Community Forum (COFO)

THE IN REAL LIFE PROJECT PAMPHLET

Foreword

Young people in Malawi, especially in Chikwawa District are marginalised educationally, socially and culturally. They have both higher dropout rates and a lower rate of primary school completion than their male peers.

Due to traditional gender norms, there is increased pressure on girls to remain at home, rather than attend school. Where there are limited resources, parents prefer to invest in the education of their sons. Within our recent baseline study, 25% of families said that gender played a role in their decision on whether to send a child to school and 32% said it make more sense to send boys to school as they are more likely to use their education. Poor quality teaching in primary school concerning sexual and reproductive health and rights (SRHR) due to teachers feeling uncomfortable to address the issues results in poor SRHR for all students in the school environment. Finally there is lack of attention to the SRH needs of girls in general, lack of support for pregnant or students mothers, is also a contributing factor to girls' low attendance, retention and achievement at school.

It is this perspective that Community Forum (COFO) with support from the **Share- Net International** is implementing this project called ***"In Real Life."*** The project aims at to tackle the challenges in a timely manner in order to reduce vulnerability among very young adolescents in the Chikwawa due to a lack of SRHR information in Chikwawa District. This is done through addressing the barriers that are preventing girls from an opportunity to stay in school and access quality primary education through training of youth clubs, matrons, patron's teachers, training of girls in health life skills which include lessons about sexual and reproductive health and rights (SRHR). By providing training for teachers and youth clubs the project will support schools to create girl-friendly learning environment and promote girls' awareness of SRHR and gender, as well as encouraging greater parental and community support and engagement through focus group discussions, (FGD). These teachers will also serve as role models to the girls in the targeted schools. The project will also improve girls' SHR knowledge and practice, confidence and participation in class leading to gains in retention, achievement and learning in school.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Treatment
GBV	Gender-based Violence
DIN	Development Initiative Network
DEC	District Executive Committee
CSE	Comprehensive Sexuality Education
HIV	Human Immunodeficiency Virus
FGD	Focus Group Discussion
M&E	Monitoring and Evaluation
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
YFHS	Youth-friendly Health Services
EMIS	Education Management Information System
HIS	Integrated Household Survey
MoFEPD	Ministry of Finance, Economic Planning and Development

GLOSSARY

Abscesses- A swollen area within body tissue, containing an accumulation of pus

Chronic- Persisting for a long time or constantly recurring.

Contraceptive- A method serving to prevent pregnancy

Eclampsia- A rare but serious condition that causes seizure during pregnancy

Haemorrhage- An escape of blood from a ruptured blood vessel, especially when profuse.

Intrauterine- Occurring within the uterus.

Menstruation/period- The normal vaginal bleeding that occurs as part of a woman's monthly cycle.

Perforation- A hole made by piercing

Primigravida - A woman who is pregnant for the first time.

Topic 1: ADOLESCENCE IN YOUNG PEOPLE AND YOUTH

Definition of adolescence:

- Phase in life, not a fixed time period: no longer a child, not yet an adult
- 10-25 years: young people (10-19 years: adolescents, 15-24 years: youth)
- Enormous changes:
    A) Physically and psychologically
    B) In social expectations and perceptions, accompanied by sexual maturation (often leading to intimate relationships)
    C) From concrete to abstract and critical thinking à self-awareness

Main changes during adolescence:

Category of change	Early 10-14 years	Middle 14-17 years	Late 17-21 years
Growth	- Secondary sexual characteristics appear (e.g. female: breasts, menstruation*, etc. male: beard, erection, change of voice, etc.) - Growth accelerates and reaches peak	- Secondary sexual characteristics advance - Growth slows down - Stature attained	- Physically mature
Cognition	- Concrete thinking - Existential orientation e.g. thinking only about today - Long range of implications of actions not perceived (e.g. "I don't want to do homework)	- Thinking becomes more abstract - Capable of long range thinking ("If I don't do my homework, I get bad grades etc.) - Reverts to concrete thinking when stressed	- Established abstract thinking - Future oriented (e.g. thinking about careers) - Perceives long range options (e.g. consequences of not paying attention at school)
Psychosocial	- Preoccupied with: - Rapid physical growth - Body change - Disrupted change	- Re-establishes body image - Preoccupation with fantasy and idealism - Sense of powerfulness	- Intellectual and functional identity established
Family	Defining boundaries of independence (coming home late, not following the rules)	Conflicts over control	Transposition of child-parent relationship to adult-adult relationship
Peer Group	Seeks affiliation to counter	Needs identification to	Favour of individual

	instability	affirm self-image Peer-group defines behaviour	friendship
Sexuality	Self-exploration and evaluation (new body à feelings about change?)	Preoccupation with romantic phantasy Testing ability to attract opposite sex (e.g. flirting, dress up for opposite sex)	Forming of stable relationships (mutuality and reciprocity) Plan for future (e.g. family)

* Adolescence may cause pupils to not pay attention and fail in school. Teachers should encourage their pupils in this period of life so that they can cope with the changes.

Topic 2: GENDER EQUALITY AND HUMAN RIGHTS

Gender equity and human rights are a prerequisite/building blocks for YFHS. It is against this background that the project embraces experiences, ideas, concerns, needs and challenges of both adolescent girls and boys as integral dimensions in the design, implementation, and M&E of the YFHS and gender programme. These dimensions are mainly addressed through:

- Promoting gender equality and empowerment of young girls
- Implementing gender transformative education among very young adolescent boys and girls (under age 14)
- Creating positive learning environments in which boys and men can change and challenge gender and cultural norms.
- Increasing use of health services by young girls, married and unmarried, including sex workers
- Promoting socio-cultural change to empower young women to use contraception that best suit their needs and ensuring that they have access to methods that give them control of their reproductive health, including injectable contraceptives and female condoms.
- Teaching young women/adolescent girls to understand their social and biological vulnerability to STI/HIV
- Ensuring accountability regarding the needs and interests of young women

Gender: Socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.

GBV: Violence targeted at girls, boys, women and men based on the gender roles assigned to them. It involves girls, boys, women and men, in which the female is usually the victim, and is derived from unequal power relationships between men and women (UN-Instraw, UNFPA 2010). Sexual abuse is any sort of non-consensual sexual contact.

Gender sensitivity: The act of being aware of the ways people think about gender, so that individuals rely less on assumptions about traditional and outdated views on the roles of men and women; being conscious of the need to understand the social relations between men and women and taking these into account before embarking on interventions (UN-Instraw, UNFPA 2010).

Gender-sensitive reproductive health (RH) programmes: RH programmes that are aware of and address the specific RH needs of women and men, boys and girls, and account for and respond to prevalent gender norms and roles in programming.

Young boys 10–14 years: Gender-based violence (GBV) is an underlying thread of special importance to YFHS. Prescribed socio-cultural norms that encourage the demonstration of masculinity by expressing emotions through anger or violence can increase acts of GBV. This display of masculinity also has harmful effects on young boys. Violent sexual practices as well as limited or no condom use results in the higher risk of contracting STIs and HIV. These norms have profound negative health effects that disproportionately affect girls and young women, and as young women continue to have less power and status than young men, they are less able to access or advocate for what they need. Youth-responsive programmes need to be well equipped to integrate GBV screening, referrals, treatment and prevention.

Investing in gender transformative programmes especially with young boys 10–14 years when they are at their most impressionable period can help reform harmful cultural norms and practices.

Topic 3: EDUCATION FOR GIRLS AND BOYS

Fewer girls than boys attain formal educational qualifications in Malawi (see accompanying graph); half of the girls drop out of school at the primary school level and very few reach secondary education mainly due to child marriages and teen pregnancy (EMIS, 2014). Continuing on this path will not enable Malawi to realise a demographic dividend. Every year spent in primary school increases a girl's earnings by 10% to 15% and each year of secondary education by up to 25%. The skills and experience gained in secondary school can position them to participate in the formal employment sector or increase the chances of securing funding for small businesses. Investing in quality education, with a focus on equal opportunity and completion of secondary schooling, especially for girls, is a protective determinant and strongly associated with healthy RH behaviours.

Evidence shows that the more educated a girl is, the more likely she is to use contraception; avoid unintended pregnancy (see accompanying graph); seek antenatal care, HIV counselling and testing and anti-retroviral treatment (ART); and thereby actively participate in productive livelihoods and/or community development activities. Access to comprehensive sexuality education (CSE), contraceptives and social protection initiatives such as cash transfers initiatives, availability of boarding facilities close to school, improving school sanitation, making schools gender-responsive, as well as community sensitisation on the benefits of female child education, can increase girls' chances of completing education.

Hence this project seeks to strengthen synergies and linkages with line ministries and other stakeholders for a robust and comprehensive YFHS programme.

Similarly, protecting those young girls and boys who proceed to tertiary education levels is equally important as youth of post-schooling age are likely to be experimenting and discovering themselves sexually and socially and may be prone to alcohol and drug use/abuse. Higher learning institutions have a role in developing professionals and citizens

who are socially responsible and conscious of their contribution to the national development agenda of the country, including mitigating the impact of the HIV/AIDS pandemic and negative SRH outcomes. As such, SRH/HIV information and information on alcohol and drug use is imperative in tertiary institutions, as well as access to contraceptives, emergency contraception, STI services, HIV-related care, support, and treatment and gender literacy.

Education Status of Youth

Indicator	Status	Source
Gross Enrolment Rate	• Primary School – 120% of children aged 6–13 years • Secondary School – 30% of children aged 14–17 years	IHS II 2010 – 2011
School Dropout Rate	• Overall 19% of girls due to teenage pregnancy. • 28% girls drop out of Standard 8 due to teenage pregnancies with less than 10% of young mothers being re-admitted into school. • 20% of girls drop out due to early marriages in primary and secondary school	EMIS 2013 MoFEPD 2013
Literacy rate	• 74% males aged 15 years and above • 57% female counterparts	IHS II 2010 – 2011

Alternative spaces

Youth clubs e.g. anti-HIV/AIDS clubs, YPLHIV clubs, environment clubs, sporting and recreational venues, youth centres, or non-formal education settings where youth meet on a regular basis. Health care providers can be invited to go to where these young people are meeting to provide information, services, and skills building.

Topic 4: SEXUAL AND REPRODUCTIVE HEALTH

Definitions:
Sexual Health: Absence of illness and injury with sexual behaviour and a sense of sexual well-being. Sexuality influences thoughts, feelings, interactions and actions among individuals.

Reproductive Health: State of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Protective and risk Factors Influencing Young People's Sexual Behaviour

Clearly, an individual's experience of sexual relations is mediated by biological (such as age of puberty), cultural norms (such as age of marriage) and social factors (such as power relations between men and women).

Family matters: Adolescents who have a positive relationship with parents are less likely to start sexual intercourse early.

School matters: Adolescents who have a positive relationship with teachers are less likely to start sexual intercourse early.

Friends matter: Adolescents who believe that their friends are sexually active are most likely to start sexual intercourse too early.
Beliefs matter: Adolescents who have spiritual belief are less likely to start sexual intercourse early.

Risk behaviours are linked: Adolescents who engage in other risk behaviours such as using alcohol and drugs are more likely to start with sexual intercourse too early.

Sexual Abuse and Commercial Sexual Exploitation

Young girls often like power, confidence and skills to refuse to have sex or negotiate safer sex. Gender norms can place them at high risk of sexual violence including coerced or forced sex. They are not encouraged or given support to take decisions regarding their choice of sexual partners, negotiate with their partners their timing and nature of sexual activity, to protect themselves from unwanted pregnancies and diseases and least of all to acknowledge their own sexual desire.

Sexual abuse, coercion and rape are tragic realities that affect young people. They can result in problems such as unwanted pregnancies, sexually transmitted infections including HIV in addition to having long lasting psychological consequences.

Economic hardship can force young boys and girls to leave home and seek a livelihood and support elsewhere. Commercial sexual exploitation and prostitution are sometimes consequences of this. In other instances the adolescents may leave home because of abuse by family members and end up living on the street or in sexually exploited relationship.

Consequences of Unprotected Sexual Relations

Health Risks to Adolescent Girls

Sexually transmitted infections (STIs) including HIV- STIs may further lead to cancer of the cervix

Premature pregnancy: adolescent bodies are not sufficiently physically developed to have a safe pregnancy and delivery.

Pregnant adolescents are more likely to suffer from eclampsia and obstructed labour than women who become pregnant in their 20s as the pelvis has not reached its full adult size at childbirth. A particularly devastating complication of obstructed labour is obstetric fistula, a hole between the vigina and the bladder or rectum. The woman constantly leaks urine and faeces, the smell is offensive and is often abandoned both by her family and the community.

She may lack social and emotional maturity to cope with the experience of becoming a mother and how it changes her life.

Unsafe abortion

Health Risks to the Baby

Babies from adolescents are more likely to have low birth weight, run a risk of being premature and an increased rate of perinatal mortality.

A major problem arises from "children having children" a young adolescent mother, barely out of childhood herself and certainly not an adult may not have the parenting skills needed to raise a child.

Social Costs of Pregnancy to the Adolescent Mother

Unmarried pregnant young women run a risk of being rejected by family and community. One problem is often linked to another, for example unable to continue their education and finding employment that will lead to low income.

Poverty and poor health often go hand in hand, rendering the mother even less able to cope and setting the child back in its development.

The Cost to the Community

Every pregnancy has negative consequences not only for the mother and the baby but also to the community. Poor, unmarried mother with little education is not only unable to contribute

to the development of the community but she and her family may become a burden. It is the community's interest for all families whether it's a two parents or single parent to be economically viable and early pregnancy does not help that to happen.

The vast majority of unsafe abortions take place in countries in which abortion is restricted by law. Many women survive the experience only to suffer throughout the rest of their lives from chronic health problems and in many cases infertility. More young girls would resort to abortion as a way of solving an unwanted pregnancy. The choice to have an abortion is not an easy one. Adolescent often state number of reasons for resorting to abortion:

- *Education*: Pregnant girls who fear expulsion from school or the interruption of their studies may believe that they have no choice but to terminate their pregnancy.
- *Economic factors*: since young women have fewer economic resources to care for a child, it is not surprising to find economic pressures influencing their decision to seek an abortion.
- *Social condemnation*: in societies where a pregnancy before marriage is considered immoral, adolescent girls choose termination of pregnancy to avoid bringing shame and condemnation on themselves and their families.
- *Having no stable relationship*: this reason is encountered more commonly among adolescents than in adults.
- *Failed contraception*: contraceptive use among young women is often low. Where they are used, this is often done so inconsistently and incorrectly. Also, less effective methods tend to be used.
- *Coerced sex (including rape and incest)*:cross-cultural data point to the fact that a larger percentage of rape and sex abuse incidents are perpetrated against young women than among adults.

Factors contributing to unsafe abortion in adolescents

- Delays in seeking care
- Resorting to unskilled providers
- Use of dangerous methods
- Legal obstacles
- Service-delivery factors

The Consequences of Unsafe Abortion

- Death
- Medical consequence e.g. sepsis, vaginal laceration, haemorrhage, perforation of the uterus, tetanus, pelvic infection or abscesses and intrauterine blood clots, anaemia, death

- Psychological consequences e.g. sense of loss and reaction of grief. Some have also expressed guilt that extends beyond the abortion itself to guilt for having engaged in sexual relation and for failing as real women by opting for abortion.

- Social and economical consequences e.g. they may have to leave school and face disapproving attitudes from their community and they risk being thrown out by their families. They often marry early, get poorly paid jobs and attempted or forced into prostitution. In short the spire of events stemming from their obtaining unsafe abortion regularly reduces their life-chances. The investments made in education and training are lost human resources which could have contributed to the nations development are lost. Unsafe abortion thus results in costs not only to individuals in families but both to communities and societies.

Diagnosis of Unsafe Abortion

History of missed menstrual period followed by an attempt to terminate the unwanted pregnancy by oneself or the assistant of a friend. This often includes excessive bleeding.

A swollen, tender abdomen, bleeding and foul-smelling discharge from the vagina with some products of conception still in the uterus.

Compared with adults, young women with an unsafe abortion are more likely to:

- Be unmarried and outside a stable relationship
- Be primi gravida
- Have a longer gestation up to the time of abortion
- Have used dangerous methods to terminates pregnancy
- Have resorted to illegal providers
- Delay seeking help
- Came to the health facility alone or with a friend, rather than with the partner
- Have ingested substances that interfere with treatment
- Have more entrenched complications

Preventing Unsafe Abortion

Communities, government and health should strive to:

- Improve access to reproductive health information and services
- Train health- care providers in comprehensive abortion care
- Involve communities in protecting and safeguarding adolescents

Preventing Adolescent pregnancy

- Abstinence- abstinence from sex (oral, anal or vaginal) is the only behaviour that is 100 percent effective at preventing adolescent pregnancy

- Contraception- besides abstinence, using contraceptives like condoms during sexual intercourse can also prevent adolescent pregnancy
- Communication- parents and teachers should talk to adolescent youth about sex, relationships, the consequences of unsafe sex, and the consequences of adolescent pregnancy.
- Don't leave anything to chance. If you have had sex and either you didn't use protection or your protection wasn't effective (e.g. condom split) then don't leave it to chance get hold of the Plan B contraceptive/morning after pill, which can prevent a possible pregnancy within 3 days of sexual intercourse (although the sooner you have it, more effective it will be).

Topic 5: SEXUALLY TRANSMITTED INFECTIONS (STIs)

Infections transmitted from one person to another primarily by sexual contact. Some STIs can be transmitted by exposure to contaminated blood and from a mother to her unborn child.

More than 30 different bacteria, viruses and parasites are known to be transmitted through sexual contact. Eight of these pathogens are linked to the greatest incidence of sexually transmitted disease.

STIs are spread predominantly by ***sexual contact, including vaginal, anal*** and ***oral sex***. Some STIs like HIV can also be spread through non-sexual means such as via **blood** or **blood-products**. Many STIs –including ***chlamydia, gonorrhoea, primarily hepatitis B, HIV*** and ***syphilis***- can also be transmitted from ***mother to child during pregnancy*** and ***childbirth***. Moreover, HIV can also be spread via breast milk through breast feeding.

Infection (organism)	***cure***	***Early symptoms***	***prevention***
Syphilis (bacteria)	Yes	Small painless sores ***Treatment: Antibiotics***	Abstinence Using condoms during vaginal, oral and anal sex Being faithful to one partner Avoiding mixing sex and alcohol Young girls should avoid older partners Comprehensive sexuality education Pregnant females
Gonorrhoea (bacteria)	Yes	Abnormal vaginal discharge, painful urination, painful bowel movements, anal itching, bleeding between periods/heavy menstrual bleeding ***Treatment: Antibiotics***	
Chlamydia (Bacteria)	Yes	Abnormal vaginal discharge, burning sensation when urinating, abdominal pain, pain during intercourse, bleeding between periods	
Trichono-miasis (Protozoa)	Yes	Vaginal discharge/itching/odor, painful urination, pain during intercourse ***Treatment: Antibiotics***	
Hepatitis B (Virus)	No	Weakness, nausea/vomiting, loss of appetite, fever, dark urine, itching, abdominal pain,	

		muscle or joint pain, yellowing of skin/eyes or ***no symptoms*** ***Treatment: prescribed medication***	should be tested for HIV, chlamydia, gonorrhoea, hepatitis B and syphilis and other ways to keep you from contracting the infections or passing them to your child
Genital herpes (herpes simplex virus/ HSV)	No	Blisters or open sores in the genital or anal areas, pain or itching around the genital area, buttocks and inner thighs ***Treatment: prescribed medication***	
Genital warts (human papilloma virus)	No	Several warts close together, itching or discomfort in the genital areas, bleeding with intercourse ***Treatment: Antiretroviral therapy***	
Human immune-deficiency virus (HIV)	No	Flu-like symptoms or ***no symptoms*** ***Treatment: Antiretroviral therapy***	
Oral herpes (HSV)	No	Painful sores in the mouth or on the lip ***Treatment: pain medication and plenty of fluids***	Avoid touching saliva, skin, or mucous membranes of people who have open sores

STIs can have serious consequences in adolescents, beyond the immediate impact of the infection itself:

- STIs like herpes and syphilis can increase the risk of HIV acquisition by three times or more.
- Mother-to-child transmission of STIs can result in stillbirth, neonatal death, low-birth-weight and prematurity, sepsis, pneumonia, neonatal conjunctivitis, and congenital deformities.
- HPV infection causes 528 000 cases of cervical cancer and 266 000 cervical cancer deaths each year.
- STIs such as gonorrhoea and chlamydia are major causes of pelvic inflammatory disease (PID) and infertility in women.
- Exposure to chlamydia and HPV may lead to cervical cancer.
- Untreated syphilis may lead to heart and brain damage
- Stigma and embarrassment can impair psychological development and attitudes towards sexuality later in life.

Global data on STIs in adolescents and young people:

- Every year more than 1 out 20 adolescents contract a curable STI, not including viral infection.
- The age at which STIs are acquired is becoming younger.

- Of the estimated 333 million new STIs that occur in the world every year, at least a third occur in young people under the age of 25.
- Globally, more than half of all new HIV infections (over 6,500 each day) are among young people aged 10-24 years.

STIs among young people in Malawi:

- Prevalence is higher in rural areas compared to urban areas
- Within regions, the prevalence of STIs is higher in the southern regions.

Factors contributing to STIs among young people in Malawi:

- Unplanned sexual relations
- Sexual relations without skills in self-protection and information on how to avoid contracting infections
- Lack of access to preventive services and protective supplies such as condoms
- Biological and social reasons making adolescent girls more susceptible to STIs
- Protective, hormonally-driven mechanisms have not yet had time to develop fully e.g. immature lining of the cervix in adolescence provide a poor barrier against infection
- Financial pressures leading to girls becoming sex workers to support their families

Factors That Hinder Adolescents from Seeking Treatment:

- STIs often have no symptoms
- Inadequate information about existing services
- Difficulty in accessing services
- Lack of money to pay for medication
- Fear of stigma and embarrassment
- Afraid of being scolded by health worker

Factors That Hinder Effective Management of STIs in Young People:

- Difficulty in accessing services
- Lack of money to pay for medication
- Self-medication
- Lengthy or painful treatment

What can you do as a teacher/student?

Topic 6: SUBSTANCE ABUSE AND YOUNG PEOPLE

Definition of substance abuse:

It is the excessive use of chemical substance to alter or modify behaviour.

Most commonly abused substances include:

- *Alcohol*- both stimulant and depressant substance with the potential to destroy health if taken in excess. Alcohol makes one feel exaggerated feeling of wellbeing and staggering gait.
- *Cigarettes*- tobacco contains nicotine, a drug that is very addictive.
- *Hemp/Chamba* (Marijuana, fodya wamkulu, Malawi gold, Ganja, Jah, Kanunundu, Nazi, Weed/Zomera, Mutu wa mbalame, Thelere). It is a dried plant material from a plant called cannabis sativa.

Why people misuse drugs:

- Compensation for anxiety
- To adjust oneself in some social skills performance
- For recreational activities, e.g. casual drinking
- Curiosity that leads to experimentation
- Lack of parental guidance
- Frustrations that may lead to boredom or depression
- Social/peer pressure
- Family history of alcohol or drug abuse
- Risk taking behaviour due to carefree approach to life
- Myths and misconceptions about

Stages before becoming abusive or dependent on drugs and alcohol:

- Abstinence (non-use)
- Experimentation- here is when you have heard about what happens or how one feels when they have taken drug or alcohol, and you would like to try.
- Occasional use (recreational/casual or compensatory for other problems)- at parties, weekends, mostly during free times for fun/relaxation, or to minimize the effects of other problems
- Abuse- at this stage, you're engaged in regular or excessive use of chemical substance to alter or modify behaviour. You can even fail to attend most important activities, for example classes, work and others. You may spend more on drugs and alcohol than anything more important to your life.

- Dependency- the addiction stage has been reached here, quitting is too hard, though not impossible. Your performance and most part of life depend on the drugs or alcohol.

Signs of drugs/alcohol abuse:

- A drop in school performance
- A change in groups or friends
- Bad behaviour
- Decline in family relationships

Effects of substance abuse on adolescence

- Deaths from accidents, suicide, sedatives have ability to trigger suicidal thought.
- Homicide
- Physical aggression that may lead to assault
- Sexual aggression or rape
- Cannabis causes irritation of throat, dryness of the mouth, bloodshot eyes, increased appetite for food, disruption of thought and speech, hydrophobia, addictions, just to mention a few.
- Increase in in dosage might result in overdependence
- Cigarettes cause lung cancer and heart attacks.
- Increased chances of being infected with HIV and others STIs, as they may become too weak to defend themselves or make a rational decision and action to have safe sex.
- A drop in school performance, which may emanate from irregular class attendance or loss of concentration during lesson delivery in class.
- They are unable to maintain a healthy romantic relationship
- They are usually looked upon as a lowlife in their community
- Ability to perform tasks is reduced.
- Regular drinking drains money from individual and family
- Theft from family and friends.
- Destroys relationships and family relationships
- Substance-abusing youth often alienated from and stigmatized by their peers.

Myths and misconceptions of substance abuse

Myth: smoking marijuana/ hemp is not harmful, it helps adolescents and young people to study, to remove stress and shyness, to be strong/powerful, and makes a person very intelligent in school

Fact: we should run away from the fact that the world needs more intelligent people, intelligent leaders, teachers and students, including counsellors and their clients. If smoking chamba can increase the number of intelligent citizens in a country, then there wouldn't be a

point in illegalizing the substance. But that is due to the fact that it poses more danger than safety among the youth and all humanity.

Myth: drug addiction is more serious problem than alcohol addiction
Fact: people assume that because alcohol is legal it must mean that it is less dangerous than those drugs that have been criminalized. This belief has been challenged and a recent study in the UK found that alcohol causes more harm than heroin or even crack cocaine.

Myth: drug addiction is voluntary behaviour.
Fact: a person starts out as an occasional drug user, and that is a voluntary decision. But as times passes, something happens, and that person goes from being a voluntary drug user to being a compulsive drug user. Why? Because over time, continued use of addictive drugs changes your brain - at times in dramatic, toxic ways, at others in more subtle ways, but virtually always in ways that result in compulsive and even uncontrollable drug use.

Myth: drinking alcohol is hereditary
Fact: most young people are initiated into drug abuse by their peers. This denotes that you can be born from a persistent substance abuse parent, and still not get involved in the behavior of substance abuse.

Myth: it is very rare for a teenager to be addicted to substances
Fact: many young people abuse the substances, they are visible in the community, and have become addicted and dependent on the substances.

Myth: drugs addicts are just bad people who choose to fall into a life or deprivation.
Fact: nobody ever intends to become a slave to drugs. By the time that the individual begins to experience problems they are already deep into denial. It is often the fact that the individual does not fit into the drug addict stereotype that gives them the courage to experiment in the first place- all people who experiment with drugs never believe that the addiction will actually happen to them.

Myth: once a drug addict always a drug addict
Fact: even those who have fallen low into the midst of addiction can return to sanity. There are many examples of individuals who gave up drug abuse and completely turned their life around.

Myth: treatment for drug addiction should be a one-shot deal.
Fact: like many other illnesses, drug addiction typically is a chronic disorder. To be sure, some people can quit drug use after receiving treatments just one time at a rehabilitation facility. But most of those who abuse drugs require longer-term treatment and, in many instances, repeated treatments.

Myth: there is only one way to escape addiction

Fact: different people have different drug abuse-related problems. And they respond very differently to similar forms of treatment, even when they're abusing the same drug. As a result, drug addicts need an array of treatments and services tailored to address their unique needs. The important thing is that the individual finds what works for them. This means being willing to consider even those things that do not sound so attractive to begin with.

Prevention of substance abuse

Role of young people

Young people need to know that involving themselves in substance abuse, is just like waging war against themselves. They are the ones thinking that they're enjoying it, but in actual sense, they are creating barrier to their brighter future. In this case, they are supposed to be at the forefront; avoiding preventing and controlling substance abuse.

Role of guardians and communication

It may be commonly understood that a child will trust their parents or guardians more than anyone they meet in life. In this case, this should be taken as a great chance for the parents to act as primary counsellors of the children.

Information, education and communication

The adolescents cannot evade, prevent or control substance abuse, unless they are informed and educated about the dangers of the substance abuse. Communication might be done through leaflets, brochures print and electronic, and the media, in which there is a need to give a clear picture on all issues surrounding substance abuse. In the same way, parents and guardians may lack some expertise in approaching the issues to do with substance abuse. Therefore, there is a need to make sure that there is sufficient knowledge of substances, prevalence of abuse and their consequences so that the young people get the correct information.

Community mobilization

The youth involved in substance abuse are raised by the community, before during and after quitting drug abuse. Some are brought into drug abuse by the norms of the community as well. For example, beer drinking is not considered as a taboo among the Ngoni tribe mainly in Dedza and Ntchewu District of Malawi, where even very young children could be encouraged to take a sip or two. To make matters worse, a good number of community members are likely to have inadequate knowledge on the evils of substance abuse.

Having observed all this, there is a need for the community to be exposed to the knowledge of issues about substance abuse. The community needs to be mobilized and educated to challenge substance abuse among the youth. They can take a further step by reporting to the police, of any of the people who are promoting use of harmful substance among the youth.

Life skills

Already, we have life skills being taught in schools, and substance abuse is among the topic in the syllabus. This need to be made available to not only the youth in school, n-but also those out of school. The fact that both parties interact in one way or the other, the tilted knowledge on the dangers of substance abuse may act against the intended results of the life skills lessons. Universal access to life skills training may create a larger number of the youth with the ability to stand peer pressure, be assertive, and make informed choices so that they are not easily compelled into substance abuse, among others.

Guidance and counselling

Guidance and counselling services are very important, and need ti be made available to the youth. The services will help young people to know the impact of being involved in substance abuse. This will enable them to make informed choices in life. Counselling will create a room for those already abusing the drugs to see and feel the need to stop bad behaviour.

Early intervention

Intervening early, before secondary school, is critical. It is suggested that patterns of substance abuse become worse in the secondary or tertiary school years. Individuals who begin using alcohol or tobacco when they are very young are more likely to abuse them later in life, when it becomes much more difficult to quit.

Conclusion

Drug abuse starts with a sip, sometimes just for an experiment, turns into something recreational, then abuse before it reaches dependence. Abuse of the substance by anyone, especially the youth has proven to be an enemy to their desired brighter future. The only good news about this is that the addiction and most he effects are reversible. The youth are very much involved in drug and substance abuse and are the victims, of the malpractice, themselves. The role of prevention and control lies not only in the hands of the counsellor, the teacher or the parent, but also the young people themselves. They are master of their own fate.