JETIR.ORG ISSN: 2349-5162 | ESTD Year : 2014 | Monthly Issue
JOURNAL OF EMERGING TECHNOLOGIES AND INNOVATIVE RESEARCH (JETIR)
An International Scholarly Open Access, Peer-reviewed, Refereed Journal

AN ASSESSMENT OF YOUTH'S UNDERSTANDING ON SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN TRADITIONAL AUTHORITY MALILI IN LILONGWE

[1]Yamikani Mtisau, [2] Esakkiappan Mugundharajan
[1]Masters Student, DMI St Eugene University [2] Lecturer, DMI St Eugene University
[1] Department of Social Work
[1]DMI St Eugene University, Lusaka, Zambia

Abstract

Background Meeting of Sexual and Reproductive Health and Rights (SRHR) of young people is an essential component of their overall well-being, yet in the recently there is a growing concern regarding the limited knowledge and awareness among youth especially from rural areas. This research paints a comprehensive assessment of Malawi youth knowledge on SRHR, thereby bridging the gap in understanding the challenges and opportunities in this critical domain.

Methods The study adopted a descriptive research design mainly to ascertain the youth knowledge on SRHR. In line with this, the study therefore used a structured questionnaire survey, focus group discussions and Key Informant Interviews to collect data on the participants' knowledge on SRHR. Assessed topics were on contraception, sexually transmitted infections, reproductive rights, attitude towards SRHR and access to healthcare services.

Results The findings of the study revealed varied levels of knowledge among the youth participants regarding SRHR topics. While some demonstrated adequate understanding on contraception and STIs, there were gaps in knowledge related to reproductive rights and access to healthcare services. Additionally, the results highlighted disparities in access to SRHR information and services based on gender, socioeconomic status, and educational level.

Conclusion This study provides valuable insights into the current level of knowledge on SRHR among youth in Ta Malili, Lilongwe, Malawi. The findings emphasize the need for tailored interventions and educational programs to improve youth awareness and access to SRHR information and services. By addressing the identified gaps, it is possible to empower young people in Ta Malili to make informed decisions about their sexual and reproductive health, ultimately contributing to their overall well-being and rights.

Key words Sexual and Reproductive Health; Youth; Gender based violence; Contraceptive; Family planning; Sexually Transmitted Infections.

Background

SRHR has become a global issue and international and national policy makers are greatly needed in an attempt to come up with SRHR laws in order to avert the ill health effects of young people. Sexual health calls for shout outs on threats, obligations, consequences and impacts of sexual deeds and practice of abstinence. It deals with a wide perspective on of physical, passionate, mental and social prosperity comparable to sexuality [11]. Sexual rights incorporate the privilege to reasonableness and not being victimized; the option to be at freedom from torment or cruel, unfeeling or disparaging control or discipline; the privilege to privacy; the privilege to the most elevated feasible norm of wellbeing; the option to participate in marriage; the option to decide the number and separating of one's youngsters; the privilege to realities and preparing; the privilege to autonomy of judgment and profession; and the privilege to a viable solution for infringement of fundamental rights [12]. A study on exploration of barriers and enabling factors for youth to access SRH services in Malawi, displayed that majority of the participants were in denial of SRHR rights [11]. There still remain a delink of information on SRHR among youth hence a call to follow further this issue.

This is the situation which the youth of Malawi and the youth of TA Malili in Lilongwe are in. If the future of the youth of TA Malili and Malawi's youth in general is to be sustained, then understanding of the term SRHR and its implications will be a plus. This then calls for tailor made SRHR interventions suitable to young people hence the execution of this research.

Malawi policy frameworks specific on SRHR

There are approximately 5 million young people in Malawi between the ages of 10 and 24. [9]. Recognizing that this demographic represents a diverse generation that needs a range of sexual and reproductive health (SRH) information and services to match their lifecycle stage, the Government of Malawi, in collaboration with Development Partners and the relevant youth stakeholders has come up with various policies and strategies for addressing issues affecting the youth in the realm of SRH as follows:

Youth-Friendly Health Services (YFHS) program

In 2007, to promote high-quality SRH services for young people, the Malawi government launched the Youth-Friendly Health Services National Standards and Youth-Friendly Health Services3 (YFHS) program. Malawi's YFHS program is designed to enable young people to access SRH services, including HIV testing, contraceptives, and contraceptive counseling, more easily. However, uptake of these services is low (13%) [4]. It is observed that youth encounter multiple barriers to access these services and these include: distance to services; perceptions that SRH services, particularly contraceptives, are only for married persons; parental pressure and messages that contraception and SRH services are not appropriate for unmarried adolescents; and concerns about confidentiality.

The Sexual and Reproductive Health Rights (SRHR) policy

In 2009, GoM launched a comprehensive and integrated sexual and reproductive health rights (SRHR) policy. The purpose of the Policy is to address SRHR problems that emerge from different age groups. Additionally, the policy also provides the framework for implementation of SRHR programmes in the country. Effort has been taken to link the SRHR Policy to within the health sector and other sectors such as agriculture, education. An analysis of the SRHR Policy reveals that it is has strong linkages to the following other Development Frameworks and Sectoral Policies:

- The Malawi National Youth Policy and Youth Friendly Health Services National Standards
- The HIV and AIDS policy which provides guidelines for implementation of HIV and AIDS activities and the rapid scaling up of testing and counselling services as well as access to ARTs and PMTCT services;
- The Malawi Gender Policy, which focuses on women empowerment and gender mainstreaming in all developmental programmes;

As a component of the Malawi National Youth Policy and Youth Friendly Health Services the Ministry of Education has also made significant inroads in incorporating WASH in schools. This has resulted in a programmatic shift of focus to schools and children. This is on the recognition that schools offer an important point of entry for raising the profile of hygiene and sanitation,

as well as improving the environmental health conditions in schools and communities. Increasingly, therefore, issues of Menstrual Hygiene Management are also become an integral component of WASH in schools (see for example, GOM, 2012).

The National Gender and HIV Implementation Plan (MOGCDSW, 2016)

This plan integrates priorities from the National Gender Policy into an operational plan for the National Strategic Plan for HIV and AIDS (2015–2020) (NSP). In alignment with the NSP, this policy stresses the importance of addressing gender inequality, harmful cultural practices, discrimination, and other human rights violations in order to meet UNAIDS 90-90-90 treatment targets. It points not only to health services, but also to the need for substantial community and behavior-change interventions to meet these targets. The final draft of the plan was submitted for review in November 2015 and was launched in 2016.

The 2001 National Reproductive Health Service Delivery Guidelines

These guidelines specifically address adolescent needs by providing a detailed guidance for public and private sector service providers as a basis for comprehensive, high-quality, and standardized care. The guidelines include a chapter specifically addressing adolescents and the characteristics of adolescent-friendly services.

The 2005 Guidelines for the Management of Sexual Assault and Rape

These guidelines, developed by the Ministry of Health contain specific instructions on dealing with children and adolescents and aim at improving Malawi's health services for all individuals (women, men, and children) who have been victims of sexual assault. They include chapters on addressing child sexual assault.

The 2008 Community-Based Injectable Contraceptive Service Guidelines

These guidelines seek to encourage youth involvement SRH by promoting the scale-up of community delivery of injectables through training health surveillance assistants to provide them. Although the guidelines do not mention youth specifically, adolescent girls benefit by the guidelines promoting increased access to an expanded method mix and choice. Moreover, the guidelines encourage the formation of youth groups to engage in dialogue on family planning and HIV. They also encourage male involvement through couples counseling, which could benefit young married women. Crucially, the guidelines do not differentiate between married and unmarried girls or women.

The 2007 Guidelines for Community Initiatives for Reproductive Health

These guidelines encourage participation of youth in program design. The guidelines outline actions to provide a standardized method of implementing community interventions for reproductive health to accelerate the reduction of maternal and neonatal mortality. Actions include increasing access to and use of family planning services. The guidelines do not specifically address youth but mention the need to include boys and girls ages 15–24 in focus group discussions for intervention design. The impact on adolescents' access is indirect, in that the guidelines mean to improve health outcomes for all women of reproductive age. Including young women in the intervention design process could help tailor solutions to the adolescent age group, including how to address access by married versus unmarried women.

The 2009 Sexual and Reproductive Health Advocacy and Communication Strategy

This includes a focus on increasing access to youth-friendly services. The strategy aims to guide systematic and strategic programming in advocacy and communication for SRHR at all service delivery points. It neither defines youth nor distinguishes between married and unmarried young women. Because of its aims to increase access to youth-friendly health services, increase men's participation, address gender relations, and reduce the vulnerabilities of women and girls, the strategy should have a positive impact on access to family planning services.

Methodology

This research adopted the descriptive research design mainly to describe the characteristics of a particular individual or of a

group [3]. In descriptive study, the researcher has the deliverable to define clearly what they want to measure and must explore adequate methods for measuring it [7] argues that descriptive research design provides accurate and valid representation of the variables that pertain to research questions. [7] view descriptive research design as a tool to coin both qualitative and quantitative methods to investigate one or morevariables. The study therefore used a structured questionnaire survey, focus group discussions and Key Informant Interviews to collect data on the participants' knowledge on SRHR. Assessed topics were on contraception, sexually transmitted infections, reproductive rights and access to healthcare services. The structured questionnaire survey also gathered information on demographic characteristics and access to SRHR information and services.

Sampling

Simple random sampling was used to select 231 youth from the population of 540 youth based in youth clubs in TA Malili. Sampling of survey respondents took the Slovin formula to figure out the sample size, which is;

n = N / (1 + Ne2)
where;n = Number of samples,
N = Total population
and e = Error tolerance (level).

The study used the confidence level of 95 percent thus giving an alpha level of 0.05.n = N / (1 + N e2)
540 / (1 + 540 * 0.05 2) =230

Thus 231 youth were selected as respondents to this study

Results

The findings of the study revealed varied levels of knowledge among the youth participants regarding SRHR topics. While some demonstrated adequate understanding on contraception and STIs, there were gaps in knowledge related to reproductive rights and access to healthcare services. Additionally, the results highlighted disparities in access to SRHR information and services based on gender, socioeconomic status, and educational level.

Contraception knowledge

The study established that the respondents were most familiar with the male condom (97%), followed by the injectable Depo Provera (86%); Implants (81%) and female sterilization (74%) as indicated in figure 1 below. Overall, the results reveal a mediocre understanding of contraceptives in the sample as evidenced by the average low score of 40.9% on the correct responses on family planning knowledge.

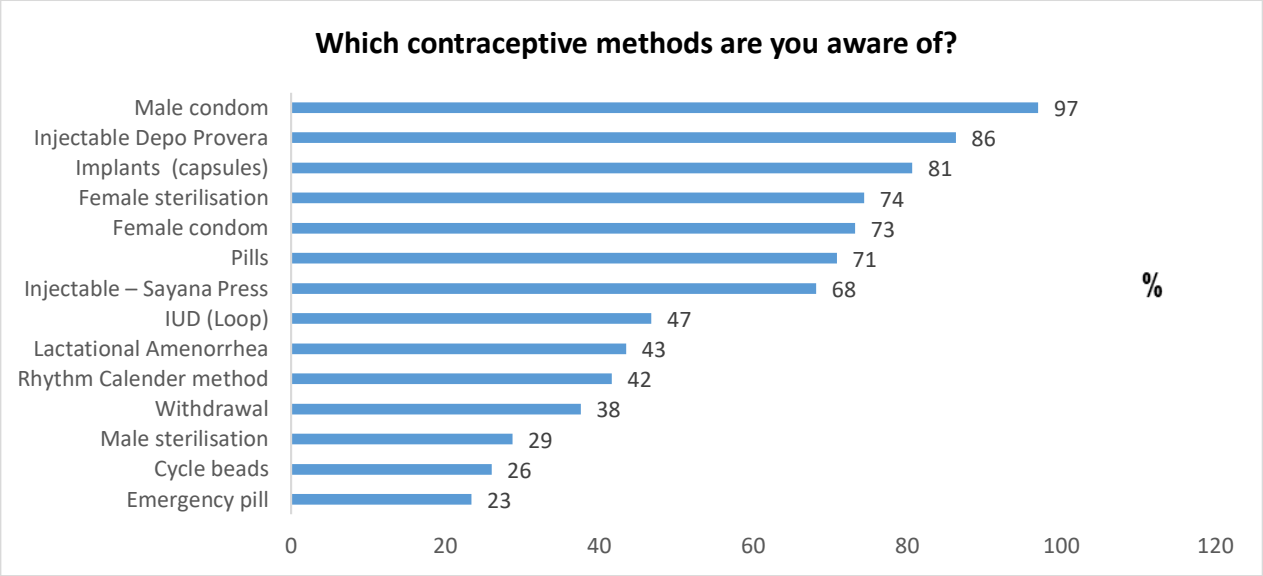

Figure 1 Contraception awareness by the youth

Knowledge on reproductive and sexual autonomy

The study sought to establish the status of reproductive sex autonomy awareness through a series of questions by exploring the choices women make in various situations. What is clear that both the male and female respondents generally agree that women have the right to engage in activities that promote their reproductive and sexual autonomy, such as accessing family planning services, counseling on reproductive and sexual health. Particularly noteworthy is the finding that the female respondents, themselves feel strongly about these rights themselves, much more than their male counterparts. This underscores the fact why young women are aware and in touch of their rights to reproductive and sexual autonomy, of prime importance is to create the space, the opportunity and the resources for them to exercise those rights. Figure 1-3 summarise the perception of the respondents towards knowledge on reproductive sex autonomy.

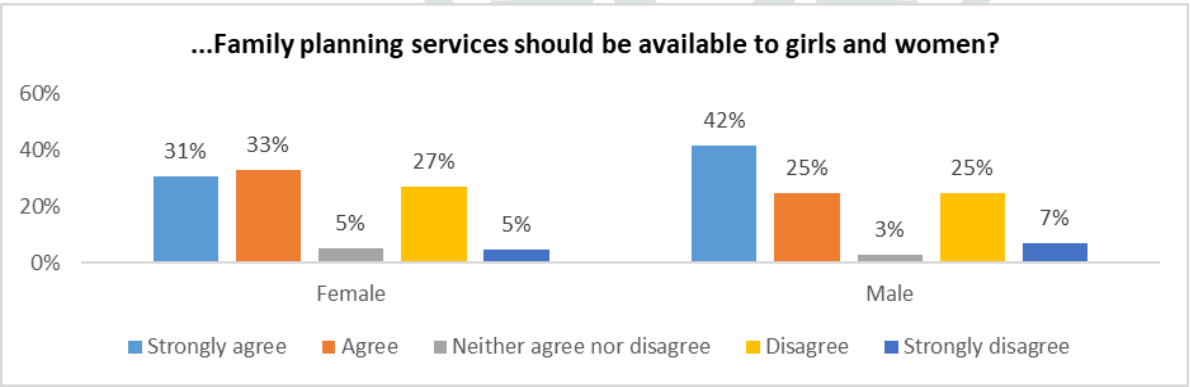

Figure 2 Perception on provision of family planning services to girls and women

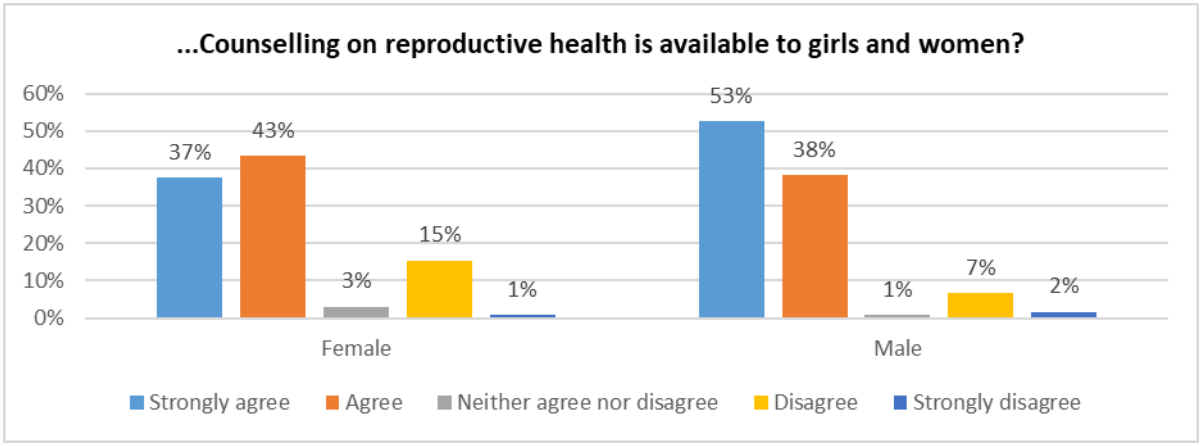

Figure 3 Perception on providing counselling on reproductive health to girls and women

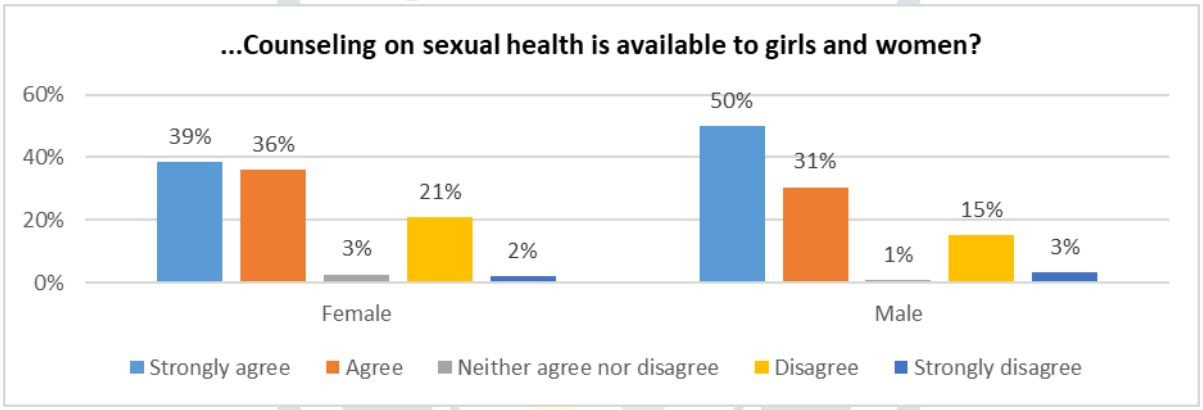

Figure 4 Perception on providing counselling on sexual health to women and girls

Knowledge on Sexually Transmitted Infections (STIs)

Majority of the participants are knowledgeable about STIs as shown in the table 2 below. However, knowledge onspecific signs and symptom and where to seek medical help proved to be difficulty to the respondents.

Table 1 Knowledge on the signs and symptoms of Sexually Transmitted Infections

		Age range of respondent		
		10-19 years	20-24 years	25-35 years
		Count	Count	Count
Do you know the signs and symptoms of STIs	No	34	23	5
	Yes	62	79	28

Knowledge of services for Gender Based Violence

Despite the respondents' high level of knowledge of the GBV structures and services, slightly over half of the respondents (51%) expressed confidence in the community to prevent violence against women; a quarter were doubtful whereas a further quarter were

totally adamant that the community could be helpful in GBV prevention.

Respondents were asked to indicate whether they were conversant with the gender based violence reporting structures. According to the findings, 87% reported being aware of where to report gender based violence, with the male respondents reporting slightly higher than their female counterparts (91.5% vs 84.9%). In terms of reporting destination, most identified the Police (39%); followed by the Village chief (32%). However, for the young and unmarried, their first point of call was their parents as indicated in figure 4 below.

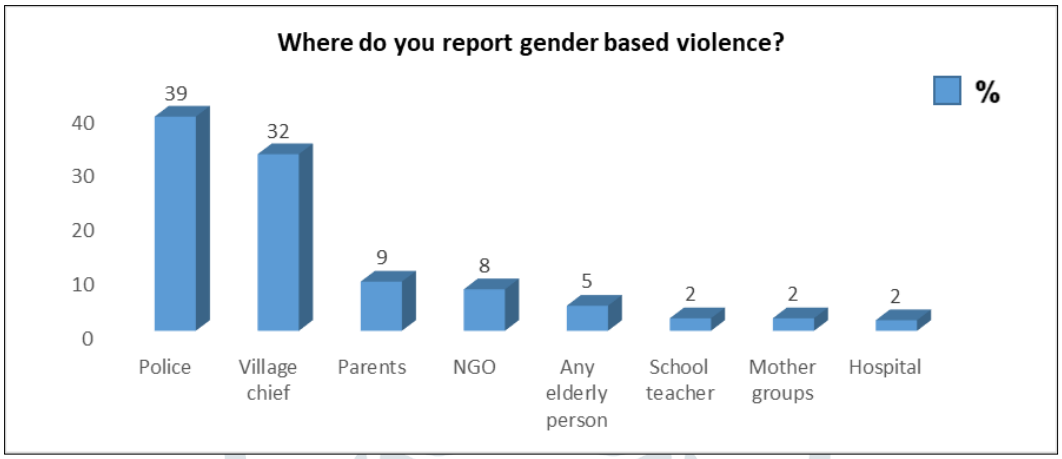

Figure 5 Reporting Gender Based Violence Structures

Sources of SRHR information

Figure 6 below show the pattern of SRH messaging to young people. It shows that radio (24%) followed by friends (22%) is the major avenue for obtaining SRH messages. The only concern is that slightly over a third (37%) had been exposed to such message in the preceding 6 months prior to the study. This is a matter of concern. When young people are denied clear, accurate and consistent information about SRH and access to contraceptives, they may be ill-prepared for sex, and unable to protect themselves from unintended pregnancies. Young people face an additional risk since family planning is controversial because sex is involved. Without accurate information and quality services young people will not be able to determine their own destiny.

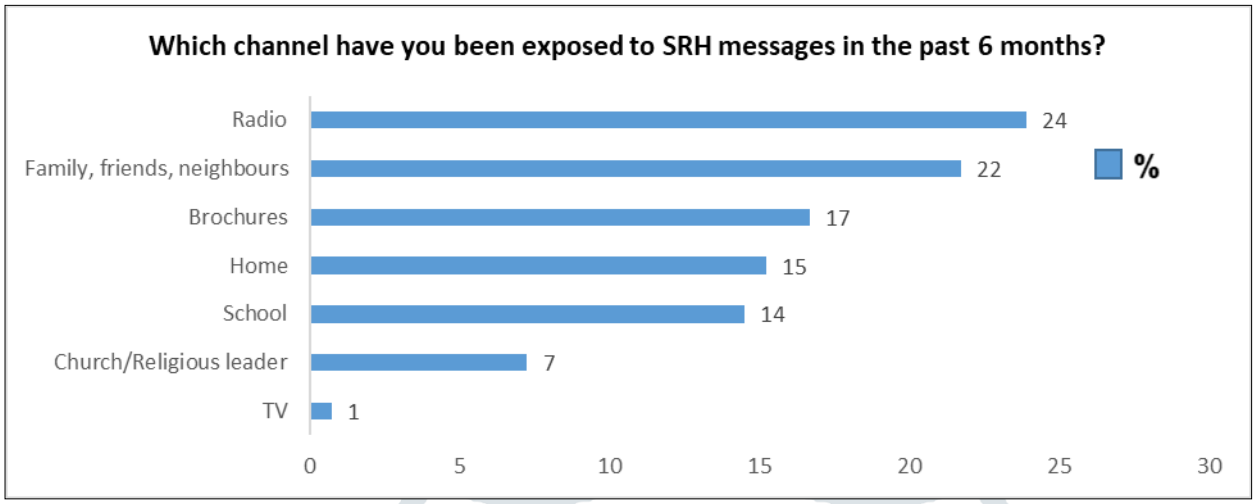

Figure 6 Sources of SRHR information

Barriers of SRHR access

SRHR access and demand among the youth are affected by personal attitude (both health personnel and the youth themselves), service availability and traditional norms nested in culture. Traditional norms and value are deeply rooted in Malili. The practice of sexuality is highly determined by these norms and values. Talking about sexual and reproductive health is considered unethical and shameful act in most of the communities in TA Malili. Service and service provider related factors were other barriers identified in the study. Lack of information about available ASRH services, inadequate services, service accessibility, lack of confidentiality, absenteeism of service providers, their behavior and sex are some of the restricting factors in the utilization of ASRH services recognized in this study as well as in previous studies.

This research has extensively provided information on youth's level of SRH knowledge. While majority of respondents have average knowledge on SRHR, the utilization of contraceptives and deep knowledge on family planning is still low hence high levels of unprotected sex leading to teenage pregnancies and STIs. Consistent with [6], this study also showed no huge difference in the knowledge level among respondents based on their age and sex. Even though male participants were more outspoken compared to female, sex of the participants didn't make any difference in the overall level of SRH knowledge.

Additionally, the participants were aware about STIs like HIV/AIDS, Syphilis and Gonorrhea. Similar findings on STIs knowledge among young and adolescents were found in previous studies [10]. This could be because all the participants had reached senior primary school where these diseases are taught comprehensively. There has been mixed findings regarding the common source of SRH information among adolescents. Radio, television, school books and friends were listed as the common source of sexual health information in this study. Similar finding was reflected in some previous studies [10]. Parents and internet sources were reported least common source of SRH information in this study unlike previous studies [10] SRHR access and demand among the youth are affected by personal attitude (both health personnel and the youth themselves), service availability and traditional norms nested in culture. Traditional norms and value are deeply rooted in Malili. The practice of sexuality is highly determined by these norms and values. Talking about sexual and reproductive health is considered unethical and shameful act in most of the communities in TA Malili. The fear of stigma and loss of social status, shame, disrespectful service provider, lack of privacy were discovered as the barriers to SRH service seeking behavior in different studies conducted in the United States, Eastern Europe and Central Asia [8]. Service and service provider related factors were other barriers identified in the study. Lack of information about available ASRH services, inadequate services, service accessibility, lack of confidentiality,

absenteeism of service providers, their behavior and sex are some of the restricting factors in the utilization of ASRH services, recognized in this study as well as in previous studies [5]. Gender and marital status are other factors that determine the utilization of SRH services [2]. Married people were recognized as the ones mostly using SRH services by this study's participants, which reciprocates previous studies findings [2]. However unlike other studies findings [2], participants of this study reported that unmarried youth are seeking SRH services.

Study Limitations

The study is prone to a number of limitations. The researcher's experience with the youth of the study area might affect the quality and type of responses given by the respondents. To illustrate on this, some informants could not provide detailed information during discussions especially when they felt that the researcher knew better and consider him as an expert [3]. However, the use of detailed research tools and probing techniques helped to solve the problem.

Additionally, since the outcomes findings were based on self-reported information, this could be subject to reporting errors and biases. This was taken care by the usage of methodological triangulation used could minimize such errors [3].

In addition, since the youth and community informants were not controlled in their movements between the intervention or non-intervention areas, there were high chances for the respondents of accessing SRH information or services aimed at boosting the knowledge status regardless of their study areas. This could affect

the study results as the participants from one study area might have an opportunity to come into contact with ASRH activities in another study area [1]. While the study addressed this by controlling for a number of background factors as stated in the eligibility criteria, the results should be interpreted with these limitations in mind.

Poor quality of documentation in the health facilities also made it difficult to have a very clear picture of service utilization in most facilities. For instance, most facilities had scanty information on SRH service utilisation by youth especially through the HAS and YCBDAs.

Furthermore, there research had time limitations. Research dealing with health related issues need a lot of time to come up with concrete results but this research was conducted within a short period.

Finally, transport logistics and frequent power outages lead to the delays in data entry and collection. The transport limitation was solved by using the most convenient mode of transport which was bicycles. Power outages was dealt with by opting to the usage of solar

Conclusions

The Study findings have highlighted a number of issues that need to be prioritized in SRH programming. The key issues are: Addressing the disconnect between policy articulation and policy implementation; leveraging the support of established girls' empowerment advocates; creating more supportive environments in the health centres for the health workers to function more optimally; institutionalizing confidentiality protocols in the health centres; recruiting more health staff and creating more capacity building opportunities for SRH providers; creating more supportive environments in the homes for youth to dialogue with their parents on ASRH issues instead of relying on inaccurate channels, such as friends; creating more supportive and informative environments at schools so that youths cannot only stay in school longer, but can also learn more from authoritative sources on matters to do ASRH; create more safety avenues for the youth to express their sexuality such youth groups and income generating activities for out of school youth and create synergies among stakeholders to avoid retrogressive duplication in ASRHR programming.

References

[1] Areskoug, Josefsson, K., Schindele, A. C., Deogan, C., & Lindroth, M. (2019). Education for sexual and reproductive health and rights (SRHR): a mapping of SRHR-related content in higher education in health care, police, law and social work in Sweden. Sex Education, 19(6), 720–729. https://doi.org/10.1080/14681811.2019.1572501

[2] Baral et al. (2012) Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis

[3] Creswell, J. W., & Creswell, J. D. (2018). Research design (5th ed.). SAGE Publications.

[4] Chandra-Mouli V, Svanemyr J, Amin A, Fogstad H, Say L,Girard F, et al. (2015) Twenty years after the International Conference onPopulation and Development: where are we with adolescentsexual and reproductive health and rights? J Adolesc Health.2015;56(Suppl 1): S1–S6. CrossRef. Medlin

[5] Dodd, S. J., & Tolman, D. (2017). Reviving a positive discourse on sexuality within social work. Social Work, 62(3), 227–234.https://doi.org/10.1093/sw/swx016

[6] Khatiwada N., Silwal P.R., Bhadra R., and Tamang T.M. (2013). Sexual and Reproductive Health of Adolescents and Youth in Nepal: Trends and Determinants: Further analysis of the 2011 Nepal

[7] Kothari, C.R. (2019) Research Methodology: Methods and Techniques. 4th Edition, New Age International Publishers, New Delhi.

[8] Lindberg C, Lewis-Spruill C, Crownover R. (2006) Barriers to sexual and reproductive health care: urban male adolescents speak out.

[9] NSO. (2019). Malawi population and housing census; Main report. Zomba, Malawi. https://doi.org/10.1097/01.gim.0000223467.60151.02

[10] Simkhada , S. & Aacharya D. R. (2012) . Sexual and reproductive health status and health service utilization of adolescent in four districts in Nepal. Duetsche Gesell

[11] UNFPA. Sexual & reproductive health [Internet]. UNFPA. 2020. https://www.unfpa.org/sexual-reproductive-health

WHO. (2018). Adolescent sexual and reproductive health program to address equity, social determinants, gender and human rights in Nepal: Report of the pilot project. New Delhi