STRATEGIES FOR IMPROVING UTILIZATION OF YOUTH-FRIENDLY HEALTH SERVICES IN BLANTYRE, MALAWI

By

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DEDICATION

I dedicate this thesis to:

The youth of Blantyre and my late father, Mhlaba Patrick Billy Thole, who encouraged me to go as high as possible with my education when I was still very young. He told me the sky was the limit.

DECLARATION

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I declare that the above thesis is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the thesis to originality-checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution.

Grace Charity Sibande Date: 15 June 2023

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STRATEGIES FOR IMPROVING UTILIZATION OF YOUTH-FRIENDLY HEALTH SERVICES IN BLANTYRE, MALAWI

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ABSTRACT

In sub-Saharan Africa, the utilisation of youth-friendly health services (YFHSs) remains unsatisfactory among the youth despite global agreements concerning their importance. The aim of this study was to develop strategies for improving the utilisation of YFHSs in rural and urban Blantyre, Malawi. A sequential, explanatory, mixed-method approach, with the quantitative method in phase one and the qualitative method in phase two, was used. In turn, the two phases informed the development of strategies for improving the utilisation of YFHSs in phase three.

The study population for phase one comprised female and male unmarried youths aged 10 to 24. Multistage sampling was used to randomly sample (N=293) unmarried youths. Phase two's study population comprised service providers from the selected health facilities (N=6) and youths (N=24).

Phase one's data were collected using a structured questionnaire, and it was analysed using a computerised statistical package for social sciences (SPSS) version 26. Chi-square (X^2) was used to test the significance of the association between variables, and p-value ($p < 0.05$) was considered significant. Regression analysis was used to examine independent variables' influence on the utilisation of the services.

For phase two, a semi-structured interview guide was used for individual interviews with service providers, and a discussion guide for focus group discussions. Thematic analysis was used to analyse the data for phase two.

Results revealed that less than half of the respondents had ever utilised YFHSs (43%). Six themes emerged from both quantitative and qualitative results as factors that influence the utilisation of YFHSs; lack of recreation and sporting activities and equipment supporting the same, lack of dedicated space for the provision of YFHSs, lack of knowledge, the need for youth-to-youth promotion, the need for female and male YFHS providers, and healthcare providers' attitude.

Strategies aimed at increasing the utilisation of YFHSs were developed in phase three to increase contraceptive uptake and reduce unintended pregnancies and their associated complications.

KEY TERMS

Adolescent; Adolescent Friendly Health Services; contraception; contraceptives; family planning methods; strategies; youth; Youth Friendly Health Services; utilisation; young people

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LIST OF ABBREVIATIONS

AA-HA	Accelerated Action for Health of Adolescents
AFHCs	Adolescent-Friendly Health Corners
AIDS	Acquired Immuno-Deficiency Syndrome
ART	Antiretroviral Therapy
GPs	General Practitioners
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
JHPIEGO	John Hopkins Program for International Education in Gynaecology and Obstetrics
MANASO	Malawi Network of AIDS Service Organization
MMR	Maternal Mortality Ratio
MVA	Manual Vacuum Aspiration
NGO	Non-Governmental Organisations
OGSM	Goals-Strategies-Measures
PDR	People’s Democratic Republic
SPSS	Statistical Package for the Social Sciences
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infections
TWC	Teen Wellness Centre
USAID	United States Agency for International Development
WHO	World Health Organization
YFHSs	Youth-Friendly Health Services

CHAPTER 1
ORIENTATION OF THE STUDY

1.1 INTRODUCTION

As a concept, youth-friendly health services (YFHSs) were first introduced by the World Health Organisation (WHO) in 2001 to provide non-judgemental, sensitive and competent services to the youth. The services were to be provided with respect and confidentiality, and in a manner acceptable to youths (Baroudi, San Sebastian, Hurtig & Goicoela 2020:780). According to the WHO (2012:7), YFHSs are defined as services that are accessible, acceptable, equitable, appropriate and effective for the youth. However, literature reveals that the uptake of these services remains low, especially in sub-Saharan Africa, including Malawi (Ninsiima, Chiumia & Ndeigo 2021:1).

Despite adolescence (ages 10 to 19) being an important age in laying the foundations for good health, many deaths and illnesses are still attributable to preventable or treatable causes (WHO 2021:1). Moreover, in sub-Saharan Africa, youths experience various problems, such as incomplete education, threats of the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), early marriages, early childbearing, and unsafe abortions (WHO 2014:3). A WHO report based on hospital studies projected the annual incidence of unsafe abortions worldwide at 20 million, with a ratio of one unsafe abortion to seven births. It further claimed that 90% of unsafe abortions occur in developing countries and contribute to 13% of pregnancy-related deaths (Bhattacharya & Stubblefield 2019:2).

The Lancet Global Health Reports determined that the annual number of unintended pregnancies worldwide increased from 108 million to 121 million between 1990 to 2019, and the number of abortions increased from 55 to 73 million during the same period. Therefore, countries facing high population growth rates in sub-Saharan Africa and elsewhere must expand sexual and reproductive health services, including family planning (The Lancet Global Health 2020:1).

In Malawi, teenage pregnancy prevalence is at 29% (Dombola, Chipeta & Manda 2020:1). This is a significant statistic since many adolescents in the region resort to unsafe abortions, conducted by unskilled providers or in unsafe conditions. This is due to socioeconomic factors, the cultural implications of being pregnant before marriage, and legal restrictions concerning access to safe abortions (Atuhaire 2019:1). This phenomenon calls for youths' use of contraceptives to prevent unintended pregnancies, yet the Health Policy Plus (2017:1) reports that the unmet need for family planning in Malawi for girls aged 15–19 is 22%.

Contraception is of great importance in preventing unintended pregnancies among youths, considering that some youths start engaging in sexual intercourse at a very early age. A study that examined outcomes associated with early sexual debut in five sub-Saharan countries (Kenya, Malawi, Nigeria, Tanzania, and Uganda) revealed that the prevalence of early sexual debut ranged from 8.6% in Tanzania to 17.7% in Malawi (Seff, Steiner & Stark 2021:1046). In that study, 'early sexual debut' was defined as having one's first sexual encounter before the age of 15. This implies that many young people had their first sexual experience before marriage.

Malawi introduced YFHSs in 2007 to develop interventions that address low contraceptive use among youths and create a platform where youths could access contraceptives in a friendly environment (USAID 2014). However, a 2014 YFHS evaluation by the United States Agency for International Development (USAID) in Malawi showed that only 13% of youths accessed YFHSs. Studies conducted in Ethiopia and Ghana also highlight similar underutilisation of these services, reflecting the need to develop strategies to increase youths' utilisation of YFHSs (Amaje, Daniel, Tefera & Sirage 2022:1; Asare, Aryee & Kotoh 2020:1; Sertsu, Eyeberu, Bete, Yadeta, Lami, Balcha, Berhanu, Alemu, Meseret, Mohammed & Alemu 2023:1).

1.2 BACKGROUND TO THE RESEARCH PROBLEM

1.2.1 The source of the research problem

Malawi has a high teenage pregnancy prevalence rate of 29% (Chirwa, Mazalale, Likupe, Nkhoma, Chiwaula & Chintsanya 2019:1). This is worrisome since unintended pregnancies can be easily prevented through the youth's use of contraceptives, which

are readily available at YFHSs in Malawi. However, there are possibly many factors that prevent youths from utilising YFHSs in government institutions where contraceptive methods are distributed at no charge. Characteristics of service provision such as acceptance, friendliness, non-judgemental provision of care and confidentiality are the most important factors in care-seeking behaviours (Radovich, Dennis, Won, Ali, Lynch, Cleland, Owolabi, Lyons-Amos & Benova 2018:279).

Embarrassment associated with seeking contraceptive services is a common barrier to youths' utilisation of YFHSs. This results in youths accessing providers like local pharmacies, which offer faster and more discreet services compared to public clinics, with a more comprehensive range of family planning methods. Other characteristics that attract young people to these limited-capacity providers are accessibility, extended opening hours, confidentiality, and quick services (Radovich et al. 2018:279).

Still, the increased prevalence of teenage pregnancy recorded in the literature could indicate that many young people are not using family planning methods to prevent these unplanned pregnancies. Anecdotal records at Queen Elizabeth Central Hospital's gynaecological ward show that in a six-month period (from May to October 2021) 2 102 women were admitted to the ward with various gynaecological conditions. Of the 2 102 admissions, 1 161 (55%) were diagnosed with incomplete abortions and were managed either by manual vacuum aspiration (MVA) or evacuation in theatre. Of the 1 161 patients with incomplete abortions, 613 (53%) were young people aged 10 to 24.

Moreover, during the COVID-19 era (March to July 2020), many young people in Malawi did not use contraceptives. A Malawi government assessment of teenage pregnancies indicated that the country recorded 40 000 cases of teen pregnancies during the COVID-19 period, representing an 11% increase from 2019. Early pregnancy prevention was recommended (UNICEF 2020:5). The magnitude of early pregnancies and abortions thus motivated the researcher to propose a study to determine what strategies might increase youths' utilisation of YFHSs, especially for counselling and contraceptive uptake, to reduce unintended pregnancies. The researcher was of the view that increased utilisation of YFHSs would assist the youth in accessing counselling and contraceptive methods.

1.2.2 Background to the research problem

Teenage pregnancy, which is defined as being pregnant during the ages of 13 to 19 years, is a major global public health issue (Abebe, Fitie, Jember, Reda & Wake 2020:1). According to Abebe et al. (2020:1), globally about 11% of all births are to girls aged 15 to 19, with 95% of these deliveries occurring in low and medium-income countries. The researchers further reported that, globally, complications during pregnancy and childbirth are the second-most prevalent cause of death among 15 to 19-year-old girls.

Kiani, Ghazanfarpour and Saeidi (2019:9750) also report that pregnancy and childbirth complications are the leading cause of death among 15 to 19-year-old girls globally, and they add that 3.9 million unsafe abortions among girls aged 15 to 19 occur each year, contributing to maternal mortality and complications. This implies that large numbers of maternal deaths in the country are attributed to illegal abortions (Odland, Membe-Gadama, Kafulafula, Jacobson, Kumwenda & Darj 2018:2). In support, the WHO Global Accelerated Action for Health of Adolescents (AA-HA) reports that the number of abortions in developing countries is estimated to be between 2.2 million and 4 million annually (WHO 2017:27). Amidst these statistics, Malawi's teenage pregnancy prevalence is at 29% (Dombola et al. 2020:1). The country has made progress in its efforts to increase overall modern contraceptive use since 2000 and reduce the overall total fertility rate in general. However, little progress has been made in addressing the unmet need for family planning services among youths (Self et al. 2018:1), though it remains a government priority. One of the strategies to enhance the uptake of family planning among the youth could be increasing their utilisation of YFHSs.

A systematic review of factors influencing access to and utilisation of YFHSs in sub-Saharan Africa revealed either structural or individual barriers (Ninsiima et al. 2021:14). Structural barriers included inconvenient operating hours, health workers' negative attitudes, and unskilled health workers. Some health workers were reported as using abusive language, while others lacked the sympathy expected of family planning service providers. It emerged that some health workers were partially trained to deliver services to young people, while others were entirely untrained. Individual barriers also

included a lack of knowledge among youths regarding YFHS issues. Access to reproductive health information was also often hindered due to stigma related to the youths' age and parental consent (Ninsiima et al. 2021:14).

While interventions have been introduced to improve Malawi's situation, evidence that YFHS uptake has improved in the country is inadequate. The problem is that previous studies focused on barriers to YFHS uptake in Malawi (Chimatiro, Hajison & Muula 2020:1; Muula, Lusinje, Phiri & Majawa 2015:1; Self et al. 2018:1) at the expense of exploring strategies that could increase the services' utilisation. Data about contraceptive use and YFHSs also tend to favour urban areas and the school-going youth in Malawi. However, Trading Economics (2022:1) reports that 82.02% of Malawi's population resides in rural areas. The present study was therefore necessary because it was envisaged that its findings would potentially influence policy, thereby improving contraceptive uptake through YFHSs in urban and rural areas. In turn, increased uptake could reduce the number of unintended pregnancies and illegal abortions among Malawi's youth.

1.3 RESEARCH PROBLEM

The Sacred Heart University Library (2020:1) defines a research problem as an area of concern, something to be improved, a difficulty to be removed or a troubling question that is present in literature, theory or practice that shows a need for understanding and investigation. This study endeavoured to address the following research problem.

The reproductive health of young females remains a global concern; curiosity about sexual activities results in young girls having unplanned pregnancies and unsafe abortions. Unplanned teenage pregnancies, sexually transmitted infections (STIs), and unsafe abortions are prevalent in developed and developing countries (Acharya & Adhikari 2021:67).

Malawi has a high maternal mortality ratio (MMR), with 349 as the latest estimate for 2017. It is commonly acknowledged that large numbers of women die from illegal abortions. Furthermore, treatment for incomplete abortions and the management of other complications related to abortion, such as sepsis and haemorrhage, means that

already limited resources in low-income countries are further depleted (Miller 2021:1; Odland et al. 2018:2).

Approximately 140 000 induced abortions are conducted annually in Malawi in the presence of a restrictive abortion law. Attempts to legalise abortion failed as the Malawian parliament unanimously rejected the bill in 2021 (Miller 2021:1). Malawi has faced an increase in unintended pregnancies, with a 29% adolescent pregnancy prevalence rate. The researcher thus envisaged that many of these unintended pregnancies end in unsafe abortions. These are unjustifiable, since YFHSs, where youths can obtain contraceptives to prevent unintended pregnancies and illegal abortions, were established some years back in Malawi (USAID 2014:3). Thus, this study was driven by the fact that the increased abortion burden could be an indication of inadequately utilised YFHSs contrary to their intended purpose (Chirwa et al. 2019:1; Self et al. 2018:1).

In 2007, family planning services were made available for the youths at no charge through YFHSs (USAID 2014:3). However, a 2014 evaluation of YFHSs in Malawi revealed that only 13% of the country's youths had ever accessed these services (USAID 2014:3). This potentially contributed to the reduced uptake of contraceptives among unmarried youths, leading to an increase in unintended pregnancies, unsafe abortions, and other associated complications. According to the Health Belief Model, counselling services that are offered through YFHSs would improve the youths' understanding that unintended pregnancies should be avoided, and they should be informed about the benefits of contraceptive use over induced abortions (Glanz, Riimmer, Vitswanath & Orleans 2008:49).

Ultimately, little has been explored concerning strategies to improve the services' uptake. Therefore, this study was necessary to explore and determine what strategies could improve youths' utilisation of YFHSs in rural and urban areas. It was envisaged that, once the strategies are known, they could influence policy and increase contraceptive uptake among the youth, thereby preventing unintended pregnancies and unsafe abortions. This could, in turn, reduce the strain on the budget spent on managing unsafe, incomplete abortions and complications.

1.4 AIM OF THE STUDY

1.4.1 Research aim

A research aim is a broad statement that describes the main goal of a research study (Research Zone 2021:1). The aim of this study was to develop strategies for improving the utilisation of YFHSs in rural and urban Blantyre, Malawi.

1.4.2 Research objectives

Research objectives are outcomes that should be achieved by conducting research. A research project may have more than one objective. The purpose of the research objectives is to drive the research project, including data collection and analysis, drawing conclusions from the study (Indeed 2021:1).

Objectives for phase one: Quantitative phase

- Determine YFHSs' accessibility in Blantyre's urban and rural areas.
- Assess youth's knowledge about YFHSs and sexual reproductive health (SRH) issues.
- Identify barriers to the utilisation of YFHSs.
- Identify YFHS utilisation factors associated with the Health Belief Model.

Objectives for phase two: Qualitative phase

- Explore and describe the factors that influence the utilisation of YFHS in Blantyre, Malawi.
- Propose suggestions to enhance the utilisation of YFHSs in Blantyre, Malawi.

Objective for phase three: Development of strategies

- Develop strategies to improve the utilisation of YFHS in Blantyre's urban and rural areas.

1.4.3 Research questions

Research questions are specific queries that researchers want to answer in addressing a research problem; they determine the type of data to be collected in a study (Polit & Beck 2017:69). This study endeavoured to answer the following research questions:

Phase one research questions:

- How accessible are YFHSs in Blantyre, Malawi?
- What knowledge do the youth have about reproductive health services?
- What are the possible barriers to the utilisation of YFHSs in Blantyre, Malawi?
- What YFHS utilisation factors are associated with the Health Belief Model?

Phase two research questions:

- What factors would influence the utilisation of YFHSs in Blantyre, Malawi?
- What strategies would enhance the utilisation of YFHSs in Blantyre, Malawi?

Phase three research question:

- How can strategies to improve YFHS uptake in Blantyre, Malawi, be developed?

1.5 SIGNIFICANCE OF THE STUDY

1.5.1 Short-term benefits

This study explored available strategies to promote the utilisation of YFHSs. The strategies that would increase the utilisation of YFHSs were isolated to be used by healthcare providers. The findings will also be shared in research workshops, conferences and through research articles. Participants of the workshops and conferences will be equipped with information on strategies to increase YFHS uptake. This would grant the participants an opportunity to use these strategies to improve utilisation in their various workstations.

1.5.2 Long-term benefits

This study's findings will be disseminated to policymakers in Malawi's Ministry of Health with the aim of influencing policies concerning strategies to mobilise youths' utilisation of YFHSs for counselling and contraceptives. The successful implementation of these policies will help reduce unintended pregnancies among the youth, decreasing illegal and unsafe abortions.

As a low-income country, a reduction in illegal and unsafe abortions in Malawi will also reduce the Ministry of Health's budgetary constraints related to the treatment of induced incomplete abortions through MVA and evacuation and the management of other complications such as sepsis and haemorrhage. Bed space will also be made available for other gynaecological conditions in the hospitals. In the long run, the MMR will improve, and doctors' and nurses' workload will also be reduced and directed to patients with other conditions.

Youths' increased uptake of contraceptives will also address population growth, considering that not all adolescent pregnancies end in abortions. Once the strategies have been deemed successful in Blantyre, they will be rolled out to other parts of the country. The study is also significant because contraception use will help young people, especially girls, to avoid dropping out of school as a result of being pregnant. This would assist them in averting the future economic hardships experienced by those who drop out of school due to unintended pregnancies.

1.6 DEFINITION OF KEY CONCEPTS

The following key concepts are used in this thesis:

1.6.1 Adolescent

The WHO defines an 'adolescent' as a person aged 10 to 19 (WHO [s.a.]: 1).

1.6.2 Contraception

Contraception is the intentional prevention of conception through various devices, sexual practices, chemicals, drugs or surgical procedures (Jain & Muralidhar 2011:626).

1.6.3 Strategy

A strategy is a detailed plan for achieving success in situations such as war, politics, business, industry or sport, or the skill of planning for such situations (Cambridge Dictionary [s.a.]).

1.6.4 Young people

Young people encompass adolescents and youths and are persons aged 10 to 24 years (WHO [s.a.]: 1).

1.6.5 Youth

The WHO defines the ‘youth’ simply as persons aged 14 to 24 (WHO [s.a.]: 1).

1.6.6 Youth-friendly health services

Malawi’s Youth-Friendly Health Services’ National Standards define ‘YFHSs’ as high-quality services that are relevant, accessible, attractive, affordable, appropriate, and acceptable to young people (Health Policy Project Brief 2015:4).

1.6.7 Utilisation

The Cambridge Dictionary defines ‘utilisation’ as the act of using something in an effective way (Cambridge Dictionary [s.a.]). The Oxford Learner’s Dictionary further defines ‘utilisation’ as the act of using something, especially for a practical purpose (Oxford Learner’s Dictionaries [s.a.]).

1.7 OPERATIONAL DEFINITIONS

An operational definition is a statement of procedures to be used by a researcher in order to measure a specific variable. Operational definitions are needed to determine exactly what a researcher is talking about when they refer to something since there might be different definitions of words depending on the context in which the word is used (Elizabeth 2018:01).

1.7.1 Adolescent

For this study, an ‘adolescent’ is defined as a boy or girl aged between 10 and 19.

1.7.2 Contraception

For this study, a contraceptive refers to a drug, device or practice used to prevent a young person from becoming pregnant.

1.7.3 Strategies

In this study, strategies are referred to as plans to increase the utilisation of YFHSs.

1.7.4 Young people

In this study, the concept of young people encompasses adolescents and youths aged 10 to 24.

1.7.5 Youth

In this study, a youth is a boy or girl aged 10 to 24.

1.7.6 Youth-friendly health services

This study used the concept ‘youth-friendly health services’ to refer to health services designed to provide reproductive health services to the youth.

1.7.7 Utilisation

For this study, the concept ‘utilisation’ refers to the act of using YFHSs to obtain contraceptives.

1.8 THEORETICAL FOUNDATIONS OF THE STUDY

1.8.1 Research paradigm

A research paradigm is a way of looking at natural phenomena. It is a worldview encompassing a set of philosophical assumptions that guides one’s approach to enquiry (Polit & Beck 2017:738).

This study adopted the pragmatism research paradigm. The paradigm was chosen because it combines quantitative and qualitative points of view as two integrated paradigms as opposed to conflicting philosophies (Maarouf 2019:1). Pragmatism permits mixed paradigms, assumptions, approaches and methods of data collection and analysis. It is oriented towards solving practical problems in the real world (Maarouf 2019:5). In this study, the quantitative approach was used to collect data from the youth through a survey, and the qualitative approach was used to collect data through interviews with service providers and focus group discussions with youths. This approach enriched the collected data, and informed the research strategies to successfully influence the youths’ utilisation of YFHSs.

1.8.2 The Health Belief Model

The Health Belief Model was used to contextualise this study. The model attempted to predict why the youths would oppose a preventive measure against a particular condition. This might be associated with the individual’s perceived susceptibility to the condition, severity of the condition, benefits of the preventive action, and barriers to taking the preventive action. The model also asserts that there are cues that can trigger action, such as environmental events, including media publicity. Other variables, referred to as modifying factors like sociopsychological and structural variables, may also indirectly influence health-related behaviours (Glanz et al. 2008:46, 47, 50).

Five constructs from a modified Health Belief Model (refer to Figure 1.1) were adapted to guide this study (Glanz et al. 2008:49). The constructs, namely perceived susceptibility, perceived severity or seriousness, perceived benefits, perceived barriers, cues to action and self-efficacy are perceived. Saghafi-Asl, Aliasgharzadeh and Asghari-Jafarabadi (2020) define 'self-efficacy' as an individual's belief about their capabilities to successfully perform a new behaviour. In this study, self-efficacy was re-defined as the intention to utilise YFHSs.

The model was chosen because of its assertion on the prediction of acting against a particular situation, which aligns with this study. Perceived susceptibility to a lack of access to YFHSs refers to youths' self-awareness of being at risk of not being able to access YFHSs. Similarly, the severity of the condition in this study referred to fears about the effects of being unable to utilise YFHSs. The benefits of the preventive action in this study refer to the benefits of utilising YFHSs, expected to trigger youths' uptake of YFHSs, while factors that would prevent utilisation were considered barriers. Cues that trigger action also applied to the current study because available support systems for the youth and available sources of information can influence the utilisation of YFHSs. As stated, the model further asserts that other variables, referred to as modifying factors, such as sociopsychological and structural variables, may indirectly influence health-related behaviours (Glanz et al. 2008:46). This was also applicable to this study because the youths' social influence could trigger their use of YFHSs.

1.9 RESEARCH METHODOLOGY AND RESEARCH DESIGN

1.9.1 Research design

A research design is a blueprint that provides structure to a researcher in planning to answer a research question or test a hypothesis (Pawar 2020:46). A sequential, explanatory mixed-method design was used in this study. This design incorporates quantitative and qualitative approaches in two consecutive phases within one study. The findings from both phases are examined and combined to draw conclusions (Wipulanusat, Panuwatwanich, Stewart & Sunkpho 2020:485). This design was chosen since it allowed the researcher to collect rich information that could not be obtained using either method singlehandedly (Almeida 2018:1).

1.9.2 Phase one: Quantitative strand

A quantitative descriptive research method was used for phase one. This method focuses on objectivity and is appropriate when collecting quantifiable measures of variables and inferences from samples of a population, and its analysis of the numerical data is performed through statistical procedures using software such as Statistical Package for Social Sciences (SPSS) version 28 (Queirós, Faria & Almeida 2017:370). This methodology was implemented in this study to understand the phenomenon of interest or occurrences affecting the youth (factors that deter the youth from utilising YFHSs) and strategies that would increase their utilisation of YFHSs (Ahmad, Wasim, Irfan, Gogoi & Srivastava 2019:1).

1.9.3 Phase two: Qualitative strand

An explanatory, qualitative research design was used in phase two of this study. According to Ahmad et al. (2019:1), qualitative research is a process of naturalistic inquiry that seeks an in-depth understanding of social phenomena within their natural setting. The authors note that qualitative research focuses on the “why” rather than the “what” of social phenomena, and it relies on the direct experiences of human beings. The qualitative methodology intends to understand a complex reality and the meaning of actions in each context (Queirós et al. 2017:369). They further explain that qualitative research is more concerned with a deepening understanding of a given problem than numerical representativity. The objective of this methodology is thus to produce in-depth and illustrative information that would assist in understanding the problem under study.

In this study, focus group discussions were conducted with youths aged 10 to 24 in the selected areas to explain their challenges in greater depth. This strategy helped the researcher understand their experiences, motivation, and the context of their health behaviours regarding the utilisation of YFHSs (Leavy 2017:19). Thus, the focus group discussions complemented the quantitative data from phase one’s survey. Individual interviews were also conducted with healthcare providers and YFHS focal persons who worked at YFHSs in the selected areas. The interviews were intended to present

participants' perspectives on factors that encourage or deter youths from utilising YFHSs and strategies that would increase uptake.

1.10 SCOPE AND LIMITATIONS OF THE STUDY

The scope of a study refers to the parameters under which the study will operate. This includes specifying the domain of the research and stating what the researcher is studying, including factors that are within the accepted range of the study (Simon & Goes 2013 as cited in Akanle, Ademuson & Shittu 2020:108). According to the University of Cyprus (2006, as cited in Akanle 2020:108), the scope of a study is a detailed description of the study that shows how the breadth, depth and detail of the study are compatible and sufficient to address the study's objectives within the time that is available, using available resources. Conversely, research limitations are characteristics of the research methodology and design that change the meaning and interpretation of research results. They constrain generalisability, the application to practice, and the value of the findings (Price & Murnan 2004, as cited in Akanle et al. 2020:109).

1.10.1 Scope of the study

The aim of this research study was to develop strategies for improving the utilisation of YFHSs in rural and urban Blantyre, Malawi. The study's population for phase one comprised female and male unmarried youths aged 10–24. A multistage sampling method was used to identify two sites in urban Blantyre and two sites in rural Blantyre, and the required sample size was determined using Leslie Kish's sampling formula. A design effect of 1.5 was considered because multistage sampling was used. In light of the possibility of non-responses, withdrawals, and the need to cover for them, the sample size was oversampled by 10%; hence, a calculated sample size of 288 respondents.

Phase two's population comprised six service providers who worked at YFHS departments. They were interviewed individually, and three focus groups were conducted with eight youths aged 10–24 in the selected areas.

In phase one, data were collected through a structured questionnaire survey and analysed using the computerised SPSS (version 28). To test the significance of the association between the variables, Chi-square (X^2) was used, and P-values were calculated. For phase two, individual interviews were conducted with healthcare providers or focal persons working at YFHS, using a semi-structured interview schedule and a question guide during focus group discussions. Thematic content analysis was used to analyse phase two's data.

Phase three focused on the strategies' development. The strategies were drawn from the findings of phases one and two.

1.10.2 Study limitations

The study's generalisability beyond Blantyre is limited due to the small sample and the study only being conducted in Blantyre.

1.11 STRUCTURE OF THE DISSERTATION

The thesis is structured as follows:

Chapter 1: Orientation of the study

This chapter discusses the orientation of the study, the background of the research problem, the study's problem statement, and the significance of the study. Furthermore, it describes the research aim and objectives, research questions, theoretical framework, operational definitions used in the thesis, and the scope and limitations of the research. Finally, it provides an overview of the research methodology and design, and offers a summary of the structure of the thesis.

Chapter 2: Literature review

Chapter 2 presents a systematic and critical appraisal of the most important literature concerning youths' utilisation of YFHSs. The review is presented under the following sub-headings: Accessibility of YFHSs; Youths' knowledge of SRH issues and services; Youths' experiences at YFHSs; Factors that would enhance the utilisation of YFHSs;

Barriers to the utilisation of YFHSs; and Strategies that would improve the utilisation of YFHSs.

Chapter 3: Research design and methodology

The chapter discusses the research designs used in both phases. The discussion includes information about the study's settings, populations, sampling techniques, instruments, ethical considerations related to data collection, data collection processes and analysis for both phases. It also addresses the study's rigour.

Chapter 4: Analysis, presentation and description of research results for phase one – quantitative phase

The chapter discusses data management, the data analysis methods used to arrive at the findings in phase one, and offers an overview of the findings for the quantitative phase.

Chapter 5: Analysis, presentation and description of research findings for phase two – qualitative phase

This chapter discusses the analysed data for phase two of the study, the qualitative phase.

Chapter 6: Interpretation of results

This chapter discusses the integration and interpretation of results from both the quantitative and qualitative phases of the study.

Chapter 7: Integrating the key themes

The chapter presents major combined findings from the quantitative and qualitative phases and key central themes that facilitated the formation of strategies to increase the utilisation of YFHSs.

Chapter 8: Phase three: Development of strategies to improve the utilisation of youth-friendly health services

In this chapter, the researcher's development of strategies to increase the utilisation of YFHSs is discussed. The strategies were dependent upon information obtained from the previous two phases.

Chapter 9: Conclusions and recommendations

This chapter offers a summary and interpretation of the research findings, conclusions, recommendations, contributions of the study, limitations and dissemination of results of the study, and concluding remarks.

1.12 SUMMARY

The development of strategies to improve the utilisation of YFHSs will be very beneficial in reducing the number of unintended pregnancies among unmarried youths aged 10 to 24. This benefit will extend to parents who lose children to abortion-related complications, and the Malawi government, in general, by averting the costs of hospital admissions related to unsafe abortions, among other benefits. Chapter 1 provided an overview of the study and what the study intended to achieve. The study's aim, significance, theoretical foundation, research design and methodology, scope, and structure of the thesis were also discussed. Chapter 2 presents a literature review on the utilisation of YFHSs.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 1 outlined the orientation of the study. Chapter 2 presents an organised and critical review of the most important literature on the utilisation of YFHSs. A literature review is a compilation of research that has been published on a topic by recognised scholars and researchers. They convey what knowledge and ideas have been established on a topic and what their strengths and weaknesses might be (University of North Carolina Libraries ([s.a.]:1). Similarly, Polit and Beck (2017:733) define a 'literature review' as a critical summary of research on a topic of interest, often prepared to put a research problem in context.

The major goal of a literature review is to develop a strong knowledge base to be used when carrying out a research study (Palmatier, Houston & Hulland 2018:2). A thorough review can determine how best to contribute to an existing body of knowledge and may facilitate the researcher's interpretation of the findings after data have been analysed (Polit & Beck 2017:88). This literature review was conducted to enhance the researcher's knowledge of the topic and research designs at hand. The information was used to fill any existing knowledge gap by building on what other researchers had said concerning youth's improved utilisation of YFHSs. The researcher also aimed to compare the study's findings with those contained in other literature, thereby identifying existing relationships between them.

2.1.1 Literature review methodology

A narrative review was used in the literature review of this study. With this strategy, the researcher attempted to summarise what has been written on youths' utilisation of YFHSs, but did not seek cumulative knowledge from what was reviewed. Instead, the researcher accumulated and synthesised the literature to demonstrate the value of a particular point of view. There were therefore no criteria for inclusion (Paré & Kitsiou 2017).

Sources of information for the current literature review comprised published and printed materials available on the internet, journal articles, abstracts, dictionaries, repositories and policies. The literature review included peer-reviewed journals from 2017 to 2023. The researcher extracted data manually and with assistance from the University of South Africa's library team. The search strategy entailed using keywords and Boolean operators ("AND" and "OR") between keywords and phrases to broaden the search. The key terms that were used to filter and seek information for this study were "YFHSs", "Health Belief Model", "Adolescent-Friendly Health Services", "Adolescent-Friendly Reproductive Health Services", "drivers and barriers to utilisation of adolescent or YFHSs". For the current study, a search was conducted of available literature locally, regionally, and globally concerning adolescents' use of YFHSs. The search engines utilised in the current study were Google Scholar and Google Advanced Search.

2.1.2 Discussion of literature review findings

The literature review unearthed findings from prior studies in light of the current study's topic. The review findings included information offering a description of YFHSs; studies conducted on the accessibility of YFHSs; youths' knowledge of SRH issues and services; youths' experiences at YFHS departments; factors that would enhance the utilisation of YFHSs; barriers to the utilisation of YFHSs; and strategies that would enhance the utilisation of YFHSs.

2.1.3 Description of YFHSs

Youth-friendly reproductive health service is defined as services that are accessible, acceptable and appropriate for the youth, offered in the right place, and delivered in the right style to be acceptable to young people. These services are effective, safe and affordable. The services include counselling, family planning, voluntary counselling and testing, and treatment for STIs (Bogale & Agero 2020:42).

The WHO (2012:7) describes five domains of YFHSs as follows:

- Accessible: Adolescents should be able to obtain readily available health services.

- Acceptable: Adolescents should be willing to receive the health services provided to them.

- Equitable: All adolescents, regardless of biographic information or class, should be able to receive health services that are available.

- Appropriate: Adolescents should receive all health services they require.

- Effective: The right health services should be provided in the right way and positively contribute to the adolescents' health.

Some researchers use additional domains to the ones listed above. For example, a survey was conducted to assess the youth-friendliness of youth clinics in northern Sweden, where six main domains were assessed, namely accessibility, equity, respect, privacy and confidentiality, judgement, and quality (Waenerlund, San Sebastian, Hurtig, Wiklund, Christianson and Goicolea 2020:2). Furthermore, in some areas, the questionnaire had sub-domains such as accessibility, which included contact access, sexual access and psychosocial access. Equity was divided into two sub-domains: diversity equity and legal equity. Lastly, quality was divided into consultation quality and facility quality. In total, ten domains were explored and provided a detailed perspective of health facilities' youth-friendliness in northern Sweden.

Similarly, in another study that explored immigrant and Swedish-Scandinavian youths' perceptions of the youth-friendliness of health services,13 sub-domains were identified and used to assess friendliness, namely access contact, access SRH, access psychosocial, fear of exposure, equity, equity with legal concerns, respect, privacy and confidentiality, no judgement, quality of consultation, quality of facility, parental support of SRH services, and parental support of psychosocial health services (Baroudi et al. 2020:781).

Adolescents are a mixed group with different expectations and preferences. However, the different groups of adolescents from various parts of the world mostly valued two

key common characteristics: to be treated with respect and for their confidentiality to be protected (WHO 2012:5).

Initiatives are being undertaken in many countries to help health providers become non-judgemental and equipped with competencies to deliver suitable services to adolescents (WHO 2012:6). Initiatives aimed at equipping health facilities with the right health services for adolescents are also available, informing adolescents where to obtain the required services, and making community members aware of the health service needs among various groups. In most areas, these efforts are championed by non-governmental organisations (NGOs). Evidence shows that making adolescent health services user-friendly leads to increased health service utilisation among this population (WHO 2012:6).

2.1.4 Benefits of YFHSs

According to the WHO (2019:4), services targeted at adolescents have promoted substantial improvements in health outcomes, such as reducing pregnancy rates; increasing visitation to healthcare services for mental health, HIV counselling and testing; outpatients' uptake of services like HIV testing; acquisition of knowledge on HIV, STIs, sexual health, sexual risk reduction behaviour such as condom use; and acceptability of the services in general. Todd and Black (2020:33) suggest that apart from counselling on contraceptive benefits, adolescent-friendly services could offer adolescents counselling concerning the non-contraceptive benefits of some contraceptives, such as improvements in heavy menstrual bleeding, dysmenorrhoea, and cycle regularity, among others. The current study was therefore designed also to determine if youths were aware of the non-contraceptive benefits of contraceptives obtainable at YFHSs.

2.2 ACCESSIBILITY OF YFHSs

Studies have been conducted to assess the accessibility of YFHSs in different parts of the world. A study by Femi-Adebayo, Kuyinu, Adejumo and Goodman (2019:1) revealed accessibility as one of the factors associated with the poor utilisation of government and non-governmental YFHSs in Lagos, Nigeria.

Physical access is ultimately necessary for young people to frequent YFHSs. A study exploring factors that impacted youths' access and acceptance of SRH services in Nepal found that physical access to these services was problematic for some adolescents (Pandey, Seale & Razee 2019:1). Therefore, despite their availability, adolescent-friendly services were not accessible to some adolescents because of physical barriers. The problem of physical barriers was also established in Abuosi and Anaba's (2019:201) study in Ghana, where it was revealed that accessibility and utilisation were not achieved due to inadequate physical space and privacy. The researchers reported that adolescents tend to attach great importance to their privacy, and they may not access health services if they perceive health facilities as failing to guarantee adequate privacy in the limited space available.

In Plateau State in Nigeria, a lack of specific space for adolescents' reproductive health services also emerged as one of the problems in a study that assessed the availability, accessibility, appropriateness and quality of adolescent SRH services in primary healthcare facilities. The study found that the majority of primary healthcare facilities that were assessed lacked dedicated space, basic equipment and essential sexual and reproductive healthcare services (Envuladu, Massar & DeWit 2021:1369). The researchers ultimately recommended structural changes, the implementation of policy and additional training for health workers to promote adolescents' SRH.

Access to space dedicated to YFHSs was a significant characteristic when rating primary healthcare facilities' youth-friendliness in Malaysia (Awang, Shamsudin, Manut, Nasir & Rashid 2022:61). In addition, financial resources are also an important factor for young people to access SRH services. A study in Enugu State in Nigeria established that services for safe motherhood and the prevention of STI, HIV and AIDS were geographically available, but few were financially accessible to adolescents. Qualitative data also revealed that the available services were not specifically aimed at adolescents but for general use (Odo, Samuel, Nwagu, Nnamani & Atama 2018:92), implying questionable availability of proper YFHSs. In some parts of Ethiopia, inaccessibility contributes to reduced YFHS utilisation. A study conducted in the southern part of the country revealed that SRH service utilisation was significantly lower among students from high schools where health facilities did not implement

youth-friendly services than among high schools in YFHSs implemented areas (Haile, Shegaze, Feleke, Glagn & Andarge 2020:2).

In contrast to the preceding studies, a Ghanaian study revealed that overall accessibility to YFHSs was fairly good in the Ashaimana district, meaning the services were available and accessible (Anokoye-Mensa 2019:1). Similarly, a study in Bangladesh revealed that unmarried adolescents were not only accessing adolescent-friendly health corners (AFHCs) but they also expressed satisfaction with service providers (Ainul, Ehsan, Tasmiah, Tanjeen & Reichenbach 2017:1). An evaluation of YFHSs in Malawi revealed services were both available and accessible despite low utilisation. Moreover, more than 60% of those who were reported as accessing the services did so through government facilities (USAID 2014:11).

Overall, reviewed literature concerning the accessibility of YFHSs shows that inaccessibility contributed to low uptake.

2.3 YOUTHS' KNOWLEDGE OF SRH AND YFHSs

Information, education and knowledge about reproductive health and YFHSs are important factors that can contribute to the services' utilisation. Fasoranti, Onwuama, and Toluwalase (2018:24) suggest that access to reproductive health information has the potential to improve young people's literacy levels, thereby preventing unplanned pregnancies, STIs and untimely deaths. Mattebo, Bogren, Brunner, Dolk, Pedersen and Erlandsson's (2019:7) study in Nepal supports the foregoing findings; that study found that a lack of information, education and knowledge affected adolescent girls' reproductive health-seeking behaviour.

Similarly, in a study to determine factors that affected adolescents' access to adolescent-friendly health services in Indonesia, Arlfah, Kusumawardani, Hendriyaningsih, Wibisono and Lestari (2020:164) found that access to the services was mainly determined by knowledge of the programme and perceived demand. The researchers suggested that it is necessary to broaden the availability of information and increase the programme through electronic media.

A study in the Ashaimana district in Ghana revealed that while many adolescents possessed low knowledge of youth-friendly services, most had positive attitudes and perceptions towards the services (Anokoye-Mensa 2019:1). Appiah-Mensah (2016:1) also revealed that in-school adolescents underutilised adolescent-friendly health services at an Ashaiman polytechnic in Ghana because of a lack of knowledge about the services. A lack of information on SRH issues, including information about contraceptives, was another contributing factor to services' use in a study conducted in Mulanje, Malawi (Nash, O'Malley, Geoffroy, Schell, Bvumbwe & Denno 2019:8).

Studies in Nepal and Ethiopia concur that reduced awareness about SRH facilities for adolescents led to their reduced utilisation (Napit, Shrestha, Magar, Paudel, Thapa, Dhakal and Amatya 2020:4; Jain, Ismail, Tobey & Erulkar 2017:1). Jain et al. (2017:1) found many youths who reported using contraceptives used the YFHSs ignorantly. This suggests that the facilities lacked well-labelled signposts that could inform young people about services' availability.

Other studies that showed knowledge played an important role in increasing utilisation of YFHSs were conducted in Ethiopia's Hadiya zone and Nigeria's Osun State, respectively (Helemo, Kusheta, Bancha, Habtu & Yohannes 2017:141; Tchokossa, Obafemi & Adeyemi 2018:1647). A recent study in Lao's People's Democratic Republic (PDR) also revealed that 65.5% of respondents had inadequate SRH literacy, and scores were significantly associated with several factors, including knowledge about SRH, attending SRH classes in school, and functional literacy on condom use (Vongxay, Albers, Thongmixay, Thongsombath, Broerse, Sychareun & Essink 2019:1). The researchers recommended comprehensive sex education and enabling information should be provided that could ensure adolescents understand SRH, acquire good decision-making skills and, in turn, access available services.

Contrary to the findings in Lao's PDR, a study in Asgede-Tsimba district in northern Ethiopia revealed that almost 100% of respondents gained knowledge about SRH services from various sources, and this had a positive impact because 69.7% of youths utilised the services (Gebreyesus, Teweldemedhin & Mamo 2019:1). The researchers also reported that despite the score being above half of the sample, it was below the national plan. However, the present researcher is of the view that the level of utilisation

was commendable because it was higher than several other studies mentioned in this literature review. Similarly, it is important to note that their study's results suggest there was a relationship between knowledge of reproductive health and available services, and utilisation of those services. This notion was corroborated by Violita and Hadi's (2019:1) study, in which only 24.3% of adolescents utilised adolescent-friendly services due to low knowledge about reproductive services. The results showed that students with high levels of knowledge were nearly twice as likely to access adolescent reproductive health services than those with low levels of knowledge.

Munakampe, Zulu and Michelo (2018:909) conducted a systematic review of adolescents' knowledge, attitudes and practices in relation to contraceptives and abortion in low and middle-income countries. The review revealed that limited knowledge about sexual and reproductive health among unmarried adolescents was the greatest cause of reduced access to contraception use and the safe termination of pregnancies. This lack of access resulted in extreme methods of contraception and abortions, such as the use of battery acid. Girls also faced additional negative consequences in dealing with the effects of unsafe pregnancy terminations. The review revealed that while parents, health workers and teachers were cited as trusted sources of information, most girls attained information from peers and other family members such as aunts and cousins. Boys resorted to peers, the media, and some used pornography as a source of information.

Regarding sources of information that influenced youths' uptake of YFHSs, Amuko's (2020:xii) study in Mombasa, Kenya, revealed that the radio, newspapers and static advertisements significantly influenced the use of YFHSs. However, less than half of the participants mentioned that they were aware of services offered in settings such as drop-in centres, community outreach and school health programmes. Overall, adolescents reported obtaining information about reproductive health issues from family and peers, which had a positive impact on their knowledge and use of adolescent reproductive services (Violita & Hadi 2019:1).

Similarly, a study conducted among adolescent girls in Nigeria revealed that the family played a critical role in assisting adolescent girls to make healthy sexual and reproductive health decisions (Fasoranti et al. 2018:24). In contrast to Fasoranti et al.'s

(2018) findings, adolescents in Nepal indicated they were not comfortable to discuss reproductive health topics with parents, elders or their teachers because, on the one hand, they believed these matters were private, and on the other, most parents were reluctant to discuss such matters with their children (Napit et al. 2020:4).

Mutumba, Wekesa and Stephenson (2018:1) highlight the importance of community-level education regarding young women's attainment of contraceptives and its use in middle-income countries. However, their study revealed that increased exposure to mass media did not positively influence the uptake of modern contraceptives. Ultimately, a lack of correct and adequate information may lead to adolescents believing in myths and misconceptions regarding their SRH. A study in Kenya revealed the presence of a mixture of biological and social myths and misconceptions around contraception, with young men strongly believing the misconceptions; this indicated low levels of contraceptive knowledge (Mwaisaka, Gonsalves, Thiongo, Waithaka, Sidha, Agwanda, Mukiira & Gichangi 2020:4).

The reviewed literature highlighted the importance of information and education in young people's decision-making processes regarding SRH. Furthermore, it has shown that information and education positively influence youths' utilisation of YFHSs.

2.4 YOUTHS' EXPERIENCES AT YFHSs

Young people's experiences with YFHSs can possibly influence their future utilisation of these services. Pastrana-Sámano, Heredia-Pi, Olvera-García, Ibáñez-Cuevas, Castro, Hernández and Torres-Pereda (2020:7) assessed the quality of adolescent-friendly services using simulated clients; they revealed that staff's attitudes were the key element in the young people's experiences. Positive attitudes with elements such as friendliness, respect, and trustworthiness, among others, generated trust and confidence among the young people who stated that they would recommend the services to their friends. In contrast, negative attitudes such as unfriendliness, rudeness, and being judgemental discouraged them from returning. Other factors included bureaucratic barriers to access, lack of privacy, and confidentiality, among others. It was also observed that young people were not subjected to physical examinations, and their reasons for appointment were not established. However, it was

found that youth-exclusive clinics offered more friendly services than nonexclusive clinics (Pastrana-Sámano, Heredia-Pi, Olvera-García, Ibáñez-Cuevas, Castro, Hernández & Torres-Pereda 2020:1).

The findings of Pastrana-Sámano et al.'s (2020) study were consistent with those of Napit et al. (2020:6). Adolescents who visited SRH facilities received negative comments from healthcare providers, which resulted in them avoiding the facilities until their problems were severe. All the adolescents in a group discussion preferred a separate room for counselling to maintain their privacy because a lack of privacy caused them to feel uncomfortable openly discussing their problems. They also feared a violation of confidentiality, especially from known providers. The adolescents emphasised the need for same-sex healthcare providers, saying they felt uncomfortable explaining their problems to a provider of the opposite sex. Another emerging issue was the need to reduce waiting times and have business hours that did not collide with school hours.

The need for confidentiality was also noted in a New Zealand study where young people were reluctant to be seen at health facilities for fear of raising curiosity or being judged by community members in the waiting room (McKinlay, Morgan, Garrett, Dunlop & Pullon 2021:159). Moreover, staff attributes made a significant difference in young people's utilisation of SRH services. McKinlay et al. (2021:160) revealed that young people were sensitive to visual facial cues and non-verbal responses from healthcare providers, which they perceived as welcoming or unwelcoming. Some adolescents said they found it easier if they formed a trusting relationship with a particular member of staff; young people also preferred younger staff as they were perceived as being less judgemental and more understanding.

The physical environment of health facilities also matters to young people. In McKinlay et al.'s (2021:160) study, young people explained that they did not like the clinical appearance of the waiting areas; they thought they could be improved by adding some colour to them to reduce their 'hospital feel'. Some also suggested making the consultation area more youth-friendly with magazines and games. Others suggested a separate youth area in another building (McKinlay et al. 2021:161).

A study that investigated young people's experiences of sexual and reproductive health services at clinics in South Africa revealed that health facilities providing a youth-friendly programme did not deliver a more positive experience to young people than that provided by those not providing the programme. Positive or negative experiences were determined by staff's attitudes. The young people characterised the more positive experience as healthcare workers being more friendly, respectful, knowing how to talk to young people, and valuing youths. Less positive experiences included having to show soiled sanitary pads to obtain contraceptives, lack of privacy, inadequate information, and healthcare workers expressing negative opinions about young people seeking sexual and reproductive health information (Geary, Webb, Clarke & Norris 2015:4).

Conversely, a study in Bangladesh revealed that unmarried adolescents expressed satisfaction with service providers' treatment. This finding is significant in light of overwhelming evidence in the literature associated with parents and community members creating social stigma associated with unmarried girls seeking SRH services (Ainul et al. 2017:1). Ultimately, the literature review illustrated that young people mostly had negative experiences at health facilities due to negative provider attitudes.

2.5 FACTORS THAT WOULD ENHANCE UTILISATION OF YFHSs

A study on predictors of young people's use of sexual and reproductive services in Nigeria revealed that the male gender, older age and lower income levels were more associated with SRH service utilisation, while tertiary education and living at school, psycho-cultural and health system factors were less associated with SRH service utilisation (Odo, Ofuebe, Anike & Samuel 2021:1). This implied that socio-demographic factors, psycho-cultural and health system factors could be used to predict the utilisation of SRH services. These findings were similar to those of a study in northern Sweden, where socioeconomic status played a role in youths' utilisation of health care. Wealthier youths utilised youth clinic services, while poorer young people mainly visited general practitioners (GPs) (Mosquera, Waenerlund, Goicolea & Gustafsson 2017:20).

In Ethiopia, it was determined that living with mothers, participation in peer education, and distance to the health centre were factors that impacted the likelihood of youths'

utilisation of sexual and reproductive services (besides socioeconomic status). It was also revealed that young people who discussed sexual and reproductive health matters with their parents, and those who had engaged in sexual intercourse were more likely to utilise the services than their counterparts. Educational background also played a role in the services' uptake. Young people who either lived with their fathers or only attained a primary level of education were less likely to utilise YFHSs (Ayehu, Kassaw & Hailu 2016:1).

The findings were consistent with those of Nyarko's (2015:50) study, which examined the prevalence and correlates of contraceptive use among female adolescents in Ghana; education emerged as one of the factors that influenced female adolescent contraceptive use. Other factors included adolescents' age, work status, knowledge of the ovulatory cycle, visits to health facilities and adolescent's marital status. In Ethiopia, Binu, Marama, Gerbaba and Sinaga (2018:64) revealed that 21.2% of school youths utilised SRH services, and the independent determinants of SRH utilisation among secondary school youths were discussions with health workers, previous history of perceived STI symptoms, sexual experience, and exposure to information from teachers.

In the previous discussion, economic status, educational background and living situations emerged as factors that contribute to youths' utilisation of YFHSs.

2.6 BARRIERS TO THE UTILISATION OF YFHSs

Adolescents face several barriers to accessing contraceptives, including restrictive laws and policies based on age or marital status, healthcare worker bias, and lack of willingness to acknowledge adolescents' sexual health needs (WHO 2018). Other barriers to contraceptive use identified by the WHO include adolescents' lack of knowledge, transportation and financial constraints.

The WHO Regional Office for Africa in Ethiopia categorised the barriers according to friendliness domains. On accessibility, the WHO reports major accessibility barriers are a shortage of dedicated healthcare professionals, unaffordability of the services, distance and transport challenges to the healthcare facilities (WHO 2021:17).

Regarding acceptability, the WHO (2021:22) reports that cultural taboos, unfriendly service set-ups and incompetent providers were some of the barriers to the utilisation of adolescent-friendly health facilities. Regarding contact utilisation, the major barrier was a lack of awareness of SRH and mental health services, contraceptives and sources of supply (WHO 2021:25). Lastly, concerning effectiveness, it was revealed that healthcare professionals had inadequate competency in dealing with young people's HIV counselling and testing (HCT), contraceptive and mental health needs. Furthermore, a lack of diagnostic facilities, medicines and inconsistent supply of contraceptives emerged as challenges (WHO 2021:25).

A study in Lao's PDR found that the main barriers that prevented young people from accessing SRH services were cognitive accessibility, which included a lack of knowledge and lack of awareness. The study further established geographical barriers were created by a scarcity of youth-friendly health clinics (Thongmixay, Essink, Greeuw, Vongxay, Sychareun & Broerse 2019:1). Moreover, in Ghana, a lack of information was similarly one of the major barriers to accessing YFHSs. Some adolescents did not receive services because they were unaware of them (Abuosi & Anaba 2019:204). Furthermore, some young people were afraid of visiting SRH facilities because they thought they would not be welcomed by healthcare providers.

A lack of information on SRH issues similarly emerged as a barrier to the utilisation of SRH facilities in studies conducted in Malawi, Nepal and Nigeria, respectively (Nash et al. 2019:8; Pandey et al. 2019:1; Mattebo et al. 2019:7; Eremutha & Gabriel 2019:40). Contrary to focusing on low knowledge among adolescents, a study was also conducted in Malawi to gain an understanding of community leaders' role concerning adolescents' HIV and sexual and reproductive health rights. Findings showed that many community leaders had low knowledge levels on the topic. This phenomenon had the potential to create a lack of support from community leaders prompting youths to utilise YFHSs (Chimatiro et al. 2020:1).

Misconceptions also serve as a barrier to the utilisation of SRH services and contraceptives in general. A study in the Mulanje district in Malawi found that most adult participants held the view that contraception was unacceptable for adolescent girls based on the belief that it was harmful to their health, in general, and, particularly,

detrimental to the childbearing potential of young people who have never given birth. Young girls also believed that contraceptives would damage their uteri (Nash et al. 2019:8). Muula et al. (2015:1) concurred misconceptions are among the factors contributing to the low utilisation of family planning methods in the same district.

These findings were also supported in Kenya, where a fear of modern methods of contraception, mainly based on myths and misconceptions, was identified. For instance, some individuals feared a particular method would cause infertility. In that study, many users did not consider condoms as contraception, and contraception was associated with promiscuity (Ochako, Mbondo, Aloo, Kaimeyi, Thompson, Temmerman & Kays 2015:118). Likewise, Kinaro, Kimani, Ikamari and Ayiemba (2015:85) determined that unfavourable perceptions among adolescents, teachers and parents contributed to low contraceptive use.

Apart from misconceptions, conservative beliefs tend to discourage young people from using SRH services and information. Napit et al. (2020:4) found that adolescents who feared being seen using SRH services and those who were shy to use the services were less likely to use YFHSs. In addition, negative attitudes from parents also prevent young people from accessing YFHS departments. In a Malawian study, most parents said they were reluctant to support youths' access to family planning (Self, Chipokosa, Misomali, Aung, Harvey, Chimchere, Chilembwe, Park, Chalimba, Monjeza, Kachale, Ndawala & Marx 2018:108). A similar lack of parental support was observed in Ghana, where young people avoided SRH services for fear of being punished by their parents if it was discovered that they had visited facilities offering these services (Abuosi & Anaba 2019:202).

A systematic review that was conducted to determine what factors influenced access to and the utilisation of YFHSs in sub-Saharan Africa also revealed that young people were hindered from accessing reproductive health information by stigma related to young age and parental consent. Other barriers included inconvenient operating hours, negative attitudes among health workers, and unskilled health workers. Healthcare providers were reported as using abusive language and being unsympathetic to the adolescents. Some healthcare providers were untrained in providing services to young people, while others were only partially trained (Ninsiima et al. 2021:14).

Anokoye-Mensah's (2019:1) study in Ghana concurred that some healthcare providers and community members showed poor attitudes towards adolescents accessing YFHSs. Similarly, provider attitudes have been found to be a barrier in other studies conducted in Malawi, Nepal and Ghana, respectively (Nash et al. 2019; Muula et al. 2015:1; Pandey et al. 2019; Mattebo et al. 2019:7; Abuosi & Anaba 2019:203). Moreover, some studies in Ghana and Malawi found cost and embarrassment to be a barrier to the utilisation of YFHS (Thatte, Bingenheimer, Ndiaye & Rimal 2016:53; Appiah-Mensah 2016:1; Barden-O'Fallon, Evans, Thakwalakwa, Alfonso & Jackson 2020:1).

Other barriers include fear of safety and of the family finding out (Thatte et al. 2016:53), inconvenient clinic times, lack of privacy, religion, and culture (Binu et al. 2018:64). Low social autonomy has also been deemed a barrier to the utilisation of YFHS, as revealed by a study in Ethiopia where young people had to get permission to leave the house from either a spouse or parent (Jain et al. 2017:1). Mattebo et al.'s (2019:7) study revealed that a lack of confidentiality and privacy was a barrier to the utilisation of SRH services by young people, consistent with the findings from Ghana (Abuosi & Anaba 2019:200).

The foregoing literature review has revealed a variety of barriers prevent young people from utilising YFHSs. Some of the barriers are a lack of knowledge about SRH services, poor attitudes of healthcare providers, misconceptions, facility-related barriers like a lack of privacy and confidentiality, and a lack of parental and community support.

2.7 STRATEGIES TO IMPROVE THE UTILISATION OF YFHSs

Various strategies, according to literature, are used in different settings in an effort to increase the utilisation of YFHSs. Eremutha and Gabriel (2019:36) suggest that community mobilisation for awareness-creation and support on SRH issues would assist in increasing services' utilisation among the youth in Nigeria. Similarly, Chimatiro et al. (2020:66) suggest that Malawian stakeholders involved in the promotion of SRH and rights should increase investments in capacity-building among community leaders to increase the utilisation of YFHSs. However, Chandra-Mouli, Lane and Wong

(2015:333) note that the strategy of bringing community members together and informing them to abandon harmful practices, often during once-off public sessions, has been shown to have little effect on these practices. Thus, long-term community conversations, such as ongoing dialogue with community leaders and members to encourage them to critically examine their traditions and help them identify solutions, are recommended.

Pandey et al. (2019:1) suggest increasing healthcare providers' capacity to deliver services without imposing their own beliefs about sexual behaviour as a strategy for improving the utilisation of YFHSs. They further suggest that capacity-building should emphasise the importance of confidentiality and non-judgemental attitudes among healthcare providers. Similarly, Onukwugha, Hayter and Magadi (2015:134) suggest that policy actors at all levels should consider the attitudinal qualities of service providers when planning and designing sexual health services for adolescents.

Helemo et al. (2017:141) recommend using school education and communication strategies to influence youths' knowledge, attitudes and practice to increase service utilisation. Likewise, Self et al. (2018:108) suggest improved counselling services, integrated family planning services and education within school curricula, and the use of youth clubs to improve family planning services among adolescents. In Nigeria, Eremutha and Gabiel (2019:39) concurred school clubs and out-of-school clubs can increase the utilisation of YFHSs.

Youth clubs' provision of SRH services is one strategy that was used to address SRH challenges in Malawi. However, a study to assess youth clubs' contribution towards the promotion of SRH services found no association between youths' attendance of youth clubs and family planning utilisation (Muula et al. 2015:1). Consistent with this finding, Chandra-Mouli et al. (2015:333) note that youth clubs, youth centres, peer education and once-off public meetings are generally ineffective when it comes to facilitating young people's access to sexual and reproductive health services, changing their behaviours, or influencing social norms around adolescent SRH. The researchers further identify comprehensive sexual health education and youth-friendly services as more effective approaches when they are appropriately implemented.

The use of mobile or outreach clinics is favoured among some youth. A South African study revealed that young people in Cape Town rated mobile clinics for African adolescents and young adults' SRH services higher than conventional clinics (Smith, Tolla, Marcus & Bekker 2019:1). In addition, Amuko's (2020: xii) study revealed that most respondents (98%) preferred staff of the same sex and age to offer services to them because they could easily understand each other. A study conducted to understand barriers that limit access to SRH services in Nigeria established that a majority (80%) of participants were in favour of youth-to-youth counselling because youth counsellors could relate better to youth-related problems (Eremutha & Gabriel 2019:39).

In contrast, Ainul et al. (2017:1) suggest integrating services as a strategy to increase YFHS uptake. This recommendation supports the global evidence that integrating adolescent-friendly services into existing health delivery systems has proven more effective than establishing separate youth centres. The researchers also found that training for service providers has a positive impact on the interaction between them and adolescent girls.

Ochako et al. (2015:118) suggest that family planning programmes should engage with the wider community through mass media and peer campaign strategies on the understanding that this would address myths and misconceptions among the youth. To increase utilisation of the services, Sotolongo, House, Swanson and Davis (2017:45) identified the following strategies as helpful in increasing adolescent health uptake: building community support for adolescent reproductive health services; opening teen wellness centres (TWCs); opening teen-centred full-service clinics; and educating teens on how to access reproductive health services.

2.8 THEORETICAL FRAMEWORK

The Health Belief Model was used to contextualise this study; the model endeavoured to predict why youths would take a preventive measure against a particular condition. This might be associated with the individual's perceived susceptibility to the condition, severity of the condition, benefits of the preventive action, and barriers to taking the preventive action (Glanz et al. 2008:46). The model also asserts that there are cues

that can trigger action, such as environmental events and media publicity. Furthermore, it asserts that other variables, referred to as modifying factors (such as sociopsychological and structural variables), may indirectly influence health-related behaviours (Glanz et al. 2008:46).

Six constructs were adapted from a modified Health Belief Model (refer to Figure 1.1) to guide this study. The constructs included perceived susceptibility, perceived severity or seriousness, perceived benefits, perceived barriers, cues to action, and intention (self-efficacy) to utilise YFHSs. The six constructs of the Adapted Health Belief Model are discussed in the following sections.

2.8.1 Perceived susceptibility

This refers to a person's subjective perception of the risk of acquiring a disease or one's opinion about the chances of contracting a health condition. Individuals who perceive themselves to be at low risk of developing an illness are more likely to engage in risky or unhealthy behaviours (LaMorte 2019:1). A study in Kerala State, India, revealed that among those who practised hand-washing and other preventive measures to avoid COVID-19, 60% did so because they perceived that they were susceptible to the virus (Jose, Narendram, Bindu, Beevi, Manju & Benny 2020:45). In the current study, perceived susceptibility refers to self-awareness of being at risk of not being able to access YFHS.

2.8.2 Perceived severity

This refers to a person's feelings about the seriousness of contracting an illness or disease, leaving the illness or disease untreated, with possible social consequences of the disease on family life, work and social relationships (LaMorte 2019:1). A combination of susceptibility and severity is called 'perceived threat' (Glanz et al. 2008:47). The Health Belief Model predicts that a higher perceived threat leads to a higher likelihood of engagement in health-promoting behaviours (Glanz et al. 2008:47). A study in Kerala State revealed that 51% of those who practised hand-washing and other COVID-19 preventive measures reported perceived severity (Jose et al.

2020:45). In the current study, perceived seriousness refers to fears about the effects of being unable to utilise YFHSs.

2.8.3 Perceived benefits

Perceived benefits refer to a person's perception of the effectiveness of various actions available to reduce the threat of illness or disease (LaMorte 2019:1). Behaviour change is usually influenced by a person's belief regarding the perceived benefits of available actions for reducing a disease threat (Glanz et al. 2008:46). The course of action a person takes in preventing or curing an illness relies on the consideration and evaluation of both perceived susceptibility and perceived benefit; a person is more likely to accept the recommended health action if they perceived it as beneficial (Glanz et al. 2008:46). In this study, perceived benefits refer to the benefits of utilising YFHSs.

2.8.4 Perceived barriers

Perceived barriers are defined as a person's feelings regarding obstacles to performing a recommended health action (LaMorte 2019:1). Similarly, Glanz et al. (2008:47) define 'perceived barriers' as potential negative aspects of a particular health action. In the current study, perceived barriers refer to attitudes such as stigma from significant others, family, peers, healthcare providers, and the community in general regarding the utilisation of YFHSs; availability of YFHSs; model of YFHSs; accessibility of YFHSs; socioeconomic factors; and social support systems.

2.8.5 Cues to action

This is the stimulus needed to trigger the decision-making process to accept a recommended health action. These cues can be internal, for instance, chest pains, or external, like advice from others, newspaper articles, and radio messages (LaMorte 2019:1). In this study, cues to action are defined as the support system available to the youth including family members, peers, the community in general, healthcare providers and available sources of information such as the radio, television or health education talks, leaflets, flyers, and posters or banners regarding YFHSs.

2.8.6 Self-efficacy

'Self-efficacy' is defined as an individual's belief about their capabilities to successfully perform a new behaviour (Saghafi-Asl et al. 2020:2). According to LaMorte (2019:1), self-efficacy refers to the level of a person's confidence in their ability to successfully perform a behaviour. In the present study, self-efficacy refers to youths' intention to utilise YFHSs.

2.8.7 Modifying factors

Modifying factors include social, psychological, demographic and structural factors that condition a person's perceptions (Glanz et al. 2008:50). In the current study, modifying factors refer to demographic variables such as age, gender, educational level, ethnicity, occupation, sociopsychological variables like income, employment status, religion, parent's/guardian's occupation, school-going or not, and previous experience with YFHSs. Figure 2.1 illustrates the Adapted Health Belief Model.

2.9 SUMMARY

The literature review looked at what YFHSs are; studies conducted on their accessibility; youths' knowledge of SRH issues and services; youths' experiences with YFHSs; factors that would enhance utilisation of YFHSs; barriers to the utilisation of YFHSs; and strategies to enhance the utilisation of YFHSs.

The literature revealed the necessity of making adolescent health services youth-friendly. The WHO recommends that YFHSs are considered youth-friendly if they achieve five domains, namely accessibility, acceptability, equitableness, appropriateness, and effectiveness. However, some researchers have expanded the domains to 13.

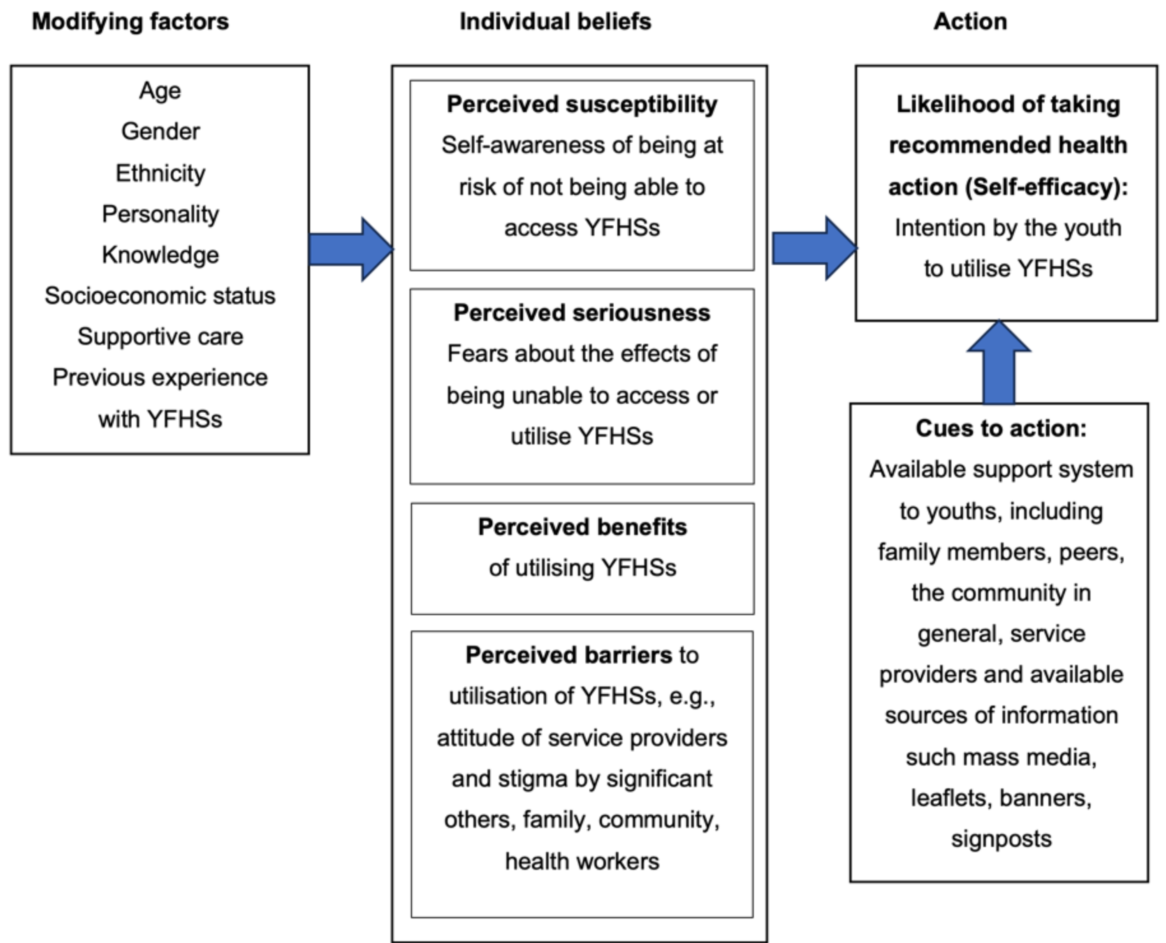

Figure 2.1: Adapted Conceptual Framework of the Health Belief Model

Source: Adapted from Glanz, Rimer and Viswanath (2008:49)

Studies concerning the accessibility of YFHSs ultimately concur that inaccessibility has contributed to the low utilisation of YFHSs in concerned areas. Various studies highlight the importance of information and education in youths' decision-making processes regarding SRH. Furthermore, it shows that information and education have a positive influence on youths' utilisation of YFHSs.

Literature also shows that young people mostly reported negative experiences in health facilities due to negative provider attitudes. There were, however, isolated reports of positive experiences registered by young people. Moreover, several factors that contribute to the utilisation of YFHS, including economic status, educational background and living with mothers or fathers, emerged from the literature review.

The literature review also revealed many barriers prevent young people from utilising YFHSs. Some of the barriers are a lack of knowledge about SRH services, poor attitudes among healthcare providers, misconceptions, facility barriers such as a lack of privacy and confidentiality, and lack of parental and community support. The literature also suggested strategies to improve young people's utilisation of YFHS.

Finally, the literature review explained how the Health Belief Model has been used in various studies, and the chapter closed with a brief explanation of how the researcher utilised the model in this study. Chapter 3 describes and explains the research methodology that the researcher used in conducting this study.

CHAPTER 3
RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

Chapter 2 presented a literature review on the utilisation of YFHSs. The purpose of this chapter is to describe and explain the research methodology that the researcher used to develop strategies for improving the utilisation of YFHSs. It was necessary to obtain data from multiple sources to develop the strategies, and the study was conducted over two phases, which ran sequentially. An explanatory, sequential, mixed-method design was used, where a quantitative research approach was used in phase one, while a qualitative method was used in phase two.

The chapter discusses the study's setting, research paradigm, research design, research method, population, sampling, ethical issues related to sampling, the sample, and the data collection approach and method. It also outlines the data collection instruments' development and testing, characteristics of the data collection instruments, data collection process, ethical considerations related to data collection, data analysis, and the rigour of the study. Moreover, the validity and reliability/trustworthiness for phases one and two are described. The combined results from these two phases were used to develop strategies for improving the utilisation of YFHSs in urban and rural Blantyre, Malawi.

3.2 STUDY SETTING

The study was conducted in four health centres and their surrounding catchment areas in Blantyre, Malawi. Two health centres (Mdeka and Madziabango) were from rural Blantyre, and two (Ndirande and Chilomoni) were from urban Blantyre. The health centres were randomly selected using multistage sampling. Refer to Figure 3.1 for a map of the Blantyre district.

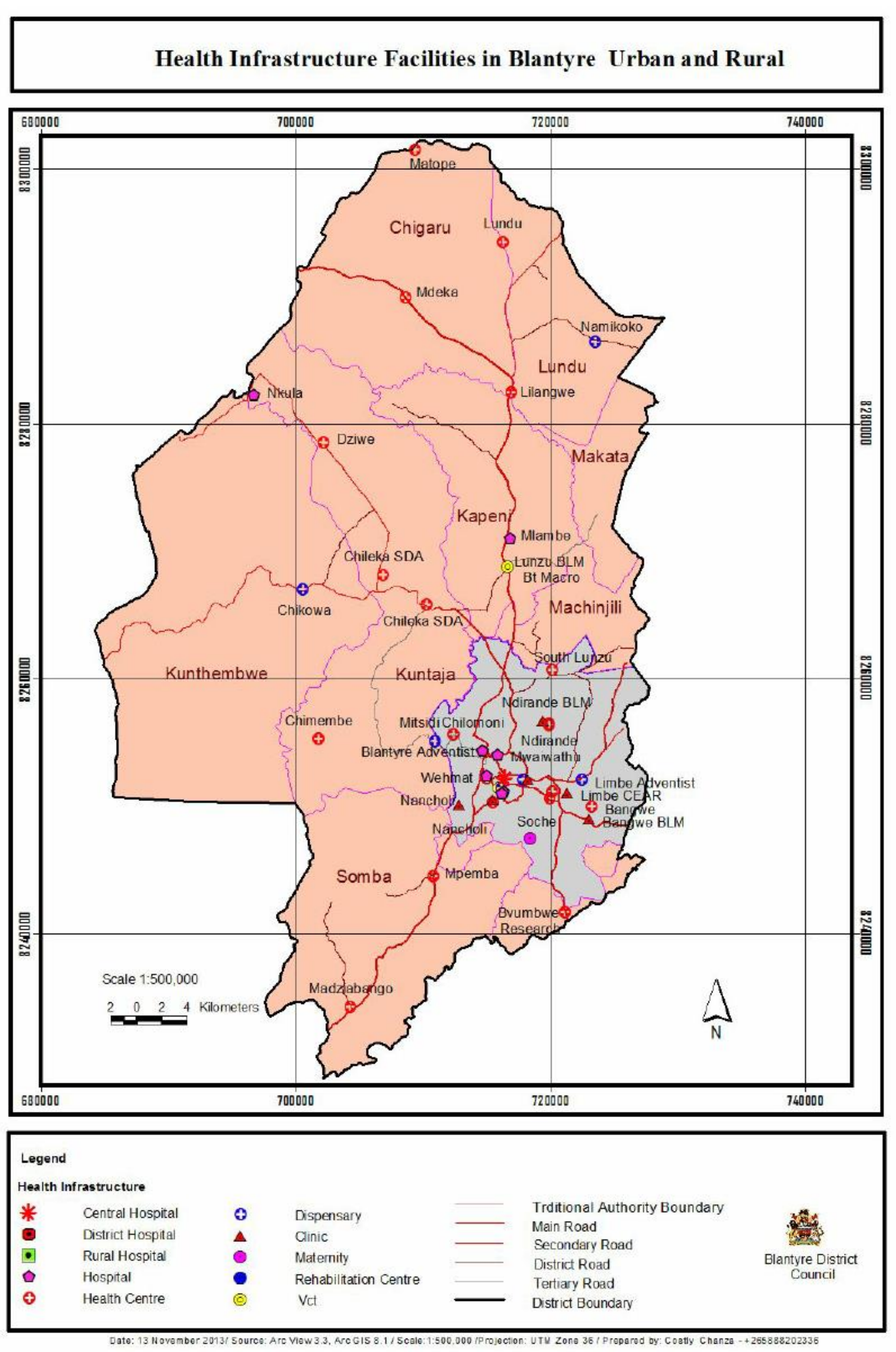

Figure 3.1: Map for Blantyre District

3.3 RESEARCH PARADIGM

A research paradigm is a way of looking at natural phenomena; it is a worldview encompassing a set of philosophical assumptions that guides one's approach to enquiry (Polit & Beck 2017:738). This study adopted the pragmatism research paradigm since it combines quantitative and qualitative paradigms' points of view as two integrated as opposed to conflicting philosophies (Maarouf 2019:1). Pragmatism permits combinations of paradigms, assumptions, approaches and methods of data collection and analysis. It is also oriented towards solving practical problems in the real world (Maarouf 2019:5). This paradigm was adopted for the current study because it used mixed methods. With this strategy, the quantitative approach was used to collect data from youths, and some of their information was verified using a qualitative approach that employed focus group discussions with the youth and interviews with the healthcare providers in the chosen health facilities. This enriched the collected data, which, in turn, informed the study's findings in terms of which strategies would be most useful in influencing more youths to utilise YFHSs.

3.4 RESEARCH DESIGN

A research design is a blueprint that provides a backbone structure to researchers for answering a research question or testing hypotheses (Pawar 2020:46). Similarly, Polit and Beck (2017:743) define a 'research design' as a plan for addressing a research question which includes specifications for augmenting the integrity of the study. An explanatory, sequential, mixed-method design was used in this study, with a quantitative descriptive research approach in phase one and a qualitative explanatory research approach in phase two. The researcher chose this design because of its ability to obtain rich conclusions supported by two data sets (Wipulanusat, Panuwatwanich, Stewart & Sunkpho 2020:485).

Mixed methods involve integrating quantitative and qualitative data in a research study, with quantitative data having closed-ended responses and qualitative data having open-ended ones (Creswell & Creswell 2018:56). The current study employed an explanatory, sequential, mixed-method design.

3.4.1 Explanatory, sequential, mixed-method design

The explanatory, sequential, mixed-method design involved two phases of data collection. Quantitative data were collected and analysed in the first phase, and its results were used to plan the second qualitative phase (Creswell & Creswell 2018:357; Leavy 2017:9) (Refer to Figure 3.1). The quantitative results informed the type of participants to be purposely selected for the qualitative phase. The overall intention of this design was for the qualitative data to explain the quantitative results in greater detail (Creswell & Creswell 2018:357). The researcher used a mixed-method design based on the assumption that collecting different data types would best provide a complete understanding of the research problem, which could not be obtained using the two approaches individually (Creswell & Creswell 2018:62).

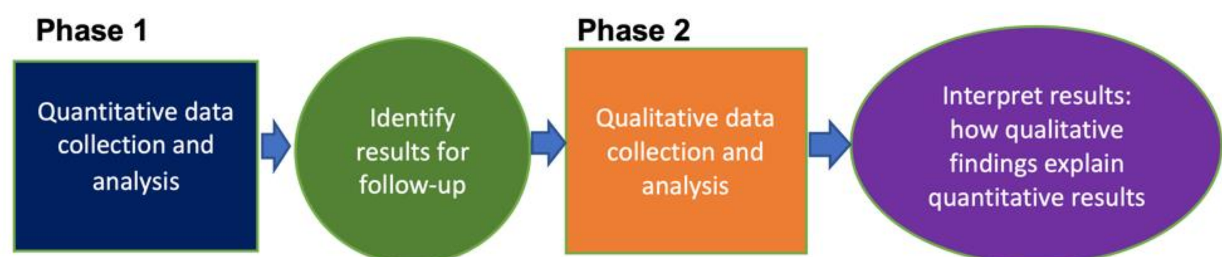

Figure 3.2: Explanatory sequential design (Two-phase design)
Adapted from Creswell and Creswell (2018:352)

3.5 PHASE ONE: QUANTITATIVE STRAND

A descriptive quantitative research design was used in phase one. In the quantitative research approach, various variables were examined by the researcher using numbers and statistics to analyse its findings. Graphs, figures, pie charts and meta-analysis were employed to present the results (Wings 2021:2). This method focused on objectivity and was appropriate when collecting quantifiable measures of variables and inferences from samples of a population. The analysis of the numerical data was performed through statistical procedures using SPSS version 26 (Queirós et al. 2017:370). This methodology was chosen because it allows participation from a large population (Wings 2021:3). The design also assisted the researcher in understanding

the phenomenon of interest or occurrences affecting the youth, including factors that deter the youth from utilising YFHSs and strategies that would increase uptake (Ahmad et al. 2019:1).

3.5.1 Research methods

Research methods are techniques that are used to structure a study, and gather and analyse information in a systematic way (Polit & Beck 2017:743). The University of Newcastle Library (2022:1) similarly defines ‘research methods’ as strategies, techniques or processes that are used in the collection of data for analysis to reveal new information or generate a better understanding of a given topic. The University of Newcastle describes three different research methods, namely qualitative, quantitative and mixed methods.

3.5.1.1 Study population

A population is the entire aggregation of cases in which a researcher is interested (Polit & Beck 2017:249). However, researchers sometimes distinguish between a target population and an accessible population. Polit and Beck (2017:249) define a ‘target population’ as the aggregate about which the researcher would like to generalise the research results, and an accessible population is the aggregate of cases that conform to the designated criteria and are accessible for the study. Similarly, Asawapoom (2020:2375) describes a ‘target population’ as an accessible list of all the subjects of the population under study. The author notes that it may not be feasible to pursue a research study using the entire population as it may be too large to define and access; hence, an accessible population is utilised. An accessible population is one that meets the target population criteria and is available.

The target population for phase one of the current study comprised female and male unmarried youths aged 10 to 24 in urban and rural Blantyre, while the accessible population comprised female and male unmarried youths aged 10 to 24 in Chilomoni and Ndirande townships for urban Blantyre, and Mdeka and Madziabango for rural Blantyre (Refer to Figure 3.1).

3.5.1.2 Inclusion criteria

One of the standards or required practices in high-quality research is the establishment of inclusion and exclusion criteria. On the one hand, the term ‘inclusion criteria’ is defined as the important features of the target population that the investigator uses to answer their research question, e.g. demographic characteristics. On the other hand, exclusion criteria are features of the potential study participants who meet the inclusion criteria but have additional characteristics that could interfere with the study’s success or increase the risk of an unfavourable result, e.g. comorbidities that could generate biased study results (Patino & Ferreira 2018:1).

The inclusion criteria for phase one of this study were:

- Boys and girls aged 10 to 24
- Not married
- Willing to participate in the study
- Consent or assent was provided to participate in the study
- Able to speak English or Chichewa

The exclusion criteria for phase one of this study were:

- Boys or girls younger than 10
- Boys or girls older than 24
- Married boys or girls
- Unwilling to participate in the study
- Consent or assent to participate in the study was not provided
- Unable to speak English or Chichewa

3.5.1.3 Sampling

Sampling is a process of selecting subjects to represent an entire population so that inferences can be made about the population, while a sample is a subset of the population (Polit & Beck 2017:250). Turner (2020:8) notes that in most research activities, it is impossible to use the whole population; therefore, a representative smaller group is relied upon for data collection. In sampling, units of a population are

called ‘elements’, and the list of all population elements is called a ‘sampling frame’ (Turner 2020:8).

Sampling techniques are classified as probability or non-probability. Probability sampling entails the random selection of elements with the probability that an element will be included in the sample, whereas in non-probability sampling, elements are selected by non-random methods (Polit & Beck 2017:250). Researchers are bound to have errors in sampling, and quantitative research strives to minimise errors (Polit & Beck 2017:250). When sampling is done properly, the researcher can draw inferences and generalise about the population without having to examine every element in the population (LoBiondo & Haber 2010:224).

In the current study, a multistage sampling technique was used to select a sample of female and male unmarried youths aged 10 to 24 for phase one. According to Zach (2021:1), multistage sampling is a technique for finding a sample from a population by splitting the population into smaller groups and taking samples of participants from the smallest resultant groups. Zach (2021:1) further notes that it is important to use a probability sampling method such as simple random sampling, stratified random sampling, cluster random sampling, or systematic random sampling at each stage. Similarly, Bhandari (2021:1) explains that multistage sampling is used for collecting data from large, dispersed populations. Bhandari (2021:1) further explains that in multistage sampling, the population is divided into clusters, which are selected at the first stage. These clusters are further divided into smaller clusters, and this process is repeated until the researcher gets to the last step, where only some members of each cluster are selected for the sample.

The Blantyre district was first divided into two clusters: urban Blantyre and rural Blantyre. Urban Blantyre had six public health centres, and two of them, namely Chilomoni and Ndirande, were selected using simple random sampling. Rural Blantyre had eight traditional authorities, which the study grouped into two clusters: north and south. Two traditional authorities, namely Chigaru, from the northern cluster, and Somba, from the southern cluster, were sampled randomly. Chigaru had three health centres from which Mdeka was randomly selected. Similarly, Madziabango Health Centre was random sampling from two health centres located in Somba. Thus, four

health centres were selected, with Ndirande and Chilomoni representing urban Blantyre, and Mdeka and Madziabango representing rural Blantyre.

The sample was selected from the health centres and households in catchment areas of the four health centres, with three catchment areas being selected for each health centre using simple random sampling (Refer to Figure 3.1 for a map reflecting the health facilities located in rural and urban Blantyre). A request letter to conduct the current study in the identified health centres was written to the District Health Officer (refer to Annexure C).

Ethical issues related to sampling may include sampling error. In the current study, a design effect of 1.5 was considered because multistage sampling was used (Amele, Desta & Woldemariam 2019). Thus, due to possible errors that would have been caused due to multistage sampling, the sample was increased by 15%. Further, it was increased by 10% because of possible issues with non-responses, voluntary participation, and freedom to withdraw.

3.5.1.4 Sample

For the current study, information obtained from Blantyre District Health Office's Health Management Information system in August 2021 indicated that Ndirande had an estimated population of 39 406 youths aged 10 to 24; Chilomoni had 2 809; Mdeka had 10 022; and Madziabango had 2 970. The estimated population from all the study settings was 75 207 youths aged 10 to 24.

The required sample size was determined by using the Leslie Kish sampling formula. The formula was chosen as it factors in the level of precision, the level of confidence or risk, and the degree of variability in the attributes being measured. The formula is shown below:

$$n = \frac{z\left(\alpha/2\right)^{2} p(1-p)}{d^{2}}$$

n = Sample size

z (α/2)2 = Confidence interval

Proportion of utilisation of YFHSs in Malawi (USAID 2014)

d = Margin of error

Therefore n = 174

As stated, a design effect of 1.5 was considered because multistage sampling was used (Amele et al. 2019).

Then: 174* 1.5 (design effect)

n = 261

The sample size calculated above assumes that the response rate will be 100%. However, problems with non-responses or withdrawals could emerge. To account for this, the sample size was oversampled by 10%, thus:

261 *1.1

n = 287.1

Therefore, the sample size for phase one of the study was 288 respondents, with the number of respondents per site being calculated proportionally after dividing the sample size into two halves for rural and urban areas. Thus, the number of respondents was as follows: eastern urban Blantyre = 91, western urban Blantyre = 53, northern rural Blantyre = 111, and southern rural Blantyre = 33.

3.5.1.5 Data collection

A survey utilising structured questionnaires was conducted on 293 sampled elements of young people aged 10 to 24 in phase one. A survey is a method used to collect information by posing questions to a predetermined group of people (Formplus 2018:1). Surveys are efficient and economical to conduct because a large population over a wide region can be covered within a short period of time. For this study, the survey took approximately 30 minutes, and data were collected in 10 days.

Surveys also have disadvantages, such as low response rates due to drop-outs and selection bias, which can affect the validity of the study (Formplus 2018:3). In the current study, the targeted sample size of 288 respondents was reached, thereby being surpassed by five respondents.

The structured questionnaire was developed based on the study's objectives, literature review, and the Health Belief Model's constructs. The researcher also adapted questions from other studies. The structured questionnaire had the following subsections: demographic information; Demographic information; accessibility of YFHSs; youths' knowledge about SRH issues and services; practices at YFHSs; barriers to the utilisation of YFHSs; and suggestions to enhance the utilisation of YFHSs (refer to Annexure L). This instrument comprised closed-ended questions. The questionnaire was translated into the local language (Chichewa) before it was used (refer to Annexure M).

3.5.1.6 Pre-testing of the data collecting instrument

Pre-testing a research instrument involves a critical examination of respondents' understanding of each question. Pre-testing needs the be conducted under actual field conditions, with a group of people similar to the concerned study population, in order to identify respondents' problems in understanding the way a question has been worded, the meaning it communicates, whether different respondents respond to the question differently, and establish whether the interpretation is different from what the researcher was trying to convey. It helps the researcher to re-examine the wording to make it clearer and unambiguous (Kumar 2014:191).

Prior to data collection for phases one and two, the researcher pre-tested the instruments with five youths from the Gateway Clinic. Information collected at this clinic was not included in the final analysis of data for phase one. This health facility was also not among the facilities included for data collection in this study. After pre-testing, ambiguous, sensitive, inappropriate and unnecessary words identified during pre-testing were removed or modified. The required time for each respondent to complete the survey was also noted during pre-testing; hence, the questions were refined or modified to match the required time. The structured questionnaire was also given to an

expert in adolescent reproductive health. All suggestions were used to improve the research instrument.

3.5.1.7 Characteristics of the data collection instruments

The structured questionnaire that was used to collect data in phase one comprised the following subsections: Demographic information; accessibility of YFHSs; youths' knowledge about SRH issues and services; practices at YFHSs; barriers to the utilisation of YFHSs; and suggestions to enhance the utilisation of YFHSs (refer to Annexure L). This instrument comprised closed-ended questions.

3.5.1.8 Data collection process

Phase one's data collection process entailed the following steps:

- The researcher established contact with community leaders with the assistance of YFHS focal persons. The community leaders were informed about the research and intended data to be collected from the area to obtain permission for the researcher and research assistants to visit the community for this purpose.
- The community YFHS focal persons informed the community members about the impending data collection exercise, so they were not alarmed by the presence of the researcher and research assistants.
- The researcher collected data as a supervisor, with the assistance of four research assistants.
- An information sheet was read to each respondent before informed consent or assent was obtained through a signature or a fingerprint from youths aged 18 and older and younger than 18, respectively. For youths younger than 18, an information sheet was read to parents or guardians of the youths and parental consent was obtained through a signature or fingerprint on a parental consent form prior to the minor signing the assent form. The respondents were also informed that they were free to withdraw at any time, without any consequences.
- The data collectors then collected the data from each youth separately using the structured questionnaire.

- The research assistants were taught to ask the questions precisely as stated in the instrument.
- Data were collected at one site at a time until the target number of youths (N=288) was reached.
- Each data collector was required to survey a maximum of 10 youths daily, each taking about 30 to 40 minutes.
- The questions required the data collectors to circle available responses on the questionnaire.
- Data collection for phase one was completed in a total of 10 days.

3.6 PHASE TWO: QUALITATIVE STRAND

The qualitative explanatory research design was used in phase two of this study. According to Ahmad et al. (2019:1), qualitative research is a process of naturalistic inquiry that seeks an in-depth understanding of social phenomena within their natural settings. Qualitative research designs always seek to answer “what” and “how” questions. It focuses on why specific theories exist, and participants’ answers to it (Wings 2021:2). In addition, Queirós et al. (2017:369) argue that qualitative research is more concerned with deepening an understanding of a given problem rather than numerical representativity. Therefore, the objective of this methodology is to produce in-depth and illustrative information that would promote an understanding of various proportions of the problem under study.

Explanatory research designs explore phenomena that have not been researched or those that have been inadequately explained with the purpose of discovering the “why” and “what” of a subject under investigation. Focus group discussions were conducted with youths aged 10 to 24 to explain issues in a language chosen by the participants in great depth to help the researcher understand their experiences, motivation and context of their health behaviours regarding the utilisation of YFHSs (Leavy 2017:19). Thus, the focus groups complemented the quantitative data from the survey conducted in phase one. Individual interviews were also conducted with healthcare providers and focal persons who worked at YFHS departments in the selected areas. The interviews were intended to generate providers’ perspectives concerning factors that encourage

or deter youths from utilising YFHSs and strategies that would increase their utilisation of YFHSs.

3.6.1 Target population

The target populations for phase two were service providers and youths.

3.6.2 Inclusion criteria

The following criteria were stipulated for participants' inclusion:

Inclusion criteria for service providers:

- Male or female YFHS providers who were currently working at YFHS departments in the selected health facilities and had been working there for at least a year
- Willing to participate in the study

Inclusion criteria for youths:

- Boys and girls aged 10 to 24
- Not married
- Willing to participate in the study
- Provided consent or assent to participate in the study
- Able to speak English or Chichewa

3.6.3 Exclusion criteria

Exclusion criteria for service providers:

- Male or female YFHS providers who were not currently working at the YFHS department in the selected health facilities
- YFHS providers not willing to participate in the study

Exclusion criteria for youths:

- Boys or girls younger than 10 years
- Boys or girls older than 24

- Married boys or girls
- Unable to speak English or Chichewa
- Not willing or consent/assent not provided to participate in the study

3.6.4 Sampling

A non-probability sampling method was used to select phase two's participants, because in qualitative research, you can only use non-probability methods (Bradshaw, Atkinson & Doody 2017:6). A purposive sampling design was used to obtain key informants and YFHS team members from the four health facilities. A primary consideration in purposive sampling is the researcher's judgement as to who can provide the best information to achieve the study's objectives (Bradshaw et al. 2017:6). The researcher chose people likely to possess the required information and willing to share this information with the researcher.

Focus groups were conducted with youths in three of the four selected areas due to data saturation. The focus groups were conducted in identified rooms at the health facilities, and included a small group of between 6 to 12 youths interested or with knowledge of a particular topic (Intrac 2021:1). In addition, Intrac (2021:1) explains that focus groups are based on a short list of guiding questions that probe for in-depth information, with discussions lasting one to two hours.

Polit and Beck (2017:511) argue that a major advantage of focus groups is that researchers obtain many people's viewpoints quickly. In the current study, the focus groups took a maximum of one hour. It is further argued that there could be deeper expressions of opinions because members react to what others say. However, Polit and Beck also note that focus groups could face challenges in people being uncomfortable expressing themselves in front of others, and a high prevalence of "group think" occurs, which inhibits individual opinions.

3.6.5 Sample

In phase two, the sample size was determined by information needs and data saturation. According to Guest, Namey and Chen (2020:2), saturation is the point in data collection and analysis when new incoming data provides little or no new information to address the research question.

Eight young people in three of the selected sites were recruited to participate in focus groups due to data saturation. Recruitment was done at the sites for two months, with the assistance of YFHS focal persons from the selected facilities. Rooms to conduct the focus group discussions were also identified with the assistance of focal persons to ensure privacy and confidentiality were maintained during the data collection process.

3.6.6 Data collection methods

Data collection instruments for phase two included a semi-structured interview guide for service providers (refer to Annexure N) containing open-ended questions. Phase two also had a focus group discussion guide for youths aged 10 to 24 (refer to Annexure P). Both instruments were translated into Chichewa by a Chichewa expert (refer to Annexure O and Annexure Q, respectively).

3.6.7 Data collection process

3.6.7.1 Individual interviews

The semi-structured interview is a data collection method that focuses on specific themes and covers the themes in a conversational style. A semi-structured interview provides valuable information, usually not anticipated by the researcher because it contains open-ended questions that address specific objectives of the study (Oxfam 2019:1). The researcher opted for a semi-structured questionnaire to interview the healthcare providers working in YFHS departments at that time and YFHS focal persons. Data collection for phase two was completed in four days. The following interview process was adapted from Oxfam (2019:1):

- Timing – The interview was scheduled for times that did not interfere with the participant's work.
- The researcher introduced herself and explained the purpose of the interview.
- The participant was informed that the interview would take a maximum of one hour.
- Consent was obtained from the participants, and they were assured about the confidentiality of the interview.
- The participant was encouraged to freely and comprehensively discuss all aspects listed in the interview guide.
- The participant was informed that the interview would be recorded, and some notes would be written down.

The researcher/research assistant used the following listening and questioning skills:

- They gave the participants their full attention. For instance, phones were either switched to silent mode or turned off.
- If they were unsure about what a participant said, the researcher paraphrased and had the interviewee confirm or correct their interpretation.
- When questioning, the researcher started with something visible before asking about abstract issues.
- Open probe questions, compare and contrast questions, impact questions, and imagining questions were asked by the researcher.
- Questions were not combined to avoid confusing participants.
- Themes for discussion were included in the semi-structured interview guide (refer to Annexure N).
- The interviewee had the opportunity to ask questions. Ample time was allocated for questions.
- The participant was reminded that what had been discussed would be reported only as part of the research.
- Only what was agreed would be recorded, and names would be relabelled during the writeup as agreed with the participant.
- As soon as the interview ended, the context of the meeting, in terms of where it took place, who was there, the atmosphere, any odd thing noticed, and final comments made as the meeting ended, were written down to avoid the need for follow-up.

- After the interview, the notes were typed within 24 hours to ensure the note-taker's memory was still fresh.

3.6.7.2 Focus group discussions

Focus group discussions with youths aged 10 to 24 were also conducted in phase two using a semi-structured discussion guide (refer to Annexure P). Focus groups were conducted with eight young people (four females and four males) in three of the four selected areas due to data saturation. The YFHS focal persons assisted in arranging the focus groups. The age groups were distributed as follows: 10 to 12 years - one male and one female; 13 to 16 years - one male and one female; 17 to 20 years - one male and one female; and 21 to 24 years - one male and one female.

Focus group discussion process:

- Appointments for the focus group discussions were made with the participants prior to the date of the focus group discussions, and for a time they were not in class for those who attended school.
- The researcher met individual participants separately to review the informed consent.
- Focus group discussions were conducted in a room that was made available by YFHS focal persons.
- The researcher briefed the participants on the purpose of the study, the time required for the focus group discussion, and expectations from the participants.
- The participants were informed that the session would be audio recorded.
- Using a discussion guide, the researcher conducted the focus group discussions for a maximum of one hour.
- The entire focus group discussion sessions were audio recorded.

3.6.8 Field notes and observations

In addition to the audio-recorded discussions, the research assistants also wrote field notes on relevant behaviours observed during the focus groups and interviews. Leavy

(2017:136) defines ‘field notes’ as written notes concerning observations made in the field. Field notes included a date and time to maintain a chronological record. The location was noted, including whether the interaction was with an individual participant or group of participants. The notes were written systematically and captured as much detail as possible, including the exact words of the participants (Leavy 2017:136).

One research assistant who was not a participant in the discussions served as a note-taker and performed the following roles (Learning for Action([s.a.]:1):

- They took verbatim notes and recorded notable quotations. The conversation was captured verbatim for the notes to reflect exactly what the participant said so that it could be related to the research question and provide quotes in the report.

- One of the duties of the note-taker was to ask clarifying or probing questions. Participants were asked to repeat or clarify what they had said if their comment was not understood clearly.

- Another role of the note-taker was to monitor time for the facilitator and to notify them when they had 15 minutes and five minutes left so that they could prioritise questions and end the discussion on time.

- The note-taker also wrote contextual notes about the focus group, e.g. aspects of the focus group that affected the conversation, such as the number of participants, gender, age range, whether they entered the conversation late or left it early, topics people were particularly interested in talking about, nonverbal agreements through nodding, or other body language.

- Finally, the note-taker cleaned the notes within 24 hours so that shorthand was spelled out and gaps were filled in so that another person who did not attend the focus group would be able to understand the notes.

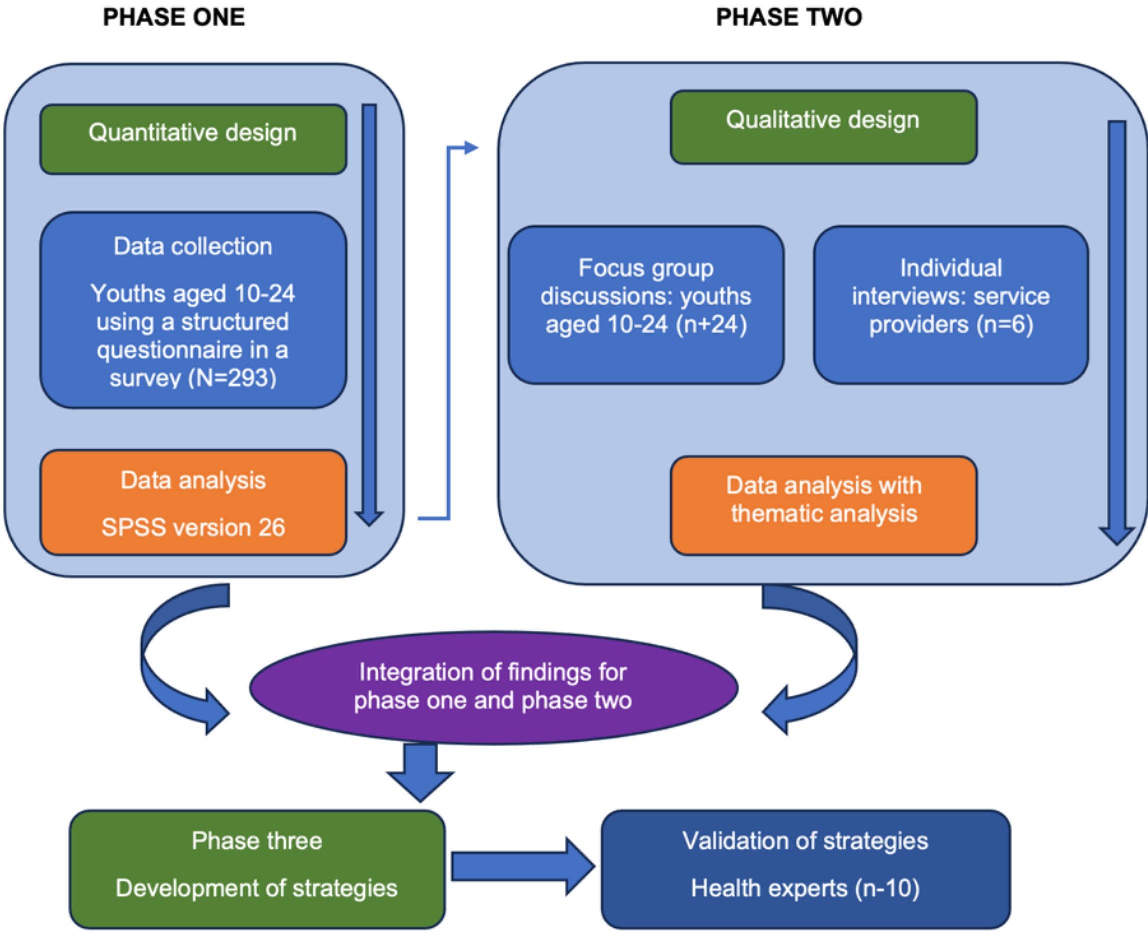

Figure 3.3: Illustration of the study flow

Source: Researcher (2023)

3.7 ETHICAL CONSIDERATION RELATED TO DATA COLLECTION

3.7.1 Permissions

Ethical approval was sought prior to conducting this study. It was necessary for the research proposal to go through ethical clearance because studies that have human beings as study participants need to ensure participants' rights are protected, especially since several human rights violations have occurred in the name of science (Polit & Beck 2017:137). The research proposal went through a review by the Research and Ethics Committee of Unisa's Department of Health Studies, which approved the research (Annexure A). The research proposal also went for ethical clearance at the National Commission for Science and Technology of Malawi, which approved the study (Annexure B). Permission was sought from the Blantyre District Health Office and the

four health facilities' clinic managers (Annexure C). Lastly, information was provided to the participants of the study before obtaining their consent to conduct the interviews and focus group discussions (Annexure D).

3.7.2 Beneficence

The principle of beneficence, which propounds the idea that it is the researcher's duty to minimise harm and maximise benefits, was adhered to (Polit & Beck 2017:139). No potential bodily harm was anticipated in this study except discomfort in responding to sensitive questions. The potential risk was minimised through the researcher's assurance and strict observation of participants' privacy and confidentiality.

3.7.3 Non-maleficence

'Non-maleficence' is defined as an obligation to avoid, prevent and minimise harm (Polit & Beck 2017:139). The researcher ensured that participants were not harmed as a result of participating in this study. To protect them from being harmed psychologically, the researcher prioritised protecting the participants, especially the youth, from invasion of their privacy and confidentiality. The youths were interviewed individually at a time and place agreed upon by the participants. The questionnaires did not reflect the respondent's name, but a code identifier was used for phase one. In phase two, focus group discussions and interviews were conducted in a room where observers were not allowed. Pseudo-names were used, and all the forms and digital recorders were kept in a locked cupboard where only staff involved in the research could access them.

3.7.4 Respect

Participants were treated respectfully throughout this study. A full explanation of what the researcher intended to do, the purpose of the study, the type of data required, the procedure of data collection, potential costs, risks, benefits, maintenance of confidentiality and contact information in the event of further questions was provided. Participants were also informed that they had a right to ask questions for clarification, not to respond to questions they felt uncomfortable answering, and that they were free

not to participate. The participants were also informed that they could withdraw from the study at any time, and that they would not be punished for doing so.

3.7.5 Informed consent

An information sheet was read to all the participants (refer to Annexure D). The researcher then obtained informed consent from each participant aged 18 and older (refer to Annexure F). Those participants willing to participate in the study voluntarily signed the consent form after taking them through the information sheet and the form and establishing that they comprehended the contents. An information sheet was also read to parents or guardians of youths under 18. Parental consent was then obtained through a signature or fingerprint on a parental consent form (refer to Annexure H) prior to the minor signing the assent form (refer to Annexure J). The participants were informed that they were free to withdraw at any time, without any consequences.

For phase two, an information sheet was read to the participants (refer to Annexure D), and similarly, the researcher obtained informed consent from each participant for phase two (refer to Annexure F). The participants who were willing to participate in the study voluntarily signed the consent form after taking them through it and establishing that they comprehended the contents. The researcher ensured that the research assistants were fluent in both English and Chichewa. The consent forms, structured questionnaires and interview schedules for phases one and two were translated from English to Chichewa by a Chichewa expert from the Queen Elizabeth Central Hospital.

3.8 RIGOUR OF THE STUDY

Validity is the extent to which the results of a study really measure what they are supposed to measure, whereas reliability is the ability of an instrument to reproduce results when the research is repeated under the same conditions (Middleton 2019:1). Thus, validity is about the accuracy of a measure while reliability is about the consistency of a measure.

3.8.1 Validity of the research instruments

Content validity is concerned with whether the measurement instrument covers all aspects of the concept being measured (Middleton 2019:3). In the current study, content validity was ensured by incorporating ideas from the literature review of similar studies. Experts in reproductive health also analysed the instrument to assess its representativeness, appropriateness and the adequacy of items representing the concept being tested. Suggestions from the experts were incorporated into the final instrument. The face validity of the instrument was enhanced by reviewing each question against the objectives of the study. The research instrument was also examined by experts in adolescent reproductive health and members of the research committees of the Department of Health Studies, the University of South Africa, and the National Commission for Science and Technology.

3.8.2 Reliability of the instrument

Four research assistants collected data in phase one, which presented a potential threat in terms of reliability. To avoid this challenge, the researcher trained the research assistants in how to ask questions (refer to Annexure R). Pre-testing the structured questionnaire with five youths also enabled the study to address the issue of reliability. The pre-testing of the instrument further assisted in the identification of anomalies, and all necessary adjustments were made. Experts in adolescent reproductive health reviewed the structured questionnaire to check if it could yield the same results on repeated measures.

On the first day of data collection, the researcher and the four research assistants completed structured questionnaires on the same interview and checked similarities and differences in the recordings. Corrections were made where necessary. The researcher also supervised the data collection process on an ongoing basis.

3.8.3 Trustworthiness

3.8.3.1 Credibility

Credibility is the confidence in the truth of the data and their interpretation (Polit & Beck 2017:559). It is believed that the respondents are the best judges of whether the research findings reflect their opinions and feelings accurately (Bradshaw et al. 2017:9). To enhance credibility, rapport and trusting relationships were developed before commencing interviews so that there was a willingness to exchange information. The interview transcript was also cross-checked by one of the participants from the health facilities included in this study.

3.8.3.2 Transferability

Polit and Beck (2017:559) define 'transferability' as the potential for the research findings to be applied in other settings or groups. In the current study, transferability was enhanced by maintaining a reflective journal and thoroughly describing the processes adopted in this research for others to replicate (Bradshaw et al. 2017:9).

3.8.3.3 Dependability

Dependability refers to the reliability of data over time. It inquires whether the findings of the research could be repeated if it were replicated with the same participants in the same context (Polit & Beck 2017:559). To ensure dependability, an audit trail was developed describing the study's procedures and processes and any changes that occurred within the study were accounted for (Bradshaw et al. 2017:9).

3.8.3.4 Confirmability

Confirmability focuses on establishing whether the research data represent the information that the participants provided, and the interpretation of that data has not been invented by the researcher (Polit & Beck 2017:560). To ensure confirmability, raw data, field notes, and audio-recorded and transcribed information in the form of themes and definitions were presented. Findings represented the data gathered and were not

biased by the researcher. This was evidenced by the inclusion of direct quotations from participants (Bradshaw et al. 2017:9).

3.9 HANDLING COVID-19

COVID-19-related challenges were taken into consideration during data collection. The researcher ensured the research participants' and data collectors' protection by providing them with masks and ensuring a physical distance of one metre apart during face-to-face interviews. Data collectors were encouraged to practice frequent hand-washing with soap or alcohol-based hand sanitisers. Study participants were also provided with COVID-19 information leaflets as part of safety precautions.

3.10 SUMMARY

This chapter described the research design and methods used in this study. The study was conducted over two phases, which ran in a sequential manner. A quantitative research method was used in phase one, while a qualitative method was used in phase two. The chapter further described sampling, ethical issues related to sampling, data collection methods, the development and testing of the data collection instruments, characteristics of the data collection instruments, and the data collection processes. The chapter also discussed ethical considerations related to data collection, data analysis, the rigour of the study, particularly validity and reliability/trustworthiness, and issues related to COVID-19. In the next chapter, data analysis and a description of phase one's findings are presented.

CHAPTER 4
ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH RESULTS FOR PHASE ONE – QUANTITATIVE PHASE

4.1 INTRODUCTION

Chapter 3 described the research methodology that the researcher used to arrive at the findings. An explanatory, sequential, mixed-method design was used, and data analysis unfolded over two phases, starting with quantitative data analysis in phase one, followed by qualitative data analysis in phase two. In this chapter, a description of phase one's results and data analysis are presented.

4.2 DATA MANAGEMENT

All data collection instruments, including questionnaires, notepads with field notes and responses to interviews and observation, audio recorders, signed consent forms, assent forms, and all the research documentation were kept in a locked cabinet with keys only accessible by the researcher and staff helping with the current research. The documentation will be disposed of five years after the study's publication in case raw data are required at any time before that. An electronic copy of the thesis will be submitted to the University of South Africa's library to be uploaded to the institutional repository.

4.3 QUANTITATIVE DATA ANALYSIS FOR PHASE ONE

This section outlines the survey questionnaire's analysis. The questionnaire comprised seven sections: Demographic information; accessibility of YFHSs; youths' knowledge about SRH issues and services; practices at YFHSs; barriers to the utilisation of YFHSs; and suggestions to enhance the utilisation of YFHSs.

A large sample size (N=293) was used. The numerical data were analysed using the computerised SPSS version 26. Descriptive statistics was used to summarise and describe the data to detect trends and patterns in the construct under study.

Descriptive data were presented as numbers, frequency distribution tables, percentages, proportions and charts (figures). This helped the researcher to describe and summarise the data, and to provide a pictorial view of the study's findings. Findings were also summarised using contingency tables or cross-tabulations to visually compare summarised data related to variables within the sample. To test the significance of the association between the variables under study, Chi-square (X^2) was used, and P-values were calculated. Regression analysis was also employed to examine independent variables' influence on youths' utilisation of YFHSs in Blantyre.

The following conventions were adopted to present and discuss the quantitative research findings in Chapter 4:

N = Total sample
n = Total of sub-variables or topics

Table 4.1: Respondents' demographic characteristics for phase one

Characteristics of respondents	Frequency (N=293)	Percentage (%)
Gender		
Male	141	48.1
Female	152	51.9
Age		
10–14	72	24.6
15–19	143	48.8
20–24	78	26.6
Living with		
Both parents	136	46.6
Mother only	79	27.0
Father only	3	1.0
Relatives	42	14.3
Friends	3	1.0
Others	30	10.2
Religion		
Christian	271	92.5
Muslim	22	7.5

Characteristics of respondents	Frequency (N=293)	Percentage (%)
Occupation		
Student	170	58
Business	39	13.3
Formal employment	36	12.3
Civil servant	2	0.7
Unemployed	46	15.7

4.3.1 Section A: Respondents' demographic profile (N=293)

A total of 293 respondents participated in the survey, from which data were analysed. Table 4.1 illustrates the respondents' socio-demographic characteristics. A majority of the respondents (n=148; 50.5%) were female. Most were aged 15 to 19 (n=143; 48.8%), implying that most respondents were adolescents. Most respondents (n=136; 46.6%) lived with both parents, followed by respondents who lived with mothers only (n=79; 27%). Most of the respondents were Christians (n=270; 92.2%), and it was not surprising that the majority of the respondents were students (n=170; 58%), considering the majority's age. This group was followed by unemployed respondents (n=46; 15.7%), showing that unemployment was a problem among the youth.

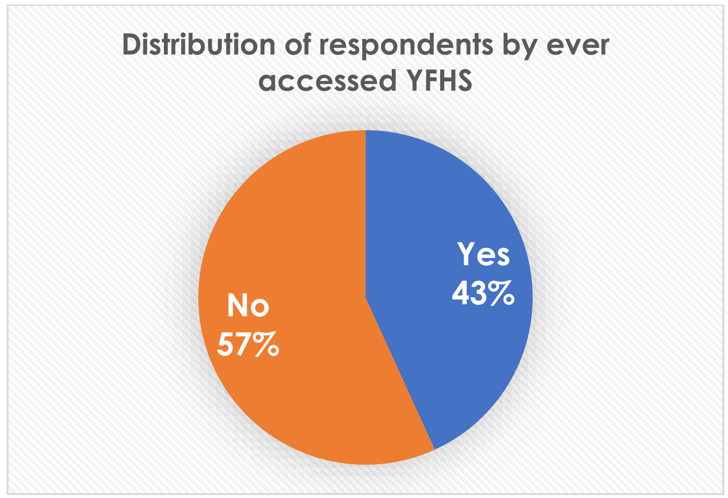

Figure 4.1: Distribution of respondents who accessed YFHSs

Table 4.2: Distribution of respondents by access factors

Characteristics	Frequency (N =293)	Percentage %
Where to access YFHS		
Government health centre	247	84.3
Private hospitals	5	1.7
Youth clubs	32	13.9
NGOs	2	0.7
Drug store/pharmacy	2	0.7
Other	5	1.7
Means of transport to a facility		
Walking	246	84
Bicycle	10	3.4
Motorbike	30	10.2
Bus/minibus	7	2.4
Time taken to reach a facility		
< 10 minutes	135	46.1
30 minutes to 1 hour	55	18.8
1 hour to 2 hours	75	25.6
More than 2 hours	28	9.6
Ever been encouraged to access YFHSs		
Yes	163	55.6
No	130	44.3
Ever been discouraged from accessing YFHSs		
Yes	88	30.0
No	205	69.9

4.3.2 Section B: Accessibility of YFHSs

Figure 4.1 illustrates that accessibility to YFHSs was a problem, as less than half of the respondents had ever accessed YFHSs (43%). According to Table 4.2, the majority of respondents preferred to access YFHSs at government health centres (n=247; 84.3%), followed by youth clubs (n=18; 6.1%). The most common means of reaching the health facility for YFHSs was walking (n=246; 84%), and more than half of the respondents had been encouraged to attend YFHSs (n=163; 55.6%) at some time in their lives.

Table 4.3: Respondents' distribution by knowledge factors

Characteristics	Frequency (N=293)	Percentage %
Has heard of YFHS		
Yes	194	66.2
No	99	33.8
Source of information of YFHS (n=194)		
Friends	110	56.7
Parents/guardians	16	8.2
Nurse	27	13.9
Media	16	8.2
Community leaders	22	1.5
Others	3	
Any knowledge of services offered at YFHS		
Yes	155	52.9
No	114	47.1
Has received any education on SRH		
Yes	231	78.8
No	62	32.1
Source of education on SRH		
Community	10	4.3
Youth clubs	99	42.9
Health centre	25	10.8
Friends	3	1.3
Parents	3	1.3
School	91	39.4
Preferred communicator about SRH issues		
Parents	60	20.5
Family	16	5.5
Community	6	2.0
Grandparents	11	3.8
Friends	61	20.8
Nurse	134	45.7
Has seen the YFHSs signpost		
Yes	105	38.2
No	181	61.8

Characteristics	Frequency (N=293)	Percentage %
Been given educational materials on SRH		
Yes	11	34.1
No	192	65.5

4.3.3 Section C: Knowledge about reproductive health services

Table 4.3 shows that two-thirds of the respondents in the current study already knew about YFHSs (n=194; 66.2%), and more than half of those who were aware of the services had obtained this information either from friends (n=110; 56.7%) or from nurses at health facilities (n=27; 13.9%). The study found that just over half of the respondents (n=155; 52.7%) also knew about the actual services offered at YFHSs. More than three-quarters of the respondents had previously received some education on SRH (n=229; 78.2%); there were two main sources of information for this, namely youth clubs (n=99; 42.9%) and schools (n=91; 39.4%). Most respondents preferred to receive information on SRH issues from nurses (n=134; 45.7%), followed by their parents (n=60; 20.5%). Regarding signage showing the availability of YFHSs at a health facility, more than half of the respondents (n=181; 61.8%) had never seen any such signage. The study also established that two-thirds of the respondents had never received any printed educational materials on reproductive health from health facilities (n=192; 65.5%).

Table 4.4: Distribution of respondents by practices at YFHSs

Characteristics	Frequency	Percentage %
Time given by the provider to explain n = 125		
Yes	103	82.4
No	22	17.6
Examined by provider n =126		
Yes	102	81.0
No	24	19.0
Treated respectfully n = 124		
Yes	117	94.4
No	7	5.6
Rate providers' character n =126		

Characteristics	Frequency	Percentage %
Normal	38	30.2
Friendly	44	34.9
Professional	40	71.7
Harsh	1	0.79
Rude	3	2.3
Treated with privacy n = 126		
Yes	108	85.7
No	18	14.3
Assured of confidentiality n = 124		
Yes	101	81.5
No	23	18.5
Provider explained or demonstrated n = 125		
Yes	118	94.4
No	7	5.6

4.3.4 Section D: Practices at the YFHS

Table 4.4 illustrates youths' experiences with YFHSs. Among the respondents who had previously accessed YFHSs, the majority (n=103; 82.4%) agreed they were given time to explain their problems to the health service providers. Most (n=102; 81.0%) agreed that the service provider examined them, and almost all the respondents who had ever accessed YFHSs (n=117; 94.4%) agreed that they were treated respectfully.

The service providers were rated highly for positive characteristics: 38 (30.2%) respondents said the providers were normal, 44 (34.9%) said the service providers were friendly, and 40 (31.7%) said that they conducted themselves in a professional manner. Only 3% of the respondents rated the healthcare providers or YFHS focal personnel as harsh or rude. Most respondents said their privacy was respected (n=108; 85.7%), and 101 (81.5%) were assured of confidentiality. Almost all the respondents agreed that the healthcare providers explained or demonstrated aspects to them where necessary (n=118; 94.4%). Thus, the current study indicates that respondents had no problems with the service providers.

Table 4.5: Possible barriers to the utilisation of YFHSs

Characteristics	Frequency (N=293)	Percentage %
Feels too shy to attend the YFHS n = 266		
Yes	37	13.9
No	229	86.1
Fear of being seen at the YFHS facility n = 264		
Yes	34	12.9
No	230	87.1
Satisfied with YFHS working days n = 166		
Yes	144	86.7
No	22	13.3
Satisfied with YFHS operating time n = 159		
Yes	148	93.1
No	11	6.9
Satisfied with YFHS outreach days n =153		
Yes	134	87.6
No	19	12.4
Health Centre environment clean n = 141		
Yes	130	92.2
No	11	7.8
Needs company to access YFHS n = 250		
Yes	30	12
No	220	88
Comfortable with seeing familiar faces at a YFHS facility n = 260		
Yes	229	88.1
No	31	11.9
Cultural value support YFHS use n = 289		
Yes	280	96.9
No	9	3.1
Religious value support for YFHS use n = 289		
Yes	280	96.9
No	9	3.1

4.3.5 Section E: Barriers to the utilisation of YFHS

As illustrated in Table 4.5, the study found that most of the possible barriers included in the current study's survey were not barriers to the utilisation of YFHSs. However, there were possible barriers, such as feeling too shy to attend YFHSs (n=229; 86.1%) and fear of being seen at the YFHS facility (n=230; 87.1%). The majority of the respondents were satisfied with the YFHS provision days (n=144; 86.7%) and operating times (n=148; 93.1%). They were also satisfied with the YFHS outreach days (n=134; 87.6%). Most were happy with the cleanliness of the health centre's environment (n=130; 92.2%). It was also noted that the majority of respondents did not need to be accompanied by anyone to attend YFHSs (n=220; 88%), and most did not mind seeing familiar faces at the facility (n=229; 88.1%). The study also established that most respondents' cultural and religious values supported their use of YFHSs (n=280; 96.9%).

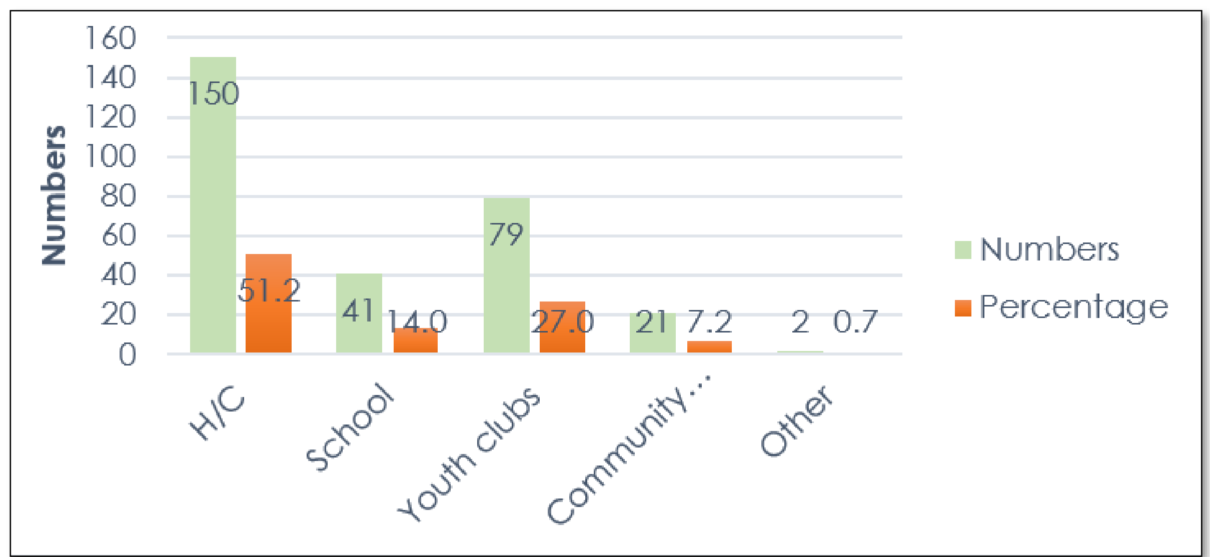

Figure 4.2: Distribution of respondents by preferred YFHS sites

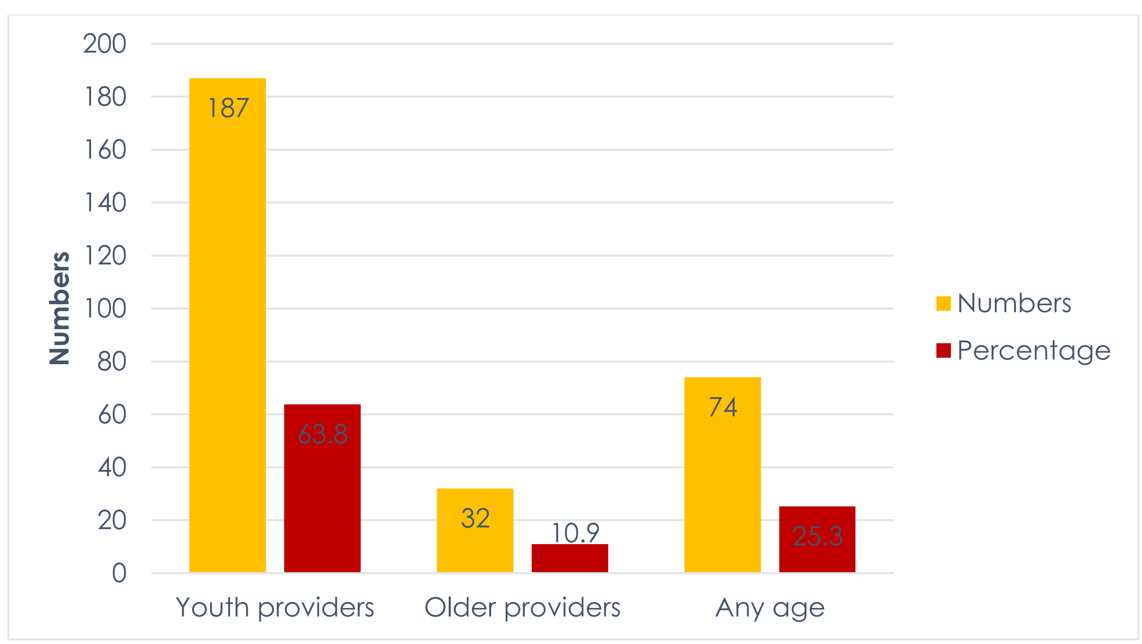

Figure 4.3: Distribution of respondents by preferred YFHS provider

4.3.6 Section F: Suggestions on what would enhance the utilisation of YFHSs

Figure 4.2 illustrates that more than half of the respondents preferred to attend YFHSs at government health centres (51.2%), followed by youth clubs (27%). According to Figure 4.3, the most preferred type of YFHS provider among respondents was youth providers (63.8%). Regarding which group of people can assist in increasing the utilisation of YFHSs, Figure 4.4 illustrates that more than one-third of the respondents concurred the youth themselves could assist in improving utilisation (39.9%), followed by healthcare providers (n=99; 33.7%). Figure 4.5 also illustrates the preferred set-up for YFHSs by the youth. More than half of the respondents preferred to have youth corners in the health facilities for conducting YFHSs (58.7%), and the second-most preferred set-up was having a special room within the health centre for YFHSs (27%).

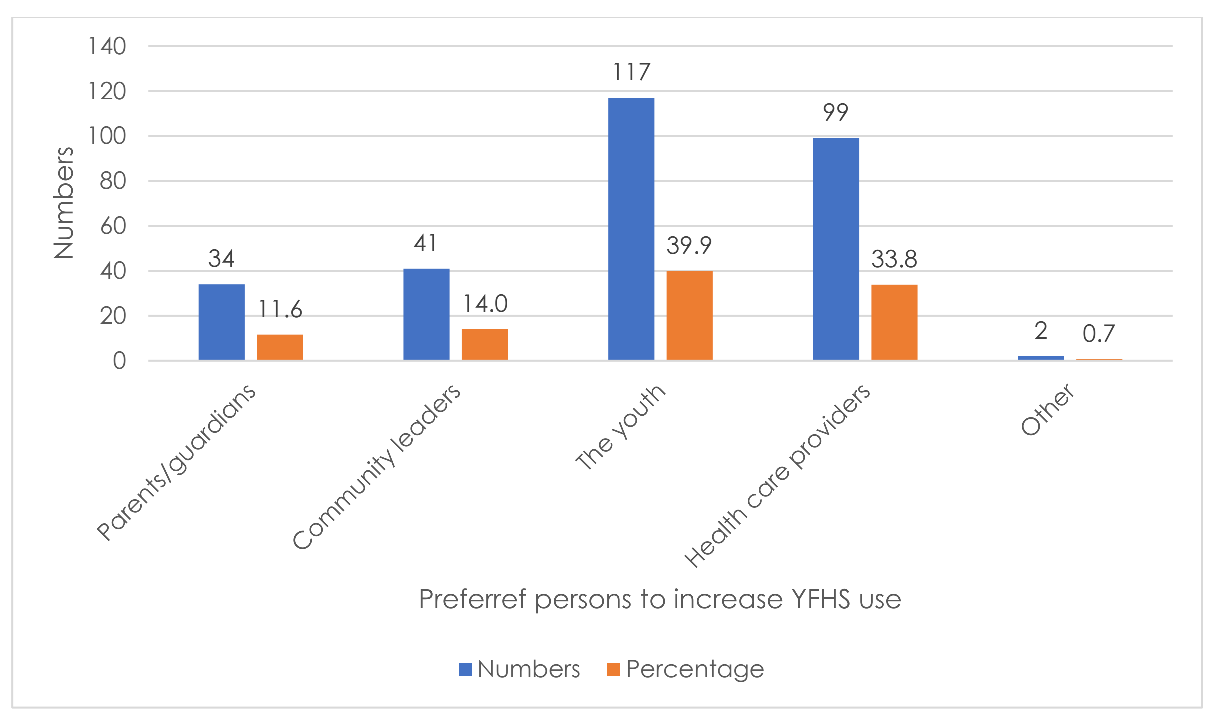

Figure 4.4: Perceived persons to increase utilisation of YFHSs

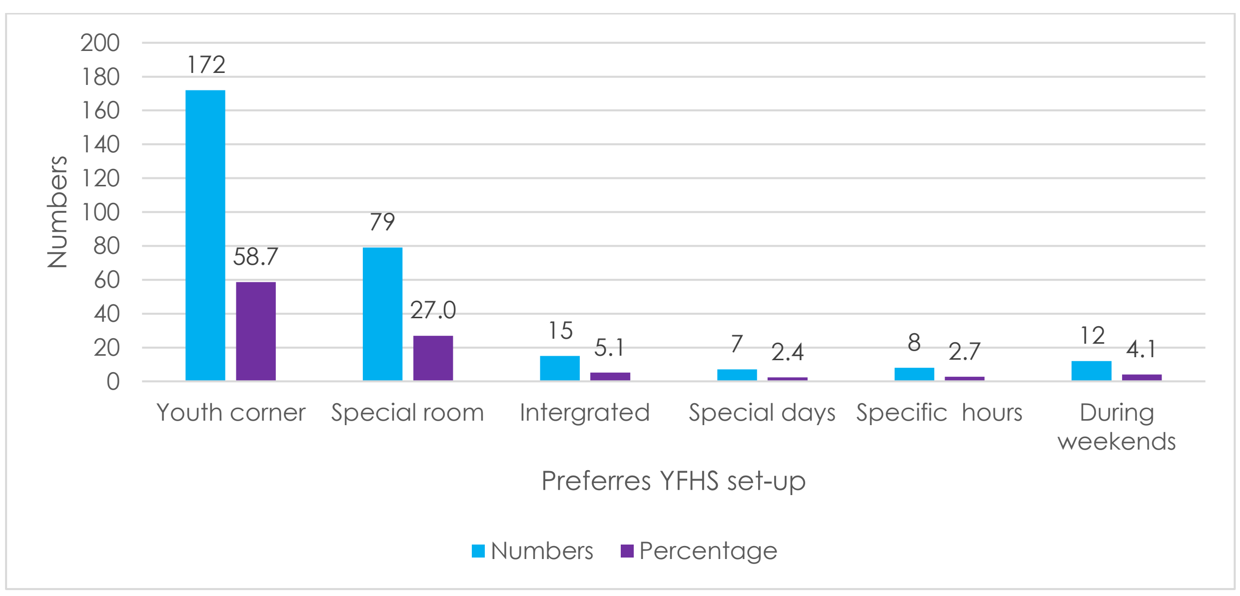

Figure 4.5: Preferred YFHS set-up

Table 4.6: Differentials in the utilisation of YFHS

Characteristics	Yes	No	n
Gender			
Male	52	89	141
Female	73	75	148
		$\chi 2$=6.07	**p=0.048**

Characteristics	Yes	No	n
Age			
10–14	20	53	72
15–19	59	82	143
20–24	46	32	78
		$\chi2$=16.12	**p=0.003**
Ever heard of services offered at YFHS			
Yes	114	40	154
No	9	104	114
		$\chi2$=115.69	**p=0.000**
Ever received SRH education			
Yes	111	228	229
No	14	45	59
		$\chi2$=16.57	**p=0.000**
Ever seen YFHS signage/signpost			
Yes	71	31	102
No	51	130	181
		$\chi2$=49.22	**p=0.000**
Given RH education materials			
Yes	64	35	99
No	60	131	191
		$\chi2$=32.99	**p=0.000**
Ever been encouraged to access YFHS			
Yes	117	42	159
No	8	119	127
		$\chi2$=420.59	**p=0.000**
Ever been discouraged from accessing YFHS			
Yes	55	31	76
No	66	129	195
		$\chi2$=26.45	**p=0.000**
Treated respectfully by the provider			
Yes	105	11	116
No	4	3	7
		$\chi2$=8.211	**p=0.016**
Religious value support for YFHS use n = 289			
Yes	105	12	117
No	5	2	7

Characteristics	Yes	No	n
		χ^2=17.07	**p=0.000**
Feels too shy to attend YFHS			
Yes	10	27	37
No	113	114	228
		χ^2=6.80	**p=0.033**
Fear of being seen at YFHS			
Yes	9	25	34
No	114	115	229
		χ^2=6.75	**p=0.034**

Note: *Significant association with utilisation of YFHS = ($p<0.05$)*

4.3.7 Statistical associations

4.3.7.1 Differentials in the accessibility of YFHSs

This investigation explored respondents' socio-demographic characteristics that included gender, age, who the young person lived with, their religion and occupation. Other sections covered knowledge about reproductive health services and available services, accessibility of YFHSs, experiences at the health facilities, barriers to the utilisation of health services, factors that enhanced utilisation of YFHSs, and strategies that could enhance utilisation. Cross-tabulations and a Pearson Chi-square at a 0.05 significance level and a 95% confidence level were employed to determine the factors that had a significant influence on youths' utilisation of YFHSs in Blantyre.

As illustrated in Table 4.6, at a 0.05 level of significance, the Chi-square test showed that the following variables had a significant association with respondents' utilisation of YFHSs ($p<0.05$): gender, age, knowledge of services offered at YFHSs, ever received SRH education, ever seen a YFHS signpost or signage, ever been encouraged or ever been discouraged from accessing YFHS, treated respectfully by the provider, issues demonstrated by the provider, felt too shy to attend YFHS, and fear of being seen at YFHSs. The variables that were found to be significantly associated with the accessibility of YFHSs ($p<0.05$) were selected for further analysis.

Table 4.7: Predictors of YFHS utilisation in Blantyre district

Characteristics	Odds Ratio (95% CI)		
	Unadjusted (OR)	Adjusted (AOR)	p-value
Respondent's gender			
Male	1.00	1.00	1.000
Female	0.60 (0.37, 0.96)	0.61 (0.37, 0.98)	0.039*
Respondent's Age			
10–14RC	1.00	1.00	1.000
15–19	0.53 (0.29, 0.99)	0.65 (0.32, 1.35)	0.245
20–24	0.27 (0.13, 0.55)	0.19 (0.06, 0.59)	0.001*
Ever heard of services offered at YFHS			
RC	1.00	1.00	1.000
Yes	33.54 (12.05, 93.35)	28.61 (10.99, 74.45)	0.000*
Ever received SRH education			
RC	1.00	1.00	1.000
Yes	3.09 (1.59, 6.02)	2.72 (1.39, 5.32)	0.002*
Ever seen YFHS signpost/signage			
RC	1.00	1.00	1.000
Yes	6.08 (3.39, 10. 92)	5.58 (3.14, 9.91)	0.000*
Given RH education materials			
RC	1.00	1.00	1.000
Yes	3.92 (2.28, 6.74)	3.74 (2.17, 6.44)	0.000*
Ever been encouraged to access YFHS			
RC	100	1.00	1.000
Yes	54.78 (15.97, 187.92)	52.26 (15.41, 177.19)	0.000*
Ever been discouraged from accessing YFHS			
RC	1.00	1.00	1.000
Yes	3.53 (2.03, 6.14)	3.41 (1.94, 6.00)	0.000*
Treated respectfully by the provider			
RC	1.00	1.00	1.000
Yes	7.22 (1.34, 38.69)	6.34 (1.28, 31.43)	0.009*

Provider demonstrated/explained issues			
RC	1.00	1.00	1.000
Yes	3.53 (0.60, 20.70)	3.82 (0.69, 20.94)	0.045*
Feels too shy to attend YFHS			
RC	1.00	1.00	1.000
Yes	0.37 (0.17, 0.81)	0.37 (0.16, 0.83)	0.012*
Fear of being seen at YFHS			
RC	1.00	1.00	1.000
Yes	0.36 (0.15, 0.81)	0.38 (0.16, 0.88)	0.020*

Note: *The assessment was based on a logistic regression model where n=293 and p-value=0.05, RC denotes reference category, *denotes a significant category*

4.3.7.2 Predictors of YFHS utilisation

According to Table 4.7, female youths showed a stronger statistical association with the utilisation of YFHS and had higher odds (Adjusted Odds Ratio (AOR) 0.61, CI: 0.37, 0.98) of using YFHSs than male youths. Young people aged between 20 to 24 (AOR 0.19, CI: 0.06, 0.59) also had higher odds of utilising YFHS than those below 20. Youths who had heard about the services offered at YFHS (AOR 28.61, CI:10.99, 74.45) and those who had previously received SRH education (AOR 2.72, CI:1.39, 5.32) also had higher odds of utilising YFHSs than those who had never heard about YFHS, the services offered, and who had never received any SRH education, respectively.

Another predictor of the utilisation of YFHSs was seeing a signpost or signage indicating the availability of YFHSs at a health facility. Those who had seen YFHS signage at a health facility had higher odds (AOR=5.58, CI:3.14, 9.91) of using it than those who had never seen any such signage.

Other predictors of the utilisation of YFHSs were SRH education materials given at YFHSs, means of transport to YFHSs, and whether the youth was encouraged or discouraged from attending YFHSs. Youths who received RH education materials at the health facilities (AOR=3.74, CI: 2.17, 6.44), youths who used motorbikes as a means of transport when attending YFHSs (AOR=3.80, CI: 1.17, 12.30), youths who

had been encouraged to attend YFHSs (AOR=52.26, CI:15.41, 177.19), and youths who had ever been discouraged from attending YFHSs (AOR=3.41, CI 1.94, 6.00) had higher odds of utilising YFHSs than their counterparts.

Provider attitude also emerged as a predictor for the utilisation of YFHSs. Those who were treated with respect by the service provider (AOR=6.34, CI:1.28, 31.43), were assisted by a service provider, and had providers able to demonstrate or explain aspects (AOR=3.82, CI0.69, 20.94) registered higher odds of utilising YFHSs than those who were not treated respectfully or did not have issues demonstrated or explained to them, respectively.

How the youths themselves felt was also a predictor for utilising YFHS. The study showed that youths who did not feel shy attending YFHSs (AOR=0.37, CI: 0.16, 0.83) and those who did not fear being seen at YFHSs (AOR=0.38, CI: 0.16, 0.88) had higher odds of utilising the services than those who felt too shy to attend or be seen at YFHSs.

Respondents' occupations also showed a strong statistical association with their utilisation of YFHSs. Youths who were not in school, such as the unemployed, those with their own business, or those formally employed, had (AOR=0.14 CI: 0.06, 0.33); (AOR=0.39, CI: 0.18, 0.84) and (AOR= 0.24, CI: 0.11, 0.55) respectively higher odds of utilising YFHSs than youths who were students.

Likewise, youths who had heard about YFHSs (AOR= 38.93, CI:10.98,138.02) or heard about the services offered at YFHSs (AOR=28.61, CI:10.99, 74.45) and those who had received SRH education (AOR 2.72, CI:1.39, 5.32) had higher odds of utilising YFHSs than youths who had never heard about YFHSs, youths who had never heard about the services that are offered at YFHSs, and youths who had never received any SRH education, respectively. The study also found that the source of SRH information was a strong predictor for youths' utilisation of YFHSs because youths who received sexual reproductive information from friends (AOR=0.51, CI: 0.24, 1.11) had higher odds of attending YFHSs than youths who received information from parents and other sources.

4.4 SUMMARY

The quantitative results in this chapter highlight factors that influenced YFHSs' uptake in Blantyre. Predictors of YFHSs' utilisation were also discussed. Chapter 5 presents an analysis and description of the research findings for phase two – the qualitative phase.

CHAPTER 5
ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS FOR PHASE TWO – QUALITATIVE PHASE

5.1 INTRODUCTION

Chapter 4 presented the analysed data and described phase one's findings. This chapter presents the analysed data and describes the study's findings for phase two. Sandelowski's (2000 as cited in Bradshaw et al. 2017:7) thematic analysis method was used to analyse data from individual interviews with six service providers or YFHS focal persons at the health facilities, and three focus groups were held with the youth in the selected study sites. Six steps of thematic analysis were followed (Braun & Clarke 2006 as cited in Xu & Zammit 2020:2; Scharp & Sanders 2019:1): (1) becoming familiar with data; (2) generating initial codes; (3) generating themes; (4) reviewing themes; (5) labelling themes; and (6) producing the report. The steps are briefly explained below.

Step1 – Becoming familiar with data

The researcher participated in the collection of qualitative data to familiarise herself with the data. After data collection, the researcher listened to the digitally recorded interviews and focus group discussions and read through all the field notes several times. After that, she transcribed the interviews and focus group recordings and, in turn, grouped and categorised the responses into textual data that were included in the analysis. This was done to promote the researcher's closeness with the data (Xu & Zammit 2020:5; Castleberry & Nolen 2018:808).

Step 2 – Generating initial codes

In this step, the researcher organised data into meaningful groups through coding. Thus, raw data were converted into usable data by identifying themes that connected with each other (Xu & Zammit 2020:5; Castleberry & Nolen 2018:808). The researcher identified similarities and differences in the collected data. Interesting features of the data were also identified systematically across the entire dataset at multiple levels. The code was used as a tag to retrieve and categorise similar data so that the researcher extracted and examined all the data across the datasets associated with that code. In

the process, definitions for each code were developed to ensure that codes were applied reliably throughout the data. The coding process ended when no new themes were identified (Castleberry & Nolen 2018:809). An independent coder received the transcripts to perform their own coding and engage in a discussion with the researcher to compare codes. There was agreement between the researcher and the independent coder on most of the codes.

Step 3 – Generating themes

In this step, relevant codes were sorted, collated and combined to form a main theme. Some themes were divided into sub-themes. Each theme captured issues that were important to the data in relation to the research questions. This represented some level of patterned response or meaning within the dataset (Xu & Zammit 2020:6; Castleberry & Nolen 2018:809). To ensure quality, a few elements were checked to confirm if they were indeed themes and not codes, if they were able to reflect something useful about the dataset or research question, the themes' boundaries and if there was enough meaningful data to support the theme, and if the data were too diverse. The themes were reviewed by other researchers to validate that the groupings were consistent with the raw data to achieve intercoder reliability (Castleberry & Nolen 2018:810).

Step 4 – Reviewing themes

This step involved reviewing and refining the themes by going back to the raw data and comparing the findings with the developed themes to make sure they were rooted in the data (Xu & Zammit 2020:6). In level 1 of step 4, data were read to ensure the data extracts formed a coherent theme, and in level 2 of step 4 it was determined whether the thematic map accurately represented the meanings in the data as a whole. The codes and themes were reworked to code additional data that were missed in previous coding stages, and it was confirmed whether the theme fit into the dataset. The researcher drew analytical conclusions from the themes (Castleberry & Nolen 2018:812).

Step 5 – Defining and naming themes

In this step, themes were defined and named in a concise and precise manner. The essence of each theme was determined and organised into a coherent and consistent account. Each theme was also slotted into a broader overall sub-theme to avoid

overlap (Xu & Zammit 2020:7). Defining and naming themes lead to interpretations and conclusions in response to the research questions (Castleberry & Nolen 2018:812).

Step 6 – Producing a report

Upon having a set of fully established themes, findings were written up. The themes that emerged from the data and prior research were analysed and discussed. The report included quotes that were captured directly from participants (Xu & Zammit 2020:7).

5.2 DEMOGRAPHIC FINDINGS FOR PHASE TWO

Two data collection methods were used in phase two: focus group discussions for youth aged 10 to 24, and individual interviews for service providers working at YFHS departments in the study sites. Focus groups were conducted with eight young people at three health facilities, and data saturation was achieved. The focus groups comprised four females and four males with age groups distributed as follows: 10 to 12 years - one male and one female; 13 to 16 years - one male and one female; 17 to 20 years - one male and one female; and 21 to 24 years - one male and one female.

Six YFHS providers currently working at the selected study sites were interviewed. Their demographic profiles are illustrated in Table 5.1.

Table 5.1: Demographic profile for the six service providers

Criterion	Characteristics	Frequency	Percentage
Age	20–24	0	0
	25–29	2	33.3%
	30–34	3	50%
	35 and older	1	16.6%
Gender	Male	2	33.3%
	Female	4	66.6%
Marital status	Married	1	16.6%
	Single	5	83.3%
Religion	Christian	6	100%
	Muslim	0	0

Criterion	Characteristics	Frequency	Percentage
	Other	0	0
Education background	Tertiary - Nurse Tertiary – other MSCE	2 2 2	33.3% 33.3% 33.3%
Years of experience in YFHS	1–2 3–4 5–6 7–Above	2 2 1 1	33.3% 33.3% 16.6% 16.6%
Type of training in YFHS	Facility briefing Training	5 1	83.3% 16.6%
When was training done?	Not trained 7 years before	5 1	83.3% 16.6%

5.3 THEMES AND SUB-THEMES

Eight themes were developed through the qualitative data analysis process, and the themes were linked to 28 sub-themes. The themes and sub-themes emerged from the analysis and interpretation of verbatim transcripts from individual interviews and focus group discussions. A summary of the themes and sub-themes is presented in Table 5.2.

Table 5.2: Themes and sub-themes

THEME	SUBTHEMES
Theme 5.3.1: Knowledge about SRH and YFHSs	5.3.1.1 Youths' knowledge of SRH issues 5.3.1.2 Youths' knowledge of YFHSs 5.3.1.3 Youths' sources of information
Theme 5.3.2: Views on the accessibility of YFHSs	5.3.2.1 How accessible are the YFHSs? 5.3.2.2 Services accessible at YFHSs 5.3.2.3 Factors that influence the accessibility of YFHSs
Theme 5.3.3: Motivating factors for the utilisation of YFHSs	5.3.3.1 Motivating factors for youths' utilisation of YFHSs 5.3.3.2 Motivating factors for YFHS providers

THEME	SUBTHEMES
Theme 5.3.4: Barriers to the utilisation of YFHSs	5.3.4.1 Shortage of medical supplies 5.3.4.2 Lack of entertainment, sporting activities and supporting equipment 5.3.4.3 Lack of dedicated space for YFHS provision 5.3.4.4 Youths' lack of knowledge 5.3.4.5 Financial constraints 5.3.4.6 Distance to the healthcare facility 5.3.4.7 Perceptions and misconceptions concerning YFHSs
Theme 5.3.5: Youths' preferences	5.3.5.1 Preferences for YFHS days 5.3.5.2 Preference in space for conducting YFHSs 5.3.5.3 Age preference for YFHS provider 5.3.5.4 Gender preference for YFHS provider
Theme 5.3.6: Attitudes of YFHS providers	
Theme 5.3.7: Current practices to increase the utilisation of YFHSs	
Theme 5.3.8: Suggestions to improve the utilisation of YFHSs	5.3.8.1 Availability of sporting equipment and medical supplies 5.3.8.2 Dedicated space for YFHSs 5.3.8.3 YFHS provision days 5.3 8 4 Age and gender of YFHS providers 5.3.8.5 Community sensitisation 5.3.8.6 Establishing youth clubs 5.3.8.7 Need for funding 5.3.8.8 Platforms for showcasing youths' talents 5.3.8.9 Promoting YFHS providers' competency

5.3.1 Theme 1: Knowledge about SRH and YFHSs

Participants shared the information they had regarding reproductive health issues and YFHSs. Three sub-themes emerged from Theme 5.3.1, and these are discussed next.

5.3.1.1 Sub-theme 1.1: Youths' knowledge of SRH issues

Focus group participants admitted that some youths had knowledge about SRH, and those who lacked this information may have been deterred from accessing YFHSs. In support, service providers also expressed during their interviews that not all the youths in the surrounding catchment areas knew about SRH and the availability of YFHSs.

Some of these participants went on the record as saying:

> *"Yeah… youths are knowledgeable about reproductive health issues through organisations such as MANASO but, I can say that not all the youths are knowledgeable"* (P1)
>
> "*Eeeh…I can say…many of them are knowledgeable through MANASO*" (P2)
>
> "*Ummh… There are some who are knowledgeable about reproductive health issues. I can say 50-50. Some get the knowledge through social media. An organization named MANASO established youth clubs and us the YFHS providers go to the youth clubs to teach the youth about RH issues*" (P6).

5.3.1.2 Sub-theme 1.2: Youths' knowledge of YFHSs

Some participants expressed that many youths in the study's catchment areas were knowledgeable about YFHSs. Some explained:

> "*Ummh…I can say…many youths are knowledgeable of YFHS as compared to those who do not know*" (P3).
>
> "*50 - 50 as well, …many are aware*" (P6).
>
> "*Eeeh...the youth are well knowledgeable about YFHS through the assistance of Health Surveillance Assistants*" (P4).
>
> "*I can say…many youths are aware about YFHS*" (P5).

Several previous studies also found that a lack of knowledge and awareness about SRH facilities for adolescents led to reduced utilisation of these health services (Abuosi & Anaba 2019:204; Eremutha & Gabriel 2019:40; Napit et al. 2020:4; Jain et al. 2017:1; Thongmixay et al. 2019:1; Nash et al. 2019:8; Pandey et al. 2019:1; Mattebo et al. 2019:7).

5.3.1.3 Sub-theme 1.3: Youths' sources of information

The participants expressed that their main source of reliable information on reproductive health issues was the health facilities. Some participants reported that they received information from parents and peers, noting that the information parents gave them was superficial. The following notable responses were received from the focus group discussions:

> "*Ahem…mostly we get the information from the hospital. Yes… parents do provide us with information but it is not rich. We get more information from the health workers*" (FGD 2, P6).

> "*As for me… I learnt about YFHS at the health centre from the health workers*" (FGD1 P1).

> "*As for me… ummh … I saw it on posters at different places then I decided to attend and see what happens there*" (FGD1 P6).

> "*Eeeh… I heard about YFHS from my friends*" (FGD1 P4).

> "*Ahem... Mostly we get the information from the hospital*" (FGD2 P6).

> "*Eeeh…I learnt about YFHS at the health centre*" (FGD3 P6).

> "*Yeah...Some of us learnt about YFHS from youth clubs*" (FGD3 P8).

Previous studies also found that youths received information from parents (Fasoranti et al. 2018:24) and, similar to the current study's finding, youths were uncomfortable

sharing SRH information with parents, just as most parents were reluctant to discuss SRH issues with their children (Napit et al. 2020:4).

Service providers attributed youths awareness of SRH and YFHSs to an NGO, the Malawi Network of AIDS Service Organization (MANASO). It establishes youth clubs in communities where education on reproductive health issues and the availability of YFHSs is provided.

5.3.2 Theme 2: Views on the accessibility of YFHSs

Participants shared information regarding the accessibility of YFHSs. Three sub-themes emerged from Theme 5.3.2, described as follows:

5.3.2.1 Sub-theme 2.1: How accessible are the YFHSs?

Participants reported that the services were accessible to youths, but the service providers explained not all youths in the catchment areas accessed the services. The general view was that the accessibility of YFHSs was limited. The providers indicated that the highest attendance rate was around 40 youths in a day; however, very few typically attended, especially if there was no entertainment or sporting activity taking place at the facility. Data collectors also observed at one health facility that only three participants attended YFHSs on a YFHS meeting day.

Some participants shared:

> "*Ummh… I can say yes… YFHS are accessible, but not all the youths in the catchment area access the services*" (P1).

> "*Yes…the services are accessible to some youths but not accessible to others due to distance and stock outs of supplies including contraceptives*" (P3).

> "*Yeah… YFHS are accessible. At first it was a challenge when they were completely separate services but this was changed and nowadays youths' access YFHS together with other services such as family planning services*" (P5).

"*Ummh… I can say it is accessible mainly because the providers are friendly despite some of us being of age*" (P6).

"*Other youths are selfish, they belittle what happens at YFHS they think they know it all"* (FG2, P4).

"*Some parents stop them because they think they will have chance to indulge in sexual activities when they go to youth clubs*" (FG3, P1).

"…*services are offered together with the adults where you can meet your father collecting condoms*" (FG3, P4).

"*We should have a place specifically for provision of services to youth everyday up to 5pm*" (FG1, P5).

5.3.2.2 Sub-theme 2.2: Services accessible at YFHSs

The youths indicated that they were able to access the following services: contraceptives, HIV testing services, STI treatment, general medical treatment, counselling on substance abuse, health education on different topics, and sporting and entertainment activities, as cited in the quotes below.

Coughs and clears throat. "*Ummh… We learn about many things including family planning*" (FGD1 P3).

"*Yeah…We also learn about HIV and AIDs, how we can prevent contracting it and also the importance of HIV testing*" (FGD1 P2).

"*Also, STI treatment*" (FGD1 P4).

"*Mmmh…We also receive education on different types of abuse*" (FGD1 P5).

"*Eeeh…we also do physical activities such as netball, football and sometimes dancing*" (FGD1 P8).

"*We receive education on a lot of things at YFHS such as how to prevent pregnancy and how to get rid of sexual desire*…" (FGD 2, P8).

"*Eeeh…When we become sick, we are assisted promptly by the health workers*…" (FGD 3, P5).

5.3.2.3 Sub-theme 2.3: Factors that influence the accessibility of YFHSs

The service providers indicated that several factors positively influenced the accessibility of YFHSs. In some areas, NGOs, such as MANASO and JEPIEGO, were involved in sensitising the youths on reproductive health issues and YFHSs, which positively contributed to the services' accessibility.

This finding was supported in a study conducted in Indonesia, where access to YFHSs was mainly determined by individuals' knowledge of the programme and perceived demand (Arifah et al. 2020:164).

Some NGOs occasionally sponsored youth sports bonanzas or organised music shows. This increased accessibility to YFHSs on such days because many youths who came to attend the bonanzas also accessed YFHSs. Some communities also have functional youth clubs led by youth champions, playing a role in attracting youths to YFHSs. In some places, the youth champions conduct awareness campaigns during youth-organised self-help activities such as market sweeping, which also assisted in promoting the accessibility of YFHSs.

The participants noted that various contraceptive methods were not always available due to stockouts, and the only contraceptive that was always available was condoms. This negatively affected participants' views on the accessibility of YFHSs. They also said there were limitations due to factors such as a lack of dedicated space for YFHSs, a lack of privacy, and long distance to the health facilities. Other participants cited a lack of knowledge about YFHSs among youths, and a lack of money to contribute

towards recreational activities, such as balls for football. However, it also transpired that some youths were unwilling to access YFHSs because they considered it unimportant. Some parents also did not allow youths to access YFHSs because they thought the youth would then find opportunities to indulge in sexual activities.

One issue that emerged repeatedly as contributing to the inaccessibility of YFHSs was the lack of activities such as sports and entertainment to attract youths. Some participants said:

> "*Eeeh…We have what we call Youth champions in the communities who sensitize youths about YFHS. Sometimes there are youth bonanzas organised by some NGOs such as Jhpiego which provides reproductive health education to youths aged 15 to 24 in the communities. This somehow contributes to accessibility of YFHS*" (P1).

> "*Ummh…I think…community sensitization about YFHS by an organization called MANASO and youth groups assist quite a lot*" (P2).

> "*I can say… mainly, it is distance to the health facility and availability of supplies such as contraceptives*" (P3).

> "*Yeah…It is because…we have hard-working and non-judgmental YFHS providers and there is also monitoring and evaluation of YFHS*" (P4).

> "*Eeeh… because many youths did not know about YFHS, we conducted awareness campaigns through music shows and we also provided awareness messages through market cleaning activities by the youth, and through awareness messages to youth in reachable primary and secondary schools. This helped to bring more youths to YFHS*" (P5).

> "*But...some find it difficult to access YFHS because, at first, we had a youth corner and it was taken away during COVID era and now there is no youth corner, so youths are shy to access services with adults and some return home without receiving help for instance those with STIs*" (P6).

"*Ummh… As I have already indicated, the openness and friendliness of providers make youths continue coming to attend YFHS*" (P6).

The findings of this study are similar to those of other studies conducted in Nepal, Ghana, Nigeria and Malaysia, where a lack of physical access or dedicated space for the provision of YFHSs affected the services' accessibility (Pandey et al. 2019:1; Abuosi & Anaba 2019:201; Envuladu et al. 2021:1369; Awang et al. 2022:61).

Participants in the current study also mentioned their socioeconomic status or financial accessibility were factors that influenced YFHS uptake. These findings corroborate those of studies conducted in northern Sweden and the Enugu state in Nigeria (Mosquera et al. 2017:20; Odo et al. 2018:92), where youths mentioned they lacked money to pay for services. However, in the present study, the youths indicated that they sometimes did not access YFHSs because they lacked funds to contribute towards sporting equipment, such as balls. The youths opted to contribute to these purchases because they lacked sponsors for such items. In the process, some youths stopped accessing YFHSs.

5.3.3 Theme 3: Motivating factors for the utilisation of YFHSs

Participants shared information regarding motivating factors for the utilisation of YFHS. Two sub-themes emerged from Theme 5.3.3, discussed as follows:

5.3.3.1 Sub-theme 3.1: Motivating factors for youths' utilisation of YFHSs

The participants explained that several factors motivated them to continue attending YFHSs. This included the health information they received on the prevention of diseases like sexually transmitted ones and unwanted pregnancies. What motivated youths to attend YFHSs is exemplified by the following quotations:

"*Yeah… "We learn different things such as how to use condoms correctly… use of emergency contraceptive pills, we also learn about HIV and AIDs, how we can prevent contracting it and also the importance of HIV testing*" (FGD1 P1).

"*True…We learn many new things… issues like fistula for girls of which other youths do not know about and we are also given teachings on how to prevent pregnancy*" (FGD1 P2).

"*As for me… It is good because it helps in prevention of diseases such as STIs and unwanted pregnancies*" (FGD2 P4).

"*Eeeh…It helps the government reduce the budget*" (FGD3 P2)

"*Ummh…It is also good for population control and at the moment, it is helping because people are not having many children as before*" (FGD3 P7).

Youths also expressed that they were motivated to continue utilising YFHSs because they easily access other healthcare services as well when they need these services, even on days not specifically dedicated to YFHSs. The youths explained that they learnt good behaviour and they learnt life skills from fellow youths, as illustrated in the following quotes:

"*Ummh…When we become sick, we are assisted promptly by the health workers*" (FGD3 P5).

"*Ahem…I can just say we receive teachings on different things including good behaviour*" (FGD3 P2).

The focal persons said that youths were motivated to attend YFHSs by friends and activities such as football games, career shows, and poetry readings, which were organised monthly in some health facilities. The focal persons agreed with the youths that the service providers made it easy for them to access other services when the youths needed these on days not specifically for YFHSs, as quoted below:

"*Ummh… I think…they are mainly motivated by friends*" (P1).

“*Mainly … it is activities such as football, career shows, poems these are done monthly*” (P2).

“*I believe...teamwork among health care workers helps and the fact that the doctor is available when the youth report to the health facility when they are sick*”. (P3).

“*Ummh… it is the activities such as football, music shows and any entertainment activity*” (P5).

5.3.3.2 Sub-theme 3.2 Motivating factors for YFHS providers

The service providers shared different factors motivated them to continue working with the youths at YFHSs. Some were motivated by their own experiences with the youth, which increased their desire for youths to do better and have a bright future. Others were motivated when more youths came for YFHSs and showed an eagerness to learn. Some were motivated by the passion they had for the youths, while others served as role models to the youths. One focal person said they were motivated by the quest to be put on the map for issues related to successful YFHS provision. Some of the notable responses follow:

laughs… “*my personal experience as a youth. I had some problems which hindered my wishes, so I want youths to do better than me*” … smiles (P1).

“*I get motivated by the willingness to learn new things by the youth and also… role modelling to the youth so that they achieve their dreams*” (P3).

“*I get motivated because I want to contribute to a bright future for the youths, I continue working hard for the health facility for our health centre to be put on the map regarding YFHS… laughs*….” (P4).

“*As for me…I get motivated to continue working with the youth because I know there are some issues where youths can cannot be open with their parents and guardians but they can freely talk to me about them and be assisted*” (P6).

Conversely, the service providers explained they sometimes became discouraged while working at health centres for different reasons, such as few youths attending YFHSs, frequent stockouts of supplies, a lack of support from other staff, insufficient involvement from NGOs, a lack of transport to attend youth clubs in remote areas, and YFHSs not being seen as a priority or considered very useful by management. Some notable responses from the YFHS provider interviews follow:

> "*Ummh … I really get demotivated when I receive inadequate support from superiors and fellow staff on issues to do with YFHS*." (P3).

> "*In life, there will always be things that will demotivate you. Laughs… I get discouraged when few youths attend YFHS and when there are poor interpersonal relationships amongst health workers*" (P5).

> "*Yes… there are some issues that demotivate us, especially when YFHS is not taken as a priority, or as not useful by our superiors. For instance, we just gave up asking for space for conducting YFHS. It was very difficult even to get an open space for the services because superiors do not take YFHS serious*" (P6).

One focal person stated that she was discouraged from continuing to work at the YFHS department due to her spiritual beliefs. She said her inner self told her it was wrong to give contraceptives to young people, but she continued to work there when she also considered the benefits of contraceptives to the youth. She said:

> "*Honestly…it conflicts with my conscious and beliefs and sometimes I feel wrong doing it but I also look at the benefits of family planning to the youth and continue providing the service*" (P6).

5.3.4 Theme 4: Barriers to the utilisation of YFHSs

Participants in the present study expressed that there were several barriers to the utilisation of YFHS. A total of seven sub-themes emerged from Theme 4.

5.3.4.1 Sub-theme 4.1: Shortage of medical supplies

The youth participants reported that resources such as certain contraceptives were not always available. The only contraceptive method that was always available in all the health facilities was condoms. This caused some youths to be discouraged from seeking contraceptives.

The service providers from all the health facilities confirmed that there were frequent stockouts of supplies, including contraceptives. They also confirmed that only condoms were always available in the health facilities. The findings were consistent with previous studies where barriers to the utilisation of YFHS included inconsistent supplies of contraceptives, a lack of diagnostic facilities, and medicines (WHO 2021:25). Some participants were quoted as saying:

> *"Ummh… Some youths maybe they stop coming because the method they want is sometimes not available. It is only condoms that we always find available...they can get condoms from community distributors"* (FGD1 P3).

> "*Yeah …also… lack of contraceptive methods that some youths want. Some youths maybe they want the injection method but they are returned that it is not available two, three times. Due to that some youths will not come back*" (FG3 P5).

> "*Also… supply of the contraceptives. Sometimes preferred contraceptive methods are not always available. This discourages some youths and they stop coming to YFHS*" (P1).

> "*Eeeh... This health centre has a big catchment area which makes it difficult for youths to walk long distances worse still not find their contraceptive method of choice. For example, one comes for an injectable contraceptive and finds it out of stock, it will be difficult for them to return*" (P5).

5.3.4.2 Sub-theme 4.2: Lack of entertainment, sporting activities and supporting equipment

Youth participants reported that they took sporting and recreational activities so seriously that they would prefer attending sporting and recreational activities rather than attending YFHSs, which mainly concern their own health education and the supply of contraceptives. They further noted that if these activities were available and offered alongside YFHSs, many youths would come for the activities, and the service providers would have an opportunity to provide health information, contraceptives and other services.

The service providers corroborated that sports and other recreational activities, equipment and materials such as balls, game boards, and ropes were lacking and, in turn, demotivated youths from utilising the YFHS in their areas. Some observations follow:

> "*Eeeh… Some youths maybe because of lack of resources for sports such as balls, bawo and they think they will be bored when they come to YFHS*" (FGD1, P4).

> "*Ummh… maybe for some youths, there is nothing to attract them to come. There are no sporting materials like balls for football or netball therefore the youths think they will be bored when they come*" (FGD 2 P6).

> "*Okay… a youth is like a child. He will go where there are games as opposed to where there is health education only. As such, we need to have balls and other resources such as game boards, playing cards. These should always be available at the health centre*" (FGD2 P5).

> *"It is difficult to gather youths in town unless there is an activity to attract them. Youths cannot come for health education all the time without things like football, netball. They may say "if I go to YFHS, it will just be health education all the time: then it is as good as going to school"* (P5).

"Ummh…as I have already said, there is no entertainment, sports and equipment such as balls, game boards playing cards, ropes hence the youth feel bored, TV screen" (P6).

This finding, although not common in literature, emerged as one of the biggest barriers that prevented youths from utilising YFHSs in all sites in the current study.

5.3.4.3 Sub-theme 4.3: Lack of dedicated space for YFHS provision

Participants from all the sites selected for this study said that there was no special room or dedicated space for YFHS provision. They specified that YFHSs were provided in areas used for other activities when such activities were not in session. At Health Facility 1, for example, YFHSs were offered outside an ART clinic in the afternoons or during weekends. Similarly, at Health Facility 2, they were being conducted at the outpatient department on Sundays because outpatient services are not offered on Sundays. At Health Facility 3, the antenatal block was used for the services, while at Health Facility 4, they were being offered in an open space within the health facility's property. These spaces made the youths uncomfortable to discuss their SRH challenges, as their privacy was being compromised. Some youths lamented:

"*Ummh … Some youths maybe are just shy or afraid to be seen at YFHS by people who know them, maybe friends of their parents… because we have our activities mainly outside as there is no office for YFHS*" (FGD1 P4).

"*Also…maybe some youths are just shy to come fearing they will be seen, also considering that we do not have a special room or corner where we provide YFHS*" (P2).

"*Yeah…another reason could be that we have no specific place for YFHS and we conduct our services on an open space…some youths may feel shy to come fearing people who know them will see them and maybe report them to their parents*" (FGD3 P5).

These findings were consistent with previous studies where youths lacked separate rooms or dedicated spaces to receive YFHSs to maintain their privacy (Abuosi & Anaba 2019:200; Mattebo et al. 2019:7; Napit et al. 2020:6).

5.3.4.4 Sub-theme 4.4: Youths' lack of knowledge

Participants lamented that a lack of knowledge among the youth was one of the barriers to their utilisation of YFHSs, as revealed in the following responses:

> "*Yes… some youths don't come maybe because they don't know about YFHS*" (FGD1 P8).

> "*Ummh… I think to some youths, it is because they don't know about YFHS and its benefits. For example, us who attend YFHS we know things like how to use condoms correctly, …we know things like emergency contraception… we learn quite a lot when we come to YFHS*" (FGD 2 P3).

> "*Yeah... some youths just belittle what happens at YFHS. they think they know everything. Some think all we do is talk about contraceptives and they think they will become promiscuous that is why they don't come*" (FGD 2 P4).

> "*Ummh… Some youths ask us questions like… 'what are we going to benefit there? Are we going to be paid?'*" (FGD3 P3).

5.3.4.5 Sub-theme 4.5: Financial constraints

Financial constraints also emerged as one of the factors deterring some youths from attending YFHSs. One of the youths, for example, said:

> "*Ummh… I would say lack of money for contributions for buying balls and other equipment prevents some youths from coming to attend YFHS because we don't have these materials at YFHS hence as youths, we opt to contribute money to buy the balls ourselves…So if they don't have money to contribute, they don't come*" (FGD1 P2).

5.3.4.6 Sub-theme 4.6: Distance to the healthcare facility

Participants also identified distance as a barrier to their utilisation of YFHSs because some catchment areas were very large. It was determined that some catchment areas were hilly, making mobility very difficult, thereby preventing the youths from attending YFHSs. The following responses substantiate this observation:

> "*For some…long distances to health facility and the hilly geographical areas that surround the health centre prevent them from coming*" (P2).

> "*Eeeh... This health centre has a big catchment area which makes it difficult for youths to walk long distances worse still not find their contraceptive method of choice. For example, one comes for an injectable contraceptive and finds it out of stock, it will be difficult for them to return*" (P5).

A scarcity of YFHSs caused by geographical barriers was also reported in previous studies (Thongmixay et al. 2019:1).

5.3.4.7 Sub-theme 4.7: Perceptions and misconceptions concerning YFHSs

The participants were of the view that some youths are guided by myths and misconceptions regarding the use of contraceptives. During focus group discussions, it transpired that some youths had misconceptions that a girl who takes contraceptives will not be sexually active, will become infertile, contraceptives will affect the normal functioning of the female body, and will reduce the male libido. The following quotes reflect what some participants had to say:

> "*Ummh…the woman will not be sexually active…we also hear the women who use contraceptives are not sweet*" (FGD1, P4).

> "*Yeah...I feel it is not good because we hear all sorts of things about a woman who uses contraceptives. For example, some people say the woman will lose their libido*" (FGD1 P3).

“*Yes…it is true. I’m also of the view that it is not good, because I have also heard that girls who use contraceptives become barren*” (FGD1 P6).

“*Laughs… It is not good indeed because some people also say contraceptives reduce male libido*” (FGD1 P4).

“*Ummh…some youths say it is not good because it will make the girls barren” (FGD2 P3).*

Similar findings were also found in previous studies (Nash et al. 2019:8; Muula et al. 2015:1). Moreover, apart from myths and misconceptions, some youths’ attitudes prevented them from utilising YFHSs. Some youths, for instance, belittled the services and believed they had outgrown them. Participants also stated that some youths were just too shy to attend YFHSs, based on communities’ misconceptions regarding YFHSs and the use of contraceptives among the youth. One response, for example, was that:

“*Yeah… some youths just belittle what happens at YFHs. they think they know everything. Some think all we do is talk about contraceptives and they think they will become promiscuous that is why they don’t come*” (FGD1 P4).

The participants also stated that many parents and the community, in general, passed their misconceptions about the utilisation of YFHSs and contraceptives onto the youth. This makes it very difficult for them to allow their children to access YFHSs. They noted that parents believed contraceptive use among young girls would lead to infertility, prostitution and, generally, bring harm to the girls’ bodies. The participants expressed that the overall community negatively viewed young girls’ contraceptive use, thinking it would encourage sexual immorality. The participants, however, noted that the misconceptions were mainly focused on girls; therefore, they were not a big challenge for boys. Some participants shared:

“*Ummh… many parents say contraceptives are not good for girls because their use will lead to prostitution*” (FGD 1 P1).

“*Yes… many parents also refuse because they believe it will lead to barrenness among girls*” (FGD1 P2).

“*Eeeh… most of the parents believe youths are young and contraceptives will harm their bodies such as making them barren*” (FGD2 P4).

“*Ummh… many parents are not happy with provision of contraceptives to the youth. They perceive a youth accessing contraceptives as being sexually immoral especially for girls*” (FGD3 P3).

“*Ummh…mostly, the community considers youths accessing contraceptives as being sexually immoral*” (FGD2 P2).

“*Yes… it is true*!” (In a chorus) (FGD2 all Participants).

“*It is not a big challenge for the boys but for girls eeh… it is a great challenge*” (FGD 3 P5).

Unfavourable perceptions among parents were also found in previous studies (Kinaro et al. 2015:85; Self et al. 2018:108; Abuosi & Anaba 2019:202). Notably, a previous study in Kenya determined there were many youth-related misconceptions regarding SRH issues. It transpired that the misconceptions were a mixture of biological and sociological issues concerning contraception, and the youth strongly believed these misconceptions (Mwaisaka et al. 2020:4).

5.3.5 Theme 5: Youths’ preferences

Participants reported meeting on different days. In Health Facility 1, YFHS days were Wednesday and Sunday from 14:00; Facility 2 offered the services on Sundays from 14:00 to 17:00; Health Facility 3 offered the services Fridays from 14:00 to 16:00; and Health Facility 4 offered the services on Saturdays from 15:00 to 17:00.

Once a month, the service providers provided health services, including health education, to the youth. The participants in all the health facilities that were studied

further explained that they received support from the YFHS focal persons on weekdays.

Regarding their preferences, participants from all the health facilities preferred to attend YFHS activities on weekends, considering that some went to school and others were busy with other activities on weekdays:

> "*Sunday afternoon is perfect as it does not burden anyone*" (FGD2, P3)

> "*Saturday is fine and it has to be at the hospital and not at school or in the village*" (FGD3, P2)

> "*Time should be in the afternoon after youths are done with house chores*" (FGD3, P6)

Previous studies contradict the present study's findings, where operating hours, increased waiting times, and opening times that collided with school hours did not emerge as a barrier to the utilisation of YFHSs (Ninsiima et al. 2021:14).

5.3.5.1 Sub-theme 5.1: Preference for YFHS days

Most participants expressed that they had no problem with the days on which YFHSs were provided. However, some participants preferred to have the services available daily.

> "*We meet on Saturday afternoon from 2 pm" (FGD1 Participants in a chorus*).

> "*Emmh…Saturday is convenient for most of us and we have had no problem meeting on this day also considering that it is in the afternoon when we have finished home chores*" (FGD1 P3).

> "*Eeeh… we meet on Sunday afternoons at the hospital at the Out-patients department*" (FGD2 P2).

"*Ummh…Sunday afternoon is perfect with us because it does not burden anyone. Those who go to church on Saturday are available and those who go to church on Sunday are also available. It is after we have finished our chores at home*" (FGD2 P3).

"*I think… they should provide YFHS even on weekdays so it is easy for us if we have a problem during the week*" (FGD2 P6).

"*Yes...we are happy with Saturday because if it is on Sunday, many youths do not come maybe because they are washing ready for school on Monday, therefore we would be happy if YFHS were also provided in week days*." (FGD3 P3).

"*Mmmh… regarding time, the afternoon is okay because we are done with home chores*" (FGD3 P6).

5.3.5.2 Sub-theme 5.2: Preference in space for conducting YFHSs

Participants expressed that they preferred having a designated place for YFHSs. Some shared:

"*Ummh…We meet outside ART clinic because there is no other place for YFHS. It would have been better if the health centre had an office where we could receive all services as youths even during the week*" (FGD1 P2)

"*Ummh…Since we do not have a special room for YFHS, when we come during week days there is lack of privacy and confidentiality in provision of services because they are offered together with the adults where you can bump into your father while collecting condoms*." (FGD1 P2).

"*Here... we meet on Saturday afternoon, around 3pm at an open space and we prefer YFHS to be at the hospital rather than at school or in the village*". (FGD2 P2).

"*Ummh…As for the place, it could be better if we had an office or room for YFHS where all services are provided in one place*" (FGD2 P3).

"*I believe… a specific room for YFHS would be better for us rather than the open space where we are currently meeting because some youths can fear being seen… If possible, our own room where we can receive all YFHS from Monday to Friday*" (FGD3 P4).

"*Eeeh…we should have a designated space for YFHS at the health facility so that we provide privacy to the youth who come for the services*" (P4).

5.3.5.3 Sub-theme 5.3: Age preference of YFHS provider

Participants in all the focus groups said that they preferred youthful providers offering YFHSs, as reflected in the following responses:

"*Eeeh… I would prefer a fellow youth because I know I can be free to talk about anything*" (FGD1 P1).

"*Yes… I also prefer fellow youths because you cannot feel shy with a fellow youth*" (FGD1 P2).

"*It is the same… better fellow youths than older people*" (Participants in a chorus).
"*As for me, Ummh… I prefer youthful health workers because I can easily open up with a fellow youth*" (FGD2 P5).

"*Yeah! I agree, I also prefer youthful health workers*" (FGD2 P6).

"*I would choose youthful workers because you cannot feel shy with a fellow youth*" (FGD3 P4).

"*As for me… I prefer a youthful provider because I can be more open with a fellow youths*" (FGD3 P3).

5.3.5.4 Sub-theme 5.4: Gender preference for YFHS provider

In terms of service providers' gender, most participants preferred to have providers of both genders offering YFHSs. However, some did not mind any gender. Many youths preferred healthcare providers of the same sex because they said they open up more easily to these individuals. Some said:

> "*Ummh…YFHS focal persons should be both male and female because some youths are shy and therefore feel uncomfortable to discuss some of their problems with providers of the opposite sex*". (FGD1 P2).

> "*As for me… I would rather be seen by a fellow man because I will be freer. Of course, not that a female provider cannot see me but I think it is better to have both genders for the sake of those who feel uncomfortable with the opposite gender*" (FGD2 P2).

> "*Yes… I think it is better to have female and male providers*" (FGD2 P6).

> "*Ummh… If we were to choose, I would choose a fellow female provider. I would not feel shy with such a provider than a male provider*" (FGD3 P5).

> "*I think… it is better to have female and male providers at YFHS*" (FGD3 P7).

> "*YFHS focal persons should be both male and female because some youths are shy and therefore feel uncomfortable to discuss some of their problems with providers of the opposite sex*". (P2).

A previous study had similar findings where adolescents preferred same-sex providers (Napit et al. 2020:6).

5.3.6 Theme 6: Attitudes of YFHS providers

The study's participants expressed satisfaction with the attitudes of service providers. They indicated that the service providers were accommodative, friendly, welcoming,

non-judgemental, and generally treated the youths respectfully. The participants stated that the providers' attitudes encouraged the youths who were attending YFHSs to continue accessing the services.

The participants also expressed that the providers not only welcomed them during the weekends when they were offering youth-specific activities but also on weekdays when the youths came to the health facility with other illnesses.

The service providers corroborated these views that they were accommodative and open with the youth, which encouraged the youths to be open with the providers. Some of the providers said:

> "*Well… it depends on who is on duty but in general they all welcome us well*" (FGD1 P3).

> "*Eeeh… we do not have any issues with them. They welcome us well and they listen to our problems* (FGD2 P5).

> "*Yeah…They are friendly to us too*" (FGD2 P2).

> "*Yes… they also treat us well when we come to hospital with other problems on days that are not for YFHS*" (FGD2 P6).

> "*Ummh…on that one, there is no problem… they are generally friendly to us despite that some are older than us*" (FGD3 P1).

> "*Yes...they welcome us well even when we come during the week for other services*" (FGD3 P2).

A similar finding was reported in Bangladesh, where unmarried adolescents who accessed AFHCs expressed satisfaction with service providers (Ainul et al. 2017:1). Significantly, however, the findings of the present study contradicted most previous studies where provider attitude was found to be a barrier to the utilisation of YFHSs and the biggest challenge for youths. The common characteristics youths demanded

from YFHSs in previous studies were to be treated with respect and to protect their confidentiality, which did not emerge as a problem in the current study (WHO 2012:5; Pastrana-Sámano 2020:1; Napit et al. 2020:6; McKinlay et al. 2021:160; Ninsiima et al. 2021:14; Anokoye-Mensah 2019:1; Nash et al. 2019:1; Muula et al. 2015:1; Mattebo et al. 2019:7; Abuosi & Anaba 2019:203).

5.3.7 Theme 7: Current practices to increase the utilisation of YFHSs

Participants reported the health facilities offered different activities. Some facilities pasted posters in various places informing youths about activities that were taking place at the health facilities. Some worked with NGOs like MANASO, offering reproductive health information to youths in communities. Information about YFHSs was also given during HCT clinics.

Some facilities initiated a 'bring a friend' campaign. The focal persons also put aside supplies to cater for the youths. At one health facility, they conducted a staff meeting to encourage staff to provide SRH services to youths in a non-judgemental manner. At another facility, the focal people, in conjunction with some youths, organised a get-together and invited many youths to accompany them, while some provided a small monetary incentive to a person who brought a friend, and according to how many friends they brought. The following extracts from the analysed data reflect this:

> "*We paste posters on different places showing that we provide YFHS, services that we offer and on which days. We also lobby from partners such as MANASO to help us give messages about YFHS in the communities*" (P1).

> "*We work with organizations such as MANASO; We provide information about YFHS during HCT clinics and we also conduct what we call… bring a friend campaign*" (P2).

> "*Mmmh…we just continue to provide services to the youth and we put aside supplies for the youth sometimes*" (P3).

> "*Ummh...not much. Youth trainings are not done; supervision is not done*" (P4).

"*Yeah! one reason why youths shunned YFHS was because some providers were judging the youths… say a 12-year-old girl reports to YFHS then find a judgmental provider: this girl will not return for more services. Sometimes, the girls would meet people they know who report them to their parents which gave them problems at home. To deal with such problems, we made the services to be private and started having the services on Friday. As for staff, we discussed with management and a staff meeting was conducted to encourage staff to provide services to the youth without judging them. Since that time, things improved*" (P5).

"*Ummh… We use a 'bring a friend' campaign. The one who brings a friend is given a token of say K200 per person, multiplied according to number of friends brought. Sometimes, we arrange get togethers where we encourage the youths to bring their friends*" (P6).

5.3.8 Theme 8: Suggestions to improve the utilisation of YFHSs

The participants proposed several strategies that could increase the utilisation of YFHSs, which are discussed below.

5.3.8.1 Sub-theme 8.1: Availability of sporting equipment and medical supplies

Participants recommended that balls, game boards, and other recreational activities should be made available to them by the health facilities. They also recommended that medical supplies such as contraceptives should always be available because it was discouraging for youths to encounter frequent stockouts of their preferred contraceptive methods; some youths gave up on the process. Participants suggested that health facilities supply sporting and recreational equipment because the health facilities could use sports, games and other recreational activities to attract youths. They also suggested sports days at the facility, with competitions among youth clubs. The YFHS focal persons could seize these opportunities to provide education to the youth on different topics affecting them, provide counselling services, and other services such as contraceptives. The youth participants further suggested that partners

should be involved to assist with medical supplies and sporting materials, such as balls and sports uniforms.

"*The YFHS Focal persons also recommended provision of sports and recreation equipment at the health facilities as this would attract more youths to attend YFHS. The following extracts represent these sentiments: "Eeeh… they should use activities that attract the youth such as football, netball, disco to bring them to YFHS. If they provide all these, many youths will come to attend YFHS*" (FGD1 P3).

"*Ummh…The government should provide enough supplies to the health centre. For example, contraceptives because it is discouraging when some youths find that the method which they want is not there… they may not return because of that*" (FGD1 P4).

"*Okay… a youth is like a child. He will go where there are games as opposed to where there is health education only. As such, we need to have balls and other resources such as game boards, playing cards. These should always be available at the health centre*" (FG2, P5).

"*There is need to have constant supply of contraceptive methods so that the youths are not returned because of these frequent stock-outs*" (P3).

"Ummh… *contraceptives should always be available. There shouldn't be situations where youth are returned because their method of choice is not available*" (P4).

"*We should also attract the youth with activities such as football, netball…also some games like bawo and the health centre should provide balls for football or netball and other games*" (P4).

"*You know… In town, there are many entertainment opportunities hence youths would rather go to places where there is recreation. Therefore, there is need to*

provide more entertainment, such as television, football and other games at YFHS" (P5).

"*Yes…as already mentioned, the youth like sporting activities. But as of now, we don't have balls and we use borrowed balls. We need our own balls and Jerseys. Maybe you can also support us with balls*." (FGD3 P1).

5.3.8.2 Sub-theme 8.2: Dedicated space for YFHSs

Youth participants suggested that health facilities should allocate dedicated space, such as a special room or youth corner, where YFHSs could be provided. This recommendation was also made by YFHS focal persons. The youth participants further recommended that the dedicated spaces should be one-stop centres, where the youths could receive all the services they require at a health facility. Some added that an office for YFHSs was required. These sentiments are reflected in the extracts below:

"*Yeah…the government should provide us with a place specifically for provision of YFHS. This place should be used for the youth services everyday up to 5pm*" (FGD1 P2).

"*Ummh… we should have infrastructure for YFHS at the health centre rather than conducting YFHS outside ART clinic*" (P2).

"*Ummh… we should have a special room for YFHS which should be a one stop centre for the youths at the health centre and should be open for the youth even on working days*" (FGD2 P2).

"*We should have a special room or a youth corner for YFHS at the health Facility"* (P3).

"Ummh…there is need for a youth corner or a special room for conducting YFHS" (P5).

"Every hospital should have a youth corner" (P6).

"*Eeeh...there should be a designated room for YFHS at the health facility for YFHS*" (FGD 3 P2.)

5.3.8.3 Sub-theme 8.3: YFHS provision days

Youth participants, as well as YFHS focal persons, recommended that YFHSs should be provided throughout the week at designated youth corners. The following extracts reflect this view:

"*We should have a place specifically for provision of YFHS everyday up to 5pm*" (FG1, P5).

"*There should be a one stop centre for the youth at the health facility even on working days*" (FG2, P8).

Eeeh…we should have a designated space for YFHS at the health facility so that we provide privacy to the youth who come for the services" (P4).

"*Ummh… a special room should be provided. It can be an office or room for YFHS where all services for youth can be provided in one place*" (FGD3 P3).

5.3.8.4 Sub-theme 8.4: Age and gender of YFHS providers

Youth participants also recommended having youthful staff at the youth corner with their genders being part of the consideration, since some youths were too shy to interact with a provider of the opposite sex. Participants mentioned:

"*Ummh…there should be more youthful service providers at the YFHS so that the youths are free to talk about their problems to a fellow youth*" (FGD3 P3)

"*Ummh… The health facilities should have both male and female service providers so that youths are free to choose the preferred gender*" (FGD1, P2).

5.3.8.5 Sub-theme 8.5: Community sensitisation

The participants recommended that community sensitisation activities about YFHSs should be conducted by YFHS focal persons together with some youths. The argument was that, done this way, the sensitisation activities could enable parents to get to know what YFHSs are about, thereby dispelling misconceptions among the youth, their families, and the community in general. The participants also recommended conducting YFHS sensitisation using the radio or television, with programmes involving the youth informing their peers about these services. They also recommended that pictures showing youth gatherings at YFHSs should be taken and posted on social media for peers to see. Others recommended sensitisation sessions in schools. YFHS focal persons suggested greater engagement from community leaders besides conducting community sensitisation sessions. This is what some of the youths and YFHS focal persons said:

> "*I think… they should intensify community sensitization about the importance of YFHS in the communities*" (FGD2 P4)

> "*I also think …a group of youths should encourage fellow youths in the communities*" (FGD2 P1)

> "*Ahem…community sensitization should be intensified by the health centre staff, or us youths informing fellow youths about YFHS and the importance of YFHS*" (FGD3 P3)

> "*Yes...maybe some youths would develop interest when they see fellow youths giving them information about YFHS as such, a group of youths should be used to encourage fellow youths in the communities*" (FGD3 P6)

> "*Conduct sensitizations in schools as well, with some motivation*" (FG3, P1)

> "*Ummh… I think providing awareness/ sensitization about YFHS at national level through radios, television can be helpful*" (P6).

5.3.8.6 Sub-theme 8.6: Establishing youth clubs

Some participants recommended forming youth clubs in remote areas, which could provide YFHSs and other activities that were being offered at health centres. They explained that service providers could provide outreach services once a month. Thus, the youth could come to the health facility only when there is a need for medical assistance. This would assist youths who fail to attend YFHSs due to long distances to access health facilities. One of the participants, for example, said:

> "*Ummh…we also need to help the youth to create youth clubs in the community, where condoms will be provided and some YFHS activities will be done. Whenever they need services of a provider, they can call us and we can also routinely supervise the youth maybe once a month*" (P5).

5.3.8.7 Sub-theme 8.7: Need for funding

Some participants expressed the need for funding for YFHS activities and supplies. The participants were of the view that activities such as bonanzas or shows for youths would attract more youths to attend, and the availability of funding would help the health facilities buy sporting equipment such as balls and some games. The process would enable YFHS providers to give health information to more youths in a light environment created by games that they would be playing with them. Extracts that capture these thoughts follow:

> "*Ummh…We also need funding for our activities like other YFHS which are funded by organisations such as UNECO, Mother to Mother, Partners in Health*" (P5).

> "*Ummh… I would say lack of money for contributions for buying balls and other equipment prevents some youths from coming to attend YFHS because we don't have these materials at YFHS hence as youths, we opt to contribute money to buy the balls ourselves…So if they don't have money to contribute, they don't come*" (FGD1 P2).

5.3.8.8 Sub-theme 8.8: Platforms for showcasing youths' talents

The youth participants also recommended the provision of a platform for youths to showcase their talents, such as music and drama. Some of them, for example, proposed organising music shows for the youth. The thinking was that such platforms would gather many youths, making it easier for focal persons to share their health education messages. YFHS focal persons expressed similar views:

> "*Grant youth opportunities to showcase their talents such as art drama and other talents. These would attract many youths to come and see the talents in the process they can also hear about the education messages*" (FG3, P2).

> "*Yeah…also bring role models with talents like singing poem writers to YFHS. Some youths apart from getting motivated in the talents, they will also access the services*" (P5).

Other recommendations included distributing leaflets at youth corners for the youth to read at home and share with others who might be ignorant about YFHSs, and organising exchange visits between YFHS groups from different health facilities to learn from each other as ways of bringing more youths to YFHSs.

The focal persons recommended training and orientation for all cadres of healthcare providers on YFHS so that all healthcare workers have a positive attitude towards the youths. They also recommended refresher courses for YFHS focal persons to acquire new information and exchange visits for focal persons to learn from colleagues. Some mentioned:

> "*Sometimes youth know current information than us and it is very embarrassing*" (P6)

> "*We should have exchange visits with other YFHS groups so we can learn from each other*" (FG1, P7)

5.3.8.9 Sub-theme 8.9: Promoting YFHS providers' competency

Some participants expressed the need for proper training among YFHS providers for them to continue handling this population group appropriately. All the providers in the current study, despite not having proper training, had undergone some orientation on how to work with young people. This was possibly why all the health centres that were studied had no participants reporting negative attitudes towards young people. The following extracts from the service providers speak volumes about their views on the importance of the training:

> "*I think…proper trainings for YFHS providers or focal persons can help and exchange visits for providers should be conducted so that we learn from each other*" (P2).

> "*Proper training of all YFHS focal persons would make us more competent to handle the youths even better*" (P3).

> "*Ummh…motivation is very important. This does not only involve money but maybe from superiors through Mentorship or trainings*" (P5).

> "*Ummh…they should update us with information through refresher courses. Sometimes the youth know current information than us and it is very embarrassing. I was trained in 2014*" (P6).

5.4 DISCUSSION OF FIELD NOTES

Field notes are written notes on observations in the field (Leavy 2017:136). The researcher observed that most participants were willing to participate in the study. They availed themselves to participate in the focus group discussions and individual interviews. Dedicated interview rooms were arranged prior to the focus group discussions and individual interviews with the assistance of the YFHS providers. After sharing information about the study, all participants signed consent forms and participated in the study. Field notes had a date and time to maintain a chronological

record. The location was also noted, including whether the interaction was with an individual or group of participants.

One research assistant who was not a participant in the discussions served as a note-taker and they ensured the smooth running of the focus groups and the individual interviews, performing a number of roles (Learning for Action [s.a.]:1). They captured verbatim notes and quotations, they asked clarifying or probing questions, they monitored the time for the facilitator, and they wrote down contextual notes about the focus group, e.g. the feel of the focus group that affected the conversation, such as the number of participants, gender, and age range, among others. Field notes were typed on the same day after exiting the field, and the information was referred to during the analysis of the data to add to the information that was transcribed. Non-verbal agreements through nodding or other body language were noted, and included:

- Ummh, which indicated trying to focus
- Yes, which indicated a feeling of agreement
- Yeah, which indicated a feeling of agreement
- Eeeh, which indicated a feeling of agreement
- Okay, which indicated a feeling of agreement
- True, which indicated a feeling of agreement
- Well, which indicated a feeling of agreement
- I think, which indicated a feeling of agreement
- Laughs, feeling of happiness and excitement

The majority said “Ummh”, which indicated their effort to focus. Laughing showed interest and excitement about the topic under discussion. According to Youssef (2023:1), non-verbal communication can be used to express attitudes, intentions and feelings that are difficult to put into words. In this study, most participants expressed happiness and an eagerness to speak.

5.5 SUMMARY

This chapter discussed the themes and sub-themes that were informed by 24 young people and six YFHS providers who took part in this study. Data were collected using focus group discussions and individual interviews, and the two methods generated worthwhile data that were supported by field notes. In the next chapter, the quantitative results from phase one and qualitative findings from phase two are integrated and interpreted.

CHAPTER 6
INTERPRETATION OF RESULTS

6.1 INTRODUCTION

Chapter 5 presented the analysed data and findings for phase two of the study. This chapter discusses the researcher's interpretation of the quantitative and qualitative results that were generated during the present study. The researcher followed a sequential, explanatory, mixed-method approach. As explained earlier, the explanatory, sequential, mixed-method comprises two phases of data collection, where quantitative data are collected in the first phase, analysed, and the results are used to plan or build the second qualitative phase (Creswell & Creswell 2018:357; Leavy 2017:9). The objective of this chapter is to discuss the central themes that emerged from both the quantitative and qualitative findings, informing the need to increase youths' utilisation of YFHSs.

6.2 QUANTITATIVE FINDINGS

Quantitative findings were obtained from 293 youths who responded to a survey questionnaire containing the following sections: Demographic information; accessibility of YFHSs; youths' knowledge about SRH issues and services; practices at YFHSs; barriers to the utilisation of YFHSs; and suggestions to enhance the utilisation of YFHSs. This section outlines the major findings from the quantitative phase.

6.2.1 Respondents' demographic profile

The majority of respondents (50.5%) were female, and most (48.8%) were aged 15 to 19. Furthermore, most respondents (46.6%) lived with both parents, followed by respondents who lived with their mothers only (27%). Most respondents were Christians (92.2%), and it was unsurprising that many were students (58%), considering the majority's age. This group was followed by unemployed (15.7%) respondents, showing that unemployment was a problem among the youth.

6.2.2 Accessibility of YFHSs

The study found the accessibility of YFHSs was still a problem, as less than half of the respondents had ever accessed YFHSs (43%). Many respondents preferred to access YFHSs at government health centres (84.3%), followed by youth clubs (6.1%). The most common means of reaching the health facility to receive YFHSs was walking (84%), followed by the use of motorbikes (6.8%).

More than half of the respondents had been encouraged to attend YFHSs at some point (55.6%). This implies that not all the respondents who had ever been encouraged to do so did access YFHSs when the figures are compared with those who actually accessed YFHSs. Surprisingly, only about a third of respondents (30%) had been discouraged from accessing YFHSs. According to the Health Belief Model, this implies reduced perceived susceptibility and perceived benefits in utilising YFHSs among the youths. It also implies reduced perceived seriousness in not accessing YFHSs.

6.2.3 Knowledge about reproductive health services

The study revealed that two-thirds of the respondents already knew about YFHSs (66.2%), and of those who were aware of it, more than half had obtained this information from friends (56.7%) or nurses at health facilities (13.9%). The study found that just over half of the respondents (52.7%) also knew about the actual services offered at YFHSs. More than three-quarters of the respondents had previously received some education on SRH (78.2%); there were two main sources from whom they obtained this information, namely youth clubs (42.9%) and schools (39.4%). Most respondents preferred to receive information on SRH issues from nurses (45.7%), followed by their parents (20.5%). Considering that more than two-thirds had heard about YFHSs, yet fewer than half had accessed the services, it implies reduced perceived seriousness in not utilising the services and low perceived benefits, according to the Health Belief Model.

Regarding signage showing the availability of YFHSs at a health facility, more than half of the respondents (61.8%) had never seen any such signage. The study also found that two-thirds of the respondents had never received any printed educational materials

on reproductive health from healthcare facilities (65.5%). This implies a need for printed educational materials such as family planning booklets or leaflets on sexual reproductive issues. Such educational materials were also requested by youths in a previous study (Barden-O'Fallon et al., 2020).

6.2.4 Practices at the YFHSs

Of the respondents who had previously accessed YFHSs, the majority (82.4%) agreed they had time to explain their problems to the health service providers. Most (81.0%) agreed that they were examined by the service provider, and almost all the respondents who had ever accessed YFHSs (94.4%) agreed that they were treated respectfully.

The service providers were rated highly for positive characteristics: 38 (30.2%) respondents said the providers were normal, 44 (34.9%) said the service providers were friendly, and 40 (31.7%) said that they conducted themselves in a professional manner. Only 3% of the respondents rated the healthcare providers or YFHS focal personnel as harsh or rude. Most respondents said they were treated well and with respect to their need for privacy (85.7%), and 101 (81.5%) were assured of confidentiality. Almost all the respondents agreed that the healthcare providers explained or demonstrated the correct use of condoms to them, where necessary (94.4%). Thus, the present study indicates that respondents had no issues with service providers. The results indicate that the positive cues to action that service providers demonstrate could attract more youths to YFHSs.

6.2.5 Barriers to the utilisation of YFHSs

The study established that many of the possible barriers included in the current study's survey were not barriers to the utilisation of YFHSs. However, there were some possible barriers, such as feeling too shy to attend YFHSs (86.1%) and fear of being seen at the healthcare facility (87.1%). The majority of the respondents were satisfied with the YFHS days (86.7%) and operating times (93.1%). They were also satisfied with the YFHS outreach days (87.6%). Most respondents were happy with the cleanliness of the health centre environment (92.2%). It was also found that the

majority of respondents did not need to be accompanied by anyone to attend YFHSs (88%), and most did not mind seeing familiar faces at the facility (88.1%). The study further noted that the cultural and religious values of the majority of respondents supported YFHS use (96.9%). The findings indicate reduced perceived barriers among the youth. This reflects the need to maintain the practices that youths support and address barriers so that more youths can attend YFHSs.

6.2.6 Suggestions on what would enhance the utilisation of YFHSs

More than half of the respondents preferred to attend YFHSs at government health centres (51.2%), followed by youth clubs (27%). The most preferred YFHS provider was youthful providers (63.8%). More than one-third of the respondents indicated that the youth themselves could assist (39.9%) in increasing the utilisation of YFHSs, followed by service providers (33.7%). More than half of the respondents also preferred to have youth corners in the health facility for YFHS provision (58.7%). The second-most preferred set-up was having a special room within the health centre for YFHSs (27%). The findings imply that working on the cues to action that youths prefer would increase the utilisation of YFHSs.

6.2.7 Differentials in the accessibility of YFHSs

Cross-tabulations and a Pearson Chi-square at 0.05 significance level and 95% confidence level were employed to determine the factors that had a significant influence on youths' utilisation of YFHSs in Blantyre.

At a 0.05 level of significance, the Chi-square test showed that the following variables had a significant association with the utilisation of YFHS ($p<0.05$): gender, age, knowledge of services offered at YFHSs, ever received SRH education, ever seen a YFHS signpost or signage, ever been encouraged or ever been discouraged from accessing YFHS, treated respectfully by the provider, issues demonstrated by the provider, felt too shy to attend YFHS, and fear of being seen at YFHSs. The variables that were found to be significantly associated with the accessibility of YFHSs ($p<0.05$) were selected for further analysis.

6.2.8 Predictors of YFHS utilisation

Female respondents showed a strong statistical association with the utilisation of YFHSs and had higher odds of utilising these services than male youths. Similarly, people aged between 20 to 24 had higher odds of utilising YFHSs than those younger than 20.

Youths who had heard about the services offered at YFHSs and those who had previously received SRH had higher odds of utilising YFHS than those who had never heard about YFHS and the services it offered, and had never received any SRH education, respectively. Another predictor of the utilisation of YFHS was seeing a signpost or signage indicating the availability of YFHSs at a health facility. Those who had seen such signage at a health facility had higher odds of utilising the services than those who had never seen any signage.

Other predictors included the availability of SRH educational materials and whether a young person was encouraged or discouraged to attend YFHSs. Those who received SRH educational materials at the health facilities and those who had been encouraged or discouraged to attend had higher odds of utilising YFHSs than their counterparts. Moreover, provider attitude was a predictor for the utilisation of YFHSs. Those who were treated with respect by the service provider, were assisted by a service provider, and had providers demonstrate or explain issues had higher odds of utilising YFHSs than those who were not treated respectfully or did not have factors demonstrated or explained, respectively.

How the youths themselves felt was also a predictor for YFHS uptake. The study showed that youths who did not feel shy attending YFHSs and those who did not fear being seen at YFHSs had higher odds of utilising the services than those who felt too shy to attend or feared being seen.

6.3 QUALITATIVE FINDINGS

Eight themes emerged from the study from which the main central themes were identified to facilitate the development of strategies to increase the utilisation of YFHSs. The major qualitative findings emerged as follows:

6.3.1 Knowledge about SRH and YFHSs

Youth participants admitted that not all youths had knowledge about SRH and the availability of YFHSs, which might have prevented some youths from accessing these services. In agreement with the youth, service providers reported that not all the youth in the surrounding catchment areas had knowledge about SRH and the availability of YFHSs. Lack of knowledge would impact the youths' perceived susceptibility and perceived seriousness of the risk of not utilising YFHSs because they have no knowledge about it.

6.3.1.1 Sources of information

Participants expressed that their main source of reliable information for reproductive health issues was the health facility. Some participants noted that they got information from parents and some from fellow youths. However, they lamented that the information their parents gave them was superficial.

6.3.2 Views on the accessibility of YFHSs

Participants reported that the services were accessible to youths. The focus group participants particularly indicated that they were able to access the following services: contraceptives, HIV testing services, STI treatment, general medical treatment, counselling on substance abuse, health education on various topics, and sporting and entertainment activities.

The service providers, however, acknowledged that not all youths in the catchment areas accessed the services. The general view was that the accessibility of YFHSs was limited. The providers indicated that the highest attendance in a day was around

40 youths, but very few typically attended, especially if no entertainment or sporting activities were being offered. Data collectors also observed in one health facility that only three youths attended YFHSs on a YFHS meeting day.

Participants were of the view that the accessibility of YFHSs was limited by factors such as a lack of dedicated space (which, in turn, violated the youths' privacy), long distance to the health facilities, lack of knowledge about YFHSs among some youths, and lack of money to contribute towards items such football balls. Practically, some youths were merely unwilling to access YFHSs because they thought it was not important, while some parents did not allow youths to access YFHSs because they thought youths would then find an opportunity to indulge in sexual activities. One issue that repeatedly emerged as causing an inaccessibility to YFHSs was the lack of activities such as sports and entertainment to attract youths.

Participants also mentioned their socioeconomic status or financial accessibility as one of the factors that influenced the accessibility of YFHSs. These findings resonate with studies conducted in northern Sweden and the Enugu state in Nigeria (Mosquera et al. 2017:20; Odo et al. 2018:92). However, financial accessibility in the current study was different from that of the study in northern Sweden and Nigeria, where youths lacked the money to pay for services. In the current study, youths lacked the funds to contribute towards sports equipment. The youths decided to contribute to these purchases because they did not have sponsors, and, ironically, in the process, some youths stopped accessing the services being offered.

The service providers also indicated several factors influenced the accessibility of YFHSs positively. In some areas, NGOs, like MANASO and JEPIEGO, conducted sensitisation sessions concerning SRH issues and YFHSs in communities. In one way or another, it positively influenced the utilisation of YFHSs through knowledge enhancement.

NGOs also occasionally sponsored sports events, bonanzas or organised music shows. This increased accessibility to YFHSs on such days. Moreover, some communities had functional youth clubs led by youth champions, which assisted in attracting youths to YFHSs. In some places, they conducted awareness campaigns

during youth-organised self-help activities such as market sweeping, enhancing YFHSs' utilisation.

6.3.3 Motivating factors for the utilisation of YFHS

6.3.3.1 Motivating factors for youths

The participants explained that they were motivated by several factors to continue attending YFHSs, which included the prevention of unintended pregnancies and diseases like STIs. Youths also reported that they were motivated to continue utilising YFHSs because they easily accessed SRH treatment and all other healthcare services, including on days not specifically allocated for YFHSs. This implies increased self-efficacy among the youth who attended YFHSs.

The service providers said that youths were often motivated to attend YFHSs by friends and activities such as football, career shows, and poetry readings, which, in some health facilities, were conducted monthly. Both the service providers and the youths were of the view that the providers made it easy for the youths to access other services on days not designated for youths.

6.3.3.2 Motivating factors for YFHS providers

The YFHS providers shared different factors motivated them to continue working with the youths. Some were motivated by their own personal experiences, wanting to see more youths do better in life and have a bright future. Some became motivated when more youths attended YFHSs. The youths' eagerness to learn also motivated some service providers. Others were motivated by their passion for the youths, while some chose to serve as role models. One service provider said they were motivated by the quest to be put on the map on issues related to successful YFHS provision.

Conversely, the focal persons explained they sometimes became discouraged while working with youths for different reasons, such as: few youths attending YFHS, frequent stockouts of medical supplies, like contraceptives, lack of support from other staff, limited involvement from NGOs, a lack of transport to reach youth clubs in distant

areas, YFHSs not being seen as a priority, and YFHSs not being considered as very useful by health facility superiors.

6.3.4 Barriers to the utilisation of YFHSs

Participants highlighted several barriers to the utilisation of YFHSs. Three barriers emerged prominently, namely frequent stockouts of medical supplies, lack of sporting activities, entertainment, and supporting equipment, and lack of dedicated space for providing YFHSs, among others.

6.3.4.1 Shortage of medical supplies

The youth participants mentioned that resources such as contraceptives were not always available. The only contraceptive method that was found to be always available in all the health facilities was condoms. This discouraged some youths from seeking contraceptives.

The service providers from all the health facilities in the study confirmed that there were frequent stockouts of supplies, including contraceptives. They also confirmed that only condoms were always available in the health facilities. The findings were consistent with previous studies where barriers to the utilisation of YFHS also included an inconsistent supply of contraceptives, and a lack of diagnostic facilities and medicines (WHO 2021:25).

6.3.4.2 Lack of entertainment, sporting activities and supporting equipment

Youth participants said that they took sporting and recreational activities so seriously that they would opt to attend places offering these activities rather than areas where only health education and a supply of contraceptives were provided. They further stated that if these activities were always available, more youths would attend, and the service providers could use the opportunity to provide them with health information, contraceptives and other services. This implies the need to work on modifying factors so that more youths attend YFHSs.

The service providers agreed that there was a lack of sports and other recreational activities to attract youths. They also concurred on the lack of recreational equipment and materials such as balls, game boards, and ropes, resulting in youths getting bored.

6.3.4.3 Lack of dedicated space for YFHS provision

Participants from all the sites raised concerns that there were no special rooms or dedicated spaces for conducting YFHSs. They specified that YFHSs were provided in areas used for other activities when such activities were not in session. An area outside the ART clinic was used in the afternoons or on weekends; outpatient departments were used on Sundays, and an antenatal block and an open space within a health facility property were utilised for YFHSs. The youths were thus uncomfortable discussing their problems because their privacy was compromised.

6.3.4.4 Youths' lack of knowledge

Participants also identified a lack of knowledge among the youths as one of the barriers to the utilisation of YFHSs.

6.3.4.5 Financial constraints

Some participants lamented that some financial constraints deterred youths from attending YFHSs.

6.3.4.6 Distance to the healthcare facility

Distance emerged as a barrier to utilising YFHSs because some catchment areas were very large. It also transpired that some catchment areas were hilly, making mobility very difficult, hence preventing the youths from attending YFHSs.

6.3.4.7 Perceptions and misconceptions concerning YFHSs

Participants reported that certain myths and misconceptions regarding the youth and their use of contraceptives were affecting their provision of these services. Focus group

discussions illustrated that some youths had misconceptions that led them to wrongly believe that a girl who takes contraceptives will not be sexually active and become infertile, and the contraceptives will affect the normal functioning of the female body in general, and reduce the male libido.

Apart from myths and misconceptions, some youths' attitudes also prevented them from utilising YFHSs. Some youths belittled YFHSs; they believed they had outgrown the services. Participants also expressed that some individuals were just too shy to attend YFHS departments, considering the misconceptions that the communities had regarding YFHSs and youths' use of contraceptives.

The participants also said that some parents and the community, in general, had misconceptions; therefore, they would not allow their children to access contraceptives. The parents believed that contraceptive use among young girls would lead to infertility, prostitution, and generally harm the girls' bodies. The misconceptions and lack of support from parents thus prevented some youths from utilising YFHSs.

Likewise, the participants were of the view that the community viewed contraceptive use for young girls negatively, thinking it would encourage prostitution or sexual immorality, and it could cause infertility. The participants, however, noted that the misconceptions were mainly aimed at girls, and they were not considered a big challenge for boys.

6.3.5 Youths' preferences

6.3.5.1 Preferences for YFHS days

Participants reported meeting on various days, mainly weekends. Once a month, the service providers joined the youths for other services and health education. The participants in all the sampled health facilities further explained that the youths were assisted by YFHS providers when they attended the health facility for various reasons during the week.

Participants from all the facilities in the current study stated that they were happy to have YFHS activities on weekends, considering that some went to school and others

were busy with other weekday activities. However, they also noted that they preferred having a youth corner where services could be provided to those who reported to the facilities on weekdays.

6.3.5.2 Preference for space for conducting YFHSs

Participants said they preferred having a designated place for YFHSs rather than the current spaces where the services are provided.

6.3.5.3 Age preference for YFHS provider

Participants in all the focus groups preferred youthful YFHS providers because they felt freer to communicate their issues to fellow youths.

6.3.5.4 Gender preference for YFHS provider

Participants preferred to have separated female and male services based on the understanding they would open up more easily to a same-gender provider.

6.3.6 Attitudes of YFHS providers

The participants were satisfied with the attitude of YFHS providers. They indicated that the providers were accommodative, friendly, welcoming, and non-judgemental and generally treated them respectfully. The youths highlighted that the providers' attitudes encouraged them to continue accessing the services.

The participants further underscored the fact that the providers did not only welcome them when they were having youth-related activities on weekends but also when they came to the health facility with other health problems during the week. The providers corroborated that they were accommodative and open with the youths, which encouraged the youths to be open with them.

6.3.7 Current practices to increase the utilisation of YFHSs

Service providers reported different strategies were being used by the facilities sampled for the current study. Some facilities pasted posters in different places informing youths about the activities being offered at the health facilities. Some worked with organisations, such as MANASO, which gave SRH information to youths in communities. Information about YFHSs was also given during HCT clinics.

Some facilities conducted 'bring a friend' campaigns. The focal persons also mentioned that they were putting aside supplies for the sake of the youth. In one health facility, they conducted a staff meeting to encourage staff to provide services in a non-judgemental manner. In another facility, the focal people, in conjunction with some youths, organised a get-together that attracted individuals by invitation. In some instances, a small monetary incentive was given to anyone who brought a friend for YFHSs.

6.3.8 Suggestions to improve the utilisation of YFHSs

The participants proposed several strategies that could increase the utilisation of YFHS. These are described as follows:

6.3.8.1 Availability of sporting equipment and medical supplies

Participants recommended that materials such as balls, game boards, and other recreational activities should be made available to them at the health facilities. They also recommended that medical supplies such as contraceptives should always be available because it was discouraging to find their preferred option repeatedly out of stock. Some youths gave up in the process.

Participants suggested that health facilities should supply sporting and recreational equipment because the health facilities could use sports, games and other activities to attract youths, e.g. by having sports days at the facility with competitions among different youth clubs. The YFHS focal persons could then seize the opportunity to educate the youths on different topics affecting them, and provide counselling and

other services such as contraceptives. The youth participants further suggested that NGO partners should be consulted to assist with medical supplies and sporting materials, such as balls and sports uniforms.

The YFHS focal persons similarly recommended the provision of sporting and recreational equipment at the health facilities on the understanding that this would attract more youths to attend YFHSs.

6.3.8.2 Dedicated space for YFHSs

Youth participants suggested that health facilities allocate dedicated space, special rooms or youth corners where YFHSs could be provided. This was also recommended by YFHS providers. The youth participants further recommended that the dedicated spaces should be made one-stop centres where the youths could receive all the services they required. Some held the view that an office for YFHSs was required. This implies that working on this modifying factor would improve the utilisation of YFHSs.

6.3.8.3 YFHS provision days

Youth participants and service providers recommended that YFHSs be provided throughout the week at designated youth corners.

6.3.8.4 Age and gender of YFHS providers

The youth participants recommended having male and female youthful staff at the youth corner because some youths were unable to interact freely with a provider of the opposite sex.

6.3.8.5 Community sensitisation

Youth participants and service providers recommended that community sensitisation about YFHSs should be conducted by YFHS focal persons and some youths. With such sensitisation, it was believed parents would learn what YFHS are all about, which may reduce misconceptions. The participants also recommended YFHS sensitisation

through the radio or television, with the youth informing peers of available services. A recommendation was also made that pictures showing youth gatherings at YFHSs should be posted on social media for others to see. Other participants recommended that sensitisations should be conducted in schools. YFHS focal persons suggested increasing community leaders' engagement apart from conducting the community sensitisation sessions.

6.3.8.6 Establishing youth clubs

Some participants recommended the establishment of youth clubs in remote areas where YFHSs and other services offered at the health centre could be provided. The service providers could provide outreach services once a month. The youth could come to the health facility only when they needed medical treatment. This would assist youths who failed to attend YFHSs due to long distances to the health facilities.

6.3.8.7 Need for funding

Participants expressed the need to lobby for funding for YFHS activities and supplies. They noted that activities such as bonanzas or shows for youths would attract more individuals to attend, and the availability of funding would help the health facilities to buy sporting equipment such as balls and some games. In turn, these would create an opportunity for the service providers to disseminate health information to the youths in a favourable environment.

6.7.8.8 Platforms for showcasing youths' talents

The youth participants also recommended the creation of a platform for youths to showcase their talents in music and drama, and other talents, such as organising music shows for the youth. The understanding was that such platforms would make it easier for YFHS focal persons to reach many youths with health education messages. YFHS providers expressed similar views.

6.3.8.9 Promoting YFHS providers' competency

The participants expressed the need for proper training for YFHS providers to continue handling the youths appropriately. All the providers in the current study, despite not having proper training, had some orientation on how to work with young people, and this possibly contributed to their positive attitudes towards the youth.

Other recommendations included the distribution of leaflets at youth corners for the youth to read at home and share with others who might not know anything about YFHS, and organising exchange visits between YFHS groups from different health facilities so that youths could learn ways of attracting more youths to attend YFHSs from each other. Service providers also recommended refresher courses for the providers and exchange visits for them to learn from colleagues.

6.4 SUMMARY

Chapter 6 described the researcher's interpretation of the study's findings from phase one and phase two. It also discussed the Health Belief Model factors identified from the two phases. The next chapter describes the integration of key themes from both the quantitative and qualitative data highlighted in Chapters 4 and 5.

CHAPTER 7
INTEGRATING THE KEY THEMES

7.1 INTRODUCTION

Chapter 6 presented the interpretation of the quantitative and qualitative results generated by the current study. This chapter describes the integration of key themes from both the quantitative and qualitative data highlighted in Chapters 5 and 6. The key themes facilitated the formation of strategies to improve the utilisation of YFHSs. Evidence from the results of both phases suggested the following key themes:

7.2 KNOWLEDGE ABOUT REPRODUCTIVE HEALTH SERVICES

This study found that knowledge about YFHSs and SRH issues are important factors in promoting the utilisation of YFHS. In this study, 66.2% of the respondents knew about the availability of youth-friendly and other services offered at YFHS departments, while 78.2% had received some SRH information. In agreement with the youth, service providers noted that many youths were knowledgeable about SRH issues and YFHSs. Contrary to this finding, however, a recent study conducted in Uganda found that a lack of SRH knowledge prevented youths from accessing YFHS (Musasizi 2023). Similarly, several previous studies showed that the majority of youths lacked knowledge about YFHS and SRH (Anokoye-Mensa 2019:1; Tchokossa et al. 2018:1647; Napit et al. 2020:4; Jain et al. 2017:1 Abuosi & Anaba 2019:204; Nash et al. 2019:8; Pandey et al. 2019:1; Mattebo et al. 2019:7; Eremutha & Gabriel 2019:40; Munakampe et al. 2018:909; Violita & Hadi 2019:1; Thongmixay et al. 2019:1).

7.2.1 Source of information

In the current study, there were two main sources of information for SRH: youth clubs (42.9%) and schools (39.4%). Most participants preferred to get information about SRH issues from nurses (45.7%), followed by parents (20.5%). However, qualitative data showed that the participants viewed information from parents as superficial. This

finding was similar to that of Munakampe et al. (2018:909), where health workers were deemed trusted sources of information.

Other previous studies also showed that adolescents obtained SRH information from family and peers (Violita & Hadi 2019:1), radio, newspapers (media), and static advertisements (Amuko 2020: xii). However, printed health information on SRH was found lacking in the current study and was a predictor of the utilisation of YFHSs. It transpired that two-thirds of the respondents (65.5%) had never received printed educational materials concerning SRH at the health facilities. This indicates the need for printed materials, such as leaflets, at the YFHS departments.

7.2.2 Signpost for YFHSs

The study also found that seeing signage or a signpost showing the availability of YFHSs at a health facility was a predictor for the utilisation of these services. More than half of the respondents (61.8%) had never seen such a signpost in the current study. This might have contributed to the lower utilisation of YFHSs. Hidden signage was another factor that influenced the utilisation of YFHSs in a study from Ghana (Asare et al. 2020). This points to the need for noticeable signposts at the facilities informing the youth about YFHSs' availability at that facility, services offered, and the days and times that they are offered, written in languages that all the youth can understand.

7.3 ACCESSIBILITY OF YFHSs

The study found that accessibility to YFHSs was still problematic, as less than half of the respondents had accessed the services (43%). Qualitative data revealed that some youths did not access YFHSs due to factors such as a lack of dedicated space for YFHSs, hence their perceived lack of privacy, long distance to the health facilities, lack of knowledge about YFHSs among some, and lack of funds to contribute for things like balls for football, some youths' unwillingness due to their failure to appreciate the importance of YFHSs, and some parents hindering youths' access to the services, fearing the youth would find opportunities to indulge in sexual activities. Surprisingly,

only 88 (30%) respondents had ever been discouraged from accessing YFHSs. Ideally, this was supposed to enhance the utilisation of YFHSs.

Similar results in Violita and Hadi's (2019) study showed that only 24.3% of adolescents utilised YFHSs. Underutilisation of YFHSs was also identified in a study conducted in Ghana (Asare et al. 2020), where utilisation was at a level of 7.9%, in eastern Ethiopia it was at 25.3% (Sertsu et al. 2023), and in northwest Ethiopia YFHS utilisation was 28.9% (Tsegaw, Kassie & Alemnew, 2023). A contradictory result was registered in a study conducted in Nepal, where more than two-thirds (67.5%) of the youths had utilised YFHSs at least once in the 12 months before the study (Sharma, Khatri, Amatya, Subedi, Upadhyaya, Sapkota & Bista, 2023).

One issue that emerged repeatedly as increasing the inaccessibility of YFHSs was the lack of activities such as sports and entertainment that could attract youths. The participants, furthermore, mentioned their socioeconomic status or financial accessibility as another factor that influenced the services' accessibility. These findings corroborate those in studies conducted in northern Sweden and the Enugu state in Nigeria (Mosquera et al. 2017:20; Odo et al. 2018:92). The youth in this study indicated that they sometimes did not access YFHSs because they did not have funds to contribute to sporting equipment, such as balls. The youth opted to contribute financially to equipment because they did not have sponsors for such items. Ironically, due to their failure to contribute, some youths, in the process, stopped accessing the services offered at YFHSs.

Most respondents preferred to access YFHSs at government health centres (84.3%), followed by youth clubs (6.1%). One of the factors influencing this pattern was possibly poor finances, considering that public facilities seldom charge for the services they offer.

The commonest means of reaching the health facility for YFHSs was walking (84%), followed by the use of motorbikes (26.8%). The study also revealed that encouragement or discouragement to attend YFHSs contributed to the accessibility of services. More than half of the respondents had been encouraged to attend YFHSs (55.6%), and only 30% had ever been discouraged from accessing YFHSs.

The service providers mentioned several factors influenced the accessibility of YFHSs positively. In some areas, NGOs conducted sensitisation sessions in the communities. For instance, organisations like MANASO and the John Hopkins Program for International Education in Gynaecology and Obstetrics (JHPIEGO) were involved in sensitising the youth on reproductive health issues and YFHSs in the communities, which likely enhanced uptake. This indicates that knowledge was vital in enhancing the utilisation of YFHSs. This finding was similar to a study conducted in Indonesia, in which access to YFHSs was mainly determined by knowledge of the programme and perceived demand (Arafah et al., 2020:164).

Once in a while, some NGOs sponsored sports bonanzas or organised music shows for youths. This also increased the accessibility of YFHSs on such days. Some communities have functional youth clubs led by youth champions, attracting peers to access YFHSs. In some places, awareness campaigns are conducted during youth-organised activities such as market sweeping. Furthermore, some providers believed that youths continued to access the services because the providers were open-minded and friendly.

7.4 SERVICE PROVIDERS' ATTITUDE

The participants in this study expressed satisfaction with the attitude of service providers. They particularly indicated that the providers were accommodating, friendly, welcoming, and non-judgemental and generally treated the youths respectfully. The youth stated that the providers' attitude encouraged them to attend and continue accessing the services.

Almost all the respondents who had ever accessed YFHSs (94.4%) said they were treated respectfully. The service providers were rated highly in positive characteristics, and 30.2% of the respondents said the providers were normal, 34.9% said they were friendly, and 31.7% reported that they conducted themselves in a professional manner. Only 3% of the respondents rated the healthcare providers or YFHS focal persons as harsh or rude.

This finding was similar to that of a study conducted in Bangladesh, where unmarried adolescents who accessed AFHCs expressed satisfaction with service providers (Ainul et al. 2017:1). A study in Nepal also noted that client satisfaction increased utilisation of YFHSs (Sharma et al. 2023).

The findings of the current study thus contradicted those of most previous studies where provider attitude was found to be a barrier to the utilisation of YFHSs and the biggest challenge for the youths. The common characteristics demanded by youths in the previous studies were to be treated with respect and to protect their confidentiality, which never emerged as issues in the current study (Pastrana-Sámano et al. 2020:1; Napit et al. 2020:6; McKinlay et al. 2021:160; Ninsiima et al. 2021:14; Anokoye-Mensah 2019:1; Nash et al. 2019:1; Mattebo et al. 2019:7; Abuosi & Anaba 2019:203).

7.5 BARRIERS TO THE UTILISATION OF YFHS

Many of the possible barriers included in the current study's survey were not barriers to the utilisation of YFHS. However, there were some possible barriers, such as feeling too shy to attend YFHSs (86.1%), and fear of being seen at the YFHS facility (87.1%). Participants in the qualitative phase identified several further barriers to the utilisation of YFHSs. Three (a shortage of medical supplies, lack of sporting activities, entertainment, supporting equipment, and lack of dedicated space for providing YFHSs) stood out.

7.5.1 Shortage of medical supplies

The youth participants expressed concern that resources such as contraceptives were not always available. The only contraceptive method that was always available in all the health facilities was condoms. This discouraged them from seeking contraceptives.

The service providers from all the health facilities confirmed the frequent stockouts of supplies, including contraceptive methods. They also concurred that only condoms were always available in the health facilities. The findings were consistent with other studies where barriers to the utilisation of YFHS included inconsistent supplies of contraceptives, and a lack of diagnostic facilities and medicines (WHO 2021:25).

7.5.2 Lack of sporting activities, entertainment, and supporting equipment

Youth participants indicated that they took sporting and recreational activities seriously and would opt to access SRH services at facilities where sporting and recreational activities were provided instead of facilities where there was only health education and a supply of contraceptives. They emphasised that if these activities were always available in health facilities, more youths would access them. The service providers could use the opportunity to provide the youths with health information, contraceptives, and other services offered at YFHSs.

Both the service providers and the youth participants considered a lack of sports and other recreational activities that could attract youths problematic. A lack of recreational equipment and materials such as balls, game boards, and ropes also caused the youth to become bored. While this finding is not common in literature, it emerged as one of the biggest reasons that prevented youths from utilising YFHS in all sites in the current study.

7.5.3 Lack of dedicated space for conducting YFHS

Participants in all the sites of the current study expressed concern that there were no special rooms or dedicated spaces for providing YFHSs in the health facilities. They specified that YFHSs were conducted in areas used for other services, such as outside the ART clinic in the afternoons or weekends, at the outpatient department on Sundays, and at the antenatal block and an open space within the health facilities' property. Youths were uncomfortable to discuss their problems because their privacy was compromised. These findings are similar to other studies in Nepal, Ghana, Nigeria and Malaysia, where a lack of physical access or dedicated space for the provision of YFHSs adversely affected its accessibility (Pandey et al. 2019:1; Abuosi & Anaba 2019:201; Envuladu et al. 2021:1369; Awang et al. 2022:61).

7.5.4 Perceptions and misconceptions about SRH issues and YFHSs

Participants held the view that there are some myths and misconceptions regarding the utilisation of YFHS and the use of contraceptives by youths, parents, and the

community in general. In this study, some youths believed that if a girl took contraceptives, she would lose her libido, become infertile, and her body would malfunction. Also, a boy who takes contraceptives would, similarly, have a reduced libido. Similar results were established in previous studies (Nash et al. 2019:8). Moreover, apart from the myths and misconceptions that they held, the attitudes that some youths had prevented them from utilising YFHSs. Some youths belittled YFHSs, thinking they had outgrown them. It also transpired that some youths were just too shy to attend YFHSs for fear of being seen accessing the services.

Participants noted that many parents had misconceptions that caused them to argue contraceptives were not suitable for their children. The parents believed contraceptive use among young girls would lead to infertility and prostitution, and generally bring harm to the girls' bodies. The misconceptions and lack of support from parents prevented some youths from utilising YFHSs. Misconceptions among parents were also prevalent in previous research (Kinaro et al. 2015:85; Self et al. 2018:108; Abuosi & Anaba 2019:202).

Likewise, the participants reported that the general community viewed contraceptive use for young girls negatively, thinking it would encourage prostitution or sexual immorality and would lead to infertility. The participants, however, noted that the misconceptions mainly concerned girls. A previous study in Kenya also found several misconceptions regarding SRH issues in relation to the youth. The misconceptions comprised biological and sociological perceptions around contraception, and the youth strongly held to these beliefs (Mwaisaka et al. 2020:4).

7.5.5 Distance to the health facility

In this study, distance was found to be a barrier to the utilisation of YFHSs. It was noted that some catchment areas were very large, thereby preventing people from accessing the services due to long travelling distances. It was also indicated that some catchment areas were hilly, making mobility very difficult, thereby preventing the youth from attending YFHSs. Geographical barriers associated with a scarcity of YFHSs were also found in previous studies (Thongmixay et al. 2019:1).

7.5.6 Financial constraints

Participants lamented that some financial constraints deterred youths from attending YFHSs. In some health facilities, youths had to contribute to buying balls and sporting equipment. The youths who did not have money to do so thus refrained from attending YFHSs.

7.5.7 Youths' preferences

7.5.7.1 Age and gender of service providers

Participants reported no problems receiving YFHSs on weekends, considering that some went to school and others were busy with other weekday activities. However, some participants preferred to have YFHSs daily. The provision of YFHSs during weekdays would assist youths who, during the week, encounter reproductive health problems such as STIs in that they would be treated promptly without waiting for the weekend.

Previous studies generated contrary findings whereby inconvenient operating hours, increased waiting times, and opening times that collided with school hours were a barrier to the utilisation of YFHSs (Ninsiima et al. 2021:14).

Focus group participants preferred to have youthful providers at YFHS because they would not feel shy to talk with them about private issues; nearly two-thirds of the respondents (63.8%) preferred a youthful service provider. The youth also preferred having both female and male providers assisting them at YFHSs. Practically, many youths preferred to be helped by someone of their gender because they said they found it easier to interact freely with same-gender service providers.

7.6 HEALTH BELIEF MODEL

The researcher is of the view that the modifying factors, combined with cues to action, contribute to the increased perceived susceptibility, seriousness, benefits and barriers to the utilisation of YFHSs in the study area. This prompted the researcher to modify the original Health Belief Model, as illustrated in Figure 7.1.

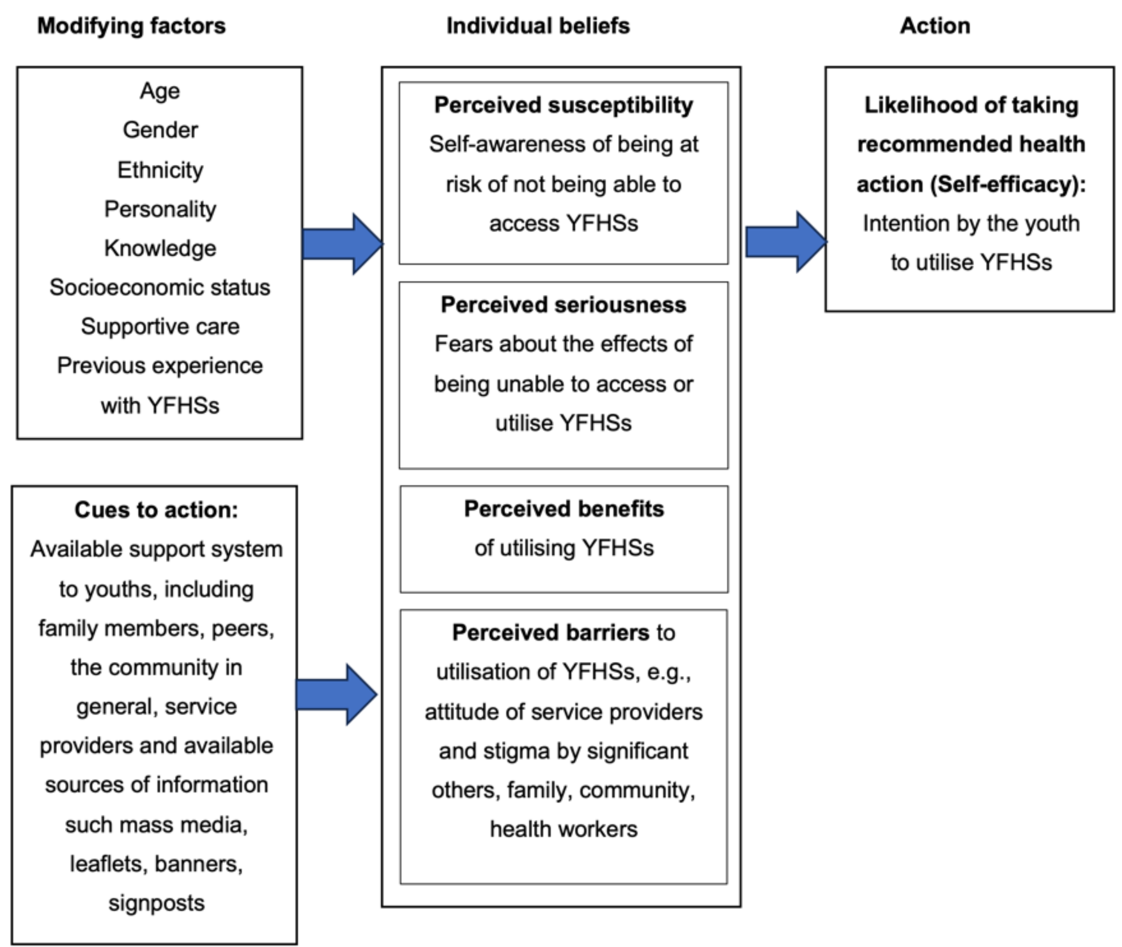

Figure 7.1: Modified Health Belief Model

Source: Adapted from Glanz et al. (2008:49)

7.6 SUGGESTIONS TO ENHANCE THE UTILISATION OF YFHSs

Youth participants recommended having youthful staff at the YFHSs of both genders because some youths could not open up to a service provider of the opposite gender. More than half of the respondents preferred having youth corners in the health facilities to receive YFHSs, followed by a special room within the health centre for YFHSs. Qualitative findings also showed that participants preferred to have dedicated space, special rooms or youth corners where YFHSs should be provided. This was also a recommendation by YFHS service providers. The youth participants further recommended that the dedicated spaces should be one-stop centres where they can

receive all the services required at the health facility. Some added that a YFHS office was needed.

Participants recommended that materials such as balls, game boards, and various recreational activities should be made available to them at the health facilities. They also recommended that medical supplies such as contraceptives should always be available because it was discouraging for youths when they found their preferred method repeatedly out of stock.

Participants suggested that health facilities should supply sporting and recreational equipment for the YFHSs because the health facilities could use sports, games, and other recreational activities to attract youth. Furthermore, they suggested that they should have sports days at the facilities with various competitions involving various youth clubs. The YFHS providers could, therefore, use the opportunity to provide education on different topics affecting them, and provide counselling and other services. The youth participants further suggested that NGO partners should be involved to assist with medical supplies and sporting materials such as balls and sports uniforms. The YFHS providers also concurred on the provision of sports and recreational equipment at the health facilities, arguing this would attract more youths to attend YFHSs.

Youth participants and focal persons recommended community sensitisation about YFHSs to be conducted by YFHS focal persons and some youths. The thinking was that, with such sensitisation, parents would get to know what YFHSs entail, which may reduce misconceptions. The participants also recommended sensitisation about YFHSs through the radio or television, with youths informing peers. Youths suggested taking photographs of youth gatherings at YFHSs and posting them on social media. Others recommended conducting sensitisation sessions in schools. YFHS providers suggested engaging community leaders to a greater extent than conducting community sensitisation about YFHSs.

Service providers recommended that staff working at YFHSs should be trained and all staff in the health facilities, including the guards, should be oriented so that they are non-judgemental against youths who attend YFHSs. It was also recommended that

policies and guidelines for YFHSs should be made available to service providers to ensure the appropriate provision of services.

7.7 SUMMARY

The results of the present study have suggested various strategies for increasing the utilisation of YFHSs. Key factors necessary for increasing the utilisation have also been highlighted. The next chapter discusses the development of strategies for increasing the utilisation of YFHSs.

CHAPTER 8
PHASE THREE: DEVELOPMENT OF STRATEGIES TO IMPROVE THE UTILISATION OF YOUTH-FRIENDLY HEALTH SERVICES

8.1 INTRODUCTION

Chapter 7 described the integration of key themes from both the quantitative and qualitative phases of the study. This chapter describes nine proposed strategies for increasing the utilisation of YFHSs. This discussion builds on information obtained from a survey questionnaire, individual interviews, focus group discussions, field notes and observations. Information shared by participants during the quantitative and qualitative phases contributed towards the strategies' development. Figure 8.1 illustrates the proposed strategies for increasing the utilisation of YFHSs, and Table 8.1 shows the plan for the strategies' implementation. The chapter also unpacks the proposed strategies' validation.

8.2 METHODOLOGY FOR THE DEVELOPMENT OF STRATEGIES

The researcher used the Objectives-Goals-Strategies-Measures (OGSM) (Khan 2023) methodology in the development of strategies with the assistance of four experts in the field of SRH and YFHSs. The OGSM method transforms objectives, goals, strategies, and measures into actionable and executable plans.

8.3 GUIDING PRINCIPLES USED FOR THE STRATEGIES' DEVELOPMENT

Using the findings from phases one and two of the study, the researcher established possible strategies to improve the utilisation of YFHSs. These proposed strategies were discussed with four experts in the field of SRH and YFHSs; a consensus was reached, and nine strategies were agreed upon (refer to Figure 8.1 for the proposed strategies). The researcher and the four experts refined the strategies before they were sent to ten additional experts in the field of SRH and YFHSs for validation.

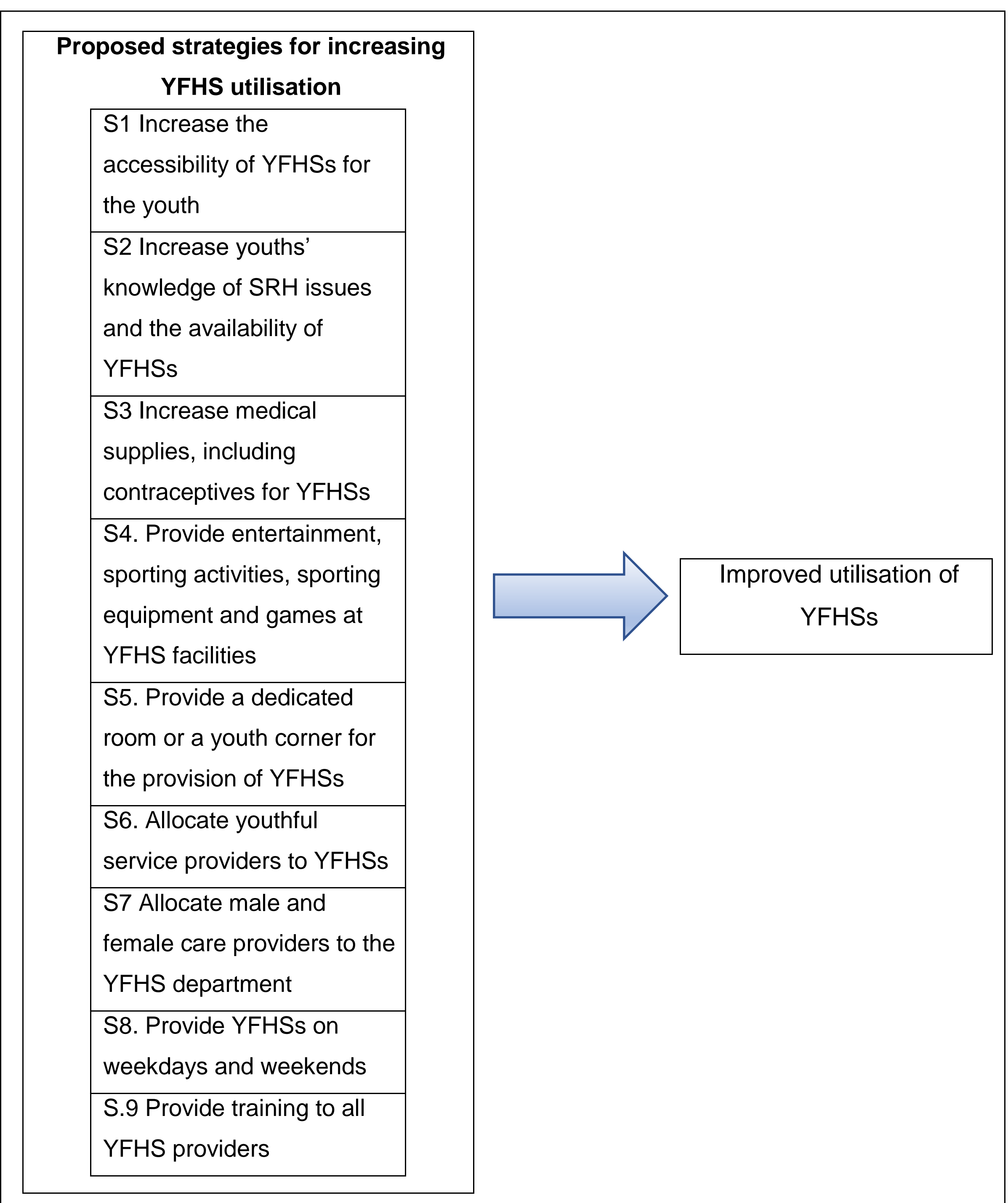

Figure 8.1: Illustration of proposed strategies to increase the utilisation of YFHSs

8.4 PROPOSED STRATEGIES

8.4.1 Strategy 1: Increase the accessibility of YFHSs for the youth

Aim of the strategy

To increase the accessibility of YFHSs for the youths of Blantyre, Malawi.

Description of the strategy

The researcher suggests that measures should be implemented to assist more youths in accessing YFHSs. Some measures that would assist youths include providing services every day of the week so that youths who are busy with other activities or school on the days set aside by the clinics are able to access the services at their convenience. Youths who have a problem with the distance to the health facilities could gain access to YFHSs through monthly outreach programmes in remote areas. The establishment of more youth clubs in the communities is recommended as a platform for the provision of YFHSs to assist in increasing access to services. A study conducted in some parts of Ethiopia concurs that the inaccessibility of YFHSs can contribute to youths' reduced utilisation of these services (Haile et al. 2020:2).

Scope of the strategy

- Provide YFHSs every day of the week and offer sporting activities on weekends.
- Conduct monthly outreach clinics to provide YFHSs in remote areas.
- Establish more youth clubs in the communities as a platform for the provision of YFHSs.
- Reach out to youths in secondary schools where youth clubs can be formed to provide information on SRH and YFHSs.

Validity of the strategy

The strategy was validated by the experts.

8.4.2 Strategy 2: Increase youths' knowledge of SRH issues and the availability of YFHSs

Aim of the strategy

To increase youths' awareness about YFHS.

Description of the strategy

The study recommends that youths should be aggressively targeted with information regarding the availability of YFHSs in public hospitals. A study to determine factors that affected adolescents' access to adolescent-friendly health services in Indonesia (Arifah

et al. 2020:164) found that access was mainly determined by knowledge of the programme and perceived demand. Messages on the topic should be intensified in mass media, such as radio and local television. Communication should not only target informing the youth about the services but also give basic SRH information so that the youth can see the importance of utilising YFHSs.

Sensitisation campaigns should also be conducted in the communities through existing youth clubs or by encouraging the establishment of youth clubs where SRH information can be provided. Community leaders should arrange sensitisation campaigns for the communities at large, including parents and guardians, to inform them of YFHSs, thereby dispelling myths and misconceptions about these services. It also emerged from this study that some NGOs already have a mandate to sensitise youths in the communities concerning SRH. An important strategy would therefore be to work in partnership with such organisations in providing sensitisation messages to more communities so that more youths can attend YFHSs.

Health education messages offered at outpatient departments, HCT clinics, antenatal clinics and family planning clinics should include informatic about the availability of YFHSs so that this information reaches as many youths as possible. All health facilities that offer YFHSs should have a large signpost at their main entrance indicating these services' availability and the types of services offered. The messages on the signposts should be in both English and youths' local language. Leaflets on basic SRH information should be printed and given to youths attending YFHSs or any health facility service. Helemo et al. (2017:141) similarly suggest using education and communication strategies in schools to influence youths' knowledge, attitudes, and practices to increase service utilisation. In Nigeria, Eremutha and Gabiel (2019:39) also concurred that school clubs and out-of-school clubs can increase the utilisation of YFHSs.

Scope of the strategy

- Share messages on the availability of YFHSs in government hospitals through the provision of health information at outpatient departments.

- Use mass media, e.g. radio and television programmes, and provide messages through community meetings.
- Visible signposts should be placed at the entrances of the facilities with messages in English and the local language showing what YFHSs are offered.
- Leaflets on basic SRH information and YFHSs should be made available at outpatient departments and at the YFHS department to be given to youths attending such services.
- Reach the youths in schools with information on SRH and YFHSs.

Validity of the strategy

The strategy was validated by the experts.

8.4.3 Strategy 3: Increase medical supplies, including contraceptives for YFHSs

Aim of the strategy

To reduce YFHS defaulters.

Description of the strategy

The Ministry of Health needs to increase the availability of medical and surgical supplies, including contraceptives, so that youths are not turned away because their contraception method of choice is out of stock. YFHSs should be considered a formal department in the health facility, and supplies have to be allocated accordingly.

Scope of the strategy

- Allocate medical supplies and contraceptives specifically to YFHSs.
- Lobby for supplies for YFHSs from NGO partners and individuals to assist in funding YFHS activities.

Validity of the strategy

The strategy was validated by the experts.

8.4.4 Strategy 4: Provide entertainment, sporting activities, equipment and games at YFHS facilities

Aim of the strategy

To attract more youths in Blantyre, Malawi, to attend YFHSs.

Description of the strategy

Since youths are attracted by entertainment and sporting activities, health facilities should provide entertainment and sporting equipment for YFHS departments. This is one of the key findings of the current study that is easily achievable and, in due course, bears very helpful fruits to the nation. The health facilities should lobby partners to assist them with such equipment, and YFHS focal persons should routinely organise sporting and recreational activities for the youth. When the youth attend such activities, the service providers may use the opportunity to provide SRH information and provide other YFHSs, including offering them contraceptives.

Scope of the strategy

- The health facilities should provide game boards such as “bawo” playing cards, and sports equipment such as balls for football or netball, or any other equipment that would provide entertainment to the youths, such as TVs, when they come for YFHSs.
- Arrange various activities for the youth, including talent shows and music concerts.

Validity of the strategy

The strategy was validated by the experts.

8.4.5 Strategy 5: Provide a dedicated room or a youth corner for the provision of YFHSs

Aim of the strategy

To provide privacy to the youths.

Description of the strategy

As one of the key findings of the present study, the provision of privacy emerged as one of the strategies for increasing the utilisation of YFHSs. All the health facilities that offer YFHSs should have a youth corner or a room dedicated to the provision of YFHSs. The youth corner should be a one-stop centre where the youth can receive all the services they require when they attend the health facility. This would attract youths because they would not be asked to move from department to department for the services they require. Napit et al.'s (2020:4) study showed that adolescents who feared being seen using SRH services and those who were too shy to use the services were less likely to use YFHSs. Such fears can be averted by providing a private room or corner where only youths can access services in one place.

Scope of the strategy

- Identify a room or corner to be used for the provision of YFHSs.
- Integrate all the YFHSs to be offered in the dedicated room or space rather than sending the youths to different departments for different services.

Validity of the strategy

The strategy was validated by the experts.

8.4.6 Strategy 6: Allocate youthful service providers to YFHSs

Aim of the strategy

To help the youths open up during service provision.

Description of the strategy

Health facilities that offer YFHSs should allocate youthful service providers to youth departments. Youths do not feel shy explaining their problems to peers, and young service providers would be in a good position to understand the problems of fellow youths.

Scope of the strategy

- Allocate youthful providers at YFHS departments.

Validity of the strategy

The strategy was validated by the experts.

8.4.7 Strategy 7: Allocate male and female care providers to the YFHS department

Aim of the strategy

To provide a good service to youths who prefer same-gender providers.

Description of the strategy

Male and female service providers should be allocated to YFHS departments because some youths are unable to open up to a provider of the opposite sex.

Scope of the strategy

- Allocate male and female providers to YFHS departments.

Validity of the strategy

The strategy was validated by the experts.

8.4.8 Strategy 8: Provide YFHSs on weekdays and weekends

Aim of the strategy

To reach youths who have other activities on designated YFHS days.

Description of the strategy

The study's findings illustrated that youths prefer to have YFHS available every day at designated youth corners and not only once a week, or worse still, mostly during weekends, as is currently the case at most health facilities. It is therefore suggested that health services be provided throughout the week, with sporting activities offered on weekends.

Scope of the strategy

- Provide YFHSs every day of the week and on weekends.
- Offer sporting activities to the youths during the weekend.

Validity of the strategy

The strategy was validated by the experts.

8.4.9 Strategy 9: Provide training to all YFHS providers

Aim of the strategy

To increase providers' competency in handling youths.

Description of the strategy

In this study, it was commendable that youths had no concerns regarding service provider attitudes. This might have been because all service providers had undergone training or some orientation on YFHSs. Strategies for increasing the utilisation of YFHSs should therefore include all service providers working at YFHS departments undergoing proper training so that they are able to treat youths respectfully and professionally. All staff members, including guards, should be oriented on YFHSs to be non-judgemental of youths who attend these services. Policies and guidelines for YFHSs should also be available to service providers to properly run the YFHS department.

A study conducted by Pastrana-Sámano et al. (2020:7), whose aim was to assess the quality of adolescent-friendly services using simulated clients, revealed that staff attitude was a key element in the young people's experiences. A good attitude with elements such as friendliness, respect, trustworthiness, and others generated trust and confidence among the young people who said they would recommend the services to their friends. This good attitude can be enhanced by training service providers.

Scope of the strategy

- Provide YFHS training to all YFHS providers.
- Send providers for YFHS refresher courses if they are already trained.

Validity of the strategy

The strategy was validated by the experts.

8.5 VALIDATION OF PROPOSED STRATEGIES

The formulated strategies were validated by soliciting the opinions of experts in the field of SRH and YFHSs. The purpose of validation was to gain health experts' perspectives to ensure that the developed strategies met the needs for which they were developed and confirm their practicality. Ten experts were identified purposefully, including those working in the Ministry of Health as district YFHS coordinators, deputy coordinators and health facility managers. Other experts were faculty members from Kamuzu University of Health Sciences involved in teaching YFHSs theoretically, and clinically teaching students during their practicals at YFHSs.

The validation was done by having face-to-face individual meetings with some experts, while others received the validation tool by email. The tool comprised nine strategies, the objectives of the strategies, anticipated activities for each strategy, the role players and suggested providers of necessary resources. The experts were to agree or disagree with the strategy and offer comments (Refer to Annexure U for the validation tool).

All ten experts responded and provided comments. All of them agreed with all the strategies except one who partially agreed with the strategy of allocating male and female service providers to YFHS departments. The expert indicated that a shortage of staff may affect this strategy's implementation, hence, the available gender is the one to be allocated. One expert suggested that the Ministry of Health should consider reaching out to the youths in secondary schools and establishing youth clubs in the schools. This could be a forum for providing SRH information and alerting the youths to the availability of YFHSs. One expert added health promotion officers as role players for strategy 2, "Increase youths' knowledge on SRH issues and the availability of YFHSs". Another expert also emphasised the involvement of peer educators in activities for strategy 6, "Allocate youthful service providers to YFHSs". This information was added to the strategies.

Table 8.1: Plan for the proposed strategies

Strategies	Objective	Activities	Role players	Resources provided by
S1 Increase the accessibility of YFHSs for the youth	To increase the accessibility of YFHSs for the youths of Blantyre, Malawi.	• Provide YFHSs every day of the week and offer sporting activities on weekends. • Conduct monthly outreach clinics to provide YFHSs in remote areas. • Establish more youth clubs in the communities as a platform for the provision of YFHSs. • Reach out to youths in secondary schools where youth clubs can be formed to provide information on SRH and YFHSs.	• District Health Officers • YFHS coordinators • Health facility managers • YFHS providers • Youth champions	Ministry of Health and development partners
S2 Increase youths' knowledge of SRH issues and the availability of YFHSs	To increase youths' awareness of YFHS.	• Share messages on the availability of YFHSs in government hospitals through the provision of health information at outpatient departments. • Use mass media, e.g. radio and television programmes, and provide messages through community meetings. • Visible signposts should be placed at the entrances of the facilities with messages in English and the local language showing what YFHSs are offered. • Leaflets on basic SRH information and YFHSs	• YFHS coordinators • Health Education unit • Health facility managers • YFHS providers • Youth champions • Health promotion officers	Ministry of Health and development partners

Strategies	Objective	Activities	Role players	Resources provided by
		should be made available at outpatient departments and at the YFHS department to be given to youths attending such services. • Reach the youths in schools with information on SRH and YFHSs.		
S3 Increase medical supplies, including contraceptives for YFHSs	To reduce YFHS defaulters.	• Allocate medical supplies and contraceptives specifically to YFHSs. • Lobby for supplies for YFHSs from NGO partners and individuals to assist in funding YFHS activities.	• District Health Officers • YFHS coordinators • Health facilities' managers • YFHS providers	Ministry of Health and development partners
S4. Provide entertainment, sporting activities, equipment and games at YFHS facilities	To attract more youths in Blantyre, Malawi, to attend YFHSs.	• The health facilities should provide game boards such as "bawo" playing cards, and sports equipment such as balls for football or netball, or any other equipment that would provide entertainment to the youths, such as TVs, when they come for YFHSs. • Arrange various activities for the youth, including talent shows and music concerts.	• District Health Officers • YFHS coordinators • Health facility managers • YFHS providers	MOH District Health Office, health facility managers and development partners
S5. Provide a dedicated room or a youth corner for the provision of YFHSs	To provide privacy to the youths.	• Identify a room or corner to be used for the provision of YFHSs. • Integrate all the YFHSs to be offered in the dedicated room or space rather than	• MOH • District Health Officers	MOH and development partners

Strategies	Objective	Activities	Role players	Resources provided by
		sending the youths to different departments for different services.	• YFHS coordinators • Health facility managers • Nurses • Clinicians	
S6. Allocate youthful service providers to YFHSs	To help the youths open up during service provision.	• Allocate youthful providers at YFHS departments.	• YFHS coordinators • Health facility managers	MOH and implementing partners
S7 Allocate male and female care providers to the YFHS department	To provide a good service to youths who prefer same-gender providers.	• Allocate male and female providers to YFHS departments.	• YFHS coordinators • Health facility managers	MOH and implementing partners
S8. Provide YFHSs on weekdays and weekends	To reach youths who have other activities on designated YFHS days.	• Provide YFHSs every day of the week and on weekends. • Offer sporting activities to the youths during the weekend.	• YFHS coordinators • Health facility managers • YFHS providers • Youth champions	MOH
S.9 Provide training to all YFHS providers	To increase providers' competency in handling youths.	• Provide YFHS training to all YFHS providers. • Send providers for YFHS refresher courses if they are already trained.		MOH and development partners

8.6 SUMMARY

The combined results from the quantitative and qualitative phases were used in phase three to develop strategies for improving the utilisation of YFHSs in Blantyre, Malawi. The present chapter focused on developing strategies for increasing the utilisation of YFHSs. The next chapter describes the conclusions and limitations of the study.

CHAPTER 9
CONCLUSIONS AND RECOMMENDATIONS

9.1 INTRODUCTION

Chapter 8 described nine proposed strategies for increasing the utilisation of YFHSs. This chapter presents conclusions drawn from the current study, the study's contributions, limitations and dissemination of results. The conclusions are based on the information obtained from participants using data triangulation methods, namely a survey questionnaire, individual interviews, and focus group discussions. Findings from the quantitative and qualitative strands were integrated, which informed the development of strategies for improving the utilisation of YFHSs.

9.2 AIM OF THE STUDY

The aim of this study was to develop strategies for improving the utilisation of YFHSs in rural and urban Blantyre, Malawi.

9.3 RESEARCH OBJECTIVES

Objectives for phase one: Quantitative phase

- Determine YFHSs' accessibility in Blantyre's urban and rural areas.
- Assess youth's knowledge about YFHSs and SRH issues.
- Identify barriers to the utilisation of YFHSs.
- Identify YFHS utilisation factors associated with the Health Belief Model.

Objectives for phase two: Qualitative phase

- Explore and describe the factors that influence the utilisation of YFHS in Blantyre, Malawi.
- Propose suggestions to enhance the utilisation of YFHSs in Blantyre, Malawi.

Objective for phase three: Development of strategies

- Develop strategies to improve the utilisation of YFHS in Blantyre's urban and rural areas.

9.4 RESEARCH QUESTIONS

Phase one research questions:

- How accessible are YFHSs in Blantyre, Malawi?
- What knowledge do the youth have about reproductive health services?
- What are the possible barriers to the utilisation of YFHSs in Blantyre, Malawi?
- What YFHS utilisation factors are associated with the Health Belief Model?

Phase two research questions:

- What factors would influence the utilisation of YFHSs in Blantyre, Malawi?
- What strategies would enhance the utilisation of YFHSs in Blantyre, Malawi?

Phase three research question:

- How can strategies to improve YFHS uptake in Blantyre, Malawi, be developed?

9.5 RESEARCH DESIGN AND METHOD

An explanatory, sequential, mixed-method design was used in this study, employing a quantitative descriptive research design in phase one and a qualitative explanatory research design in phase two. The research design was chosen so the researcher could obtain rich conclusions supported by the two datasets (Wipulanusat, Panuwatwanich, Stewart & Sunkpho 2020:485).

9.5.1 Phase one: Quantitative component

A descriptive quantitative research design was used in phase one. In the quantitative phase, various variables were examined by the researcher using numbers and statistics to analyse its findings. Graphs, figures, pie charts and meta-analysis were also employed (Wings 2021:2). This method focused on objectivity and was

appropriate for collecting quantifiable measures of variables and inferences from samples of the population. The numerical data were analysed through statistical procedures using SPSS version 26 software (Queirós et al. 2017:370).

This methodology was chosen because it allowed for the participation of a large number of people (Wings 2021:3). The design also assisted the researcher in understanding the phenomenon of interest or occurrences affecting the youth, including factors that deter the youth from utilising YFHSs and strategies that would increase its utilisation (Ahmad et al. 2019:1).

9.5.2 Phase two: Qualitative component

A qualitative, explanatory research design was used in phase two of this study. According to Ahmad et al. (2019:1), qualitative research is a process of naturalistic inquiry that seeks an in-depth understanding of social phenomena within their natural settings. The qualitative research design seeks to answer “what” and “how” questions related to the research phenomenon. It focuses on why a specific theory exists and the participant’s answer to it (Wings 2021:2). In addition, Queirós et al. (2017:369) argue that qualitative research is more concerned with a deepened understanding of a given problem than numerical representativity. The objective of this methodology is to produce in-depth and illustrative information to assist researchers in understanding various proportions of the problem under study.

Explanatory research designs explore phenomena that have not been researched or adequately explained, with the purpose of discovering the “why” and “what” of a subject under investigation. Focus group discussions were conducted with youths aged 10 to 24 to explain issues in greater depth and help the researcher understand their experiences, motivation and context of their health behaviours regarding the utilisation of YFHSs (Leavy 2017:19). Thus, the focus group discussions complemented the quantitative results that were obtained from phase one’s survey. Individual interviews were also conducted with service providers and focal persons who worked at YFHSs in the selected areas. The interviews intended to explore providers’ perspectives on

factors that encourage or deter youth from utilising YFHSs and strategies that would increase their uptake among this population.

9.5.3 Phase three: Strategy development

This phase was informed by integrating the results from the quantitative and qualitative strands.

9.5.4 Research methodology

The population for phase one was unmarried youths aged 10 to 24. A multistage sampling technique was used to identify four health facilities where a total sample of 293 respondents was recruited for data collection. A survey, utilising a structured questionnaire, was used to collect data. Data were analysed using SPSS, and the results were, in turn, used to plan or build on the qualitative phase (Creswell & Creswell 2018:357; Leavy 2017:9).

The population for phase two was unmarried youths aged 10 to 24 and YFHS providers. Purposive sampling was used to select a sample of six service providers for individual interviews and 24 youths for three focus group discussions. The data collection tools in phase two were a structured interview guide and a discussion guide, respectively. Data were analysed using thematic analysis, and eight themes emerged, which were further categorised into 28 sub-themes.

9.6 SUMMARY OF INTEGRATED RESEARCH RESULTS

As previously discussed, findings from both the quantitative and qualitative phases were highlighted in order to identify central themes that facilitated the strategies' formulation to improve the utilisation of YFHSs. A summary and interpretation of the research findings follow.

9.6.1 Knowledge about YFHS and SRH

The study found that 66.2% of the respondents knew about the availability of YFHSs and the services that were included. Furthermore, it was established that 78.2% had received some SRH information. This implies that knowledge about YFHSs and SRH is crucial for the utilisation of YFHSs.

In the current study, there were two main sources of information for SRH: youth clubs (42.9%) and schools (39.4%). This implies that the establishment of youth clubs should be encouraged because they provide youths with a forum where they can get information relating to different aspects of their lives. Moreover, placing information on reproductive health in the country's school syllabi is essential.

Most participants preferred to get information on SRH issues from nurses (45.7%), followed by parents (20.5%). However, the qualitative data showed that the participants claimed information from parents was superficial. The finding shows that nurses play a significant role in providing health information through the health talks given at the health facilities. It was, however, found that printed health information on SRH was lacking in the current study; it transpired that two-thirds of the respondents (65.5%) had never received printed materials on SRH at the health facilities. This finding reflects the need for the Ministry of Health to provide printed materials to youths in the health facilities, which could reach other youths if carried home.

9.6.2 Accessibility of YFHSs

The current study found that accessibility to YFHSs was problematic, as less than half of the respondents had ever accessed YFHSs (43%). The qualitative phase revealed that some youths did not access YFHSs due to a lack of dedicated space for the service, which implied a lack of privacy for the youths; long travel distance to the health facilities; lack of knowledge about YFHSs; and a lack of money to contribute towards sports equipment to be used at the facilities. Furthermore, while some youths were unwilling to benefit from YFHSs simply because they thought the services were not important, some youths' parents were not allowing them to access the services

because they thought doing so would create an opportunity for the youths to indulge in sexual activities.

One issue repeatedly mentioned as contributing to the inaccessibility of YFHSs was the lack of activities to attract youths, such as sporting and entertainment activities at the health facilities. Participants also mentioned their socioeconomic status influenced the accessibility of YFHS. Participants indicated that they sometimes did not access YFHSs because they did not have money to contribute towards buying sporting equipment for the facilities, such as balls. The youth sometimes opted to contribute financially because they did not have sponsors for these resources. Ironically, in the process, some youths stopped accessing YFHSs due to their inability to make the agreed financial contribution.

The majority of respondents preferred to access YFHSs at the government health centres (84.3%). One of the factors behind this was financial difficulties; the youths were encouraged to visit government facilities because their services were offered at no charge. It also emerged from the study that encouragement or discouragement to attend YFHSs contributed to YFHS uptake. More than half of the respondents had been encouraged to attend YFHSs (55.6%), but evidently not all of the respondents who had ever been encouraged to do so accessed the services.

The YFHS focal persons also mentioned several factors that positively influenced the accessibility of YFHSs. In some areas, NGOs conducted sensitisation sessions in the communities. For instance, organisations such as MANASO and JHPIEGO were involved in sensitising the youth on reproductive health issues and YFHSs in the communities, and this, in one way or another, positively affected YFHS uptake. In other words, knowledge about YFHSs enhanced its utilisation.

Some NGOs sponsored youth sports bonanzas or organised music shows occasionally. This strategy increased accessibility to YFHSs on such days, thereby attracting youths to access the services. In some places, they conducted awareness campaigns during youth-organised self-help activities, such as sweeping in a marketplace. This aligns with the Ministry of Health's National Strategy (2015–2020:23)

Priority Area 2 and Specific Objective 2, which discusses increasing access and utilisation of age-appropriate YFHSs among young people.

9.6.3 Service providers' attitudes

In this study, youths were satisfied with the attitude of service providers. They indicated that the providers were accommodating, friendly, welcoming, non-judgemental and generally treated them with respect. The youth stated that the providers' attitudes encouraged those who were attending YFHSs to continue accessing the services.

Almost all the respondents who had ever accessed YFHSs (94.4%) said they were treated respectfully. The service providers were rated high in terms of their positive characteristics: 30.2% of the respondents said the providers were normal, 34.9% said they were friendly, and 31.7% claimed that they conducted themselves in a professional manner. Only 3% of the respondents rated the healthcare providers or YFHS focal persons as harsh or rude.

The service providers corroborated the youths' reports that they were accommodating and open with the youth, encouraging them to open up to them. This finding contradicted most previous studies where providers' attitude was a barrier to the utilisation of YFHSs, and the biggest challenge for the youth. The common characteristics demanded by youths in previous studies were the need to be treated with respect and to protect their confidentiality, which did not emerge as a problem in the current study. This implies that there is a need to support the service providers at YFHSs by providing training and refresher courses so that all service providers treat youths with respect and without judgement.

9.6.4 Barriers to the utilisation of YFHS

Most of the suggested factors included in phase one were not barriers to the respondents' utilisation of YFHSs in all facilities that were studied. However, the qualitative phase of the study revealed several barriers to the utilisation of YFHSs. Three were prominent, namely frequent stockouts of medical supplies, lack of sporting

activities, entertainment and supporting equipment, and lack of dedicated space for YFHS provision.

9.6.4.1 Shortage of medical supplies

The study revealed that resources, such as contraceptives, were not always available at the health facilities. The only contraceptive method that was always available in all the health facilities was condoms. This caused some youths to be discouraged from seeking contraception methods and returning to YFHS facilities. The service providers from all the sites in the current study also confirmed frequent stockouts of supplies, including contraceptives. They concurred that only condoms were always available in the health facilities.

9.6.4.2 Lack of sporting activities, entertainment and supporting equipment

The study found that youth participants took sporting and recreational activities very seriously, and they opted to visit YFHS facilities that offered sporting and recreational activities instead of those only offering health education and a supply of contraceptives. This implies that if these activities were always available, more youths might attend, and service providers could use the opportunity to provide health information, contraceptives and other services offered at YFHSs. This finding is not common in literature, but in the current study, it was reported to be one of the biggest factors preventing youths from utilising YFHSs in all the sampled health facilities.

9.6.4.3 Lack of dedicated space for conducting YFHSs

The study revealed that YFHSs in all the sampled sites lacked dedicated space. YFHSs were provided in borrowed spaces, such as the antenatal clinic, outside the HCT clinic, and mainly in open spaces. This compromised the youths’ privacy, and some were discouraged from attending YFHSs for fear of being seen by others. Youth participants suggested that health facilities allocate dedicated space, special rooms or youth corners where YFHSs should be provided. YFHS focal persons similarly shared this recommendation. The youth participants further recommended that the dedicated

spaces should be one-stop centres where they can receive all the services they require from the health facility. Some added that a YFHS office was required.

9.6.4.4 Perceptions and misconceptions about SRH issues and YFHSs

The study also uncovered certain myths and misconceptions regarding youths' use of contraceptives. During focus group discussions, some youths reported misconceptions that led them to believe a girl who takes contraceptives would not be sexually active, she would become infertile, the contraceptives would negatively affect the normal functioning of the female body; and when used by boys, the contraceptives would reduce the male libido.

Apart from myths and misconceptions, the attitude of some youths also prevented them from utilising YFHSs; some believed they had outgrown the services. The study also revealed that some youths were just too shy to attend YFHSs, based on communities' misconceptions regarding YFHSs and the use of contraceptives. Participants also expressed that many parents had misconceptions and therefore would not allow their children to access contraceptives. The parents believed contraceptive use among young girls would lead to infertility and prostitution, and generally harm the girls' bodies. These misconceptions and lack of support from parents prevented some youths from accessing YFHSs.

Likewise, it was found that the community, in general, viewed young girls' contraceptive use negatively, arguing it would encourage prostitution and cause infertility. The participants, however, noted that these misconceptions were mainly related to girls and not boys.

9.6.4.5 Distance to the health facility

Distance was also found to be a barrier to the utilisation of YFHSs because some catchment areas were large. It was determined that some catchment areas were hilly, making it difficult for some youths to access YFHSs due to poor mobility.

9.6.4.6 Youth preference on the day, service provider and gender of service provider

The study found that YFHS activities were offered on different days of the week but mainly during weekends; however, participants in all the health facilities under study were quick to mention that the youth were also being assisted by the YFHS providers when they came for help during the week. Regarding their preferences, participants from all the studied facilities preferred YFHS activities on weekends, considering that some went to school, and others were busy during weekdays. They also proposed that a youth corner be opened in the health facility to offer services to the youth every weekday.

The study found that the youth preferred youthful providers, based on the understanding that the youth would easily open up to peers and would not feel shy to talk about private issues with them. The quantitative data showed that about two-thirds of the respondents (63.8%) preferred youthful service providers.

Regarding the gender of service providers, it transpired that the youths preferred to have both genders always available at the YFHS facility because some found it difficult to talk freely with a service provider of the opposite gender.

9.6.4.7 Health Belief Model application

The Health Belief Model was applied to the study's results. It was implied that a lack of knowledge about YFHSs reduced some youths' perceived susceptibility to utilising YFHSs and reduced the perceived seriousness of not utilising YFHSs. It was therefore necessary to improve the modifying factors and increase the cues to action to improve the utilisation of YFHSs.

9.6.4.8 Suggestions to improve the utilisation of YFHSs

More than half of the study's respondents preferred to attend YFHSs at government health centres (51.2%), followed by youth clubs (27%). The most preferred YFHS provider by the respondents was youth providers (63.8%). Youth participants

recommended having youthful staff at the youth corner of both genders because some were unable to talk freely with a service provider of the opposite sex. More than half of the respondents preferred to have dedicated youth corners in the health facilities for YFHSs (58.7%). The qualitative findings also showed that participants preferred to have dedicated spaces, special rooms or youth corners where YFHSs could be provided. This recommendation was also made by YFHS focal persons. The youth participants further recommended that the dedicated spaces should be one-stop centres, where they can receive all the services they require. Some added that an office for YFHSs was required.

Participants recommended that balls, game boards, and other recreational activities should be made available to them by the health facilities. Participants recommended that health facilities supply sporting and recreational equipment to attract youths. The service providers could then use the opportunity to educate the youth on different topics affecting them, provide counselling and other services, and provide contraceptives. They recommended that medical supplies, such as contraceptives, should always be available because it was discouraging for youths to find their contraceptive method of choice repeatedly out of stock, and some stopped attending YFHSs as a result. The youth participants further suggested that NGO partners should be approached to assist with medical supplies and sporting materials.

The participants also recommended community sensitisation about YFHSs should be conducted by YFHS focal persons and some youths. In the process, parents would get to know what YFHSs entail, which might, in turn, reduce misconceptions. The participants also recommended sensitisation about YFHSs using the radio or television, with programmes allowing the youth to inform their peers. YFHS focal persons suggested engaging community leaders in more strategies, besides conducting community sensitisation sessions.

Service providers recommended training for staff working at YFHSs and orientation for all staff in the health facilities, including security guards, so that they are non-judgemental towards youths who attend the facilities. They further recommended that policies and guidelines for YFHSs should be made available to service providers to ensure the proper running of YFHS departments.

9.6.4.9 Summary of the developed strategies

Based on the findings from phases one and two, the following strategies were developed and validated by experts in the field of SRH and YFHSs:

S1. Increase the accessibility of YFHSs for the youth
S2. Increase youths' knowledge of SRH issues and the availability of YFHSs
S3. Increase medical supplies, including contraceptives for YFHSs
S4. Provide entertainment, sporting activities, sporting equipment and games at YFHS facilities
S5. Provide a dedicated room or a youth corner for the provision of YFHSs
S6. Allocate youthful service providers to YFHSs
S7. Allocate male and female care providers to the YFHS department
S8. Provide YFHSs on weekdays and weekends
S.9 Provide training to all YFHS providers

9.7 CONCLUSION OF THE STUDY

The study's findings suggest that the utilisation of YFHS was still low in Blantyre (43%). Evidence from the study concluded on five key themes, namely knowledge about YFHSs, accessibility of YFHSs, the attitude of service providers, barriers to the utilisation of YFHSs (including frequent stockouts of medical supplies, lack of sporting activities, entertainment and supporting equipment) lack of dedicated space for providing YFHSs, and youths' preference on the YFHS days, service provider age and gender. The researcher concluded that resolving the main barriers to the utilisation of YFHSs, as identified in the current study, would assist in increasing YFHS uptake. Thus, the study filled this knowledge gap by identifying strategies to increase the utilisation of YFHSs.

9.8 CONTRIBUTIONS OF THE STUDY

The study has contributed to the expansion of frontiers of knowledge because it identified three main barriers to the utilisation of YFHSs in Blantyre, namely frequent stockouts of medical supplies, lack of sporting activities, entertainment and supporting

equipment, and lack of dedicated space for providing YFHSs. These findings are inconsistent with the barriers commonly acknowledged in literature on this subject, namely poor attitudes among service providers and lack of respect for the youth.

The study advocates for the need to solve the described barriers so that the utilisation of YFHSs can be improved. The study thus developed strategies to increase the utilisation of YFHSs.

Literature emphasised training for service providers to change their judgemental attitudes, but service provider attitude was not a problem in this study. The study has therefore bridged an identified gap regarding the main barriers to the utilisation of YFHSs in Blantyre. Further research will be needed to evaluate the utilisation of YFHSs following the strategies' implementation, and another study is required to evaluate the country's abortion rate after the strategies have successfully been implemented.

9.9 IMPLICATIONS OF THE STUDY

9.9 1 Implications for practice

9.9.1.1 Gender of the youth

Evidence from this study suggests that it is important to focus on both female and male youths when encouraging YFHS uptake. Even though girls experience more negative effects from unintended pregnancies, boys also ought to be knowledgeable about reproductive health issues to complement the prevention of unintended pregnancies.

9.9.1.2 Focus on younger adolescents

The study suggests that there is a need to increase the focus on younger adolescents so that more of them can utilise YFHSs. This group, unlike older youths, is more likely to face childbearing complications should they succumb to unintended pregnancies. Considering that most adolescents are in school, there is a need for policymakers to draft policies that increase information on SRH and YFHSs in primary and secondary schools.

9.9.1.3 Establishing youth clubs

The study suggests that YFHS focal persons should assist in addressing the need to establish youth clubs in areas far from government health facilities. The clubs could provide YFHSs within the communities, while the YFHS focal persons could visit the youth clubs and provide services to them once a month.

9.9.1.4 SRH education and sensitisation about YFHSs

The study suggests a need to intensify the provision of SRH education and sensitisation for the youth regarding the availability of YFHSs in different settings, including schools, youth clubs, health facilities' outpatient departments, and communities. The use of mass media, such as radio and television programmes, could also help in intensifying SRH education and sensitisation, with assistance from the Ministry of Health in partnership with NGOs that already focus on SRH.

9.9.1.5 Training for YFHS providers

The study identified that the providers had undergone training or orientation concerning the provision of youth-specific services. This possibly contributed to their positive and non-judgemental attitudes towards the youth in all the study sites. This, significantly, points to the need for all YFHS providers to be trained before being allocated to YFHS departments. This is in agreement with the Ministry of Health's National Strategy (2015-2020:22) Priority Area 2 and Specific Objective 1 "To enhance the capacity of service providers and implementing partners to deliver quality YFHSs".

9.9.2 Implications for policy

9.9.2.1 School curriculum

The study highlights the need for primary and secondary school curricula to include information concerning the availability of YFHSs in health facilities and, in turn, encourage the youth to utilise these services.

9.9.2.2 YFHS signposts

Evidence from this study suggests that health facilities should have clear and visible signposts indicating the availability of YFHSs. The signage should be in both English and relevant local languages so that the youth and others can easily read and become informed about the available services.

9.9.2.3 Printed SRH materials

The study also suggests the need for the Ministry of Health to have printed materials, such as leaflets on SRH and YFHSs placed in the YFHS departments so that the youth can read these when they visit the facilities. Some may be carried home to ensure information about SRH reaches those who have never attended the facilities, potentially encouraging them to visit.

9.9.2.4 Dedicated space for YFHSs

The study recommends the provision of dedicated space for YFHSs, considering that some young people may be too shy or afraid to be seen accessing YFHSs at health facilities by people that they know. This calls for health facilities to provide space, such as youth corners or rooms dedicated to YFHSs. This could help to increase the number of youths attending YFHS.

9.9.2.5 Provision of adequate supplies and sporting equipment for YFHSs

The study recommends the provision of adequate supplies for YFHSs, including contraceptives and sporting equipment in government health facilities. This will attract more youths to attend YFHSs, thereby increasing their uptake of contraceptives and reducing the number of unintended pregnancies and unsafe abortions among this population.

9.9.2.6 Youth-to-youth service provision

The study proposes a deliberate policy to encourage the recruitment of youthful YFHS providers in government health facilities to enable the youth to interact easily with service providers when they visit the facilities, since youths tend to open up more easily to fellow young people.

9.9.2.7 Gender for providers

A deliberate policy for female and male YFHS providers is recommended to attract the youths who prefer to interact with service providers of their gender to utilise the YFHSs, thereby helping to increase YFHS uptake.

9.9.3 Implications for future research

Future research is recommended to determine the YFHS providers' friendliness in Malawi. There is also a need for further research to evaluate the proposed strategies' effectiveness in increasing youths' utilisation of YFHSs.

9.10 LIMITATIONS OF THE STUDY

The study's generalisability beyond Blantyre is limited due to a small sample that was justified by the fact that the study was conducted in one district only. However, the results of the study shed adequate light on strategies that could increase the utilisation of YFHSs, with policymakers benefitting from improving the services' utilisation.

9.11 DISSEMINATION OF RESULTS

An electronic copy of this thesis will be submitted to the University of South Africa's library to be uploaded to the institutional repository. The findings will be disseminated to the Blantyre District Health Office and the health facilities that were involved in the study. The findings will also be shared through research workshops, conferences and research articles. Two to three articles will be sent for publication in reputable journals. The findings will also be disseminated to policymakers in the Ministry of Health of

Malawi to influence policies on strategies that could improve YFHS uptake of counselling and contraceptives.

9.12 CONCLUDING REMARKS

The purpose of this study was to develop strategies for improving the utilisation of YFHSs. Based on the information acquired from respondents in the quantitative phase and participants in the qualitative phase, strategies were developed to increase the utilisation of YFHSs. It is important that the Ministry of Health, health facility management teams, YFHS providers, NGOs and all relevant stakeholders consider the proposed strategies. The study ultimately recommends prioritising solutions for the three main barriers to uptake that were identified, namely frequent stockouts of medical supplies, lack of sporting activities, entertainment and supporting equipment, and lack of dedicated space for providing YFHSs. There is a need for further research to evaluate the proposed strategies' effectiveness in increasing YFHS utilisation. Future research is also recommended to determine the friendliness of YFHSs in Malawi.

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ANNEXURE A: UNISA ETHICS APPROVAL CERTIFICATE

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

29 October 2021

Dear MRS Grace Charity Sibande

Decision:
Ethics Approval from 29 October 2021 to 29 October 2026

NHREC Registration # : Rec-240816-052
CREC Reference # : 67129765_CREC_CHS_2021

Researcher(s): Name: Mrs Grace Charity Sibande
Contact details: 67129765@unisa.ac.za
Supervisor: Name: Dr. R.G. Malapela
Contact details: emalapr@unisa.ac.za

Title: STRATEGIES FOR IMPROVING UTILIZATION OF YOUTH FRIENDLY HEALTH SERVICES IN BLANTYRE, MALAWI

Degree Purpose: PhD

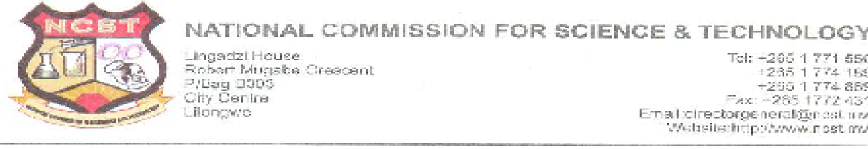
Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for five years.

The *medium risk application was reviewed by* College of Human Sciences Research Ethics Committee, in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the

ANNEXURE B: ETHICAL APPROVAL FROM NATIONAL COMMITTEE ON RESEARCH IN THE SOCIAL SCIENCES AND HUMANITIES


NATIONAL COMMISSION FOR SCIENCE & TECHNOLOGY
Lingadzi House
City Centre
Lilongwe

NATIONAL COMMITTEE ON RESEARCH IN THE SOCIAL SCIENCES AND HUMANITIES

Ref No: NCST/RTT/2/6 **6th September 2022**

Mrs Grace Charity Sibande,

KUHES,

P.O. Box 415,

Blantyre.

Email: gsibande@kcn.unima.mw

Dear Mrs Sibande,

RESEARCH ETHICS AND REGULATORY APPROVAL AND PERMIT FOR PROTOCOL NO. P.08/22/663: STRATEGIES FOR IMPROVING UTILIZATION OF YOUTH FRIENDLY HEALTH SERVICES IN BLANTYRE, MALAWI

Having satisfied all the relevant ethical and regulatory requirements, I am pleased to inform you that the above referred research protocol has officially been approved. You are now permitted to proceed with its implementation. Should there be any amendments to the approved protocol in the course of implementing it, you shall be required to seek approval of such amendments before implementation of the same.

This approval is valid for one year from the date of issuance of this approval. If the study goes beyond one year, an annual approval for continuation shall be required to be sought from the National Committee on Research in the Social Sciences and Humanities (NCRSH) in a format that is available at the Secretariat. Once the study is finalised, you are required to furnish the Committee and the

Committee Address:
Secretariat, National Committee on Research in the Social Sciences and Humanities, National Commission for Science and Technology, Lingadzi House, City Centre, P/Bag B303, Capital City, Lilongwe3, Malawi. Telephone Nos: +265 771 550/774 869; E-mail address: ncrsh@ncst.mw

Commission with a final report of the study. The committee reserves the right to carry out compliance inspection of this approved protocol at any time as may be deemed by it. As such, you are expected to properly maintain all study documents including consent forms.

Wishing you a successful implementation of your study.

Yours Sincerely,

Yalonda .I. Mwanza
NCRSH ADMINISTRATOR
HEALTH, SOCIAL SCIENCES AND HUMANITIES DIVISION

For: CHAIRPERSON OF NCRSH

Committee Address:
Secretariat, National Committee on Research in the Social Sciences and Humanities, National Commission for Science and Technology, Lingadzi House, City Centre, P/Bag B303, Capital City, Lilongwe3, Malawi. Telephone Nos: +265 771 550/774 869; E-mail address: ncrsh@ncst.mw

ANNEXURE C: APPROVAL TO CONDUCT STUDY FROM BLANTYRE DHO

UNISA university of south africa

Approved

Blantyre District Council
Director of Health & Social Services
29 JUL 2022

29 July 2022

The District Health Officer
Blantyre DHO
Private Bag 66
Blantyre

Dear Sir or Madam,

PERMISSION TO CONDUCT RESEARCH STUDY AT NDIRANDE, CHILOMONI, MDEKA AND MADZIABANGO HEALTH CENTRES AND PILOT STUDY AT GATEWAY CLINIC

I write to seek permission to use Ndirande, Chilomoni, Mdeka and Madziabango health centres as study sites and Gateway clinic as a site for pilot study.

I am a lecturer at Kamuzu University of Health Sciences (KUHES) currently pursuing my PhD in Public Health with the University of South Africa. As a requirement for the fulfilment of the programme, I am supposed to conduct a research study. My research topic is "Strategies for improving utilization of Youth Friendly Health Services (YFHS) in Blantyre, Malawi. The aim of the study is to develop strategies to improve utilization of YFHS by unmarried youth in Blantyre. Data will be collected in two phases, where phase one will be a survey for youths aged 10 to 24 in the catchment areas surrounding the selected health facilities, and phase two will include individual interviews for service providers working at YFHS in the selected facilities and focus group discussions with the youth aged 10 to 24 in the selected areas which will be determined by data saturation.

The research study has already received ethical approval from the University of South Africa and permission from your office is one of the requirements for ethical clearance from the National Council for Science and Technology of Malawi. Attached is the ethical clearance certificate from the University of South Africa, scanned copy of my National identity and KUHEs identity and the signed supervisor agreement form.

Looking forward to your timely response.

Yours Faithfully,

Mrs. Grace Charity Sibande

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

ANNEXURE D: PARTICIPANT INFORMATION SHEET

UNISA university of south africa

Ethics clearance reference number: Rec-240816-052

Research permission reference number: 67129765_CREC_CHS_2021

9 August, 2022

Title: “Strategies for improving utilisation of Youth Friendly Health Services in Blantyre, Malawi.

Dear Prospective Participant

My name is Grace Charity Sibande, am doing research with Dr. Rakgadi Grace Malapela, a Senior lecturer in the Department of Health studies, towards a PhD in Public Health at the University of South Africa. We are inviting you to participate in our study entitled “Strategies for improving utilisation of Youth Friendly Health Services in Blantyre, Malawi.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of the research study is to develop strategies for improving utilisation of Youth Friendly Health Services in Blantyre.

WHY AM I BEING INVITED TO PARTICIPATE?

You are being invited to participate in this study because you provide reproductive health services hence your perspective and experiences could be invaluable in the research.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

The study will entail asking you questions about your perspectives in relation to different areas of utilisation of Youth Friendly Health Services. The interview will take approximately 45 to 50 minutes. You will be audio taped using a tape recorder so that the researcher does not miss out on the important information that will provide.

You will be recruited into the study along with other nurse/midwives from the four health centres providing reproductive health services namely: Ndirande, Chilomoni, Mdeka and Madziabango.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason. Whether you participate, not participate or withdraw, it will not affect you in any way whatsoever. Therefore, you have the right to decide voluntarily to participate in the study; ask questions for clarification; refuse to give information or withdraw from the study at any stage without incurring any negative consequences.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

You may not receive a direct benefit; however, it is anticipated that the information obtained from this research would improve utilisation of Youth Friendly Health Services using health provider's perspectives. It could also help to identify gaps that need to be addressed in the provision of Youth Friendly Health Services and policies that govern I

ARE THEIR ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

There are no anticipated risks attached to participating in this study. If you are unhappy with some of the questions you are allowed not to respond.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

All the information collected will be confidential. You have the right to insist that your name will not be recorded anywhere and that no one apart from the researcher and identified members of the research team will know about your involvement in the research. Your answers will be given a code number and you will be referred to in this way in the data, any publications or other research reporting methods such as conference proceedings.

The signed consent form will be placed in a separate bag from the one containing completed interview schedules. All completed interview schedules will be kept under lock and key and only the researcher will have access to this locker.

Records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

Hard copies of your answers will be stored by the researcher for a minimum period of five years in a locked cupboard in the researcher's office. For future research or academic purposes; electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

Participation in this study is not associated with payment or reward of any kind. Transport cost for the purpose of the study will be reimbursed.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study has received written approval from the Research Ethics Review Committee, Unisa. A copy of the approval letter can be obtained from the researcher if you so wish.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, or should you require any further information or want to contact the researcher about any aspect of this study, please contact: Grace Charity Sibande, Kamuzu University of Health Sciences, Blantyre campus, P. O. Box 415, Blantyre. Cell phone number +265 (0) 995 297 078. Email: gsibande @kuhes.ac.mw.

Should you have concerns about the way in which the research has been conducted, you may contact Dr R.G. Malapela, Telephone number:0124294506/ 0825986881; E-mail: emalapr@unisa.ac.za fax: 0124296688. Contact the research ethics chairperson if you have any ethical concerns or you want to report violation of your rights on the following address: Secretariat, National Committee on Research in the Social Sciences and Humanities, National Commission for Science and Technology, Lingadzi House, City Centre, P/Bag B303, Capital City, Lilongwe3, Malawi. Telephone Nos: +265 771 550/774 869; E-mail address: ncrsh@ncst.mw

Thank you for taking time to read this information sheet and for considering to participate in the current study. If you are willing to participate in this study, kindly complete the consent form below.

Yours sincerely,

Grace Charity Sibande - Researcher.

ANNEXURE E: UTHENGA KWA OTENGA MBALI

UNISA university of south africa

Ethics clearance reference number: Rec-240816-052

Research permission reference number (if applicable): 67129765_CREC_CHS_2021

09 August, 2022

Mutu wa kafukufuku "Njira zopititsira patsogolo kagwiritsidwe ntchito ka chipatala cha achinyamata ku Blantyre, Malawi.

Okondedwa Otenga mbali

Dzina langa ndine Grace Charity Sibande, ndikupanga kafukufuku ndi a dokotala a Rakgadi Grace Malapela, mphunzitsi wamkulu ku gawo la maphunziro a za umoyo, iyi ndi mbali imodzi yamaphunziro anga a ukachenjede oti ndikhale dokotala. Ndikuphunzira kusukulu ya ukachenjede ku South Africa. Tikukupemphani kuti mutenge nawo mbali mu kafukufuku yemwe dzina lake ndi "Njira zopititsira patsogolo kagwiritsidwe ntchito ka chipatala cha achinyamata ku Blantyre, Malawi."

CHOLINGA CHA KAFUKUFUKU?

Cholinga cha kafukufukuyu ndi kupeza njira zopititsira patsogolo kagwiritsidwe ntchito ka zipatala za achinyamata mu madera a kumudzi ndi kutawuni m'boma la Blantyre.

CHIFUKWA CHANI MWAYITANIDWA KUTI MUTENGE NAWO MBALI?

Mwaitanidwa kuti mutenge nawo mbali mu kafukufukuyu chifukwa ndinu achinyamata apakati pa zaka 10 mpaka 24 kapena mumapereka thandizo pankhani zogonanan ndi ubereki pachifukwa icho mmene mumaonera zinthu zitha kukhala zothandiza kwambiri mu kafukufukuyu.

KUTENGA NAWO MBALI MU KAFUKUFUKUYU KUKHALA KOTANI?

Mu kafukufukuyu mufunsidwa mafunso okhudza mmene mumaonera zinthu mu madera osiyanasiyana a kagwiritsidwe ntchito ka chipatala cha achinyamata. Mafunso omwe mufunsidwe akititengera nthawi yokwana mphindi 45 kufikira 50. Zomwe tidzicheza zijambulidwa ndi chotepera mawu zimene zimathandiza kuti opanga kafukufuku asaphonye zinthu zofunika zomwe mutanene.

Mulowa mu kafukufuku ndi achinyamata ndi anamwino komanso azamba ena ochokera mu zipatala zazing'ono zinayi omwe amapereka thandizo lokhudza nkhani zogonana komanso ubereki. Maina azipatalazi ndi: Ndirande, Chilomoni, Mdeka komanso Madziabango.

KODI NDINGATHE KUSIYA KUTENGA NAWO MBALI INGAKHALE NDITAPEREKA KALE CHILOLEZO CHOTI NDITHA KUTENGA NAWO MBALI?

Kutenga nawo mbali mukafukufukuyu ndi mwakufuna kwanu ndipo palibe chiopsezo chilichonse kuti muvomereze kutenga nawo mbali. Ngati mungavomereze kutenga nawo mbali mu kafukufukuyu, mudzapatsidwa chikalata chofotokoza za kafukufukuyu kuti musunge. Ndipo mudzapemphedwa kuti mulembe dzina lanu kusonyeza kuti mwapereka chililozo kuti mutenge nawo mbali. Ndinu omasuka kusiya kutenga nawo mbali mukafukufukuyu panthawi ina iliyonse komanso osapereka chifukwa cha zomwe mwasiyira kutenga nawo mbali. Kutenga nawo mbali kapena ayi, kusatenga nawo mbali komanso kukana kutenga nawo mbali sikudzaika chiopsezo chinachilichonse kwa inu. Pachifukwa ichi muli ndi ufulu osankha mosakakamizidwa kutenga nawo mbali mu kafukufuku, kufunsa mafunso kuti mumvetsetse, kukana kupereka uthenga wina kapena kusiya kutenga nawo mbali mukafukufuku panthawi ina iliyonse osakumana ndi mavuto ena alionse.

KODI PHINDU LOTENGA NAWO MBALI MUKAFUKUFUKUYU NDILOTANI?

Mutha osapeza phindu lobwera kwa inu mwachindunji, koma tikuyembekezera kuti uthenga omwe titapeze kuchokera mu kafukufukuyu apititsa patsogolo kagwiritsidwe ntchito ka chipatala cha achinyamata kuchokera ku zomwe inu mutanene. Zithanso kuthandizira kupeza zinthu zomwe sitikuchita bwino kuti zikonzedwe mu kupereka thandizo kwa chipatala cha achinyamata komanso malamulo amene amawayang'anira.

KODI PALI CHIOPSEZO KWA INE NDIKATENGA NAWO GAWO MU KAFUKUFUKUYU?

Palibe chiopsezo chomwe tikuchiyembekezera mukatenga nawo gawo mu kafukufukuyi. Ngati simuli okondwa ndi mafunso ena ndinu ololedwa kusawayankha.

KODI ZINTHU ZOMWE NDITAMUFOTOKOZERE MWINI KAFUKUFUKU KOMANSO DZINA LANGA ZISUNGIDWA MWA CHINSINSI?

Zonse zimene munene zikhala za chinsinsi. Muli ndi ufulu onena kuti dzina lanu lisalembedwe pena paliponse ndipo kuti pasapezeke munthu kupatula omwe akupanga kafukufuku komanso anthu omwe akudziwika mu kafukufuku kuti asadziwe za kutenga nawo mbali kwanu mukafukufuku. Mayankho anu adzapatsidwa nambala ndipo mudzatchulidwa pogwiritsa ntchito numbalayi mu nkhani zanu, muzolembedwa mmabuku kapena zokamba zina za kafukufuku ngati za mmisonkhano. Chikalata chanu chopereka chilolezo chomwe chidzakhale ndi dzina lanu chidzaikidwa mu pepala losiyana ndi lomwe muli nkhani zanu. Zonse zocheza nanu zizasungidwa mukabati yotsekera ndi loko ndipo opanga kafukufuku okha ndi omwe adzathe kutsegula mu kabatiyi.

Zolemba zonse zomwe zitha kuzakuzindikilitsani zizakhala zopezeka kwa anthu okhawo omwe akupanga nawo kafukufuku, pokhapokha mutapereka chilolezo kuti ena aone, ndipomwe zingadzatero.

KODI ANTHU OPANGA KAFUKUFUKU ADZATETEZA BWANJI NKHANI ZA MUKAFUKUFUKUYU?

Mapepala a mayankho anu adzasungidwa ndi eni kafukufuku kwa nthawi yokwanira zaka five, adzasunga mu kabati yotseka ndi loko mu chipinda chogwirira ntchito mwini kafukufuku. Kupangira kafukufuku wamtsogolo kapena cholinga cha maphunziro.

Zolembedwa zina zidzasungidwa mu komputa yomwe ili ndi nambala yotetezedwa potsegula. Kuti zolembedwazo zigwiritsidwenso ntchito, chilolezo chidzapemphedwa kuchokera ku bungwe lopereka chilolezo cha kafukufuku.

KODI NDIDZALANDIRA MALIPIRO KAPENA CHOTHOKOZA CHILICHONSE CHIFUKWA CHOTENGA NAWO MBALI MUKAFUKUFUKUYU?

Palibe malipiro kapena mphoto ya mtundu ulionse yomwe idzaperekedwe chifukwa chotenga nawo mbali mukafukufukuyi. Tidzakubwenzerani ndalama imene mudzayendere podzapanga nawo kafukufukuyu.

KODI KAFUKUFUKUYU NDIOVOMEREZEDWA NDI MABUNGWE OTETEZA ANTHU PANKHANI YAKAFUKUFUKU?

Kafukufukuyi walandira chilolezo kuchokera ku bungwe loteteza anthu pankhani yakafukufuku, sukulu ya ukachenjede yak u south Africa. Kalata ya chitetezo mutha kuiona kuchokera kwa opanga kafukufukuyu ngati mungafune.

NDIDZAUZIDWA BWANJI ZOTSATIRA ZA KAFUKUFUKUYU

Ngati mukufuna kudzauzidwa zotsatira zomaliza za kafukufukuyu, kapena ngati mungafune uthenga wina ulionse kapena ngati mukufuna kuyankhula ndi opanga kafukufukuyu pachinachilichonse cha kafukufukuyu, chonde ndipezeni pa: Grace Charity Sibande, Kamuzu University of Health Sciences, Blantyre campus, P. O. Box 415, Blantyre. Nambala ya foni yammanja, +265 (0) 995 297 078. Email: gsibande @kuhes.ac.mw.

Ngati mungakhale ndi dandaulo ndi m'men kafukufukuyu wachitikila, mutha kuyankhula ndi Dr R.G. Malapela, nambala ya foni :0124294506/ 0825986881; E-mail: emalapr@unisa.ac.za fax: 0124296688. Ngati muli ndi nkhawa pankhani ya zoteteza ufulu wa anthu pankhani ya kafukufuku, mutha kulembela kalata wapampando wa bungwe li pa addiresi iyi: Secretariat, National Committee on Research in the Social Sciences and Humanities, National Commission for Science and Technology, Lingadzi House, City Centre, P/Bag B303, Capital City, Lilongwe3, Malawi; E-mail address: ncrsh@ncst.mw kapena kuyimba pa nambala izi : +265 771 550/774 869.

Zikomo kwambiri potenga nthawi yanu kuwerenga nkhanizi komanso poganizira kuti mutenge nawo gawo mu kafukufukuyu. Ngati muli omasuka kutenga nawo gawo mu kafukufukuyu, chonde lembani dzina lanu ndi tsiku pa chipepela cha chilolezo chili mmusimu.

Ndatha ine wanu,

Grace Charity Sibande. Mwini kafukufuku.

ANNEXURE F: CONSENT TO PARTICIPATE IN THE STUDY

Ethics clearance reference number: Rec-240816-052

Research permission reference number: 67129765_CREC_CHS_2021

I, __________________ (participant name), confirm that the person asked for my consent to take part in this research.

The researcher has told me about the nature, procedure, potential benefits and anticipated inconvenience of

participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or

conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the <insert specific data collection method>.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname………………………………………………..…….. (Please print)

Participant Signature……………………………………………..Date…………………

Researcher's Name & Surname………………………………………………………… (Please print)

Researcher's signature…………………………………………..Date…………………

ANNEXURE G: CHILOLEZO CHOTENGA NAWO MBALI MUKAFUKUFUKU

Ethics clearance reference number: Rec-240816-052

Research permission reference number: 67129765_CREC_CHS_2021

Ine, __________________ (dzina la otenga mbali), ndikutsimikiza kuti andipempha kuti nditenge nawo mbali mu kafukufukuyi.

Opanga kafukufuku andiuza za mtundu wa kafukufuku, zomwe zichitike, phindu lake komanso zoyembekezera zomwe zingabwere potenga nawo mbali (anticipated inconvenience of participation).

Ndawerenga (kapena andiwerengera) ndipo ndamvetsetsa za kafukufukuyi mmene afotokozera mu kalata ya uthengayo.

Ndakhala ndinthawi yokwanira yofunsa mafunso ndipo ndili okonzeka kutenga nawo mbali.

Ndamvetsetsa kuti kutenga nawo mbali kwanga ndikosakakamiza ndipo ndine omasuka kusiya nthawi ina iliyonse opanda chiopsezo chinachilichonse.

Ndizidziwa kuti zotsatira za kafukufukuyu zizalembedwa mu kalata yopereka ndondomeko yonse ya kafukufuku, mabuku komanso

Misonkhano, komanso kutenga nawo mbali kwanga kudzasungidwa mwachinsinsi mwina pokhapokha nditachita kunena.

Ndivomereza kujambulidwa mawu (lembani mwachidunji njira imene idzagwiritsidwe ntchito)

Andipatsa chipepala chosaina dzina langa chovomereza kutenga gawo mu kafukufuku.

Dzina loyamba ndi labambo la munthu otenga mbali…………………………………..………(chonde lembani)

Saini ya munthu otenga mbali ……………………………………Tsiku…………..………………

Dzina loyamba ndi la bambo la munthu opanga kafukufuku …………………….……………… (Chonde lembani)

Saini ya munthu opanga kafukufuku ……………………………..Tsiku …………………………

ANNEXURE H: PARENTAL CONSENT FOR A MINOR TO PARTICIPATE IN THE STUDY

I, __________________ (Parent's/ Legal Guardian's name), confirm that the person asked for my consent for my child/dependant to take part in this research.

The researcher has told me about the nature, procedure, potential benefits and anticipated inconvenience of

participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and I give consent for my child/dependant to participate in the study.

I understand that my child/dependant has the autonomy to provide assent irrespective of my consent

I understand that my child's/dependant's participation is voluntary and that he/she is free to withdraw at any time without penalty.

I am aware that the findings of this study will be processed into a research report, journal publications and/or

conference proceedings, but that my child's/dependant's participation will be kept confidential unless otherwise specified.

I agree to the recording of the information my child will provide

I have received a signed copy of the informed consent agreement.

Parent's/ legal guardian's name & surname…………………………………………………..…….. (Please print)

Parent's/ legal guardian's signature…………………………………………..Date…………………

Researcher's Name & Surname………………………………………………………… (Please print)

Researcher's signature………………………………………..Date…………………

ANNEXURE I: CHILOLEZO CHOTI MWANA WANGA ATENGE NAWO MBALI MUKAFUKUFUKU

Ethics clearance reference number: Rec-240816-052

Research permission reference number: 67129765_CREC_CHS_2021

Ine, __________________ (dzina la otenga mbali), ndikutsimikiza kuti andipempha kuti mwana wanga atenge nawo mbali mu kafukufukuyi.

Opanga kafukufuku andiuza za mtundu wa kafukufuku, zomwe zichitike, phindu lake komanso zoyembekezera zomwe zingabwere potenga nawo mbali (anticipated inconvenience of participation).

Ndawerenga (kapena andiwerengera) ndipo ndamvetsetsa za kafukufukuyi mmene afotokozera mu kalata ya uthengayo.

Ndakhala ndinthawi yokwanira yofunsa mafunso ndipo ndavomela kuti mwana wanga atenge nawo mbali.

Ndamvetsetsa kuti mwana wanga ali ndi mphamvu kulola kapena kukana kutenga nawo mbali mkafukufukuyu posatengera chilolezo changa.

Ndamvetsetsa kuti kutenga nawo mbali kwa mwana wanga ndikosakakamiza ndipo mwana wanga ndi omasuka kusiya nthawi ina iliyonse opanda chiopsezo chinachilichonse.

Ndizindikira kuti zotsatira za kafukufukuyu zizalembedwa mu kalata yopereka ndondomeko yonse ya kafukufuku, mabuku, komanso misonkhano. Ndizindikiranso kuti kutenga nawo mbali kwa mwana wanga kudzasungidwa mwachinsinsi mwina pokhapokha nditachita kunena.

Ndivomereza kujambulidwa mawu kwa mwana wanga mu nthawi ya kafukufuku.

Andipatsa chipepala chosaina dzina langa chovomereza kutenga gawo mu kafukufuku

Dzina loyamba ndi labambo la kholo papena omusunga mwana………………………………(chonde lembani)

Saini ya kholo papena omusunga mwana ……………………………………Tsiku…………………

Dzina loyamba ndi la bambo la munthu opanga kafukufuku ……………………………… (Chonde lembani)

Saini ya munthu opanga kafukufuku ……………………………..Tsiku …………………

ANNEXURE J: ASSENT FORM

Ethics clearance reference number: Rec-240816-052

Research permission reference number: 67129765_CREC_CHS_2021

We, Grace Charity Sibande with Dr. Rakgadi Grace Malapela, are researchers from the University of South Africa. We are conducting the research to develop strategies for improving utilisation of Youth Friendly Health Services in rural and urban Blantyre. You are being invited to participate in this study because you belong to a group of youths aged between 12 to 24 years.

For this research, we will provide you with a set of questions and request you to respond to questions verbally. There will be no wrong or right answer as these will be your views (perceptions), based purely on your experiences with Youth Friendly Health Services. You will be given adequate time to think and respond to the question while we write your responses on the interview schedule. We will keep all your answers private, and will not show them to your teachers or parents/guardians. Only people from University of South Africa working on the study will see them.

We do not think that any big problems will happen to you as part of this study, but you might feel sad when being asked to share your experiences as a youth. You must know that the other youths will not see your answers.

By participating in this study, you will be a contributor to the body of scientific knowledge that seeks to explore by means of different methodologies, strategies for improving utilisation of Youth Friendly Health Services in rural and urban Blantyre. Your participation will also assist to identify gaps that need to be addressed in the provision of Youth Friendly Health Services and policies that govern it.

You should know that:

- You do not have to be in this study if you do not want to. You won't get into any trouble with University of South Africa,
- You may stop being in the study at any time. If there is a question you do not was to answer, just leave it (but you are encouraged to answer all questions)
- Your parent(s)/guardian(s) were asked if it is OK for you to be in this study. Even if they say it is OK, it is still your choice whether or not to take part.
- You can ask any questions you have, now or later. If you think of a question later, you or your parents can contact the principal researcher: Grace Charity Sibande, Kamuzu University of Health Sciences, Blantyre campus, P. O. Box 415, Blantyre. Cell phone number +265 (0) 995 297 078. Email: gsibande @kuhes.ac.mw.
-

<u>Sign this form only if you:</u>

- have understood what you will be doing for this study,
- have had all your questions answered,
- have talked to your parent(s)/legal guardian about this project, and
- agree to take part in this research

Your Signature___________________Printed Name__________________________Date______________

Name of Parent(s) or Legal Guardian(s)________________________________

Researcher explaining study

Signature__________________ Printed Name_________________________________Date_____________

ANNEXURE K: CHILOLEZO CHOTENGA NAWO MBALI MUKAFUKUFUKU KWA WACHINYAMATA OCHEPELA ZAKA 18

Ethics clearance reference number: Rec-240816-052

Research permission reference number: 67129765_CREC_CHS_2021

Ine Grace Charity Sibande ndi adokotala a Rakgadi Grace Malapela, ndife opanga kafukufuku ku sukulu ya ukachenjede ya ku South Africa. Tikupanga kafukufuku kuti tipititse patsogolo kagwiritsidwe ntchito ka chipatala cha achinyamata mmaboma a kutawuni ndi mmidzi m'boma la Blantyre. Mwayitanidwa kuti mutenge nawo gawo mukafukufukuyu chifukwa muli mu gulu la achinyamata a zaka zapakati 12 kufikila 24.

Mukafukufukuyu, tikupatsani mafunso ndipo tikupemphani kuti muyankhe mafunsowo ndipakamwa. Palibe yankho lolakwika kapena lolondola chifukwa izi zikhala mmene mumaonera zinthu kuchipatala cha achinyamata. Mupatsidwa nthawi yokwanira kuti muganize ndi kuyankha mafunso pamene ine ndikhala ndikulemba mayankho anu pa pepala la mafunso. Tidzasunga mayankho anu onse mwachinsinsi, ndipo sitidzawaonetsa aphunzitsi kapena makolo/okusungani. Anthu okhawo a ku sukulu ya ukachenjede ku South Africa omwe akupanga nawo kafukufukuyu ndiamene adzaone.
Sitikuyembekezera kuti pakhala vuto lalikulu lina lililonse kwa inu panthawi yakafukufukuyu. Koma mwina mutha kukhala okhumudwa pamene mwafunsidwa kutiuza za zochitika pamoyo wanu waunyamata. Mudziwe kuti achinyamata ena saona nawo mayankho anu.

Pakutengapo nawo mbali mukafukufukuyu, mukhala mukuonjezera kuchidziwitso cha za science (scientific knowledge) chimene chikufuna kudziwa podzera njira zosiyanasiyana njira zopititsira patsogolo kagwiritsidwe ntchito ka chipatala cha achinyamata mu madera a ku tauni ndi mmidzi yak u Blantyre.

Kutenga nawo mbali kwanu kuthandizanso kuona momwe sitikupanga bwino ndipo mukufunika kukonzedwa pakupereka chithandizo ku chipatala cha achinyamata komanso malamulo amene amawatsogolera.

Mudziwe kuti:
Simukuyenera kutenga nawo mbali mu kafukufukuyu ngati simukufuna. Simudzakhala pamavuto ena alionse ndi sukulu ya ukachenjede yaku South Africa, Mutha kusiya kutenga mbali mukafukufukuyu panthawi iliyonse. Ngati pali funso limene simukufuna kuyankha, mutha kulisiya (koma tikukulimbikitsani kuyankha mafunso onse)

Makolo anu/okusungani anapemphedwa kuti mutenge nawo gawo mukafukufukuyu. Koma ingakhale anapereka chilolezo, ndichisankho chanube kuti mutenge nawo gawo kapena ayi.

Mutha kufunsa mafunso ena alionse omwe muli nawo, panopa kapena nthawi ina. Ngati mungakhale ndi funso nthawi ina, inuyo kapena makolo anu mutha kuyankhula ndi wamkulu wakafukufukuyu: Grace Charity Sibande, Kamuzu University of Health Sciences, Blantyre campus, P. O. Box 415, Blantyre. Nambala ya phone yammanja +265 (0) 995 297 078. Email: gsibande @kuhes.ac.mw.

Lembani dzina lanu papepalapa pokhapokha ngati:
Ngati mwamvetsetsa zomwe mudzipanga mukafukufukuyi ,
Ngati mafunso anu onse ayankhidwa,
Mwayankhulana ndi makolo anu kapena okusungani za kafukufukuyi
Komanso mwavomeleza kutenga mbali mukafukufukuyi

Saini yanu……………………Dzina …………………………..….(Lembani)
Tsiku…….…………………………….

Wakafukufuku ofotokoza za kafukufuku: Dzina…………….…….……..
Saini…………………Tsiku…………………

ANNEXURE L: STRUCTURED QUESTIONNARE FOR YOUTHS AGED 10 TO 24

“Strategies for improving utilisation of Youth Friendly Health Services in Blantyre, Malawi”

Ethics clearance reference number: Rec-240816-052

Research permission reference number: 67129765_CREC_CHS_2021

NAME OF COMMUNITY……………………………...………INTERVIEWER NITIALS……………

INSTRUCTION: CIRCLE THE OPTION THAT APPLIES. (NOTE: SOME QUESTIONS HAVE MORE THAN ONE OPTION THAT APPLIES, IN SUCH CASES TICK ALL OPTIONS THAT APPLY)

	SECTION A: DEMOGRAPHIC INFORMATION	
1	Identification number	
2	Gender	A. Male
		B Female
		C Other, specify
3	How old are you?	A. 10 - 14
		B. 15 - 19
		C. 20 - 24
4	Who are you living with?	A. Both parents
		B. Mother only
		C. Father only
		D. Relatives
		E. Friends
		F. Other (specify)
5	What is your education level?	A. Primary
		B. Secondary
		C. College/Diploma
		D. University/graduate
		E. No formal education
6	What is your religion?	A. Christian
		B. Moslem,
		C. Other: Specify
7	What is your occupation?	A. Student
		B. Business

		C. Formal employment	
		D. Civil Servant	
		E. Unemployed	
	SECTION B: ACCESSIBILITY OF YFHS		
8	Have you ever accessed YFHS anywhere?	Yes	No
9	If yes what was the factor that influenced your access to YFHS?	A. Geographical area	
		B. Age	
		C. Gender	
		D. Level of education	
		E. Lack of knowledge about the service	
		Other, specify	
10	If no what was the factor that influenced your lack of access to YFHS?	A. Geographical area	
		B. Age	
		C. Gender	
		D. Level of education	
		E. Lack of knowledge about the service	
		Other, specify	
11	If you have never accessed YFHS, do you intend to access the services? (How do you rate your intention?)	High	low
12	What is the means of transport from your home to a health facility or venue for YFHS?	A. Walking	
		B. Bicycle	
		C. Motor bike	
		D. Bus/Minibus	
13	How long can it take you to walk to a health centre to access YFHS?	A. Less than 30 minutes	
		B. 30 minutes to 1 hour	
		C. 1 hour to 2 hours	
		D. More than 2 hours	
14	Have you ever been encouraged to access YFHS?	Yes	No
15	If yes by who?	A. Friends	
		B. Parents/guardians	
		C. Aunt/ Uncle	
		D. Nurse	
		E. Community	
16	Have you ever been discouraged from accessing YFHS	Yes	No
17	If yes by who?	A. Friends	

		B. Parents/guardians	
		C. Aunt/ Uncle	
		D. Nurse	
		E. Community	
	SECTION C: YOUTH'S KNOWLEDGE ABOUT SEXUAL REPRODUCTIVE HEALTH ISSUES AND SERVICES.		
18	Have you ever heard about Youth Friendly Health Services (YFHS)?	Yes	No
19	Who gave you information about YFHS	A. Friends	
		B. Parents/ guardians	
		C. Aunt/ Uncle	
		D. Nurse	
		E. Media	
		F. Community leaders	
20	Have you ever heard about services offered at YFHS?	Yes	No
21	Who gave you information about services offered at YFHS	A. Friends	
		B. Parents/ guardians	
		C. Aunt/ Uncle	
		D. Nurse	
		E. Media	
		F. Community leaders	
22	Where do youth access sexual reproductive health services in the community?	A. Government health centre	
		B. Private hospitals	
		C. Youth clubs	
		D. NGOs	
		E. Drug store/ pharmacy	
		F. Other (Specify)	
23	Have you ever received any education on sexual reproductive 11health?	Yes	No
24	If y12es, where did you receive the education on sexual reproductive health issues?	A. Community	
		B. Youth Clubs	
		C. Health centre	
		D. Friends	
		E. Parents	
		F. Family	
		G. At school	
25		A. Parents	

	What is your preference for communication regarding sexual reproductive health issues	B. Family	
		C. Community	
		D. Grandparents	
		E. Friends	
		F. Nurse	
26	Have you seen any sign post showing presence of YFHS at the health centre?	Yes	No
27	Are educational materials on reproductive health given to you at the health centre?	Yes	No
28	How are the chances (how susceptible) for you to get an intended pregnancy (Question for girls)	High	low
29	How are the chances of you impregnating a girl unintentionally (Question for boys)	High	low
30	How do you rate the seriousness of you as a youth having an intended pregnancy	High	low
31	How do you rate the seriousness of you as a youth impregnating a girl unintentionally?	High	low
32	What is your perception about benefits of youth utilising contraceptives? (Do you rate the benefits high or low?)	High	low
	SECTION D: PRACTICES AT YOUTH FRIENDLY HEALTH SERVICES		
33	In the past 6 months, have you visited a YFHS?	Yes	No
34	Which services were available at the YFHS?	A. Counseling services	
		B. Contraceptive	
		C. HIV testing and ART	
		D. STI treatment	
		E. General medical treatment	
		F. I don't know	
35	Which family planning method was readily available for youths?	A. Contraceptive pills	
		B. Injectables	
		C. Implants	
		D. Condoms	
		E. Any method of choice	
36	Did the service provider give you time to explain your problems and needs?	Yes	No
37	Did the service provider examine you before offering you the service?	Yes	No
38	Did the service provider respectfully treat you?	Yes	No

39	How do you rate the service provider who attended you?	A. Normal	
		B. Friendly	
		C. Professional	
		D. Harsh	
		E. Rude	
40	Were the services provided in a private space?	Yes	No
41	Did the service provider assure you that your information will be confidential?	Yes	No
42	Did the service provider explain or demonstrate issues to your understanding?	Yes	No
43	Did the service provider condemn any of your decisions or actions?	Yes	No
	SECTION E: BARRIERS TO UTILISATION OF YOUTH FRIENDLY HEALTH SERVICES.		
44	What is your perception of barriers to your utilisation of YFHS? (Do you rate the barriers as high or low?)	High	low
45	Do you feel shy to attend YFHS?	Yes	No
46	Do you fear being seen at YFHS?	Yes	No
47	Are you satisfied with the working days for the YFHS at the health centre?	Yes	No
48	Are you satisfied with the days for outreach services in the community?	Yes	No
49	Are you satisfied with the operating times for the YFHS?	Yes	No
50	Is the health centre environment adequately cleaned?	Yes	No
51	Are you able to pick all the medicines prescribed for you at the pharmacy?	Yes	No
52	Does someone have to accompany you to the health centre to access YFHS?	Yes	No
53	Would you feel comfortable if you notice a familiar face from the community when you get to a health centre for YFHSs?	Yes	No
54	Do your cultural values support your accessing health facilities for YFHSs?	Yes	No
55	Do your religious values support your accessing health facilities for YFHSs?	Yes	No
	SECTION F: SUGGESTIONS TO ENHANCE UTILISATION OF YOUTH FRIENDLY HEALTH SERVICES		
56	From which site would you be comfortable receiving YFHS?	A. Health centre	
		B. At school	
		C. At youth Clubs	

		D. Community outreach
		E. Other (Specify)
57	Which health care providers would you prefer at a YFHS?	A. Youth providers
		B. Older providers
		C. Any age
58	Which group of people would assist more in increasing utilisation of YFHS?	A. Parents/ Guardians
		B. Community leaders
		C. The Youth
		D. Health care providers
		E. Other (Specify)
59	which is your preferred set-up for YFHS at a Health centre?	A Youth Corner B. Special room in the facility C. Integrated with adult services D. Special days within the week E. Specific hours during the day F. During the weekend
	END OF QUESTIONNAIRE	

ANNEXURE M: MAFUNSO A ACHINYAMATA A ZAKA 10 KUFIKILA 24

Ethics clearance reference number: Rec-240816-052

Research permission reference number: 67129765_CREC_CHS_2021

DZINA LA MUDZI…………………………...CHILEMBO CHOYAMBA CHA MUNTHU OFUNSA MAFUNSO ……………

LANGIZO: ZUNGULIZANI YANKHO LOMWE MWASANKHA (DZIWANI: MAFUNSO ENA ALI NDI MAYANKHO OPOSERA AWIRI, MUCHIMENECHI ZUNGULIZANI MONSE MOMWE MWASANKHA)

	GAWO A: Mbiri yanu	
1	Nambala ya chizindikilo	
2	Mamuna kapena Mkazi	A. Mamuna
		B. Mkazi
3	Muli ndi zaka zingati?	A. 10 – 14
		B. 15 – 19
		C. 20 – 24
4	Mumakhala ndi ndani?	A. Makolo onse
		B. Amayi okha
		C. Abambo okha
		D. Achibale
		E. Anzako
		F. Ena (Tchulani)
5	Maphunziro munafika nawo pati	A. Pulayimale
		B. Sekondale
		C. College/Diploma
		D. Ukachenjede
		E. Simunapite ku sukulu
6	Ndinu a chipembedzo chanji?	A. Akhristu
		B. Achisilamu
		C. Zina, Tchulani
7	Ndalama mumazipeza mwa njira yanji?	A. Ophunzira ku sukulu
		B. Ogulitsa malonda
		C. Ntchito yolembedwa
		D. Ntchito ya m'boma
		E. Simungwira ntchito
	GAWO B: ZOMWE ACHINYAMATA AKUDZIWA PANKHANI YA CHITHANDIZO PA NKHANI YOGONANA KOMANSO YA UBEREKI	

8	Munamvapo za chipatala cha achinyamata (YFHS)?	Eya	Ayi
9	Anakudziwitsani ndani za chipatala cha achinyamata?	A. Anzanu	
		B. Makolo/omwe mumakhala nawo	
		C. Azakhali/Amalume	
		D. Namwino	
		E. Njira zamakono zofalitsa uthenga	
		F. Atsogoleri ammudzi	
10	Munamvapo za chithandizo chomwe chimaperekedwa ku chipatala cha achinyamata?	Eya	Ayi
11	Anakudziwitsani ndani za chithandizo chomwe chimaperekedwa ku chipatala cha achinyamata?	A. Anzanu	
		B. Makolo/omwe mumakhala nawo	
		C. Azakhali/Amalume	
		D. Namwino	
		E. Njira zamakono zofalitsa uthenga	
		F. Atsogoleri ammudzi	
12	Kodi thandizo lokhudzana ndi za ubereki (reproductive health services) mumalipeza kuti mudera lanu lino?	A. Chipatala chaching'ono cha boma	
		B. Zipatala zolipira	
		C. Mabungwe a achinyamata	
		D. Mabungwe odziimila paokha	
		E. Malo ogulitsa mankhwala	
		F. Zina (Tchulani)	
13	Kodi munalandirapo maphunziro pa nkhani yazogonana komanso za ubereki?	Eya	Ayi
14	Ngati yankho lanu lili eya, kodi munalandira kuti maphunziro a zogonana komanso za ubereki?	A. Kudera lomwe mumakhala	
		B. Malo okumana achinyamata	
		C. Chipatala chaching'ono	
		D. Anzanu	
		E. Makolo	
		F. Kubanja lakwanu	
		G. Kusukulu	
15	Kodi inu mungakonde kuti mauthenga okhudza zogonana ndi za ubereki mudzimvera kwa ndani?	A. Makolo	
		B. Akubanja lanu	
		C. Anthu a mmudzi mwanu	
		D. Agogo	
		E. Anzanu	
		F. Anamwino	

16	Munaonapo chikwangwani chinachilichonse choonetsa kupezek kwa chipatala cha achinyamata pa chipatala?	Eya	Ayi
17	Kodi munapatsidwapo mauthenga owerenga a zaubeleki mukapita ku chipatala kuti mudzitha kukawerenga kwanu?	Eya	Ayi
18	Chiophsyezo chako nchotani chotenga mimba mosayembekezela (atsikana)	Chochuluka	Chochepa
19	Chiophyezo chako nchotani chopereka mimba mosayembekezela (anyamata)	Chochuluka	Chochepa
20	Kuophsya kotenga mimba yosambekezela kwa achinyamata ungakuike pa mlingo wanji?	Kwambiri	Pan'gono
21	Kuophsya kopereka mimba yosambekezela kwa achinyamata ungakuike pa mlingo wanji?	Kwambiri	Pan'gono
22	Mukuona kwanu, kodi ubwino woti achinyamata adzigwiritsa ntchito njira zolerela mungauike mulingo wanji	Wochuluka	Wochepa
	GAWO C: KAGWIRITSIDWE NTCHITO KA CHIPATALA CHA ACHINYAMATA		
23	Kodi munayamba mwalandirapo thandizo ku chipatala cha achinyamata (YFHS)?	Eya	Ayi
24	Ngati yankho lanu liri eya, kodi chinakulimbikitsani kukalandira thandizo ku chipatala cha achinyamata ndi chani?	A. Kutalikira kwa Dela lomwe mumakhala	
		B. Dzaka zakubadwa	
		C. Kukhala wammuna kapena wamkazi	
		D. Mulingo wa maphunziro	
		E. Kudziwa za kupezeka kwa thandizoli	
		F. Zifukwa zina (nenani)	
25	Ngati yankho lanu liri ayi, kodi chimakukanikitsani kukalandira thandizo ku chipatala cha achinyamata ndi chani?	A. Kutalikira kwa dela lomwe mumakhala	
		B. Dzaka zakubadwa	
		C. Kukhala wammuna kapena wamkazi	
		D. Mulingo wa maphunziro	
		E. Kusadziwa za kupezeka kwa thandizoli	
		F. Zifukwa zina (nenani)	
26	Ngati simunalandirepo thandizo kuchipatala kwa achinyamata, kodi muli ndi lingaliro loti mutha kudzapita kukalandira thandizoli? (Malingaliro amenewa mungawayike pa mulingo wanji?)	Waukulu	Pang'ono
27		A. Kuyenda pansi	

	Kodi mumagwiritsa ntchito njira yanji yamayendedwe popita kuchipatala chaching’ono kapena Kumalo a chipatala cha achinyamata?	B. Njinga yopalasa	
		C. Njinga yamoto	
		D. Bus yayikulu kapena bus yaying’ono	
28	Kodi zimakutengerani nthawi yayitali bwanji kuti mukafike kumalo komwe mungakalandire thandizo la chipatala cha achinyamata mutati mukuyenda wapansi?	A. Theka la ola limodzi	
		B. theka kufikila ola limodzi	
		C. Ola limodzi kufikila maola awiri	
		D. Kuposera maola awiri	
29	Kodi munayamba mwalimbikitsidwapo kupita kukalandira thandizo kuchipatala cha achinyamata?	Eya	Ayi
30	Ngati yankho lanu lili eya, ndindani anakulimbikitsani?	A. Anzanu	
		B. Makolo	
		C Otisunga	
		D. Azakhali kapena amalume	
		E. Namwino	
		F. Dera komwe mumakhala	
31	Kodi munayamba mwafooketsedwapo kukalandira thandizo kuchipatala cha achinyamata?	Eya	Ayi
32	Ngati yankho lanu lili eya, ndindani anakufooketsani?	A. Anzanu	
		B. Makolo kapena omwe mukukhala nawo	
		C. Azakhali kapena Amalume	
		D. Namwino	
		E. Kudera komwe mumakhala	
	GAWO D: ZOMWE ACHINYAMATA AMAKUMANA NAZO AKAPITA KUCHIPATALA CHA ACHINYAMATA		
33	Kodi mu miyezi isanu ndi umodzi yapitayi munapitako ku chipatala cha achinyamata?	Eya	Ayi
34	Kodi kunali ma thandizo otani?	A. Uphungu	
		B. Njira zolera	
		C. Kuyezetsa kachilombo ka HIV komanso kulandira mankhwala otalikitsa moyo (ART)	
		D. Kulandira mankhwala a nthenda zopatsirana pogonana	
		E. Kulandira thandizo pamatenda alionse	
		F. Sindikudziwa	
35	Kodi ndi njira iti ya maleredwe yomwe inali yopezekeratu kwa achinyamata?	A. mapilisi	
		B. Jakisoni	

		C. Njira yolerela yapamkono	
		D. Makondomu	
		E. Njira iliyonse yomwe munthu wasankha	
36	Kodi opereka thandizo anakupatsani nthawi yoti mufotokoze mavuto komanso zofuna zanu?	Eya	Ayi
37	Kodi opereka thandizo anakuyezani asanakupatseni thandizo?	Eya	Ayi
38	Kodi Opereka thandizo anakuthandizani mwa ulemu?	Eya	Ayi
39	Kodi amene anakuthandizani mungawapatse mulingo wanji?	A. Abwinobwino	
		B. Ansangala	
		C. Odziwa kugwira ntchito	
		D. Ankhanza	
		E. Amwano	
40	Kodi thandizo linaperekedwa malo achinsinsi?	Eya	Ayi
41	Kodi ogwira ntchito anakutsimikizirani kuti thandizo lomwe amapereka limakhala lachinsinsi?	Eya	Ayi
42	Kodi ogwira ntchito anakufotokozerani china chirichonse moti umvetsetse?	Eya	Ayi
43	Kodi ogwira ntchito anakudzudzulani za chisankho chanu kapena zomwe mumapanga?	Eya	Ayi
	GAWO E: ZOLEPHERETSA KAGWIRITSIDWE NTCHITO CHIPATALA CHA A CHINYAMATA.		
44	Mukuganiza kwanu zolepheletsa achinyamata kupita ku chipatala cha anchinyamata (YFHS) mungaziike pa mulingo wotani?	Zambiri	zochepa
45	Mumachita manyazi kupita kuchipatala cha achinyamata?	Eya	Ayi
46	Kodi mumawopa kuti anthu akuonani muli kuchipatala cha achinyamata?	Eya	Ayi
47	Kodi ndinu okhutitsidwa ndi masiku amene chipatala cha achinyamata, chimagwira ntchito ku chipatalaku?	Eya	Ayi
48	Kodi ndinu okhutisidwa ndi masiku amene chipatala cha mmudzi chimagwira ntchito za chipatala cha achinyamata?	Eya	Ayi
49	Kodi ndinu okhutitsidwa ndi nthawi imene chipatala cha achinyamata chimakhala chikugwira ntchito?	Eya	Ayi

<table>
<tr><td>50</td><td>Kodi chipatala chimakhala chaukhondo mokwanira?</td><td>Eya</td><td>Ayi</td></tr>
<tr><td>51</td><td>Kodi zimatheka kulandira njira iliyonse yolelera imene mwasankha mukapita ku chipatala cha achinyamata</td><td>Eya</td><td>Ayi</td></tr>
<tr><td>52</td><td>Kodi zimafunika kuti munthu akuperekezeni kuchipatala kuti mukalandire ndathizo ku chipatala cha achinyamata?</td><td>Eya</td><td>Ayi</td></tr>
<tr><td>53</td><td>Kodi mungakhala omasuka mutakumana ndi munthu omudziwa wa kudera lomwe mumakhala pamene mwafika ku chipatala cha achinyamata?</td><td>Eya</td><td>Ayi</td></tr>
<tr><td>54</td><td>Kodi chikhalidwe chanu chimakulorani kulandira thandizo kuchipatala cha achinyamata?</td><td>Eya</td><td>Ayi</td></tr>
<tr><td>55</td><td>Kodi chipembedzo chanu chimakuvomerezani kuti mutha kukalandira thandizo ku chipatala cha achinyamata?</td><td>Eya</td><td>Ayi</td></tr>
<tr><td></td><td colspan="3">GAWO F: NJIRA ZIMENE ZINGALIMBIKITSE ACHINYAMATA KUGWIRITSA NTCHITO CHIPATALA CHA ACHINYAMATA</td></tr>
<tr><td rowspan="5">56</td><td rowspan="5">Kodi mungakonde kuti mudzikalandira thandizo kuchipatala cha achinyamata kumalo ati?</td><td colspan="2">A. Kuchipatala</td></tr>
<tr><td colspan="2">B. Kusukulu</td></tr>
<tr><td colspan="2">C. Kumagulu a achinyamata (youth club)</td></tr>
<tr><td colspan="2">D. Kuchipatala chammudzi</td></tr>
<tr><td colspan="2">E. Ena (Tchulani)</td></tr>
<tr><td rowspan="3">57</td><td rowspan="3">Kodi mungakonde kuti mudzithandizidwa ndi anthu otani kuchipatala cha achinyamata?</td><td colspan="2">A. Ogwira ntchito a chinyamata</td></tr>
<tr><td colspan="2">B. Ogwira ntchito achikulire</td></tr>
<tr><td colspan="2">C.Ogwira ntchito a zaka zilizonse</td></tr>
<tr><td rowspan="5">58</td><td rowspan="5">Kodi ndi anthu ati amene angathandize kwambiri kupititsa patsogolo kagwiritsidwe ntchito ka chipatala cha achinyamata?</td><td colspan="2">A. Makolo/Otisunga</td></tr>
<tr><td colspan="2">B. Atsogoleri a mmudzi mwanu</td></tr>
<tr><td colspan="2">C. Achinyamata</td></tr>
<tr><td colspan="2">D. Ogwira ntchito ya za umoyo</td></tr>
<tr><td colspan="2">E. Ena (Tchulani)</td></tr>
<tr><td rowspan="6">59</td><td rowspan="6">Kodi malo omwe mungakonde kupangira chipatala cha achinyamata pa chipatala ndi ati?</td><td colspan="2">A Mbali yoikika mchipatala ya achinyamata okhaokha (youth corner)</td></tr>
<tr><td colspan="2">B. Chipinda chapadera mu chipatala</td></tr>
<tr><td colspan="2">C. Kulandira thandizo pamodzi ndi akulu</td></tr>
<tr><td colspan="2">D. Masiku oikika mkati mwa sabata</td></tr>
<tr><td colspan="2">E. Maola oikika patsiku</td></tr>
<tr><td colspan="2">F. Kumathero a sabata</td></tr>
<tr><td></td><td colspan="3">PAMAPETO A MAFUNSO</td></tr>
</table>

ANNEXURE N: INTERVIEW GUIDE FOR HEALTH CARE PROVIDERS (ENGLISH)

Ethics clearance reference number: Rec-240816-052

Research permission reference number: 67129765_CREC_CHS_2021

RESPONDENT'S NUMBER…………………. HEALTH CENTRE…………………...…………....

INITIALS OF THE INTERVIEWER……………………...

SECTION A: DEMOGRAPHIC DATA

1.1 What is your age?..

1.2 What is your Marital status?...

1.3 What is your religion?..

1.4 What is your cadre? ………………………………………………………………………………

1.5 How many years have you been providing YFHS at this facility?...

1.6 Have you ever been trained as a provider in YFHS?...

1.7 If yes when?...

SECTION B - CENTRAL QUESTION: WHAT ARE THE FACTORS THAT INFLUENCE UTILISATION OF YOUTH FRIENDLY SERVICES AT BLANTYRE, MALAWI?

SUB-QUESTIONS:

2.1 How accessible are YFHS at this health facility?

2.2 What influences the accessibility of YFHS at this health facility?

2.3 How knowledgeable are youths in the surrounding catchment areas about reproductive health issues?

2.4 How knowledgeable are youths in the surrounding catchment areas about YFHS?

2.5 What is the set-up for YFHS at this health facility in terms of location?

2.6 What are the working days for YFHS in this health facility?

2.7 What are the operating times for the YFHS in this health centre?

2.8 Which contraceptives are available for the youths at the health facility?

2.9 Which contraceptive is available at all times?

2.11 What do you think are barriers to utilisation of YFHS by the youths?

2.12 What protocols, guidelines or policies do you have that facilitate provision of YFHS?

2.13 What factors influence delivery of YFHS at this facility.

2.14 What is your experience regarding utilisation of YFHS by unmarried youth from the surrounding catchment areas?

2.15 What is being done by your facility to enhance utilisation of YFHS by the youth

2.16 What is your experience on how unmarried youth open up to you regarding reproductive health issues

2.17 What factors motivate you while working at YFHS?

2.18 What factors demotivate you while working at YFHS

2.19 Does provision of contraceptives to unmarried youth conflict with any of your beliefs or values?

2. 20 Is there anything that needs to be done to enhance provider competency in provision of YFHS?

2. 21 In your opinion, what strategies would help to increase utilisation of YFHS at this facility?

ANNEXURE O: MAFUNSO KWA OGWIRA NTCHITO YA ZAUMOYO

Ethics clearance reference number: Rec-240816-052

Research permission reference number: 67129765_CREC_CHS_2021

NAMBALA YA OFUNSIDWA MAFUNSO ………………….

CHIPATALA ……………………...…………...

CHILEMBO CHOYAMBA CHA DZILA LA OFUNSA MAFUNSO……………………...

GAWO A: MBIRI YA MUNTHU

1.1 Muli ndi zaka zingati?..
1.2 Muli pabanja?...
1.3 Ndinu a chipembezo chanji?...
1.4 Maphunziro munafika nawo pati (cadre)?...
1.5 Mwakhala mukupereka thandizo ku chipatala cha achinyamata kwa nthawi yaitali bwanji pa chipatala pano?...…
1.6 Kodi munalandirapo maphunziro okhudza chipatala cha achinyamata?
1.7 Ngati yankho lanu lili inde, munaphunzira liti? ....

GAWO B KAGWIRITSIDWE NTCHITO KA CHIPATALA CHA ACHINYAMATA

2.1 Chipatala cha achinyamata ndichofikirika motani pachipatala pano?

2.2 Chimathandizira kufikirika kwa chipatala cha achinyamata pachipatala pano ndi chani?

2.3 Achinyamata a madera ozungulira chipatalachi akudziwa zotani pa nkhani za ubereki?

2.4 Achinyamata ozungulira madera a chipatalachi akudziwa zotani zokhudza chipatala cha achinyamata

(YFHS)?

2.5 Chipatala cha achinyamata (YFHS) mupangira mbali iti pa chipatala pano ?

2.6 Chipatala cha achinyamata chimachitika masiku ati pa chipatala pano?

2.7 Chipatala cha achinyamata chimapangidwa nthawi yanji?

2.8 Mungandifotokozere njira zolera zomwe zimapezeka kwa achinyamata pachipatala pano?

2.9 Ndi njira zolera ziti zomwe zimapezeka nthawi zonse?

2.11 Mukuganiza kuti ndi zinthu ziti zomwe zingalepheretse achinyamata kugwiritsa ntchito kapena kubwela ku

chipatala cha achinyamata?

2.12 Kodi ndi malamulo ati, njira ziti, komanso ndondomeko zanji zomwe zimapititsa patsogolo kagwiritsidwe

ntchito ka chipatala cha achinyamata?

2.13 Kodi ndi zinthu ziti zimene zimathandizila kaperekedwe ka thandizo kuchipatala cha achinyamata (YFHS)

Pachipatala pano?

2.14 Kutengera pa zomwe mumakumana nazo, kuchuluka kwa kagwiritsidwe ntchito ka chipatala cha

achinyamata omwe sali pabanja nkotani?

2.15 Chipatala chanu chikupangapo chani kuti chilimbikitse achinyamata kuti azigwiritsa ntchito chipatala cha

achinyamata?

2.16 Kutengera mu zomwe mumakumana nazo, kodi mumaona bwanji kumasuka komwe achinyamata omwe Sali

pabanja amakhala nako pankhani ya ubereki?

2.17 Ndizinthu ziti zimene zimakulimbikitsani pomwe mukugwira ntchito ku chipatala cha achinyamata?

2.18 Ndi zinthu ziti zomwe zimakufooketsani pogwira ntchito ku chipatala cha achinyamata?

2.19 Kupereka njira za kulera kwa achinyamata omwe sali pabanja zimasutsana ndi zikhulupiliro zanu kapena

zinthuzomwe mumazilemekeza?

2. 20 Mukuona kuti pali chinthu chomwe tingapange kuti tipititse patsogolo ukaswiri pa ntchito wa ogwira ntchito

pomwe akupereka thandizo kwa achinyamata?

2. 21 M'malingaliro anu kodi ndi njira ziti zomwe zingapititse patsogolo kagwiritsidwe ntchito ka

chipatala cha achinyamata pachipatala pano?

ANNEXURE P: FOCUS GROUP GUIDE

Ethics clearance reference number: Rec-240816-052

Research permission reference number: 67129765_CREC_CHS_2021

CENTRAL QUESTION: WHAT ARE THE FACTORS THAT INFLUENCE UTILISATION OF YFHS IN BLANTYRE MALAWI?

SUB-QUESTIONS:

1. What do you know about Youth Friendly Health Services?
2. Which services are readily available at the YFHS?
3. How did you get to know about sexual reproductive health and YFHS?
4. Where do you get information on sexual reproductive health?
5. What are your thoughts about providing contraception to the youth?
6. How do parents and guardians view provision of contraception to the youth?
7. How does the community view provision of contraception to the youth?
8. What factors bar young people from attending YFHS?
9. What are your views on characteristics including cleanliness of the health care facility where you attended YFHS?
10. What are your views on attitudes shown by health service providers when you attended YFHS?
11. How best should YFHS be provided in terms of location, days, time and any other factors?
12. What is your preference regarding service providers? Do you prefer to be served by fellow youths, older service providers or either of them? Give reasons.
13. What should the Government of Malawi or Ministry of Health do to improve YFHS?
14. In your opinion what strategies should be utilized increase utilisation of YFHS?

ANNEXURE Q: MAFUNSO OKAMBIRANA PAGULU

Ethics clearance reference number: Rec-240816-052

Research permission reference number: 67129765_CREC_CHS_2021

1. Mumadziwapo chani pankhani chipatala cha achinyamata (YFHS)?
2. Kodi ndi thandizo liti limene limapezeka kuchipatala kwa achinyamata?
3. Munalandirapo maphunziro a nkhani za ubeleki (Reproductive Health) Kuti?
4. Nkhani za kugonana ndi ubereki mumazimvera kwa ndani?
5. Maganizo anu ndi otani pankhani yopereka njira zolera kwa achinyamata?
6. Kodi makolo anu ndi anthu otisunga amayiona bwanji nkhani ya kupereka njira zolera kwa achinyamata?
7. Kodi anthu a mdera lomwe mumakhala amayiona bwanji nkhani yopereka njira zolera kwa achinyamata?
8. Ndi zinthu ziti zimene zimalepheretsa achinyamata kupita kokalandira thandizo ku chipatala cha achinyamata.
9. Kodi ukhondo wa ku chipatala cha achinyamata komwe mumapita kukalandira thandizo ndi otani?
10. Kodi Khalidwe lomwe ogwira ntchito ya zaumoyo amakuonetserani mukapita kuchipatala cha achinyamata (YFHS) ndi lotani?
11. Kodi mungakonde chipatala cha achinyamata chidzipangidwa motani pankhani ya malo opangira, kaya masiku, nthawi komanso zochitika zonse?
12. Mungakonde ogwira ntchito otani? Kodi mungakonde kuti mudzithandizidwa ndi ogwira ntchito achinyamata anzanu, ogwira ntchito akuluakulu kapena aliyense? Perekani zifukwa
13. Mukuona kwanu, kodi boma kaya Unduna wa zaumoyo angapange chani kuti kagwiritsidwe ntchito ka chipatala cha achinyamata kupite patsogolo?
14. Mukuona kwanu, Kodi ndi njira ziti zomwe zingapangitse kuti ku chipatala cha achinyamata (YFHS) kuzibwera achinyamata ochuluka?

ANNEXURE R: ASPECTS TO ORIENT RESEARCH ASSISTANTS

1. OVERVIEW OF THE STUDY

- Background of the study
- Objectives
- Required sample
- Data collection sites
- Period for data collection

2. RECRUITMENT OF SUBJECTS

3. CONDUCTINGSTRUCTURED INTERVIEWS

- How to use the structured questionnaire and structured interview guides for the current study
- Practice sessions with research assistants

4. ETHICAL CONSIDERATIONS

- Ethical consideration affecting participants, institutions
- Research integrity

5. DATA QUALITY

6. PRE-TESTING THE STRUCTURED QUESTIONNARE AND INTERVIEW GUIDE

7. CORRECTIONS ON STRUCTURED QUESTIONNARE AND INTERVIEW GUIDES AFTER PRE-TESTING

ANNEXURE S1: TRANSCRIPT FOR FOCUS GROUP DISCUSSION 1

For the sake of confidentiality, and anonymity pseudonyms were used. Focus group discussions were digitally recorded and permissions obtained for the recording. The focus group discussions were conducted in local language, Chewa and scheduled according to the participant's preferences

Title: "Strategies for increasing utilization of Youth Friendly Health Services in Blantyre, Malawi"

Focus group	Question asked	Response
Madziabango focus group. 14hr:15 to 14hr:58, 40 minutes discussion with 8 youths aged 10 to 24 years	Introduction	My name is Grace Sibande and the researcher. Welcome to this Focus group discussion where we will discuss issues to do with Youth Friendly health services (YFHS). Thank you for accepting to be part of the discussions. Do you grant me permission to record this session? Participants: Yes, in a chorus. The discussions will last 30 to 60 minutes Purpose of this study: To develop strategies for increasing utilisation of Youth Friendly Health Services in Blantyre, Malawi
	Knowledge about YFHS	Interviewer: What do you know about YFHS? Participant 1: "eeeh… It is where we share ideas as youths. You know as youths we

		encounter many things but when we come to teach each other one or two things" Participant 2: "Yeah… just to add, his is where we get services that are free because you know as youths it is difficult to find money to make us attend paying services" Participant 4: "Yes… it is where we help each other to solve problems" Interviewer: Okay, Any more contributions? Participants: quiet.
	Where youths got information about YFHS	Interviewer: How did you get to know about YFHS? Participant 1: "As for me… I learnt about YFHS at the health centre from the health workers" Participant 6: "As for me… ummh … I saw it on posters at different places then I decided to attend and see what happens there" Participant 4: "Eeeh… I heard about YFHS from my friends"

	Services available at YFHS	Interviewer: Which services are readily available at YFHS? Participant 1: "Yeah… "We learn different things such as how to use condoms correctly… use of emergency contraceptive pills, we also learn about HIV and AIDs, how we can prevent contracting it and also the importance of HIV testing" Participant 2: "True…We learn many new things… issues like fistula for girls of which other youths do not know about and we are also given teachings on how to prevent pregnancy" Participant 3: Coughs and clears throat… "Ummh… We learn about many things including family planning" Participant 4: "Also, STI treatment" Participant 5: "Ummh…We also receive education on different types of abuse" Participant 8: "Eeeh…we also do physical activities such as netball, football and sometimes dancing"

	Sexual reproductive health knowledge	Interviewer: Where do you get information on sexual reproductive health? Participant 1: "Ummh, we learn about reproductive health issues at the hospital Participant 3: "As for me…I learnt about RH issues at the youth club"
	Perceptions about provision of contraceptive to youths	Interviewer: What are your thoughts about providing contraceptives to youths? Participant 7: "Laughs…To me, it is good because at least there will be reduced rate of school dropouts" Participant 4: "Ummh…the woman will not be sexually active…we also hear the women who use contraceptives are not sweet" Participant 3: "Yeah...I feel it is not good because we hear all sorts of things about a woman who uses contraceptives. For example, some people say the woman will lose their libido". Participant 6: "Yes…it is true. I'm also of the view that it is not good, because I have also heard that girls who use contraceptives become barren"

		Participant 4: "Laughs… It is not good indeed because some people also say contraceptives reduce male libido" All the participants laughing……
	Parental perceptions	Interviewer: How do parents and guardians view provision of contraceptives to youths? Participant 1: "Ummh… many parents say contraceptives are not good for girls because their use will lead to prostitution" Participant 2: "Yes… many parents also refuse because they believe it will lead to barrenness among girls" Participants agree in unison "yes it is true!"
	Community perceptions	Interviewer: How about the community? How does the community in general view provision of contraceptives to youths? Participant 5: "Similar to parents…the community has a negative attitude towards contraceptives among youths for fear of prostitution and barrenness among girls"

	Barriers to utilization of YFHS	Interviewer: In your own opinion, what factors bar young people from attending YFHS? Participant 2: "Ummh… I would say lack of money for contributions for buying balls and other equipment prevents some youths from coming to attend YFHS because we don't have these materials at YFHS hence as youths, we opt to contribute money to buy the balls ourselves…So if they don't have money to contribute, they don't come" Interviwer: Do you contribute money to buy balls? All participants in a chorus"… yes!" Participant 8: "Yes… some youths don't come maybe because they don't know about YFHS" Participant 4: "Ummh … Some youths maybe are just shy or afraid to be seen at YFHS by people who know them, maybe friends of their parents… because we have our activities mainly outside as there is no office for YFHS" Participant 3: "Ummh… Some youths maybe they stop coming because the method they want is sometimes not available. It is only condoms that we always find available...they

		can get condoms from community distributors" Participant 4: "Eeeh… Some youths maybe because of lack of resources for sports such as balls, bawo and they think they will be bored when they come to YFHS"
	Cleanliness of the health facility	Interviewer: How clean is the place where YFHS are offered at this facility? Participant 4: "Ummh, the cleaners clean the meeting area. We find it clean when we come for YFHS". The rest of the participants agree in a chorus… "It is true"
	Attitude of service providers	Interviewer: What are your views on attitude of service providers when you attend YFHS? Participant 3: "Well… it depends on who is on duty but in general they all welcome us well.
	Location, days and time for YFHS	Interviewer: Where and when are YFHS provided in terms of place, days and time conducted?

		Participants: (chorus) “We meet outside ART clinic on Saturday afternoon from 2 Pm” Participant 2: “Ummh…We meet outside ART clinic because there is no other place for YFHS. It would have been better if the health centre had an office where we could receive all services as youths even during the week” Participant 1: “Ummh…Since we do not have a special room for YFHS, when we come during week days there is lack of privacy and confidentiality in provision of services because they are offered together with the adults where you can bump into your father while collecting condoms”. Interviewer: Do you have any problem with the day you meet? Several Participants: “….No!” Participant 3 “Emmh…Saturday is convenient for most of us and we have had no problem meeting on this day also considering that it is in the afternoon when we have finished home chores”

	Preference on age of service providers	Interviewer: What is your preference regarding age of service providers at YFHS? Do you prefer to be served by fellow youths, older service providers or either of them? Give reasons for your answers Participant 1: “Eeeh… I would prefer a fellow youth because I know I can be free to talk about anything” Participant 2: “Yes! I also prefer fellow youths because you cannot feel shy with a fellow youth” Interviewer: What about others? Participants: “It is the same… better fellow youths than older people” (chorus) Interviwer: What about the gender of the provider? Participant 2: “Ummh…YFHS focal persons should be both male and female because some youths are shy and therefore feel uncomfortable to discuss some of their problems with providers of the opposite sex”.

	What Ministry of Health can improve on	Interviewer: What should the Ministry of Health do to improve YFHS? Participant 4: Clears the throat… "As we have told you, there is need for a room that will be used for YFHS. It can be a special room or a youth corner where we can receive services for YFHS". Participant 3: "Eeeh…donors should help us for instance by supplying us with sports equipment such as balls and also FP methods" Participant 2: "Ummh… we also need leaflets. They should provide us with leaflets so we can read at home".
	Strategies to increase utilization of YFHS	Interviewer: In your opinion, what strategies should be used to increase utilization of YFHS? Participant 1: "Eeeh… they should use activities that attract the youth such as football, netball, disco to bring them to YFHS. If they provide all these, many youths will come to attend YFHS" Participant 4: "Ummh…The government should provide enough supplies to the health centre. For example… contraceptives

		because it is discouraging when some youths find that the method which they want is not there… they may not return because of that” Participant 3: “Yes… I agree… they should provide youths with resources for sports activities and games such as balls, game boards” Participant 2: “Yeah…the government should provide us with a place specifically for provision of YFHS. This place should be used for the youth services everyday up to 5pm” Participant 6: “I think… They should also place condoms in different places such as toilets where youth can access them”. Participant 4: “Eeeh… they should arrange for us to have exchange visits so that we learn from fellow youths Participant 3: “Ummh They should continue providing education on YFHS” Participant 2: “Ummh… The health facilities should have both male and female service providers so that youths are free to choose the preferred gender”.

		Interviewer: We are about to end the session and the recorder will be switched off. Thank you very much for your in-puts Participants: “Thank you”
		THE END

ANNEXURE S2: TRANSCRIPT FOR FOCUS GROUP DISCUSSION 2

For the sake of confidentiality, and anonymity pseudonyms were used. Focus group discussions were digitally recorded and permissions obtained for the recording. The focus group discussions were conducted in local language, Chewa and scheduled according to the participant's preferences

Title: "Strategies for increasing utilization of Youth Friendly Health Services in Blantyre, Malawi"

Focus group	Question asked	Response
Madziabango focus group. 14hr:15 to 14hr:58, 40 minutes discussion with 8 youths aged 10 to 24 years	Introduction	My name is Grace Sibande and the researcher. Welcome to this Focus group discussion where we will discuss issues to do with Youth Friendly health services (YFHS). Thank you for accepting to be part of the discussions. Do you grant me permission to record this session? Participants: Yes, in a chorus. The discussions will last 30 to 60 minutes Purpose of this study: To develop strategies for increasing utilisation of Youth Friendly Health Services in Blantyre, Malawi
	Knowledge about YFHS	Interviewer: What do you know about YFHS? Participant 1: "Ummh… It involves youth meeting to discuss different health issues"

		Participant 2: "As youths, we are taught about the services that are offered. Participant 4: "Eeeh… As youth we meet for recreation but now, we have run out of resources that were provided by an American, no organizations are coming forward for assistance. That is the problem that we have now" Participant 3: "Yes… For us to manage to conduct activities at YFHS, we source funds by contributing to operationalize our club and we also do charity works"
	Where the youth get information about YFHS from	Interviewer: How did you get to know about YFHS? Participant 6: Ahem... Mostly we get the information from the hospital. Yes… parents do provide us with information but it is not rich. We get more information from the health workers" Interviewer: Is it the same for everyone? Participants: "Yes…" (in a chorus)
	Services available at YFHS	Interviewer: Which services are readily available at YFHS?

		Participant 7: “We receive education on many things at YFHS”. Interviewer: Ahem, Such as what? Participant 2: “Family planning methods” Participant 4: “Yeah…We learn many new things… issues like fistula for girls of which other youths do not know about and we are also given teachings on how to prevent pregnancy” Participant 8: “Yes…We receive education on a lot of things at YFHS such as how to prevent pregnancy and how to get rid of sexual desire…” Many participants laughing…
	Sexual reproductive health knowledge	Interviewer: Where do you get information on sexual reproductive health? Participant 7: “Clears the throat…Parents do provide information on SRH, but I can say it is not rich”.

		Participant 5: “Eeeh. I prefer getting the SRH information from the health workers because they give us full information”. Participants: “Yes, yes… we learn more at the at the health centre” (chorus)
	Perceptions about provision of contraceptive to youths	Interviewer: What are your thoughts about providing contraceptives to youths? Participant 6: “Eeeh, as for me, it is good because it helps the youth to prevent unplanned pregnancies” Participant 3: “Ummh…some youths say it is not good because it will make the girls barren” Participant 2: “As for me, it is good because it protects us from STIs”
	Parental perceptions	Interviewer: How do parents and guardians view provision of contraceptives to youths? Participant 1: “Eeeh… most of the parents believe youths are young and contraceptives will harm their bodies such as making them barren”

	Community perceptions	Interviewer: How does the community view provision of contraceptives to youths? Participant 2: “Ummh…mostly, the community considers youths accessing contraceptives as being sexually immoral” Participants: “Yes… it is true!” (In a chorus)
	Barriers to utilization of YFHS	Interviewer: In your own opinion, what factors bar young people from attending YFHS? Participant 6: “Ummh… maybe for some youths, there is nothing to attract them to come. There are no sporting materials like balls for football or netball therefore the youths think they will be bored when they come” Participant 4: “Yeah... some youths just belittle what happens at YFHS. they think they know everything. Some think all we do is talk about contraceptives and they think they will become promiscuous that is why they don’t come” Participant 3: “Ummh… I think to some youths, it is because they don’t know about YFHS and its benefits. For example, us who attend YFHS we know things like how to use

		condoms correctly, …we know things like emergency contraception… we learn quite a lot when we come to YFHS”
	Cleanliness of the health facility	Interviewer: How clean is the place where YFHS are conducted: Participant 2: “Ummh we have no problem with the cleanliness of the meeting area, we find it clean”.
	Attitude of service providers	Interviewer: What are your views on attitude of service providers when you attend YFHS? Participant 5: “Eeeh… we do not have any issues with them. They welcome us well and they listen to our problems”. Participant:2 “Yeah…They are friendly to us too” Participant 6: “Yes… they also treat us well when we come to hospital with other problems on days that are not for YFHS”.
	Location, days and time for YFHS	Interviewer: Where and when are YFHS provided in terms of location, days and time?

		Participant 2 “Eeeh… we meet on Sundays afternoon at the hospital at the Out-patients department”. Interviwer: Do you have any preferences on the days, place or time for YFHS? Participant 3: “Ummh…Sunday afternoon is perfect with us because it does not burden anyone. Those who go to church on Saturday, are available and those who go to church on Sunday are also available. It is after we have finished our chores at home”. Participant 6: “I think… they should provide YFHS even on week days so it is easy for us if we have a problem during the week”. Participant 3: “Ummh…As for the place, it could be better if we had an office or room for YFHS where all services are provided in one place”
	Age of service providers	Interviewer: What is your preference regarding age and gender of service providers at YFHS? Do you prefer to be served by fellow youths, older service providers or either of them? Give reasons for your answers

		Participant 5: “As for me, Ummh… I prefer youthful health workers because I can easily open up with a fellow youth” Participant 6: “Yeah… I agree, I also prefer youthful health workers Interviewer: What about the gender of the provider, which one do you prefer? Participant 2: “As for me… I would rather be seen by a fellow man because I will be freer. Of course, not that a female provider cannot see me but I think it is better to have both genders for the sake of those who feel uncomfortable with the opposite gender” Participant 4: “Yes… I think it is better to have female and male providers”
	What Ministry of Health can improve on	Interviewer: What should the Ministry of Health do to improve YFHS? Participant 4: “Ummh… they should give us enough recreation service and things like balls, game boards so that we do not get bored when we come for YFHS”. Participant 1: “I agree…we need to have enough recreational materials at the health centre”

		Participant 2: “Eeee…The government should establish youth friendly health services that run throughout the week” Participant 4: “The government should provide us with an office or room special for the youth at the hospital. We need our own room where YFHS can be provided”.
	Strategies to increase utilization of YFHS	Interviewer: In your opinion, what strategies should be used to increase utilization of YFHS? Participant 3: “Ummh, we would like to have a specific office or room for YFHS where all services are provided in one place” Participant 6: “In addition, we need to get regular visits by YFHS officials to provide supportive supervision. I think this would encourage youths to come for YFHS because for some, to be listening the from chairperson all the time, other youths may think it is childish”. Participant 2: “Ummh… we should have a special room for YFHS which should be a one stop centre for the youths at the health centre and should be open for the youth even on working days”

		Participant 4: "I think… they should intensify community sensitization about the importance of YFHS in the communities" Participant 1: "I also think …a group of youths should encourage fellow youths in the communities" Participant 5: "Okay… a youth is like a child. He will go where there are games as opposed to where there is health education only. As such, we need to have balls and other resources such as game boards, playing cards. These should always be available at the health centre".
		Interviewer: We are about to end the session and the recorder will be switched off. Thank you very much for your in-puts. Participants: "Thank you"
		THE END

ANNEXURE S3: TRANSCRIPT FOR FOCUS GROUP DISCUSSION 3

For the sake of confidentiality, and anonymity pseudonyms were used. Focus group discussions were digitally recorded and permissions obtained for the recording. The focus group discussions were conducted in local language, Chewa and scheduled according to the participant's preferences

Title: "Strategies for increasing utilization of Youth Friendly Health Services in Blantyre, Malawi"

Focus group	Question asked	Response
Madziabango focus group. 14hr:15 to 14hr:58, 40 minutes discussion with 8 youths aged 10 to 24 years	Introduction	My name is Grace Sibande and the researcher. Welcome to this Focus group discussion where we will discuss issues to do with Youth Friendly health services (YFHS). Thank you for accepting to be part of the discussions. Do you grant me permission to record this session? Participants: Yes… in a chorus. The discussions will last 30 to 60 minutes Purpose of this study: To develop strategies for increasing utilisation of Youth Friendly Health Services in Blantyre, Malawi
g	Knowledge about YFHS	Interviewer: What do you know about YFHS? Whatever you know

		Participant 1: "Ummh… It is like coming together and discussing health issues and how to generally live a healthy life". Participant 4: "I would say…it is a group of people discussing good behaviour so that we are different from those who do not come to YFHS for example how to avoid bad habits like smocking and how to avoid contacting HIV and STIs" Participant 7: "…and also how to prevent unwanted pregnancies by using family planning methods" Participant 3: "Just to add… we also discuss why we should avoid pregnancies and ways which may help us to prevent diseases".
	Where youths got information about YFHS	Interviewer: Where did you learn about YFHS and SRH issues? Participant 6: Eeeh…I learnt about YFHS at the health centre. Participant 8: "Yeah…Some of us learnt from Youth clubs" Interviwer: "Okay".

		Interviewer: Where do you receive sexual reproductive health information? Participant 4: "Ummh… I can say we get reproductive health information mainly at the health centre Participant 6: "Yeah…we also learn SRH issues at the youth clubs". Participant 2: "Yes… even at school. I learnt that at school and we also heard similar information at the health centre"
	Services available at YFHS	Interviewer: Which services are readily available at YFHS? Participant 1: "Ummh…Family planning methods" Participant 3: "Also HIV testing". Participant 1: "Eeeh…we also receive medical services when we are sick Interviewer: What do others say?

		Participant 4: “Ummh…We also receive counselling on issues like substance abuse”. Participant 5: “Ummh…When we become sick, we are assisted promptly by the health workers” Participant 2: “Ahem…I can just say we receive teachings on different things including good behavior.”
	Perceptions about provision of contraceptive to youths	Interviewer: What are your thoughts about providing contraceptives to youths? Participant 3: “As for me… It is good because it helps in prevention of diseases such as STIs and unwanted pregnancies” Participant 2: “Eeeh…It helps the government reduce the budget” Participant 7: “Ummh…It is also good for population control and at the moment, it is helping because people are not having many children as before”

	Parental perceptions	Interviewer: How do parents and guardians view provision of contraceptives to youths? Participant 3: “Ummh… many parents are not happy with provision of contraceptives to the youth. They perceive a youth accessing contraceptives as being sexually immoral especially for girls.”
	Community perceptions	Interviewer: How does the community view provision of contraceptives to youths? Participant 3: “Mmmh… similar to parents, the community also perceive a youth accessing contraceptives as being sexually immoral”. Participant :5: “It is not a big challenge for the boys but for girls eeeh… it is a great challenge”.
	Barriers to utilization of YFHS	Interviewer: In your own opinion, what factors bar young people from attending YFHS? Participant 1: “Ummh… lack of materials for sports like balls for football or netball or bawo”

		Participant 5: "Yeah …also… lack of contraceptive methods that some youths want. Some youths maybe they want the injection method but they are returned that it is not available two, three times. Due to that some youths will not come back" Participant 4: "I think…other youths are just selfish; they belittle what happens at YFHS they think they know everything". Participant 3: "Ummh… Some youths ask us questions like… "what are we going to benefit there? Are we going to be paid?" Participant 5: "Yeah…another reason could be that we have no specific place for YFHS and we conduct our services on an open space…some youths may feel shy to come fearing people who know them will see them and maybe report them to their parents" Participant 2: Distance…Some youths stay very far from the health centre Participant 1: "Eeeh… parents also bar some youths from attending YFHS. For example, one was attending Youth and became pregnant, this makes other parents to think

		that those who go to youth just engage in sexual activities”
	Cleanliness of the health facility	Interviewer: How clean is the place where you conduct YFHS? Participant 2: “Ummh… Most of the times we find the meeting area clean, well mopped when we come to the health centre for YFHS
	Attitude of service providers	Interviewer: What are your views on attitude of service providers when you attend YFHS? Participant 1: “Ummh…on that one, there is no problem… they are generally friendly to us despite that some are older than us Participant 2: “Yes...they welcome us well even when we come during the week for other services”
	Location, days and time for YFHS	Interviewer: Where are youth friendly conducted in terms of place, day and time Participant 2: “Here... we meet on Saturday afternoon, around 3pm at an open space and we prefer YFHS to be at the hospital rather than at school or in the village”.

		Participant 3: "Yes...we are happy with Saturday because if it is on Sunday, many youths do not come maybe because they are washing ready for school on Monday, therefore we would be happy if YFHS were also provided in week days." Participant 6: "Mmmh… regarding time, the afternoon is okay because we are done with home chores" Participant 4: "A specific room for YFHS would be better for us rather than the open space where we are currently meeting because some youths can fear being seen… If possible, our own room where we can receive all YFHS from Monday to Friday"
	Age of service providers	Interviewer: What is your preference regarding age of service providers at YFHS? Do you prefer to be served by fellow youths, older service providers or either of them? Give reasons for your answers Participant 4: "I would choose youthful workers because you cannot feel shy with a fellow youth"

		Participant 3: "As for me… I prefer a youthful provider because I can be more open with a fellow youths" Participant 4: "As for me…both old and youthful because the old can keep confidentiality and they have passed through a lot in life also if they can be complemented with the youth, then we can learn from both age groups." Interviewer: How about gender, what is your preference on gender of the service provider? Participant 5: "Ummh… If we were to choose, I would choose a fellow female provider. I would not feel shy with such a provider than a male provider" Participant 7: "I think… it is better to have female and male providers at YFHS"
	What Ministry of Health can improve on	Interviewer: What should the Ministry of Health do to improve YFHS? Participant1: "Ummh… maybe if we can have exchange visits where we can learn from each other"

		Participant 7: “We should have sports days at YFHS” Participant 2: “Eeeh…I think there should be opportunities for youth to showcase their talents at YFHS for example, art. This will attract the youths”. Participant 5: “Ummh…we also need resources for sports such as balls and gameboards Participant 7: “Ehee...we have a radio station here in Ndirande. Sensitization about YFHS can be done at Ndirande FM” Participant 1: “Ummh… I think what we need the most are balls and jerseys. Please if you can help us with these items we can appreciate. Participant 3: Ahem…there should be shows like music shows or drama shows which can be showcased on some YFHS days. This could attract some youths”. Participant 4: “Eeeh… we need a room where we can receive all YFHS from Monday to Friday then we can have games, shows and other sports on Saturday or Sunday sports”

	Strategies to increase utilization of YFHS	Interviewer: In your opinion, what strategies should be used to increase utilization of YFHS? Participant 3: “Ummh… a special room should be provided. It can be an office or room for YFHS where all services for youth can be provided in one place” Participant 1: “Yes…as already mentioned, the youth like sporting activities. But as of now, we don’t have balls and we use borrowed balls. We need our own balls and Jerseys. Maybe you can also support us with balls.” Participants: …laughing Participant 2: “Eeeh…we can go to radio stations and talk about YFHS. It will be like an advertisement about YFHS for the youths who have never heard about YFHS and some youths would be attracted and start coming to attend. We have several radio stations” Participant 6: “Ummh...we should get regular visits by health care professionals

		Participant 2: "Eeeh...there should be a designated room for YFHS at the health facility for YFHS". Participant 3: "Ahem…community sensitization should be intensified by the health centre staff, or us youths informing fellow youths about YFHS and the importance of youth friendly health services". Participant 3: "Ummh…there should be more youthful service providers a the YFHS so that the youths are free to talk about their problems to a fellow youth". Participant 6: "Yes...maybe some youths would develop interest when they see fellow youths giving them information about YFHS as such, a group of youths should be used to encourage fellow youths in the communities" Participant 1: "Conduct sensitizations in schools as well, with some motivation" Participant 2: "Grant youths opportunities to showcase their talents such as art drama and other talents. These would attract many youths to come and see the talents in the process they can also hear about the education messages"

		Participant 5: “Eeeh...balls and other resources such as game boards, playing cards should be available at the health centre all the time so that youths should not get bored when they come to attend YFHS”.
		Interviewer: We are about to end the session and the recorder will be switched off. Thank you very much for your in-puts. Participants: “Thank you”
		THE END

ANNEXURE S4: TRANSCRIPT FOR INDIVIDUAL INTERVIEW 1

For the sake of confidentiality, and anonymity pseudonyms were used. Interviews were digitally recorded and permissions obtained for the recording. Interviews were conducted in local language, Chewa and scheduled according to the participant's preferences

Title: "Strategies for increasing utilization of Youth Friendly Health Services in Blantyre, Malawi"

Participant	Question asked	Response
Participant 01:GS (Female) Interviewed 21 September 09hr:33 to 10hr:11, 38 minutes face to face 31-year-old Nurse Midwife Technician, not trained in YFHS but had a facility briefing about YFHS	Introduction	My name is Grace Sibande and the researcher. Welcome to this interview session Do you grant me permission to record this session? Participant: Yes The interview will last 30 to 60 minutes Purpose of this study: To develop strategies for increasing utilisation of Youth Friendly Health Services (YFHS) in Blantyre, Malawi
	Knowledge about reproductive health by the youth	Interviewer: How knowledgeable are the Youth about Reproductive health issues? Participant GS: "Yeah… youths are knowledgeable about reproductive health issues through organisations such as MANASO but, I can say that not all the youths are knowledgeable"
	Knowledge about YFHS	Interviewer: How about YFHS…How knowledgeable are the youth about YFHS?

		Participant GS: “I think… many youths have heard about YFHS”.
	Accessibility of YFHS	Interviewer: How accessible are YFHS at this health facility? Participant GS: “Ummh… I can say yes… YFHS are accessible, but not all the youths in the catchment area access the services” Interviewer: What do you think influences the accessibility? Participant GS: “Eeeh… We have what we call Youth champions in the communities who sensitize youths about YFHS. Sometimes there are youth bonanzas organised by some NGOs such as Jhpiego which provides reproductive health education to youths aged 15 to 24 in the communities This somehow contributes to accessibility of YFHS” Interviewer: Oh okay.
	Set up of YFHS at the facility	Interviewer: What is the set-up of YFHS at this facility in terms of location, working days and times?

		Participant GS: “In terms of room, there is no special room for YFHS. The services are conducted outside the ART department. Regarding days – the services are offered on Wednesdays and Saturdays and usually the YFHS start at 2pm”
	Available contraceptives	Interviewer: Which contraceptives are available for youths at this facility? Participant GS: “Eeee… All the contraceptive are available for the youth…Condoms, contraceptive pills, injectables, implants” Interviewer: Are these contraceptives always available? if not, which contraceptive is always available at YFHS? Participant GS: Ummh…condoms only.
	Barriers to utilization of YFHS	Interviewer: What do you think are barriers to utilization of YFHS in this facility? Participant GS: “Well, attitude of some health workers. They are not so welcoming to the youths; they sort of judge the youths”. “Also… supply of contraceptives. Sometimes preferred contraceptive methods are not always available. This discourages some

		youths and they stop coming to YFHS and also for some youths, maybe…operating days for YFHS are not convenient for them”
	Guidelines and policies to guide in working at YFHS	Interviewer: What protocols, guidelines or policies do you have that facilitate provision of YFHS? Participant GS: “Eeee…We operate YFHS using the Ministry of Health guidelines”
	Factors influencing youths to attend YFHS	Interviewer: What factors influence youths to attend YFHS? Participant GS: “Ummh… I think…they are mainly motivated by friends”
	Usability of YFHS	Interviewer: What is your experience regarding usability of YFHS in this facility? Participant GS: I would say… not much. Interviewer: Do they reach 100 youths per session? Participant GS, when there is a bonanza, I can say yes… but on a normal day, mmm…mmm (shakes her head). the highest they can go is around 30 to 40 youths.

	Being done to enhance usability	Interviewer: What is currently being done to enhance utilization of YFHS at this Health Centre? Participant GS: “We paste posters on different places showing that we provide YFHS, services that we offer and on which days. We also lobby from partners such as MANASO to help us give messages about YFHS in the communities”
	Openness of youths to service providers	Interviewer: What is your experience on openness of the youth regarding reproductive health issues to you? Participant GS: “Ummh…Some youths are open some are not but we try to open up with them so that they open up with us”
	Factors that motivate the service provider	Interviewer: What factors motivate you to continue pushing as a YFHS provider? Participant GS: laughs… “my personal experience as a youth. I had some problems which hindered my wishes, so I want youths to do better than me” …smiles
	Factors that demotivate the service provider	Interviewer: What factors demotivate you as a service provider?

		Participant GS: “Eeeh… I get demotivated when youths do not come for YFHS; if contraceptive methods of choice for the youths are not available. I also get frustrated because of not being able to assist the youth on Saturdays because I am a member of the Seventh Day Adventist church”
	Conflict with beliefs of provider	Interviewer: Does provision of contraceptives to youths conflict with any of your beliefs and values? Participant GS: I have no problem with youths getting contraceptives, it does not conflict with my beliefs.
	What can enhance provider competency	Interviewer: What do you think should be done to enhance provider competency Participant GS: “Eeeh…training should be provided to all YFHS providers and all cadres of staff should receive orientation about YFHS.”
	Strategies that can increase utilization of YFHS	Interviewer: In your own opinion, what strategies would help to increase utilization of YFHS? Participant GS: “Firstly…Youths should be engaged on school days as well; Community leaders should be engaged also so that they are well knowledgeable about YFHS; Also, a

		place specifically for conducting YFHS should be provided for at the health Centre”.

ANNEXURE S5: TRANSCRIPT FOR INDIVIDUAL INTERVIEW 2

For the sake of confidentiality, and anonymity pseudonyms were used. Interviews were digitally recorded and permissions obtained for the recording. Interviews were conducted in local language, Chewa and scheduled according to the participant's preferences

Title: "Strategies for increasing utilization of Youth Friendly Health Services in Blantyre, Malawi"

Participant	Question asked	Response
Participant 02:TS (Female) Interviewed 21 September 14hr:07 to 14hr:47 40 minutes face to face 30-year-old Advanced Diploma IT, Not trained in YFHS but had a facility briefing about YFHS	Introduction	My name is Grace Sibande and the researcher. Welcome to this interview session Do you grant me permission to record this session? Participant: Yes. The interview will last 30 to 60 minutes Purpose of this study: To develop strategies for increasing utilisation of Youth Friendly Health Services (YFHS) in Blantyre, Malawi
	Knowledge about reproductive health issues	Interviewer: How knowledgeable are the Youth about Reproductive health issues? Participant TS: "Eeeh… I can say…many of them are knowledgeable through MANASO"
	Knowledge about YFHS	Interviewer: How knowledgeable are the youth about YFHS?

		Participant TS: "Yeah…many of the youths are knowledgeable about YFHS"
	Accessibility of YFHS	Interviewer: How accessible are YFHS at this health facility? Participant TS: "Ummh… Not all youths access YFHS just some" Interviewer: What influences the accessibility? Participant TS: "I think…community sensitization about YFHS by an organization called MANASO and youth groups assist quite a lot"
	Set up of YFHS at the facility	Interviewer: What is the set-up of YFHS at this facility in terms of location, working days and times? Participant TS: "There is no special room for YFHS. The services are conducted outside the ART department" "Eeeh…YFHS are provided on Wednesday and Saturdays from 2pm"

	Available contraceptives	Interviewer: Which contraceptives are available for youths at this facility? Participant TS: "Ummh…Pills, injectables, implants, condoms" Interviewer: Which contraceptive is always available at YFHS? Participant TS: "Only condoms are available all the time"
	Barriers to utilization of YFHS	Interviewer: What do you think are barriers to utilization of YFHS in this facility? Participant TS: "Mumm… attitude of the youths... some feel they have overgrown YFHS, for some youths… lack of knowledge about YFHS" "Also…maybe some youths are just shy to come fearing they will be seen also considering that we do not have a special room or corner where we provide YFHS". "For some…long distances to health facility and the hilly geographical areas that surround the health centre prevent them from coming"

	Guidelines and policies to guide in working at YFHS	Interviewer: What protocols, guidelines or policies do you have that facilitate provision of YFHS? Participant TS: “We have protocols from the Ministry of Health and we also have some facility made policies”.
	Factors influencing youths to attend YFHS	Interviewer: What do you think are the factors that influence youths to attend YFHS at this health facility? Participant TS: “Mainly, it is activities such as football, career shows, poems these are done monthly”
	Usability of YFHS	Interviewer: What is your experience regarding usability of YFHS in this facility? Participant TS: “Eeee… not many youths attend YFHS. I can say there are less girls compared to boys who attend YFHS”
	Being done to enhance usability	Interviewer: What is currently being done to enhance utilization of YFHS? Participant TS: “We work with organizations such as MANASO; We provide information about YFHS during HCT clinics and we also

		conduct what we call… bring a friend campaigns”.
	Openness of youths to service providers	Interviewer: What is your experience on openness of the youth regarding reproductive health issues? Participant TS: “Mmmm…many of them are open but we still have some youths who are not open especially girls”
	Factors that motivate the service provider	Interviewer: What factors motivate you as a YFHS provider? Participant TS: “I get motivated when more youths come to attend YFHS”
	Factors that demotivate the service provider	Interviewer: What factors demotivate you as a provider Participant TS: “Eeee… I get demotivated when I do not get support on YFHS issues from other staff…also when we get less involvement on YFHS by organizations”
	Conflict with beliefs of provider	Interviewer: Does provision of contraceptives to youths conflict with any of your beliefs and values?

		Participant TS: No…family planning for youths does not interfere with any of my beliefs
	What can enhance provider competency	Interviewer: What do you think should be done to enhance YFHS provider competency? Participant TS: "I think…proper trainings for YFHS providers or focal persons can help and exchange visits for providers should be conducted so that we learn from each other"
	Strategies that can increase utilization of YFHS	Interviewer: In your own opinion, what strategies would help to increase utilization of YFHS? If can list them do so. Participant TS: "Ummh… we should have infrastructure for YFHS at the health centre rather than conducting YFHS outside ART clinic". "Mmmh… we also need to provide daily service to the youth and not only weekly services as we are doing now" "I think we should also Involve the youth in formulation of an action plan for YFHS.
		Interviewer: We are about to end the session and the recorder will be switched off. Thank you very much for your in-puts.

		Participant: “Thank you”
		THE END

ANNEXURE S6: TRANSCRIPT FOR INDIVIDUAL INTERVIEW 3

For the sake of confidentiality, and anonymity pseudonyms were used. Interviews were digitally recorded and permissions obtained for the recording. Interviews were conducted in local language, Chewa and scheduled according to the participant's preferences

Title: "Strategies for increasing utilization of Youth Friendly Health Services in Blantyre, Malawi"

Participant	Question asked	Response
Participant 03: NM (Female) Interviewed 22 September 09hr:46 to 10hr:28 42 minutes face to face 30-year-old Diploma Nurse, Not trained in YFHS but briefed by an organization called EGPAF	Introduction	My name is Grace Sibande and the researcher. Welcome to this interview session Do you grant me permission to record this session? Participant: Yes The interview will last 30 to 60 minutes Purpose of this study: To develop strategies for increasing utilisation of Youth Friendly Health Services (YFHS) in Blantyre, Malawi.
	Knowledge about reproductive health issues	Interviewer: How knowledgeable are the Youths about Reproductive health issues? Participant NM: "Eeeh… many youths are knowledgeable about reproductive health issues through youth community chairpersons".
	Knowledge about YFHS	Interviewer: How knowledgeable are the Youth about YFHS?

		Participant NM: “Ummh…I can say…many youths are knowledgeable of YFHS as compared to those who do not know”.
	Accessibility of YFHS	Interviewer: How accessible are YFHS at this health facility? Participant NM: “Yes…the services are accessible to some youths but not accessible to others due to distance and stock outs of supplies including contraceptives” Interviewer: What influences the accessibility? Participant NM: “I can say… mainly, it is distance to the health facility and availability of supplies such as contraceptives”
	Set up of YFHS at the facility	Interviewer: What is the set-up of YFHS at this facility in terms of location, working days and times? Participant NM: “Ummh… There is no special room for YFHS. The services are conducted at Out-Patient-Department because this area is not used on Sundays…YFHS are conducted on Sundays as already indicated,

		but during week days, the youths are assisted through focal persons” “YFHS are conducted on Sundays but during week days the youths are assisted through the focal person” Time – “14:00hrs to 17:00 hours”
	Available contraceptives	Interviewer: Which contraceptives are available for youths at this facility? Participant NM: “Condoms and Depo-Provera” Interviewer: Which contraceptive is always available at YFHS? Participant NM: “Condoms”.
	Barriers to utilization of YFHS	Interviewer: What do you think are barriers to utilization of YFHS in this facility? Participant NM: “I think...lack of proper space or room for conducting YFHS; Walking long distances and stock outs for contraceptive methods”

	Guidelines and policies to guide in working at YFHS	Interviewer: What protocols, guidelines or policies do you have that facilitate provision of YFHS? Participant NM: "Ummh...there are no protocols at this health facility"
	Factors influencing youths to attend YFHS	Interviewer: What factors influence youths to attend YFHS? Participant NM: "I believe...teamwork among health care workers and the fact that the doctor is available when the youth report to the health facility when they are sick".
	Usability of YFHS	Interviewer: What is your experience regarding usability of YFHS in this facility? Participant NM: "I would say not much… the biggest number we get is between 30 to 40 youths"
	Being done to enhance usability	Interviewer: What is currently being done to enhance utilization of YFHS? Participant NM: "Mmmh…we just continue to provide services to the youth and we put aside supplies for the youth sometimes"

	Openness of youths to service providers	Interviewer: What is your experience on openness of the youth regarding reproductive health issues? Participant NM: “Eeee...the youths are open to express their needs. We do not have a problem with that”.
	Factors that motivate the service provider	Interviewer: What factors motivate you as a YFHS provider to keep on pushing providing the services despite barriers? Participant NM: “I get motivated by the willingness to learn new things by the youth and also… role modeling to the youth so that they achieve their dreams”.
	Factors that demotivate the service provider	Interviewer: What factors demotivate you as a provider? Participant NM: Ummh … I really get demotivated when I receive inadequate support from superiors and fellow staff on issues to do with YFHS.
	Conflict with beliefs of provider	Interviewer: Does provision of contraceptives to the youth conflict with any of your beliefs and values?

		Participant NM: "No… It does not interfere with any of my beliefs"
	What can enhance provider competency	Interviewer: What do you think should be done to enhance provider competency Participant NM: "Proper training of all YFHS focal persons would make us more competent to handle the youths even better"
	Strategies that can increase utilization of YFHS	Interviewer: In your own opinion, what strategies would help to increase utilization of YFHS? You may list them Participant NM: "We should have a special room or a youth corner for YFHS at the health Facility". "There is need to have constant supply of contraceptive methods so that the youths are not returned because of these frequent stock-outs" "Proper training of all YFHS focal persons would make us more competent to handle the youths even better" "The health facility should provide activities such as football, netball and we should provide balls for football or netball

		Interviewer: We are about to end the session and the recorder will be switched off. Thank you very much for your in-puts. Participant: “Thank you”
		THE END

ANNEXURE S7: TRANSCRIPT FOR INDIVIDUAL INTERVIEW 4

For the sake of confidentiality, and anonymity pseudonyms were used. Interviews were digitally recorded and permissions obtained for the recording. Interviews were conducted in local language, Chewa and scheduled according to the participant's preferences

Title: "Strategies for increasing utilization of Youth Friendly Health Services in Blantyre, Malawi"

Participant	Question asked	Response
Participant 04:KM (Male) Interviewed 22 September 11hr:32 to 12hr:13 41 minutes face to face 25-year-old, Has MSCE certificate Not trained but had a two-day briefing by Pakachere	Introduction	My name is Grace Sibande and the researcher. Welcome to this interview session Do you grant me permission to record this session? Participant: Yes The interview will last 30 to 60 minutes Purpose of this study: To develop strategies for increasing utilisation of Youth Friendly Health Services (YFHS) in Blantyre, Malawi
	Knowledge about reproductive health issues	Interviewer: How knowledgeable are the Youth about Reproductive health issues? Participant KM: "Ummh…The youth are knowledgeable about reproductive health issues with the assistance of Blantyre synod counsellors"
	Knowledge about YFHS	Interviewer: How knowledgeable are the Youth YFHS?

		Participant KM: “Eeeeh...the youth are well knowledgeable about YFHS through the assistance of Health Surveillance Assistants”
	Accessibility of YFHS	Interviewer: How accessible are YFHS at this health facility? Participant KM: “Mmmm… The services are well accessible” Interviewer: What influences the accessibility? Participant KM: “Yeah…It is because… we have hard working and non-judgmental YFHS providers and there is also monitoring and evaluation of YFHS.
	Set up of YFHS at the facility	Interviewer: What is the set-up of YFHS at this facility in terms of location, working days and times? Participant KM: In terms of room… there is no special room for YFHS. The services are conducted at OPD department because there is no OPD on Sunday. YFHS are mainly offered on Sundays and sometimes on Thursdays from 2pm”

		Time – "from 14:00hrs"
	Available contraceptives	Interviewer: Which contraceptives are available for youths at this facility? Participant KM: "We have condoms, Injectables" Interviewer: Which contraceptive is always available at YFHS? Participant KM: Condoms
	Barriers to utilization of YFHS	Interviewer: What do you think are barriers to utilization of YFHS in this facility? Participant KM: "I think…culture; attitude of some youths, who belittle YFHS; myths about contraceptives; lack of entertainment materials such as balls, game boards etc. Als... No office for YFHS and Lack of exchange visits. Some youths also want leaflets but we do not have".
	Guidelines and policies to guide in working at YFHS	Interviewer: What protocols, guidelines or policies do you have that facilitate provision of YFHS?

		Participant KM: “There are no protocols at least that I have seen”.
	Factors influencing youths to attend YFHS	Interviewer: What factors influence youths to attend YFHS? Participant KM: “Mmmh…monitoring and evaluation by partners encourage the youths to continue attending YFHS; The new information that the youth gain from here and I think … EGPAF youth trainings on family planning also help”
	Usability of YFHS	Interviewer: What is your experience regarding usability of YFHS in this facility? Participant KM: “Eeee. Not many youths attend, I think because of long distances.
	Being done to enhance usability	Interviewer: What is currently being done to enhance utilization of YFHS? Participant KM: “Ummh...not much. Youth trainings are not done; supervision is not done”
	Openness of youths to service providers	Interviewer: What is your experience on openness of the youth regarding reproductive health issues?

		Participant KM: “I can say…the youths are generally open to us. We don’t have any problem with that”
	Factors that motivate the service provider	Interviewer: What factors motivate you as a YFHS provider? Participant KM: “I get motivated because I want to contribute to a bright future for the youths, I continue working hard for the health facility for our health centre to be put on the map regarding YFHS laughs….”
	Factors that demotivate the service provider	Interviewer: What factors demotivate you as a provider Participant KM: “I get very discouraged because I Lack of transport to visit youth clubs in far distances”.
	Conflict with beliefs of provider	Interviewer: Does provision of contraceptives to youths conflict with any of your beliefs and values? Participant KM: “No… it does not conflict with any of my beliefs”
	What can enhance provider competency	Interviewer: What do you think should be done to enhance provider competency

		Participant KM: "I think this can be achieved by working with organizations"
	Strategies that can increase utilization of YFHS	Interviewer: In your own opinion, what strategies would help to increase utilization of YFHS? You may list them. Participant KM:1. "Eeeh…we should have a designated space for YFHS at the health facility so that we provide privacy to the youth who come for the services" 2. "Ummh…Contraceptives should always be available. There shouldn't be situations where youth are returned because their method of choice is not available". 3. "We should also attract the youth with activities such as football, netball…also some games like bawo and the health centre should provide balls for football or netball and other games" 4. "I also think competitions at YFHS can help".
		Interviewer: We are about to end the session and the recorder will be switched off. Thank you very much for your in-puts.

		Participant: “Thank you”
		THE END

ANNEXURE S8: TRANSCRIPT FOR INDIVIDUAL INTERVIEW 5

For the sake of confidentiality, and anonymity pseudonyms were used. Interviews were digitally recorded and permissions obtained for the recording. Interviews were conducted in local language, Chewa and scheduled according to the participant's preferences

Title: "Strategies for increasing utilization of Youth Friendly Health Services in Blantyre, Malawi"

Participant	Question asked	Response
Participant 05: CP (Male) Interviewed 27 September 09hr:37 to 10hr:17 40 minutes face to face 29-year-old Tertiary education Not trained in YFHS but had a facility briefing on YFHS	Introduction	My name is Maureen Muleso research assistant for Grace Sibande the researcher. Welcome to this interview session Do you grant me permission to record this session? Participant: Yes The interview will last 30 to 60 minutes Purpose of this study: To develop strategies for increasing utilisation of Youth Friendly Health Services (YFHS) in Blantyre, Malawi
	Knowledge about reproductive health issues	Interviewer: How knowledgeable are the Youth about Reproductive health issues? Participant CP: Many youths do not have reproductive health knowledge
	Knowledge about YFHS	Interviewer: How knowledgeable are the Youth about YFHS?

		Participant CP: "I can say…many youths are aware about YFHS"
	Accessibility of YFHS	Interviewer: How accessible are YFHS at this health facility? Participant CP: "Yeah… YFHS are accessible. At first it was a challenge when they were completely separate services but this was changed and nowadays Youths access YFHS together with other services such as family planning services" Interviewer: What influences the accessibility? Participant CP: "Eeeh… because many youths did not know about YFHS, we conducted awareness campaigns through music shows and we also provided awareness messages through market cleaning activities by the youth, and through awareness messages to youth in reachable primary and secondary schools. This helped to bring more youths to YFHS"
	Set up of YFHS at the facility	Interviewer: What is the set-up of YFHS at this facility in terms of location, working days and times?

		Participant CP: "Ummh… Since we do not have a special room for YFHS, the services are conducted at Antenatal block when the block is not being used for ante-natal clinics. We conduct YFHS on Fridays but for special activities such as inter-visit exchange, music shows we conduct Days – "Fridays for services and Saturdays for youth activities" Time – "in the afternoons 14:00hrs to 16:30hrs"
	Available contraceptives	Interviewer: Which contraceptives are available for youths at this facility? Participant CP: "Eeeh…okay, we are supposed to have all the methods Pills, injectables, implants. Condoms, but we do not always have them in stock" Interviewer: Which contraceptive is always available at YFHS? Participant CP: "Eeee. Condoms yeah"!
	Barriers to utilization of YFHS	Interviewer: What do you think are barriers to utilization of YFHS in this facility?

		Participant CP: "Eeeh... This health centre has a big catchment area which makes it difficult for youths to walk long distances worse still not find their contraceptive method of choice. For example, one comes for an injectable contraceptive and find it out of stock, it will be difficult for them to return" Secondly, "It is difficult to gather youths in town unless there is an activity to attract them. Youths cannot come for health education all the time without things like football, netball. They may say "if I go to YFHS, it will just be health education all the time: then it is as good as going to school"
	Guidelines and policies to guide in working at YFHS	Interviewer: What protocols, guidelines or policies do you have that facilitate provision of YFHS? Participant CP: "Mmmm…We do not have any protocols".
	Factors influencing youths to attend YFHS	Interviewer: What factors influence youths to attend YFHS? Participant CP: "Ummh… it is the activities such as football, music shows and any entertainment activity"

	Usability of YFHS	Interviewer: What is your experience regarding usability of YFHS in this facility? Participant CP: "It is just quarter of total attendance. A few youths attend YFHS here".
	Being done to enhance usability	Interviewer: What is currently being done to enhance utilization of YFHS? Participant CP: "Yeah! one reason why youths shunned YFHS was because some providers were judging the youths… say a 12-year-old girl reports to YFHS then find a judgmental provider: this girl will not return for more services. Sometimes, the girls would meet people they know who report them to their parents which gave them problems at home. To deal with such problems, we made the services to be private and started having the services on Friday. As for staff, we discussed with management and a staff meeting was conducted to encourage staff to provide services to the youth without judging them. Since that time, things improved".
	Openness of youths to service providers	Interviewer: What is your experience on openness of the youth regarding reproductive health issues at YFHS? Participant CP: "Yeah… the youths are open because we give them time to talk"

	Factors that motivate the service provider	Interviewer: What factors motivate you as a YFHS provider? Participant CP: “Eeeh… maybe, passion for youth, role modelling to the youths”
	Factors that demotivate the service provider	Interviewer: What factors demotivate you as a provider Participant CP: “In life, there will always be things that will demotivate you. laughs… I get discouraged when few youths attend YFHS and when there are poor interpersonal relationships amongst health workers”
	Conflict with beliefs of provider	Interviewer: Does provision of contraceptives for the youth conflict with any of your beliefs and values? Participant CP: “No, it does not conflict with any of my beliefs”
	What can enhance provider competency	Interviewer: What do you think should be done to enhance provider competency Participant CP: “Ummh…motivation is very important. This does not only involve money but maybe from superiors through Mentorship or trainings” … I was discouraged when a

		training opportunity was given to someone who was not working at YFHS. So, superiors should reduce discrimination when there are mentorship/training opportunities””
	Strategies that can increase utilization of YFHS	Interviewer: In your own opinion, what strategies would help to increase utilization of YFHS? Participant CP: “You know… In town, there are many entertainment opportunities hence youths would rather go to places where there is recreation. Therefore, there is need to provide more entertainment, such as television, football and other games at YFHS” “Ummh…We also need funding for our activities like other YFHS which are funded by organisations such as UNECO, Mother to Mother, Partners in Health” Ummh…there is need for a youth corner or a special room for conducting YFHS Ummh…youths should not queue when they come to hospital for services when they come within the week for example, they have contracted an STI, they do not need to wait for a YFHS day”.

		"Ummh…we also need to help the youth to create youth clubs in the community, where condoms are provided and some YFHS activities will be done. Whenever they need services of a provider, they can call us and we can also routinely supervise the youth maybe once a month" "Yeah…also bring role models with talents like singing poem writers to YFHS. Some youths apart from getting motivated in the talents, they will also access the services"
		Interviewer: We are about to end the session and the recorder will be switched off. Thank you very much for your in-puts. Participant: "Thank you"
		THE END

ANNEXURE S9: TRANSCRIPT FOR INDIVIDUAL INTERVIEW 6

For the sake of confidentiality, and anonymity pseudonyms were used. Interviews were digitally recorded and permissions obtained for the recording. Interviews were conducted in local language, Chewa and scheduled according to the participant's preferences

Title: "Strategies for increasing utilization of Youth Friendly Health Services in Blantyre, Malawi"

Participant	Question asked	Response
Participant 06:NP (Female) Interviewed 29 September 2022 10hr:31 to 11hr:14 43 minutes face to face 35-year-old Had a 7-day training in YFHS	Introduction	My name is Brenda Dzimbiri a research assistant for Grace Sibande the researcher. Welcome to this interview session Do you grant me permission to record this session? Participant: Yes The interview will last 30 to 60 minutes Purpose of this study: To develop strategies for increasing utilisation of Youth Friendly Health Services (YFHS) in Blantyre, Malawi
	Knowledge about reproductive health issues	Interviewer: How knowledgeable are the Youth about Reproductive health issues? Participant NP: "Ummh. There are some who are knowledgeable about reproductive health issues. I can say 50-50. Some get the knowledge through social media. An organization named MANASO established youth clubs and the YFHS providers go to the youth clubs to teach the youth about RH issues"

	Knowledge about YFHS	Interviewer: How knowledgeable are the Youth about YFHS? Participant NP: 5 “Ummh… I can say 50-50 as well. Many are aware but there are challenges like lack of games and entertainment which brings them back, because they cannot have health education all the time” There is a sign post for YFHS at the facility entrance which indicates all the services that we offer and we think some youths read that and know about the services.
	Accessibility of YFHS	Interviewer: How accessible are YFHS at this health facility? Participant NP: “Ummh… I can say it is accessible mainly because the providers are friendly despite some of us being of age. But… Some find it difficult to access YFHS because at first, we had a youth corner and it was taken away during COVID era and now there is no youth corner, so youths are shy to access services with adults and some return home without receiving help for instance those with STIs” Interviewer: What influences the accessibility?

		Participant NP: "Ummh… As I have already indicated, the openness and friendliness of providers make youths continue coming to attend YFHS"
	Set up of YFHS at the facility	Interviewer: What is the set-up of YFHS at this facility in terms of location, working days and times? Participant NP: "Here…at first, we were conducting YFHS at the family planning block but because we stopped due to covid for 4 months then another group started using the space. After the break we asked from management and there was no space hence we meet at an open ground". "Eeeh… we can say everyday a youth is provided with services when they come to hospital but specifically, we meet on Saturday afternoon from 3pm to 5pm but you know, sometimes"
	Available contraceptives	Interviewer: Which contraceptives are available for youths at this facility? Participant NP: "At YFHS…the methods that are provider are: condoms pills depo Sayana All methods are available" Interviewer: Which contraceptive is always available at YFHS?

		Participant NP: I can say all methods are available but sometimes there is no provider.
	Barriers to utilization of YFHS	Interviewer: What do you think are barriers to utilization of YFHS in this facility? Participant NP: “Ummh…as I have already said, there is no entertainment, sports and equipment such as balls, game boards playing cards, ropes hence the youth feel bored, TV screen”. “Yeah…another reason could be could be that we have no specific venue for YFHS and we conduct our services on an open space…some youths may feel shy to come for fear of being seen by people who know them.”
	Guidelines and policies to guide in working at YFHS	Interviewer: What protocols, guidelines or policies do you have that facilitate provision of YFHS? Participant NP: “Ummh… facility made Protocols are available such as youths do not queue but have to be seen by their provider immediately, Another issue is that service providers should provide confidentiality and privacy to the youth.

	Factors influencing youths to attend YFHS	Interviewer: What factors influence youths to attend YFHS? Participant NP: “Ummh… We have our partner organization named EGPAF which helps us with posters, sign post on YFHS, also gives allowance to staff who work on weekends to help youths”
	Usability of YFHS	Interviewer: What is your experience regarding usability of YFHS in this facility? Participant NP: “We can say maybe because they are not open enough maybe they don’t come but the youths do utilize the service but not always
	Being done to enhance usability	Interviewer: What is currently being done to enhance utilization of YFHS? Participant NP: “Ummh… We use a “bring a friend campaign. The one who brings a friend is given a token of say K200 per person, multiplied according to number of friends brought. Sometimes, we arrange get togethers where we encourage the youths to bring their friends”
	Openness of youths to service providers	Interviewer: What is your experience on openness of the youth regarding reproductive health issues?

		Participant NP: "I cannot lie, the youths are open up with us because we are also open to them because the providers are also open"
	Factors that motivate the service provider	Interviewer: What factors motivate you as a YFHS provider? Participant NP: "As for me, I get motivated to continue working with the youth because I know there are some issues where youths can cannot be open with their parents and guardians but they can freely talk to me about them and be assisted"
	Factors that demotivate the service provider	Interviewer: What factors demotivate you as a provider? Participant NP: "Yes… there are some issues that demotivate us… Especially when YFHS is not taken as a priority, or as not useful by our superiors. For instance, we just gave up asking for space for conducting YFHS. It was very difficult even to get an open space for the services because superiors do not take YFHS serious"
	Conflict with beliefs of provider	Interviewer: Does provision of contraceptives to youths conflict with any of your beliefs and values?

		Participant NP: Laughs… "This is a very difficult issue. Honestly, it conflicts with my conscious and beliefs and sometimes I feel it is wrong giving young people contraceptives sometimes very young. Yes… we assist them and we continue doing it because we also look at the benefits of contraceptives to the youth in preventing pregnancy rather than her becoming pregnant and conducting unsafe abortion".
	What can enhance provider competency	Interviewer: What do you think should be done to enhance provider competency Participant NP: "Ummh…they should update us with information through refresher courses. Sometimes youth know current information than us and it is very embarrassing. I was trained in 2014"
	Strategies that can increase utilization of YFHS	Interviewer: In your own opinion, what strategies would help to increase utilization of YFHS? You may list them Participant NP: "Ummh… I think providing awareness/ sensitization about YFHS at national level through radios, television can be helpful" 2. I also think… every hospital should have a youth corner so that when the youths they find their own place

		3. Every facility should also have enough equipment for teaching, books and learning for demonstration and resources, manuals. This should also include sporting equipment because we can be discussing some issues while playing a game 4.they should also train YFHS focal persons simple things like provision of pills and injecting Depoprovera 5They should also provide enough staff for YFHS. Have enough staff Include vocational skills on trainings so that apart from health education, youths can also learn skills
		Interviewer: We are about to end the session and the recorder will be switched off. Thank you very much for your in-puts. Participant: “Thank you”
		THE END

ANNEXURE T1: CONFIDENTIALITY AGREEMENT WITH DATA COLLECTOR 1

ANNEXURE T: CONFIDENTIALITY AGREEMENT WITH DATA CUPTURER

Hereby, I, Anthony Henry, in my personal capacity as a data capturer collaborating with Grace Charity Sibande on a research titled Strategies for improving utilisation of Youth Friendly Health Services in Blantyre, Malawi acknowledge that I am aware of and familiar with the stipulations and contents of the conditions of ethical clearance specific to this study. I shall conform to and abide by these conditions. Furthermore, I am aware of the sensitivity of the information collected and the need for strict controls to ensure confidentiality obligations associated with the study.

I agree to the privacy and confidentiality of the information that I am granted access to in my duties as a data capturer. I will not disclose nor sell the information that I have been granted permission to gain access to in good faith, to anyone.

I also confirm that I have been briefed by the research team on the protocols and expectations of my behaviour and involvement in the research as a data capturer

SIGNED: ____________________

Date: 19th September 2022

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ANNEXURE T2: CONFIDENTIALITY AGREEMENT WITH DATA COLLECTOR 2

ANNEXURE T: CONFIDENTIALITY AGREEMENT WITH DATA CUPTURER

Hereby, I Brenda Dzimbiri, (WTJAJK2D) in my personal capacity as a data capturer collaborating with Grace Charity Sibande on a research titled Strategies for improving utilisation of Youth Friendly Health Services in Blantyre, Malawi acknowledge that I am aware of and familiar with the stipulations and contents of the conditions of ethical clearance specific to this study. I shall conform to and abide by these conditions. Furthermore, I am aware of the sensitivity of the information collected and the need for strict controls to ensure confidentiality obligations associated with the study.

I agree to the privacy and confidentiality of the information that I am granted access to in my duties as a data capturer. I will not disclose nor sell the information that I have been granted permission to gain access to in good faith, to anyone.

I also confirm that I have been briefed by the research team on the protocols and expectations of my behaviour and involvement in the research as a data capturer

SIGNED:

Date: 19TH September, 2022

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ANNEXURE T3: CONFIDENTIALITY AGREEMENT WITH DATA COLLECTOR 3

ANNEXURE T: CONFIDENTIALITY AGREEMENT WITH DATA CUPTURER

Hereby, I Maureen Muleso in my personal capacity as a data capturer collaborating with Grace Charity Sibande on a research titled Strategies for improving utilisation of Youth Friendly Health Services in Blantyre, Malawi acknowledge that I am aware of and familiar with the stipulations and contents of the conditions of ethical clearance specific to this study. I shall conform to and abide by these conditions. Furthermore, I am aware of the sensitivity of the information collected and the need for strict controls to ensure confidentiality obligations associated with the study.

I agree to the privacy and confidentiality of the information that I am granted access to in my duties as a data capturer. I will not disclose nor sell the information that I have been granted permission to gain access to in good faith, to anyone.

I also confirm that I have been briefed by the research team on the protocols and expectations of my behaviour and involvement in the research as a data capturer

SIGNED: ____________________

Date: 19th September 2022

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ANNEXURE T4: CONFIDENTIALITY AGREEMENT WITH DATA COLLECTOR 4

ANNEXURE T: CONFIDENTIALITY AGREEMENT WITH DATA CUPTURER

Hereby, I Teleza Mwawembe, ID Number WV1SHD59 in my personal capacity as a data capturer collaborating with Grace Charity Sibande on a research titled Strategies for improving utilisation of Youth Friendly Health Services in Blantyre, Malawi acknowledge that I am aware of and familiar with the stipulations and contents of the conditions of ethical clearance specific to this study. I shall conform to and abide by these conditions. Furthermore, I am aware of the sensitivity of the information collected and the need for strict controls to ensure confidentiality obligations associated with the study.

I agree to the privacy and confidentiality of the information that I am granted access to in my duties as a data capturer. I will not disclose nor sell the information that I have been granted permission to gain access to in good faith, to anyone.

I also confirm that I have been briefed by the research team on the protocols and expectations of my behaviour and involvement in the research as a data capturer

SIGNED: ____________________

Date: 20th September, 2022.

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ANNEXURE T5: CONFIDENTIALITY AGREEMENT WITH STATISTICIAN

ANNEXURE U: CONFIDENTIALITY AGREEMENT WITH STATISTICIAN

Hereby, I Jonas Sagawa in my personal capacity as a statistician, collaborating with Grace Charity Sibande on research titled Strategies for improving utilisation of Youth Friendly Health Services in Blantyre, Malawi acknowledge that I am aware of and familiar with the stipulations and contents of the conditions of ethical clearance specific to this study. I shall conform to and abide by these conditions. Furthermore, I am aware of the sensitivity of the information collected and the need for strict controls to ensure confidentiality obligations associated with the study.

I agree to the privacy and confidentiality of the information that I am granted access to in my duties as a statistician. I will not disclose nor sell the information that I have been granted permission to gain access to in good faith, to anyone.

I also confirm that I have been briefed by the research team on the protocols and expectations of my behaviour and involvement in the research as a statistician

SIGNED: [signature]

Date: 12/10/2022

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ANNEXURE T6: CONFIDENTIALITY AGREEMENT WITH INDEPENDENT CODER

ANNEXURE U: CONFIDENTIALITY AGREEMENT WITH AN INDEPENDENT CODER

Hereby, I Angela Jambo in my personal capacity as an independent coder, collaborating with Grace Charity Sibande on research titled Strategies for improving utilisation of Youth Friendly Health Services in Blantyre, Malawi acknowledge that I am aware of and familiar with the stipulations and contents of the conditions of ethical clearance specific to this study. I shall conform to and abide by these conditions. Furthermore, I am aware of the sensitivity of the information collected and the need for strict controls to ensure confidentiality obligations associated with the study.

I agree to the privacy and confidentiality of the information that I am granted access to in my duties as a coder. I will not disclose nor sell the information that I have been granted permission to gain access to in good faith, to anyone.

I also confirm that I have been briefed by the research team on the protocols and expectations of my behaviour and involvement in the research as a coder

SIGNED: [signature]

Date: 10th January 2023

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ANNEXURE U: VALIDATION TOOL FOR THE STRATEGIES

The following strategies were developed to improve utilisation of Youth Friendly Health Services (YFHS) in Blantyre, Malawi. Please tick whether you agree or disagree with the strategy and give your comments where necessary in the appropriate columns.

Strategy	Objective	Activities	Role players	Resources provided by	Agree	Disagree	Comment
S1Increase accessibility to YFHS by the Youth	To increase numbers of youth who utilise YFHS	Provide YFHS every day of the week and weekend for other youth activities Conduct monthly outreach clinics to provide YFHS distant areas to the health facility Establish more youth clubs in the communities as a platform for provision of YFHS	District Health Officers, YFHS coordinators Heath facility managers YFHS providers and Youth champions	Ministry of Health (MOH) and Partners			
S2 Increase knowledge for the youth about SRH issues and availability of YFHS	To increase awareness for youth about YFHS	Reach the youth with messages on availability of YFHS in government hospitals through provision of health information at out-patients departments, Using mass media e.g. radio and television programmes, Provide messages through Community meetings, Visible signpost should be placed at the entrances of the facilities with messages in English and local language showing services offered at YFHS Leaflets on basic SRH information and YFHS should be made available at out-patient departments and at the YFHS	YFHS Co-coordinators, Health Education unit, Heath facility managers, YFHS providers and Youth champions	Ministry of Health and Partners			

Strategy	Objective	Activities	Role players	Resources provided by	Agree	Disagree	Comment
		department to given to youths attending such services Collaborate with non-governmental organisations that already have a mandate in SRH activities for the youth to assist in providing information about YFHS to the communities .					
S3 Increase medical supplies including contraceptives for YFHS	To reduce YFHS defaulters	Allocate medical supplies and contraceptives specifically to YFHS. lobby for supplies for YFHS activities from partners, NGOs and individuals to assist fund YFHS activities	District Health Officers YFHS Co-ordinators Heath facilities managers YFHS providers	Ministry of Health and Partners			
S4. Provide entertainment, sporting activities, Sporting equipment and games at YFHS	To attract more youth to attend YFHS hence increase utilisation of YFHS	The health facilities should provide game boards such as "bawo" playing cards, and sports equipment such as balls for football, netball, or anything that would provide entertainment to the youth such as TV when they come for YFHS. Provide platforms where youths can showcase their talents such as drama, music and others. Arrange various activities for the youth, including talent shows and music shows.	District Health Officers, YFHS Co-ordinators, Heath facility managers YFHS providers	MOH District Health office, Health facility managers and Partners			
S5. Provide a dedicated room, or a youth corner for YFHS	To provide privacy to the youth	Identify a room or corner to be used for YFHS Integrate all the YFHS to be offered	MOH District Health Officers,	MOH Partners			

Strategy	Objective	Activities	Role players	Resources provided by	Agree	Disagree	Comment
	To provide all YFHS at one place	at the YFHS dedicated room or space rather than sending the youth to different departments for different services	YFHS coordinators, Heath facility managers Nurses Clinicians				
S6. Allocate youthful service providers at the YFHS	To promote youth-to-youth service provision	Allocate youthful providers at YFHS departments	YFHS coordinators, Heath facility managers	N/A			
S7 Allocate Male and female providers to YFHS department	To provide a good service to youth that prefer same gender providers	Allocate male and female providers at YFHS departments	YFHS coordinators, Heath facility managers	MOH Partners			
S8. Provide YFHS during the weekdays and weekend		Provide YFHS services on each day of the week and Offer sporting activities during the weekend	YFHS coordinators, Heath facility managers YFHS providers Youth champions	MOH Partners			
S.9 Provide training for all YFHS providers	To increase competency in handling the youths for the providers	Provide YFHS training to all YFHS providers Send serving providers for YFHS refresher courses if already trained	YFHS Co-ordinators, Heath facility managers YFHS	MOH Partners			

ANNEXURE V: CERTIFICATE FROM LANGUAGE EDITOR

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13/6/23

To Whom It May Concern

Dear Sir/Madam,

Proof of Thesis Copy Editing

This is to certify that I have edited the language of Grace Charity Sibande's PhD thesis titled, *Strategies for Improving Utilization of Youth-Friendly Health Services in Blantyre, Malawi*. Sincerely,

Dr. Sydney F. Kankuzi

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By

MRS GRACE CHARITY SIBANDE

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