

Strengthening the Delivery and Accessibility of Youth Friendly Health Services in Malawi

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Policy Brief

Introduction

Around the world, the number of young people needing reproductive health care, especially prevention services, is growing. In many places, this need is a result of a longer period of non-marital sexual activity related to earlier menarche, later marriage, greater economic opportunities for women, increased urbanization, and liberalising attitudes influenced considerably by modern mass communications (Senderowitz 1999). Yet, as Akinyi (2009) indicates “access to and utilisation of YFRHS [youth friendly reproductive health services] services is a primary concern surrounding the promotion of sexual and reproductive health and rights..... This is attributed to the sensitive nature of sex and sexuality issues among youth which have not been fully addressed and to a large extent the way the reproductive health services are being offered”.

Youth Friendly Reproductive Health Services (YFHS) are needed if young people are to be adequately provided with sexual and reproductive health (SRH) care. YFHS are expected to meet adolescence age-specific needs including providing reproductive health services, programmes formerly reserved for older and married women. While younger, married women were allowed to receive such services in the past, limited consideration was given to their special needs because of their biological development and emotional maturity. Unmarried, young women and young men were effectively excluded. Furthermore, their sexual activity is occurring in the midst of an HIV pandemic that disproportionately affects adolescents and young adults.

Given that young people tend not to use existing reproductive health services, specialised approaches must be established to attract, serve, and retain young clients. According to Senderowitz (1999), YFHS are able to effectively attract young people, meet their needs comfortably and responsively, and succeed in retaining them for continuing care. Meeting the reproductive health needs of the youth is one important strategy in addressing the social and economic implications of a rapidly growing population and managing development.

In Malawi, youth aged 10-24 years constitute more than one-third of the population (NSO 2008). There is need to have a healthy youth population that can contribute positively to the nation's socio-economic development. The Ministry of Health (MoH) (2005) observed that with prompt and effective use of YFHS, a lot of related health problems will be reduced, resulting in better adolescent and youth school performance and better future adult population.

Key Messages

- Youth Friendly Reproductive Health Services are needed if young people are to be adequately provided with sexual and reproductive health care.
- Given that young people tend not to use existing reproductive health services, specialized approaches must be established to attract, serve, and retain young clients.
- Despite efforts to provide youth-friendly services in Malawi, the uptake of services by young people is limited.
- For successful YFHS programming, Malawi needs to build strong linkages in both policy and institutional arrangements.

Youth Friendly Health Services in Malawi

According to Senderowitz (1999), YFHS comprises the following: sexual and reproductive health (RH) education and counseling, physical examinations, including pelvic and breast examinations for females and testicular examinations for males, cervical cancer screening (e.g., pap smears), sexually transmitted infections' screening, counseling, and treatment, HIV testing and counseling, contraceptive method choice, adoption, and follow-up, pregnancy testing and options counseling, abortion services (where legal) and post-abortion care, prenatal and postpartum care, well-baby care and nutritional services. Quality aspects of youth friendly services are: respecting confidentiality, giving choices, and raising awareness of rights. Apart from delivery settings, the friendliness also includes community acceptance and support of young people's sexual and reproductive health rights (SRHR).

Realising that adolescents and young people form a large population segment that is exposed to a broad range of SRH challenges including unwanted pregnancies, sexually transmitted infections (STIs), and HIV and AIDS, the Government of Malawi

through the MoH in 2007 began implementing a comprehensive YFHS programme. This is a strategy to make all health services more acceptable, accessible, and affordable to young people. Other players such as Ministry of Youth and National Youth Council (with funding from UNICEF) had been implementing YFHS since around 2000.

According to the report Evaluation of Youth-Friendly Health Services in Malawi (2014), the implementation of the government's five YFHS standards are rated as medium. This meant that: i) 50-70% of health facilities were implementing a standard element, ii) more than 60% of health facilities had copies of the YFHS standards on-site; iii) less than one-third of health facilities had a clear sign advertising YFHS, provided outreach services specific to youth, had trained providers on the YFHS Standards, and had youth-specific information, education and communication (IEC) materials. In the report, about half of health facilities have organised community meetings to provide information on YFHS. However, less than 40% of facilities reported disaggregated data by age, sex, school and marital status, yet this is the information that can inform service provision based on where young people are in their lifecycle stages.

What is the problem with YFHS?

Despite efforts to provide youth-friendly services, the uptake of services by young people is limited. YFHS Evaluation Report of 2014 shows that awareness and ever use of the YFHS programme in Malawi is low, with less than one-third of community youth survey respondents reporting to have heard about YFHS and 13% reporting to have ever used YFHS. Those living in communities where health facilities offer YFHS report knowing more about YFHS than those living in communities where facilities do not; about 35% versus 25%, respectively. However, ever use of YFHS does not vary by whether or not a community has a facility that offers YFHS. Studies by Family Health International further showed that attracting the youth to the clinical services has remained a challenge and that there is need to create demand and improve health-seeking behaviour of youth.

The findings above are reinforced by Erulkar and others (2005), who state that numerous studies have revealed that adolescents are neither well-received nor comfortable in mainstream family planning clinics, which are mostly government-

owned maternal and child health/family planning (MCH/FP) facilities.

Low uptake of YFHS among young people has many consequences including, low knowledge about how to prevent HIV. In Malawi, only 59% of men aged 15-19, and 42% of women in the same age bracket know how to prevent HIV (Ringheim and Gribble 2010). Munthali (2004) states that 35% of females aged 15-19 were either pregnant or mothers preceding the 2000 DHS study. The figures are collaborated with the DHS (2010) that found that 5% of men aged 15-19 had two or more sexual partners in the 12 months preceding the study. Furthermore, 13% of males aged 15-19 years had had some type of STI and low utilisation of VCT services, in 2000, with only 7% of adolescent men aged 15-19 having ever had an HIV test (Munthali et al., 2004).

Youth Friendly Health Service approaches that work

Where community support is mobilised

In her research, Munthali (2011) says:

“the majority of adolescents reported that culture was one of the major factors that prevented most adolescents from accessing youth friendly sexual and reproductive health services. There was still high resistance from religious and community leaders to openly discuss sexual and reproductive health issues with adolescents. Most of them reported that parents, elders and society at large act as ‘negative’ gatekeepers since they are uninformed about adolescents sexual and reproductive health needs”

Kesterton and others (2010) argue that dealing with youth in isolation is not helpful and engaging influential people in young people's lives may be necessary to sustain changes in behaviour. Kesterton (2010) recommends a comprehensive approach which has been observed to be the most promising. Furthermore, it is recommended that programmes need to involve the adults around young people (teachers, parents, etc.) and that broader community mobilization activities can help garner even wider support for youth SRH programmes and ease some of the barriers hindering adolescents from accessing services.

Methodology

This policy brief is based on a comprehensive review of existing literature. The literature reviewed included scientific papers, research reports and government policy documents.

Discussion of Policy Options

Laws and policies in many countries including Malawi restrict access to certain kinds of health services (including access to specific commodities such as contraception) according to age, marital status, or both. Service providers in traditional reproductive health services often discriminate against young people, sometimes by requiring a minimum age or parental consent to access services.

A policy directive by the Ministry of Education restricts SRH services and service providers from accessing schools and students to provide SRH information and services. Even where the law does not specify restrictions, health facilities, health workers and other providers (such as pharmacists) sometimes establish their “own policies” that prevent or diminish adolescents’ access to services. There is strong recommendation to review the content of sex education to ensure 10-14 year olds, in particular, are getting the information they need about sex, contraception, and pregnancy (MoH 2014).

Dealing with Operational Barriers

Where there is a safe and supportive environment young people will be motivated to make, reinforce and maintain healthy choices. YFHS should be accessible, acceptable, equitable, appropriate, and effective. However, observation has shown that even when clinics and other service programmes do not intend to prevent adolescent clients’ access to their services, operational policies or clinic characteristics can inadvertently serve to reduce access. Erulkar and others (2005) studied mainstream clinics and found that these clinics have long waiting time, long distance to clinics, inadequate provider and client interactions, and insufficient time spent for consultation.

Munthali (2011) argues that recreational or sports facilities and libraries or reading corners do create a conducive environment for young people in accessing YFHS. Furthermore, such facilities could help to keep young people active, provide them with alternatives to sexual activity, and give them a place where they can gather to talk, discuss, brainstorm, learn, and share with each other their experiences. Evidence provided by Kesterton and others (2010) from three centres (namely, Centre Dushishoze in Rwanda, Pathfinder International’s centre in Gweru Zimbabwe and the ABTEF youth

centre in Togo), reveal that combining services with recreational activities, peer education and in the case of Togo, use of the media, help to increase access and utilisation of sexual health reproductive services by young people

Information to young people

If young people are provided with the right information, they will be compelled to seek more information, guidance and medical attention about their emerging sexuality and development. Often, their friends are the source of information. Young people tend to remain poorly informed—or even misinformed about such matters as body physical and emotional changes and emerging needs, awareness on pregnancy and STIs, services available and where they are located.

Senderowitz (1999) outlines how community forums, libraries, the media and social gatherings can foster exchange of information and messages amongst young people, service providers and community. YFHS can be effective if trained young adults and community counselors are used as outreach workers to provide sex education, family planning information, and contraceptive referral to young people.

Young people’s feelings of discomfort

Perhaps the most widespread explanation for young people’s avoidance of clinics and service providers is their discomfort with real or perceived clinic conditions and attitudes of providers. Such perceptions result from their own experiences, second-hand information from peers, or a general reputation about the services. Other researchers are of the view that some models appear to accomplish their objectives more successfully and cost effectively than the fixed-site service model (clinical), which is the most common model used in Malawi.

In a comparison of fixed-site and peer-outreach services in Mexico, for example, an evaluation found that the Community Youth Programme of the Prosuperacion Familiar Neolonesa (PSFN) was more effective in reaching their targets at less cost than the Integrated Youth Centers (Senderowitz 1999). Braeken and Rondinelli (2012) found that young people utilise services more often when outreach activities are available; the services and condoms are free, and educators and professionals

are young and non-judgmental, of the same gender, and have positive attitude towards young people sexuality.

Recommendations

Mobilising community support – in an African cultural setup, providing public RH services to young people can be a sensitive issue. The community should be made aware to see a positive role for these services. Once the community accepts and is ready to take up responsibility, it can help ensure success, but this requires an organised campaign of public education.

Building policy linkages - collaboration with youth groups, health and other service organisations, and government agencies in pursuing a common agenda is critical. Senderowitz (1999) found that intersectoral cooperation among several ministries in Peru, for example, resulted in a key change in the law related to allowing pregnant young women to remain in school. For successful YFHS programming, there is need to build strong linkages in both policy and institutional arrangements.

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Removing operational barriers - under the international, regional, and domestic law, adolescents are entitled to measures ensuring the highest attainable standard of health. Identify gaps, policy barriers, and inconsistencies in legal protection that can create age-related barriers to YFHS. Allocating specific times and/or space and well qualified health personnel to serve youth is crucial to increase YFHS uptake by the young people.

Providing adequate information to young people - Adolescent clients must know that youth-friendly SRH services exist, the facility location, and its hours. It is important that any publicity on services also stresses that young people are welcome and that they will be served respectfully and confidentially.

Addressing young people's feelings of discomfort –the services should emphasize protection of confidentiality. Health services providers should be in a position to explain the limits of confidentiality as a matter of caring rather than of law. Young people develop confidence if they know they will access a supportive adult who will respond to their worries and concerns.

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