 (N=383)	Total (N=411)	12–14 (N=173)	15–19 (N=669)	Total (N=842)
Number of lifetime sex partners						
1	[67.9]	66.6	66.7	63.6	42.6	46.9
2	[21.4]	24.8	24.6	12.7	23.2	21.0
3	[10.7]	6.0	6.3	10.4	13.8	13.1
4+	[0.0]	2.6	2.4	13.3	20.5	19.0
Number of sex partners in last 12 months						
0	[24.1]	22.4	22.5	30.5	36.6	35.4
1	[62.1]	72.0	71.3	65.5	52.3	55.0
2	[13.8]	5.0	5.6	2.9	10.7	9.0
3	[0.0]	0.3	0.2	1.1	0.3	0.5
4+	[0.0]	0.0	0.0	0.0	0.2	0.1
Don't know	[0.0]	0.3	0.2	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Notes: Ns are weighted. [] = N is 25–49.

TABLE 4.9 Percentage distribution of adolescents who had had sexual intercourse in the 12 months prior to the survey, by characteristics of last sex partner, according to sex, age and union status, 2004 National Survey of Adolescents

Characteristic	Females				Males		
	12-14 (N=21)	15-19 Not in union (N=153)	15-19 In union (N=143)	Total (N=318)	12-14 (N=121)	15-19 (N=423)	Total (N=544)
Relationship to last sex partner in last 12 months							
Spouse	--	0.0	67.8	30.5	0.0	0.7	0.6
Live-in partner	--	0.0	32.2	15.1	0.0	4.5	3.5
Boyfriend/girlfriend	--	96.8	0.0	52.5	79.5	82.4	81.7
Casual acquaintance	--	0.0	0.0	0.0	18.9	11.0	12.7
Commercial sex worker	--	0.0	0.0	0.0	0.0	0.5	0.4
Other	--	3.2	0.0	1.9	1.6	1.0	1.1
Age difference with last sex partner in last 12 months							
Partner is 10+ years older	--	2.6	3.5	2.8	3.3	0.0	0.7
Partner is 5-9 years older	--	5.9	21.0	13.5	0.0	0.0	0.0
Partner is 1-4 years older	--	55.6	49.7	52.5	10.7	5.2	6.4
Partner is older, don't know specific age	--	10.5	9.1	9.4	3.3	2.6	2.8
Partner is same age or younger	--	22.9	12.6	18.6	81.8	88.9	87.3
Don't know	--	2.6	4.2	3.1	0.8	3.3	2.8
Duration of relationship (months)							
Had sex one time only	--	22.9	2.1	13.8	46.7	28.6	32.7
3 months or less	--	15.0	11.2	14.4	36.9	41.1	40.1
4-11 months	--	24.2	26.6	26.0	7.4	17.4	15.2
1 year	--	19.6	21.7	19.4	2.5	7.9	6.7
2 years	--	8.5	9.8	8.5	3.3	1.7	2.0
More than 2 years	--	9.8	28.7	17.9	3.3	3.3	3.3
Gifts or money received for sex from last sex partner in last 12 months*							
Received gifts or money	--	77.8	N/A	78.6	8.2	8.3	8.3
No gifts or money	--	22.2	N/A	21.4	91.8	91.7	91.7
Alcohol use at last sex in last 12 months†							
Respondent drank alcohol at last sex	--	0.0	0.0	0.0	0.0	0.0	0.0
Partner drank alcohol at last sex	--	4.9	4.3	4.3	0.0	1.5	1.2
Both respondent and partner drank alcohol at last sex	--	0.0	0.7	0.4	0.0	0.0	0.0
No alcohol at last sex	--	95.1	95.0	95.3	100.0	98.5	98.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

*Question not asked if most recent partner was the first sex partner ever and had sex only one time or if partner was a spouse or cohabiting partner. Sample sizes: females 12-14 (N=14); females 15-19 not in union (N=117); males 12-14 (N=73); males 15-19 (N=314). †Question not asked if most recent partner was the first sex partner ever and had sex only once. Sample sizes: females 12-14 (N=16); females 15-19 not in union (N=123); females 15-19 in union (N=139); males 12-14 (N=76); males 15-19 (N=340). Notes: Ns are weighted. "--" = N is 24 or fewer.

TABLE 4.10 Percentage distribution of adolescents aged 12–19 who had sexual intercourse with partners who were not spouses or cohabiting partners in the 12 months prior to the survey, by experiences of transactional sex, according to sex, 2004 National Survey of Adolescents

Characteristic	Females	Males
	12–19 (N=137)	12–19 (N=393)
Money or other items received in exchange for sex with any partner in last 12 months*		
No gifts or money	19.7	90.8
Received gifts or money	80.3	9.2
Money or other items received in exchange for sex†		
Money	95.5	[38.9]
Food	8.2	[40.0]
School fees	0.0	[0.0]
Drugs (including glue)	0.0	[0.0]
Alcohol	0.0	[0.0]
Shelter/rent	0.9	[0.0]
Clothes	51.8	[27.8]
Transport	0.9	[0.0]
Jewelry/cosmetics	26.4	[16.7]
Entertainment (e.g., video games)	0.0	[0.0]
Other	1.8	[13.9]
Total	100.0	100.0

*Question not asked if most recent partner was the first sex partner ever and had sex only one time, or if partner was a spouse or cohabiting partner. †Totals may exceed 100 because multiple responses are possible. Question asked only of those who received something in exchange for sex and responses are for up to three recent partners in the 12 months prior to the survey. Sample sizes: females 12–19 (N=110); males 12–19 (N=36). Notes: Ns are weighted. [] = N is 25–49.

Table 4.11 Percentage of adolescents, by knowledge and experience of anal sex and using herbs or chemicals to dry the vagina during sexual intercourse, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14	15-19	Total	12-14	15-19	Total
Anal sex*	(N=561)	(N=654)	(N=1215)	(N=581)	(N=654)	(N=1235)
Heard of it	8.6	28.0	19.0	21.9	47.1	35.2
Know close friends who have done it†	[72.9]	33.9	42.0	51.6	28.2	35.1
Have done it†	[2.1]	7.1	6.1	10.2	4.2	6.0
Ever heard of herbs or chemicals used to dry the vagina during sexual intercourse‡	(N=943)	(N=1053)	(N=1996)	(N=903)	(N=1125)	(N=2028)
	8.1	19.8	14.2	7.9	23.4	16.5
(Ever/had sex with someone who) used herbs or chemicals to remain dry during sexual intercourse, among those who ever had sex§	(N=4)	(N=60)	(N=64)	(N=12)	(N=117)	(N=129)
	--	10.0	9.4	--	4.3	3.9

*Asked of only one adolescent per household and if no one over the age of three was present or listening.

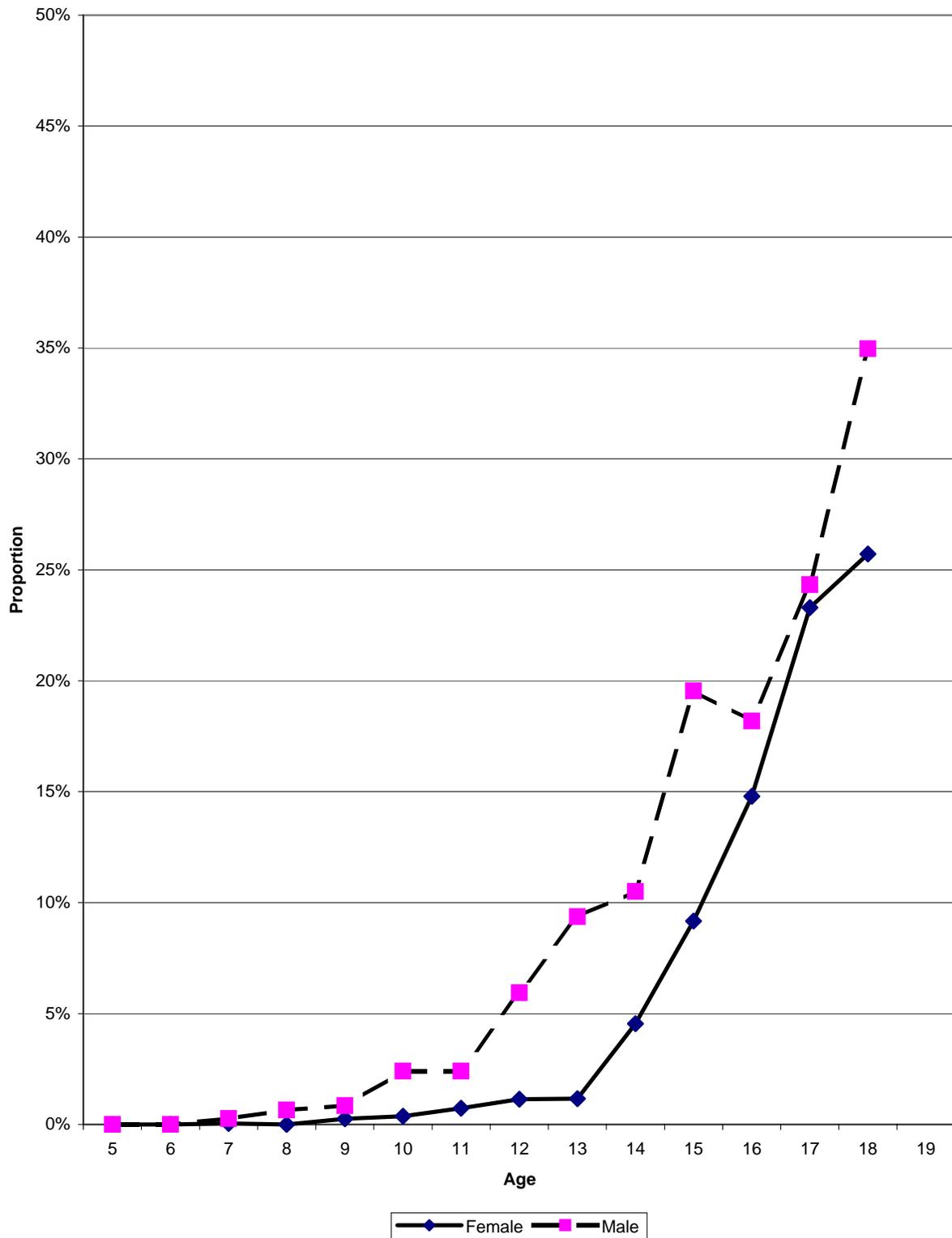
†Limited to those who have heard of anal sex. Sample sizes: females 12-14 (N=48); females 15-19 (N=183); males 12-14 (N=128); males 15-19 (N=308). ‡ Asked of all survey respondents. §Limited to those who have had sex. Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25-49.

TABLE 4.12 Percentage distribution of adolescents, by experiences of sexual abuse and coercion, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=562)	15–19 (N=654)	Total (N=1216)	12–14 (N=580)	15–19 (N=654)	Total (N=1234)
Ever been touched, kissed, grabbed or fondled in an unwanted sexual way*						
Yes	12.1	22.5	17.7	15.5	19.3	17.5
No	87.9	77.2	82.2	83.6	80.7	82.1
Refused to answer	0.0	0.0	0.0	0.2	0.0	0.1
Don't know	0.0	0.0	0.0	0.2	0.0	0.1
Missing	0.0	0.3	0.2	0.5	0.0	0.2
Ever been physically forced, hurt or threatened into having sexual intercourse*						
Yes	4.1	9.8	7.2	2.4	4.0	3.2
No	95.9	90.2	92.8	97.6	96.0	96.8
Refused to answer	0.0	0.0	0.0	0.0	0.0	0.0
Don't know	0.0	0.0	0.0	0.0	0.0	0.0
Relationship to respondent of person(s) who forced the respondent into having sex†						
Spouse or live-in partner	--	0.0	0.0	--	[0.0]	[0.0]
Boyfriend/girlfriend	--	0.0	0.0	--	[26.9]	[17.5]
Friend	--	22.2	20.9	--	[15.4]	[25.6]
Parent	--	0.0	0.0	--	[0.0]	[0.0]
Sibling	--	0.0	0.0	--	[3.8]	[2.5]
Uncle/aunt	--	1.6	2.3	--	[0.0]	[0.0]
Other family	--	9.7	7.1	--	[7.7]	[5.0]
Schoolmate	--	14.5	15.3	--	[7.7]	[15.4]
Acquaintance	--	3.2	4.7	--	[19.2]	[12.5]
Teacher	--	0.0	0.0	--	[0.0]	[0.0]
Stranger	--	49.2	47.1	--	[15.4]	[17.9]
Neighbor	--	0.0	0.0	--	[0.0]	[0.0]
Other	--	6.3	8.0	--	[3.8]	[2.6]
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Questions asked of only one eligible adolescent per household and only if no one over the age of three was present or within hearing range. †Multiple responses possible and sample limited to those who said they had ever been forced into having sexual intercourse. Sample sizes: females 12–14 (N=23); females 15–19 (N=63); males 12–14 (N=14); males 15–19 (N=26). Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25–49.

Chart 4.1 Proportion of adolescents who have had their first sexual experience (life table estimates), by age and gender, 2004 National Survey of Adolescents



Chapter 5

Contraception

This chapter describes young people's knowledge and use of contraceptive methods and characteristics of contraceptive use at last sex. Knowledge of these methods is relevant for all young people—those who are already sexually active, as well as those who are not. Such knowledge is essential preparation for those who are not yet sexually active to be able to protect themselves when they do begin to have sex. Use of contraceptives is measured among those who have initiated sexual activity as the relevant group who have used a method. In addition, current contraceptive use and recent use is discussed with regard to those adolescents who are currently sexually active and those who were sexually active in the past year. Results on sources of contraceptive information and services are presented in Chapter 9.

Contraceptive Method Knowledge

Table 5.1 shows the proportion of adolescents who knew any method (prompted and unprompted), the proportion who knew each contraceptive method (including the male and female condom), as well as the average number of methods known.

Knowledge of any contraceptive method is very high among adolescents with 82% of females and 90% of males knowing at least one method. Relatively more male adolescents than females reported knowledge of any modern method and a higher proportion of 15–19-year-olds had heard of modern and traditional methods compared with the 12–14-year-olds. More than 90% of 15–19-year-old female and male adolescents knew a modern method and more than half had heard of a traditional method. The most frequently named methods were male condoms, followed by female sterilization, injectables, pills and male sterilization, in that order. Fewer than 15% of the 12–14-year-olds had heard of the IUD/coil, implants, female condoms and emergency contraception. Foams and jellies were the least known methods among respondents of both sexes. On average, 12–14-year-olds of both sexes had heard of

three modern methods, while the 15–19-year-olds had heard of approximately five modern methods. Among traditional methods, the rhythm method was the most widely known followed by withdrawal and use of a string. While fewer than 20% of both female and male 12–14-year-olds had heard of withdrawal and the rhythm method, at least 40% had heard about these methods among 15–19-year-olds.

Knowledge of the Fertile Period and the Withdrawal Method

Table 5.2 shows adolescents' knowledge of the fertile period for those who had ever used the rhythm method and those who had not used the method in order to determine whether those who had used the method had correct knowledge of the fertile period (i.e., that a woman is most likely to conceive halfway between two menstrual periods).

Generally much higher proportions of females than males (regardless of age and ever-use of the rhythm method) knew that there are certain days when a woman is more likely to get pregnant. Three quarters of females and 56% of males who had never used the method had heard of the fertile period. Seventy-two percent of the males and 93% of the females who had ever used the rhythm method had heard of the fertile period. The fact that about 7% of females and 28% of males who reported to have ever used the rhythm method indicated that they do not know or do not think there are certain days when a woman is more likely to get pregnant suggests that some of the respondents misunderstood the question or gave incorrect information on either of the two questions. This pattern is in line with the finding that, in comparison to women, men in Malawi tend to overreport positive responses on issues they think make one appear more modern or progressive.³⁷

The proportion of both male and female adolescents who ever used the rhythm method and also had the correct knowledge of the fertile period was very low.

Overall, only one in five male and female adolescents who ever used the method and said they knew there were certain days when a woman could get pregnant could *correctly identify* the time when a woman is more likely to get pregnant. Correct knowledge of the fertile period was higher among females who had used the rhythm method (28%) than among those who had not (20%). A similar pattern prevails for males.

Table 5.3 shows adolescents' knowledge of the withdrawal method by whether they report ever using that method. Withdrawal, even when practiced correctly, carries with it the risk of pregnancy because sperm can be present in preejaculate. Among both those who had never used and those who had used the withdrawal method before, a large proportion of both females and males were unaware that there is some risk of pregnancy if withdrawal is used. Among both males and females who had used withdrawal, roughly 69% thought that a girl cannot get pregnant if a boy withdraws before ejaculating. Among those who have never used the method, the proportion of those with incorrect knowledge was as high as 81% among the males and 62% among females. In sum, there was greater confidence in the method than the method actually affords its practitioners.

Attitudes About the Impact of Availability of Contraceptives on Sexual Behavior

The survey also included an attitudinal question about contraceptive methods. Adolescents who had heard of any contraceptive methods were asked whether they thought that having family planning methods available to young people encouraged young people to have sexual intercourse. Some arguments against making contraceptive method information available to young adolescents are based on the assumption that making comprehensive sex education available encourages adolescents to have sex. In 2004, around 70% of 12–14-year-olds reported that having family planning methods available to young people does not encourage them to have sexual intercourse (Table 5.4). Interestingly, slightly more 15–19-year-olds (at least one-third) than 12–14-year-olds (23% of females and 29% of males) thought that making contraceptives available to young people encourages them to have sexual intercourse.

Ever-Use of Contraceptives

Table 5.5 shows the percentage of adolescents who have ever used a contraceptive method, either for pregnancy prevention or to prevent STIs, including HIV,

among those who were sexually experienced. Information on method use (ever-use and current use) is based on responses from questions about current use of contraceptive methods to prevent pregnancy and separate questions about method use with up to three sex partners in the 12 months prior to the survey.

More than half of sexually experienced female adolescents in this survey had used a contraceptive method at some time. Fifty percent had ever used a modern method and 28% had used a traditional method. Ever use of any method among females was more common among 15–19-year-olds (58%) than the 12–14-year-olds (28%). Among sexually experienced male adolescents, about 43% had ever used a contraceptive method. Forty percent had used a modern method, and 15% had used a traditional method. The percentage of males aged 15–19 who had ever used any method (49%) was more than two times that of the 12–14-year-olds (19%).

Of the modern methods ever used, the male condom was the most common method for both males and females. The next most common methods among females were injectables and the pill. Ever-use of other modern methods among the males was negligible. The rhythm method was the most common traditional method ever used among females (19%) followed by withdrawal (10%). Among the males, fewer than 10% had ever used either method. For both sexes, use of the other traditional methods was negligible.

Current Use of Contraceptives

Table 5.6 shows current contraceptive use for adolescents who were currently sexually active at the time of the survey (i.e., they had had sexual intercourse in the three months prior to the survey interview).

A higher proportion of sexually active unmarried females aged 15–19 (39%) were practicing contraception, compared with those in union (21%). Most of the use among both males and females is composed of male condoms with injections composing a significant proportion of use among females in a union. It is possible that males were unaware that their partner was using a method, as indicated by the fact that slightly more than 2% of females reported pill use, while no males reported that their partner used the pill. Therefore, the method use as reported by males may be an underestimate. The level of use of any method among the 15–19-year-old males is twice that for the 12–14-year-olds. Fewer than 5% of both females and males were currently using traditional methods.

Characteristics of Those Using Contraception At Last Intercourse

Table 5.7 shows differences in contraceptive use at last sex among adolescents who had sex in the 12 months prior to the survey, according to a range of relationship characteristics. One of the questions this table addresses is: In what kinds of sexual relationships are adolescents practicing contraception?

Among females, those whose last sexual partner was a boyfriend more often used contraception at last sex (39%) than those whose last sex partner was their spouse (21%). About one in three males used a contraceptive method at last sex with girlfriends (38%) or casual acquaintances (29%). Females are most likely to have used a method if they had sex only one time, as opposed to multiple times. Yet this pattern did not hold for males. Males aged 15–19 were most likely to practice contraception in relationships of 4–6 months' (55%) or one year's duration (53%). Individuals who talked with their partner about contraception were more than twice as likely to have used a method at last intercourse as those who never talked with the partner about contraception.

Table 5.8 indicates that, while two-thirds of the males said they were the ones who suggested use of the male condom, only one in four females said they themselves made this suggestion. Only 16% of the females said it was their partner's suggestion. For the females, use of male condoms was mainly by joint decision with a partner (37%). Over 30% of young women used the male condom to either prevent pregnancy only or to prevent STIs, including HIV, only. Among the males, 43% used condoms to prevent STIs/HIV only, while 13% used them for pregnancy prevention only. Use of male condoms for dual protection was cited more commonly among the males (44%) than females (26%).

Policy and Programmatic Implications

- Although levels of knowledge of at least one contraceptive method are quite high, some methods are not as universally known and more effort should be directed towards teaching adolescents the different types of modern methods and how they are used. Additionally, it is important that contraceptive methods are made readily available and that obstacles to accessibility are addressed so that adolescents have more options when selecting a contraceptive method.
- Given that many adolescents are not in unions and often have sporadic sex, there is need to equip them with information and services on coital-based methods (like condoms and the rhythm method). Institutions

such as schools, youth groups, clubs and the media should take every opportunity to enhance correct knowledge of the fertile period and effective use of the rhythm method, especially in areas where modern contraceptives are not very accessible to adolescents.

- The finding that a third of adolescents think that providing family planning services to youth would promote promiscuity or sexual activity highlights the need to strengthen educational campaigns and provide more evidence of the positive impact of providing such services to young people.
- Adolescents know the implications of unprotected sex (STIs and pregnancy), but few use protection at first sex or currently. The finding that despite high levels of knowledge of methods of family planning, more than two-thirds of adolescents who are sexually active are not practicing contraception highlights the need to intensify efforts to address low levels contraceptive use. Efforts should be directed toward increasing access to family planning methods among sexually active adolescents and providing of information to those not yet sexually active.
- Given their role in protecting against both pregnancy and STIs, including HIV, condoms are a very important tool for sexually active adolescents. There is need to increase availability and accessibility of condoms to young people and to educate adolescents on how to use them.

TABLE 5.1 Percentage distribution of adolescents, by knowledge of contraceptive methods, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=943)	15-19 (N=1055)	Total (N=1998)	12-14 (N=908)	15-19 (N=1126)	Total (N=2034)
Knowledge of any method						
No	27.3	9.2	17.7	18.9	2.9	10.1
Yes	72.7	90.8	82.3	81.1	97.1	89.9
Knowledge of any modern method*	72.5	90.8	82.2	81.0	97.1	89.9
Female sterilization	49.0	76.2	63.4	51.5	80.1	67.4
Male sterilization	23.9	50.7	38.0	37.8	67.1	54.0
Pill	40.2	69.2	55.5	38.5	71.9	57.0
IUD/coil	13.3	38.3	26.5	13.9	39.2	27.9
Injectables	46.8	78.7	63.6	39.2	71.6	57.1
Implants	11.5	37.3	25.1	7.4	25.0	17.1
Male condom	60.6	82.8	72.3	76.8	94.1	86.4
Female condom	13.6	32.1	23.3	13.5	42.5	29.5
Foam/jelly	4.1	9.6	7.0	4.7	12.5	9.1
Emergency contraceptive	9.7	27.2	18.9	8.1	28.1	19.2
Mean number of modern methods known	2.7	5.0	3.9	2.9	5.3	4.2
Knowledge of any traditional method*	17.7	53.7	36.7	22.6	61.1	43.9
Rhythm	12.0	39.0	26.2	16.9	47.8	34.0
Withdrawal	7.3	29.7	19.1	11.2	39.2	26.7
Abstinence	n/a	n/a	n/a	n/a	n/a	n/a
Herbs	n/a	n/a	n/a	n/a	n/a	n/a
String	1.7	8.0	5.0	0.1	1.2	0.7
Other	3.5	14.9	9.5	0.2	6.4	3.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted. n/a=not available/applicable.

TABLE 5.2 Percentage distribution of sexually experienced 12–19-year-olds, by knowledge of fertile period, according to ever-use of rhythm method and sex, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	Never used rhythm (N=333)	Ever used rhythm (N=76)	Total (N=409)	Never used (N=777)	Ever used rhythm (N=64)	Total (N=841)
Knows there are certain days when a woman is more likely to get pregnant						
Yes	77.2	93.4	80.2	56.0	71.9	57.2
No	13.5	1.3	11.2	22.7	21.9	22.6
Don't know	9.3	5.3	8.6	21.4	6.3	20.2
Time when woman more likely to get pregnant*						
Just before period begins	28.0	34.7	29.5	33.0	[32.6]	32.9
During period	10.5	5.6	9.4	18.1	[4.3]	16.8
Right after period has ended	40.1	29.2	37.7	28.6	[37.0]	29.4
Halfway between periods	19.5	27.8	21.3	18.8	[23.9]	19.3
Other	0.0	0.0	0.0	0.2	[0.0]	0.2
Don't know	1.9	2.8	2.1	1.4	[2.2]	1.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who say there are certain days when a woman is more likely to get pregnant. Sample sizes: female, never used (N=257); female, ever used (N=72); male, never used (N=437); male, ever used (N=46). Notes: Ns are weighted. [] = N is 25–49.

TABLE 5.3 Percentage distribution of sexually experienced 12–19-year-olds, by knowledge of pregnancy prevention, according to ever-use of withdrawal method and sex, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	Never used withdrawal (N=366)	Ever used withdrawal (N=42)	Total (N=408)	Never used withdrawal (N=783)	Ever used withdrawal (N=59)	Total (N=842)
A girl can get pregnant if a boy withdraws before ejaculating						
Yes	27.3	[31.0]	27.7	11.6	20.3	12.2
No	62.0	[69.0]	62.7	81.1	69.5	80.3
Don't know	10.7	[0.0]	9.6	7.3	10.2	7.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

Notes: Ns are weighted. [] = N is 25–49.

TABLE 5.4 Adolescents who know of any method, by attitude about availability of methods, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=684)	15-19 (N=958)	Total (N=1642)	12-14 (N=733)	15-19 (N=1089)	Total (N=1822)
Do you think that having family planning methods available to young people encourages young people to have sexual intercourse?						
Yes	22.5	34.1	29.3	28.5	36.4	33.2
No	72.8	62.4	66.7	67.8	62.1	64.4
Unsure	4.7	3.4	4.0	3.7	1.6	2.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Notes: Ns are weighted.

TABLE 5.5 Percentage of adolescents who ever had sexual intercourse, by ever-use of contraceptive methods for any reason, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=29)	15-19 (N=379)	Total (N=408)	12-14 (N=175)	15-19 (N=666)	Total (N=841)
Ever use of any method						
Yes	[27.6]	58.0	55.9	19.4	48.8	42.7
No	[72.4]	42.0	44.1	80.6	51.2	57.3
Any modern methods*	[17.2]	52.1	49.6	19.4	44.7	39.5
Female sterilization	[0.0]	0.0	0.0	0.0	0.0	0.0
Male sterilization	[0.0]	0.0	0.0	0.0	0.0	0.0
Pill	[3.4]	5.0	4.9	0.0	1.8	1.4
IUD/coil	[0.0]	0.8	0.7	0.0	0.0	0.0
Injectables	[3.4]	13.7	13.0	0.0	1.0	0.8
Implants	[0.0]	0.8	0.7	0.0	0.0	0.0
Male condom	[13.8]	42.5	40.4	19.4	44.6	39.4
Female condom	[0.0]	1.6	1.5	0.0	1.7	1.3
Foam	[0.0]	0.8	0.7	0.0	0.8	0.6
Emergency contraception	[0.0]	1.6	1.5	0.0	0.8	0.6
Any traditional methods*	[10.7]	29.5	28.2	3.4	17.6	14.6
Rhythm	[10.3]	19.2	18.6	1.7	9.1	7.6
Withdrawal	[0.0]	11.1	10.3	2.3	8.3	7.0
Abstinence	[0.0]	0.0	0.0	0.0	0.0	0.0
Herbs	[0.0]	0.8	0.7	0.0	0.5	0.4
String	[0.0]	0.8	0.7	0.0	0.3	0.2
Other	[0.0]	6.9	6.4	0.6	5.0	4.0

*Multiple responses are possible. Notes: Ns are weighted. [] = N is 25-49.

TABLE 5.6 Percentage of adolescents who had sex in the three months prior to the survey, by current use of contraceptive methods for any reason, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female				Male		
	12–14	15–19		Total	12–14	15–19	Total
	(N=18)	Not in union (N=89)	In union (N=106)	(N=212)	(N=83)	(N=288)	(N=371)
Current use of any method							
Yes	--	38.6	20.8	29.2	19.3	38.5	34.2
No	--	61.4	79.2	70.8	80.7	61.5	65.8
Current use of modern method*	--	38.6	17.9	26.5	19.3	36.1	32.3
Not using any method	--	60.7	79.2	71.1	80.7	61.5	65.8
Female sterilization	--	0.0	0.0	0.0	0.0	0.0	0.0
Male sterilization	--	0.0	0.0	0.0	0.0	0.0	0.0
Pill	--	2.2	0.0	0.9	0.0	0.0	0.0
IUD	--	0.0	0.0	0.0	0.0	0.0	0.0
Injectables	--	2.2	8.5	4.7	0.0	0.3	0.3
Implants	--	0.0	1.9	0.9	0.0	0.0	0.0
Male condom	--	34.8	7.5	19.9	19.3	35.8	32.1
Female condom	--	0.0	0.0	0.0	0.0	0.0	0.0
Emergency contraceptive	--	0.0	0.0	0.0	0.0	0.0	0.0
Current use of traditional method*	--	5.6	3.8	4.8	1.2	5.2	4.3
Rhythm or periodic abstinence	--	0.0	0.0	0.9	0.0	1.4	1.1
Withdrawal	--	0.0	0.0	0.0	0.0	0.0	0.0
Other	--	0.0	2.8	1.4	0.0	1.0	0.8

*Multiple responses are possible. Notes: Ns are weighted. "--" = N is 24 or fewer.

TABLE 5.7 Percentage of adolescents who had sexual intercourse in the 12 months prior to the survey and used any contraceptive method at last sex, by relationship characteristic, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=22)	15–19 (N=297)	Total (N=319)	12–14 (N=122)	15–19 (N=420)	Total (N=542)
Relationship to last sex partner						
Spouse	--	20.8	20.8	--	--	--
Live-in partner	--	[12.8]	[12.2]	--	--	--
Boyfriend/girlfriend	--	40.3	38.9	24.7	41.3	37.7
Casual acquaintance	--	--	--	--	[43.5]	29.4
Commercial sex worker	--	--	--	--	--	--
Other	--	--	--	--	--	--
Duration of sexual relationship (in months)						
Had sex one time only	--	[52.6]	[50.0]	17.5	40.8	33.3
3 months or less	--	[25.6]	[24.4]	[17.8]	38.7	34.1
4–6 months	--	[26.2]	[27.7]	--	[55.3]	54.9
7–11 months	--	[24.2]	[22.2]	--	[38.5]	[31.3]
1 year	--	29.5	29.5	--	[51.5]	[52.8]
2 years	--	[25.9]	[25.9]	--	--	--
More than 2 years	--	22.8	22.8	--	--	--
Ever talked with partner about contraceptive methods						
Had sex one time only (not asked question)	--	[51.4]	[48.8]	15.7	33.3	26.1
Yes	--	36.1	36.0	--	67.1	67.7
No	--	15.9	16.2	13.1	24.7	22.2
Don't know	--	--	--	--	--	--

Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25–49.

TABLE 5.8 Percentage distribution of adolescents who had sexual intercourse in the 12 months prior to the survey and used a male condom, by characteristics of condom use at last sex, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=4)	15–19 (N=69)	Total (N=73)	12–14 (N=22)	15–19 (N=163)	Total (N=185)
Who suggested use of male condom						
Had sex one time only	--	24.6	23.3	--	15.4	17.9
Participant	--	21.7	23.3	--	66.0	62.5
Partner	--	15.9	16.4	--	5.6	6.0
Joint decision	--	37.7	37.0	--	13.0	13.6
Don't know	--	0.0	0.0	--	0.0	0.0
Refused to respond	--	0.0	0.0	--	0.0	0.0
Reason for using male condom						
Prevent pregnancy	--	37.1	35.6	--	14.4	12.7
Prevent HIV and other STIs	--	31.4	31.5	--	40.0	42.5
Prevent both pregnancy and STIs	--	24.3	26.0	--	45.0	43.6
Other	--	2.9	2.7	--	0.0	0.0
Don't know	--	4.3	4.1	--	0.6	1.1
Total	--	100.0	100.0	--	100.0	100.0

Notes: Ns are weighted. "--" = N is 24 or fewer.

Chapter 6

Pregnancy and Childbearing

Pregnancy and childbearing during early adolescence may be biologically dangerous to the mother and to the child if the mother is physiologically immature. Physiological immaturity due to poor nutrition can mean that even an older adolescent may not be able to safely carry a pregnancy to term. These risks are, of course, present regardless of marital status. Other risks to the young woman, such as resorting to unsafe abortion, also occur when a pregnancy is unwanted, which is often the case among unmarried adolescents. In this chapter we present key findings on a number of issues related to adolescent pregnancy and childbearing, including levels of knowledge and misperceptions about how pregnancy occurs, levels of early childbearing, preferences regarding timing of recent and future births, knowledge about abortion and personal experience of abortion. Understanding adolescents' motivation to prevent unintended pregnancy is important in order to better understand adolescents' motivation to prevent STIs.

Perceptions of How Pregnancy Happens

Perceptions of the way pregnancy occurs can influence whether adolescents feel they need to use contraceptive methods. Table 6.1 presents information on some common misperceptions about how pregnancy occurs.

Forty percent of females and 45% of males held the misperception that a girl cannot get pregnant the very first time she has sexual intercourse (prompted response). This misperception was more common among the 12–14-year-old adolescents, especially males (52%), than among older adolescents. In all, slightly more females than males held this belief. This misconception could be part of the explanation for the low contraceptive use at first sex shown in Table 4.7.

On the other hand, slightly more females (46%) than males (42%) held the misperception that a girl cannot get pregnant if she has sex standing up (prompted response). More 15–19-year-old females (45%) held this misperception compared with 38% of their male coun-

terparts. The adolescents were also asked whether they thought a girl can get pregnant if she washes herself thoroughly immediately after sex. More females than males and more younger than older adolescents thought that a girl who washes soon after sex cannot get pregnant (prompted response). Approximately half of females and 70% of males thought that a girl could not get pregnant if a boy withdrew before ejaculation.

These results show that misconceptions about how pregnancy occurs are widespread among the female and male adolescents in Malawi. Misconceptions were especially prevalent among younger adolescents.

Pregnancy and Childbearing Experiences

This section examines adolescents' childbearing experiences and, given the very low levels of pregnancy and childbearing among 12–14-year-olds, focuses on adolescents aged 15–19. The level of adolescent childbearing, the extent to which childbearing occurs before marriage and the level of very early childbearing (before age 15) are examined for adolescent women. The proportion of adolescent men who report having ever made someone pregnant or fathered a child is extremely low. A summary of this information is displayed in Table 6.2.

From Table 6.2 it is evident that, as would be expected, there were significant differences between the 15–19 female adolescents in union and those not in union. While one in 10 females not in union had ever been pregnant, almost all females in union (86%) had been. Eight percent of females not in union had ever given birth, compared with 64% of females in union. Fewer than 2% of the males of the same age-group had ever made a girl pregnant or fathered a child.

Among those females who ever given birth, 57% who were not in union had a premarital birth, while 4% of those in union had had a premarital birth.* The proportion of women who had ever given birth by the age

*This was determined by comparing dates of these events.

15 was higher among females in union (14%) compared with those who were not in union (2%).

Table 6.2 also shows that nearly one in four females in union were pregnant at the time of the survey. Slightly more than half of these young women wanted the current pregnancy, while 27% never wanted the current pregnancy. (Note: all these figures should be read with caution as sample sizes are small). Among those in union who ever had a birth, slightly more than half wanted their last birth then, 22% wanted it later and 24% never wanted the birth at all. The relatively high proportion of adolescent women who were in union but either did not want their last birth the time it took place, or never wanted the last birth at all (altogether almost 50%) suggests that although young married women are expected to start childbearing soon after marriage, and although there is significant social prestige attached to bearing children (especially among married women), many young married women would have preferred to delay having a birth (in some cases their first and in some cases a second or later birth). These young women may have faced various barriers (e.g., lack of availability of family planning methods) to using contraceptives to prevent the unintended pregnancy, as well as social and familial pressure to prove fecundity.

About half of the females who were not in union and had given birth before did not want the last birth, while more than a third wanted the last birth at a later time; only 17% wanted the last birth at the time it occurred. The problem of unmet need for contraceptives and the consequent unplanned or unwanted pregnancies is even more acute for female adolescents not in union where the majority of the females not in union (83%) did not want their last birth or wanted it later.

Desired Timing of Pregnancy or Birth

This section examines adolescents' desired timing of the first or next birth. Table 6.3 shows that there were notable differences by age, sex and marital status of the respondent. Most of the younger adolescents, females aged 15–19 not in a union and male adolescents aged 15–19 were prepared to wait for five years or more before having a (or another) child. The group that desired to wait the shortest amount of time was older female adolescents in a union: Almost 46% of females in union, compared with about 11% among their age-mates not in union, desired to have a (or another) child within one or two years. Overall, 17% of the female and 28% of the male adolescents indicated that they wanted to wait nine or more years before having a (or another) child. Fourteen percent of females and 13% of

males said they would wait until marriage. Only 3% said that they were leaving that decision up to God.

Abortion

Abortion is only permitted in Malawi to save the life of the mother, and spousal authorization is required. Accessible abortion methods are unsafe and thus can result in harmful health consequences including the risk of death. Table 6.4 presents the percentage of adolescents who knew of ways to terminate a pregnancy, those who knew friends who have ever had an abortion and those who have tried to abort a pregnancy. Overall, about half of both female and male adolescents did not know any ways to abort a pregnancy. More than two-thirds of the 12–14-year-olds did not know of any ways to terminate a pregnancy, while approximately two-thirds of 15–19-year-olds did know of at least one method.

The results show that only 20% of female and 13% of male 15–19-year-olds were aware of the relatively safe surgical abortion. Herbal drinks and tablets/pills were the most commonly cited ways of terminating a pregnancy. It should be noted that these more widely known methods are relatively unsafe and seem to be locally available and easily accessible to the adolescents. Young women using these unsafe methods place extra burden on the already scarce resources of the health care system and may be contributing to the maternal mortality rate of 0.3 among 15–19-year-olds.³⁸ Around one in 10 adolescents also mentioned drinking bitter medicines as a way of inducing abortion. This could be one of the explanations why some pregnant women in Malawi refuse to take chloroquine as a prophylactic against malaria during pregnancy since it is bitter and hence assumed to induce abortion.³⁹

Fewer than 1% of the adolescents 15–19 years of age reported to have ever tried to end a pregnancy or had any involvement in ending a pregnancy. While the prevalence of abortion as reported by adolescents is noted, the figures are likely to be grossly underreported, since abortion is a very sensitive and stigmatized experience. Because of the likely underreporting of personal experiences, the percentage of adolescents who say they have close friends who tried to end a pregnancy may be a proxy for how common abortion is among adolescents. The adolescents' responses to this question indicated that 29% of the female and 28% of the male adolescents had a close friend or friends who ever tried to end a pregnancy. More of the 15–19-year-old adolescents, 39% of females and about 35% of males, had had at least one close friend who ever

tried to end a pregnancy, compared with about 19% of females and 20% of males aged 12–14.

Policy and Programmatic Implications

- Ensuring that adolescents begin childbearing when they want to should be a cornerstone of adolescent sexual and reproductive health. The high levels of mistimed and unwanted pregnancies and births reported in this study underscore the need for policies and programs to address reasons that underlie the low level of contraceptive use among adolescents.
- Findings that adolescents in union start childbearing earlier (with a substantial proportion of the births or pregnancies being mistimed) and are less likely to use contraceptives than their counterparts who are not in union demonstrates the need to pay attention to this often ignored category of adolescents. Despite being married, these adolescents still face the adverse effects associated with early childbearing and early initiation of sex.
- The fact that most adolescents do not want to have children soon could provide a strong positive selling point to convince them and their parents/ guardians to accept information and services to prevent premature and unwanted pregnancies among young people.
- Addressing common misconceptions about how pregnancy occurs should be a major program priority in order to reduce the incidence of mistimed and unwanted pregnancy. More female adolescents than males hold misperceptions regarding how pregnancy happens. As with information on women's fertile period, accurate information on pregnancy can be disseminated through sex education campaigns in schools, youth clubs, groups and components of the media that are patronized by adolescents.
- The finding that the vast majority of those who are familiar with methods for terminating pregnancy know of the easily accessible and potentially dangerous methods (herbal medicines and chemicals), and that close to three in 10 respondents know of someone who has had an abortion warrants further investigation on the actual prevalence of abortion, commonly used methods and ways to address this problem.

TABLE 6.1 Percentage distribution of adolescents, by perceptions of how pregnancy occurs, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=942)	15–19 (N=1055)	Total (N=1997)	12–14 (N=907)	15–19 (N=1125)	Total (N=2032)
Can a girl get pregnant the very first time she has sexual intercourse?						
Yes	38.6	58.3	49.0	33.6	57.4	46.8
No	45.5	35.8	40.4	51.9	39.1	44.8
Don't know	15.8	5.9	10.6	14.4	3.5	8.4
Can a girl get pregnant if she has sex standing up?						
Yes	33.4	44.3	39.2	34.0	56.8	46.7
No	47.4	44.5	45.9	47.2	37.5	41.8
Don't know	19.2	11.2	15.0	18.8	5.7	11.5
Can a girl get pregnant if she washes herself thoroughly immediately after sex?						
Yes	36.3	51.8	44.5	40.8	61.3	52.2
No	42.3	38.3	40.2	39.0	33.5	36.0
Don't know	21.4	9.9	15.3	20.2	5.2	11.9
Can a girl get pregnant if a boy withdraws before ejaculating or coming?						
Yes	23.6	25.2	24.5	16.7	12.3	14.3
No	43.4	59.3	51.8	58.8	79.0	70.0
Don't know	33.0	15.5	23.7	24.4	8.7	15.7
Knows there are certain days when a woman is more likely to get pregnant						
Yes	30.8	62.6	47.5	22.1	57.2	41.5
No	29.9	19.0	24.1	32.3	22.7	27.0
Don't know	39.3	18.5	28.3	45.6	20.1	31.5
Time when woman more likely to get pregnant*						
Just before period begins	24.1	29.3	27.7	21.1	35.0	31.8
During period	14.5	11.5	12.4	23.1	16.9	18.4
Right after period has ended	33.4	36.1	35.3	20.1	27.4	25.7
Halfway between periods	20.3	21.4	21.1	27.1	18.8	20.7
Other	0.0	0.2	0.1	1.0	0.3	0.5
Don't know	7.6	1.5	3.4	7.5	1.6	3.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who say there are certain days when a woman is more likely to get pregnant. Sample sizes: females 12–14 (N=290); females 15–19 (N=659); males 12–14 (N=199); males 15–19 (N=645). Notes: Ns are weighted.

TABLE 6.2 Percentage distribution of older adolescents, by pregnancy and childbearing status, according to sex and union status, 2004 National Survey of Adolescents

Characteristic	Female 15-19			Male 15-19
	Not in union (N=913)	In union (N=141)	Total (N=1054)	Total (N=2033)
Ever been pregnant/made someone pregnant				
No	89.6	14.2	79.5	98.8
Yes	10.4	85.8	20.5	1.2
Ever had a birth/fathered a child				
No	91.8	35.7	84.3	99.2
Yes	8.2	64.3	15.7	0.8
Ever had a premarital birth*				
No	43.2	95.6	72.0	N/A
Yes	56.8	4.4	28.0	N/A
Ever had a birth by age 15				
No	98.1	86.5	96.6	N/A
Yes	1.9	13.5	3.4	N/A
Currently pregnant				
No	98.5	75.9	95.4	N/A
Yes	1.5	24.1	4.6	N/A
Wantedness of current pregnancy†				
Then	--	[52.9]	[38.3]	N/A
Later	--	[20.6]	[27.7]	N/A
Not at all	--	[26.6]	[34.0]	N/A
Don't know	--	[0.0]	[0.0]	N/A
Wantedness of last birth*				
Then	16.9	53.3	37.3	N/A
Later	33.8	22.2	27.3	N/A
Not at all	47.9	24.4	34.8	N/A
Don't know	1.4	0.0	0.6	N/A
Total	100.0	100.0	100.0	100.0

*Limited to those who ever had a birth. Sample sizes: female not in union (N=71); female in union (N=90). †Limited to those who are currently pregnant. Sample sizes: female not in union (N=13); female in union (N=34). Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25–49.

TABLE 6.3 Percentage distribution of adolescents, by desired timing of next birth, according to sex, age and union status, 2004 National Survey of Adolescents

Characteristic	Female				Male		
	12-14 (N=940)	15-19 Not in union (N=912)	15-19 In union (N=137)	Total (N=1992)	12-14 (N=907)	15-19 (N=1125)	Total (N=2032)
Desired time to wait before having a(another) child							
1-2 years	1.8	11.2	46.0	9.1	0.7	8.4	5.0
3-4 years	3.0	17.8	26.3	11.4	2.5	15.5	9.7
5-6 years	13.7	18.0	10.2	15.5	6.9	18.2	13.2
7-8 years	18.6	10.4	2.9	13.8	14.4	13.7	14.0
9 or more years	21.7	13.9	2.2	16.8	34.7	23.0	28.2
What God decides	3.9	2.6	1.5	3.2	4.5	1.9	3.1
Wait until marriage	13.7	16.9	0.7	14.2	14.2	11.2	12.5
Don't want a(another) child	0.4	1.3	2.2	1.0	0.1	0.0	0.0
Don't know	23.1	7.9	8.0	15.1	21.8	8.1	14.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Notes: Ns are weighted.

TABLE 6.4 Percentage distribution of adolescents, by knowledge and experience of abortion, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=943)	15–19 (N=1054)	Total (N=1997)	12–14 (N=907)	15–19 (N=1126)	Total (N=2033)
Knowledge of ways to abort pregnancy*						
Don't know any way	69.8	41.1	54.6	67.4	33.9	48.8
Surgical abortion	8.6	19.7	14.5	5.3	13.0	9.5
Herbal drink	21.0	40.9	31.5	25.9	54.1	41.5
Guinness or malt and sugar	N/A	N/A	N/A	N/A	N/A	N/A
Drinking bitter medicines	8.9	15.7	12.5	3.5	11.7	8.1
Coffee and sugar	N/A	N/A	N/A	N/A	N/A	N/A
Eating okra	0.0	0.1	0.1	0.3	0.7	0.5
Use of sharp objects	1.2	1.9	1.6	0.1	0.3	0.2
Quinine or sb3 tablets	2.5	11.1	7.1	0.9	3.9	2.6
Tablet or pills	11.0	29.1	20.6	11.7	25.6	19.4
Massage	0.2	0.2	0.2	0.0	0.3	0.1
Jumping/Falling	0.3	0.0	0.2	0.1	0.0	0.0
Insert herbs	N/A	N/A	N/A	N/A	N/A	N/A
Taking washing detergent	4.8	10.6	7.9	3.3	11.9	8.1
Ingesting glass	N/A	N/A	N/A	N/A	N/A	N/A
Soft drink and sugar/other	N/A	N/A	N/A	N/A	N/A	N/A
Caustic agent	N/A	N/A	N/A	N/A	N/A	N/A
Anti-malarial medication	N/A	N/A	N/A	N/A	N/A	N/A
Injections	N/A	N/A	N/A	N/A	N/A	N/A
Other method	0.3	1.5	1.0	0.3	0.9	0.6
Have any close friends who ever tried to end a pregnancy						
Yes	18.5	39.1	29.4	20.2	34.9	28.4
No	79.6	59.4	69.0	74.1	63.7	68.3
Refuse to answer	0.0	0.0	0.0	0.9	0.0	0.4
Don't know	1.9	1.4	1.7	4.9	1.4	3.0
Ever tried to end a pregnancy/been involved in ending a pregnancy						
No	100.0	99.6	99.8	100.0	99.6	99.8
Yes	0.0	0.4	0.2	0.0	0.4	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because multiple responses are possible. Note: Ns are weighted.

Chapter 7

HIV/AIDS and Other STIs

HIV/AIDS and other STIs are critical health problems facing adolescents in Malawi. This chapter presents information on adolescents' awareness and knowledge about HIV/AIDS and other STIs and their experiences with STI symptoms.

Knowledge About HIV/AIDS Transmission and Prevention

Awareness among adolescents about HIV/AIDS has been shown to be high in other surveys, such as the Demographic and Health Surveys. Table 7.1 presents new information for those aged 12–14 that indicates that there is a high level of awareness even among younger adolescents. During the 2004 survey, adolescents were asked whether they had heard about AIDS. Whilst there were no large differences in awareness levels between male and female adolescents, there were differentials between age-groups. A higher percentage (more than 96%) of the 15–19-year-old adolescents had heard about HIV/AIDS, compared with about 91% among the 12–14-year-old adolescents. Awareness among both rural and urban adolescents was also quite high, with over 98% of male and female urban adolescents aware of HIV/AIDS, compared with about 94% of rural adolescents (data not shown).

While awareness of HIV/AIDS is important, understanding how HIV can be transmitted and knowing effective ways of preventing transmission are even more important for adolescents to be able to take action to protect themselves. Responses shown in Table 7.1 are a combination of responses to prompted questions about modes of transmission and prevention plus responses to a spontaneous question asked afterward if there was “anything (else) a person can do to avoid or reduce their chances of getting AIDS.” Prompted questions were used in the survey in order to construct standardized knowledge indicators that are comparable across countries.

Table 7.1 indicates that knowledge was highest regarding HIV transmission through sex with persons in-

fectured with the virus, sharing razors or other sharp objects, getting injections with a needle used by someone else and blood transfusion. Urban adolescents were better informed than their rural counterparts (data not shown), as were older rather than younger adolescents and females rather than males. Fifteen–19-year-old adolescents showed a higher level of knowledge of HIV transmission than 12–14-year-old adolescents. Among 12–14-year-olds, knowledge of transmission of HIV through sex was higher among females (92%) than males (88%).

A considerable percentage of adolescents held misperceptions regarding modes of HIV transmission. Some believed that HIV can be transmitted through sharing food, mosquito bites, and witchcraft or supernatural means. More 15–19-year-olds believed that HIV could be transmitted through mosquito bites than 12–14-year-olds, especially among males. Generally, though, more 12–14-year-olds than 15–19-year-olds held misconceptions about HIV/AIDS.

Table 7.1 shows that most adolescents were aware of the ways of reducing HIV transmission. Abstaining from sex was the most commonly known way of preventing the transmission of HIV (88% of females and 91% of males), followed by having just one sex partner (68% of females and 79% of males), using condoms correctly and consistently (76% of females and 86% of males) and avoiding sharing needles (82% of females and 86% of males). Despite such high levels of awareness, many adolescents were not taking appropriate measures to reduce the risk of contracting HIV as has been demonstrated in the preceding chapters.

Personal Ties to and Attitudes About People with HIV/AIDS

Personal ties to people with HIV/AIDS make the AIDS epidemic a real part of adolescents' lives. Having a personal tie to someone with HIV/AIDS could also make adolescents more cautious in their own risk and protective behaviors. The data in Table 7.2 show that about

40% of females and 44% of males personally knew someone who had the virus that causes AIDS. The 15–19-year-old adolescents were more likely to have known someone who had the virus than the 12–14-year-olds. In addition to simply knowing someone who had HIV, about 67% of female adolescents personally knew someone who had died of AIDS or who people said had died of AIDS. The corresponding level for male adolescent was about 72%. In general, knowing someone who has the virus and knowing someone who died of HIV/AIDS or who people said had died of AIDS was higher among males than females and among 15–19-year-olds than 12–14-year-olds.

Holding negative attitudes towards people with HIV/AIDS—a key aspect of HIV/AIDS stigma—can influence one’s own willingness to acknowledge risk and to get tested for HIV. Several indicators of HIV/AIDS stigma were measured. The question about school teachers was phrased in terms of a *female* teacher in order to prevent respondents from thinking about the separate issue of male teachers having sexual relationships with students.*⁴⁰

The question of whether a female teacher who has the AIDS virus should be allowed to teach in school indicates a high level of stigma especially among 12–14-year-olds: About 70% of younger females said that a female teacher with AIDS should not be allowed to teach, as compared with about 55% of younger males. In general, the level of stigma on this aspect is higher (61%) among females than it is (46%) among males.

The adolescents’ responses to a question on whether they would buy fresh vegetables from a shopkeeper or food seller known to have HIV elicited the highest levels of prejudice, compared with other indicators. Overall, about 62% of females and 51% of males indicated that they would not buy vegetables from a vendor who had HIV. The levels of stigma for this indicator followed the same pattern as that described above: Stigma was highest among the young and the female adolescents. A larger proportion of male than female adolescents and older than younger adolescents would want it to be a secret if a family member became infected with the AIDS virus.

In an effort to measure the level of adolescents’ tolerance to a family member if she or he became infected with the AIDS virus, a question was posed regarding whether the respondent would be willing to care for a family member in this condition. A larger proportion

of female respondents than male respondents said they would not be willing to care for him or her (23% versus 18%). Younger adolescents (12–14-year-olds) had much lower tolerance than the older ones.

Knowledge of STIs

Table 7.3 shows the proportion of adolescents who had heard of STIs other than HIV/AIDS. About 63% of females and 68% of males had ever heard of other STIs. Substantially fewer 12–14-year-olds (about one in two) had heard of STIs apart from HIV, compared with 15–19-year-olds (three quarters or more). Those who had ever heard of other STIs were asked about the types of symptoms of STIs they have heard of (an open-ended question) and whether they had experienced an STI or STI-related symptoms.

Having an ulcer or sore on private parts was the STI symptom that most adolescents had heard of (59% of the females and 50% of the males). The other STI symptoms adolescents had heard of included genital discharge, warts or growths on private parts, and burning pain during urination. Only about 10% of the adolescents had heard of the STI symptoms itching in one’s private parts and lower abdominal tenderness/pain. In general, a larger proportion of females than males had heard of STI symptoms, and a larger percentage of the 15–19-year-olds than younger adolescents had heard of the STI symptoms. The data indicate that the level of adolescents’ awareness of HIV is much higher than their awareness of other STIs and this is possibly because there have been a lot of HIV/AIDS awareness campaigns.

Experience of STIs

Adolescents who had heard of STIs were asked whether they had ever had an STI and also whether they had ever experienced bad smelling or abnormal discharge or genital sores or ulcers. Given that it is sexually experienced individuals who are at risk of STIs, data are also presented according to sexual experience.

While self-reports of STIs are a much less valid indicator than clinical tests, especially given that a number of STIs do not commonly manifest with noticeable symptoms, self-reports provide an estimate of STI prevalence among the study population. A further qualification is the fact that symptoms are often less evident in women than men; hence, self-reported data for women may be a greater underestimate of actual prevalence as compared with men.

Table 7.3 indicates that the prevalence of STIs reported by adolescents who heard of STIs is lower than

*A prior study by UNAIDS/MEASURE found an influence of reports about teachers raping schoolgirls on how respondents understood the stigma question about a teacher with the AIDS virus.

the prevalence either of the two identified symptoms. The prevalence of bad-smelling, abnormal discharge is 4% among females and 5% among males, while the prevalence of genital sores is 3% for females and 5% for males. The compound measure of the prevalence of an STI as measured by having answered “yes” to the direct question about having an STI or a “yes” to either of the two symptoms is much higher than the estimate of STIs based on the direct question alone. Using this compound measure, 6% of females and 8% of males had experienced an STI. This is closer to the prevalence rates for ever having had an STI among sexually experienced adolescents. The latter’s prevalence rates are 8% for females and 12% for males. The prevalence rates across all the different measures are higher among those aged 15–19 than among younger adolescents.

Policy and Programmatic Implications

- The high levels of stigma and negative attitudes reported by adolescents in this study demonstrate that a lot of work is still needed to reduce stigmatization and intolerance of people living with HIV/AIDS among young people, with particular emphasis on 12–14-year-olds. Ongoing sensitization programs aimed at reducing the levels of stigma against those having the AIDS virus such as radio programs, dramas, etc., should be strengthened to address this problem.
- The finding that substantial proportions of adolescents mentioned sharing food, mosquito bites and witchcraft as ways through which the AIDS virus can be transmitted underscores the need for programs to focus on understanding the knowledge that adolescents have and addressing misconceptions about AIDS, its spread and its prevention.
- The finding that 8% of sexually experienced female and 12% of sexually experienced male adolescents report having ever had an STI highlights the need to increase the use of condoms to protect against STIs. Given that other STIs increase the likelihood of HIV infection through sexual intercourse and that levels of knowledge of other STIs are relatively low among adolescents, sex education programs should improve knowledge of STIs and their linkage to HIV infection. Programs should also focus on ensuring that adolescents who experience such infections have access to treatment.

TABLE 7.1 Percentage distribution of adolescents, by awareness of and knowledge about HIV/AIDS, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=943)	15-19 (N=1055)	Total (N=1998)	12-14 (N=907)	15-19 (N=1126)	Total (N=2033)
Ever heard of AIDS						
Yes	92.5	96.7	94.7	90.6	98.7	95.1
No	6.9	3.3	5.0	7.4	1.2	4.0
Don't know	0.6	0.0	0.3	2.0	0.1	0.9
The AIDS virus can be transmitted by:*†						
Having sex with persons who are infected with the virus	92.2	95.6	94.0	88.8	97.0	93.5
A mother to child during pregnancy	62.8	78.5	71.3	65.5	80.8	74.3
A mother to child during delivery	56.5	76.3	67.2	55.6	72.4	65.3
A mother to child during breastfeeding	66.4	80.9	74.2	61.6	75.2	69.4
Sharing razors or other sharp objects	86.9	92.7	90.1	87.8	96.4	92.8
Getting injections with a needle used by someone else	83.8	94.0	89.3	85.4	95.6	91.3
A blood transfusion	82.3	89.1	86.0	82.2	93.8	88.9
Sharing food	17.4	17.0	17.1	17.7	9.8	13.1
Mosquito bites	32.3	33.3	32.9	34.3	39.1	37.0
Witchcraft or supernatural means	25.8	23.0	24.3	26.7	20.2	23.0
Transmission of the AIDS virus can be reduced by:*†						
Not having sex at all	85.4	90.5	88.2	87.8	93.8	91.3
Having just 1 partner who is not infected and who has no other partners	62.5	72.7	68.0	74.6	82.0	78.9
Using a condom correctly at every sexual intercourse	67.7	82.6	75.7	79.1	90.2	85.5
Avoiding sharing injections/needles	78.7	84.4	81.8	81.7	89.3	86.1
Can a man infected with the AIDS virus be cured if he has sex with a virgin?†						
Yes	4.2	5.6	5.0	4.0	7.6	6.1
No	91.6	93.2	92.5	87.7	89.7	88.9
Don't know	4.1	1.2	2.5	8.3	2.7	5.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who have heard of the AIDS virus. Sample sizes: females 12-14 (N=871); females 15-19 (N=1019); males 12-14 (N=820); males 15-19 (N=1111). †Totals may exceed 100 because multiple responses are possible.

Notes: Ns are weighted.

TABLE 7.2 Percentage distributions of adolescents who have heard of AIDS, by personal ties to and attitudes about persons with HIV/AIDS, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=873)	15-19 (N=1018)	Total (N=1891)	12-14 (N=822)	15-19 (N=1111)	Total (N=1933)
Personally knows someone who has the virus that causes AIDS						
Yes	37.2	42.5	40.1	35.4	50.8	44.2
No	61.6	57.3	59.3	64.0	49.1	55.4
Don't know	1.1	0.2	0.6	0.6	0.2	0.4
Personally knows someone who has died from AIDS or who people said died of AIDS						
Yes	59.1	72.8	66.5	62.4	79.5	72.2
No	40.5	26.9	33.2	37.1	20.5	27.6
Don't know	0.5	0.3	0.4	0.5	0.0	0.2
If a female teacher has the AIDS virus, she should be allowed to teach in school						
Yes	28.2	46.2	37.9	43.1	61.5	53.6
No	70.0	53.2	60.9	55.4	38.2	45.5
Don't know	1.8	0.6	1.2	1.6	0.4	0.9
If knew shopkeeper or food seller had AIDS virus, would buy fresh vegetables from him/her						
Yes	27.4	46.1	37.5	36.5	58.7	49.3
No	72.4	53.6	62.3	63.5	41.1	50.6
Don't Know	0.2	0.3	0.3	0.0	0.2	0.1
If a family member became infected with AIDS virus, would want it to be a secret						
Yes	42.5	45.8	44.3	50.7	55.4	53.4
No	57.0	53.9	55.3	48.7	44.6	46.4
Don't know	0.5	0.3	0.4	0.6	0.0	0.3
If a family member became infected with AIDS virus, would be willing to care for him or her						
Yes	68.5	82.8	76.2	76.5	86.4	82.2
No	31.2	16.6	23.3	23.2	13.6	17.7
Don't know	0.3	0.6	0.5	0.2	0.0	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 7.3 Percentages of adolescents, by awareness of and knowledge about STIs and symptoms experienced, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=943)	15-19 (N=1055)	Total (N=1998)	12-14 (N=907)	15-19 (N=1125)	Total (N=2032)
Ever heard of STIs other than HIV/AIDS						
Yes	48.3	76.7	63.3	49.9	82.2	67.8
No	51.7	23.3	36.7	50.1	17.8	32.2
Symptoms of STIs:*						
Ulcer/sore on private parts	51.1	62.9	58.6	35.3	57.2	50.0
Genital discharge	28.4	41.5	36.7	14.0	33.5	27.1
Itching in private parts	8.4	11.0	10.0	6.2	12.1	10.2
Lower abdominal tenderness/pain	9.5	11.6	10.8	6.7	10.5	9.2
Warts or growths on private parts	28.8	31.8	30.7	14.2	29.3	24.4
Burning pain in urination	13.6	18.4	16.7	14.2	21.6	19.2
Other	1.3	2.4	2.0	2.4	4.2	3.6
Don't know	33.6	23.2	26.9	47.0	22.7	30.7
Ever had:*						
An STI ('yes' to direct question)	0.0	0.5	0.3	0.4	1.5	1.2
A bad-smelling, abnormal discharge	2.9	4.6	4.0	1.8	6.5	4.9
A genital sore or ulcer	2.2	4.0	3.3	2.0	5.8	4.6
An STI ('yes' to direct question or experienced a specific symptom)	4.6	7.1	6.2	2.9	10.5	8.0
Among sexually-experienced adolescents, ever had:†						
An STI ('yes' to direct question or experienced a specific symptom)	--	7.7	7.5	2.7	13.6	11.9

*Limited to those who have heard of STIs. Totals may exceed 100 because multiple responses are possible. Sample sizes: females 12-14 (N=456); females 15-19 (N=803); males 12-14 (N=451); males 15-19 (N=925). †Limited to those who have ever had sex. Sample sizes: females 12-14 (N=23); females 15-19 (N=325); males 12-14 (N=110); males 15-19 (N=573). Notes: Ns are weighted. "--" = N is 24 or fewer.

Chapter 8

Profiles of Young People's Risk and Protective Behaviors

This chapter provides an overview of the level of risk and protective behaviors among all adolescents by synthesizing information on indicators of the current status of adolescents' sexual behavior and condom use. In addition, information on the consistency and correctness of condom use and on attitudes about condoms is presented in this chapter. Information about the context of adolescent sexual behavior, such as alcohol use and the receipt of money or gifts for sex, is also shown.

Self-perceived Risk of Contracting HIV

Self-perceived risk of HIV can serve as a motivation for adolescents to change the behaviors that place them at risk of HIV. The question asked during the 2004 survey to measure self-perceived risk was: "Do you think your chances of getting HIV/AIDS are great, moderate, small or you have no chance at all?" Chart 8.1 shows the percentage distribution of adolescents' perceptions of their own risk of HIV by sex and age-groups.

While more than a third of adolescents perceive themselves at great risk of contracting HIV, the proportion who believe they had "no chance at all" of contracting HIV accounted for another third of all adolescents. Twelve–14-year-olds were more likely to see themselves as not being at risk for HIV than 15–19-year-olds. Older adolescents might perceive themselves to have a greater chance of getting HIV because they are engaging in more risky behaviors or because they are more aware of which behaviors put them at risk. Slightly more males perceive themselves to be at any kind of risk than females. This is supported by earlier findings that higher proportions of males than females had had sex.

Chart 8.2 shows self-perceived risk of contracting HIV among sexually experienced 15–19-year-old females by union status. The chart shows that half of females in union considered themselves to be at great risk of getting HIV, compared with 42% among those not in union. Only 28% of those in union perceived them-

selves to have "no chance at all" of getting HIV, compared with 40% of the females not in union. Married females could perceive themselves to be at great risk because of increased coital frequency in marriage, because of the increased difficulty in introducing condoms into sexual intercourse within a union and/or because of greater concern about their partners' HIV status.

Profiles of Adolescent Sexual Behavior and Condom Use

We present two indicators of adolescent sexual behavior, each highlighting different perspectives on exposure to the risk of HIV, other STIs and pregnancy. The first set of charts presents sexual activity and condom use at last sex in the 12 months prior to the survey according to union status, detailing changing patterns of risk and protection across the adolescent years. The second set of charts presents sexual activity in the 12 months prior to the survey and condom use at last sex, according to number of sexual partners.

Charts 8.3 and 8.4 present condom use and partner at last sex in the last 12 months. Categories are defined to be mutually exclusive and are based on standard behavioral indicators developed by the Joint United Nations Programme on HIV/AIDS and other organizations to guide monitoring and evaluation of national AIDS prevention programs. These categories are: never had sex, had sex but not in the last 12 months, had sex in the last 12 months with a cohabiting partner (includes spouse) and used a male condom, had sex in the last 12 months with a cohabiting partner (includes spouse) and did not use a condom, had sex in the last 12 months with a noncohabiting partner and used a condom, and had sex in the last 12 months with a noncohabiting partner and did not use a condom at last sex. Results are reported according to single years of age.

It can be seen from Chart 8.3 that virtually no females were sexually active at age 12. However, by the age of 14, almost 5% of the females had had at least one sexual experience and by the age of 17 about 35%

had had at least one sexual experience, with this proportion rising to about 68% by the age of 19. (See Table 4.3 for reasons why adolescents have not had sex.) Fourteen percent of those aged 19 had not had sex in the 12 month period prior to the survey.

Risky behavior captured on the chart shows that about 5% of the females aged 15 had had sex in the last 12 months with a noncohabiting partner without using a condom. This percentage gradually rose to 14% among females aged 18. The proportion of females who had had sex in the 12 months prior to the survey with a spouse/cohabiting partner without a condom rose from about 4% among those aged 16 to 32% among those aged 19. To the extent that Malawi is similar to Kenya and Zambia in terms of males' patterns of sexual behavior, married women might in fact be at greater risk of acquiring HIV than unmarried women.⁴¹

The pattern observed above for females differs from that of males only in magnitude, as can be seen from Chart 8.4. Eighty-nine percent of males had not had sex by the age of 12, as opposed to 99% of females, and the proportion of those that had had at least one sexual experience increased with age. Unlike for females, the proportion of males who are sexually active does not increase monotonically. The proportion of the sample that is sexually experienced is the highest for males aged 18, with a slightly lower proportion of 19-year-olds having had sex. This might be a misleading result if sexually active 19-year-old males were less likely to make it into the sample. This may have happened if they had refused to participate with greater frequency than males of other ages or if the interviewers were less likely to capture them in our household sample (either because they lived in institutions or on the street).

Among 15–19-year-old males, between 19% and 26% were sexually-experienced but had not had sex in the last 12 months (reasons for not having had sex in the last 12 months are summarized in Table 4.4). This is a much larger proportion of the sexually experienced population than it is for females, demonstrating that females are more likely to have more frequent sexual intercourse than males once they become sexually active because a larger proportion of them are married. The majority of sexually active males had intercourse with a noncohabiting partner and did not use a condom. On the basis of levels of condom use, 19-year-olds demonstrated better protective behavior than any other age group.

Results on the number of partners in the last 12 months and condom use are presented in Charts 8.5 and 8.6 for adolescents who had had sexual intercourse in the last 12 months. Those at highest risk were those

who had two or more partners in the last 12 months and did not use a condom. Those who had sex in the last 12 months with one partner and did not use a condom were also at risk—dependent upon the risk that that partner presents (e.g., contingent on his/her past sexual partners).

Charts 8.5 and 8.6 show that 21% of females and 28% of males had sex in the last 12 months with one partner and used a condom. Approximately three quarters of females and 57% of males had sex with one partner in the last twelve months without a condom. The percentage with two or more sex partners in the last 12 months was smaller for females than for males, as would be expected. Females who had more than two partners in the last 12 months were more than twice as likely to have had sex without a condom, compared with other females in this same risk group. Males who had more than two sex partners in the last 12 months were only slightly more likely to have had sex without a condom (8% versus 7%).

Condom Use at Last Intercourse

Condom use often depends on the nature of the relationship (e.g., whether the partner is a boyfriend/girlfriend or a more casual partner), the relative power that the adolescent has in the relationship (e.g., whether one partner is significantly older or has given the adolescent money or gifts in exchange for sex) and whether alcohol was consumed around the time of sexual intercourse. Table 8.1 shows the percentage of adolescents who used a male condom at last sex in the 12 months prior to the survey by different characteristics of the sexual relationship. Questions about money and gifts in exchange for sex and alcohol use at last sex were asked only for those who reported having had a sex partner in the last 12 months. (Because of a skip pattern, if an adolescent had sex only one time in the last 12 months with their first ever sex partner, questions about alcohol use and sex in exchange for money or gifts were not asked.)

Table 8.1 shows that the most common last sex partner for females was either a boyfriend or a spouse, while for males it was a casual acquaintance or girlfriend. About one in three females whose last sex partner was a boyfriend used a condom compared to only 10% of females whose last sex was with their spouse. For males, the only category with a sufficient number of cases is those who had sex with a girlfriend. About one in four 12–14-year-olds and 39% of 15–19-year-olds used a condom at last sex with their girlfriend. Among males aged 15–19, there is higher use of con-

doms with casual acquaintances (44%) than with a girlfriend (39%).

The age difference between the respondent and his or her partner is a proxy for where power resides in the relationship. The age of the partner is also a proxy for exposure to sexual activity and consequently risk for STIs: The older the partner, the more likely he is to have had more sexual partners and thus be carrying an STI. However, our insights into the relationship between age difference and condom use are hindered by small sample size.

Among females not in union whose sex partner was 1–4 years older, about a third used a condom at last sex, and 45% of those whose partner was the same age or younger used a condom at last sex. Although the sample size is small in the latter group, these numbers suggest that the older the male partner is relative to the female partner, the smaller the probability of condom use. Among males, respondents were most likely to use condoms with partners the same age or younger than themselves. Twelve–14-year-olds remain half as likely to have used condoms compared with 15–19-year-olds, suggesting that, other things being equal, condom use increases with age.

Condom use is highest for those who had sex one time only. Condom use is slightly higher for those 15–19-year-olds who are not in union where the length of the relationship is one year, than those who have been in the relationship 4–11 months. For those in union, condom use decreases as the length of the relationship increases. A longer relationship for females not in a union might increase the couple's investment in not getting pregnant, while length of time in union may decrease the couple's investment in avoiding pregnancy. Condom use appeared to be slightly higher for females 15–19 years old when no gifts or money were received for sex and when no alcohol was used at last sex, but sample sizes are small for some of these groups.

Males 12–14 years of age are less than half as likely as males 15–19 years of age to use a condom at last sex if they had sex only one time. The percent using a condom at last sex is higher for males having sex in a relationship lasting four or more months than if the relationship lasted three months or less. This suggests that relationships which last four months or more increase the male's investment in avoiding pregnancy or STIs. Males 15–19 years of age were less likely to have used a condom at last sex if money or gifts were received (although the sample size was small).

Across each of the variables, there is higher report-

ing of condom use by males than by females. This could be a result of the age difference between the respondents and their sexual partners—females tended to have sex with older males who may have been less likely to use a condom, whereas adolescent males who were closer in age to their sex partners were more likely to use a condom. It is also possible that some females may not be aware of their partner's condom use.

There is no difference in condom use between females who have ever received gifts or money in exchange for sex and those who have not; however, males who have never received gifts were more likely to use condoms than those who received gifts.

Table 8.2 gives the spontaneously reported reasons for nonuse of condoms at last sex among adolescents who had sex in the 12 months prior to the survey. This question was not asked of respondents who had sex only one time with only their first sex partner. Respondents were allowed to give multiple responses. Overall, 54% of females and 44% of males did not use a condom because they felt safe. This percentage was almost identical for females in union and females not in union. Twenty-two percent of females and 38% of males did not use a condom because they did not have one. Only a small percentage—fewer than 10%—said they did not use a condom because their partner refused (8% of females 15–19 years of age not in union, 3% of females 15–19 years of age in union, 7% of males 15–19, and 0% of males 12–14 years of age). Fourteen percent of females in union and only 2% of the 15–19-year-old males and females not in union did not use a condom because they wanted to get pregnant or wanted their partner to get pregnant. No females said that they did not use a condom because they did not know how to use it and only very small numbers of males said that they did not use a condom because of this reason: 3% of 12–14-year-olds and 2% of 15–19-year-olds. These data suggest, then, that although access to contraception plays a significant role, especially among males, false perceptions of security play a critical role as well.

Consistency of Condom Use and Problems with Recent Condom Use

The effectiveness of condoms at preventing pregnancy and the transmission of HIV is determined by how consistently and correctly they are used. The measure of condom use shown in most studies is condom use at last sex, which assumes that condom use at the last sex is a proxy of condom use at every act of sexual intercourse. Yet this survey went farther than that, includ-

ing questions about the frequency of sexual intercourse and condom use for adolescent males in the three months prior to the survey with up to three different sex partners. These questions were not asked of female adolescents for three reasons: 1) the assumption was that females would not be as accurate in reporting condom use problems as males; 2) female adolescents are more likely than males to report fewer sex partners than they have had; and 3) the focus of these questions was on condom use patterns among adolescents with multiple sex partners (i.e., those at high risk of HIV and other STIs) of whom there is a much larger proportion who are male.

Table 8.3 shows different measures of condom use consistency and the percentage of young men who recently experienced problems in using condoms correctly. These measures are based on the summary of all events in the three months prior to the survey (sex acts and condom use at each, for up to three partners). Those who reported “don’t know” or who refused to answer were coded as missing on the measures of sexual intercourse and condom use.

One can see from the table that almost 75% of sexually active males aged 12–19 had had sexual intercourse three or fewer times over the past three months. Almost 20% had sexual intercourse between four and six times in that interval, while 4% had sex 7–9 times. Only 3% had sex 10 or more times. Therefore, the mean frequency of sex acts was 3.0 in the previous three months, 2.6 of which took place with a girlfriend or a cohabiting partner.

Almost 60% of the sample did not use a condom during the sex act which took place in the three months prior to the survey. About one in five used a condom just once and 10% used condoms twice in the preceding interval. Another 10% used a condom between three and six times in the preceding interval. While just over 7% had sex seven or more times in the preceding interval, only 1% of sexually active males used condoms seven or more times.

The mean number of times that condoms were used by sexually active males in the preceding three months was 0.8 times. The mean number of times it was used with a girlfriend or cohabiting partner was 0.8 as well, while the number of times it was used with another type of partner (casual acquaintance, commercial sex worker or other) was only 0.1. This demonstrates that males are much more likely to forego condoms when having sex with someone other than their girlfriend or cohabiting partner, exposing themselves to a higher probability of contracting an STI. In all, 24% of ado-

lescent male sexual acts in the three months prior to the survey were protected by condoms. In contrast, 60% of sexual acts were not protected at all.

For male respondents who had sex more than once, more than 18% said that at some time during the last three months they had put on a condom after they started having sex, while fewer than 5% said that they experienced condom breakage or slippage in the last three months. This suggests that incorrect information or possibly poor method use is accountable for a much greater proportion of incorrect condom use than actual product failure, especially when we consider that part of the condom breakage could also be due incorrect use or information.

Knowledge and Attitudes About Male Condoms

One of the correlates of correct condom use is knowledge about condom use, captured here in the measure of whether adolescents had seen a formal condom demonstration and whether they knew how to use a condom correctly.

Table 8.4 shows adolescents’ knowledge about the correct use of condoms. The data show relatively low levels of participation in demonstrations on how to use a condom and substantial levels of incorrect knowledge of how condoms should be used. In total, only 15% of females and 24% of males who ever heard of the male condom had actually seen a formal condom demonstration. For both males and females, about half as many 12–14-year-olds had seen a formal condom demonstration, as compared with 15–19-year-olds, with more males than females having been exposed to such instruction. Regarding knowledge of correct condom use, 21% of females and 15% of males (with the percentages being higher among 12–14-year-olds for both sexes) disagreed with the statement that a “condom should always be put on before sexual intercourse starts.” An even bigger percentage (32% for females and 16% for males, again with a greater percentage among 12–14-year-olds) disagreed with the statement that a “condom should be put on the penis only if the penis is fully erect or stiff.” Eleven percent of females answered “don’t know” to this question, compared with only 4% of males. Slightly more than 44% of the females and only 32% of the males agreed with the statement that a condom can be used more than once. In general, males appear to be more knowledgeable about the correct use of a condom than females.

Adolescents’ attitudes about condom use can influence whether and how they will use condoms. Negative attitudes such as “condoms reduce sexual pleas-

ure” are likely to make adolescents less willing to use condoms consistently. Table 8.5 shows adolescents’ attitudes about condom use and about adolescents’ confidence in using condoms among those who know of the male condom. (Results are from all respondents who have heard about condoms, not only those who are sexually active.)

The table shows that a larger proportion (45%) of the males agreed with the statement that a condom reduces sexual pleasure than females (37%). More males (49%) than females (44%) agreed with the statement that using a condom is a sign of not trusting your partner, with more 15–19-year-olds answering in the affirmative, irrespective of sex. A positive indicator in the data is that 50% of 12–14-year-old females, 63% of 12–14-year-old males, almost 60% of 15–19-year-old females and 71% of 15–19-year-old males disagreed with the statement that “it is embarrassing to buy or ask for condoms.” Although a greater proportion of females seem to be made uncomfortable by this experience than males, it appears that a minority of adolescents would fail to access condoms due to embarrassment.

Self-efficacy is included here as the adolescents’ level of confidence in getting one’s male partner to wear a condom (for females) or knowing how to use a condom (for males). For females, this variable is capturing their perceived ability to influence their partner’s behavior, whereas for males, it is capturing males’ perceived ability to use a condom effectively. (Males’ answers may or may not include their comfort in introducing the condom to the sexual relation or the anticipated reaction that introducing a male condom would elicit from their partner.)

Confidence increased with age among both sexes. As would be expected, low self-efficacy was most prevalent among 12–14-year-old females. Whereas about 30% of 12–14-year-old females were “very confident” that they could get their male partner to wear a condom, almost 44% of 15–19-year-olds were “very confident.” Over 50% of female 12–14-year-olds and 37% of 15–19-year-olds were not confident at all that they could get their male partner to use a condom.

Males expressed relatively greater confidence in knowing how to use a condom: Some 32% of 12–14-year-olds and 60% of 15–19-year-olds were “very confident.” The number of males who were “not confident at all” that they knew how to use a condom was high for 12–14-year-old males at 46%, as compared with 23% for 15–19-year-olds.

The above discussion points to the fact that the ado-

lescents’ attitudes towards condoms could be a greater barrier to the use of condoms than the problem of failure to buy or ask for condoms due to embarrassment.

Recent Experiences with Cutting, Piercing and Injections

Other sociocultural practices that can potentially place adolescents at risk of HIV transmission are using unclean, sharp instruments or blades for cutting or piercing and using unclean needles for injections. The belief in injections as a powerful method of restoring or maintaining health is one of the factors that has led to the wide misuse of injections. In a study conducted in Uganda, van Staa and Hardon report that when interviewees were asked where the last injection in the household was given, 30% reported that these were given at home by informal providers.⁴² A study conducted in Malawi also found that the use of local injection doctors is widespread.⁴³

Table 8.6 shows the percentage of adolescents reporting that they received any cuts or piercings with blades or sharp instruments in the 12 months prior to the survey. Exposure to cuts or piercings in the 12 months prior to the interview was slightly higher among 15–19-year-old males and females than among younger adolescents; the numbers were slightly higher for females in both age-groups than for males (16% for all females and 14% for all males). Questions were not asked about whether the blades or sharp instruments were sterilized or were shared with others because of the assumption that adolescents would not readily know. The measure is simply a rough proxy for exposure to potentially unsafe blades or other sharp instruments.

Table 8.6 also shows the percentage of adolescents who received an injection in the 12 months prior to the survey, the number of injections received and the type of person who administered the last injection. The questions are based on World Health Organization injection practice indicators. Again, questions were not asked about whether the injection needle was sterilized or had been shared with others. The measures do *not* show exposure to HIV transmission—they simply indicate the prevalence of injection use (number per person per year) and the administration of injections by unqualified people. The table shows that 26% of the females and 31% of the males had received an injection in the last 12 months. Over one-third had received just one injection. Nineteen percent of females and 16% of males had received three injections. Slightly more than 10% of both males and females had received at least

four injections in the last 12 months.

Table 8.6 further indicates that the most common person to have administered the last injection was a doctor (males were more likely than females to have been injected by a doctor), followed by a nurse (females were about twice as likely to have been injected by a nurse as were males). The only other type of administrator to account for a significant portion of the total shots administered was the local injection doctor, who administered 10% of the injections for males and 3% of the injections for females. Local injection doctors are members of the community who administer injections, sometimes without adequate knowledge or proper sterilization procedures. Yet recent research has shown that unsafe injections are not a major mode of HIV transmission in Sub-Saharan Africa, and that sexual transmission remains the primary means by which HIV has spread in the continent.⁴⁴

Policy and Programmatic Implications

- Correct condom use should be taught to minimize condom failure, including breakage, due to misuse. Condom demonstrations prior to the onset of sexual intercourse will help insure that condoms are used consistently and correctly.
- Better information can be included with condoms and condom demonstrations should become common at condom distribution sites.
- A significant proportion of adolescents hold attitudes that may discourage them from using condoms, such as beliefs that condoms reduce sexual pressure; that using condoms is a sign that you do not trust your partner; and that it is embarrassing to buy or ask for a condom. Therefore, in addition to material barriers, educational programs need to address these social barriers to condom use.
- Material barriers to condom use deserve attention as well, since the second most commonly mentioned reason for not using a condom at last sex, “did not have a condom,” points to the need to address factors that affect access to condoms by young people.
- Since lack of condom use is most frequently a result of feeling safe, adolescents’ inaccuracy of self-perceived risk should be addressed by educational campaigns focusing on the correct definition and assessment of risk and safety, and targeting in particular 12–14-year-old females with the hope that this will lead adolescents to engage in more self-protective behavior.
- Since females who had more than two partners in the last 12 months were more than twice as likely to have

had sex without a condom, compared with other females in this same risk group, while males who had more than two sex partners in the last 12 months were only slightly more likely to have sex without a condom, there is a need for more female-controlled prophylactic methods.

- The finding that only a small percentage of female adolescents would feel very confident in getting their male partner to wear a condom highlights the need for educational programs to focus on empowering girls to develop stronger negotiation skills and internalize the fact that they should have greater control regarding what happens in their sexual relationships. Given that condom use decreases as the partner’s age increases, one point of empowerment would be to encourage young women to avoid getting in relationships with much older men.

TABLE 8.1 Percentages of adolescents who had sexual intercourse in the last 12 months and used a male condom at last sex, by relationship type, age of partner, duration of sexual relationship, gifts or money received, and alcohol use, according to sex, age and union status, 2004 National Survey of Adolescents

Characteristic	Females				Males		
	12–14 (N=21)	15–19 Not in union (N=165)	15–19 In union (N=132)	Total (N=316)	12–14 (N=122)	15–19 (N=420)	Total (N=540)
% using condom, by relationship to last sex partner							
Spouse	--	--	11.8	10.4	--	--	--
Live-in partner	--	--	[5.0]	[6.3]	--	--	--
Boyfriend/girlfriend	--	38.0	--	35.3	22.7	38.7	35.2
Casual acquaintance	--	--	--	0.0	--	[43.5]	29.4
Commercial sex worker	--	--	--	--	--	--	--
Other	--	--	--	20.0	--	--	--
% using condom, by age difference with last sex partner							
Partner is 10+ years older	--	--	--	--	--	--	--
Partner is 5–9 years older	--	--	[8.0]	[11.6]	--	--	--
Partner is 1–4 years older	--	32.9	12.7	24.0	--	--	[27.3]
Partner is older, don't know specific age	--	--	--	[20.0]	--	--	--
Partner is same age or younger	--	[44.7]	--	33.9	17.2	41.2	36.4
Don't know	--	--	--	--	--	--	--
% using condom, by duration of last sexual relationship (months)							
Had sex one time only	--	[47.4]	--	[41.9]	17.5	38.3	31.6
3 months or less	--	--	--	[24.4]	[13.3]	34.7	30.3
4–11 months	--	[28.9]	[16.2]	22.9	--	46.6	43.2
1 year	--	[32.4]	[14.8]	24.2	--	[51.5]	[52.8]
2 years	--	--	--	[17.9]	--	--	--
More than 2 years	--	--	[7.5]	8.9	--	--	--
% using condom, by gifts or money received for sex*							
Received gifts or money	--	36.0	N/A	35.9	--	[30.8]	[24.2]
No gifts or money	--	[41.7]	N/A	[35.7]	20.9	42.9	38.9
% using condom, by alcohol use at last sex†							
Partner or respondent drank alcohol at last sex	--	--	--	--	--	--	--
No alcohol at last sex	--	32.3	8.9	20.8	18.4	41.1	36.9

*Question not asked if most recent partner was the first sex partner ever and had sex only one time or if partner was a spouse or cohabiting partner. Sample sizes: females 12–14 (N=13); females 15–19 not in union (N=110); females 15–19 in union (N=131); males 12–14 (N=73); males 15–19 (N=315). †Question not asked if most recent partner was the first sex partner ever and had sex only one time. Sample sizes: females 12–14 (N=16); females 15–19 not in union (N=130); females 15–19 in union (N=131); males 12–14 (N=76); males 15–19 (N=341). Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25–49.

TABLE 8.2 Percentage distribution of adolescents who had sex in last 12 months and did not use a condom, by reasons for nonuse of condoms* at last sex, according to sex, age and union status, 2004 National Survey of Adolescents

Characteristic	Female				Male		
	12-14 (N=12)	15-19 Not in union (N=88)	15-19 In union (N=118)	Total (N=219)	12-14 (N=62)	15-19 (N=200)	Total (N=262)
Wanted to get pregnant/make someone pregnant	--	2.3	13.6	8.2	0.0	1.5	1.1
Partner refused	--	8.0	2.5	5.0	0.0	7.0	5.3
Didn't have condom	--	27.3	16.1	21.9	41.9	37.0	38.2
Felt safe	--	54.5	53.4	53.9	40.3	45.0	43.9
Didn't know how to use	--	0.0	0.0	0.0	3.2	1.5	1.9
Other	--	5.7	7.6	6.4	14.5	4.5	6.9
Pregnant/partner pregnant	--	0.0	0.0	0.0	0.0	0.0	0.0
Don't know	--	2.3	6.8	4.6	0.0	3.5	2.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

† Question not asked if respondent had sex only one time with first sex partner. Notes: Ns are weighted. "--" = N is 24 or fewer.

TABLE 8.3 Percentage of males aged 12–19 who had sex in the last three months, by frequency of sexual intercourse, condom use and experiences with condom problems, 2004 National Survey of Adolescents

Characteristic	Males (N=347)
Number of acts of sexual intercourse in last 3 months	
1	37.9
2	20.9
3	14.2
4	8.9
5	5.8
6	4.9
7	2.0
8	0.7
9	1.3
10	1.7
11+	1.5
Total	100.0
Mean number of acts of sexual intercourse in last 3 months per sexually active young man	
Total	3.0
With a girlfriend or cohabiting partner	2.6
With other type of partner (casual acquaintance, commercial sex worker, other)	0.3
Number of times a male condom was used in last 3 months	
0	59.8
1	19.1
2	10.2
3	6.2
4	2.2
5	0.9
6	0.4
7	0.6
8	0.0
9	0.5
10	0.0
11+	0.1
Total	100.0
Mean number of times a male condom was used in last 3 months per sexually active young man	
Total	0.8
With a girlfriend or cohabiting partner	0.8
With other type of partner (casual acquaintance, commercial sex worker, other)	0.1
Proportion of acts of sexual intercourse where a male condom was used per sexually active young man	
0%	59.8
1–25%	3.0
36–50%	7.5
51–75%	5.8
76–99%	0.4
100%	23.6
Total	100.0
Ever started having sex without a male condom and then put one on later in last 3 months*	
No	81.8
Yes	18.2
Total	100.0
Ever had a male condom break or slip off during sex in the last 3 months*	
No	95.2
Yes	4.8
Total	100.0

*Question not asked if partner was the first sex partner ever and had sex only one time. Sample size is: males (N=126). Notes: Ns are weighted.

TABLE 8.4 Percentage distributions of adolescents who have ever heard of a male condom, by knowledge about male condoms, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=565)	15-19 (N=870)	Total (N=1435)	12-14 (N=693)	15-19 (N=1053)	Total (N=1746)
Ever seen a formal condom demonstration						
Yes	9.0	19.5	15.4	15.0	29.7	23.9
No	90.8	80.5	84.5	84.7	70.3	76.0
Don't know	0.2	0.0	0.1	0.3	0.0	0.1
Condom should always be put on before sexual intercourse starts						
Agree	69.5	80.7	76.3	74.6	88.3	82.9
Disagree	25.6	18.8	21.4	20.7	10.9	14.8
Don't know	4.9	0.6	2.3	4.6	0.8	2.3
Condom should be put on only if the penis is fully erect or stiff						
Agree	44.4	65.2	57.0	72.4	84.8	79.9
Disagree	38.3	27.7	31.9	20.3	13.9	16.4
Don't know	17.3	7.0	11.1	7.4	1.3	3.7
Condom can be used more than once						
Agree	38.4	47.8	44.1	33.6	31.1	32.1
Disagree	54.0	49.9	51.5	60.1	68.3	65.0
Don't know	7.6	2.3	4.4	6.3	0.7	2.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

Notes: Ns are weighted.

TABLE 8.5 Percentage distribution of adolescents, by attitudes about male condoms, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=567)	15–19 (N=869)	Total (N=1436)	12–14 (N=692)	15–19 (N=1051)	Total (N=1743)
Condom reduces sexual pleasure						
Agree	30.2	41.9	37.3	38.9	49.2	45.1
Disagree	48.5	47.1	47.6	43.5	43.8	43.7
Don't know	21.3	11.0	15.1	17.6	7.0	11.2
Using a condom is a sign of not trusting your partner						
Agree	41.3	46.2	44.2	41.0	54.5	49.1
Disagree	52.4	51.6	51.9	50.4	44.0	46.5
Don't know	6.3	2.2	3.8	8.7	1.5	4.4
It is embarrassing to buy or ask for condoms						
Agree	45.9	40.4	42.5	33.4	27.1	29.6
Disagree	49.6	58.9	55.2	62.6	71.3	67.9
Don't know	4.6	0.7	2.2	4.0	1.5	2.5
Level of confidence in getting male partner to wear a condom (females)/knowing how to use a condom (males)						
Very confident	29.4	43.7	38.1	31.7	60.4	49.0
Somewhat confident	19.4	19.8	19.6	22.8	17.1	19.3
Not at all confident	51.2	36.5	42.3	45.5	22.5	31.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 8.6. Percentage distribution of adolescents, by recent experiences with other potential sociocultural risk factors, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=942)	15-19 (N=1053)	Total (N=1995)	12-14 (N=906)	15-19 (N=1124)	Total (N=2030)
Received any cuts or piercing with blades or other sharp instruments in last 12 months						
Yes	13.8	17.8	15.9	11.9	14.9	13.5
No	86.2	82.2	84.1	88.1	85.1	86.5
Received any injections in last 12 months						
Yes	25.2	27.3	26.3	34.3	27.4	30.5
No	74.8	72.7	73.7	65.7	72.6	69.5
Number of injections received in last 12 months*						
1	40.5	33.1	36.5	39.8	41.1	40.5
2	32.9	33.4	33.2	29.4	34.5	32.0
3	17.3	20.2	18.9	16.5	14.8	15.7
4	3.4	3.1	3.2	6.1	1.6	3.9
5	3.8	3.5	3.6	3.6	2.6	3.1
6+	2.1	6.6	4.6	4.5	5.3	4.9
Person who administered last injection received in last 12 months*						
Doctor	57.4	50.2	53.4	67.2	61.4	64.3
Nurse	37.1	43.2	40.5	15.4	26.0	20.7
Pharmacist	0.8	0.7	0.8	1.0	1.0	1.0
Drug vendor	0.4	0.3	0.4	0.3	0.0	0.2
Self	0.0	0.3	0.2	0.3	0.6	0.5
Friends or family	0.4	1.4	1.0	2.9	1.0	1.9
Local injection doctor	2.5	3.5	3.1	11.9	8.1	10.0
Other	1.3	0.3	0.8	1.0	1.9	1.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to adolescents who received an injection in the last 12 months. Sample sizes: females 12-14 (N=237); females 15-19 (N=287); males 12-14 (N=309); males 15-19 (N=304). *Note:* Ns are weighted.

Chart 8.1 Adolescents' self-perceived risk of HIV, by sex and age, 2004 National Survey of Adolescents

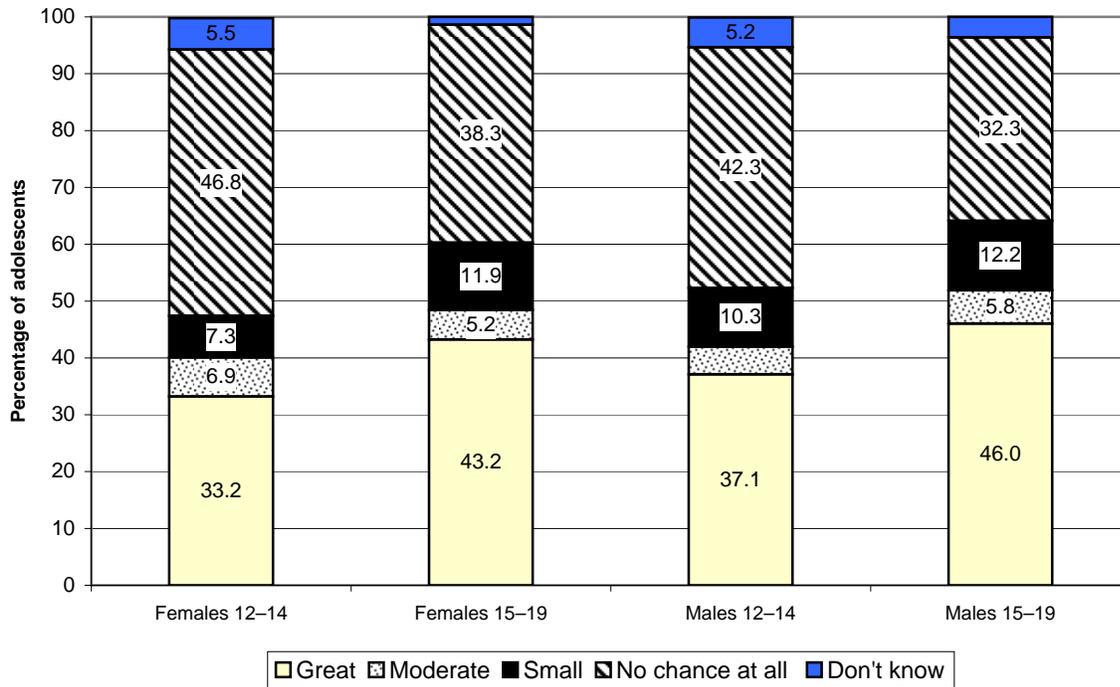


Chart 8.2 Self-perceived risk of HIV among 15-19-year-old females, by union status, 2004 National Survey of Adolescents

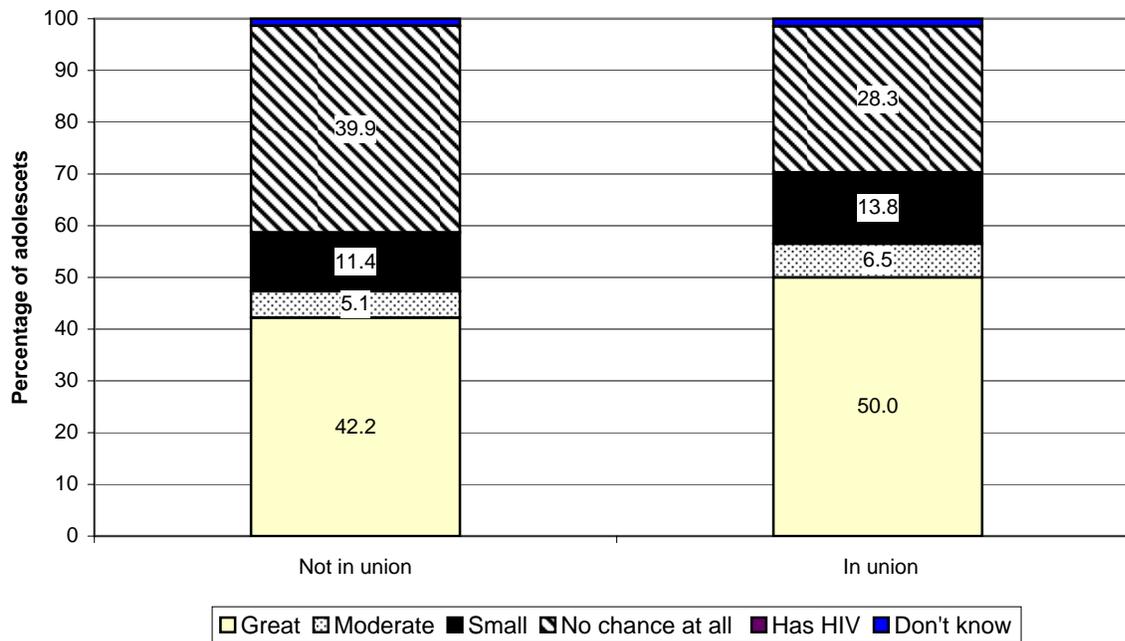


Chart 8.3 Sexual behavior and condom use at last sex among female 12–19-year-olds, 2004 National Survey of Adolescents

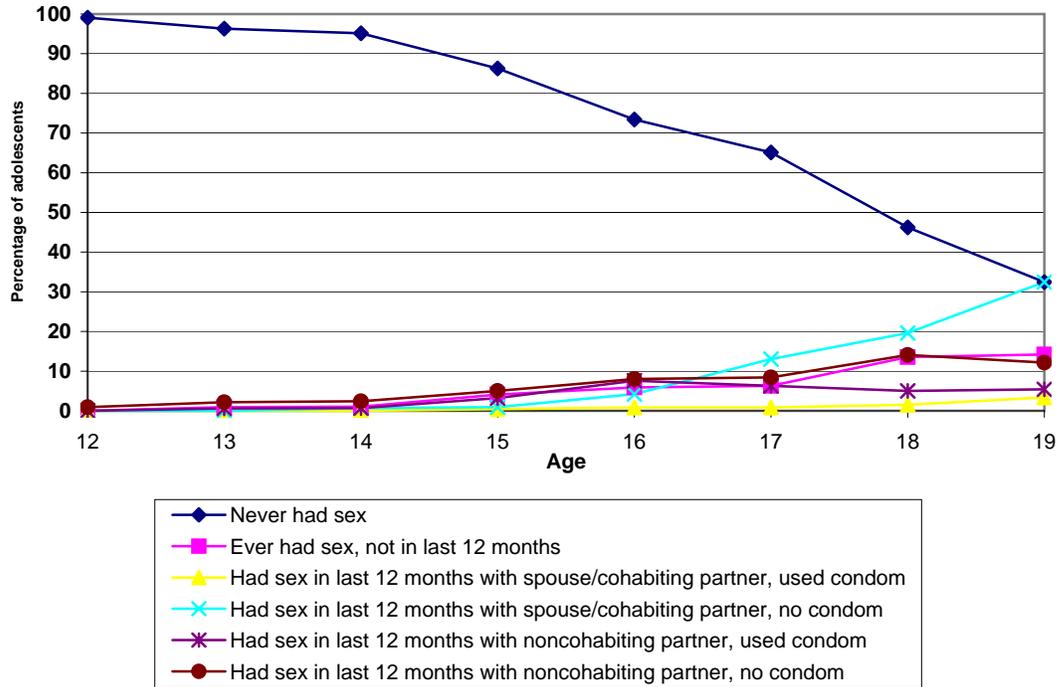


Chart 8.4 Sexual behavior and condom use at last sex among male 12–19-year-olds, 2004 National Survey of Adolescents

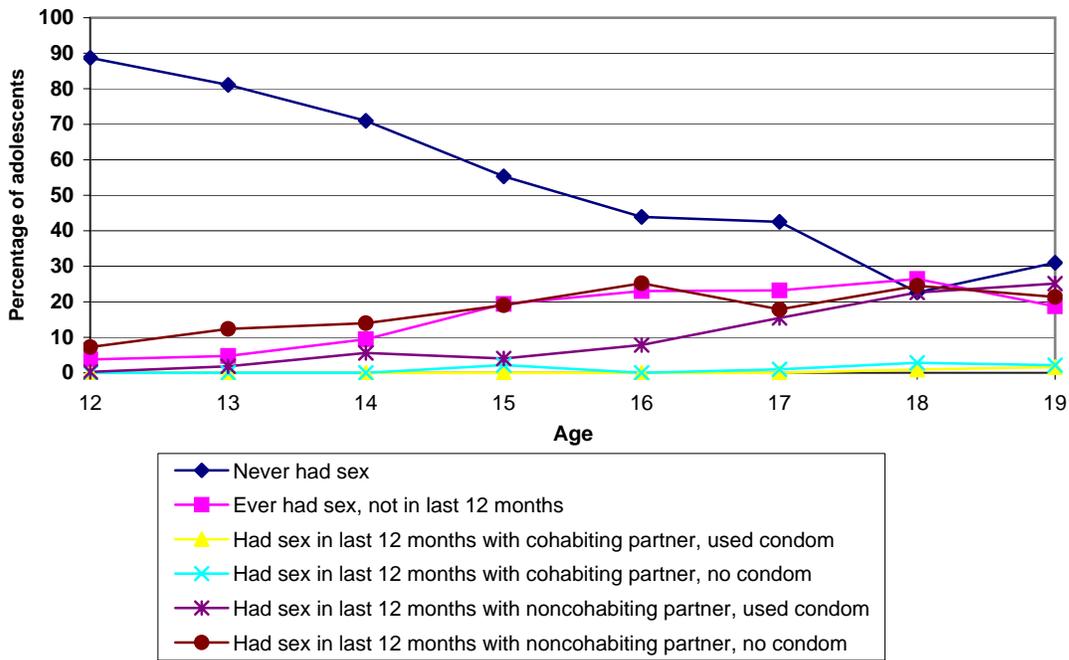


Chart 8.5 Sexual behavior and condom use at last sex among female 12–19-year-olds who had sex in last 12 months, 2004 National Survey of Adolescents

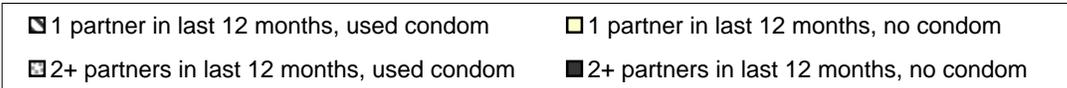
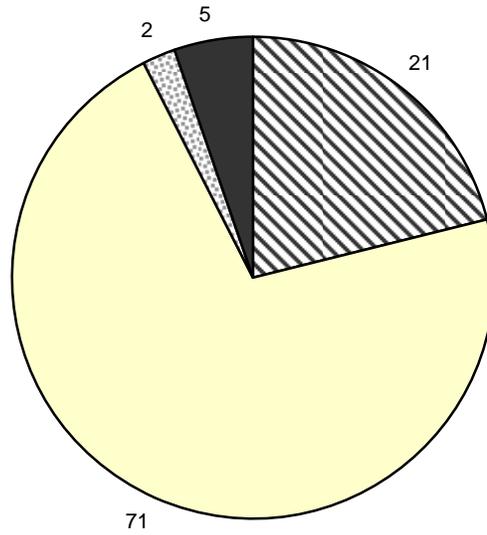
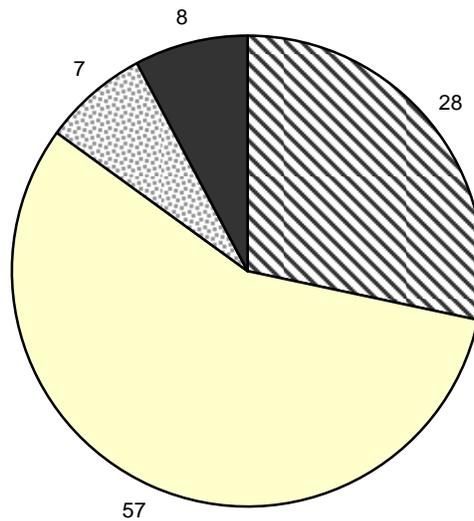


Chart 8.6 Sexual behavior and condom use at last sex among male 12–19-year-olds who had sex in last 12 months, 2004 National Survey of Adolescents



Chapter 9

Sexual and Reproductive Health Information and Services

This chapter addresses adolescents' awareness, preferences, evaluations and utilization of different types of information sources and health providers for contraceptive methods, STI treatment, HIV prevention, and voluntary counseling and testing for HIV. We present results according to type of provider (modern versus traditional) and for the public versus private sectors, as this is relevant for determining policy and program implications. Adolescents' reports of barriers to obtaining information and treatment for different sexual and reproductive health problems are also described.

Mass Media

The mass media are one means of conveying information to adolescents and to the public at large. An advantage for this mechanism is that it has the potential to reach the general population and its potential audience is less constrained than some other mechanisms (e.g., formal sex education is constrained by school attendance). Mass media's disadvantage is that not everyone has access. This is evidenced by the data displayed in Table 9.1, which gives the frequency with which adolescents listen to the radio, watch television and read magazines, among other media sources. Information from this table indicates the lack of access as given by the results that 21% among females and 11% among males did not listen to the radio at all; 72% of the females and 49% of the males did not watch television; whilst 60% of females and 55% of males who ever went to school had never read a newspaper or magazine. In general, the problem of access to mass media appears to affect females more than males.

The data show that the radio was the most accessible media source for adolescents, as measured by the frequency with which they listened. Almost 42% of the females and 54% of the males listened to the radio almost daily. Only 7% of females and 9% of males watched television daily, and 15% of females and 29% of males watched television less than once a week. Fourteen percent of females and 11% of males who

ever attended school read a newspaper or magazine at least once a week.

The table also gives the level of exposure to mass media. Overall, 40% of females and 31% of males were exposed to just one mass media source, 27-28% were exposed to two sources and 17% of females and 33% of males were exposed to three or more mass media sources. Sixteen percent of females and only 9% of males had no exposure to mass media.

The 2004 Malawi National Survey of Adolescents (MNSA) is the first survey conducted in Malawi that collected information on the use of the Internet among adolescents who ever attended school. The results show that irrespective of both age and sex, fewer than 1% of the adolescents reported having ever used the Internet. This indicates the scarcity of the Internet in Malawi.

Sex Education Experiences and Attitudes

This section discusses the adolescents' schooling status and their exposure to sex education in schools. Chart 9.1 shows that the proportion of adolescents who never attended school is small (3% of females and 2% of males). However, 67% of females and 61% of males reported having attended schools that did not offer any classes or talks on sex education. In a smaller number of cases, adolescents have attended schools which offer sex education but have not attended the sex education classes or talks. Females were less likely than males to have attended those talks (16% versus 11%). Only 14% of females and 26% of males had received some kind of sex education in school.

According to the 2004 Malawi Demographic and Health Survey, the median age at first sex for women was estimated at 17.4 years and that of males was estimated at 18.1 years (among 20–24-year-olds).⁴⁵ The MNSA data indicate that the receipt of sex education classes for those adolescents who ever attended a sex education class or talk is most frequently happening before first sex. Table 9.2 shows that 73% of females

and 64% of males, had received sex education before the age of 15. In addition, a considerable proportion of these, 28% of females and 20% of males had received sex education before the age of 12. According to adolescents, about 93% of the females and about 73% of the males who attended sex education classes or talks did so before first sex.

For those who had ever attended a sex education class or talk, the content varied. According to respondents, STIs were the most frequently covered topic for females and the second most frequently covered topic for males. Abstinence was the topic most frequently covered for males and second most frequently covered for females. Contraception was next, followed by how pregnancy happens. The difference in content between the two genders may be a result of sex segregation in the classroom or perhaps simply recall differences that are influenced by gender. Irrespective of sex, more of the 15–19 age-group reported having covered these topics compared with the 12–14-year-olds.

The methods utilized in conducting these classes were mainly lectures, small group discussions and role plays. Lectures were the most common method (experienced by 66% of females and 87% of males who received sex education), while more interactive teaching approaches like small groups and role plays were used less extensively. Videos or films had only been used by about 6% of the adolescents. The majority of the classes were conducted by teachers. Females were also asked if they had ever received any information on sex-related matters from *anankungwi*, or traditional initiators. Only 6% of the females had received such information (data not shown).

Some key stakeholders on adolescent sexual and reproductive health in Malawi, such as faith-based groups and some parents, argue that teaching sex education encourages young people to have sex. However, the results of the 2004 MNSA survey show that the majority of adolescents who ever attended school did not agree with this notion. Information given in Table 9.3 indicates that 68% of both females and males disagreed with this idea. Another 67% of females and 73% of males felt that it is important for sex education to be taught in schools. Adolescents were also asked whether “how to avoid AIDS” and “using a condom to avoid AIDS” should be taught to 12–14-year-olds in schools. Over 70% of the adolescents irrespective of sex said yes to each of the two questions.

Information and Service Sources for Contraceptive Methods

The data collected in the 2004 MNSA survey included information sources for contraceptive methods, as well as the preferred sources of such information. Questions soliciting this information were asked of adolescents who knew at least one method. The responses were spontaneous in that the answer categories were not read out to the adolescent. The results of the analysis of the data from these questions are given in Table 9.4. Teachers or health providers were the major sources of information on contraception. More adolescents aged 15–19 mentioned health care providers or teachers than those aged 12–14. Mass media was the next most common source. Family members were the least common source of information on contraception for adolescents: Only one in five males and approximately one in three females reported getting information from family.

Regarding the types of mass media used, the data show that the radio is a major source of contraceptive information. The data suggest that males might have greater access to the radio than females. Friends of the same sex are another important source of information. Friends of the opposite sex are a negligible source of contraceptive information for adolescents.

Adolescents prefer to get their health information from health providers, while teachers rank a distant second. Though the radio is one of the important sources of information, few adolescents reported the radio as a preferred source. There is a big discrepancy between adolescents’ current sources of information on contraception and their preferred sources. While health workers are the most commonly mentioned current and preferred source of this information, considerably fewer adolescents who currently get information from family members, friend, teachers and the mass media would prefer these sources. As stated earlier, the MNSA is the first survey that has included the Internet as one of the mass media sources where adolescents can seek information. No adolescents named the Internet as their preferred source of information.

Charts 9.2 and 9.3 reveal rural-urban differentials for males and females in the information sources for contraception methods used. These differences are expected because there is a greater scarcity of health centers, doctors and nurses in the rural areas than in urban areas. Contraceptive methods are only offered in 57 static government health facilities and only 10% of these provide a full range of contraceptive options. At 417, the number of Malawi government and Christian Hospital Association of Malawi health centers are well

short of the required 1,000 to meet optimal standards.* Coupled with this is the problem of access: In rural areas, one has to travel long distances to get to the nearest health center. Therefore, health centers in rural areas are mainly visited when there is a pressing need to do so, making it unlikely that an adolescent would travel the long distance to a health center simply to get information on contraceptives. A reason why teachers may also be a less utilized source of information on contraceptives in rural areas is that most rural schools experience shortages of teachers, limiting his/her time to talk about contraception. Chart 9.4 shows information sources for contraceptive methods used and preferred among adolescents who know at least one method. For both males and females, teachers and health workers constituted the most important source of information on contraceptive methods, followed by any mass media and friends. Both males and females preferred teachers/health workers as sources of information on contraceptive methods.

Table 9.5 gives information on barriers to obtaining contraceptive methods among adolescents who knew at least one method. The responses were spontaneous in that the answer categories were not read out to the adolescent. The major barriers adolescents experienced are feeling embarrassed or shy as well as being afraid or fearful, which were more prevalent among females and 15–19-year-olds than males and younger adolescents. More females' than males' ability to get contraceptives was curtailed by the fact that females are not allowed to go alone to where contraceptive methods are obtained. Almost all barriers affect a larger proportion of females than of males, except knowing where to go to get contraceptives. Eighteen percent of females and 16% of males reported experiencing no barriers to obtaining contraceptive methods and there were no substantial age differentials on this.

Table 9.6 summarizes known and preferred contraceptive sources among adolescents who know at least one method. Government clinics/hospitals are the most well-known source for contraceptive method, as well as being the most preferred source of methods. The fact that health care in government clinics and hospitals is free in Malawi could contribute significantly to the result that they are the most preferred sources of contraceptive methods. The second most well-known source is the private clinic/hospital/doctor (30% of females and 20% of males). However, this source is only preferred by about 5% of the females and 3% of the males who know any sources for contraceptives. Banja La Mtsogolo (BLM) is the third most well-known source

and the second most preferred source. BLM is a non-governmental organization and a leading provider of sexual and reproductive health services, including contraceptive services. It operates 29 clinics through which it conducts outreach programs to remote areas. About 17% of females and 20% of males preferred BLM (while about 23% of females and males reported it as a current source). Yet it is noteworthy that over a third of adolescents who knew of at least one contraceptive method did not know of any sources for obtaining contraceptives.

Information was also solicited on the perceptions of government clinics or hospitals as sources of contraceptive methods among adolescents who knew this source and knew of at least one method. Table 9.7 shows that 85% of adolescents perceived that the information shared at a government clinic or hospital would be confidential. Even more perceived that it would be easy to get there and also that they would be treated with respect. A slightly lower proportion perceived that they would be able to pay for the services if there were charges. In general, adolescents' perceptions of government clinics or hospitals as a source of contraceptive methods are positive as given by the fact that only about 35% of the adolescents gave a negative response to one or more of the queried dimensions of care.

Table 9.8 shows adolescents' perceptions of their most preferred source for contraceptive methods among those who knew at least one method. The perceptions asked about were the same dimensions as above: confidentiality, respect and accessibility for government clinics/hospitals, private clinics/hospitals and drug shops. While government services continued to be the preferred source of contraceptive methods, the most important barrier to not only this source but private sources as well was the perceived inability to pay for the services.

Table 9.9 shows source of contraceptive methods ever used by adolescents. The sample size for the adolescents that actually used sources of contraceptive methods was very low, especially for 12–14-year-olds. Eighty percent of the females and 56% of the males had ever used government clinics/hospitals to get contraceptive methods, compared with the 20% of females and 7% of males who used BLM. Eleven percent of females and 4% of males had ever used private clinics/hospitals. None of the females had ever used drug shops or pharmacies, while 31% of the males reported

*According to a 1994 paper prepared by the World Bank called Better Health for Africa, it is estimated that a standard ratio of one health centre per a population of 10,000 is sufficient to meet optimal standards.

having done so because they are a common source of condoms.

Mass media is one of the important channels through which messages about family planning can be given to adolescents. Table 9.10 shows that the mass media messages to which the adolescents were most exposed originated from the radio, health workers and community or social club meetings with the radio leading the rest. Very few adolescents were exposed to family planning messages from a leaflet or brochure (8%). The table also indicates that 15–19-year-olds had a significantly higher level of exposure to all media sources than 12–14-year-olds, irrespective of sex.

Information and Service Sources for STIs

Similar questions to the ones asked to adolescents concerning sources for contraceptive methods used and preferred were also asked about sources of information about STIs (apart from HIV/AIDS). Table 9.11 shows that teachers or health providers were the major source of information on STIs followed by the mass media. A third of the adolescents who knew of any STIs mentioned friends while family was the least cited source of information on STIs. A higher proportion of females than males mentioned teachers/health providers and family members as sources of information, while more males said they got their information from the media.

The major source of information on STIs differed by sex. For females, doctors/nurses/clinics were the most important source of information on STIs, followed by teachers, the radio and female friends. Among males, the radio was the most important source of information on STIs, followed by teachers, doctors or nurses and male friends. With the advent of HIV/AIDS, anti-AIDS clubs have been established throughout Malawi to help young people develop improved critical thinking and communication skills. Approximately one in five respondents mentioned these clubs as sources of information on STIs.

On preferred sources of information on STIs among adolescents who knew of a source, health providers were the most preferred source of information for both males and females. This was followed by teachers and then the radio. While more females than males preferred health providers and teachers, more males than females preferred the radio as a source of information on STIs. Approximately 10% of the females preferred female friends. The Internet was not a preferred source of information for anyone.

Adolescents who did not know of any STIs (apart from HIV/AIDS) were asked where young people

could get information about infections people get from sexual contact. Table 9.12 shows that the vast majority of adolescents (more than four in five) did not know of any source young people could go to for such information. Of those who did name a source, doctor/nurse/clinic was the most common source known by both females (9%) and the males (14%).

Table 9.13 gives information on barriers to obtaining advice or treatment for STIs among adolescents who knew of any STIs. As in the earlier section, the responses reported on information sources and barriers involving STI advice and treatment were spontaneous: The answer categories were not read out to the adolescents. Just as was the case with contraceptive methods, the table shows that the major barriers are feeling embarrassed or shy and feeling afraid or fearful. The latter was more common among females than it was among males. A higher percentage of the 15–19-year-olds mentioned these barriers than did their younger counterparts, irrespective of sex. The other barrier that affected females (4%) more than males (6%) was the idea that privacy would not be respected. In general, almost all barriers were cited by more females than by males, irrespective of age, except the barriers of not being treated nicely by a staff member. Approximately one in ten reported experiencing no barriers to obtaining STI advice or treatment.

Table 9.14 summarizes data on sources known and sources most preferred to get treatment for STIs among adolescents who know of any STI. Government clinics/hospitals was the most well-known and the most preferred source for STI treatment. As pointed out before, health care in government clinics and hospitals is free in Malawi. This could contribute significantly to the result that the government clinic/hospital was also the most preferred source to get treatment for STIs. The second most well-known source to get treatment for STIs was the private clinic/hospital/doctor followed by BLM. However, only about 4% of the females and 5% of the males preferred private clinics/hospitals/doctors, probably because the adolescents cannot afford the cost of the treatment. About 11% of the adolescents preferred BLM for STI treatment.

Information was also solicited on the perceptions of government clinics or hospitals as a source to get treatment for STIs among adolescents who knew this source and knew of any STIs. Table 9.15 shows that 80% or more adolescents of both sexes, irrespective of age, perceived that the STI information shared at a government clinic or hospital would be confidential. Similarly, over 90% perceived that it would be easy to get

there and close to 90% believed that they would be treated with respect. About 78%, perceived that they would be able to pay for the STI treatment at the government clinics or hospitals. In general, adolescents' perceptions about government clinics or hospitals as a source to get STI treatment are positive considering that only about one-third of the respondents gave a negative response to at least one of the above dimensions.

Data collected in the MNSA included adolescents' perceptions of their most preferred source for STI treatment among those who knew any STIs. Data on perceptions included the same dimensions as above (namely, confidentiality, respect and accessibility) and covered government clinics/hospitals, private clinics/hospitals and nongovernmental organizations. Table 9.16 shows that the most important barrier to all of these preferred sources of STI treatment was perceived to be the ability to pay for the services.

The number of adolescents who reported to have ever experienced STI symptoms and reported a treatment was small. Very few 12–14-year-old adolescents had ever gone for STI treatment, whilst a larger percentage in the older age-group, especially among females (44%), had ever gone for treatment. The corresponding percentage among males was 33%. The data further show that 55% of the females and 69% of the males had used government clinics/hospitals as a service source at the latest visit. Almost a third had visited a traditional or spiritual healer. Very few adolescents had utilized private clinics or hospitals at the last visit. The majority who did not go for treatment were embarrassed, did not want other people to know or did not know where to go. The preferred source was a government clinic/hospital.

Information Sources and Exposure to Mass Media Messages About HIV/AIDS

The data collected in 2004 included actual and preferred sources of information on HIV/AIDS. Questions soliciting this information were asked of adolescents who knew of HIV/AIDS. Table 9.18 shows that teachers and health providers are collectively the main source of information for HIV/AIDS, where about 77% of the females and 67% of the males reported having gotten information from this source. Forty percent of the females and about 27% of the males did not indicate mass media as a source of information about HIV/AIDS. The data indicate that 32% of females and 22% of males received HIV/AIDS information from a family member.

The radio was a major source for HIV/AIDS infor-

mation as reflected by the finding that 59% of the females and 71% of the males reported it as an information source, indicating a higher level of access to the radio for males, compared with females, as far as HIV/AIDS is concerned. The table further shows that friends of the same sex are another important source of information as reported by about 36% of the females and 42% of the males. Friends of the opposite sex are a negligible source of information for HIV/AIDS to adolescents.

Health providers are the most preferred source for both females (56%) and males (about 47%) who know any source, whilst teachers are a preferred source to a lesser extent (26% among females and 25% among males). Very low percentages reported preferring any of their relatives as sources of information for HIV/AIDS. Though the radio was one of the important sources of information, only about 20% of the females and 25% of the males indicated the radio as their preferred source of information.

Table 9.19 indicates that the 15–19-year-olds had a higher level of exposure to all media sources than the 12–14-year-olds. The media messages to which the adolescents were most exposed to originated from the radio, health workers, and community or social club meetings. Leaflets or brochures were not a major source of information (13% of females and 12% of males).

Further tabulations were made that indicated the level of adolescents' exposure to HIV/AIDS messages in recent months. The table shows high levels of exposure to HIV/AIDS messages: 41% of females and 53% of males had been exposed to 3–7 messages in recent months. This may be due to the increased initiative by the Malawi government and other stakeholders in trying to sensitize the masses about the dangers of HIV/AIDS. When prompted, about 61% of females and 67% of males had heard of "TOTO Clubs" or anti-AIDS clubs. TOTO clubs are for in- and out-of-school youth and are designed to help members develop improved skills in critical thinking and communication. Among other activities, these clubs are involved in HIV/AIDS-related activities, including drama, debates, quizzes and sports, aimed at increasing awareness about HIV and AIDS and helping young people change the behavior of their fellow youth.⁴⁶ Another source of slogans is Population Services International that has a program called Youth Alert that addresses Malawian youths on HIV/AIDS and other related issues. When prompted, 50% of the females and 61% of the males who knew of HIV/AIDS had heard of the slogan

“Youth Alert.” “Why wait?” is part of lessons addressing issues dealing with HIV/AIDS included in the education curriculum of some of the primary and secondary schools in Malawi. The data show that when prompted about 25% of females and 19% of male adolescents had heard of the “Why wait?” slogan. More older adolescents 15–19 had heard about the slogan “My future, my life”, compared with younger adolescents. Among older adolescents, males (66%) were more likely to have heard about this compared with females (54%).

HIV Voluntary Counseling and Testing

Information on HIV voluntary counseling and testing was collected, and some of this information is summarized in Chart 9.5. There were a considerable number of adolescents—15% of the females and 12% of the males—who knew of HIV/AIDS but did not know of the test to diagnose the disease. Only 8% of the females and 7% of the males had heard about HIV/AIDS as well as the fact that an HIV/AIDS test is available but did not know where testing services were offered. And 69% of females and 73% of males had heard about the HIV/AIDS test and a place or places where the test was offered, but had never been tested. There were more of the 15–19-year-olds who had heard of HIV/AIDS and of a place or places to get tested but had not been tested, compared with the 12–14-year-olds, irrespective of sex. Very low proportions of females and males (3%) had actually been tested.

Table 9.20 shows testing experiences for HIV among adolescents according to sex and age. Though the numbers of those who had been tested was low, most of them indicated that the main reason for having the test was to know their status. For some, the main reason they were tested was because they were receiving prenatal care (14% of females tested), while for others the main reason was because they were encouraged by a peer counselor or educator to get tested (9% of females and 6% of males). The HIV/AIDS tests were mainly received at a government clinic or hospital, followed by Malawi Counselling and Resource Organisation (MACRO) and private clinics or hospitals. Almost all adolescents who were tested, over 95%, received counseling at the time of test, as well as the results of the test. As can be seen from Table 9.21, 15% of females and 9% of males who knew of a place to get tested indicated that a person has to pay to get tested, despite the fact that government clinics/hospitals and at MACRO, which are the places the majority of the adolescents knew, do not charge for these services.

However, knowing a place where one can get tested does not necessarily mean that he or she knows what happens in the facility where this service is offered.

About 71% of the females and 79% of the males indicated that they would want to be tested for HIV/AIDS, as can be seen in Table 9.22. Those who wanted to be tested but had not been tested were asked why they had not been tested. The majority, about 44% among females and 33% among males, said that they had not been tested because they were not at risk. Another 25% of the females and 24% of the males had not been tested because they were not sexually active. Among those who did not want to be tested, 21% of the females and 15% of the males did not want to know their status.

Policy and Programmatic Implications

- This study has shown that adolescents get information on contraceptive methods and STIs (including HIV/AIDS) from different sources: health workers, mass media, friends and teachers. Programs should aim at reaching as many adolescents as possible and hence a multiplicity of methods should be used in order to reach as many adolescents as possible. In Malawi, almost every adolescent had been to school, therefore schools could be used to reach adolescents with sex education.
- The use of internet as a source of information on sexual and reproductive health issues need to be promoted. While increasing availability is important, at the same time the is need to provide the requisite skills to young men and women on how this service can be used, including the type of information that can be accessed through this.
- Media messages should be backed up with information on services and where adolescents can obtain those services. Such information can be broadcasted via the same media messages that promote contraceptive knowledge.
- Although almost all adolescents know of HIV/AIDS, very few have been tested for it. More emphasis has to be put on encouraging adolescents to obtain for HIV/AIDS tests.

TABLE 9.1 Percentage distribution of adolescents, by exposure to mass media, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=941)	15-19 (N=1052)	Total (N=1993)	12-14 (N=907)	15-19 (N=1127)	Total (N=2034)
Frequency of listening to the radio						
Almost every day	42.3	40.8	41.5	50.2	56.3	53.6
At least once a week	18.8	21.1	20.0	16.5	17.7	17.2
Less than once a week	18.3	16.3	17.3	19.3	17.2	18.1
Not at all	20.6	21.8	21.2	14.0	8.7	11.1
Frequency of watching television						
Almost every day	6.4	7.3	6.9	8.3	9.4	8.9
At least once a week	4.8	7.5	6.2	12.5	13.0	12.7
Less than once a week	14.5	14.9	14.7	26.8	31.5	29.4
Not at all	74.3	70.3	72.2	52.5	46.1	49.0
Frequency of reading a newspaper or magazine*						
Almost every day	3.3	4.1	3.7	2.9	5.0	4.1
At least once a week	11.1	16.7	14.0	8.4	13.4	11.2
Less than once a week	22.5	23.0	22.8	23.5	35.3	30.0
Not at all	63.1	56.1	59.5	65.2	46.2	54.7
Number of mass media sources†						
0	15.7	16.1	15.9	11.0	6.7	8.6
1	42.7	36.7	39.5	35.2	28.4	31.4
2	26.3	28.8	27.6	28.9	25.7	27.1
3 or more	15.3	18.4	16.9	24.9	39.3	32.9
Ever used the internet*						
Yes	0.2	0.6	0.4	0.6	0.6	0.6
No	61.7	71.8	67.0	56.5	64.3	60.8
Don't know internet	38.1	27.6	32.6	43.0	35.0	38.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Question asked of those who ever attended school. Sample sizes: females 12-14 (N=926); females 15-19 (N=1929); males 12-14 (N=893); males 15-19 (N=1095). †Media sources include radio, television and newspaper. Note: Ns are weighted.

TABLE 9.2 Percentage of adolescents, by exposure to, content of and form of sex education, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=943)	15–19 (N=1054)	Total (N=1997)	12–14 (N=907)	15–19 (N=1126)	Total (N=2033)
Ever attended school						
No	1.7	4.6	3.2	1.4	2.8	2.2
Yes	98.3	95.4	96.8	98.6	97.2	97.8
Any of respondent's schools offered any classes or talks on sex education*						
Yes	30.4	30.8	30.6	31.2	42.7	37.6
No	68.5	69.0	68.8	67.0	56.3	61.1
Don't know	1.1	0.2	0.6	1.8	1.0	1.4
Ever attended sex education classes or talks†						
Yes	42.6	48.1	45.4	60.6	75.2	69.7
No	57.4	51.9	54.6	39.4	24.8	30.3
Age when first attended sex education classes or talks‡						
<12	48.7	12.0	28.3	41.4	9.3	19.7
12	21.8	12.7	16.7	24.9	6.2	12.3
13	25.2	18.0	21.2	25.4	11.6	16.1
14	0.8	12.0	7.1	7.1	20.4	16.1
15	0.0	22.0	12.3	0.0	24.4	16.5
16	0.0	12.0	6.7	0.0	13.9	9.4
17–19	0.0	10.7	5.9	0.0	13.3	9.0
Don't know	3.4	0.7	1.9	1.2	0.8	1.0
Attended sex education classes or talks before first sex‡						
No	0.0	12.8	7.2	11.9	33.7	26.6
Yes	100.0	87.2	92.8	88.1	66.3	73.4
Subjects covered in classes/talks‡						
How pregnancy happens	40.8	71.8	58.0	49.4	74.4	66.3
Contraception/how to prevent pregnancy	52.5	73.8	64.3	55.6	83.0	74.1
Abstinence/say 'no' to sex	72.5	89.3	81.8	84.6	91.2	89.1
STIs and other diseases	73.3	93.3	84.4	74.0	93.2	86.9
How classes/talks were conducted‡						
Lecture	67.5	65.1	66.2	81.7	89.5	87.0
Small group discussion	40.0	48.3	44.6	33.1	44.0	40.5
Role play	25.2	24.8	25.0	21.9	25.2	24.1
Video/film	5.9	6.0	6.0	7.7	4.5	5.6
Other	0.0	0.0	0.0	0.0	0.6	0.4
Don't know	0.0	0.0	0.0	0.0	0.0	0.0
Who mainly led the classes/talks‡						
Teachers	86.6	74.3	79.8	89.3	89.5	89.5
Students	8.4	14.9	12.0	4.7	4.5	4.6
Nurses	3.4	8.8	6.4	4.7	5.1	5.0
Other	1.7	2.0	1.9	1.2	0.8	1.0
Don't know	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who have attended school. Sample sizes: females 12–14 (N=927); females 15–19 (N=1006); males 12–14 (N=894); males 15–19 (N=1095). †Limited to those who reported any schools offered sex education classes or talks. Sample sizes: females 12–14 (N=282); females 15–19 (N=310); males 12–14 (N=279); males 15–19 (N=468). ‡Limited to those who ever attended a sex education class or talk. Sample sizes: females 12–14 (N=119); females 15–19 (N=150); males 12–14 (N=169); males 15–19 (N=353). Totals may exceed 100 because multiple responses are possible for subjects covered and how classes/talks were conducted. *Note:* Ns are weighted.

TABLE 9.3 Adolescents, by attitudes about sex education, condoms and AIDS instruction, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=927)	15–19 (N=1006)	Total (N=1933)	12–14 (N=894)	15–19 (N=1095)	Total (N=1989)
It is important for sex education to be taught in schools*						
Agree	65.4	68.7	67.1	69.9	75.3	72.9
Disagree	32.4	30.3	31.3	27.4	24.6	25.8
Don't know	2.3	1.0	1.6	2.7	0.2	1.3
Discussing sex education with young people encourages young people to have sex*						
Agree	28.5	31.1	29.9	26.8	30.2	28.7
Disagree	68.3	68.1	68.2	67.6	68.5	68.1
Don't know	3.2	0.8	2.0	5.6	1.3	3.2
12–14-year-olds should be taught about how to avoid AIDS†						
Yes	72.8	83.8	78.7	68.0	79.6	74.6
No	26.9	15.7	20.9	31.7	20.3	25.1
Don't know	0.2	0.5	0.4	0.4	0.2	0.3
12–14-year-olds should be taught about using a condom to avoid AIDS‡						
Yes	66.8	80.8	75.5	63.9	77.8	72.7
No	32.3	19.0	24.0	34.9	21.9	26.7
Don't know	0.9	0.3	0.5	1.2	0.2	0.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Question asked of those who ever attended school. †Limited to those who have heard of AIDS. Sample sizes: females 12–14 (N=872); females 15–19 (N=1019); males 12–14 (N=821); males 15–19 (N=1111). ‡Limited to those who have heard of AIDS and male condom. Sample sizes: females 12–14 (N=449); females 15–19 (N=743); males 12–14 (N=498); males 15–19 (N=853). *Note*: Ns are weighted.

TABLE 9.4 Percentages of adolescents who know of at least one contraceptive method, by used and preferred sources of information about methods, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=684)	15–19 (N=957)	Total (N=1641)	12–14 (N=714)	15–19 (N=1077)	Total (N=1791)
Where respondent got information about contraceptive methods*						
Any family	29.7	30.1	29.9	20.1	20.5	20.4
Any friends	45.1	46.5	45.9	47.3	47.5	47.5
Any teacher or health provider	62.7	74.8	69.8	49.7	65.5	59.1
Any mass media	44.7	51.1	48.4	55.5	60.8	58.7
Mother	10.8	10.4	10.6	3.7	2.9	3.2
Father	1.0	2.6	2.0	2.9	4.7	3.9
Spouse/partner	0.0	0.3	0.2	0.0	0.1	0.1
Brother	0.4	0.2	0.3	3.0	2.9	3.0
Sister	3.2	1.7	2.3	1.2	0.7	0.9
Other female family member	19.4	21.0	20.3	4.9	4.1	4.4
Other male family member	1.2	0.2	0.6	10.2	11.6	11.0
Female friends	43.6	46.0	45.0	3.4	3.3	3.3
Male friends	5.0	2.8	3.7	45.7	46.1	45.9
Teacher/school	44.0	45.0	44.6	37.0	48.4	43.8
Doctor/nurse/clinic	41.1	59.6	51.9	24.6	41.2	34.5
Banja la Mtsogolo	5.8	8.8	7.6	4.6	13.1	9.7
Traditional or spiritual healer/herbalist	0.7	2.5	1.8	0.0	1.3	0.8
Church	4.7	8.0	6.6	3.0	5.0	4.2
Community/neighborhood	n/a	n/a	n/a	n/a	n/a	n/a
Newspaper	4.1	5.4	4.9	1.4	9.5	6.3
Books/magazines	2.5	2.9	2.7	3.0	9.4	6.8
Radio	43.1	49.8	47.0	53.6	59.1	56.9
Television	3.7	4.7	4.3	6.1	9.4	8.1
Internet	0.0	0.0	0.0	0.0	0.0	0.0
Poster/billboard	0.4	0.8	0.7	1.5	3.3	2.6
Other	4.7	4.8	4.8	7.6	12.0	10.3
Don't Know/unsure	6.7	5.4	6.0	11.4	2.8	6.2
Preferred sources for information about contraceptive methods*						
Any family	7.8	4.5	5.9	6.2	4.3	5.0
Any friends	11.4	9.6	10.3	12.7	8.6	10.2
Any teacher or health provider	69.6	77.8	74.4	53.4	64.5	60.1
Any mass media	18.3	14.4	16.0	18.6	19.3	19.1
Mother	4.3	2.1	3.0	2.2	0.7	1.3
Father	0.6	0.6	0.6	1.4	1.3	1.3
Spouse/partner	0.0	0.0	0.0	0.0	0.0	0.0
Brother	0.0	0.0	0.0	1.1	0.5	0.7
Sister	0.7	0.5	0.6	0.4	0.2	0.3
Other female family member	2.9	2.2	2.5	1.1	1.0	1.1
Other male family member	0.1	0.1	0.1	1.8	1.3	1.5
Female friends	10.9	9.3	10.0	0.8	0.6	0.7
Male friends	0.7	0.5	0.6	11.9	8.0	9.6
Teacher/school	20.8	14.5	17.1	17.8	18.7	18.3
Doctor/nurse/clinic	57.8	70.2	65.0	39.6	52.0	47.0
Banja la Mtsogolo	5.9	10.9	8.8	5.9	16.0	12.0
Traditional or spiritual healer/herbalist	0.7	0.4	0.6	0.4	1.1	0.8
Church	1.6	2.2	2.0	0.6	2.3	1.6
Newspaper	0.6	0.6	0.6	0.4	0.5	0.4
Books/magazines	0.0	0.2	0.1	0.1	1.0	0.7
Radio	17.7	13.8	15.4	17.8	18.2	18.0
Television	0.3	0.6	0.5	0.6	1.2	0.9
Internet	0.0	0.0	0.0	0.0	0.0	0.0
Poster/billboard	0.0	0.0	0.0	0.0	0.2	0.1
Other	2.4	3.1	2.8	3.2	7.6	5.9
Don't know	9.6	6.2	7.6	16.7	6.2	10.4

*Totals may exceed 100 because multiple responses are possible. Note: Ns are weighted.

TABLE 9.5 Percentages of adolescents who know of at least one contraceptive method, by perceived barriers to obtaining methods, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=685)	15–19 (N=958)	Total (N=1643)	12–14 (N=735)	15–19 (N=1090)	Total (N=1825)
Barriers*						
No barriers	19.6	17.6	18.4	16.7	16.1	16.4
Not knowing where to go	4.1	5.4	4.9	6.9	9.0	8.2
Not knowing how to get there	3.2	3.0	3.1	3.0	5.2	4.3
Inconvenient hours/days	2.0	2.4	2.3	1.2	2.7	2.1
Privacy not respected	4.5	12.3	9.1	1.4	7.2	4.8
Not treated nicely by person/staff	3.2	6.3	5.0	3.8	10.8	8.0
Costly/not able to pay for services	5.1	8.5	7.1	3.7	7.5	6.0
No same sex provider	2.9	3.8	3.4	0.4	2.3	1.5
Not being allowed to go alone	10.1	10.0	10.1	0.4	2.5	1.6
Afraid or fearful	28.4	34.9	32.2	11.7	19.1	16.1
Embarrassed or shy	27.8	37.4	33.4	18.5	33.2	27.3
Too young	0.1	0.1	0.1	0.4	0.5	0.4
Feel bad/spoiled	n/a	n/a	n/a	n/a	n/a	n/a
Other	0.3	2.2	1.4	0.5	2.7	1.8
Don't know	35.6	25.5	29.7	50.3	31.8	39.3

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 9.6 Percentage distribution of adolescents who know of at least one contraceptive method, by known and preferred sources for methods, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=684)	15–19 (N=957)	Total (N=1641)	12–14 (N=735)	15–19 (N=1090)	Total (N=1825)
Known sources for contraceptive methods*						
Government clinic/hospital	47.7	67.7	59.4	50.5	68.6	61.3
Private clinic/hospital/doctor	21.9	36.4	30.3	16.7	22.8	20.4
NGO clinic	0.6	3.7	2.4	3.7	11.0	8.1
Banja la Mtsogolo	14.2	30.0	23.4	13.7	28.8	22.7
Drug shop/pharmacy	4.2	4.6	4.4	9.5	12.3	11.2
Street vendor	0.4	1.1	0.9	0.0	0.3	0.2
Traditional or spiritual healer/herbalist	3.4	5.9	4.8	4.8	7.5	6.4
Friends	3.2	1.7	2.3	1.9	2.2	2.1
School/school counselor	5.0	4.9	4.9	4.1	7.3	6.0
Church	1.8	2.0	1.9	0.1	2.1	1.3
Parents	n/a	n/a	n/a	n/a	n/a	n/a
Retail shops	n/a	n/a	n/a	n/a	n/a	n/a
Other	1.8	2.2	2.0	1.9	3.9	3.1
No source known	51.0	30.3	38.9	47.2	27.7	35.6
Most preferred source for contraceptive methods†						
Government clinic/hospital	78.2	72.3	74.3	72.4	65.4	67.7
Private clinic/hospital/doctor	2.1	5.7	4.5	2.1	3.4	3.0
NGO clinic	0.0	0.2	0.1	0.3	1.4	1.0
Banja la Mtsogolo	15.2	18.2	17.2	16.5	22.0	20.2
Drug shop/pharmacy	0.3	0.0	0.1	2.6	2.5	2.6
Street vendor	0.0	0.3	0.2	0.0	0.0	0.0
Traditional or spiritual healer/herbalist	0.9	0.5	0.6	0.8	1.4	1.2
Friends	0.0	0.0	0.0	0.8	0.0	0.3
School/school counselor	0.0	0.3	0.2	1.5	1.5	1.5
Church	0.9	0.5	0.6	0.0	0.5	0.3
Other	0.6	1.2	1.0	1.8	1.4	1.5
Don't know	1.8	0.9	1.2	1.3	0.4	0.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because multiple responses are possible. †Limited to those who know of any source. Sample sizes: females 12–14 (N=335); females 15–19 (N=665); males 12–14 (N=388); males 15–19 (N=786). Notes: Ns are weighted. n/a=not available/applicable.

TABLE 9.7 Percentage distribution of adolescents who know of a government clinic or hospital and who know of at least one method, by perceptions of government clinics or hospitals as a source for contraceptive methods, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=323)	15–19 (N=641)	Total (N=964)	12–14 (N=367)	15–19 (N=745)	Total (N=1112)
Any information shared would be confidential						
Yes	85.1	84.6	84.8	83.4	87.7	86.2
No	14.2	14.2	14.2	14.4	11.0	12.1
Don't know	0.6	1.2	1.0	2.2	1.3	1.6
Respondent would be able to get there easily						
Yes	88.5	89.2	89.0	88.0	92.4	90.9
No	10.5	10.8	10.7	11.4	7.1	8.5
Don't know	0.9	0.0	0.3	0.5	0.5	0.5
Respondent would be treated with respect						
Yes	86.1	88.3	87.6	87.2	86.5	86.7
No	11.7	10.6	11.0	10.9	10.9	10.9
Don't know	2.2	1.1	1.5	1.9	2.7	2.4
Respondent would be able to pay for the services						
Yes	73.0	82.9	79.6	72.0	82.6	79.1
No	24.5	16.1	19.0	25.5	16.8	19.7
Don't know	2.5	0.9	1.5	2.4	0.7	1.3
Reported "no" to at least one dimension of service						
	37.5	33.1	34.6	42.0	30.6	34.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 9.8 Percentage distribution of adolescents who know of at least one method, by perceptions of most preferred source for contraceptive methods, according to type of preferred source and sex, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	Most preferred source			Most preferred source		
	Govt (N=743)	Private (N=46)	Drug shop (N=1)	Govt (N=795)	Private (N=35)	Drug shop (N=30)
At (preferred source), information shared would be confidential						
Yes	86.3	[93.5]	--	86.8	[91.4]	[73.3]
No	12.7	[6.5]	--	11.8	[8.6]	[26.7]
Don't know	1.1	[0.0]	--	1.4	[0.0]	[0.0]
Respondent would be able to get there easily						
Yes	89.0	[73.9]	--	90.3	[88.6]	[93.3]
No	10.6	[26.1]	--	8.9	[11.4]	[6.7]
Don't know	0.4	[0.0]	--	0.8	[0.0]	[0.0]
Respondent would be treated with respect						
Yes	91.6	[73.3]	--	87.7	[100.0]	[93.3]
No	7.0	[13.3]	--	9.3	[0.0]	[6.7]
Don't know	1.3	[13.3]	--	3.0	[0.0]	[0.0]
Respondent would be able to pay for the services						
Yes	81.8	[53.3]	--	76.1	[88.9]	[96.6]
No	17.0	[44.4]	--	22.4	[11.1]	[3.4]
Don't know	1.2	[2.2]	--	1.5	[0.0]	[0.0]
Reported "no" to at least one dimension of service						
	30.7	[58.7]	--	35.1	[28.6]	[33.3]
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 9.9 Percentage of adolescents who have ever obtained a contraceptive method, by source of method, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=2)	15–19 (N=67)	Total (N=69)	12–14 (N=9)	15–19 (N=103)	Total (N=112)
Sources ever used to get contraceptive methods*						
Government clinic/hospital	--	79.1	79.7	--	53.4	56.3
Private clinic/hospital/doctor	--	11.9	11.4	--	3.8	3.6
NGO clinic	--	3.0	2.9	--	1.0	0.9
Banja la Mtsogolo	--	20.9	20.3	--	7.8	7.2
Drug shop/pharmacy	--	0.0	0.0	--	31.1	28.8
Street vendor	--	2.9	2.8	--	0.0	0.0
Traditional or spiritual healer/herbalist	--	0.0	0.0	--	2.9	2.7
Friends	--	1.5	1.4	--	6.8	6.3
School/school counselor	--	4.5	4.3	--	8.7	8.0
Church	--	0.0	0.0	--	3.8	3.6
Retail shops	n/a	n/a	n/a	n/a	n/a	n/a
Parents	n/a	n/a	n/a	n/a	n/a	n/a
Other	--	2.9	2.8	--	2.9	2.7
Don't know	--	0.0	0.0	--	0.0	0.0

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 9.10 Percentage distribution of adolescents, by exposure to mass media messages about family planning, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=943)	15-19 (N=1056)	Total (N=1999)	12-14 (N=907)	15-19 (N=1126)	Total (N=2033)
Source(s) of messages about family planning in the last few months*						
Radio	48.6	65.1	57.3	61.8	76.7	70.1
Television	10.6	13.4	12.1	11.8	15.5	13.9
Newspaper or magazine	17.6	27.6	22.9	15.9	32.9	25.3
Poster	12.4	24.0	18.5	17.9	34.8	27.3
Leaflet or brochure	5.5	10.3	8.0	4.6	11.0	8.2
Health worker	26.3	42.5	34.8	23.3	45.0	35.3
Community or social club meeting	23.9	35.5	30.0	24.9	45.1	36.1
Number of exposures to family planning messages in recent months						
0	42.2	26.7	34.0	31.0	14.3	21.7
1	22.5	20.7	21.6	28.1	21.9	24.7
2	12.1	13.7	13.0	16.9	13.8	15.2
3-7	23.2	38.8	31.5	24.0	50.0	38.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because "yes" responses to multiple items are shown. *Note:* Ns are weighted.

TABLE 9.11 Percentage of adolescents who know of any STIs, by used and preferred sources of information on STIs (other than HIV/AIDS), according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=455)	15-19 (N=809)	Total (N=1264)	12-14 (N=453)	15-19 (N=926)	Total (N=1379)
Where respondent got information about STIs (other than HIV/AIDS)*						
Any family	22.9	23.6	23.3	16.8	14.6	15.3
Any friend	38.0	35.0	36.1	37.1	36.1	36.4
Any teacher or health provider	73.9	81.1	78.5	62.9	71.7	68.8
Any mass media	50.1	47.6	48.5	59.2	59.6	59.5
Mother	10.7	10.5	10.6	3.8	3.9	3.9
Father	2.6	4.6	3.9	4.0	4.9	4.6
Spouse/partner	0.0	0.2	0.2	0.0	0.2	0.1
Brother	0.9	1.6	1.4	2.4	2.2	2.3
Sister	1.3	2.7	2.2	0.7	0.3	0.4
Other female family member	14.7	13.9	14.2	2.2	2.1	2.1
Other male family member	1.8	1.6	1.7	8.7	7.9	8.2
Female friends	36.8	34.6	35.4	1.6	2.8	2.4
Male friends	6.4	2.4	3.8	36.8	35.1	35.6
Teacher/school	57.1	54.2	55.2	46.6	52.8	50.7
Doctor/nurse/clinic	47.7	62.4	57.1	35.9	47.1	43.5
Banja la Mtsogolo	6.2	8.2	7.5	3.8	12.0	9.3
Traditional or spiritual healer/herbalist	1.1	3.6	2.7	1.1	1.2	1.2
Church	7.3	6.7	6.9	2.7	3.9	3.5
Anti-AIDS club	17.1	19.8	18.8	15.3	26.4	22.7
Malawi AIDS Counselling & Resource Organisation (MACRO)/Salima AIDS Support Organisation (SASO)	0.0	0.9	0.6	0.2	0.9	0.7
Community/neighborhood	N/A	N/A	N/A	N/A	N/A	N/A
Newspaper	6.4	6.4	6.4	5.3	11.8	9.7
Books/magazines	3.5	3.6	3.6	6.9	10.4	9.2
Radio	48.8	46.0	47.0	57.0	57.4	57.3
Television	5.9	4.7	5.2	6.2	5.9	6.0
Internet	0.0	0.0	0.0	0.0	0.2	0.1
Poster/billboard	1.3	2.1	1.8	1.3	1.6	1.5
Other	2.6	4.6	3.9	4.2	6.5	5.7
Don't know/unsure	2.0	1.6	1.7	3.1	2.4	2.6
Preferred sources for information about STIs*						
Any family	7.7	6.4	6.9	3.8	3.0	3.3
Any friend	13.4	7.8	9.8	7.9	6.7	7.1
Any teacher or health provider	69.5	78.1	75.0	63.6	67.3	66.1
Any mass media	20.0	15.3	17.0	22.5	23.7	23.3
Mother	5.1	4.0	4.4	1.4	0.4	0.7
Father	0.9	1.5	1.3	2.5	0.7	1.2
Spouse/partner	0.0	0.1	0.1	0.0	0.1	0.1
Brother	0.4	0.3	0.3	0.7	0.1	0.3
Sister	0.4	0.6	0.6	0.5	0.2	0.3
Other female family member	2.2	1.8	1.9	0.5	0.4	0.4
Other male family member	0.0	0.0	0.0	0.9	1.4	1.2
Female friends	13.3	7.9	9.9	0.2	0.5	0.4
Male friends	0.9	0.0	0.3	8.1	6.3	6.9
Teacher/school	30.0	26.2	27.6	24.1	23.8	23.9
Doctor/nurse/clinic	52.2	67.9	62.2	47.9	52.7	51.1
Banja la Mtsogolo	7.1	8.0	7.7	4.5	10.6	8.6
Traditional or spiritual healer/herbalist	1.1	1.4	1.3	1.1	1.1	1.1
Church	3.3	3.5	3.4	0.9	0.3	0.5
Anti-AIDS club	9.8	12.7	11.6	9.7	12.8	11.8
Malawi AIDS Counselling & Resource Organisation (MACRO)/Salima AIDS Support Organisation (SASO)	0.0	0.8	0.5	0.5	1.3	1.0
Community/neighborhood	N/A	N/A	N/A	N/A	N/A	N/A
Newspaper	1.6	1.3	1.4	0.2	0.3	0.3
Books/magazines	1.3	1.0	1.1	0.0	0.8	0.5
Radio	17.6	14.1	15.3	22.1	23.0	22.7
Television	1.6	1.1	1.3	0.9	0.0	0.3
Internet	0.0	0.0	0.0	0.0	0.0	0.0
Poster/billboard	0.0	0.5	0.3	0.0	0.1	0.1
Other	1.8	2.8	2.4	1.6	3.9	3.2
Don't know	3.8	2.4	2.9	4.5	4.0	4.2

*Totals may exceed 100 because multiple responses are possible. Note: Ns are weighted.

TABLE 9.12 Percentage of adolescents who do not know any STIs, by perceived sources of information on STIs other than HIV/AIDS, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=488)	15-19 (N=246)	Total (N=734)	12-14 (N=454)	15-19 (N=200)	Total (N=654)
Sources of information on STIs other than HIV/AIDS*						
Any family	3.5	0.8	2.6	1.5	2.0	1.7
Any teacher or health provider	9.2	9.8	9.4	11.7	20.4	14.4
Any mass media	2.7	2.8	2.7	3.1	6.5	4.1
No source known	89.3	86.6	88.4	85.1	75.1	82.0
Mother	2.7	0.0	1.8	0.7	0.5	0.6
Father	0.8	0.0	0.5	0.4	2.0	0.9
Spouse/partner	0.0	0.0	0.0	0.0	0.5	0.2
Brother	0.0	0.0	0.0	0.0	1.0	0.3
Sister	0.4	0.0	0.3	0.0	0.0	0.0
Other female family member	0.0	0.0	0.0	0.0	0.0	0.0
Other male family member	1.4	0.8	1.2	0.9	0.0	0.6
Female friends	0.4	1.6	0.8	0.4	0.0	0.3
Male friends	0.0	0.0	0.0	2.7	2.5	2.6
Teacher/school	3.3	3.3	3.3	3.1	6.5	4.2
Doctor/nurse/clinic	8.6	9.3	8.9	10.7	19.9	13.5
Banja la Mtsogolo	0.6	2.0	1.1	0.0	3.0	0.9
Traditional or spiritual healer/herbalist	0.6	0.0	0.4	0.4	0.0	0.3
Church	0.0	0.4	0.1	0.0	1.0	0.3
Newspaper	0.6	0.0	0.4	0.4	0.5	0.5
Books/magazines	0.0	0.0	0.0	0.0	1.0	0.3
Radio	2.7	2.8	2.7	3.1	5.5	3.8
Television	0.6	0.0	0.4	0.0	1.0	0.3
Internet	0.0	0.0	0.0	0.0	0.0	0.0
Poster/billboard	0.0	0.0	0.0	0.0	0.0	0.0
Anti-AIDS clinic	1.6	1.2	1.5	1.1	4.5	2.2
Other	0.4	2.0	1.0	0.7	1.0	0.8
Don't know/unsure	0.0	0.0	0.0	0.2	0.0	0.2

*Totals may exceed 100 because multiple responses are possible. Note: Ns are weighted.

TABLE 9.13 Percentage of adolescents who know of any STIs, by perceived barriers to obtaining advice or treatment for STIs, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=455)	15–19 (N=803)	Total (N=1258)	12–14 (N=451)	15–19 (N=924)	Total (N=1375)
Barriers*						
No barriers	14.1	10.2	11.6	12.4	10.0	10.8
Not knowing where to go	4.8	5.9	5.5	8.2	10.5	9.8
Not knowing how to get there	4.0	3.0	3.3	1.6	6.7	5.0
Inconvenient hours/days	0.9	2.6	2.0	3.1	2.2	2.5
Privacy not respected	10.1	16.2	14.0	3.1	7.7	6.2
Not treated nicely by person/staff	1.5	7.1	5.1	6.0	13.3	10.9
Costly/not able to pay for services	9.2	7.7	8.3	4.2	6.7	5.9
No same sex provider	3.7	6.1	5.2	0.7	3.9	2.8
Not being allowed to go alone	4.4	7.7	6.5	1.1	1.7	1.5
Afraid or fearful	35.7	37.1	36.6	19.5	26.3	24.1
Embarrassed or shy	44.4	49.8	47.9	35.1	45.4	42.0
Treatment not effective	3.1	6.1	5.0	0.9	3.1	2.4
Too young	N/A	N/A	N/A	N/A	N/A	N/A
Feel bad/spoiled	N/A	N/A	N/A	N/A	N/A	N/A
Other	0.4	1.5	1.1	1.3	2.5	2.1
Don't know	29.6	24.9	26.6	37.0	25.2	29.1

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 9.14. Percentage distribution of adolescents who know of any STIs, by known and most preferred sources for STI treatment, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=456)	15–19 (N=803)	Total (N=1259)	12–14 (N=451)	15–19 (N=924)	Total (N=1375)
Known sources to get treatment for STIs*						
Government clinic/hospital	61.0	72.1	68.1	67.4	80.3	76.1
Private clinic/hospital/doctor	28.3	36.5	33.5	29.3	31.6	30.8
NGO clinic	3.5	5.6	4.8	7.8	13.5	11.6
Banja la Mtsogolo	12.7	26.4	21.5	15.7	25.8	22.5
Drug shop/pharmacy	3.5	3.7	3.7	3.5	3.5	3.5
Street vendor	0.0	0.0	0.0	0.0	0.2	0.1
Traditional or spiritual healer/herbalist	12.1	14.3	13.5	16.9	18.5	18.0
Friends	2.4	1.5	1.8	0.9	0.4	0.6
School/school counselor	5.5	4.2	4.7	2.7	2.2	2.3
Church	2.2	1.6	1.8	0.4	1.3	1.0
Parents	n/a	n/a	n/a	n/a	n/a	n/a
Retail shops	n/a	n/a	n/a	n/a	n/a	n/a
Other	3.3	2.0	2.5	0.4	2.5	1.8
No source known	37.6	26.5	30.5	31.3	19.0	23.1
Most preferred source to get treatment for STIs†						
Government clinic/hospital	82.5	79.7	80.6	82.2	76.2	78.0
Private clinic/hospital/doctor	2.5	4.4	3.8	6.5	4.9	5.4
NGO clinic	0.7	0.8	0.8	0.3	0.8	0.7
Banja la Mtsogolo	9.1	12.2	11.2	7.4	13.2	11.5
Drug shop/pharmacy	0.0	0.0	0.0	0.3	0.4	0.4
Street vendor	0.0	0.0	0.0	0.0	0.0	0.0
Traditional or spiritual healer/herbalist	2.1	0.7	1.1	2.3	2.9	2.7
Friends	0.0	0.0	0.0	0.6	0.0	0.2
School/school counselor	0.0	0.7	0.5	0.3	0.4	0.4
Church	0.7	0.2	0.3	0.0	0.1	0.1
Other	2.1	0.3	0.9	0.0	0.8	0.6
Don't know	0.4	1.0	0.8	0.0	0.1	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because multiple responses are possible. †Limited to those who know of any source. Sample sizes: females 12–14 (N=285); females 15–19 (N=590); males 12–14 (N=309); males 15–19 (N=748). Notes: Ns are weighted. n/a=not available/applicable.

TABLE 9.15 Percentage distribution of adolescents who know of a government clinic or hospital and who know of any STIs, by perceptions of government clinics or hospitals as a source for STI treatment, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=277)	15–19 (N=575)	Total (N=852)	12–14 (N=298)	15–19 (N=733)	Total (N=1031)
Information shared would be confidential						
Yes	79.8	82.6	81.7	86.6	87.4	87.2
No	20.2	17.4	18.3	12.1	11.9	11.9
Don't know	0.0	0.0	0.0	1.3	0.7	0.9
Respondent would be able to get there easily						
Yes	91.3	92.2	91.9	93.0	93.0	93.0
No	8.7	7.5	7.9	7.0	6.7	6.8
Don't know	0.0	0.3	0.2	0.0	0.3	0.2
Respondent would be treated with respect						
Yes	88.8	89.0	89.0	88.6	89.2	89.0
No	9.1	10.3	9.9	9.4	9.3	9.3
Don't know	2.2	0.7	1.2	2.0	1.5	1.6
Respondent would be able to pay for						
Yes	73.2	80.5	78.1	68.5	81.4	77.7
No	26.8	18.4	21.2	29.5	17.8	21.2
Don't know	0.0	1.0	0.7	2.0	0.8	1.2
Responded "no" to at least one dimension of service						
	41.3	34.1	36.4	40.9	31.7	34.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 9.16 Percentage distribution of adolescents who know of any STIs, by most preferred source for STI treatment, according to type of preferred source and sex, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	Most preferred source			Most preferred source		
	Govt (N=705)	Private (N=34)	NGO (N=7)	Govt (N=824)	Private (N=58)	NGO (N=8)
At (preferred source), information shared would be confidential						
Yes	83.1	[85.3]	--	87.9	96.5	--
No	16.9	[14.7]	--	11.7	3.5	--
Don't know	0.0	[0.0]	--	0.5	0.0	--
Respondent would be able to get there easily						
Yes	92.5	[84.8]	--	93.7	91.4	--
No	7.2	[12.1]	--	6.1	8.6	--
Don't know	0.3	[3.0]	--	0.2	0.0	--
Respondent would be treated with respect						
Yes	89.6	[100.0]	--	90.2	100.0	--
No	9.2	[0.0]	--	8.1	0.0	--
Don't know	1.1	[0.0]	--	1.7	0.0	--
Respondent would be able to pay for the services						
Yes	76.7	[67.7]	--	75.4	84.5	--
No	22.4	[32.3]	--	23.4	15.5	--
Don't know	0.9	[0.0]	--	1.2	0.0	--
Responded "no" to at least one dimension of service						
	35.3	[33.3]	--	35.1	22.4	--
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: Ns are weighted.

TABLE 9.17 Percentage distribution of adolescents who have ever experienced STI symptoms, by self-reported treatment behavior, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=21)	15–19 (N=55)	Total (N=76)	12–14 (N=10)	15–19 (N=92)	Total (N=102)
Ever gone for treatment for STI*						
Yes	[23.8]	43.6	38.2	--	32.6	33.3
No	[76.2]	56.4	61.8	--	67.4	66.7
Service sources at last visit†						
Government clinic/hospital	--	--	[55.2]	--	[64.5]	[68.6]
Private clinic/hospital/doctor	--	--	[6.9]	--	[3.2]	[2.9]
NGO clinic	--	--	n/a	n/a	n/a	n/a
Banja la Mtsogolo	--	--	[0.0]	--	[0.0]	[0.0]
Drug shop/pharmacy	--	--	n/a	n/a	n/a	n/a
Street vendor	--	--	n/a	n/a	n/a	n/a
Traditional or spiritual healer/herbalist	--	--	[31.0]	--	[32.3]	[28.6]
Friends	--	--	n/a	n/a	n/a	n/a
School/school counselor	--	--	n/a	n/a	n/a	n/a
Church	--	--	n/a	n/a	n/a	n/a
Other	--	--	[6.9]	n/a	n/a	n/a
Don't know	--	--	n/a	n/a	n/a	n/a
Reasons did not go for treatment‡						
Embarrassed	--	[61.3]	[53.2]	--	12.9	11.8
Don't want partner to know	--	[0.0]	[0.0]	--	0.0	0.0
Don't want other people to know	--	[35.5]	[29.8]	--	6.6	6.0
Don't know where to go	--	[22.6]	[21.3]	--	17.7	20.9
Cost	--	[0.0]	[12.8]	--	14.8	13.4
Not a serious problem	--	[0.0]	[4.2]	--	8.1	7.4
Not painful	n/a	n/a	n/a	n/a	n/a	n/a
Normal/natural condition	n/a	n/a	n/a	n/a	n/a	n/a
Other	--	[6.5]	[4.3]	--	37.1	37.3
Don't know	--	[6.5]	[4.3]	--	4.8	4.4
Preferred service sources‡						
Government clinic/hospital	--	[83.9]	[85.4]	--	74.6	70.6
Private clinic/hospital/doctor	--	[6.5]	[8.3]	--	11.1	14.7
NGO clinic	n/a	n/a	n/a	n/a	n/a	n/a
Banja la Mtsogolo	--	[0.0]	[0.0]	--	0.0	0.0
Drug shop/pharmacy	n/a	n/a	n/a	n/a	n/a	n/a
Street vendor	n/a	n/a	n/a	n/a	n/a	n/a
Traditional or spiritual healer/herbalist	--	[6.5]	[4.2]	--	1.6	1.5
Friends	n/a	n/a	n/a	n/a	n/a	n/a
School/school counselor	n/a	n/a	n/a	n/a	n/a	n/a
Church	n/a	n/a	n/a	n/a	n/a	n/a
Other	n/a	n/a	n/a	--	0.0	0.0
Nowhere	--	[3.2]	[2.1]	--	11.1	10.3
Don't know	n/a	n/a	n/a	--	1.6	2.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who have ever had a STI. †Limited to those who have ever gone for treatment. Sample sizes: females 12–14 (N=5); females 15–19 (N=24); males 12–14 (N=4); males 15–19 (N=31). Multiple responses possible. ‡Limited to those who have not gone for treatment. Sample sizes: females 12–14 (N=17); females 15–19 (N=31); males 12–14 (N=6); males 15–19 (N=62). Multiple responses possible. Notes: Ns are weighted. n/a=not available/applicable.

TABLE 9.18 Percentage of adolescents who know of HIV/AIDS, by HIV/AIDS information sources used and preferred, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=872)	15-19 (N=1020)	Total (N=1892)	12-14 (N=822)	15-19 (N=1111)	Total (N=1933)
Where respondent got information about HIV/AIDS*						
Any family	33.5	31.0	32.1	22.9	21.6	22.1
Any friend	38.9	35.0	36.8	44.2	42.5	43.2
Any teacher or health provider	71.7	82.0	77.3	60.3	71.6	66.8
Any mass media	56.9	63.4	60.4	70.0	75.4	73.1
Mother	18.1	12.8	15.3	6.4	6.8	6.7
Father	6.0	6.0	6.0	7.4	7.4	7.4
Spouse/partner	0.0	0.4	0.2	0.0	0.2	0.1
Brother	0.5	1.1	0.8	1.8	3.0	2.5
Sister	3.4	1.5	2.4	1.0	0.5	0.7
Other female family member	17.9	20.2	19.1	4.9	2.8	3.7
Other male family member	3.3	3.1	3.2	11.6	13.9	12.9
Female friends	37.5	34.3	35.8	4.5	3.2	3.8
Male friends	5.5	3.5	4.4	42.7	41.8	42.2
Teacher/school	59.5	57.6	58.5	50.7	56.2	53.9
Doctor/nurse/clinic	40.7	62.2	52.3	27.6	46.7	38.6
Traditional and spiritual healer/herbalist	0.7	1.6	1.2	0.7	0.7	0.7
Church	9.9	15.1	12.7	6.2	8.7	7.7
Anti-AIDS club	12.3	23.1	18.1	14.2	26.5	21.3
Malawi AIDS Counselling & Resource Organisation (MACRO)	0.3	0.8	0.6	1.0	1.1	1.0
Community/neighborhood	n/a	n/a	n/a	n/a	n/a	n/a
Newspaper	8.1	9.2	8.7	6.3	14.9	11.3
Books/magazines	3.8	3.9	3.9	5.8	14.3	10.7
Radio	55.8	62.2	59.3	67.9	72.6	70.6
Television	9.4	8.2	8.8	10.2	12.9	11.7
Internet	0.0	0.0	0.0	0.0	0.2	0.1
Poster/billboard	1.7	2.2	2.0	1.5	4.7	3.3
Other	3.9	8.3	6.3	6.8	10.3	8.8
Don't know/unsure	3.3	1.8	2.5	2.2	0.4	1.1
Preferred sources for information about HIV/AIDS*						
Any family	8.7	6.4	7.4	8.3	2.3	4.8
Any friend	10.2	7.5	8.8	11.9	8.4	9.9
Any teacher or health provider	65.7	76.0	71.2	55.4	68.3	62.8
Any mass media	22.6	20.7	21.6	25.7	27.7	26.8
Mother	5.2	3.2	4.1	2.1	0.6	1.3
Father	1.8	2.1	2.0	3.1	0.7	1.7
Spouse/partner	0.0	0.1	0.1	0.0	0.0	0.0
Brother	0.2	0.2	0.2	1.0	0.6	0.8
Sister	1.3	0.1	0.6	0.1	0.3	0.2
Other female family member	2.4	3.1	2.8	1.5	0.4	0.8
Other male family member	0.1	0.4	0.3	2.7	1.1	1.8
Female friends	10.1	7.5	8.7	1.0	0.3	0.6
Male friends	0.7	0.3	0.5	11.5	8.3	9.6
Teacher/school	28.3	24.5	26.2	23.8	26.1	25.1
Doctor/nurse/clinic	47.0	64.0	56.2	38.7	53.9	47.4
Banja la Mtsogolo	1.5	1.4	1.4	0.6	1.4	1.0
Traditional or spiritual healer/herbalist	0.3	0.6	0.5	0.6	0.7	0.7
Church	3.6	6.1	4.9	0.6	2.2	1.5
Anti-AIDS club	8.5	13.2	11.0	7.4	13.5	10.9
Malawi AIDS Counselling & Resource Organisation (MACRO)	0.3	0.9	0.6	0.9	2.4	1.7
Community/neighborhood	n/a	n/a	n/a	n/a	n/a	n/a
Newspaper	1.6	2.4	2.0	0.5	1.2	0.9
Books/magazines	0.5	0.3	0.4	0.7	2.2	1.6
Radio	19.7	19.3	19.5	24.5	25.9	25.3
Television	3.2	1.2	2.1	1.6	1.3	1.4
Internet	0.0	0.0	0.0	0.0	0.0	0.0
Poster/billboard	0.0	0.2	0.1	0.1	0.5	0.3
Other	1.3	3.0	2.2	2.0	3.6	2.9
Don't know	8.3	3.9	5.9	9.9	4.6	6.9

*Totals may exceed 100 because multiple responses are possible. Note: Ns are weighted.

TABLE 9.19 Percentage of adolescents who know of HIV/AIDS, by exposure to mass media messages about HIV/AIDS, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=873)	15–19 (N=1020)	Total (N=1893)	12–14 (N=822)	15–19 (N=1111)	Total (N=1933)
Sources of messages about HIV/AIDS in the last few months*						
Radio	69.0	76.7	73.2	79.4	87.7	84.2
Television	17.3	22.0	19.8	20.2	23.2	21.9
Newspaper or magazine	27.9	35.0	31.7	28.2	46.3	38.6
Poster	19.2	31.1	25.6	25.7	40.6	34.2
Leaflet or brochure	10.4	15.9	13.4	7.9	14.8	11.9
Health worker	37.6	50.3	44.4	36.7	54.7	47.0
Community or social club meeting	32.0	45.6	39.3	40.8	57.2	50.2
Level of exposure to HIV/AIDS messages in recent months						
No exposure	25.1	17.9	21.2	15.1	7.5	10.7
1 exposure	23.0	18.6	20.7	24.9	17.6	20.7
2 exposures	17.8	16.6	17.1	17.9	14.5	15.9
3–7 exposures	34.1	46.9	41.0	42.1	60.5	52.7
Has heard of:*						
"Youth Alert"	44.3	54.5	49.8	50.1	69.1	61.0
"Why wait?"	19.3	29.7	24.9	12.5	23.5	18.8
"My future, my life"	43.2	53.9	49.0	46.5	66.1	57.7
"Edzi Toto" ("Stop AIDS") clubs or other anti-AIDS clubs	51.9	68.7	61.0	54.6	76.2	67.0
"No sex before marriage"	N/A	N/A	N/A	N/A	N/A	N/A
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Totals may exceed 100 because "yes" responses to multiple items are shown. *Note:* Ns are weighted.

TABLE 9.20 Percentage distribution of adolescents, by HIV testing experiences, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12-14 (N=586)	15-19 (N=851)	Total (N=1437)	12-14 (N=570)	15-19 (N=964)	Total (N=1534)
Ever been tested for HIV*						
Yes	0.7	7.4	4.7	0.9	4.9	3.4
No	99.3	92.6	95.3	99.1	95.1	96.6
Refuse to answer	0.0	0.0	0.0	0.0	0.0	0.0
Voluntary status of test†						
Respondent asked for the test	--	39.3	39.4	--	[46.8]	47.2
Testing was offered and respondent accepted	--	19.7	18.2	--	[14.9]	15.1
Testing was required	--	41.0	42.4	--	[38.3]	37.7
Main reason for getting tested‡						
To know status	--	71.0	72.7	--	[83.0]	80.8
Pregnant/prenatal	--	14.5	13.6	--	[0.0]	0.0
Sexually active	--	0.0	0.0	--	[4.3]	3.8
Encouraged by counselor	--	4.8	4.5	--	[4.3]	3.8
Encouraged by peer educators	--	4.8	4.5	--	[2.1]	1.9
Encouraged by parents or family	--	0.0	0.0	--	[4.3]	3.8
Encouraged by peers	--	0.0	0.0	--	[0.0]	0.0
To get married	--	1.6	1.5	--	[0.0]	0.0
Partner told me to do so	--	0.0	0.0	--	[0.0]	0.0
Blood donation	--	3.2	3.0	--	[2.1]	5.8
Concern about a partner	--	0.0	0.0	--	[0.0]	0.0
Required to get a job	--	0.0	0.0	--	[0.0]	0.0
Other	--	0.0	0.0	--	[0.0]	0.0
Place last tested‡						
Government clinic/hospital	--	58.1	56.7	--	[46.8]	48.1
Private clinic/hospital/doctor	--	11.3	10.4	--	[19.1]	21.2
NGO Clinic	--	0.0	0.0	--	[4.3]	3.8
Banja la Mtsogolo	--	1.6	1.5	--	[0.0]	0.0
Drug shop/pharmacy	--	0.0	0.0	--	[0.0]	0.0
Mobile clinic	--	1.6	1.5	--	[0.0]	0.0
Stand alone testing center	--	6.5	6.0	--	[2.1]	1.9
Malawi AIDS Counselling & Resource Organisation (MACRO)	--	19.4	22.4	--	[21.3]	19.2
Other	--	1.6	1.5	--	[6.4]	5.8
Received counseling at time of test†						
Yes	--	98.4	98.5	--	[95.8]	96.2
No	--	1.6	1.5	--	[4.2]	3.8
Received test results‡						
Yes	--	95.2	95.5	--	[93.6]	94.2
No	--	4.8	4.5	--	[6.4]	5.8
Refuse to Answer	--	0.0	0.0	--	[0.0]	0.0
Told anyone test results‡						
Yes	--	81.4	76.6	--	[88.6]	[85.7]
No	--	18.6	23.4	--	[11.4]	[14.3]
People whom respondent told‡						
Partner/spouse	--	15.3	14.3	--	[4.5]	[8.2]
Boyfriend/girlfriend	--	11.7	10.9	--	[25.0]	[22.4]
Mother	--	39.0	36.5	--	[35.6]	[34.0]
Father	--	22.0	20.6	--	[18.2]	[16.3]
Brother	--	15.3	14.3	--	[31.8]	[32.7]
Sister	--	28.3	26.6	--	[15.9]	[18.4]
Other female family member	--	8.3	7.8	--	[9.1]	[8.2]
Other male family member	--	3.3	3.1	--	[11.4]	[10.2]
Female friend	--	15.3	14.3	--	[56.8]	[55.1]
Male friend	--	23.7	22.2	--	[15.6]	[18.0]
Teacher	--	0.0	0.0	--	[4.4]	[4.0]
Doctor/nurse	--	11.9	11.1	--	[0.0]	[0.0]
Traditional or spiritual healer/herbalist	--	0.0	0.0	--	[0.0]	[0.0]
Pharmacist	--	0.0	0.0	--	[0.0]	[0.0]
Peer educator	--	5.1	4.8	--	[0.0]	[0.0]
Other	--	3.4	3.2	--	[0.0]	[0.0]
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who know a place for AIDS testing. †Limited to those who have ever tested for AIDS. Sample sizes: females 12-14 (N=5); females 15-19 (N=61); males 12-14 (N=5); males 15-19 (N=47). ‡Limited to those who received test results. Sample sizes: females 12-14 (N=5); females 15-19 (N=59); males 12-14 (N=5); males 15-19 (N=44). Note: Ns are weighted.

TABLE 9.21 Percentage distribution of adolescents who know of HIV/AIDS, by knowledge about voluntary counseling and testing, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=869)	15–19 (N=1020)	Total (N=1889)	12–14 (N=821)	15–19 (N=1111)	Total (N=1932)
Has heard that people can get tested for HIV/AIDS						
Yes	77.1	90.5	84.3	79.4	92.8	87.1
No	22.9	9.5	15.7	20.6	7.2	12.9
Knows of a place to get an HIV/AIDS test*						
Yes	87.6	92.1	90.2	87.4	93.9	91.4
No	12.4	7.9	9.8	12.6	6.1	8.6
Places known for HIV/AIDS test†						
Government clinic/hospital	92.1	92.0	92.1	89.3	82.3	84.9
Private clinic/hospital/doctor	28.8	30.5	29.8	25.2	23.8	24.3
NGO clinic	13.2	13.8	13.5	13.7	21.5	18.6
Banja la Mtsogolo	1.9	2.7	2.4	1.6	3.3	2.7
Drug shop/pharmacy	0.2	0.4	0.3	0.7	0.4	0.5
Mobile clinic	0.2	1.3	0.8	0.4	0.2	0.3
Stand alone testing center	2.4	2.2	2.3	1.2	2.8	2.2
Malawi AIDS Counselling & Resource Organisation (MACRO)	27.2	42.4	36.2	23.9	44.0	36.6
The AIDS Support Organization (TASO)	n/a	n/a	n/a	n/a	n/a	n/a
Other	4.4	3.5	3.9	3.2	3.8	3.6
Does a person have to pay to get tested†						
Yes	17.4	13.2	14.9	10.2	8.6	9.2
No	70.4	76.0	73.7	80.2	85.8	83.7
Don't know	12.3	10.8	11.4	9.6	5.6	7.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

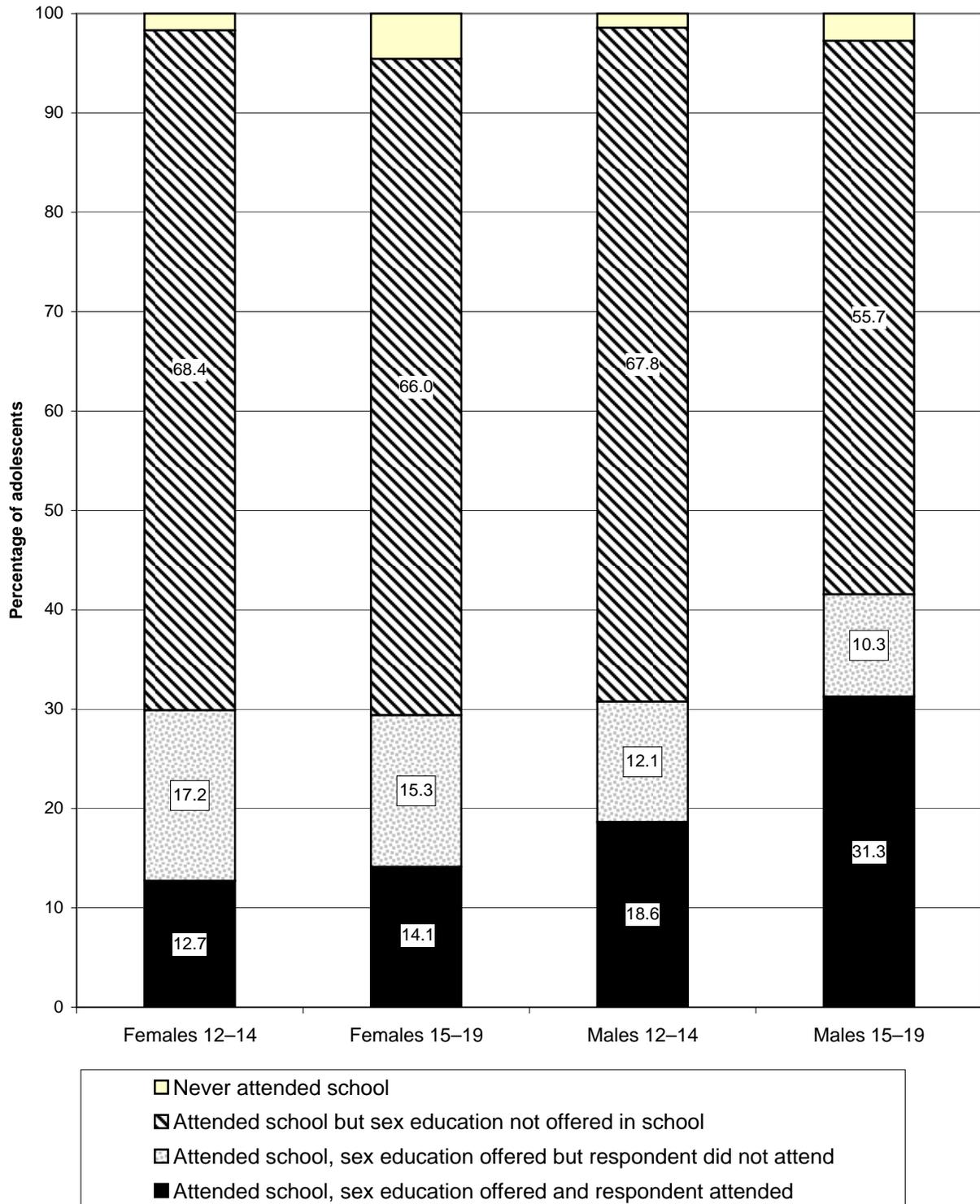
*Limited to those who are aware of a test for HIV/AIDS. Sample sizes: females 12–14 (N=670); females 15–19 (N=923); males 12–14 (N=652); males 15–19 (N=1028). †Question asked of those who know of a place to get tested. Sample sizes: females 12–14 (N=585); females 15–19 (N=849); males 12–14 (N=568); males 15–19 (N=964). Totals may exceed 100 because multiple responses are possible. Note: Ns are weighted.

TABLE 9.22 Percentage distribution of adolescents who have never been tested for HIV and who know that a person can be tested, by desire to be tested reasons for not being tested, according to sex and age, 2004 National Survey of Adolescents

Characteristic	Female			Male		
	12–14 (N=665)	15–19 (N=861)	Total (N=1526)	12–14 (N=647)	15–19 (N=984)	Total (N=1631)
Want to be tested for AIDS virus						
Yes	65.4	74.7	70.6	74.0	81.7	78.7
No	34.0	25.1	29.0	25.5	18.3	21.2
Don't know	0.6	0.2	0.4	0.5	0.0	0.2
Main reason for not having been tested*						
Not sexually active	30.9	20.2	24.5	31.6	18.9	23.6
Not at risk for other reasons	43.2	43.7	43.5	32.4	33.0	32.8
Do not know where to go	8.1	2.6	4.8	10.0	7.3	8.3
Costs too much	5.8	7.2	6.6	5.0	9.8	8.0
Can get infection from test	1.2	1.6	1.4	1.9	1.2	1.5
Don't want to know status	6.5	15.1	11.6	6.7	8.4	7.8
Don't want to be seen	0.5	1.2	0.9	0.8	0.6	0.7
Too young	0.7	0.3	0.5	2.5	1.0	1.6
No money for test	0.0	0.3	0.2	0.2	0.7	0.5
No time	0.5	0.5	0.5	1.0	3.9	2.8
Too far	0.9	2.3	1.8	1.3	5.1	3.7
Inconvenient hours/days	0.0	1.1	0.7	1.9	4.8	3.7
Not infected	n/a	n/a	n/a	n/a	n/a	n/a
No reason	n/a	n/a	n/a	n/a	n/a	n/a
Other	1.8	3.9	3.1	4.6	5.1	4.9
Main reason do not want to be tested†						
Not sexually active	40.0	36.5	38.3	39.9	23.9	31.6
Not at risk for other reasons	30.0	26.9	28.5	39.3	48.9	44.3
Do not know where to go	0.9	0.5	0.7	0.0	1.7	0.9
Costs too much	1.7	5.5	3.6	1.2	0.0	0.6
Can get infection from test	3.5	2.7	3.1	3.0	4.4	3.7
Don't want to know status	18.3	23.3	20.7	12.5	17.2	14.9
Don't want to be seen	0.9	1.4	1.1	1.2	1.1	1.1
Too young	1.7	0.5	1.1	1.8	0.6	1.1
Not infected	n/a	n/a	n/a	n/a	n/a	n/a
No reason	n/a	n/a	n/a	n/a	n/a	n/a
Other	3.0	2.7	2.9	1.2	2.2	1.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Limited to those who want to be tested. Sample sizes: females 12–14 (N=433); females 15–19 (N=643); males 12–14 (N=478); males 15–19 (N=805). †Limited to those who do not want to be tested. Sample sizes: females 12–14 (N=230); females 15–19 (N=219); males 12–14 (N=168); males 15–19 (N=180). Notes: Ns are weighted. n/a=not available/applicable.

Chart 9.1 Adolescents, by school attendance and exposure to sex education, according to sex and age 2004 National Survey of Adolescents



**Chart 9.2 Female adolescents who know of at least one method, by urban-rural difference in sources for contraceptive method information
2004 National Survey of Adolescents**

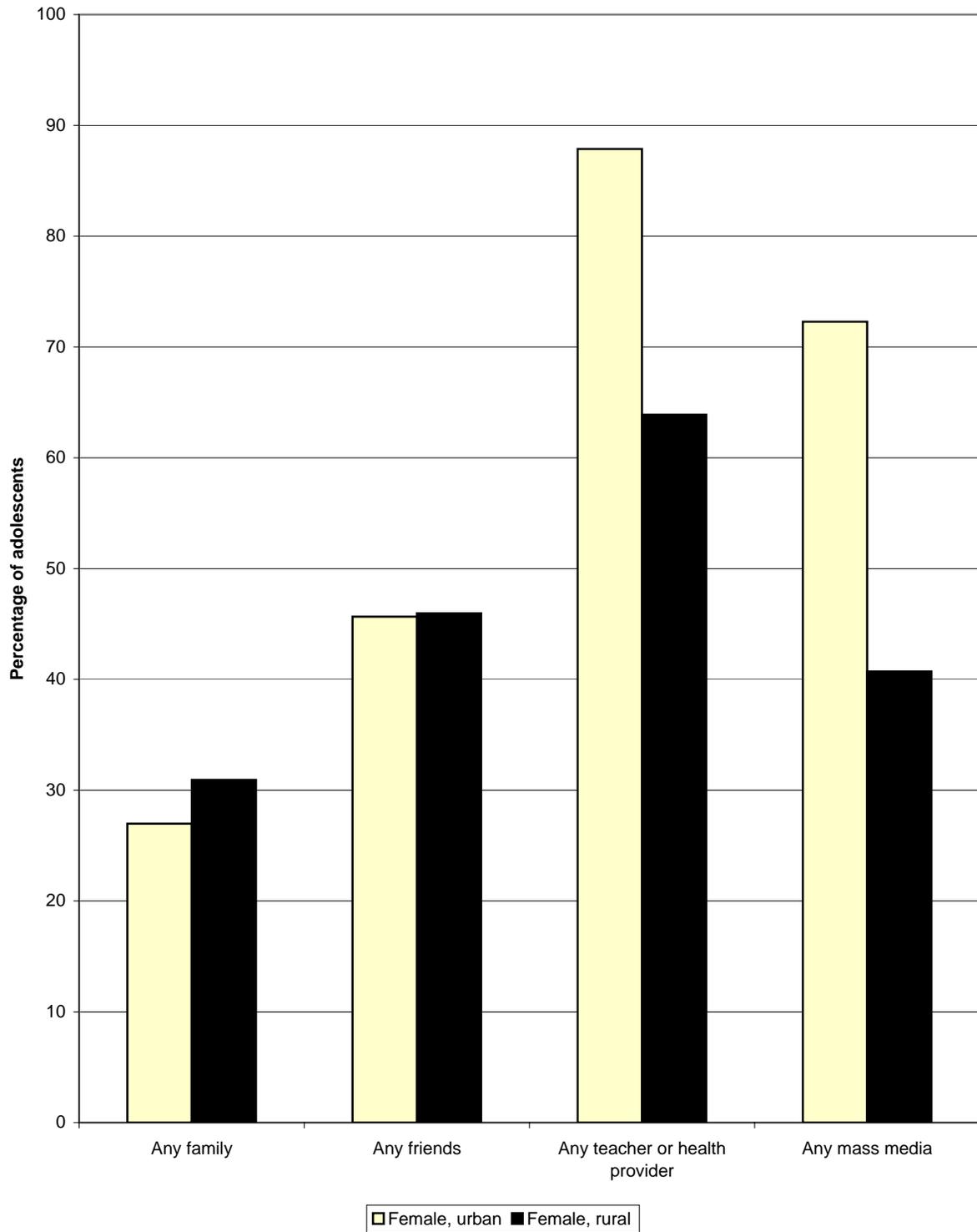


Chart 9.3 Male adolescents who know of at least one contraceptive method, by urban-rural difference in sources for contraception information, 2004
National Survey of Adolescents

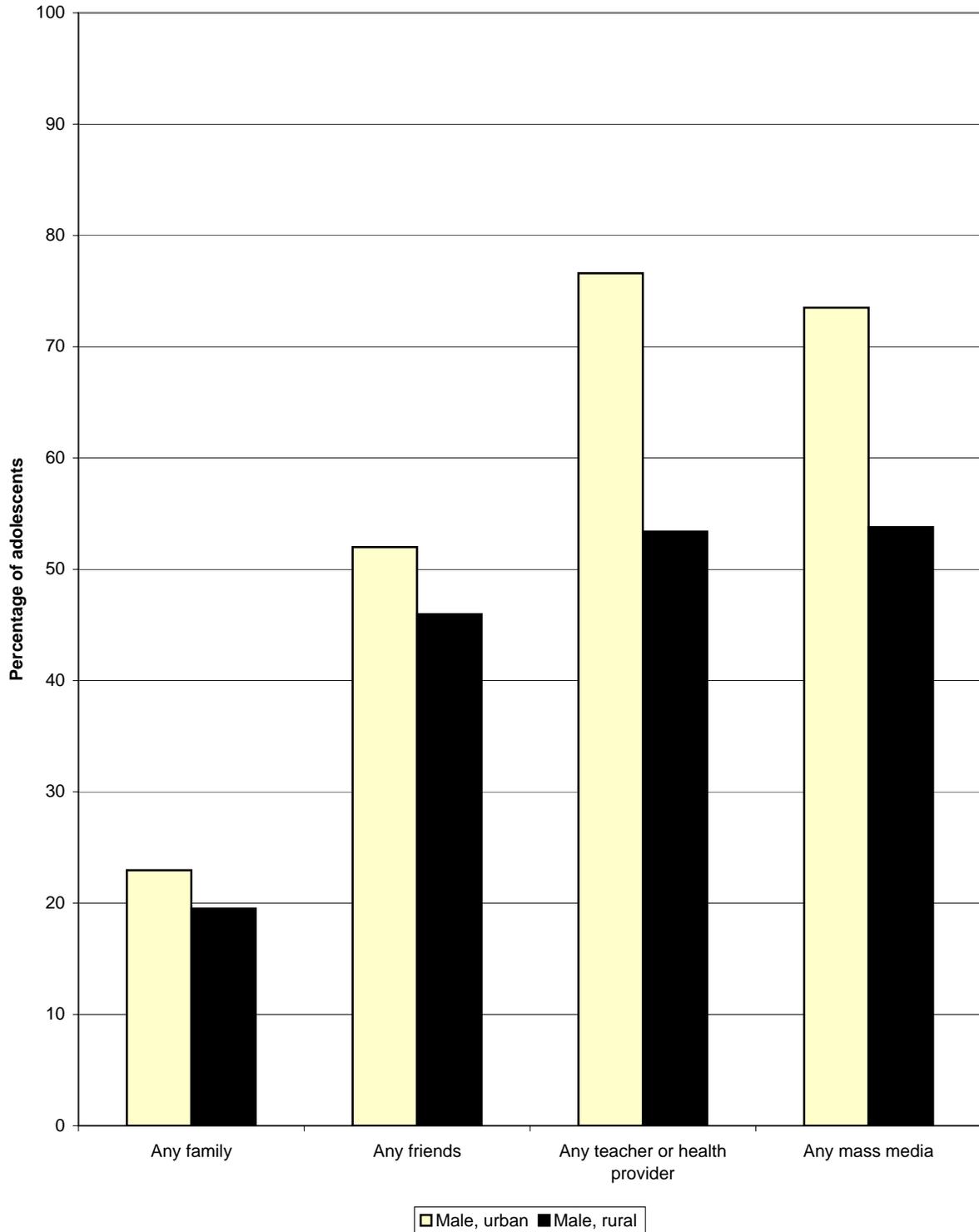


Chart 9.4 Adolescents who know of at least one method, by used and preferred sources of information on contraceptive methods, 2004 National Survey of Adolescents

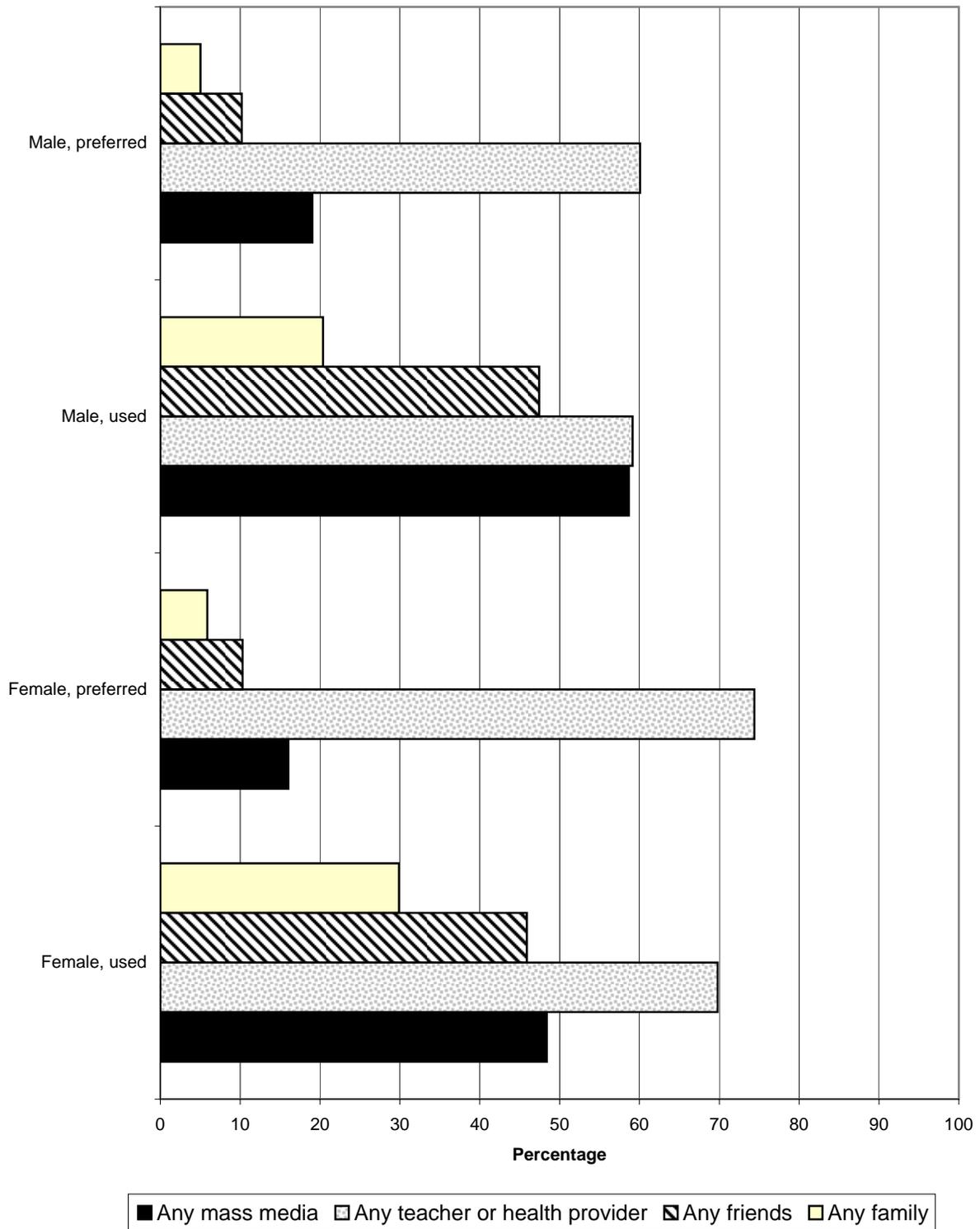
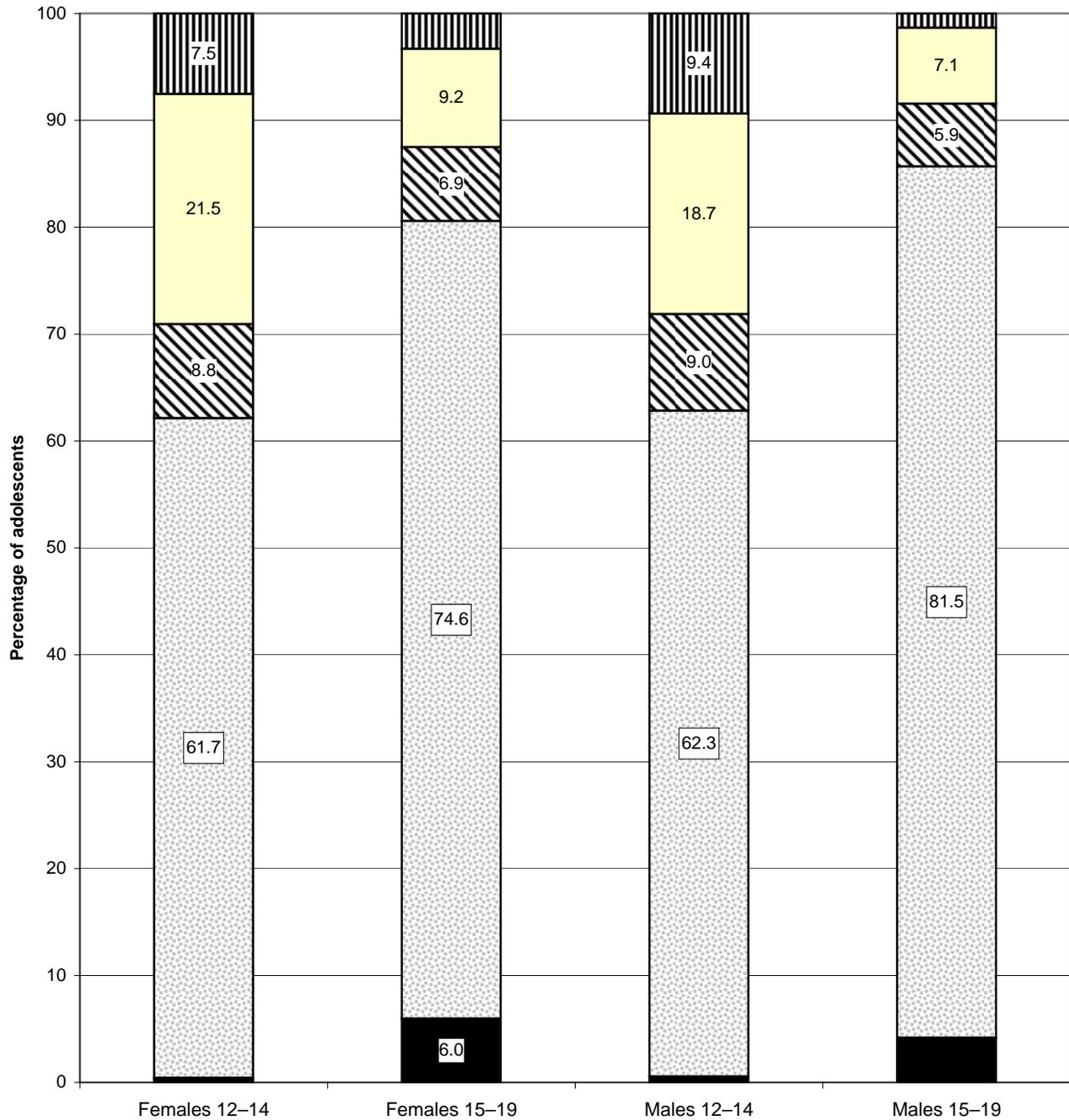


Chart 9.5 Adolescents, by knowledge and experience of voluntary counseling and testing, according to sex and age, 2004 National Survey of Adolescents



■ Heard of HIV/AIDS, test and place, and has been tested
 □ Heard of HIV/AIDS, test and place, but never tested
 ▨ Heard of HIV/AIDS and test, but do not know place for test
 ▩ Heard of HIV/AIDS, but do not know test for HIV
 ▤ Never heard of HIV/AIDS

Chapter 10

Conclusions

The results from the 2004 Malawi National Survey of Adolescents was aimed at assessing the current levels of adolescent knowledge, attitudes and behaviors that either put them at risk for HIV infection and unwanted pregnancy or that are protective; examining why some adolescents are at higher risk of HIV transmission and unwanted pregnancy than other adolescents; and documenting adolescents' barriers to seeking sexual and reproductive health services and information. The study also aimed at providing new information about what very young adolescents (aged 12–14) know and do with respect to sexual and reproductive health. This study fills some of these knowledge gaps and hence it provides guidance on what youth sexual and reproductive health programs should be focusing on.

The conceptual framework presented at the beginning of the report was meant to help locate the data presented in this report within a conceptual structure. Since the data presented in the report were not tested for significance, it is not possible to say which pieces of the framework are most relevant in determining adolescent sexual and reproductive health in Malawi. Rather, the report presents prevalence estimates of the variables in the conceptual framework which informs, but does not test, the ideas put forth.

Due to the universal free primary education, almost all of the respondents had attended school but at the time of the survey, only 74% of females and 81% of males were attending school. Around 84% of adolescents had not progressed past primary school; however more than 70% expected to continue their education, pointing to the frustrated demand for increased schooling among the respondents. Keeping youth in school improves their future livelihoods, acts as a disincentive for early pregnancy and provides a forum through which information about how to protect oneself from unintended pregnancy and STIs, including HIV, can be communicated. The fact that youth did not name initiation counselors as a primary source of information on sexual matters demonstrates the fact that traditional av-

enues of information transmission on these topics are not as relevant or are much less common than in the past.

The data revealed that adolescents, especially older adolescents, are having sexual intercourse: Some 60% of the males and 37% of the females (slightly less than half of whom are in union) aged 15–19 have had sexual intercourse. Yet contraceptive use is not the norm. More than 60% of sexual acts in the three months prior to the survey were unprotected and the use of contraceptives at first sex is not common. Knowledge about contraception among adolescents is quite high. Therefore, one hypothesis for why contraception was not practiced was that sex was not planned: The majority of adolescents believed that people do not plan to have sex, it just happens. It could also be that contraceptives were not used because the sex was not wanted, as 38% of females and 7% of males said that they were not willing at all at their sexual debut. Yet that does not explain why current contraceptive use remains alarming low among sexually active adolescents: 34% among males and 29% among females.

While the majority of the respondents who had had sex had only one partner, a significant proportion of adolescents aged 15–19 had had four or more sex partners in their lifetime, with males having a higher number of partners than females. The fact that the majority of the sexual acts are unprotected and that a proportion of the adolescent population is switching partners puts adolescents at risk of contracting HIV and other STIs or experiencing an unintended pregnancy. Females, especially those in union, are at higher risk of contracting HIV, as the use of condoms for those in a union is lower than for those not in a union. Most female adolescents are having sex with older males which might, in part, explain their failure to have safer/protected sexual intercourse.

There are other sexual practices that place adolescents at greater risk of HIV infection than traditional vaginal intercourse: anal sex and dry sex. Even though

fewer than 10% of the respondents reported having experienced anal or dry sex, a considerably higher proportion of respondents reported having friends who had practiced done so. Such sexual practices are therefore more prevalent than previously thought and might be responsible for a disproportionate number of HIV cases. An alarming proportion of adolescents also reported that they have been forced or coerced to have sex. In such circumstances, the probability of using protective measures is reduced, making these behaviors not just psychologically damaging but physically dangerous, as well as placing the actors at increased risk of STIs, including HIV.

While adolescents are aware of some aspects of how pregnancy occurs, misperceptions still exist; for example, many adolescents believed that a female cannot get pregnant the first time she has sex, if she has sex standing up or if she washes herself after sexual intercourse. Misunderstandings of when one is vulnerable to becoming pregnant may reduce adolescents' perceived need to use contraceptives. The high level of unintended pregnancies experienced by the respondents points to the fact that adolescents are not adequately equipped to prevent an unintended pregnancy from occurring. Only 18% of females and 17% of males gave an ambiguous answer regarding when they would like to have a (or another) child, while others wanted to wait at least one to two years. Although only 0.4% of 15–19-year-olds said that they themselves had attempted to end a pregnancy or had been involved in ending a pregnancy, almost 30% of all respondents had had a close friend who ever tried to end a pregnancy, providing an idea of the level of induced abortion among adolescents.

The radio, teachers, health providers and same-sex friends are the primary information sources for contraceptive methods and HIV/AIDS. Though the radio is the most frequently cited source of information on these two issues, most adolescents said they prefer getting information on contraception and HIV/AIDS from health workers. The major barriers to getting such information, particularly among females, are being embarrassed or shy and being afraid or fearful.

The high level of prejudice that the respondents expressed toward those with HIV/AIDS, which was even higher among the younger respondents, runs contrary to the high proportion of respondents who know someone with HIV and who said that they would care for a family member infected with HIV. It may be that adolescents are making distinctions between strangers with HIV and loved ones with HIV and this might account, then, for the apparent contradiction in respons-

es. Yet any demonstration of stigmatization of HIV-positive individuals may make people more disinclined to get tested for HIV, admit to having HIV and take protective measures that might protect their sexual partners from contracting the disease.

While fewer than 10% of respondents said they had experienced an STI via indirect diagnosis, the presence of STIs greatly increases adolescents' risk of HIV infection. Therefore, timely and effective treatment of these infections remains a crucial point at which HIV might be able to be stymied. Teachers were the most important sources of information for females, while the radio was for the males. Health workers were the most preferred sources of STI information, followed teachers and the radio. Major barriers to getting advice or treatment for STIs were feeling embarrassed or shy and being afraid or fearful. Government health facilities were the most preferred source for STI treatment, possibly because treatment is offered free of charge.

On voluntary counseling and testing services, the majority of the respondents who had heard about AIDS and the existence of an HIV test had not been tested: Only 3% of the respondents had been tested. For those who had been tested, it was mainly because they wanted to know their status, or they were tested as part of Preventing Mother-to-Child Transmission services, while some were encouraged by peer counselors. Most of the tests were done at government health facilities, Malawi AIDS Counselling & Resource Organisation (MACRO) and private clinics. More than 70% of the respondents wanted to get tested.

Policy and Programmatic Implications

- Making it possible for adolescents to achieve their educational goals is likely to have a positive impact on their knowledge about sexual and reproductive matters and thus an indirect effect on the timing of first births, since with increased education, females have a greater incentive to delay union formation and childbearing.
- The need for more information about sexual matters should be prioritized because of the multiple ways that this lack of information affects young people's lives. Incorrect knowledge about the fertile period, low levels of contraceptive use at first and subsequent sexual encounters, and lack of knowledge about contraceptive methods other than condoms is common. This leaves young people vulnerable to unintended pregnancies and STIs. The sexually active adolescents who are not practicing contraception and do not want to have a child deserve urgent attention.

- The fact that shyness, embarrassment and fear are major barriers to accessing information on contraceptives, HIV and other STIs, and sexual and reproductive health advice and treatment underscores the need to bring information and services to young people. Health care providers and teachers are the preferred sources of information, so their ability to communicate with adolescents on these matters should be facilitated and supported via sex education in the classroom, community outreach classes led by teachers and health care providers, and adolescent clinics or periods of time during the week when clinics cater specifically to adolescents.
- Since government health facilities are the best-known and most preferred sources of contraceptives, followed by private clinics and Banja La Mtsogolo (BLM), extra effort should be made to make sure that these sites are welcoming to adolescents and provide services in a discreet and confidential manner. Any reduction in barriers adolescents face in being able to take care of their sexual and reproductive health has the potential of having a positive impact on their ability to take care of themselves.
- Another avenue through which to reach adolescents with accurate information is through their various clubs. Many youth belong to clubs which could be sharing information. Therefore, efforts to fortify the information that AIDS clubs or sports clubs, for example, are sharing should be supported, as these are nonintimidating and accessible venues for adolescents to acquire information.
- Because adolescents, particularly males, talk to their friends about sexual matters, efforts should be made to enhance peer education programs that focus on reproductive health information as ways of reaching young people with appropriate and accurate information.
- Adolescents who have not had sex are a population requiring sexual and reproductive health information and services as well. Within this population, some are closer to having sexual intercourse than others. Those who are abstaining from intercourse because they do not have a partner may not be abstaining for much longer. Therefore, programs should be created to help young people transition to being sexually active individuals who are as responsible and well-protected as possible.
- While religion is very important to the majority of respondents, it is not an important reason given by adolescents for not having sex. Therefore, faith-based abstinence only messages may have limited impact on

this population.

- Efforts to reduce the stigmatization of HIV-positive individuals might increase the number of individuals willing to get tested for HIV. Increasing the number of people who definitively know their HIV status can potentially increase the probability that these individuals will take protective measures not to expose their sexual partners to the disease and thereby slow down the rate of transmission.

In sum, there is need for a multipronged approach: Increase the number of adolescents receiving sexuality education, decrease the stigma experienced by adolescents surrounding accessing information on sexual and reproductive health matters, and make services more adolescent-friendly and accessible. Malawi's extremely high rate of HIV prevalence demands that greater attention be paid to any and all entry points by which to reach young people and help them reduce risky behaviors and increase their ability to enact protective behaviors. This report provides the evidence needed to design programs to meet the knowledge gaps that leave adolescents vulnerable and to communicate with adolescents via preferred information sources. This report also demonstrates that fear, embarrassment and shyness are the primary barriers to accessing contraceptives. A coordinated referral system through which young people are escorted by trusted sources has the potential of meeting the full scope of adolescents' sexual and reproductive health needs.

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