ORIGINAL RESEARCH ARTICLE

What's holding back youth-friendly health services in Blantyre, Malawi? A qualitative exploration

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Abstract

The use of Youth Friendly Health Services remains sub-optimal in Sub-Saharan Africa despite global agreements on the same. The aim of this study was to explore barriers to utilization of Youth Friendly Health Services in Blantyre, Malawi. This was a qualitative study drawing on three focus group discussions of youths aged 10 to 24 (N=24) and individual interviews with Youth Friendly Health Service providers from four health facilities (N=6). Thematic analysis by Braun and Clark 2006 was used to analyse collected data. Seven themes emerged from the findings: frequent stockouts of medical supplies, lack of entertainment, sporting activities and supporting equipment, lack of dedicated space for Youth Friendly Health Services, lack of knowledge, financial constraints, misconceptions, and distance to the health facilities. Addressing these barriers would increase the utilization of Youth Friendly Health Services and, in turn, increase contraceptive uptake, hence reducing unintended pregnancies and their associated complications. *(Afr J Reprod Health 2023; 27 [9]: 57-64).*

Keywords: Adolescent, barriers, youth, youth friendly health services, utilization

Résumé

Le recours aux services de santé adaptés aux jeunes reste sous-optimal en Afrique subsaharienne malgré les accords mondiaux en la matière. Le but de cette étude était d'explorer les obstacles à l'utilisation des services de santé adaptés aux jeunes à Blantyre, au Malawi. Il s'agissait d'une étude qualitative s'appuyant sur trois discussions de groupe de jeunes âgés de 10 à 24 ans (N=24) et des entretiens individuels avec des prestataires de services de santé adaptés aux jeunes de quatre établissements de santé (N=6). L'analyse thématique réalisée par Braun et Clark 2006 a été utilisée pour analyser les données collectées. Sept thèmes ont émergé des résultats : ruptures de stock fréquentes de fournitures médicales, manque de divertissements, d'activités sportives et d'équipements de soutien, manque d'espace dédié aux services de santé adaptés aux jeunes, manque de connaissances, contraintes financières, idées fausses et distance par rapport aux établissements de santé. S'attaquer à ces obstacles augmenterait l'utilisation des services de santé adaptés aux jeunes et, par conséquent, augmenterait le recours à la contraception, réduisant ainsi les grossesses non désirées et leurs complications associées. *(Afr J Reprod Health 2023; 27 [9]: 57-64).*

Mots-clés: Adolescents, obstacles, jeunes, services de santé adaptés aux jeunes, utilization

Introduction

The concept, of Youth Friendly Health Services (YFHS) was created in 2001 by the World Health Organisation (WHO) to benefit the youth globally. The WHO introduced YFHS with the purpose of providing the youth with acceptable services, delivered by non-judgemental, sensitive, and competent service providers who can provide the services with respect and confidentiality[1]. Ironically, however, YFHS remain underutilised globally, including in Sub-Saharan countries such as Malawi[2]. For instance, a study conducted by the United States Agency for International Development (USAID) in Malawi in 2014 indicated that only 13% of youth had ever used YFHS, and only 31.7% had ever heard about it[3]. Underutilization of YFHS was also noted in studies conducted in Ethiopia and Ghana with utilization being at 32.8% and 7.9% respectively[4,5].

The WHO identified barriers to the utilization of YFHS such as unfriendly setups, incompetent providers, and lack of awareness of Sexual Reproductive Health[6]. Besides, the WHO barriers, another study identified embarrassment

experienced by the youth when seeking contraceptive services, and a lack of confidentiality as barriers. The embarrassment influenced the youth to prefer providers that offer more discreet services such as local pharmacies but lack the comprehensive range of contraceptives found in public clinics[7] A previous study in Malawi highlighted limiting factors for use of family planning by youths including misconceptions, side effects, cost and societal attitudes towards family planning[8]. Additionally, the systematic review conducted for sub-Saharan Africa (including Malawi) identified individual, structural, cultural, and socio-economic barriers[2].

In Malawi, YFHS were introduced in 2007 to address the problem of low contraceptive use among the youth and to help the youth receive contraceptives in a youth-friendly environment[7]. With Malawi's unmet need for family planning rated at 22%[9] and the prevalence of teenage pregnancy being at 29%[10], there is a great need for contraception among the youth. In Malawi, just like in many parts of the world, factors such as legal restrictions regarding access to safe abortions influence many teenage pregnancies to end up in unsafe abortions conducted by unskilled providers[11].

Large numbers of maternal deaths are said to have resulted from illegal abortions in Malawi[12]. The researcher was of the view that unintended pregnancies that lead to complications in Malawi are not justifiable considering that YFHS are available in the country. This intrigued the researcher to explore further on barriers to utilization of YFHS in Blantyre and build on the existing body of knowledge. The researcher had this research question: What are the barriers to the utilization of Youth-Friendly Health Services in Blantyre Malawi? The aim of this study was therefore to explore barriers to the utilization of YFHS in Blantyre, Malawi.

Methods

Study design

An explorative qualitative research design was employed with purposive sampling being used to select YFHS providers from the selected health centres for individual interviews. Recruitment was done for two months after gaining consent from the District Health Office and the health centre managers. YFHS providers were utilized as key informants and they assisted in arranging eight-person focus groups comprised of unmarried youths aged 10 to 24.

Settings

The study was conducted in 4 health centres in Blantyre. Two health centres, Ndirande and Chilomoni, were from Blantyre Urban while two health centres, namely Mdeka and Madziabango were from Blantyre Rural to capture youths from both urban and rural. The health centres were randomly selected using multistage sampling. Blantyre district was first divided into two clusters, Blantyre urban and Blantyre rural. Blantyre urban has six public health centres from which two were selected using simple random sampling. Blantyre rural on the other hand has eight Traditional Authorities (TAs) which were grouped into two clusters, North and South. Two TAs, one from the Northern cluster and the other from the Southern cluster were then selected using simple random sampling. Using simple random sampling, one health centre was selected from the Northern cluster and one from the Southern cluster. In total, therefore, four health centres were selected: two from Blantyre urban and two from Blantyre rural. The sample was then purposefully selected from the selected sites.

Study population and sampling strategy

Inclusion criteria

The inclusion criteria for this study were: male or female service providers that were working at YFHS in the selected health facilities at the time of data collection and for focus groups were boys and girls aged 10 to 24, not married, willing to participate in the study, consent or assent to participate in the study provided and able to speak English or Chichewa

Exclusion criteria

The exclusion criteria were: male or female service providers not working at YFHS in the selected health facilities at the time of data collection. For

focus groups, the criteria were: boys and girls aged below 10 or above 24, married, not willing to participate in the study, consent or assent to participate in the study not provided and unable to speak English or Chichewa.

Data collection

Data was collected in September 2022 by the researcher and four trained research assistants. Two data collection instruments were used, namely a semi-structured interview guide for the individual interviews and a discussion guide for focus group discussions. Both instruments were translated into Chichewa by a Chichewa expert. The instruments were pretested on 5 youths and a service provider at Gateway Clinic in Blantyre, which was not among the health centres for the study after which the instruments were reviewed based on the pre-test. YFHS providers (N=6) from the four health centres were interviewed individually for 45 to 60 minutes. Three focus groups were conducted (N=24) in three of the four selected health centres. The sequencing of focus group discussion centres was randomly done and after the third focus group discussion data saturation was realized hence the fourth focus group discussion was skipped. At most, the focus group discussions were one hour long. Both the individual interviews and focus group discussions were audio-recorded.

Data analysis

Analysis of data generated from the individual interviews and focus group discussions was guided by Braun and Clark's thematic analysis cited in Bradshaw et al[13]. Braun and Clarke's (2006)'s six steps of thematic analysis as quoted in Xu and Zammit[14] were followed; (1) familiarizing with data whereby the researcher listened to the digitally recorded interviews and focus group discussions, and read through field notes several times before data transcription (2) generating initial codes, where codes were used as a tag to retrieve and categorize similar data (3) generating themes, where relevant codes were sorted collated and combined to form a main theme, with some themes being sub-divided into subthemes (4) reviewing themes, which involved reviewing and refining themes by going back to raw data and comparing with the developed themes to make sure the developed themes were rooted in the data (5) labelling themes, where themes were defined and named in a concise and precise manner, and (6) producing a written report.

Results

The demographic profile for the youths (N=24) was as follows: each focus group was composed of four females and four males with one male and one female aged 10 to 12 years; one male and one female aged 13 to 16 years; one male and one female aged 17 to 20 years; and one male and one female aged 21 to 24 years. All the participants were unmarried.

The demographic profile of the participants for individual interviews: all the participants were above 24 years of age, with one participant being married. Five participants (n=5) were female and only one was male. All the participants were Christians, two of them had attended tertiary education and were nurses, while the other two had attended secondary education. Only one of the participants had undergone proper provider training for YFHS but the rest had only received facility briefing upon joining the department. All participants had worked at the YFHS for more than a year, with one of them working at YFHS for more than 7 years. Seven themes were identified namely, frequent stockouts of contraceptives and medical supplies; Lack of entertainment, sporting activities and supporting equipment; lack of dedicated space for YFHS; lack of knowledge; financial constraints; distance to the health facilities and misconceptions about YFHS.

Themes and sub-themes

Through the process of qualitative data analysis and interpretation of verbatim transcripts from individual interviews and focus group discussions, 6 themes were identified. A summary of the themes and sub-themes are outlined in Table 1.

Frequent stockouts of contraceptives and medical supplies

The youth participants reported that all contraceptives, except condoms, were not always

Table 1: Themes and sub-themes on barriers to the utilization of YFHS

Theme 1	Frequent stockouts of contraceptives and medical supplies
Theme 2	Value attached to YFHS as compared to entertainment and sporting activities
Theme 3	Lack of dedicated space for the YFHS
Theme 4	Lack of knowledge
Theme 5	Distance to the health facility
Theme 6	Misconceptions about YFHS
Sub-theme 6.1	Misconceptions of YFHS from the youth
Sub-theme 6.2	Misconceptions about YFHS from parents
Sub-theme 6.3	Misconceptions about YFHS from the community

available in health centres. This discouraged some youths from seeking contraceptive methods at YFHS. The service providers from all the health centres under study corroborated with the youth that indeed the health facilities experienced frequent stockouts of supplies including contraceptives.

"Yeah …also… lack of contraceptive methods that we want. Sometimes we want the injection method but we are returned that it is not available two, three times. Due to that, we get discouraged and we stop coming to YFHS and go elsewhere to be assisted" (FG3 Ndirande P5).

"Also… supply of the contraceptives. Sometimes preferred contraceptives by the youth are not available in this health facility. This discourages some youths and they stop coming to YFHS" (Service provider Madziabango, P1).

The common frequent stockouts in all sampled health facilities imply a need for attention by the relevant authorities.

Value attached to YFHS as compared to entertainment and sporting activities

Youth participants said that they valued sporting and recreational activities more such that they would prefer to patronise places with sporting and recreational activities to YFHS that provide only health education and contraceptives. The youth were of the view that the availability of sporting activities at YFHS could influence many youths to patronise the services thereby offering service providers an opportunity to provide them with health information, contraceptives, and other services offered at YFHS. The service providers corroborated with the youth regarding the unavailability of sporting activities, entertainment, and sporting equipment in the health facilities.

"*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 and will attract us as youths and more youths to attend YFHS*" (FGD2 Mdeka, P5).

Valuing entertainment and sporting activities more that YFHS is not a common finding in the literature, but it was found to be one of the biggest reasons that prevented youths from utilizing YFHS in all the study sites. Policy makers need to consider provision of such at YFHS so as to attract more youths.

Lack of dedicated space for conducting YFHS

Participants in all the sampled sites stated that there were neither special rooms nor dedicated spaces for conducting YFHS. They explained that YFHS were conducted in spaces meant for other activities, for example In Health Facility 1, YFHS are conducted outside the ART clinic in the afternoons and in Health Facility 2, outside the ante-natal clinic. With such arrangements, the youth found it uncomfortable to discuss their problems due to compromised privacy.

"Yeah…another reason is that we have no specific place for YFHS and we conduct our services on an open space…some youths feel shy to come fearing people who know them will see them and maybe report them to their parents hence they don't come" (FGD2, Mdeka, P5)

Lack of dedicated space for YFHS was thus one of the big barriers to the utilization of YFHS in this study.

Lack of knowledge about YFHS

Youth participants' lack of knowledge about the availability of YFHS emerged as one of the barriers to the utilization of YFHS.

"*Yes… some youths don't come because they don't know about YFHS"* (FGD1, Madziabango, P8)
The study, thus suggests the need to intensify measures for increasing youth awareness about YFHS.

Distance to the Health Facility

Participants reported travel distance as one of the barriers to the utilization of YFHS for some youths, especially in very big and hilly catchment areas.

"Eeeh... This health centre has a big catchment area which makes it difficult for youths to walk long distances…."(Service provider, Chilomoni P5).

This finding led the study to suggest the introduction of strategies that could alleviate the transportation problem for these youth, including or reaching them in their distant locations.

Misconceptions about SRH issues and YFHS

Misconceptions from the youths

It transpired from the study that misconceptions regarding the use of contraceptives by youths were preventing youths from attending YFHS. Some youth participants believed that a girl who takes contraceptives would become infertile, that contraceptive use affects the normal functioning of the female body, and that contraceptive use would reduce male libido.

"*Ummh…the woman will not be sexually active…we also hear the women who use contraceptives are not sweet" "Laughs… It is not good indeed because some people also say contraceptives reduce male libido* (FGD Madziabango, P4)

Misconceptions from parents

The participants also reported that many parents held misconceptions that influenced them to disallow their children to access contraceptives. They said that some parents believed that contraceptive use among young girls would make the girls infertile, influence them to engage in prostitution, and, generally, harm their bodies.
"Yes… many parents also refuse because they believe it will lead to barrenness among girls" (FGD Madziabango, P2)

Put differently, misconceptions and lack of support from parents prevented some youths from utilizing YFHS.

Misconceptions from the community

The participants further observed that, generally, the community negatively viewed contraceptive use by young girls by thinking that it would not only encourage prostitution or sexual immorality in the community but it would also cause infertility in young people. The participants, however, highlighted that the misconceptions were mainly targeted at girls as opposed to boys.

"It is not a big challenge for the boys but for girls eeh… it is a great challenge" (FGD3, Ndirande, P5).

Discussion

It transpired from the study that there were frequent stock-outs of resources such as contraceptives at the sampled health facilities. The only contraceptive method that was always available in all the health facilities was condoms. This tendency discouraged some youths from coming to seek contraceptive methods and from returning to YFHS Furthermore, some youths held some myths about condoms which prevented them from using the condoms believing that they reduced pleasure during sex, hence their seeking for the other contraceptive methods. Stock-outs had the potential to risk the youth to unintended pregnancies and to increase their risks for HIV and STIs.

The findings were consistent with those of previous studies in which barriers to utilization of YFHS also included the inconsistent supply of contraceptives[6]. Frequent stock-outs of contraceptives need special attention from the Ministry of Health because it appoints to government's need to increase supply of contraceptives to health facilities, especially considering that YFHS also depend on such supplies. Such government effort, however, would need to be complemented with encouraging the youths to use condoms for dual protection.

The study found that youths considered sporting and recreational activities so important that they would prefer attending sporting events and

recreational activities to attending YFHS where health education was the main activity. This implies that making sporting activities and some entertainment available to youths would encourage many youths to attend YFHS thereby giving providers opportunity to provide health information, contraceptives, and other services to the youth. This finding is uncommon in literature, therefore, the fact that it was found to be one of the biggest opportunities to the utilization of YFHS in all the study sites in this study cannot be taken for granted.

The researcher is of the view that this problem could easily be surmounted by collaborating with partners in areas around the facilities who could be asked to provide sporting equipment. Facility managers could also regularly budget for sporting equipment, considering that the benefits of more youths attending YFHS are many to the nation.

There is also a need for policymakers to consider providing dedicated spaces for YFHS services in health facilities because their lack compromises privacy for the targeted youth to the extent of discouraging them from attending YFHS facilities. Actually, more importantly, there is a need to make such spaces one-stop centres instead of requiring the youth to move around the health centre for different services. This finding is consistent with those of previous studies in which youths lacked separate rooms or dedicated spaces for YFHS to maintain their privacy[15,16]

Walking long distances to attend YFHS discouraged some youths from attending YFHS. Significantly, geographical barriers also emerged in previous studies as part of this challenge[16] This calls for the introduction of strategies such as monthly outreach clinics implemented through youth clubs established in distant places.

Lack of knowledge about YFHS also emerged as a barrier to the utilization of YFHS, a finding that is consistent with those of previous studies in which adolescents' behaviour concerning seeking SRH advice was affected by lack of knowledge[17]. Considering this finding, strategies for educating and sensitizing the youth about the availability of YFHS need to be put in place through school-based education and community sensitization. There is also a need for noticeable signposts at the facilities informing the youth about the YFHS facility's availability and actual services being offered at the facilities. The Ministry of Health also needs to produce printed educational materials on Sexual Reproductive Health and YFHS to be given to the youth at the health facilities. Other modern and youth-friendly strategies include using social media platforms such as Tik-Tok, WhatsApp and Facebook to reach the youth. It would also be helpful to the youth if some services were made available on line through virtual consultations or informational webinars.

Misconceptions among the youth, parents and community, in general, were also found to be a barrier to the utilization of YFHS in this study. Similar findings were, significantly, established by previous studies conducted elsewhere[16,17] Community sensitizations about Sexual Reproductive Health issues have the potential to correct these misconceptions and others that may exist. Health information disseminated during hospital clinics and sporting activities can also increase Sexual Reproductive Health knowledge among the youth. The use of the mass media, especially radio and television programmes, could also assist to increase awareness among many youths.

Strengths and limitations

The generalizability of this study beyond Blantyre is limited owing to the use of non-probability sampling methods and to the fact that the study was conducted in one district only. Another limitation of the study owes to the fact that parents were not included in the study considering that perspectives of parents could add more value to the study. The findings of this study, however, remain important in that they shed light concerning barriers to the utilization of YFHS, which creates an opportunity for policymakers to use the study to improve the utilization of the services.

Conclusion

The study uncovered barriers to YFHS utilization in Blantyre, Malawi and it argues that addressing the barriers would increase YFHS utilization in the district. It is envisaged by the researcher that increased YFHS access, would reduce the number

of unintended pregnancies among the youth, hence the reduction of unsafe induced abortions and their associated complications, including those leading to maternal deaths.

Ethical considerations

Ethical approval was sought prior to conducting this study. It was necessary for the research proposal to go through ethical clearance because studies involving human beings as study participants need to ensure that all participants' rights are protected bearing in mind that human rights violations have ever occurred in the name of science[18]. The research proposal was reviewed by the UNISA Research and Ethics Committee, which approved the research. (NHREC Registration number: Rec-240816-052; CREC Reference number: 67129765_CREC_CHS_2021). The ethics approval is valid from 29 October 2021 to 29 October 2026. The research proposal was also submitted to the National Commission for Science and Technology of Malawi for ethical clearance and the study was approved by the commission (Ref No: NCST/RTT/2/6 Protocol NO. P.08/22/663). Permission was also sought from the Blantyre District Health Office, the head office for all four health centres in the study.

The aim and objectives of the study were explained to the participants and an information sheet was read to them. Participation in the study was voluntary and the respondents had the right to withdraw from it at any time without them experiencing any consequence. Written informed consent forms, parental consent forms or assent forms were reviewed with each respondent and either a signature or a fingerprint was obtained from all participants as well as from the parents of those below the age of 18. Participant anonymity was preserved by identifying each participant with a number. All procedures during data collection were in accordance with the standards of UNISA and the National Commission for Science and Technology of Malawi research ethics committees and the 1964 Helsinki Declaration and its later amendments or comparable ethical standards (Williams 2008).

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