

Act2Live

A Study on Neglected Health Issues among
Neglected and Vulnerable Young People in
Sub-Saharan Africa

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Abbreviations and acronyms

AU	African Union
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CBO	Community Based Organisation
CRC	Coordinated Response Centre
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
HBC	Home-Based Care
ICPD	International Conference for Population and Development
INEFJA	Institut National d'Education et de Formation de Jeunes Aveugles.
NGO	Non-Governmental Organisation
MCHI	Multi-Country Health Initiative
MoH	Ministry of Health
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
SIDA	Swedish International Development Agency
SMC	Swedish Mission Council
STDs	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
VSU	Victim Support Unit
WHO	World Health Organisation
YMCA	Young Men Christian Association
YWCA	Young Women's Christian Association

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The youth-led research on neglected health issues will contribute to existing efforts to address health issues disproportionately affecting young people, including hard to reach groups; and to understand status of youth-friendly health care services for specific hard to reach target groups identified in six sub-Saharan African countries.

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Foreword

In 2007, the AAYMCA and our member national movements adopted a shared vision: Empowering Young People for the African Renaissance. At the same time, African YMCAs decided that their core identity was based on African-ness, ecumenism and a youth focus.

With this in mind, in 2008, the AAYMCA commissioned a study on the status of young people in Africa. From this, "From Subject to Citizen", S2C was developed as our Change Model: the lens through which we view the world and deliver our interventions. This Change Model enables the African YMCAs give greater focus to young people as our primary constituency, for whom and to who all our energies and resources are channelled. S2C addresses attitude, values and skills of young people and seeks to create a voice in the young people, space for them to articulate this voice and the ability to influence within the provided space(s)..

In 2012, African YMCAs conducted a research to better understand the health issues among its primary constituency and to establish a baseline to inform the design of appropriate and responsive strategies for planned, current and future interventions. As part of this research process young women and men were actively recruited as research assistants, not simply to work for an allowance. This was a deliberate effort to build important skills for their own subjective competence and actual skills building for academic and/or employability purpose. Most significant was the fact that the young people would themselves be the drivers of change on the neglected health issues identified, thus it was important for them to see and hear first-hand the health challenges of their peers.

It is envisioned that both the experience during the research phase, and the information highlighted in the research findings, will enable youth to lead and participate in informed advocacy.

It is this aspect that makes this research and subsequent advocacy initiatives unique: the fact that it is youth-led making the advocacy agenda more powerful as the voices of young Africans come through. This is an important driver for the African Renaissance: creating voice, space and ability of key groups within our communities to influence.



Carlos Sanvee
General Secretary
Africa Alliance of YMCAs

Executive summary



YMCAs in Africa have a long tradition of health interventions for their primary constituency: adolescents, young women and men up to 35 years old. Out of this long track record, it was realised that in spite of YMCA and other agencies' interventions, the health status of young people continues to be of concern. This ranges from the highly visible concerns of sexual and reproductive health, HIV/AIDS, early childbearing, female circumcision, and substance abuse (alcohol, tobacco and drugs) to less visible issues of psycho-social effects based on household poverty levels such as poor nutritional status, inadequate diet, physical activity and hygiene. "The average 15-year

old boy has a 90% chance of surviving to the age of 60 in Western Europe or North America, but only a 50% chance in sub-Saharan Africa primarily due to spread of communicable diseases, such as HIV/AIDS." (World Development Report, 2007)

Youth and adolescent health is a real development issue essential for personal development which translates into societal advancement. The benefits accrued to the wider community include reduction in the cost of supporting the health care system and better participation in all spheres of the community. Notably, the gravest concerns are on access to adequate and appropriate information to enable young people

take better prevention measures. Key policy actions are needed throughout sub-Saharan Africa that expand youth opportunities, to give them the skills to participate fully in the economy and public life, and promote healthy behaviour (Ashford, 2007)

The primary motivation for African YMCAs and the YWCA in undertaking this study was to highlight other health concerns for young people that ought to be addressed at country and continental level.

“The majority of African nation-states have not met their health financing commitments.”

The 2001 African Heads of States meeting in Abuja, Nigeria, established the importance of countries dedicating 15% of their national budget towards health. Health funding has risen in Africa since 2001, but it still has not reached the level that the Abuja Declaration promised. From 2001 to 2011, health budgets in AU Member States increased from 9% to 11% of public expenditures. Six AU Member States namely Liberia, Madagascar, Malawi, Rwanda, Togo and Zambia are reported to have achieved the Abuja target of allocating 15% of public expenditure to health. Other countries include Djibouti, Ethiopia, Lesotho and Swaziland are within reach of the 15% target.

The research also aimed to empower young people by making them key actors in the research process as research enumerators. This had a positive result as it not only enriched them with data collection and research skills, but also engendered a full understanding of neglected health issues through interaction with their peers. This makes an agenda for advocacy far more powerful as the youth voice underpins the research and its methodology.

The researches at country level allow some comparison and consolidation of findings that presents a concise picture of the state of youth health issues. The results of the research provide information about young people with regard to:

- Current neglected health issues affecting youth with a special focus on the most vulnerable groups;
- The state of young people’s knowledge, attitudes, practices and behaviours of and towards selected health issues;
- Access levels to health services with a special focus on youth-friendly health services;
- Identification of existing policy and practice guiding and/or affecting young people’s access to youth-friendly health care information and services in target communities;

The findings of the research indicate that young people in Africa continue to face challenges in relation to health care services and relevant health promotion information and education messages. The study findings indicate that the neglected health issues among young people include:

1. The rising use of alcohol and tobacco with few interventions by public or private agencies to prevent or treat drug and substance abuse.
2. The cost of treatment is a barrier for young people to access curative health services.
3. Access to relevant health information for vulnerable youth and those in rural areas. As a result many young people depend on their peers, the media, self-medication and traditional healers for information and services.
4. Attitudes of health service providers towards young people are a barrier to access to preventive and curative health services. Visits to health centres are often measures of last resort and only when the medical conditions has advanced.



This research report is organised as follows:

Chapter 1 presents the research methods applied in this study;

Chapter 2 answers questions on the current health issues (both physical and mental) affecting young women and young men in the target areas, with a focus on the most vulnerable groups; and of the health issues identified, pin-point the most neglected by existing health care service provision;

Chapter 3 identifies levels of understanding and awareness of certain health issues, possible risk-taking behaviours amongst young people, as well as other factors such as stigma, discrimination and peer attitudes that may prevent access to health services;

Chapter 4 identifies forms of youth- friendly health care services that currently exist in the target areas (e.g. local health centres, hospitals, youth centres); the extent to which young people are able to access them and the most significant barriers to young people and in particular, marginalised groups of young people, in accessing these health care services;

Chapter 5 specifies relevant policy and practice guiding and/or affecting young people's access to youth-friendly health care information and services in target communities and more widely; as well as other organisations and/or agencies working within target communities to address the identified health needs of young people; and in

Chapter 6 AAYMCA draws conclusions and makes recommendations for young women and men on their responsibility for their health status, and targets policy makers on policy development and practice.

Chapter 1

Methods of data collection and analysis



Compilation of this report involved a detailed review of the seven research reports from the six countries in sub-Saharan Africa. Although each partner developed their own data collection tools, the method of data collection and analysis was also similar. The lead researcher's involved in the study are professionals in their respective fields. Brief profiles are provided in Annex 2.

1.1 Design of the studies

The studies were cross-sectional in nature. Information was collected from 2,625 selected respondents to

capture the state of health and health care delivery infrastructure at one point in time. To increase validity and reliability of the data, efforts were made to triangulate data sources whereby data from secondary sources was used to complement primary data collected from the sampled young women and men. A detailed discussion of methodologies used in the surveys is presented in this Chapter's subsections 1.2 to 1.8.

1.2 Types of data and data sources

Both primary and secondary data was collected. Quantitative primary data was collected through a structured questionnaire

and complemented by qualitative data collected through focus group discussions. In addition, collection of secondary data involved document review. The key sources included social and economic studies, media reports, government strategy papers and reports, policy documents, field reports from other NGOs, and research papers. Details are provided in Annex 1 on Bibliographic References.

1.3 Sampling techniques

All the studies used multi-stage stratified probability sampling to ensure that the findings could be generalized to the general youth population. All young people in sites that local YMCA was implementing projects were eligible to participate in the study. Each report, however, had a different sample size because of the differences in the sizes of the target youth population. Each country survey was required to focus on special categories of vulnerable young people.

The sample of young people who participated in the survey as respondents is presented in Table 1.

Table 1 Number of study participants by country and age

Country	Total number of respondents	Age bracket
Liberia	120	15 – 35
Madagascar	516	15 – 25
Senegal	352	15 – 24
Togo	228	15 – 25
Zambia (YMCA)*	296	17 – 41
Zambia (YWCA)	300	15 – 25
Zimbabwe	813	13 - 24

*The study was conducted by Zambia YMCA and Zambia YWCA in separate regions of the country. However the figures could not be combined due to variation in age limits in their samples.

1.4 Characteristics of respondents

The respondents in this study are African youth. The definition of youth in this study was guided by the

national context for each research. The research sample requirement was that at least 75% of the respondents be within the nationally defined age bracket of youth.

The studies had generally equal representation of male and female respondents with the exception of Liberia which had strikingly more male than female participants (79% and 21% respectively). The majority of these respondents were young people aged between 15 and 25 years old across all the seven studies with those aged 15 to 21 years old accounting for the bulk of the sample. On the other hand, a few respondents aged less than 15 years and older than 25 years were also included in some samples. Further, the sample was distributed proportionately across different regions in each country, while at the same time taking into consideration rural-urban dichotomy as necessary. The studies also made deliberate efforts to include vulnerable and hard to reach young women and men such as street children, the handicapped, orphans, young people affected by conflict, and commercial sex workers

1.5 Key research questions

A structured questionnaire was used to collect quantitative data. The questionnaire was developed in each country by a selected group of young researchers with the support of a technical consultant and input from YCI. The participation of young women and men as researchers was among the unique approaches in this research. These young people worked as research assistants and included young men and women from the targeted groups as described in Table 2.

Quantitative data was complemented with key informant interviews among drawn from relevant government ministries and departments as well as youth serving organisations such as local and international non-governmental organisations (NGOs) and local community based organisations (CBOs). To further improve the reliability of the data, Focus Group Discussion (FGD) were used in collecting data with two

FGDs conducted at each project site. The number of participants for FGDs varied from one FGD to another.

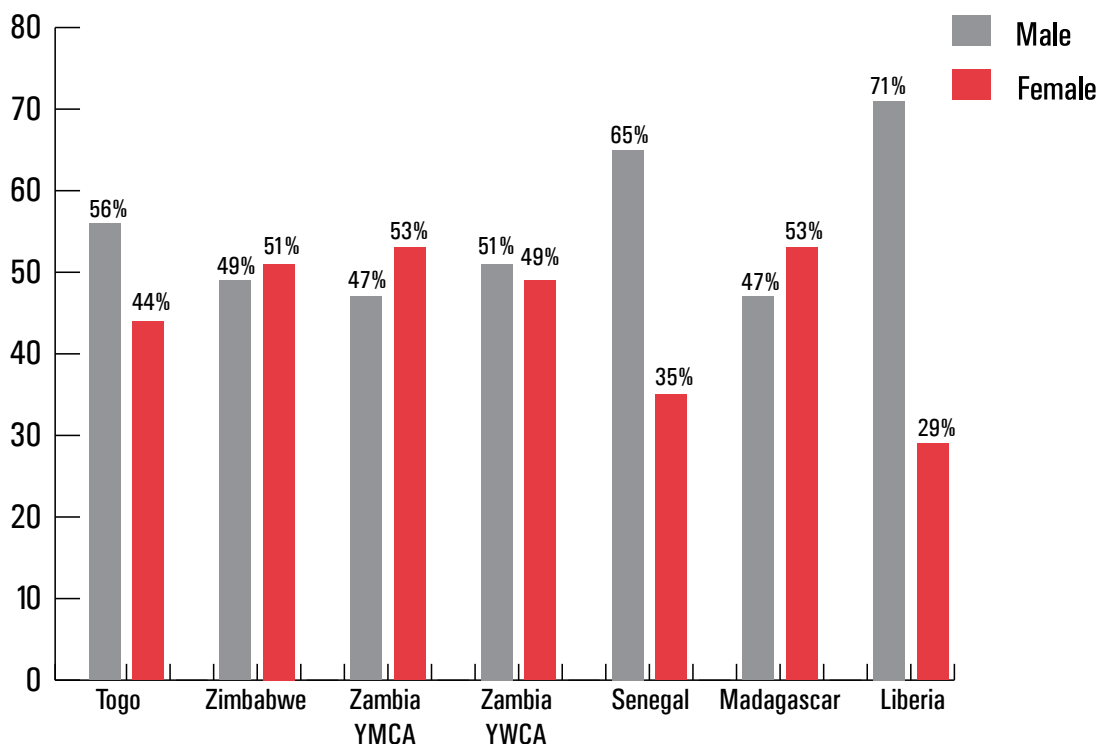
Research assistants who helped in data collection were all trained prior to data collection. Training involved sensitisation on interviewer skills, reviewing of the study instruments, mock interviews, and pretesting of the final tools. This was followed by data collection. Research assistants administered the questionnaire in a face-to-face interview to the sampled young people residing in the selected households while consultants coordinated

and supervised the activity to ensure data quality.

Additionally, the research team consulted with key stakeholders and field practitioners in the target areas, such as relevant local / regional government and non-governmental representatives (including from youth organisations, local CBOs, and community representatives) as well as key government stakeholders at national level (e.g. Ministry of Health and Ministry of Youth).

Table 2 Distribution of respondents by country, region and target Group

Country	Region/Research Site	Target Group
Liberia YMCA	Bong, Lofa, Montserrado Counties	Young people affected by conflict and violence, particularly ex-combatants, commercial sex workers
Madagascar YMCA	Ankazomanga, Sambaina, Canon, Ambohijanaka, Ambanitsena, Morarano Station	Commercial sex workers, Young people living in slum settlements, Young people living with, or affected by, HIV/AIDS
Senegal YMCA	Thies, Kaolack, Ziguinchor	Young people in conflict with the law (detained without charge in prison or ex-offenders), Orphans, Children and young people living or working on the street, Young people with disabilities.
Togo YMCA	Akodessewa, Akassime, Gbossime, Youth in the Juvenile Institution in Lome, Youth in the Port Area of Lome.	Young people in conflict with the law (detained without charge in prison or ex-offenders), Orphans, Children and young people living or working on the street, Young people living in slum settlements
Zambia YMCA	Lusaka, Kitwe, Chibombo	Orphans, Children and young people living or working on the street, Young people living with, or affected by, HIV/AIDS, People with disabilities
Zambia YWCA	Chipata, Kaoma, Lusaka	Orphans, Children and young people living or working on the street,
Zimbabwe YMCA	Chegututu, Kadoma, Harare, Rusape (Tanda)	Victims of political violence, Commercial sex workers, Orphans, Young people living with, or affected by, HIV/AIDS, Orphans.

Figure 1 Distribution of respondents by gender

1.6 Participation of beneficiaries

The participation of young people through all aspects of the research process achieved two goals: to improve research skills of young people; and to increase the target group's sense of ownership of the overall project. The inclusion of young people in the research process was also an important factor in drawing out information from respondents because of greater trust and understanding between peers.

The selection of research assistants was based on clear criteria that considered level of study and professional experience as regards the research. In the development of survey instruments, they participated by suggesting items they considered important for this study. A pre-test was done with the youth to assess the research tools and necessary corrections made.

For data collection, young women and men formed the base by being at the centre of operations. Thus, in each region, the youth involved facilitated the focus groups

and administered questionnaires. Finally, with the support of the study statistician, entry and tabulation were done by young people from each region. In Liberia for instance these included young people from the targeted communities who were trained in basic research methods and served as data collectors in field.

1.7 Key research questions

The study was guided by the following research questions.

- i. Knowledge, Attitudes, Practices and Behaviours: Identify levels of understanding and awareness of certain health issues, possible risk taking behaviours amongst young people, as well as other factors such as stigma, discrimination and peer attitudes that may prevent access to health services

- ii. Access to health care services: Identify what, if any, forms of youth friendly health care services currently exist in the target areas (e.g. local health centres, hospitals, youth centres); where are they located; and to what extent are young people able to access them. What are the most significant barriers to young people – and in particular, marginalised groups of young people – accessing these health care services?
- iii. Policy and practice: Identify relevant policy and practice guiding and/or affecting young people's access to youth friendly health care information and services in target communities and more widely (i.e. nationally)
- iv. Other organisations: Identify other organisations and/or agencies working in the target communities and assess their capacity in addressing the identified health needs of young people. Where do the gaps and/or weaknesses lie? Where are the opportunities for collaboration?

The findings of question (iv) are not included in this research report. Programmatic information needed to be confirmed and verified by each institution. This was not available in time for publishing..

1.8 Ethical considerations

In planning and implementing the research process, the survey implementers referred to YCI's "Working



with Children and Young People Policy and Procedures" taking particular note of the code of conduct and procedures relating to confidentiality, consent and soliciting information from young people. Consideration was made to ensure meeting places were safe and friendly for young people, appropriate training for young people involved the research team organising the research around their study/work schedules and valuing young people's contribution (e.g. providing a certificate of achievement).

1.9 Weaknesses of the study

The youth led research on neglected health issues while unique and contributing to existing efforts to address youth health issues is not without its challenges and weaknesses. These mainly arise from the diversity of the multiple countries involved in the project, the desire to be stringent in process while flexible in approach, and the contextual differences therein. As such this study appreciates the following two weaknesses:

- i. A clear terms of reference was developed to guide the study in each country. However the interpretation of these guidelines was different in each country and this therefore led to divergence in determination of sample sizes and differences in the variables measured by the research. Consequently the level of detail in the findings of the report from each country differed and therefore limits the extent of the consolidation and synthesis that is in this summary report.
- ii. That there is no universally agreed definition of "neglected health issues" as well as the need to distinguish these from "major health issues" also posed a challenge in the process of the study. This research as made efforts to focus attention on those not widely discussed nor are interventions highly visible. In the end, the reader should understand that the findings address health issues of concern to young people that require action.

Chapter 2

Neglected health issues among the youth



Young people in sub-Saharan Africa are faced with many health challenges. The World Health Organisation (WHO) reported in 2002 that deaths of young African men were attributable first to AIDS, followed by Tuberculosis, violence, other unintentional injuries and war. Among young women, AIDS was followed by maternal complications, Tuberculosis, sexually transmitted diseases other than HIV/AIDS, and Malaria. In more recent years, countries have reported decreases in AIDS mortality as a result of reduced prevalence, and the introduction of Highly

Active Antiretroviral Treatment (HAART). Structural challenges and weak healthcare systems contribute to the high mortality rates of young people in the region. (UNECA 2013). The challenge of describing the length and breadth of health issues facing young people is challenged by limited current data on causes of mortality. Mortality is one measure of health and if based on this single attribute then "...today's young people are healthier than any other time in history. Young people in developing countries mortality rate is less than 3%" (World Development Report, 2007)



In this study, we focus on young people who are considered particularly vulnerable and the health issues they consider neglected, as well as other attributes of health. At the outset that there is no universally agreed upon definition of the term “neglected health issues”. The health issues facing young men and women in Africa include diseases as well as prevalent conditions which inhibit their ability to live healthy and productive lives. The UN has taken its definition of neglected health issues from a WHO publication as those diseases that “affect almost exclusively poor and powerless people living in rural parts of low-income countries”¹.

The findings of the research indicate that there are health issues among young people that ought to be

addressed more keenly by policy makers and by the service delivery system. Further, there are health issues which young people themselves must take charge of in order to lead healthy and productive lives. In this synthesized report, the findings - present- four broad areas of focus: Health Issues; Knowledge, Attitudes, Practices and Behavior; Access to health care services; Policy and practice.

In this chapter we therefore tease out the main health issues identified by the study from responses by targeted young people and key informants.

¹ UN Health and Human Rights Working paper Series No.4, *Neglected Diseases, Social Justice and Human Rights: Some Preliminary Observations*. Berlin, December 2003.



2.1 Sexual health

Besides HIV/AIDS, general sexual and reproductive health issues are also considered a major concern by the young women and men who participated in the seven studies.

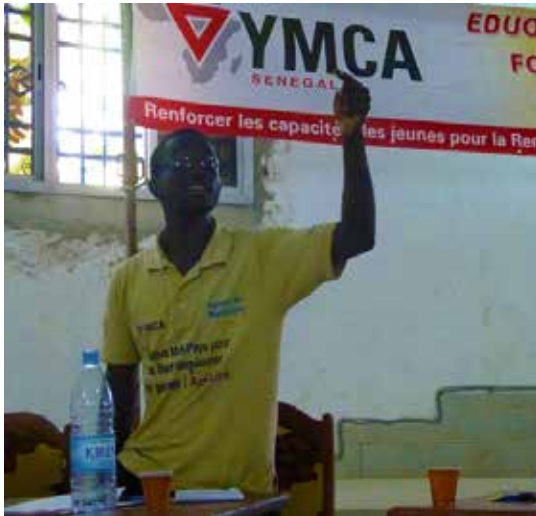
The research findings indicate that sexual health problems emanating from early marriage and pregnancy were considered “neglected issues” because of the perceived lack of special focus by governments and the local civil society organisations.

Sexual health includes the ability to make healthy decisions about sex and accessing services to prevent and treat sexual health related problems. Sexual activity exposes young people to STIs and pregnancy. If untreated, STIs can progress to serious reproductive and other health problems including infertility. (Simmons et al 2009). Early marriage and childbirth has a direct link to increased risk of sexually transmitted infections, maternal mortality and morbidity and other reproductive health problems.

In Zambia, early marriage was identified as a health problem as it may lead to increased risk for sexually transmitted diseases as well as complications in giving birth due to the mother’s tender age.

Survey results from Senegal indicate that young women and men from vulnerable households are noticeably lower in age at first sexual encounter. At 15 years, 10.4% of young females have already had their first sexual encounter against 23.8% for boys. At 17 years old they are 12.5%, against 6.0% among boys. Boys seem to have a more intense sexual life than girls. Further to this 60.7% of vulnerable and marginalized young women and men reported having had sex; 38.1% of youth with disabilities against 37.6% of Youth in general. Indeed in situations of pervasive poverty, parents put low premium on education and may implicitly or explicit encourage their daughters to marry and start families of their own. On the other hand, unmarried adolescents may engage in casual sex not necessarily to get pregnant immediately but as a strategy to get and keep a husband. The result is often early pregnancy or unwanted or unplanned pregnancy.

According to the findings from the seven studies, early marriage and pregnancy among girls are viewed as a viable pathway to escape from poverty.



2.2. HIV/AIDS

According to the seven studies under review, HIV/AIDS is still a major sexual and reproductive health issue in Africa. Indeed all the reports consistently ranked HIV/AIDS high up the ladder of youth health concerns. HIV/AIDS was frequently noted as a neglected health issue by respondents because of the barriers they encounter in accessing relevant information and quality health services.

2.3. Malaria

Malaria is identified in all seven reports as a major youth health issue. In Togo for instance young people rank Malaria as the highest health issue that is of concern to them and that requires medical attention. Respondents identified the lack of hygiene and sanitation in the areas sampled as a contribution to the proliferation of mosquitoes and hence the easy spread of Malaria. In addition, young prisoners in Togo noted that Malaria is the most recurring disease among inmates. In Zambia, one of the reasons identified by the respondents in their vulnerability to Malaria is the failure to sleep under mosquito nets. This is especially the case for young people living on the streets as they are unable to access the nets and are not living in an environment that supports their use.

2.4. Mental health

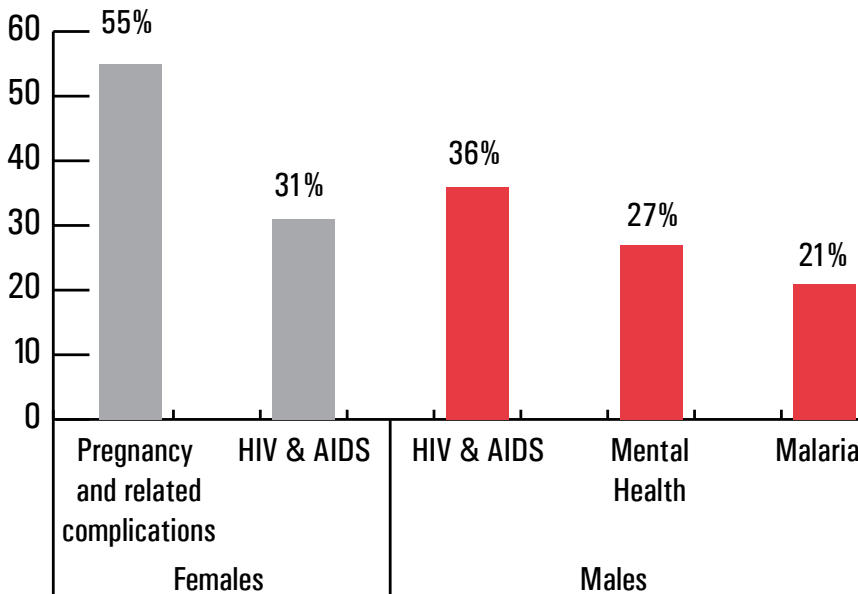
Mental health is largely ignored in this region: not a single country could be ranked as doing well in the area of mental health management in general, and mental health management among the young women and men in particular. This situation is especially dire in some contexts such as communities in post-conflict era. In Liberia, for instance, ranking of health issues in Liberia among male respondents, mental health was ranked second to HIV and AIDS as shown in Figure 2.

Young people with mental illness are usually considered as drug users or perpetrators of violence during the civil war or suffer consequences in the aftermath; however, there are no health services to cater for their condition. The situation is confounded by the fact that mental health issues are not talked about.

“Popular culture promotes blaming the victim of mental health for his or her condition.”

According to many of the young people in the focus group discussions carried out in Liberia, young people with mental health are stigmatised and neglected which pushes them to hopelessness and suicide.

Mental Health is therefore not only an issue among the young women and men in sub-Saharan Africa but also among the general population across the world. 14% of the global burden of the disease is attributed to mental illness - which includes a broad spectrum of diagnoses, from common mental illnesses such as anxiety and substance abuse, to severe illnesses like psychosis. Mental health well-being is closely associated to several Millennium Development Goals, with areas as broad as education, maternal health, HIV and poverty all entwined with the problems of mental illness. (Gordon, 2011)

Figure 2 Ranking of major health concerns among the youth in Liberia

2.5 . Nutrition and physical health

Young people are said to be energetic and full of vigor. Good physical health is important for the positive development of young people and it includes exercise, eating well, maintaining a healthy weight, and participating in positive recreational activities (Carillo et al 2011). The study findings show that Malnutrition is wide spread in the areas where the research was conducted. In Zimbabwe, Malnutrition is identified as a source of stigma alongside HIV/AIDS and teenage pregnancy. In Zambia nutritional support is identified as a challenge for young people infected and affected by HIV/AIDS. This concern stems from the appreciation that nutrition goes hand in hand with adherence to antiretroviral treatment. Young people in Liberia further identify unemployment and subsequently the lack of a regular income impedes their ability to access a good diet and good hygiene and sanitation facilities. This confirms that due to economic hardships most of the young people in developing world and especially SSA are not able to afford the required healthy foods.

Healthy eating during adolescence is important for proper growth and development and for preventing some health problems that persist into adulthood.

2.6. Alcohol and drug abuse

According to the study results, drug and substance abuse is prevalent in the countries surveyed, and this might be an indication of the prevailing situation in sub-Saharan Africa. For example in Liberia, 76% of the respondents said that drug and substance abuse was a prevalent problem among the young people in the country while 66% of the respondents in Zimbabwe indicated the same. In Togo, drug abuse was rated as the third major problem affecting the young women and men.

Findings for Zambia, Zimbabwe and Togo further show that young people are keenly aware of the link between drug abuse and their own development. First, studies show that young people are aware that they are highly vulnerable to drug abuse because of

peer pressure, compulsive desire to experiment with drug, and availability of drugs in their neighborhoods. Second, they are also aware of the effects of drug abuse such as physical injuries, social and emotional difficulties, physical and sexual violence, and other deviant behaviours. Marijuana use can lead to loss of coordination, as well as learning and memory problems. Other drugs are associated with seizures, kidney failures and long-term brain damage.

All surveyed countries reported that substance abuse

is a neglected health concern affecting many young women and men. No country could boast of an efficient, accessible, and comprehensive infrastructure addressing drug abuse including state-financed treatment and rehabilitation of drug users. This scenario is complicated further by the fact that people with drug use problems do not access other health services that are readily available to the general Youth population because of fear of stigma and discrimination by health service providers.



Table 3 Summary of Neglected health issues identified by youth

Health Issues	Nature of Neglect	Country
1. Sexual and reproductive health; early child-bearing and its consequences	Includes prevention and treatment of STIs and HIV/ AIDS, unmet need for contraceptives especially among young girls due to structural barriers.	Zimbabwe Togo Zambia Senegal Madagascar Liberia
2. Early Childbearing and its Consequences	There is a “perceived” lack of special focus by the governments on early marriages and pregnancy among the young women in which families see as a viable pathway to escape from poverty. Health issues arising from this include Fistula which is widespread and where there is a lack of information and access to timely and adequate health services	Zambia Liberia
3. Malaria	Prevention of Malaria has been largely advocated for pregnant mothers and young children leaving the young people vulnerable. This coupled with unavailability of anti-Malarial drugs and availability of counterfeit drugs in the market makes Malaria a health concern among the young women and men. Also, due to financial barriers, majority of the youth cannot afford mosquito nets.	Togo Zambia Senegal Madagascar Liberia
4. Tuberculosis (TB)	Though in some countries TB drugs are subsidised, access to TB health services by the young women and men still remains a challenge due to structural and cognitive barriers.	Togo Zambia Senegal
5. Mental health	There are general inadequacies within the health delivery infrastructure to effectively handle mental health. This is worsened by communities either being silent about these conditions and blaming victims of mental health for their condition. Mental health descriptions range from psycho-social to psychiatric issues. Mental disorders, Insomnia , Memory loss, stress, depression , anxiety	Zimbabwe Madagascar Liberia
6. Nutrition and physical health	Healthy eating during adolescence is important for proper growth and development and for preventing some health problems that persist into adulthood; but due to economic hardships most of the young people in developing world and especially SSA are not able to afford the required healthy foods. Physical health is further inhibited by inadequate hygiene and sanitation facilities.	Togo Zambia Zimbabwe Senegal Liberia
7. Alcohol and drug abuse	There are no efficient, accessible, and comprehensive infrastructure addressing drug abuse including state-financed treatment and rehabilitation of drug users. This scenario is complicated further by the fact that people with drug use problems do not access other health services that are readily available to the general youth population because of fear of stigma and discrimination by health service providers.	Zimbabwe Togo Zambia Senegal Liberia

Chapter 3

Knowledge, Attitudes, Practices and Behaviour



Health seeking behaviour is affected by the amount of knowledge a person possesses and his or her willingness and ability to act on the basis of that knowledge. This chapter analyses the level of knowledge of young people about health issues and selected diseases as well as their attitudes and behaviours related to those issues and diseases.

3.1 Level of knowledge on health

How knowledgeable are young with respect to the common health issues they face? The level of knowledge

and perceptions of young people in relation to certain diseases appears somewhat mixed in all the surveyed countries. At least two thirds of respondents claimed to have knowledge about the effects and symptoms of various diseases. In Togo young people identified at least 18 diseases that they know about with knowledge of Malaria and HIV/AIDS topping the list.

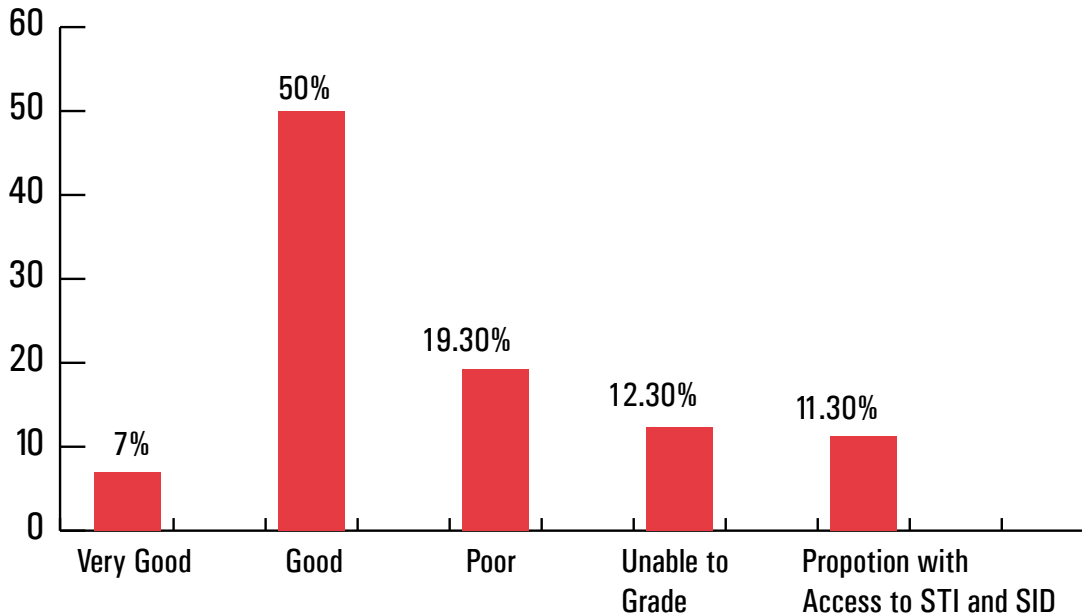
In most countries, the school curriculum incorporates health education. It is therefore through this system of education that young people, especially those who

have gone to school, gain knowledge about their health. Generally, the higher the level of education a person has attained, the higher the level of knowledge about health issues. This finding is consistent across all the countries where the studies were carried out.

On the whole, young people are more knowledgeable about pregnancy and HIV and AIDS less about other

Generally, unlike with HIV, there are no huge mass media campaigns about adolescent sexuality hence young people rely heavily on social networks such as peers and older relatives who may not always have accurate information.

Figure 3 Zambia: Level of knowledge about STIs and STDs



health issues. This may be due to efforts that have gone into creating awareness about prevention of early pregnancies and HIV/AIDS.

In contrast, knowledge about STIs and other reproductive health issues is relatively lower than that of HIV and AIDS. For instance, according to one key informant in Senegal,

“Young people are familiar with Malaria in its various modes of transmission and prevention but where there still are grey areas, is in the knowledge of STIs”. As shown in the Figure 3, the proportion of respondents who said their knowledge of STIs and STDs is “very good” was only 7 per cent in Zambia.

This may be responsible for dissemination of conflicting definitions of normative sexual behaviour.

Knowledge of drug and substance abuse effects is also high among young people. In Zimbabwe 64.5% of young people reported that drug abuse was on the increase in their community with alcohol abuse being the most rampant according to 54.1% of the respondents. Togo young people acknowledged the link between substance abuse and other health issues such as early pregnancies, STIs and the predisposition to violence.

3.2 Health-related attitudes

Analysis of the seven researches shows that the moderately high knowledge about various issues is not

matched with correspondingly high positive attitudes and behaviours. For example, in Liberia, despite over 80% of the young women and men surveyed being knowledgeable about sexually and reproductive health issues, 25% of them could not openly discuss sex issues even with the interviewer.

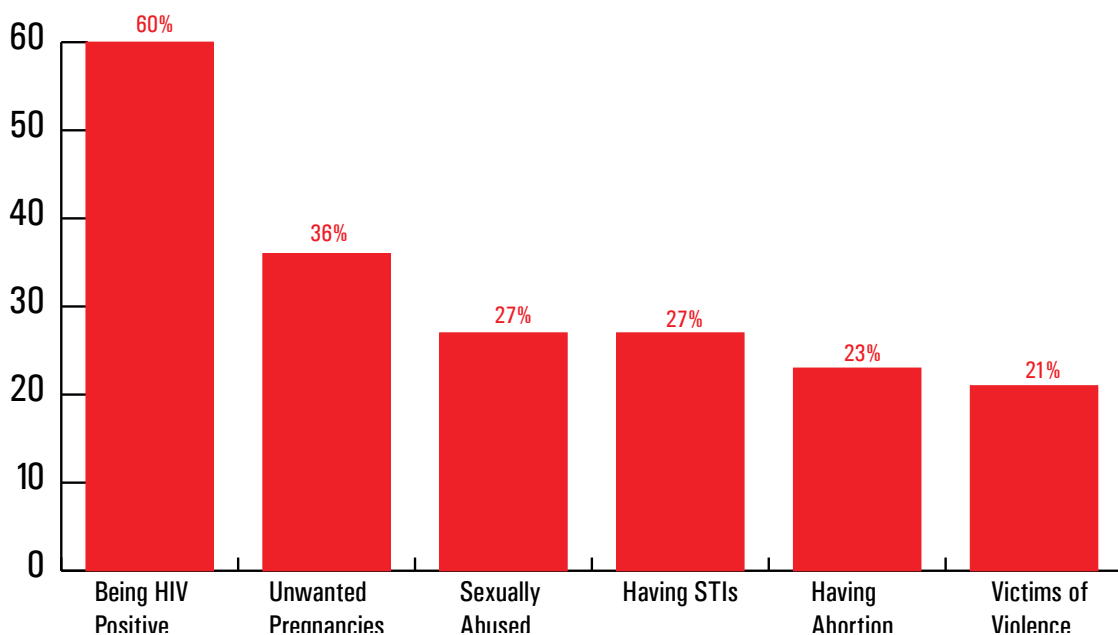
Negative attitude towards people suffering from HIV/AIDS was also prevalent in all the 6 countries surveyed. For instance in Zimbabwe, being HIV positive was highlighted as the most important source of stigma and discrimination among young people. This information is presented in Figure 4.

Though there is support extended to family member and friends suffering from the disease, not many of them showed supportive attitude towards strangers who got AIDS. Self-discrimination is also prevalent in all the countries in that, many young women and men claimed they would try to avoid other people after they were infected with HIV or any other disease that marks them as a “disgrace” to the society. In many African societies, HIV/AIDS is associated with being

promiscuous and those with such a belief tended to be negative towards AIDS patients. All this is despite the extensive knowledge about AIDS-related issues. In Zambia, according to the study findings, about 21% of the respondents had confidence in talking to parents about their health issues, while 11% had confidence in health workers, 9% in relatives, 7% in friends, and 5% peer counsellors.

Following closely is contraceptive use. Many young people have a negative attitude towards contraceptive use including condoms despite the fact that they are already engaging in sexual activities. They perceive contraceptive use as meant for the married people. This negative attitude is aggravated by lack of youth friendly centers where such can be availed. In many cases, young people are not aware of the services provided in general health facilities within their reach and therefore cannot access the services offered. Where these services exist young people’s attitudes towards the health service providers acts as a barrier as one female respondent from Zambia put it

Figure 4 Zimbabwe: Ranking of sources of stigma among the youth



“As young people, we find it difficult to collect contraceptives from clinics because most of the people who work at the health centres are adults who are age mates and friends to our parents. . . .so we fear that they may inform our parents that we are getting contraceptives. . . .”

Stigma is also faced by those infected with TB in Zambia and Togo. As indicated in Table 3 treatment for TB has been made available by many governments at almost no cost to patients. However the availability of health centres coupled by stigma related to the disease continues to hinder access to services especially for young men and women. In Zimbabwe, Malnutrition is also a subject of stigma alongside Obesity, STIs, and victims of violence.

3.3 Practices and behaviour

Given the level of knowledge and attitude as observed in the study, it's evident that the health seeking behaviour of the young women and men is quite poor in SSA. Many youth reported that their sexual encounters were largely unplanned and that they did not like using condoms or their partners did not want to use condoms. There are also many instances of girls having sex with older men for monetary gain which exposes girls to STIs and related problems because of their diminished ability to negotiate condom use in such relationships. Thus, it may be argued that knowledge might be necessary but insufficient for changing behaviour and therefore more needs to be done to influence behaviour change among the young people in developing countries, especially SSA.

Although some countries did not collect data on age of sexual debut, where data was collected, it is evident that young men and women engage in sexual relations at a

very young age. In Senegal, the survey results confirm that over a third of respondents (39.0%) have had sex during their lives. The age of first sexual intercourse began as young as 10 years old with a mean age at first intercourse of 16.6 years (16.3 years for males and 17.3 years for females). Of those who have had sex, 23.4% of them, the first sexual encounter was forced upon them. Moreover, apart from this first experience, 20.0% women and 21.3% of men said they have suffered other non-consensual sexual experiences. During the past sexual experience, more than half of respondents (56.4%) state that there was no condom use. In Liberia, study results show that girls get married at a younger age, as young as 14 years old, men on the other hand get married between the ages 30 – 45 years. This indicates that young women get into sexual relations with men much older than them.

The conflicting norms and values experienced by young people have significant influence on a number of sexual health related behaviours, including an inability to discuss sex and relationships with family and community members. Young people felt that social expectations prevented any discussion or recognition of young people's sexuality, and need for information or support. Some participants singled out their parents'/ carers' or community's lack of engagement in supporting young people around sexual health as a key factor in their life.

Practice and behaviour around health issues such as malaria, poor nutrition, poor physical health and mental health issues and disease are highly affected by barriers to access to services as discussed in detail in Chapter 4. For instance financial barriers affect access to good nutrition and mosquito nets for the prevention of Malaria. In addition to this, structural barrier in the form of lack of relevant services makes it difficult for young people to take up information and services around Mental health.

Chapter 4

Access to health care services



According to UNFPA, since the ICPD in 1994, there has been an upsurge in efforts to provide appropriate sexual and reproductive health services to young people. These new initiatives have been developed in response to the evidence that young people often feel unwelcome at traditional family planning or reproductive health clinics, combined with an increased awareness of the special needs and rights of youth in the area of sexual and reproductive health. There is also a growing concern among the young people and health service providers that youth friendly services are needed if young people are to adequately feel that their health needs are well catered for. If such services are provided, they are likely to effectively attract young

people, address their health needs confidentially, and create an environment of trust between the care provider and the patient and thus retaining these young clients for continuing care.

Although there is a perceived equality regarding access to health care in many developing countries, our study shows that the young people are faced with distinctive barriers due to their age, cultural norms and community expectations. In this chapter, we synthesise the challenges faced by young people in accessing health care services. Overall, the indicators of responses collected in different visited localities point to multiple barriers in the health districts. These barriers can be categorised into financial, structural and cognitive barriers

4.1 Structural barriers

Structural issues denote the health care system's availability. The barriers may be found within or outside of health care facilities. Structural barriers may occur externally to the processes of care, as when people seek access to health care services (Carillo et al 2011). These barriers, as defined by recent studies, include (but are not limited to) availability and proximity of facilities, transportation, child care, and structural characteristics of care. Structural barriers are also experienced within the health care facility. Barriers such as excessive waiting times may affect care-seekers who have low incomes and live in neighbourhoods of social and economic distress.

In many countries health care facilities are sparsely distributed making accessibility a problem due to long distances one has to travel. This is a challenge particularly faced by those in rural areas where there is poor infrastructure. This inhibits the young people's willingness to seek health care due to distance as a factor in itself, and related costs of travel. As will be discussed in the next chapter, putting in place youth friendly facilities can go a long way in addressing structural barriers.

In Senegal's Kaolack area, young people bemoan the lack of health facilities, access to medicines, training and availability of skilled health personnel, prevention outreach and the creation of testing services exclusively attributed to youth. Though over 95% of the respondents lived near a health facility, access to the services offered was limited due to poor quality of hospitalization and unprofessional health personnel and inadequate medical equipment

In Madagascar, the precarious socio-economic conditions exacerbate the situation of young people who do not access quality care and adequate services. Young women and men pointed out their inability to access health care services due to poor road network and the lack of drug supplies in the facilities make it unnecessary to visit them anyway.

The perspectives of respondents on the nature and type of health care facilities available to them in each participating country, and whether they are well equipped to address the needs of the young people are analysed and presented in Table 4. This analysis of ideal youth friendly services in sub-Saharan Africa is guided by a framework proposed by UNFPA.

Some countries in sub-Saharan Africa have practically no health facilities or referral centres for the young people. This is especially true for Liberia where even the general health facilities have no special amenities for the youth. The only service delivery structures that closely approximate youth friendly facilities are the Children Assistance Program (CAP) which focusses on counselling and testing for pregnancy, STIs and HIV, the Planned Parenthood Association of Liberia and a small youth drop-in center by YMCA.

It should also be noted that even in countries where there are youth friendly health facilities, service provision does not meet the criteria noted in table 4. For instance in Zimbabwe and Madagascar, such centres suffer from inadequate funding hence cannot offer all the services needed. In addition, such centres are often located in urban areas only. In many countries young people do not access these centres due to lack of equipment, long distances to the facilities, lack of services and medicines, and more importantly, lack of confidentiality. These



challenges are confounded by absence of clear linkages with public health institutions for referral, high turnover of peer educators, and lack of partnerships between health care providers.

4.2 Cognitive barriers

The survey sought to establish the severity of cognitive barriers to accessing health services among the young women and men in sub-Saharan Africa. Cognitive barriers are rooted in the patient's beliefs and knowledge of disease, prevention, and treatment as well as in the communication that occurs in the patient-provider encounter. A patient's lack of awareness of accessible health services may also compound health barriers (Carillo et al 2011). Availability and access to information through different kind of mediums for the young people is limited. In most health facilities, targeted information packages include ante-natal and post-natal services for women/mothers, or afflictions of the elderly or immunization of young children, leaving the young women and men to synthesise the information provided to suit their own situations.

Results from Liberia show that victims of epilepsy have limited access to health care services, and they are usually rejected by their community. During an FGD, participants indicated that there is usually a belief that patients of Epilepsy are witches and wizards and as such they are treated as outcast. In the rural communities, patients are chained or tied to keep them away from other community members instead of being treated as victims of an illness.

In Senegal, young people decried poor reception at health facilities by the health care provider. These interactions between the patient and the provider contribute in increasing the negative stereotypes the young people have towards hospitals and other health services. Young people perceive the health care providers as non-confidential, and therefore they are unwilling to visit health facilities.

Many health workers are said to be impolite to and impatient with young patients, especially the female health workers as one of participants in an FGD in Madagascar put it thus

“... female health workers ring insults at young female patients, talk about the patient's problems openly and even laugh about it with their colleagues...”

Another participant said

“... they behave with this attitude because young patients cannot give bribes to the health workers as would an adult patient...”

Although virtually all countries in sub-Saharan Africa have put in place specific youth centred policies and programmes to address health issues, some issues are currently receiving limited attention either across large populations of young people or among the vulnerable youth such as those who live in the streets, commercial sex workers and orphans.

Furthermore, young people cited their personal deportment and style of dressing as a barrier to accessing services. The pressure to be well dressed while visiting the doctor in order to be served well yet these young people are unable to purchase new or good clothes. As a result many young people choose to self-medicate using the medication that is available in the local pharmacies and shops.

4.3 Financial barriers

Financial barriers to health care access arise in vulnerable populations when patients have no financial ability to cater for their health care⁹(Carillo 2011). In Senegal for instance, financial limitations faced by the young women and men act as a deterrent from accessing health care. According to the Director of Studies of INEFJA in Thies, Senegal

“I am not aware of the existence of government policies that give young people the opportunity to have access to quality care . . . Once you get to the hospital for health needs, doctors are quick to give you a huge batch of orders. And unfortunately, almost all patients cannot afford these charge orders. There is no solidarity leverage implemented to help people with Disabilities. There are only awareness campaigns”

The adoption of cost-sharing policies by many African governments in provision of various health services has had a negative impact on access to health care. Maternity services, TB, and in some instances malaria and HIV/AIDS are the few where charges are subsidised or eliminated. In almost all health facilities, charges such as consultation fees are applied before treatment is initiated. Most of the participants said the cost of services for their main health concerns was very high and as such they believe that these concerns are being neglected. They made specific mention to high cost of services for health problems such as Fistula, Epilepsy, Mental health, and HIV/AIDS.

In Madagascar young women and men pointed out their inability to access quality health services because they have no money. This is linked to high youth unemployment.

The high costs of health care and financial limitations, push young people towards self-medication or traditional medicines. For example in Liberia, the Government has a free treatment scheme available at public health facilities, in many but not all rural communities. Poverty remains a critical factor to access to health care in public facilities in Liberia health and private health facilities are quite expensive for poor and vulnerable groups of people. In Madagascar, young people cited cash-basis of services as the highest barrier to accessing treatment by both male and female youth, 55.6% and 66.4% respectively. As a result, young people who have no income or money cannot access health care.

Some countries in sub-Saharan Africa have practically no health facilities or referral centres for the young people. This is especially true for Liberia where even the general health facilities have no special amenities for the young women and men.

It should also be noted that even in countries where there are Youth friendly health facilities, service provision does not meet the criteria noted above. For instance in Zimbabwe and Madagascar, such centres suffer from inadequate funding hence cannot offer all the services needed. In addition, such centres are often located in urban areas only. In many countries young people do not access these centres due to lack of equipment, long distances to the facilities, lack of services and medicines, and more importantly, lack of confidentiality. These challenges are confounded by absence of clear linkages with public health institutions for referral, high turnover of peer educators, and lack of partnerships between health care providers.



Table 4 Assessment of available youth friendly health services

Characteristics of youth friendly services	Zimbabwe	Zambia	Senegal	Togo	Liberia	Madagascar
Essential						
Convenient open hours	n/a	X	x	√	x	√
Privacy ensured	X	X	√	X	x	n/a
Competent staff	X	X	√	X	X	X
Respect for youth	X	n/a	X	X	X	n/a
Package of essential services available	X	X	X	X	X	√
Sufficient supply of commodities and drugs	X	X	x	X	X	X
Range of contraceptive offered	X	X	X	X	x	X
Emphasis on dual protection/condoms (male and female)	X	X	X	X	X	X
Referrals available	X	X	X	X	X	√
Confidentiality	X	X	√	x	X	n/a
Waiting time not excessive	n/a	X	n/a	n/a	n/a	√
Affordable fees	X	X	X	x	x	X
Separate space and/or hours for youth	X	X	x	x	X	√
Supportive						
Youth input/feedback to operation	X	√	x	√	x	√
Accessible location	√	X	x	√	x	√
Publicity that informs and reassures young people	X	X	x	x	x	X
Comfortable setting	X	X	x	x	x	X
Peer providers/counsellors available	X	√ (low)	X	x	x	√
Educational material available	X	√ (low)	x	x	x	√
Partners welcomed and served	X	n/a	n/a	n/a	n/a	n/a
Non-medical staff oriented	√	√	x	x	x	√
Provision of additional educational opportunities	X	X	√	x	x	x
Outreach services available	X	√	x	x	x	√

Source: www.unfpa.org/adolescents/youngwomenandmenfriendly.htm#friendly

Key: X – No √ – Yes n/a- Information not available

Chapter 5

Policy and Practice



In recent decades, a number of global and regional initiatives have been adopted by Governments to push the youth development agenda forward.

In 2002, the Special Session of the UN General Assembly on Children recognized the need to “formulate and implement national policies and programs of public health, with targets and indicators of achievement and focused on adolescents in order to contribute to their physical and mental health.” Many countries, developing and developed have since adopted policies that impact on the wellbeing of the young people. However, implementation of these policies is still challenging in

many developing countries mainly due to inadequate funding and human resource constraints. In this chapter focus shall be on Regional and National Level policies and initiatives towards advancing the development agenda for young people.

Regional Level Action

The Abuja Declaration 2001 was a landmark decision by heads of states relating to health. Key in this declaration is the commitment by state leaders to commit at least 15% of the national budgets to health especially Tuberculosis, Malaria and HIV/AIDS. Actual implementation to this

commitment is varied and considering the state of availability and access to health services for young people from this research and on-going continental discussions on this, it is clear that investment made if any has not been specifically to youth health issues.

The African Union, the pan-African institution in which member states are affiliated driven by shared Mission and Vision for a cohesive, productive and strong continent has made policy declarations to inform initiatives by member states to address issues facing young women and men. Specifically, in 2006, the African Union Heads of State adopted the African Youth Charter, a legal instrument defining the rights, duties and freedoms of young people, which underpins youth empowerment. The Charter emphasizes the importance of education and skills development for improving the livelihoods of young women and men. As of May 2011, 23 countries have ratified the Charter, and 37 have signed the charter.

The African Youth Charter Article 16 states that every young person shall have the right to enjoy the best attainable state of physical, mental and spiritual health. The Charter stipulates that Governments: Make available equitable and ready access to medical assistance and health care especially in rural and poor urban areas with an emphasis on the development of primary health care; Secure the full involvement of youth

in identifying their reproductive and health needs and designing programmes that respond to these needs with special attention to vulnerable and disadvantaged youth; Provide access to youth friendly reproductive health services including contraceptives, antenatal and post natal services. The charter further speaks to different youth health issues including prevention of abortions, drug and substance abuse and transmission of HIV/AIDS.

Of the countries in this study, Table 5 indicates the status of the Africa Youth Charter in each country# Within the framework of the New Partnership for Africa's Development (NEPAD), an initiative of AU in 2001, launched a Youth Desk that gives young women and men a platform for dialogue and enabled them to contribute to policy debates. The AU has further developed other tools and instruments to effectively engage young women and men, such as: the 2009-2018 Ten-Year AU Plan of Action for Youth Empowerment and Development that is aimed at accelerating the implementation of the Africa Youth Charter at the regional level and National Youth Policies at the local level; the AU Youth Volunteer Corps Programme and; the African Youth Day. The AU also celebrated the launch of the International Year of the Youth on 1 November 2010.

Table 5: Status of ratification of the Africa youth charter

		Status of Ratification of the African Youth Charter	
Country		Signed	Ratified
1	Zambia	10 April 2008	02 October 2009
2	Zimbabwe	Not signed	21 August 2009
3	Madagascar	Not Signed	Not Ratified
4	Senegal	09 October 2007	17 September 2009
5	Togo	20 November 2006	28 December 2008
6	Liberia	18 June 2008	2 March 2011

Source: <http://www.africa-youth.org/ratification>

Other guiding, global policy documents include the Millennium Development Goals (MDGs), specifically the MDG 4 to reduce maternal mortality and MDG 6 to reduce HIV/AIDS. However, from the findings of the research the key health concerns of young people indicate that they were insufficiently addressed and in a sense felt their issues in relation these goals were neglected.

National Level Action

Besides these global policies, national governments in sub-Saharan Africa have made a commendable job in the formulation of youth centred policies all of which touch on youth health and livelihoods. In the surveyed countries, the National Youth Policy is the significant policy document that specifies the importance of addressing health concerns of young women and men.

The National Youth Policy in Zambia (1994) recognizes that drug abuse, alcohol, prostitution and teenage pregnancies are issues affecting young people. The policy links these to lack of proper guidance and counseling for young people. However, following this policy there is no specific or dedicated strategy for addressing youth health.

The Zimbabwe National Youth Policy (2000) contains two sub-sections describing the youth health challenges and strategies to address the challenge.

Among the key strategies include access to youth friendly services, increased health education in schools through peer education and improving relationships among young people their parents and teachers.

Madagascar's National Youth Policy (2004) indicates an intention to engage young people in modernization of the fight against drug abuse, endemic diseases and HIV/AIDS. There have been no subsequent efforts to develop a dedicated strategy to address youth health.

The National Youth Policy in Liberia (2011) identifies sexual and reproductive health, HIV/AIDS and alcohol drugs and substance abuse as health issues affecting young people. The policy thereafter describes initiatives to address risky behaviour in among young people, the need for appropriate legislation and for improved access to health care for young people.

There is much work to be done by youth, youth development agencies and youth groups/ organizations to ensure that the provisions of these policy documents translate into better health for young people. The first step to achieve this goal is to create awareness among the youth on the existence of these policies, linked also to the National Health Sector Development plans where they exist.



Chapter 6

Recommendations and Conclusions



Arguably youth is a transient state. Thus age shall not be the only basis for lobbying and advocacy for responses to youth health concerns. However, human society will always have young people. Moreover, the current population of young people is at the highest globally, and within Africa than ever. Data from the United Nations Population Division shows that in 2010 there were 364 million Africans aged 15–34 years and 209 million aged 15–24 years. These accounted for 35.6% and 20.2% of the total African population, respectively. The Africa Economic Outlook Report projects that by the year 2045 the population of youth in Africa will have doubled.

While the needs of each generation of young women and men may change, this change will only be in form and not in substance. There will always be health concerns among young people that need to be addressed.

This survey recommends that state and non-state actors in health develop specific strategies to address health issues to be responsive to the present, and sustainable to adapt to the arising needs and concerns of young women and men even in 2050.

“See. Assess. Act. This is the principle that leads to empowerment. The young people particularly the hard

to reach groups have to be involved in every step of the process of improvement of their wellbeing. They have to go through a process of integration to their environment by their involvement in the research. Then they can see with their own eyes what is happening to them and their surrounding and increase their awareness of the issues they are facing and act towards these issues” Lantonirina Rakotomalala, Madagascar YMCA

1. Delivering the promise

The advocacy and lobbying agenda by youth groups, youth organisations and institutions should push national governments towards meeting their commitments, first for those who have subscribed to the Abuja Declaration; and second to those national youth policies that clearly outline health as a major issue to be addressed. The health concerns of young Africans are broad, beyond sexual and reproductive health, and HIV/AIDS. In an increasingly high pressure and stressful urban environment especially, mental health (psychiatric and psychological) is a neglected health issue.

The United Nations General Assembly Special Session (UNGASS 1998) agreed on key international commitments to control drug and substance abuse. The Declaration issued by Member States requested that they address drug abuse in a holistic manner and that they set up effective drug prevention, treatment and rehabilitation programmes that should be culturally valid and based on knowledge acquired from research as well as lessons derived from past programmes UNODC 2005.

Government Ministries, Departments and Agencies (MDAs) should work in concert with the local, regional and international non-state actors including CSOs to shape a review of national policies dealing with the youth so as to improve access to health services, funding the youth friendly facilities, helping the

more disadvantaged youth, and campaigning against discrimination and stigma associated with various health conditions. Government-CSO collaboration can also play a central role to address the cost of services and consequently to increase access among the young women and men.

2. Addressing the access challenge

Specific recommendations by youth participants in the survey point to the need for increased spaces and opportunities for greater access to health information (preventive care) and health services (palative or curative care) that are responsive to their concerns. This is a responsibility of both private and public health institutions who have the facilities and resources to respond.

These services can take a range of forms from drop in centers, health centers/ clinics, hospitals, to mobile health clinics. The human resource within these facilities should include trained health care providers as well as peer educators. The primary concern is to ensure that they are well-resourced, aware of sensitivities to young people and skilled to improve interpersonal skills that gives young people confidence and assurance of confidentiality.

3. Closing the communication gap

Young men and women face barriers in the communication loop: Open communication systems and structures to access information and provide feedback. For example, adolescents cannot open up to their parents/guardian to share their emerging primary sex experiences, even sexual abuse is further reinforced at household level. Moreover, sometimes existing policies fail to be comprehensive enough to address real issues that young people face. New or revised policies are needed to cater for hard to reach groups (children on the streets, commercial sex workers etc). However no formal structures exist where these can be communicated to health service providers and/or youth advocates or policy makers.

4. Building strong and strategic partnerships and linkages

Partnerships are essential for successful support to young people in addressing neglected health issues. Partnerships between state and non-state actors such as NGOs and CBOs; partnerships among NGOs addressing different health concerns; and partnerships between NGOs, CBOs and private health providers.

This shall build a larger pool of resources available to meet the health needs and concerns of young Africans. For instance, the establishment of youth-friendly health services that are accessible to young people whether in reducing distance or resourced with sensitive medical professionals has proved a continuing challenge.

The evidence assembled from the surveyed countries demonstrates that young people will almost always shun health services provided in centres for the general public especially when the services they need touch on the sensitive subject of sex and sexuality. A successful-goal oriented partnership could build and resource such centres to offer not only information but also a wide array of services that the youth are not comfortable accessing in the general public health centres.

For instance, the studies found that a number of civil society organisations including YMCA have set up youth friendly centres in different countries. For instance, YMCA has set up two youth friendly centres in Antananarivo and Carion in Madagascar. The sites can be considered model centres in sub-Saharan Africa given the wide range of services offered (including counselling on reproductive health and life skills training) and the fact that their focus is entirely on young people.

5. Responsive health service providers

Capacity building is critical especially for effective provider-client relations to be realised. Health service providers and medical professionals should be trained to understand issues faced by young women and men and more importantly how to address them. Issues of confidentiality and empathy should be given special attention. Such training can also be extended to community health workers and peers working for the youth in respective communities so that the youth programme can have a greater impact in reaching all the young women and men including the vulnerable and the hard to reach.



6. Overcoming the financial barrier

The cost and affordability of health care is a concern across all the countries surveyed. National governments should consider the establishment of a Youth Health Insurance scheme. This can be initiated to solve the financial barrier of vulnerable youth. Young people can be encouraged to form insurance groups in their villages where members contribute regularly to a health fund. The contribution is not linked to an individual's individual risk and access to the fund for health services is not dependent on the capital investment. Every young member has a voice in the deliberations and surplus at end of any period is distributed among the members or mutual asset reserves.

7. Responding to youth as a heterogeneous group

To address information gaps on health care needs of young people in Africa, and ensure that broader health concerns do not remain neglected, there is need for extensive research, especially research touching on knowledge, attitude and practice.

The research should ensure that youth is an all encompassing term to include the groups of young people considered hard to reach. It is important that the definition is expanded to include young people with no education or low levels of education since they too are under-served by existing health care infrastructure, have low levels of knowledge about various health issues, and are more vulnerable in different spheres of life compared with their more educated counterparts. Special focus on young people with disabilities is also essential.

Conclusion

This research study provides a valuable basis for further research on neglected health issues. The growing youth population in sub-Saharan Africa and the potential to contribute to development requires that their youth health needs begin to be addressed. More studies such as this one by the YMCA and YWCA will therefore provide

clarity on the neglected and major youth health issues, gaps in the health system that will require specialised youth friendly services and the policies and legislation that make interventions around youth health issues sustainable for current and future generations.

Currently there exist commitments by African Governments to meet the health needs of the youth. As mentioned in the recommendations, there is need for these commitments to be fulfilled prior to their revision to reflect emerging youth health issues. Young people also need to be empowered to advocate for their needs as well as realise the opportunities they have to influence and participate in the development of health systems that respond to their health needs. The spaces created by the commitment of their National Governments need to be exploited as they agitate for more opportunities to engage with their leaders, decision makers and stakeholders in the health system. Further to this, there is the present need for more coordination and partnership between national, regional and global stakeholders in the health sector to ensure widespread development in the health sector. In this research we have established that there are a number of organisations working in addressing health issues affecting the young people. There is therefore need to build strong long-term partnerships to address the concerns of young people and especially the vulnerable and "hard to reach" groups.

African YMCAs share the vision of "empowering young people for the African Renaissance". The primary focus of the YMCA and YWCA is building young people who are strong healthy in mind body and spirit. The Act2Live Programme under which this study was conducted is committed to empowering young people to be agents of change among their peers and to influence decisions around health systems in favour of young people. The Africa YMCAs vision drives the movement to engage in empowering young people to be at the forefront of transforming their communities in the social, political and economic spheres. We seek to build lasting partnerships with organisations committed to this vision to address overarching development needs of young people.

ANNEXES

ANNEX 1: Bibliographic references

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ANNEX 2

Profile of researchers in each country

Southern Africa

Madagascar YMCA commissioned Dr. RANDRIAMANGA René (MD-MPH), a trained General Practitioner and who holds a Masters in Public and Community Health to conduct the research. He has worked in the humanitarian and development agencies working in community and public health programmes for various organisations including MEDECINS DU MONDE and Population Services International (PSI).

Currently, Dr. Randriamanga works for a Non-Governmental Organization called Zetra, as an Auditor; working in community and public health in the region Boina, Alaotra Mangoro. He is also serving as a Technical Advisor on the board of the Amontana Association working in the fight against poverty using the approach “REFLECT” and PRA / PHAST / CLTS tools.

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Zambia YWCA commissioned Mr. Joseph Mumba Zulu who holds a Master of Science Degree in Social and Cultural Anthropology from the Virje University Amsterdam. Currently, he is pursuing a PhD in Public Health at the Umeå University in Sweden and University of Zambia. His PhD thesis is titled “Integrating Community Health Workers into the Health System and HIV/AIDS Interventions in Zambia.”

Mr Zulu works at the University Zambia as a lecturer in the Public Health Department and has 7 years’ experience in conducting research mainly in health systems strengthening, gender, and human resources for health, social protection and health policy, priority setting in the health sector, HIV and AIDS as well as sexual and reproductive health matters.

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Zambia YMCA commissioned Mr Thomas Chirwa who holds a Bachelor of Social Work (BSW) Degree with Merit from the University of Zambia (2010) to conduct the research. He is currently writing his thesis for a Master of Science in Epidemiology. Mr Chirwa is currently working for the Human Rights Commission as a Human Rights Officer. He has been in the research field since 2010 and has been involved in research studies of varying complexity ranging from social research to health research.

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Zimbabwe YMCA commissioned Dr. Florance Matarise BA(NUL),MSc (McMaster, Canada), DPhil (UZ), an experienced Researcher and Statistician. Dr. Matarise has worked as a lecturer in the Department of Statistics at the University of Zimbabwe in Harare. As a Research Consultant, she worked with various organisations in Zimbabwe including Government Universities and Private companies.

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West Africa

Liberia YMCA commissioned Mr. Mohamed Kallon to conduct the research. Mr Kallon holds a Masters and a Bachelor's degree in Agriculture from Njala University in Sierra Leone. He is currently the Senior Consultant at ODIC Consultancy. He has at least 7 years experience in research and has provided consultancy services in studies conducted by USAID and International Medica Corps (IMC) in Liberia around Agriculture, Livelihoods, Gender and Youth issues.

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Senegal YMCA commissioned Mr Cheikh Fall to conduct the research. Mr Fall is currently pursuing a master in Quality Management and Sustainable Development in the African Management Institute. He also holds two other Masters Degrees in Sociology and an under graduate degree from the Cheik Anta Diop University in Senegal.

Mr Fall has over seven years' experience conducting social research in a variety of thematic areas including HIV/AIDS, Sexual Reproductive Health and other related issues for various organisations in Senegal. Currently he is working as a the Programme Officer for Monitoring / Evaluation in the implementation of the Global Fund / ANCS / Round 9 for universal access to prevention, care program, treatment and support.

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Togo YMCA commissioned Mr. AMOUZOU Midodji to conduct the research. Mr Amouzou holds a Masters in Innovation, Development and Society / International Institute of Engineering Water and Environment and a Masters in Computer Applications Management, Studies, Surveys and E-Learning. He has also received training in monitoring and evaluation of projects and programs. Mr Amouzou currently works as an independent consultant and has provided services to various organisations in Research and Capacity Building. He has over 10 years working experience has worked both in the non-profit and private sectors in Togo.

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