Youth Friendly Reproductive Health Services in Malawi: A Qualitative Investigation

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YOUTH FRIENDLY REPRODUCTIVE HEALTH SERVICES IN MALAWI: A QUALITATIVE INVESTIGATION

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Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>BLM</td>
<td>Banja la Mtsogolo</td>
</tr>
<tr>
<td>CBDA</td>
<td>Community Based Distribution Agent</td>
</tr>
<tr>
<td>CHAM</td>
<td>Christian Health Association of Malawi</td>
</tr>
<tr>
<td>DHO</td>
<td>District Health Office</td>
</tr>
<tr>
<td>DNHA</td>
<td>Division of Nutrition, HIV, and AIDS</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus group discussions</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>FPAM</td>
<td>Family Planning Association of Malawi</td>
</tr>
<tr>
<td>HSA</td>
<td>Health Surveillance Assistant</td>
</tr>
<tr>
<td>HW</td>
<td>Health worker</td>
</tr>
<tr>
<td>IDI</td>
<td>In-depth interview</td>
</tr>
<tr>
<td>IIP-JHU</td>
<td>Institute for International Programs at Johns Hopkins University</td>
</tr>
<tr>
<td>IRB</td>
<td>Institutional Review Board</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
</tr>
<tr>
<td>LARC</td>
<td>Long Acting Reversible Contraception</td>
</tr>
<tr>
<td>MDHS</td>
<td>Malawi Demographic Health Survey</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NEP</td>
<td>National Evaluation Platform</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NSO</td>
<td>National Statistical Office</td>
</tr>
<tr>
<td>RHD</td>
<td>Reproductive Health Directorate</td>
</tr>
<tr>
<td>SPA</td>
<td>Service Provision Assessment</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Diseases</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
</tr>
<tr>
<td>YFHS</td>
<td>Youth Friendly Health Services</td>
</tr>
<tr>
<td>YFRHS</td>
<td>Youth Friendly Reproductive Health Services</td>
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Executive Summary

Background

Youth aged 15-24 years make up almost one-fifth of the population in Malawi and two-thirds of the population is under the age of 25. From a fertility, maternal health, and socio-economic perspective, this age group has become a priority constituency for policy. As part of the broader government effort aimed at improving youth friendly reproductive health services, managing population growth and national development, the Ministry of Health collaborated with the National Evaluation Platform (NEP) to conduct a study with the aim to understand factors that facilitate and limit youth’s access to sexual and reproductive health services. The study’s objectives:

1. To determine how family planning providers and their characteristics influence youths’ perceptions and utilization of family planning services;
2. To identify drivers and barriers of youth accessing and using family planning services;
3. To solicit youths’, parents’, and health providers’ ideas on how to improve the delivery of family planning services for youth.

Methods

The study adopted a qualitative approach. In July-August 2016, NEP held 34 focus group discussions with youth (in school and out-of-school; married and unmarried; males and females disaggregated into smaller age groups) and parents. Seventeen in-depth interviews with family planning providers at both facility and community levels were conducted in selected health facilities and communities in Dowa, Machinga, and Phalombe districts. The districts were selected based on variation in reproductive health outcomes from the 2010 Demographic Health Survey (MDHS) and 2013 Service Provision Assessment (SPA) surveys, organizations providing family planning, and logistical considerations.

An independent team of consultants from the Malawi College of Health Sciences translated and transcribed the focus group discussion and in-depth interview audio recordings. The team used a modified framework analysis method to analyze the transcripts to identify broader themes and patterns about youth friendly reproductive health services in Malawi.

Results

Key findings from this study are presented below by thematic area:

Family planning availability, knowledge, and information

- The most preferred and available methods for youth include condoms, pills and injections. Intrauterine devices (IUD), implants, and sterilization were only available at larger health facilities and hospitals. Participants knew about available contraceptive methods. However, numerous misconceptions on family planning methods reflect an incomplete and distorted knowledge on how the methods work.
**Drivers of youth accessing family planning**
- Most participants cited the desire to protect themselves from sexually transmitted infections, unwanted pregnancies, and dropping out of school as key drivers that motivate them to seek and use family planning services.

**Role of peers and peer networks**
- The study found that peer networks play a key role in facilitating family planning information flow. Health workers (HWs), parents, and youth value the role of youth clubs in creating space for youth to discuss issues around family planning, sexually transmitted infections, and HIV.

**Barriers to youth accessing family planning services**
- Findings indicate that parents, religion, unwelcoming HW attitudes, and age-based discrimination are key barriers to youth accessing family planning services.

**Suggestions for improving family planning services**
- Participants had a variety of suggestions to improve youth health services access and utilization. The suggestions fit into five broad themes: institutional, HW conduct, service delivery, family planning education and information, and parents and society.

**Recommendations**

The study recommends the following actions:

- Strengthen youth clubs at all levels with proper infrastructure, periodic sexual and reproductive health refresher trainings, and updates to promote flow of correct sexual and reproductive health information to the youth
- Improve dialogue with parents, community leaders, and religious leaders about sexual and reproductive health
- Revise life skills curricula to include comprehensive family planning education
- Strengthen community based service delivery
- Improve supply chains of the most preferred family planning commodities: condoms and Depo-Provera
- Train more family planning providers on youth friendly health services and intensify supervision to facilities and community providers
- Increase the number of structures (youth clubs/youth drop in centers) for youth friendly health services
- Empower communities to increase male involvement in youth family planning promotion
Introduction

Malawi’s population is predominantly young, with almost two-thirds of the population aged 25 years and below and over half of the population aged is below 18. Malawi’s total fertility rate (TFR) decreased slowly from a TFR of 6.3 in 2000 to a TFR of 5.7 in 2010. However, Malawi achieved a remarkable reduction in TFR over the last five years, to 4.4 children per woman in 2015. Despite these promising reductions in TFR, progress with promoting family planning among youth has been slow. Teenage pregnancies increased over the past 5 years. Married women under 19 years of age have the highest unmet need for contraceptives, and almost forty percent of mothers aged below 20 express a desire to have their next child at a later time.

Given current fertility projections, Malawi’s TFR is expected to remain relatively high compared to other African countries and the East Africa region. Malawi’s population grew rapidly from 6.16 million people in 1980 to 16.8 million people in 2015, an average annual growth rate of 2.8%. Based on population projections, Malawi’s population will grow to 26 million by 2030, and soar further to 45 million people by the year 2050. This high rate of population growth will have adverse effects on existing problems including poverty, food insecurity, insufficient funding for provision of public goods/services, such as health and education, and exacerbating environmental degradation.

Improvements in child survival have contributed to population growth in Malawi over the past decade. Malawi’s young population will continue to drive population growth in coming years as youth begin child-bearing. The demographic situation in Malawi (where nearly 65% of the population is under 25), coupled with the family planning figures referenced above, make youth, as defined by the UN to be 15-24, an incredibly important population to target with family planning programs. Thus, the Ministry of Health (MoH) has singled out youth as a key constituency that merits better understanding and prioritization. The 2014/15 Joint Annual Review for the Malawi Health Sector-Wide Approach (September 2015), singled out high population growth-rate as key risk to Malawi’s development agenda. In response, the government called for greater collaboration and prioritization of population management.

In September 2016, the National Conference on Population and Development further emphasized youth as a key constituency for policy. By increasing contraceptive prevalence, reducing unwanted pregnancies, and improving health outcomes (among other aspects), Malawi will be able to take full advantage of a young, healthy, and productive population in the future to attain greater economic gains. This idea of attaining the “demographic dividend”—the economic growth that occurs when a population’s age structure switches from high to low death and birth rates—in Malawi is appealing economically and politically.

Study Rationale

Over the past two decades much attention has been given to youth friendly health services (YFHS). The WHO laid out their vision for adolescent (10-19 years old) friendly health services in a 2002 report that put equity, effectiveness, accessibility, acceptability, and appropriateness of care at the core of these health services. Youth are a critical population to target if a country is to improve the overall health of its population. Youth are essential to target for improving health outcomes associated with tobacco control, reducing new HIV infections, preventing and reducing the burden of injuries, improving maternal health, and slowing the growing rate of non-communicable diseases as more low and middle income countries undergo the epidemiologic transition.

Furthermore, focusing on sexual and reproductive health for youth is a proven way to improve
health outcomes. Improving modern contraceptive prevalence is a cost effective method to improve the health and economic outcomes for women. Improving family planning for youth can increase child spacing, reduce unwanted pregnancies, reduce unsafe abortions, improve schooling for girls, and improve economic outcomes. Recognizing this, Malawi has adopted a YFHS strategy.

Malawi’s 2014 Evaluation of Youth Friendly Health Services, National Youth Friendly Health Services Strategy, 2015-2020, and Costed Implementation Plan for Family Planning, 2016-2020 are clear evidence of Malawi’s realization of the significance of targeting youths with sexual and reproductive health (SRH) services, and its commitment to address the population problem. The results of that evaluation fed into the National Strategy that informed the Costed plan.

The National Evaluation Platform (NEP) conducted this study as part of a larger evaluation of YFHS in Malawi. This larger evaluation explores, readiness/strength and quality of programs, service utilization, and coverage of reproductive health services for youth in Malawi. NEP is a rigorous new approach to compiling and analyzing health and nutrition data from diverse sources, so that the Government can get strategic, evidence-based answers to their most pressing MNCH&N program and policy questions. Led by the National Statistical Office of Malawi, NEP is being built in Malawi between 2014-2017 with funding support from the Government of Canada and technical guidance and capacity building support from the Institute for International Programs at Johns Hopkins University (IIP-JHU). NEP and implementing partners of the Malawi M&E Technical Working Group supported this qualitative study into youth friendly health services in June-August 2016.

At the time we conducted this study, the National Youth Friendly Health Services Strategy, 2015-2020 had not yet been fully implemented, but some non-governmental organizations (NGOs) and government activities had begun. This study provides the MoH and SRH stakeholders with insight and suggestions on making YFHS more available, accessible, and usable by the youth, and ultimately promote reproductive health and developmental outcomes.

**Study Aims and Research Questions**

**Study aims:**

1. Describe perceptions of providers, parents, and youth about youth-friendly family planning services in Malawi
2. Elucidate barriers to access to family planning services among youth in Malawi
3. Compile the experiences and opinions of youth and providers around family planning for youth that can assist the Ministry of Health to improve youth friendly family planning services in Malawi

**Research questions:**

1. How do different family planning service providers and provider characteristics influence youths’ perceptions and utilization of family planning services?
2. What are the drivers and barriers of youth accessing and using family planning services? What are youths, parents, and health workers’ ideas to improve family planning services for youth?
3. What are the strengths and weaknesses of current youth friendly health service provision models? How can the weaknesses be improved to best meet the needs of youth in Malawi?
Methods

Data collection

We conducted semi-structured in-depth interviews (IDI) and focus group discussions (FGD) to collect qualitative data about youth-friendly family planning (FP) services in Malawi between July-August 2016. We conducted a total of 34 FGDs and 17 IDIs in Dowa, Machinga, and Phalombe (See Appendix 2). We selected these districts based on variation in reproductive health outcomes from the 2010 Demographic Health Survey (DHS) and 2013 Service Provision Assessment (SPA), types of FP providers, and travel logistics. We held FGDs with: (1) in school females, 15-17 years of age; (2) in school males, 15-17 years of age; (3) out of school females, unmarried, 15-24 years of age; (4) out of school males, 15-24 years of age; (5) married females, 15-24 years of age; and (6) parents of youth. We held IDIs with facility-based and community-based FP providers.

A team of five qualitative researchers representing the National Statistical Office (NSO) and the Ministry of Health’s (MoH) Departments of Nutrition, HIV/AIDS (DNHA), the Reproductive Health Directorate (RHD), Lilongwe district health office (DHO), and Machinga DHO, conducted all FGDs and IDIs. The team obtained consent from all individuals regarding participation in the study. The team conducted all FGDs and IDIs in Chichewa using semi-structured guides, which covered the topics listed in table 1. See appendices 3-6 for related documentation.

Table 1. Focus group and in-depth interview topics

<table>
<thead>
<tr>
<th>Focus group discussion</th>
<th>Semi-structured interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Youth friendly health service knowledge</td>
<td>• Roles and responsibilities as a health provider</td>
</tr>
<tr>
<td>• Youth friendly reproductive health service availability in the community</td>
<td>• Youth friendly health service knowledge</td>
</tr>
<tr>
<td>• Contraceptive knowledge</td>
<td>• Family planning services offered</td>
</tr>
<tr>
<td>• Influence of societal factors on family planning access and utilization</td>
<td>• Barriers to health workers providing quality family planning services</td>
</tr>
<tr>
<td>• Suggestions for improving reproductive health services for youth</td>
<td>• Scenarios of family planning provision to different demographics</td>
</tr>
<tr>
<td>• Norms around family size, marriage ages, and mother’s age at first birth</td>
<td>• Suggestions for improving reproductive health services for youth</td>
</tr>
<tr>
<td></td>
<td>• Norms around family size, marriage ages, and mother’s age at first birth</td>
</tr>
</tbody>
</table>

An independent consultant from the Malawi College of Health Sciences transcribed and translated all FGD and IDI recordings. Members of the interview team and NSO staff cross-validated a selection of the transcripts to check quality.

Ethics

Johns Hopkins Bloomberg School of Public Health institutional review board (IRB) granted ethics approval for the study. The Malawi National Health Sciences Research Committee received the full study protocol and waived the study from full scientific and ethical review. We took additional steps to protect study participants, which included; (1) requiring participant and parent/guardian consent for those 15-17 who are not married or emancipated, and (2) requesting that participants provide prospective of their peers rather than their own views. Relevant IRB approvals, waivers, consent, assent, and permission forms are in the appendix.
Data analysis

We excluded 2 of 34 FGDs and 1 of 17 IDIs from analysis due to quality concerns. We developed a codebook (see appendix) and coded transcripts using the qualitative analysis software Dedoose. We analyzed codes using a matrix approach to identify broader themes and patterns.

Results

Participant demographics

The breakdown of FGDs and IDIs are in Table 2. We held a total of 34 FGD with 295 participants. FGDs occurred in local schools, hospital rooms, or an open space in the village. We conducted a total of 17 IDIs with health providers, of which 9 were with a facility based provider and 8 were community health workers; 12 of them were female. Twelve of the health providers served in public MoH-supported settings and the other 5 providers were from the Christian Health Association of Malawi (CHAM) (n=2), the Family Planning Association of Malawi (FPAM) (n=1), and Banja la Mtsogolo (BLM) (n=2). Most of the IDIs occurred at the facility of the provider or the facility to which the provider reported. In one instance the interview occurred at the house of a CBDA.

Table 2. Breakdown of focus groups and in-depth interviews by participant type

<table>
<thead>
<tr>
<th>Participant type</th>
<th>Number of in-depth interviews</th>
<th>Number of focus groups</th>
<th>Number of focus group participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female Youth</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In school</td>
<td>-</td>
<td>6</td>
<td>10, 10, 8, 10, 9, 8</td>
</tr>
<tr>
<td>Out of school</td>
<td>-</td>
<td>5</td>
<td>7, 9, 10, 10, 6</td>
</tr>
<tr>
<td>Married</td>
<td>-</td>
<td>6</td>
<td>10, 10, 10, 10, 10, 9</td>
</tr>
<tr>
<td><strong>Male Youth</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In school</td>
<td>-</td>
<td>5</td>
<td>10, 10, 10, 9, 7</td>
</tr>
<tr>
<td>Out of school</td>
<td>-</td>
<td>6</td>
<td>10, 8, 10, 9, 10, 6</td>
</tr>
<tr>
<td>Parents*</td>
<td>-</td>
<td>6</td>
<td>6, 6, 6, 5, 9, 8</td>
</tr>
<tr>
<td><strong>Health Providers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility Based</td>
<td>9</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Community Health Workers</td>
<td>8</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17</td>
<td>34</td>
<td>295</td>
</tr>
</tbody>
</table>

* Parents of legal guardians

The study’s findings are presented by the following thematic areas:

1. Family planning availability, knowledge, and information
2. Drivers of youth accessing family planning
Service availability

Focus group participants and HWs were asked about the available services in their areas. Condoms, pills and injectables are the most reported methods for 15-24 year olds and they were widely reported as being available in all areas. HWs mentioned IUDs, implants, and sterilization being available at larger health facilities and hospitals. In many areas NGOs provide long acting reversible contraceptive (LARCs), such as implants, during routine community outreach activities. Sexually transmitted disease testing and counseling in addition to voluntary testing and counseling for HIV were reported as being available alongside FP services. Supplies for FP provision were sometimes limited, especially materials for removing implants. They were reported on several occasions as being out of stock or required a user fee.

Participants mentioned that some communities have health facilities with youth specific rooms, days, or times for providing family planning services. The majority of participants reported MoH ran facilities and MoH personnel as the main source of FP information and services. Others included NGOs, social networks, and pharmacies. Radios were a common source of family planning messaging. Others included posters, community outreach and education, youth groups, clubs, plays, social networks, schools, phones, and internet.

Youth friendly health services

Interviewers asked participants what they thought YFHS and youth friendly reproductive health services (YFRHS) are and if they are available. Youth and health providers gave different descriptions of YFHS and YFRHS. Some FGD and IDI respondents mentioned that those services are available in their communities while others claimed they are unavailable. Descriptions of YFRHS from FGDs included:

- Providing family planning services and commodities to youth
- Providing family planning counseling
- Using games and clubs to distribute family planning services

HWs gave more detailed descriptions of YFRHS than FGD participants’. Not all HWs reported providing services in a youth friendly way, but most could explain that they included:

- Providing private and confidential spaces for services
- Treating youth with respect
- Avoiding judgement
- Providing detailed family planning counseling

Interviewer: “Ok, which services can make health services youth friendly?”

Provider: “We as care providers; we want to welcome our clients very well...we also need to be polite and gain their confidence. Privacy also needs to be upheld.” (NGO provider IDI)
Counseling

Most counseling is about contraceptive pros and cons, how methods work, and potential complications. HWs aimed to provide accurate information and allow clients to make an informed choice after counseling. Youth expressed wanting more information about method pros and cons, how methods work, and potential complications prior to youth reaching a facility or HW. Most counseling information comes from HWs, followed by youth clubs and NGOs, and then by other social networks and schools.

“We tell them the kind of family planning methods that we offer here at this hospital, there advantages, disadvantages and side effects. The person has a choice of what method she will use. It depends on their choice” (Facility health worker IDI)

Knowledge

In general, participants could list available contraceptive methods. Responses varied when probed on how methods work and their pros and cons. Numerous misconceptions on family planning methods (see Appendix 1) reflect an incomplete and distorted knowledge about how methods work. The pros and cons expressed by participants are also shown in Appendix 1. Pills had the most misconceptions associated with them and they mainly came from male FGD participants.

Table 3. Contraception misconceptions

<table>
<thead>
<tr>
<th>Method</th>
<th>Misconceptions</th>
</tr>
</thead>
</table>
| Male condoms    | • Expired condoms can cause infections  
                   • Oils/lubricants can cause cancer, stomach pains, and sores on penis  
                   • Worms in the packaging                                                   |
| Oral contraceptive pills | • Cause barrenness  
                                   • Cause tumors in the stomach  
                                   • Lowers men and women’s libido  
                                   • Cause illness and even death  
                                   • Weakens sperm cells  
                                   • Pills clog up and accumulate in stomach  
                                   • Make the woman unattractive  
                                   • Ruins the inside of a person, harms the uterus                      |
| Depo-Provera    | • Cause barrenness  
                   • Tumors in stomach  
                   • Dose accumulates in the stomach  
                   • Weakens sperm cells  
                   • Damages the ovaries and destroys egg cells  
                   • Weaken the man’s libido  
                   • Prevents women from getting cancer  
                   • Causes illness  
                   • Sperm accumulation in women’s body                                  |
| Implants        | • Cause barrenness  
                   • Moves around body and cause illness  
                   • Closes the birth canal and obstructs pregnancy                       |
Protection/consequences

The need to protect themselves and avoid negative consequences from unprotected sex was another motivating factor for youth. Participants expressed their desire to use contraceptives for protection from sexually transmitted diseases (STDs), unwanted pregnancies, birth-related complications, fistula and other maternal related health risks. Motivation for protection extended beyond health concerns to include avoiding dropping out of school from unplanned pregnancies, early marriages, and overall failure to attain desired education goals. In addition, male respondents tended to value protection from STDs more, while female respondents’ concerns for protection included STDs in addition to other aspects such as failure to attain education goals among others.

<table>
<thead>
<tr>
<th>Method</th>
<th>Misconceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implants (continued)</td>
<td>• Damages organs, nerves, and blood vessels</td>
</tr>
<tr>
<td></td>
<td>• Causes uterine Cancer</td>
</tr>
<tr>
<td></td>
<td>• Twins when you stop using the method</td>
</tr>
<tr>
<td>IUDs</td>
<td>• Birth complications</td>
</tr>
<tr>
<td></td>
<td>• Can cause death</td>
</tr>
<tr>
<td></td>
<td>• Removal strings can harm the man</td>
</tr>
</tbody>
</table>

Reasons youth want to access family planning

One of the research questions sought to understand factors that motivate youth to access and use FP services. Findings indicate that there are two main factors that encourage youth to access FP services in addition to HWs’ motivation to provide quality FP services.

Societal pros

“When the population grows, we are faced with a lot of challenges… food becomes scarce. Some kids are stunted because of this.”

(Female FGD participant)

Participants identified society-wide benefits from practicing FP as one key driver that motivates them to access and use services. These benefits include managing population growth; reducing demand for public/social services; and reduced population-related adverse effects, such as land pressure and conflicts, food and water shortages, environmental degradation, and unsustainable pressure on the government to provide public goods and services.

Protection/consequences

“If condoms are used while having sex you can protect yourself from STIs.”

(Male FGD participant)

“If we use contraceptives we can have a manageable number of children, rather than having so many that we can’t raise them. Through contraceptives the woman has time to raise her child, and the child can grow healthily.”

(Female FGD participant)
Health worker motivation

Findings from this study indicate that heavy workloads in the health system can demotivate HWs. However, HWs identified several intrinsic aspects as key drivers that motivate them to continue to provide FP services to the youth. These include their perceived role in helping youth to avoid STDs and unwanted pregnancies, the praise and appreciation they receive from the communities, as well as additional knowledge they gain from YFHS trainings.

“…also when you are supervised it gives you encouragement. Also refresher trainings are important because it reminds us of our roles and responsibilities.” (Community health worker IDI)

Societal influences

This study sought to understand the roles that different facets of society play in youths’ decisions to access and use reproductive health services. These include peer networks, family and community, parents, religious groups and schools. The sections below explain findings on how each of these influence youths’ decisions making.

Role of peers

Both youth and parents shared that they learn about family planning from their peers. Youth interactions sometimes support but can also obstruct access. Participants reported that peers help spread SRH information, provide advice, in addition to sharing SRH news and events.

“…let’s say the ministry of health extension workers called for a gathering and one of the youth missed out on the event. His or her peer can share what he or she got out of the gathering to their friend.” (Parent FGD participant)

However, youth also spread inaccurate information and misconceptions. Findings also indicate that peers can make fun of each other and mock those that use family planning services.

HWs, parents, and youth participating in the study emphasized the value and role of youth clubs in creating space for peer platform to discuss issues around FP, STDs, and HIV. Participants agreed on the need to empower youth clubs with correct information so that youth receive accurate SRH information and reduce FP misconceptions.
Role of family and community

Findings indicate that parents are often not open to discuss SRH issues with their children. Participants shared an expectation that relatives should help educate youth on FP.

Depending on FP knowledge, relatives seem to promote or discourage use of FP by youth. Study participants stated that relatives mainly promote abstinence. Community based youth organizations and health organizations play a supportive role in promoting use of FP among youth. The findings also indicate that traditional authority leaders and other community leaders have not been active in promoting and encouraging FP use. However, participants’ thought community leaders represent a great opportunity to harness support because of their respected position. Participants also suggested civic education to create the right environment for promoting youth access and utilization of FP services.

Role of parents

Parents play a role in facilitating and hindering youth FP access and knowledge. Youth and parents participating in the study shared differing opinions on whether parents encourage or discourage youth from accessing FP services.

Both youth and parent FGD participants shared that parents encourage abstinence, because they consider youth that practice FP as promiscuous. Participants suggested that parents can be intimidating when it comes to discussing SRH.

“…as a parent I cannot tell my child to go and receive injections, that means I want my child to be go out and be involved in sexual intercourse.” (Parent FGD participant)

Findings also suggest that parents:

- Spread misconceptions
- Use scare tactics to discourage youth
- Encourage youth to have more babies

HWs participating in the study overwhelmingly viewed parents as a barrier to youth accessing and using FP. Health worker interviews indicate that parents use scare tactics and spread misconceptions as a way to prevent youth from accessing FP. HWs also highlight the need to engage parents to increase youth learning and access to FP services.

“So some parents tell their children that once you use family planning methods, you shall not be able to give birth. So people have these kinds of concerns, but we [health workers] tell them that once they want to conceive then they shall conceive.” (Facility health worker IDI)
Role of religion

The study found religion as a barrier to youth FP access and use. Findings indicate that most churches and mosques are against FP promotion. However, some religious institutions were mentioned as teaching safe motherhood, child spacing, and general counseling. Respondents indicated that much of the opposition from religious groups originates from strong religious standing and teachings, that FP is a sin and people must “multiply like sand.”

Role of school

Schools were reported to play both a supportive and unsupportive role in youth friendly FP services. Schools reportedly teach about FP in the life skills course, which covers healthy motherhood, child spacing, abstinence, avoiding unwanted pregnancies, STD prevention, and waiting to have sex after marriage. However, respondents pointed out that school regulations strictly prohibit provision of FP services in schools; hindering youth from learning about and accessing FP services at schools. Most of what is taught in schools focuses on abstinence only. HWs think schools should play a larger role in providing access to FP commodities and information, but participants acknowledge that politics and policies prevent this and that the issue is sensitive. One health worker said the school will “chase me away,” if health workers try to teach FP in schools.

“Community health workers should conduct health education on family planning in both the communities as well as in schools. That way [youth] might be able to understand or ask questions wherever they are not clear. The other thing is that family planning materials should be readily available in the communities in order to remove challenges of walking long distances for these services.” (Community health worker IDI)

Moderator: “What do [youth] learn about [family planning] in school?

Participant 1: “We just learn about abstaining as a way to protect ourselves.”

Moderator: “Anything else?”

Participant 2: “Protecting ourselves by not indulging in bad activities.”

(Female FGD participants)
Youth barriers

Distance

Participants expressed long distances to service delivery points as demotivating. Youth said they cannot afford to pay transport fares because they are still dependents.

Youth suggested that FP services should be provided in their communities to minimize the travel distance to health facilities. However, other youth had reservations about FP services being brought in their communities. Youth said it is very easy for other community members to notice them accessing FP services and community members may report them to their parents.

Discrimination

Participants in this study mentioned that youth face discrimination based on age, marriage status, and sex when seeking family planning services. Youth reported age-based discrimination from FP providers, parents, and other youth including:

- For a client who is below the age 18 and in school, providers may tell them they are not old enough to use contraceptives
- All participants shared that youth should focus on completing their education and not using FP
- Parents believe the youth are not old enough to be sexually active.

In other instances, youth are discriminated against based on their marital status. Society views FP services to be for married couples because they are the ones that are culturally allowed to be sexually active.

Gender also influences FP provision. In general, females are more encouraged to use FP services than males are. This is because females bear direct consequences of pregnancy such as complications during child birth, school drop-out, and struggles of raising a child.

“There are the ones who are most encouraged [to use FP], since we are the ones who carry the baby while a man on the other hand can deny responsibility.” (Female FGD participant)
Moderator: “Do you think there is a difference in encouragement [for accessing family planning] between boys and girls?”

Participant 1: “Yes, they want that the girls should finish school.”

Moderator: “What about the boys?”

Participant 2: “They don’t encourage them.”

Participant 1: “They know that once a boy impregnates a girl, he can still continue with school.” (Female FGD participants)

Confidentiality

Most youth expressed lack of privacy and confidentiality in service delivery points as a major hindrance for them to access FP services. An example that came up several times was the lack of designated places for youth to access FP methods. Youth mentioned that they must stand in line together with older clients, which they said makes them uncomfortable. On several occurrences youth mentioned that HWs or older clients may report youth to their parents, so they fear of going to such facilities to access FP services. Another example came from FGDs with married women. Some of these women mentioned wanting to access services privately since their husbands did not approve of them using FP methods and they feared that their husbands might find out.

Female participants raised privacy and confidentiality issues more frequently than male participants. Facility based providers raised more privacy concerns compared to their community based counterparts. Participants mentioned that facilities are usually crowded making it difficult for youth to receive family planning services privately. On other hand, participants said that community based providers see fewer clients, live within the community, and are flexible in terms of time they offer services for example, youth clients can come back after hours if they want to ensure privacy. However, community based providers know the clients. Some youth mentioned they are afraid that a HW may report them to their parents.

Provider and institutional barriers

Health worker treatment

A common theme among participants was how HWs treat youth. While HWs were able to convey how to properly work with youth, many participants had the perception that there were times when HWs did not treat youth properly. Some attributed this to the lack of training and understanding among HWs when providing services to the youth.
Participants expressed the following concerns with HWs:

- Lack of confidentiality
- Disclosure to parents
- Stigma - especially around age
- Not being welcomed properly
- Not being taken seriously when youth seek FP services.

**Stock outs**

Youth participating in the study reported preferring condoms the most compared to other FP methods. As a result, condom stock outs were of greatest concern among participants. In some cases, stock outs were reported to last three to four months or more. Public hospitals were reported as the most reliable location to obtain FP commodities in terms of the stock and variety of methods available. Community health workers and NGO health providers were often reported as having a more limited stock of methods and being less reliable in terms of family planning method availability. Unavailability of equipment for insertion and removal of implants was also mentioned frequently.

**Costs**

FP services are supposed to be free from government sponsored clinics, government health workers, and CHAM. Health workers at these clinics mentioned that their services are free to all. HWs at some private clinics (BLM and FPAM) do charge for some services as part of their protocol, while condoms and other outreach services are free. Some FGD participants in Phalombe mentioned that public facilities and health workers are charging for services that are supposed to be free.

Participant 1: “These [government FP] services are there to assist the youth and they are asking us to pay, but most of us do not have money.”

Participant 2: “So one may want to have these services but because of the fee that is attached to it they fail, and in the process become pregnant and drop off from school.” (Female FGD participants)

Transportation costs were also an issue among participants. Even if services are free, the time and travel costs associated with seeking FP services is a barrier.

“For one, we don’t have transport money. So when we ask for transport money from our husbands to go to [the hospital] they say ‘I don’t have it.’ You urgently need to go for an injection, but you have to wait. By the time we go for the injection they tell us that we are pregnant which leaves us shocked wondering how that occurred.” (Female FGD participant)
Another charge mentioned by participants was a fee associated with getting an implant removed before the implant’s time for removal (three to five years). On a related note, HWs reported that stock of implant removal kits is often low. HWs consider it a waste of resources if they remove implants before the time for removal.

“…the equipment for family planning are always available apart from the kit for implant, especially the needles and the metal needles we use to remove the implant. In addition we usually do not have the medicine we use to ease the pain.” (Facility health worker IDI)

“The health workers] demand money for the removal of the implant. They say because it is not the due date for removal. They charge 5,000 Kwacha.” (Female FGD participant)

Lastly, HWs must follow protocol before distributing hormonal FP methods. Participants said if a woman does not pass the screening questions to rule out pregnancy they must have a pregnancy test before they can receive the method. However, participants and health workers report that pregnancy tests are often out of stock at health facilities and youth must go purchase a pregnancy test elsewhere to prove they are not pregnant or wait until their next menstrual cycle.

Health worker barriers

There were a variety of barriers that HWs faced including:

- FP provision protocols - for instance, certain health conditions may make someone ineligible for their choice FP method
- Lack of competency in implant insertion and removal
- More competent health workers are overwhelmed with work
- Stock outs of FP methods, the lack of availability of resources such as equipment
- Health worker bias for certain methods increases consumption of one method over the other leading to stock outs
- Youth come at odd hours of the day or during the weekend when staffing is low
- Lack of private and confidential spaces for YFHS
- Lack of resources such as umbrellas, gumboots in rainy season and transportation in hard to reach areas for community based services
- Lack of respect from clients/youth/community towards health workers

“I think I am not providing services well. When I rate how we offer these services, I can put it at 30% because we do not have enough space, we have insufficient materials, so even provision of youth health friendly services is insufficient… on my side, I can say that my services are inadequate because sometimes I’m busy with other work. So for me to help the youth at the same time becomes difficult for me. For instance, I have been failing to conduct a youth talk because I am so busy with other duties here at the hospital.” (Facility health worker IDI)
Health worker training

Almost all HWs interviewed recognized the importance of YFHS training in providing services to youth. A few public facility providers reported never having undergone youth specific FP trainings. There was variability in the content of the trainings and some providers had forgotten what they learned in trainings. Some of the HWs we interviewed also said that their training was general and not specific to YFHS. A majority of providers received training at least 5 to 10 years ago. Health workers emphasized the need for youth specific refresher courses.

In some cases, trained health workers had left institutions, leaving capacity gaps among institutional staff. Some health workers, especially HSAs, were trained as Depo-Provera providers, which only allowed them to offer Depo-Provera. Health workers shared other similar restrictions such as some HSA and community providers not being able to distribute pills.

FP providers from NGOs were more likely to mention attending youth specific training as a part of their job. They expressed confidence in their knowledge on how to provide youth FP.

Preferences

Organizational preference

Participants preferred going to public hospitals compared to other institutions because of their reliability and consistently available methods, counseling, and privacy.

“I think the hospital is best because you are able to ask for the services that you want unlike in the community.” (Male FGD participant)

Other participants liked HSAs because of their vicinity, but HSAs had varying reputations in terms of how reliable and fairly they distributed FP methods along with confidentiality issues.

“[People prefer] Banja La Mtsogolo and the doctors because HSAs have dishonest conduct. If I see that the hospital is full and the doctors are busy, I can just go to an HSA with 200 Kwacha and receive an injection.” (Female FGD participant)

Some participants mentioned preferring Banja La Mtsogolo (BLM) and other private clinics because of their accessibility. However, participants also mentioned the costs of private clinics and the timing of FP distribution, especially for community outreach, as challenging. Participants’ context influences their preferences. For example, if there were youth organizations, BLM, FPAM, or hospitals nearby, this could influence youth preference. In comparison, youth in more rural areas had to rely on outreach services. The main factors that influenced their preferences were: cost, reliability and consistency of FP method availability, vicinity, counseling, privacy, timeliness of service, and openness of the provider.
Health worker preference

There was little variability in youth FGD participant’s preferences for a health care provider’s age and sex. Age and sex were reported to matter to some participants but there was no consensus. Knowledge, attitude, and maturity of the health worker was more important than the age and sex of a provider. Both males and females mentioned being more comfortable with a member of the same sex, but that professionalism of the HW was more important. There were various responses in terms of age of HW offering the services. Some youth said they prefer somebody of their age, while others prefer an older HW and some youth said only care if the HW is knowledgeable. Youth mostly wanted providers who were mature, experienced, and have used the methods. Some youth mentioned wanting a provider their age because they would be more open. Youth who preferred older health workers thought they are more respectful and could keep secrets.

Location

Hospitals were preferred by some youth for their reliability, privacy, and counseling. The community was preferred most for its privacy, easier access in terms of distance, in addition to the impact of services being in the community and their ability to sensitize the community. Males leaned towards preferring community based services and females leaned towards facility based services. Long distances to services were discouraging and costly because of travel. There was some evidence that location preferences have to do with the method preference. Young males prefer condoms in the community and young females prefer long-acting reversible contraceptives (LARCs) from a larger facility.

Contraceptive preferences

Participants reported that youth preferred condoms and injectables the most. Study participants reported that youth 15-19 years preferred condoms and injectables and youth 20-24 years prefer injectables and implants. Participants said contraceptive pills were not preferred because they are not discrete and must be taken every day. Among study participants, non-married youth like condoms whereas married youth prefer LARCs. Study participants like LARCs since they can avoid the hospital after starting the method thus decreasing their chances of being seen and decreasing time and travel costs. Condoms and injectables were thought of as being discrete adding to their appeal. Participants shared that messaging plays a role in building demand for modern methods among youth. Female condoms were not popular among participants, as such, health workers said they expire on shelves. Another reason youth preferred condoms was that they don’t have the side effects that other methods have.

Norms

Gender role

Respondents cite different responsibilities for females and males when it comes to FP. Many stated that compared to men, women are more responsible for FP seeking out services. Some stated that women seek out services more often because of the burden on women to care for children. Respondents gave several examples of the disproportionate burden on women:

- School drop out if they become pregnant
- Responsibility of bringing a sick child to the hospital
Family size

Participants had different opinions on ideal family size, but a majority of respondents cited less than 4 children. Respondents described limited resources (finances, land, ability to send to school, food, and overpopulation in Malawi) as reasons to limit family size. A few people advocated for larger family size (5+ children) because a child could die early.

Marriage age

Most respondents said that individuals should marry in their early 20s. Some individuals stated females should be 18 when they get married. Respondents universally gave age estimates where the male is older than the female, claiming that women mature quicker.

Birth age

There are mixed opinions on what ages are most appropriate for first birth, however, a majority of respondents said that a woman should be around 20 years of age. Reasons provided include that the woman is mature enough for birth, has finished her education, and is financially secure. Similar to marriage ages, respondents consistently reported that females should be younger than males when they have their first child.

Participant’s Suggestions for Improving Youth Friendly Reproductive Health Services

Youth, parents and health workers offered several suggestions for improving FP services. The most popular suggestion was formulation of youth clubs, where youth would share FP information and health workers would come and offer various FP services. Participants also suggested the need for detailed FP counseling for youth to ensure they fully understand the importance of family planning, how each method works for them to make informed decisions. Suggestions are arranged by five thematic areas and suggestions are ranked from the most to least mentioned within each theme.

“Girls are the most encouraged [to use FP]. Girls are the ones who carry the burden of child birth. The man can walk around freely and claim that he has no children, while girls cannot, they have to carry the baby on their back.” (Female FGD participant)
### Table 4. Participant suggestions by theme

| Institutional | 1. Schedule more youth days/times  
| | 2. Create youth specific rooms for FP provision  
| | 3. Provide health worker supervision/training  
| | 4. Ensure health workers have necessary materials  
| | 5. Recruit more health workers for FP services  
| | 6. Apply feedback from clients  
| Health worker conduct | 1. Give more detailed FP counseling  
| | 2. Ensure confidentiality  
| | 3. Avoid judging youth  
| | 4. Stop soliciting fees for FP services  
| Service delivery | 1. Utilize youth clubs  
| | 2. Expand community-based delivery  
| | 3. Ensure a reliable supply of FP products  
| | 4. Support more government/NGO partnerships  
| | 5. Integrate FP into recreational activities  
| FP education and information | 1. Provide FP information and provision in schools  
| | 2. Conduct more community sensitization  
| | 3. Hold health talks with parents and leaders  
| | 4. Provide FP education via peer networks  
| Parents and society | 1. Involve community leaders in FP talks  
| | 2. Dispel FP misconceptions  
| | 3. Encourage parents to be more supportive  
| | 4. Support openness towards youth about FP  

### Conclusions

Youth, parents and HWs offered several suggestions for improving FP services. The most popular suggestion was formulation of youth clubs, where youth would share family planning information and HWs would come and offer various FP services. Participants also suggested the need for detailed FP counseling for youth to ensure they fully understand the importance of FP, and how each method works for them to make informed decisions. Suggestions are arranged by five thematic areas and suggestions are ranked from the most to least mentioned within each theme.

- Peer networks play a key role in facilitating information flow to the youth regarding SRH services, and some of that information is wrong. Strengthening peer networks and youth clubs and informing them with correct information is therefore key to addressing misconceptions and promoting correct FP knowledge among the youth.

- Youth face several challenges when accessing FP services such as distance, discrimination, lack of privacy and confidentiality. Efforts to alleviate these challenges will increase youth’s
Recommendations

Revive and strengthen youth clubs at all levels with proper infrastructure and provide them with periodic sexual and reproductive health refresher trainings and updates to promote flow of accurate information to the youth

- Establishment of youth clubs was the most common suggestion from youth. Youth said this is a platform where they can discuss various issues regarding their sexual life, family planning, their career and everyday issues that affect them. Providers and organizations can also use these groups to reach youth and provide FP services.

Implement quarterly sexual and reproductive health community engagement/dialogue programs to increase sexual and reproductive health awareness among parents, and community, and religious leaders

- Study findings show that parents and community/religious leaders are a barrier to youth accessing and using SRH services. A well-designed and purposefully tailored dialogue program with this target audience that critically considers individual and society-wide effects of a high birthrate among youths and benefits of using SRH services has the potential to increase awareness and reduce resistance. This could be facilitated by local community leaders using already existing structures, with support from health experts and role models (individuals and/or families) that have benefited from using SRH services. Such dialogue has the potential to engage religious leaders to examine the deep-rooted social and religious beliefs and values that challenge accessing FP services.
Include comprehensive family planning information in school curriculum using already existing school health programs

- Participants felt early sensitization of youth on FP will prepare them to make informed decisions when they are sexually active. A school setting provides the best existing platform to reach the youth where FP information can be included in the school curriculum and provided to youth. Collaboration between the MoH and the Ministry of Education, Science, and Technology would be beneficial to determine FP information to prioritize for school curriculum.

Strengthen community based service delivery to minimize travel distance by increasing number of outreach visits and equipping community based providers with necessary supplies

- Travel distance was one of the major barriers among youth that inhibit seeking FP services. Ensuring services are readily available in the communities will increase youth access to FP services.

Ensure consistent supply of condoms and Depo-Provera at all service delivery points

- Youth said they preferred condoms and Depo-Provera compared to other FP methods. Stock outs of these two methods leave them vulnerable to unwanted pregnancies. Consistent supply of these methods is therefore crucial to ensuring youth use FP services consistently.

Train more family planning providers on youth friendly health services and intensify supervision to facilities and community providers

- From the study, it appears that many FP providers have not yet received YFHS training. It is therefore imperative to train more providers to ensure they are equipped with knowledge on how to best provide services to youth. In addition, supervision of FP providers is required to ensure providers uphold professional standards in FP service delivery and any challenges they face are detected and promptly rectified.

Increase number of YFHS structures (youth clubs/youth drop in centers)

- The youth clubs/youth drop in centers will allow the youth to share information and access FP services at designated times and schedules that they are comfortable with. This will help address the issues of confidentiality as there will be no older clients accessing services at the same time as youth.

Empower communities to increase male involvement in family planning issues

- Participants of the study stated that there is limited male involvement in ensuring use of FP methods. Women are primarily responsible for seeking out FP information. Sensitizing communities to encourage men to equally participate in such meetings will increase use of FP services.
References

## Appendix 1 - Summarized contraceptive method pros, cons, and misconceptions

<table>
<thead>
<tr>
<th>Method</th>
<th>Pros</th>
<th>Cons</th>
<th>Misconceptions</th>
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<tbody>
<tr>
<td><strong>Injectables</strong></td>
<td>• Discrete&lt;br&gt;• Protects from unwanted pregnancy (Ukangobaya Umangolera) - Once you get a jab you are free.&lt;br&gt;• Long lasting - 3 months&lt;br&gt;• Readily available in village clinics and from HSAs&lt;br&gt;• Highly effective and reliable&lt;br&gt;• Skin glows and you look healthy</td>
<td>• No STI protection&lt;br&gt;• Loose/Gain weight&lt;br&gt;• Can be burdensome, may miss injection date -&gt; then required pregnancy test before next injection, however pregnancy test are often out of stock or the woman must pay for one&lt;br&gt;• Loss of libido&lt;br&gt;• Body pains and sickness&lt;br&gt;• Pain in the feet&lt;br&gt;• Costly because of frequent transport&lt;br&gt;• Popular so can be out of stock&lt;br&gt;• Mutu wa ching alang ala “Migraine headaches”&lt;br&gt;• High blood pressure can cause complications</td>
<td>• Tumors in stomach&lt;br&gt;• Cause barrenness&lt;br&gt;• Dose accumulates in the stomach&lt;br&gt;• Weaken the sperm cells when they enter the body&lt;br&gt;• Damages the ovaries and destroy egg cells&lt;br&gt;• Weaken the man’s libido&lt;br&gt;• Prevents women from getting cancer&lt;br&gt;• Causes illness&lt;br&gt;• Sperm accumulation in women’s body</td>
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<tr>
<td><strong>Male Condoms</strong></td>
<td>• Dual protection from STIs and unwanted pregnancy&lt;br&gt;• They are reliable&lt;br&gt;• Readily available in the community&lt;br&gt;• No side effects&lt;br&gt;• Doesn’t ruin the body, like other methods do</td>
<td>• Using a condom shows “there is not trust between the couple. I must show love to my husband.”&lt;br&gt;• It can burst during intercourse&lt;br&gt;• It itches and causes irritation&lt;br&gt;• Not effective if it isn’t used properly&lt;br&gt;• Can ruin the mood, time consuming to put on, men may lose their erection&lt;br&gt;• Women don’t have power/control over it&lt;br&gt;• A sweet is not eaten in the wrapper&lt;br&gt;• Men can poke holes in them&lt;br&gt;• Can come off and remain in the vagina</td>
<td>• Expired condoms can cause infections&lt;br&gt;• Oils/Lubricants can cause cancer, stomach pains, and sores on penis&lt;br&gt;• Worms in the packaging</td>
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<td>Method</td>
<td>Pros</td>
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<td>Misconceptions</td>
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<td>Pills</td>
<td>• Few side effects compared to injections and implants</td>
<td>• Must be taken every day so it is easy to forget and then you may fall pregnant</td>
<td>• Cause tumors in the stomach</td>
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<td></td>
<td>• Effective is used properly</td>
<td>• Hard to hide pills</td>
<td>• Destroys women’s libido</td>
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<tr>
<td></td>
<td>• Readily available</td>
<td>• Cause nausea, headache, stomach aches</td>
<td>• Makes the man weak (in regards to sex)</td>
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<td></td>
<td>• Easy to use</td>
<td>• Irregular periods</td>
<td>• Cause illness and even death</td>
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<tr>
<td></td>
<td>• No pain with menstruation</td>
<td>• No STI protection</td>
<td>• Weaken sperm cells</td>
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<td></td>
<td>• Have monthly periods</td>
<td>• High BP</td>
<td>• Cause barrenness</td>
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<td>• Lowers libido</td>
<td>• Pills clog up and accumulate in stomach</td>
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<td>• Encourages promiscuity</td>
<td>• Cause the woman unattractive</td>
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<td>• Makes women unattractive</td>
<td>• Ruins the inside of a person</td>
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<td>Implants</td>
<td>• Long lasting allows proper child spacing</td>
<td>• Expensive and may have to pay to get it removed</td>
<td>• Cause barrenness</td>
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<td>• Protects from unwanted pregnancy</td>
<td>• Requires a trained provider to insert and take out</td>
<td>• Moves around body and causes illness</td>
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<tr>
<td></td>
<td>• Loose/Gain weight</td>
<td>• Prolonged menstrual cycle</td>
<td>• Closes the birth canal and obstructs pregnancy</td>
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<td></td>
<td>• Skip periods</td>
<td>• ARV/Implant interaction</td>
<td>• Damages organs, nerves, and blood vessels</td>
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<td></td>
<td>• Long duration means less cost in long term</td>
<td>• Headaches and back pains</td>
<td>• Uterine Cancer</td>
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<tr>
<td>Sterilization</td>
<td>• If you are done having children so you can have sex without worry of pregnancy</td>
<td>• It is permanent so you can’t change your mind</td>
<td>• Twins when you stop using the method</td>
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<td></td>
<td>• Highly effective</td>
<td>• Stop performing</td>
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<td>• May re-marry then you can’t have children</td>
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<td>• Destroys the person</td>
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</tr>
<tr>
<td>Method</td>
<td>Pros</td>
<td>Cons</td>
<td>Misconceptions</td>
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<tr>
<td>IUD</td>
<td>• Long lasting up to 10 years&lt;br&gt;• Prevents unwanted pregnancy</td>
<td>• Painful during insertion&lt;br&gt;• Causes illness&lt;br&gt;• Cause birth complications</td>
<td>• Birth complications&lt;br&gt;• Can cause death&lt;br&gt;• Removal threads can harm the man</td>
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<td>Traditional Methods</td>
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<td>• Nkuzi (a thread worn around the waist) can inactivate sperm</td>
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Appendix 2 - District Selection Maps

Malawi ASFR 15-19 Years by 2010 DHS District Data

Malawi ASFR 20-24 Years by 2010 DHS District Data
# Appendix 3 - IRB Documentation

## JHSPH IRB Approval

**FWA #00000287**

### INITIAL APPLICATION APPROVAL NOTICE

**Date:** July 15, 2016  
**To:** Melissa Marx, PhD  
Department of International Health  
**From:** Luke C. Mullany, PhD, MHS  
Chair, IRB-X  
**Re:** Study Title: “Youth Friendly Reproductive Health Provision Preferences among Youth, Parents, and Health Providers in Malawi”  
**IRB No:** 00007246

The JHSPH IRB-X voted to approve the above referenced application at its meeting on June 30, 2016. The Board made the following determinations:

Approval of the research is for the period of **June 30, 2016** to **June 29, 2017**. Please submit a progress report no later than 6 weeks before the approval lapse date. We recommend that YOU USE YOUR OUTLOOK CALENDAR, OR OTHER ELECTRONIC REMINDER CALENDAR TOOL, to set a timely reminder notification for this submission to avoid a lapse in approval.

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<th>Single Reviewer</th>
<th>Convened</th>
<th>Consent/Parental Permission Required From:</th>
<th>Form of Consent/Permission:</th>
<th>Study Site(s):</th>
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<td>Waiver of Informed Consent..</td>
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### Vulnerable Populations:

- Children .................. ❑  
- Foster Care Children ........

- Assent Required From:  
  - No children (waived) ... □  
  - Children aged: 15-17.... ❑

- Pregnant Women/Fetuses  
  - 46.204.................  

- Neonates  
  - 46.205 .................

- Sample Size: (screened plus enrolled)  
  - FGD=360  
  - IDI=18

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JHSPH IRB Initial Application Approval Notice  
V14, 18Sep2014
Jameson Ndawala
National Statistical Office
Box 333
Zomba

Dear Sir,

RE: REQUEST TO CONDUCT A ROUTINE DATA QUALITY ASSESSMENT (DQA) AS ENDORSED BY THE M&E TWG TASK TEAM, ANALYSIS OF PNEUMONIA DATA, AND COLLECTION OF QUALITATIVE DATA ON FAMILY PLANNING AMONG YOUTH

Thank you for the above titled study that you submitted to the National Health Sciences Research Committee for review.

The committee reviewed the study and exempted it from scientific and ethical review because it is an audit of an existing Ministry of Health (MOH) program. However, should the researchers wish to publish the results, they should share with the NHSRC.

Kind regards from the Secretariat.

Rage Majamanda
FOR: CHAIRMAN, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE
Appendix 4 - Focus group and in-depth interview guides

An example of a FGD and IDI guide in English and Chichewa are provided. All of the forms were not included due to the size of them and only minor differences in the wording exist.
Introduction:

Thank you for taking your time to talk with us today. I’m (name) and I will be leading the focus group today. We are here to discuss youth friendly reproductive health services in Malawi. We want this to be an open discussion.

First we need to set some rules. What do you all think some rules for our discussion should be?
(Suggest these if they don’t mention them)

1. Only one person speaking at a time.
2. Respect what others have to say.
3. Don’t interrupt people.
4. Please silence all phones.
5. Keep what is said in this discussion in this discussion. Please don’t discuss what people said outside of this discussion.
6. Don’t say anything you don’t want everyone to hear.
7. Please do not use people’s names during the discussion. We don’t want any true names to be recorded.

Now that we have some rules I want to tell you how this will work. I will be moderating the discussion, so I will ask some questions and I want you all to discuss the questions and your answers. We want to hear your thoughts and opinions about the topics. This is meant to be a discussion not an interview. We want to hear from everyone so please do not be afraid to share. This audio recorder is going to record the discussion so we can transcribe and translate the discussion. My partner (name of notetaker) will be taking notes during the interview. As the moderator I will not play an active role in the discussion of topics. I will pose questions and guide the discussion, but I will refrain from joining the discussion.

Do you all have any final questions before we get started?
1. Let’s start by talking about youth friendly health services. What do you all think youth friendly health services are?
   a. Have you heard of youth friendly reproductive health services before?
   b. What would make a health service youth friendly?
      i. What factors are the most important to you?
         1. These could include things like: Quality – commodity availability, friendliness, waiting times, counseling quality, privacy. Say this if people are not speaking and get their ideas about those and if they are important or not.
   c. Are youth friendly services available in your community? Have you heard about anyone using these kinds of services?
      i. If so, do you think it is important that they are available and why?
      ii. If not, do you think they should be available in your community and why?
      iii. What do you all think youth would like or dislike about health services that are targeted at youth?

2. Now I want to talk a little more about youth friendly reproductive health services (such as family planning). What different reproductive health services are available in your community?
   a. Do you know who the providers of these services are?
      i. Do you think youth prefer seeing one type of provider over another?
         1. Why would someone prefer one provider over another?
            (probe: community, facility based)
         2. Would you all prefer to go somewhere to access services or have someone bring services to you? To your school? To another location?
      ii. How do youth know where to go for services?
      iii. What do you think providers tell youth about these services?
         1. Do you think health providers encourage youth to use them?
   b. Do you think people learn about reproductive health in school?
      i. What do you think they learned?
         1. Who would teach students about these things?
      ii. Besides school where else do youth learn about reproductive health?
         1. Friends? Parents? Youth groups? Church?
3. Next I want to talk some about contraception, I don’t want you to talk about your experiences, but I want to know what you know about different contraception methods?
   a. What are some contraceptive methods you all know of?
      i. Probe on what they are and how they work
      ii. Where can someone your age access these?
         2. What places are mostly likely to be accessed for contraception services?
   iii. Do you think people your age would seek these services out?
      1. Why? If no, probe on why youth would not seek these services out. If yes why would youth seek these services out?
      2. What would make youth more likely/less likely to access and utilize these services?
      3. What are the reasons why someone would not use these services?
         a. Probe on: Method? Misconceptions (side effects, how to get pregnant, HIV)? Religious issues?

4. What role does society (parents, community, schools, church, friends) play in people’s decisions to use and access reproductive health services?
   a. What groups are supportive?
      i. Probe on how they are supportive, what makes them supportive?
   b. What groups are not supportive?
      i. Probe on how they are not supportive, what makes them not supportive?
   c. Do you all think there are differences in the level of support for:
      i. Male vs female
      ii. Married vs unmarried
      iii. Others?

5. Do you all have any recommendations for how to improve reproductive health services for youth? Are there things that you believe providers are doing well for youth and should keep doing?

6. We’ve talked a lot about your perceptions of YFHS, but lastly I want to discuss some of your beliefs and perceptions about fertility and marriage are in Malawi
   a. What do you all think should be the ideal family size in Malawi?
      i. What are the reasons for that?
   b. At what age do you all think should women start having children?
      i. What are the reasons for that?
c. At what age do you all think should women and men start getting married?
   i. What are the reasons for that?

7. Additional Topics to probe on if they come up: questions on facility versus community based FP provision? Any supply issues (many youths get their condoms from markets, not health facilities or workers), quality of provision questions? Knowledge of, comfort using YFHS?

8. Are there any other topics you would like to discuss? Have you thought of anything else based on our discussion?

Thank you very much for taking your time to participate in this discussion today? We really appreciate your openness and insight. We will now provide you some snacks.
FGD – Guide for females 15-17 in school – Chichewa

Pl Name | Melissa Marx, International Health
Study Title | Perceptions about barriers to accessing family planning services among youth in Malawi
IRB No. | IRB #7246
Pl Version No./Date | Version 2; July 08, 2016

FGD – Guide for females 15-17 in school
Chiyambi:
Tikuthokozeni polola kuti tikambilane nanu lero. Dzina langa ndi (Dzina) ndi amene nditsogolere zokambirana zathu za pa guluzi. Tili pano kutaikambilane za ntchito za uchembre wa bwino wa a chinyamata mMalawi muno. Tikufuna kuta zakambirana zathu zikhale zosabisa kanthu.

Poyamba tiyenera tikhazikitse malamulo pa zokambiranazi. Mukuganiza kuta malamulo amene tingathe kupanga angakhale ati?
(Tchulani zinthu izi ngati sa zitchula)
1. Munthu mmodzi adziyankhula pa nthawi. (Munthu wina akamayankhula ena adzinvetsera)
2. Tilemekeze zimene angalankhule ena.
3. Tilemekeze zimene angalankhule ena.
4. Ma phone onse ammanja asachite phokoso.
7. Chonde musatchule maina a anthu pa zokambiranazi. Sitikufuna maina a anthu eni eni kuti ajambulidwe.

(Yambanikujambula)
1. Tiyenzi tiyambe ndi kulankhula zokhudzana ndi ntchito za umoyo zokomera a chinyamata. Kodi mukuganiza kuti ntchito za umoyo zokomera achinyamata ndi chiyani?
   a. Kodi munanvapo za uchembele wa bwino wokomera a chinyamata mbuyomu?
   b. Kodi chimene chingapangitse ntchito za umoyo kukhala zokomera a chinyamata ndi chiyani?
      i. Kodi ndi zinthu ziti zimene zili zofunika kwambiri kwa inu?
         1. Zinthuzi ndi monga izi: maonekedwe - kupezeka kwa zipangizo, ubale wa bwino, nthawi yodikilira, kapelekedwe ka uphungu, chinsinsi. (funsani izi ngati anthu sakulankhulapo ndipo munve malingaliro awo pa zinthu zo ngati zili ofunika kapena ayi)
   c. Kodi mu dera lanu lino muli chithandizo cha chipatala chothandiza a chinyamata? Kodi mwamvapo amene akugwiritsa ntchito chithandizochi?
      i. Ngati ndi choncho, mukuganiza kuti nkofunikira kuti chithandizochi chizipezeka, chifukwa chiyani?
      ii. Ngati mulibe chithandizo chimenechi, kodi mukuona kuti nkofunikira kuti chizipezeka mdera lanu lino, chifukwa chiyani?
      iii. Kodi mukuganiza kuti achinyamata angakonde komaso kudana ndi zinthu ngati ziti pa chithandizo cha umoyo chimene ndi chothandiza a chinyamata?

2. Tsopano ndikufuna ndikambepo zokhudzana ndi ntchito za uchembele wabwino wa a chinyamata (monga za kulera). Ndi njira zanji zo lelera zimene zikupezaka ku dera lanu lino?
   a. Kodi mukudziwa amene amapeleka njira za kulerazi?
      i. Kodi mukuganiza kuti achinyamata amakonda opeleka njira za kulera ena kuposa ena?
         1. Kodi chimene chingampangitse wa chinyamata kukonda opeleka njira za kulera mmodzi kuposa wina ndi chiyani? (probe:community, facility based)
         2. Kodi nonse mungakonde kupita kwina kukalandira chithandizo kapena wina azikubweletselani chithandizocho konkuno? Ku Sukulu ya mdera lanu? kapena malo ena?
      ii. Kodi achinyamata amadziwa bwanji za kopita kukapeza thandizo?
      iii. Kodi mukuganiza kuti opeleka zolera amawauza chiyani achinyamata za ntchito za kulera?
         1. Kodi mukuganiza kuti opeleka zakulera amalimbikitsa achinyamata kuti adzigwiritsa ntchito njirazi?
   b. Kodi mukuganiza kuti anthu amaphunzira za uchembere wa bwino ku Sukulu?
      i. Mukuganiza kuti amaphunzira chiyani?
1. Kodi ndi ndani angaphunzitse ophunzira za zinthu zanji?
   ii. Kupatula ku Sukulu ndi kuti kwina kumene achinyamata amaphunzira za uchembele wa bwino?
3. Tsopano ndikufuna tikambilane nkhani zokhudza njira zolera, sindikufuna kuti muyankhule zo khudza inuyo, koma zomwe mukudziwa za njira zosiyanasiyana za kulera?
   a. Ndi njira ziti za kulera zomwe mukudziwa?
      i. Funsitsani njirazo ndi mmene zimagwilira ntchito
      ii. Kodi munthu wa nsinkhu ngati wanuwu angakapeze kuti njirazi?
         2. kodi ndi malo ati amene kawirikawiri amapitidwa kukapeza njira zolera?
   iii. Kodi mukuganiza kuti anthu amisinkhu yanuyi angakatenge njirazi?
      1. Ngati sichencho ndi chifukwa chiyani a chinyamata sangakatenge njira zimenezi. Ngati ndi choncho ndi chifukwa chiyani a chinyamata angakatengere njirazi?
      2. Kodi kwenikweni chimene chingapangise/sichingapangise achinyamata kufikira ndi kugwiritsa ntchito njirazi ndi chiyani?
      3. Kodi ndi zifukwa zanjimwe ena sangagwiritse ntchito njirazi?
         a. Fufuzani za: Njira? Kuganiza molakwika (mavuto amene amabwera, mmene ungatengere mimba, HIV)?

4. Ndi mbali yanji imene fuko (makolo, dela, Sukulu,zipembedzo,anzanu) limatenga pamene anthu akupanga ziganizo pa kupeza ndi kugwiritsa ntchito njira zolera.
   a. Kodi ndi magulu ati amene amalimbikitsa (njira zakaleledwe?)
      i. Funsitsani mmene amalimbikitsira, chimawapangitsa kuti azilimbikitsa ndi chiyani?
      b. Kodi ndi magulu ati amene samalimbikitsa (njira za kaleledwe)?
         i. Funsitsani mmene samalimbikitsira, chimene chimawapangitsa kuti asamalimbikitsa ndi chiyani?
         c. Kodi mukuganiza kuti pali kusiyanja pa kalimbikitsidwe pakati pa:
            i. Amuna ndi akazi
            ii. Okwatira ndi osakwatira
            iii. Ena onse?
   5. Kodi muli ndi ndondomeko za mmene ntchito za uchembere wabwino wa a chinyamata zingapitire patosgolo? Kodi pali zinthu zimene mukukhulupilira kuti opeleka chithandizo cholera kwa a chinyamata akuchita bwino ndipo apitilize?
   6. Takambilana kwambiri za mmene mukuonera ntchito za uchembere wabwino wa a chinyamata, pomaliza ndimafuna tikambilane za zikhulupiliro zanu ndi mmene mumazionera zokhuzana ndi kubeleka ndi ukwati kuno ku Malawi.
a. Kodi mukuganiza kuti banja labwino likuyenera kukhala ndi anthu angati ku Malawi kuno?
   i. Kodi zifukwa zake ndi ziti?

b. Kodi mukuganiza kuti azimayi aziyamba kubeleka ali ndi zaka zingati?
   i. Kodi zifukwa zake ndi ziti?

c. Kodi mukuganiza kuti akazi ndi amuna azikwatirana ali ndi zaka zingati?
   i. Kodi zifukwa zake ndi ziti?

7. Mituyowonjezera kufunsitsa ngati ingabwere: mafunso okhuza za njira zolera zopelekedwa ku chipatala poyelezeza ndi ku mudzi? Nkhani iliyonse yokhudza kapezekedwe ka zinthu(achinyamata ambiri amapeza ma kondomu ku msika, osati ku chipatala kapena kwa azaumoyo), mafunso abwino okhuza zopeleka? kudziwa ndi kumasuka po gwiritsa ntchito uchembere wabwino wa a chinyamata?

8. Kodi pali mitu ina imene mungakonde kuti tikambilane? Mwaganizapo zinazilizonse zokhudzana ndi kukambilana kwathuku?

Zikomo kwambili chifukwa cha nthawi yanu potenga nawo mbali pazokambirana zathuzi lero. Tayamikira kumasuka kwanu ndi zomwe mwatiunikira. Tsopano ndi nthawi yoti tikupatseni zozilitsa kukhozi.
Health Worker IDI Guide - English

<table>
<thead>
<tr>
<th>PI Name</th>
<th>Melissa Marx, International Health</th>
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</tr>
<tr>
<td>PI Version No./Date</td>
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</table>

IDI Health Care Worker guide

Introduction:

Thank you for taking your time to talk with us today. I’m (name) and I will be talking with you about youth friendly reproductive health services in Malawi. I want to hear your thoughts and opinions about the topics. While this is an interview, we encourage you to be open and share openly about the topic. This audio recorder is going to record the discussion so we can transcribe and translate the discussion. I will be taking notes during the interview, so please continue talking even if you see me writing something.

Do you have any questions be we get started? If not we will begin.

(Start recording)

1. To start can you tell me about your work?
   a. What is a typical day like?
   b. What kind of services do you provide?
   c. Do you do more outreach or facility based work?

2. Have you heard of the concept of youth friendly health services?
   a. What do you think youth friendly health services are?
      i. Do you consider yourself to be a provider of youth friendly health services?
         1. Why?
      ii. What are the most important aspects of youth friendly health services?

3. Now I want to talk more about the services you provide. Can you tell me about the different family planning services you provide?
   a. What contraceptive methods are most provided to youth?
      i. Why do you think that is?
   b. Do you prefer to provide one method over another for adults, youth, married vs. unmarried?
      i. If so why?
c. What determines whether you provide contraceptive services to youth?
   i. If they have a question?
   ii. When they are pregnant?
   iii. Guidelines?
   iv. Age?
   v. Parental permission?

d. When telling someone about family planning services what do you tell them?
   i. Why do you tell them those things?
   ii. Is there anything that you don’t tell them?
      1. Why?

e. Have you ever heard of a healthcare worker not providing reproductive health services to youth?
   i. Probe on this if they say yes or no. It can be a hypothetical situation. What are some reasons why a service provider would not provide family planning to someone?
      1. Ask them to elaborate on reasons that mentioned.

f. What are the reasons youth may express for deciding to use or not use contraceptives?
   i. Ask them to elaborate on reasons that mentioned.

4. Youth face many barriers to accessing reproductive health services. These include stigma, price, distance etc. From your perspective what are some effective ways to remove barriers to youth accessing reproductive health services?
   a. How will these assist in improving access to reproductive health services?

5. Healthcare workers also face many barriers to providing quality youth friendly health services. These can include supply of contraceptives, time, workload, social pressure etc. Have you experienced any of these in your work?
   a. What can be done to remove these barriers to you doing an even better job at providing youth friendly health services?
      i. What have you done in the past that you felt was successful in helping youth with their reproductive health?
         1. Could others do the same?
         2. Is there something you’d like to do to improve your services but are currently unable to do?
            a. Why are you unable to do it?

6. Scenarios:
   a. How would you feel if a 15-year-old single female asked you for contraception?
i. What would you tell them? What would you ask them?
b. Repeat for 15-year-old single male, 24-year-old married female, 22-year-old married male, and others as relevant
7. We’ve talked a lot about your work and what your role is in providing YFHS, but lastly I want to discuss some of your beliefs and perceptions about fertility and marriage are in Malawi
   a. What do you think should be the ideal family size in Malawi?
       i. What are the reasons for that?
   b. At what age do you think should women start having children?
       i. What are the reasons for that?
   c. At what age should women and men start getting married?
       i. What are the reasons for that?

Thank you so much for taking time to talk with us today. We really appreciate it and hope this information will help improve youth friendly health services in Malawi.

Participant Characteristics:

Sex_____ Age_____ Type of provider ___________ Catchment area _____
Health Worker IDI Guide - Chichewa

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IDI Health Care Worker Guide

Chiyambi:


Muli ndi mafuso ena aliwose tisanayambe? (yambani kujambula)

1. Poyamba ndiuzeni zokhudza ntchito yanu?
   a. Kawirikawiri patsiku mumatani pa ntchito yanu?
   b. Mumapereka chithandizo chatoni chokhudza kulera?
   c. Nthawi zambiri mumagwirira ntchito yanu ku outreach kapena ku chipatala?

2. Munayamba mwanvapo za uchembere wabwino wa achinyamata?
   a. Mukuona ngati uchembwere wabwino wa chinyamata ndi chain?
      i. Mukuona ngati ndinu munthu oti mumapereka uchembere wabwino wachinyamata?
         1. Chifukwa chiyani?
      ii. Kodi ndizinthu ziti zofunikira pa nkhanzi ya uchembere wabwino wachinyamata?

3. Panopa ndikufuna tikambe zambiri zokhudza chithandizo chomwe mumapereka. Mungandiuzeko za chithandizo cha kulera chimene mumapereka?
   a. Ndi njira ziti zakulera zimene zimaperekedwa kawirikawiri kw a chinyamata
      i. Mukuganiza kuti ndi chifukwa chiyani?
b. Kodi pali njira yakulera imene mumakonda kupereka kwa a chinyamata, akuluakulu, anthu a pa banja vs amene Sali pa banja.
   i. Ngati zili choncho chifukwa chiyani?

c. Nchani chimene chimakupangitsani kupereka kapena kusapereka chithandizo cha kulera kwa a chinyamata?
   i. Akakhala ndi fuso?
   ii. Akakhala oyembekezera?
   iii. Ndondomeko?
   iv. Zaka?
   v. Akakhala ndi chilolezo chochokerera kwa makolo?

d. Mukamuza munthu za kulera, mumamuza chani?
   i. Nchifukwa chiyani mumawauza zinthu zimenezo?
   ii. Kodi pali zinthu zina zimene simumawauza?
      1. Chifukwa chiyan?

e. Kodi munayamba mwanvako kiti wa zaumoyo sakupereka chithandizo cha kulera kwa a chinyamata?
   i. Fusisitsani ngati avomera kapen kukana, zikhoza kukhala zongopeka. Kodi ndi zifukwa ziti zimene wa zaumoyo
      1. Afuseni afotokoze zifukwa zimene apereka

f. Kodi ndi zifukwa zanji zimene a chinyamata angapereke popanga chiganizo chogwiritsa ntchito kapena kusagwiritsa ntchito njira zakulera?
   i. Afuseni kuti a fotokoze zifukwa zimene apereka

   a. Kodi njira zimenezi zingathandize bwanji kapezedwe ka chinthandizo cha kulera kwa a chinyamata?

5. Ogwira ntchito za umoyo amakumana ndi zopinga/mavuto ambiri popereka chithandizo cha kulera kwa a chinyamata. Izi zikhoza kukhala kupeza kwa zipangizo za kulera, nthawi, kuchuluka kwa ntchito, chikhalidwe ndi zina zotero. Kodi mwakumanako ndi mavuto ngati amenewa pa ntchito yanu?
   a. Kodi ndi chani chimene chikufunika kupchitika kuti zopinga/mavuto amenewa athe kuti muzitha kupereka chithandiza cha kulera kwa a chinyamata bwinobwino.
      i. Kodi mudapangapo chani mbuyomu chimene mumaona kuti munathandiza achinyamata ndi chithandizo cha kulera.
         1. Kodi anthu ena akhoza kupanga chimodzimodzi?
2. Kodi pali chinthu chimene mumafuna mutapanga kuti muthane ndi mavutowa koma panopa mukulephera kupanga?
   a. Kodi mukukanikiranji kupanga zimenezo?

6. Zimene zingachitike
   a. Kodi mukhoza kumwa bwanji mtsikana wa zaka 15 oti sanakwatiwe atakupemphani chithandizo cha kulera?
      i. Kodi mukhoza kumuuza chani? Mukhoza kumufusa fuso lanji?
   b. Fusani mafuso omwewa kwa mnyamata wa zaka 15 osakwatira, mzmayi wa zaka 24 wa pa banja, mnyamata wa zaka 22 okwatira, ndi ena ofunikira.

7. Takamba zambiri zokhudza ntchito yanu ndi udindo wanu popereka chithandizo cha kulera kwa achinyamata. Koma pomaliza ndikufuna kuti ticheze za zikhuluibiriro kapena maganizo anu okhudza kuberekazidzi ndi banja ku Malawi kuno
   a. Kodimukuganizakutibanjalabwinolikuyenerakukhalandianthuangatiku Malawi kuno?
      i. Kodizifikuwakendzi ziti?
   b. Kodimukuganizakutiazimayizambakubalekalindizakizingati?
      i. Kodizifikuwakendzi ziti?
   c. Kodimukuganizakutiaziyambakubelekalindizakizingati?
      i. Kodizifikuwakendzi ziti?

Zikomo kwambiri chifikwa chotipatsa mpata kuti ticheze nanu lero. Tikuthokozni kwambiri ndipo tili ndi chikhuluibiriro kuti mayankho amene mwatipatsa athandiza kupititsa potsogolo kapereedwe ka chithandizo cha kulera kwa a chinyamata

zokhudza amene mumacheza naye:

wammuna/wankazi __________ zaka __________

bungwe limene likupereka chithandizo ____________ dera ____________
Appendix 5 - Recruitment script for focus groups

Recruitment Script for community partners to recruit FGD participants

All FGD Participants

Youth friendly reproductive health provision preferences among youth, parents, and health providers in Malawi

Hello, my name is ____________________ and I work at ___________________. I want to tell you about a study that is being conducted with the National Evaluation Platform or “NEP”. NEP is a joint initiative of the Ministry of Health, the National Statistics Office, and Johns Hopkins University. NEP is conducting a study related to youth friendly health services in Malawi. They are interviewing both female and male youth, health care workers, and parents in Malawi. They would like to ask if you are interested in learning more about the study and possibly participating in a focus group discussion on this topic. The focus group will discuss perceptions and opinions about family planning services being offered to youth.

Recruiter: collect data below.

CIRCLE Gender: Female  Male
Are you married? (circle)?  YES  NO
How old are you? _________
(If less than 18) Do you attend school (circle)?  YES  NO

Group (circle):
1. Married young women aged 15-24*
2. Unmarried young women who are not in school aged 15-24*+
3. Young women attending school aged 15-17*+
4. Parents of young women 15-17
5. Young men who are in school aged 15-17*
6. Young men who are not in school aged 15-24*

*If you are under 18 and not married or emancipated, please come with a parent or guardian. You will only be able to participate if s/he comes with you and agrees that you can participate. +If you are female & 15-17 years, your parent may be asked to stay for a separate discussion.

(Find location, date, time on list)
If you’re interested, please go to (Location) __________________________ on (Day) ______ at (Time) ______ sharp to talk about participating. The study staff can tell you more about the study and participating. If you decide to participate, you will need to stay for about 2-and-a-half-hours at that time. The first to arrive will be given the first chance to participate.

Planned Focus Groups in ____________catchment of _______________ District:

<table>
<thead>
<tr>
<th>Count of referred</th>
<th>Group</th>
<th>Location</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Married young women aged 15-24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unmarried young women who are not in school aged 15-24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Young women attending school aged 15-17</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Parents of young women 15-17</td>
<td></td>
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<td></td>
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<td></td>
<td>Young men who are in school aged 15-17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Young men who are not in school aged 15-24</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Referral source:__________________________________
Appendix 6 - Consent, assent, and parent permission forms

An example of each type of consent form is provided in English and Chichewa. All of the forms were not included due to the size of them and only minor differences in the wording exist.
IDI Consent - English

IDI_HCW_CONSENT

PI Name: Melissa Marx
Study Title: Youth friendly reproductive health provision preferences among youth, parents, and health providers in Malawi
IRB No.: 7296
PI Version/Date: Version 2, July 10, 2016

We want to talk to you about a research study we are doing. A research study is a way to learn information about something. We are working to understand health care workers, perceptions, experiences, and opinions about youth friendly reproductive health services in Malawi. We are asking you to join our study because you are a health care worker and provide family planning services in your community.

If you agree to join this study, we will ask you to sit in a private place and ask you to answer questions about your experiences and perceptions about youth friendly reproductive health services in Malawi as a provider. We will also ask you your thoughts on the ways to improve these health services. It will take one and half hours at most.

During the interview you may feel uncomfortable discussing certain topics or answering questions. If you feel uncomfortable you do not need to answer the question. You can tell me to skip any question. You do not have to answer all the questions. You may stop at any time. We will not use your name when we talk about what we found in this study.

Being in this study will not help you directly. But we hope what we learn from you will help the Ministry of Health to improve health programs for people your age.

We would like to audio record this interview. Taping helps us remember clearly what everyone said. We will just tape your voice. We will not ask you to give your name on tape. You can ask us to stop recording at any time by asking the interviewer to stop it.

It is possible that your privacy may be breached in the event that data is lost, stolen, or handled improperly. The study team will be trained to protect your privacy. They will lock all paper documents and recorders in a backpack and securely store all documents and files to help protect you.

You do not have to join this study. It is up to you. You can say yes now, and change your mind later. You just have to tell us. No one will be mad at you if you change your mind.

At the end of the interview we will give you a small snack and repay travel costs if you had them. You can have snacks and transport reimbursement even if you say yes to be part of the study but change your mind later.

Before you say yes to joining this study, we want to answer any questions you have.

Melissa Marx, IDI_HCW_CONSENT_V2
If you want to ask someone else questions now or after you take part, you can contact Melissa Marx at mmarx@jhu.edu or +01 410 502 1942.

If you want to talk to someone else about anything, including problems or concerns, you can contact the U.S. or Malawi Ethics Committees that approved this study:

Malawi Research Ethics Committee
National Health Sciences Research Committee Ministry of Health P.O. Box 30377 Lilongwe 3 MALAWI
Tel:+265 1 789400/414 Fax: +235 1 789 527/536 Email: doccentre@malawi.net

Johns Hopkins Bloomberg School of Public Health
615 N. Wolfe Street, Suite E1300 Baltimore, MD 21205
Telephone: 410-955-3133 Toll free: 1-888-262-3242 Fax: 410-502-0584
E-mail: JHSPHICOFFICE@jhu.edu

Your initials (or thumbprint/mark) on this form means:
• You have been told about the purpose, procedures, possible benefits & risks of this study.
• You have been given the chance to ask questions before you sign.
• You have voluntarily agreed to be in this study.
• You say we can record this interview.

Initials of Participant ___________________________ Date _______________

Ask the participant to mark a “left thumb impression” in this box if the participant (or participant’s parent) is unable to provide a signature above.

SIGN BELOW ONLY IF THUMBPRINT USED

_________________________ Signature of Witness ___________ Date ______
Name of Witness

_________________________ Name of Person Obtaining ___________________________ Signature of Person Obtaining Consent ________ Date ______

Melissa Marx, IDU_HCW_CONSENT_V2
IDI Consent – Chichewa

IDI_HCW_CONSENT

PI Name: Melissa Marx
Study Title: Youth friendly reproductive health provision preferences among youth, parents, and health providers in Malawi
IRB No.: 7246
PI Version/Date: Version 2, July 10, 2016


Ngati mungavomereze kutenganawo mbali pa kafukufuku yu, tikupephani kuti mukhale pa mulo panokha (podukamphepo) ndikufufunsani kuti muyankhe mafunso okuhuzana ndi zomwe mumakumana nazo ndi momwe mumazionera zokhudzana ndi uchembere wabwino wa a chinyamata mMalawi monga inu opeleka chithandizo. Tikufufunizino maganizo anu mmene njira za uchembere wabwino zingapitire patsogolo. Zokambilani zitenga pafupifi pa olamodzi ndi theka (one and half hours)


Paiibe thandizo lopezerakuta totenga nawi mbali pa kafukufukuyu. Koma tikukhulupiliira kuti zimene tiphenzire kwa inu zithandiza unduna wa za umoyo kukanzanto ndondomeko za umoyo wa anthu a misinkhu yanuvi.

Zimene takambilana panu zikhoza kuululika zitaipheka kuti zinthu zathu zabezwa kapena sizinsamalileke mokwanira. Gulu limene tikupanga kafukufuku lifunzitsidwa mmene lingareterezere zokambirana zathu. Akakhomera ma pepala onse komaso zodabira/kutepera mawu mu chikwama ndi kusungu pa bwinu kuti zsaululike.


Pa mapeto a zokambirana zathuizi tipheko zakumwa zozizitsa kakhozi ndi kawoza ndalama zomwe mwayendena pottenza kuno ngati munzerto. Mukhoza kulanidza zakawo zozizitsa kukhozi ndi kubwezeredwa ndalama zomwe mwayendena ngakhale mumenva kutenga nawi mbali pa kafukufukuyu kenako ndi kusintha maganizo kuupitaliza nawi kalukufukuyu.

Melissa Marx, IDI_HCW_CONSENT
Musanavomereze kutenga n'ango m'beli pa kafukufukuyu, tikufuna tikuyankheni mafunso amene mulinawo.

Ngati mungakhole ndi mafunso panopla kapena mutamaliza kafukufukuyi, mutha kulumikizana ndi Melissa Marx pa rmmars@jhu.edu kapena kuyimba lami pa nambala lyl +01 410 502 1942.

Ngati mungafune kuyankhula ndi wina alyense pa chilichonse kuphatikizapo mavuto kapena nkha zanu, mutha kulumikizana ndi U.S. kapena Malawi Ethics Committee amene anavomereza kafukufukuyi.

Malawi Research Ethics Committee
National Health Sciences Research Committee Minister of Health P.O. Box 30377 Lilongwe 3 MALAWI
Tel:+265 1 789400/414 Fax: +235 1 178 527/536 Email: doccentre@malawi.net

Johns Hopkins Bloomberg School of Public Health
615 N. Wolfe Street, Suite E1100 Baltimore, MD 21205
Telephone: 410-955-3193 Toll Free: 1-888-262-3242 Fax: 410-502-0584
E-mail: JHSPH.irboffice@jhu.edu

Kusayina kapena kudinda pa form kukuthanuza kuti:
- Mwauziwda za choliga, ndondomekon cholowa ndi zovuta za kafukufukuyu
- Mwapsitiwida mwayi cfunsa mafunso musanaysayine.
- Mwavomera mwa mufulanji n'ango m'beli pa kafukufukuyu
- Mwavomera kujambidwa mawu pa kafukufukuyu
Ma initial a munthu mukecheza naye

Tsiku

Muuzeni munthu amene mukecheza naye kuti adinde chala chake chachikulu cha ku mazeru mu box iyi ngati sangathe kusaina pamwambapo

LEMBANI ZOKHUDZA MBONI NGATI CHIDENDO CHAGWIRITSIDWA NTCHITO

Dzina ia mbon ya mboni Tsiku

Dzina ia munthu amene akufusa mafuso ya munthu amene akufusa mafuso Tsiku

Date

Melissa Marx, IDI_HCW_CONSENT
FGD_femalemarried_CONSENT

PI Name: Melissa Marx
Study Title: Youth friendly reproductive health provision preferences among youth, parents, and health providers in Malawi
IRB No.: 7246
PI Version/Date: Version 2, July 10, 2016

We want to talk to you about a research study we are doing. A research study is a way to learn information about something. We would like to find out more about youth friendly reproductive health services in Malawi. We are asking you to join the study because you are a married and emancipated female, 15-24 years old, are out of school and live in this community.

If you agree to join this study, we will ask you to sit in a private place with other people your age who are also married. We will ask the whole group what they know and think about youth friendly reproductive health services in your community. We will also ask how these services could be improved so people like you would want to use them. We will not ask you if you use these services. We will ask if people like you use them or want to use them. We will talk about these things for about 2 hours.

Talking about reproductive health services in a group might make you uncomfortable. You do not need to answer any question that makes you feel uncomfortable. You can say no to answering any question that we ask. You do not have to talk about anything you do not want to talk about. You can ask to leave the discussion group any time for any reason. Just say so.

We would like to audio record this interview. Taping it helps us remember clearly what everyone said. We will just tape your voice. We will not ask you to give your name on tape. You can ask us to stop recording at any time by asking the interviewer to stop it.

It is possible that your privacy may be breached in the event that data is lost, stolen, or handled improperly. The study team will be trained to protect your privacy. They will lock all paper documents and recorders in a backpack and securely store all documents and files to help protect you.

Being in this study will not help you directly. But we hope what we learn from you will help the Ministry of Health to improve health programs for people your age.

You do not have to join this study. It is up to you. You can say yes now, and change your mind later. You just have to tell us. No one will be mad at you if you change your mind.

At the end of the group discussion we will give you a small snack and repay travel costs if you had them. You can have snacks and transport reimbursement even if you say no to be part of the study but change your mind later. Before you say yes to joining this study, we want to answer any questions you have.

If you want to ask someone else questions now or after you take part, you can contact Melissa Marx at mmarx@jhu.edu or +01 410 502 1942.
If you want to talk to someone else about anything, including problems or concerns, you can contact the U.S. or Malawi Ethics Committees that approved this study:

Malawi Research Ethics Committee
National Health Sciences Research Committee Ministry of Health P.O. Box 30377 Lilongwe 3 MALAWI
Tel:+265 1 789400/414 Fax: +235 1 789 527/536 Email: doccentre@malawi.net

Johns Hopkins Bloomberg School of Public Health
615 N. Wolfe Street, Suite E1100 Baltimore, MD 21205
Telephone: 410-955-3133 Toll Free: 1-888-262-3242 Fax: 410-502-0584
E-mail: JHSPHIRboffice@jhu.edu

Your initials (or thumbprint/mark) on this form means:
- You have been told about the purpose, procedures, possible benefits & risks of this study.
- You have been given the chance to ask questions before you sign.
- You have voluntarily agreed to be in this study.
- You say we can record this interview.

Initials of Participant ___________________________ Date _______________

Ask the participant to mark a “left thumb impression” in this box if the participant (or participant’s parent) is unable to provide a signature above.

SIGN BELOW ONLY IF THUMBPRINT USED

Name of Witness ___________________________ Signature of Witness _______________ Date _______________

Name of Person Obtaining Consent ___________________________ Signature of Person Obtaining Consent _______________ Date _______________

Melissa Marx, FGD_femalesmarried_CONSENT_V2
Adult Consent – Chichewa

FGD_femalemarried_CONSENT

PI Name: Melissa Marx
Study Title: Youth friendly reproductive health provision preferences among youth, parents, and health providers in Malawi
IRB No.: 7246
PI Version/Date: Version 2, July 10, 2016


Ngeti mungavomeneze kutengenawo mbaali pa kafukufuku yu, tikupenhani kuti mukhala pa malo parokha (poukamphepo) pamodzi ndi amai anzu amisinkhu yenu komanso okwatiwa. Tifunsa gulu lanulo zomwe mukudziwa ndi kuganiza zokhudzana ndi nthcho za uchembere wa bwino wa achinyamata mu dera lanu lino. Tikufunsaniso mmene nthcho zimenezi zingakonzedwere bwino kuti anthu ngati inu mungathe kuzigwiritsa nthcho. Sitiikufunsani ngati inuyo mumagwiritsa nthcho njira zimenezi. Tikufunsani ngati anthu manga inuyo amagwiritsa nthcho kapena amafuna atagwiritsa nthcho njira zimenezi. Tikambilana zokhudzana ndi zinthu ili kwa maola awiri (2 hours)


Zimene takambilana pano zikhoza kuululika zitapecika kuti zinthu zathu zabezda kapena szinasamalilike mokwani. Gulu limene likupanga kafukufuku liphunzitsidwa mmene lingatetezerere zakambilana zathu. Akhekherona ma paliyeste komanso codabira/kutepera mawu mu chikuwa ndi kusunga pa bwino kuti zisaululike.
Palibe thandizo ipepekeratu potenga nawo mbalwi pa kafukufukuyu. Korna tikukhulupila kuti zimene tiphunzire kwa inu zithandiza unduna wa za umoyo kukoziyarso ndondomeko za umoyo wa anthu a misinhu yanuvi.


Pa mapeto a zokambirana zathuzi tipeleka zakumwa zoziilita kukuholi ndi kubwera ndalama zomwe mwayendera pobwera kuno ngati munatero. Mukhoza kualandira zakumwa zoziilita kukuholi ndi kubwezeredwa ndalama zomwe mwayendera ngakhale muentomera kutenga nawo mbalwi pa kafukufukuyu kenako ndi kusintha maganizo kusaptitiza nawo kafukufukuyu.

Musananomereze kutenga nawo mbalwi pa kafukufukuyu, tikufuna tikuyankhenci mafunso amene mulanario.

Ngati mungakhale ndi mafunso panopo kapena mutamaliza kafukufukuyi, mutna kulumikizana ndi Melissa Marx pa rmmar@jhu.edu kapena kuyamba lamy pa nambala iyi +01 410 502 1942.

Ngati mungafune kuyankhula ndi wina alyense pa chilichonse kuphatikizapo magwuto kapena nkhawa zanu, mutna kulumikizana ndi U.S. kapena Malawi Ethics Committees amene anavomereza kafukufukuyi.

Malawi Research Ethics Committee
National Health Sciences Research Committee Ministry of Health P.O. Box 30377 Lilongwe 3 MALAWI
Tel:+265 1 789400/414 Fax: +265 1 789 527/536 Email: doccentre@malawi.net

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Telephone: 410-955-3193 Toll Free: 1-888-262-3242 Fax: 410-502-0584
E-mail: JHSPH.irmoffice@jhu.edu

Melissa Marx, FGD_femalesmarried_CONSENT
Kusayina kapena kudinda pa form kukutanhuva kuti:
- Mwauzidwa za cholanga, ndondomeko, cholowa ndi zovuta za kafukufukuyu.
- Mwapatsiľwa mwayi cfunsa mafunso musanasyine.
- Mwavomera mwa ululu kutenga nawo mbali pa kefuku/ukuyu
- Mwavomera kujambidwa mawu pa tafulukuyu.

Ma initial a munthu mukucheza naye

Tiiku

Musuzeni munthu amene mukucheza naye kuti aNdinde chala chaka chakikulu cha ku mazere mu box iyi ngati sangathe kusaina pamwambapo

LEMBANI ZOKHUDZA MBONI NGATI CHIDINDO CHAGWIRITSIDWA NTCHITO

Dzina la mbon

ya mboni

Tsiku

Dzina la munthu amene akufusa mafuso

ya munthu amene akufusa mafuso

Tsiku

Melissa Marx, FGD_femalesmarried_CONSENT
We want to talk to you about a research study we are doing. A research study is a way to learn information about something. We would like to find out more about youth friendly reproductive health services in Malawi. We are asking you to join the study because you are a female between 15-17 years old, who is in school and lives in this community.

If you agree to join this study, we will ask you to sit in a private place with other people your age who are also enrolled in school. We will ask the whole group what they know and think about youth friendly reproductive health services in your community. We will also ask how these services could be improved so people like you would want to use them. We will not ask you if you use these services. We will ask if people like you use them or want to use them. We will talk about these things for about 2 hours.

Talking about reproductive health services in a group might make you uncomfortable. You do not need to answer any question that makes you feel uncomfortable. You can say no to answering any question that we ask. You do not have to talk about anything you do not want to talk about. You can ask to leave the discussion group any time for any reason. Just say so.

We would like to audio record this interview. Taping it helps us remember clearly what everyone said. We will just tape your voice. We will not ask you to give your name on tape. You can ask us to stop recording at any time by asking the interviewer to stop it.

It is possible that your privacy may be breached in the event that data is lost, stolen, or handled improperly. The study team will be trained to protect your privacy. They will lock all paper documents and recorders in a backpack and securely store all documents and files to help protect you.

Being in this study will not help you directly. But we hope what we learn from you will help the Ministry of Health to improve health programs for people your age.

You do not have to join this study. It is up to you. You can say yes now, and change your mind later. You just have to tell us. No one will be mad at you if you change your mind.

At the end of the group discussion we will give you a small snack and repay travel costs if you had them. You can have snacks and transport reimbursement even if you say yes to be part of the study but change your mind later.
Before you say yes to joining this study, we want to answer any questions you have.

If you want to ask someone else questions now or after you take part, you can contact Melissa Marx at mmarx@jhu.edu or +01 410 502 1942.

Melissa Marx, FGD_femalerighorschool_ASSENT_V2
If you want to talk to someone else about anything, including problems or concerns, you can contact the U.S. or Malawi Ethics Committees that approved this study:

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National Health Sciences Research Committee Ministry of Health P.O. Box 30377 Lilongwe 3 MALAWI
Tel: +265 1 789400/414 Fax: +235 1 789 527/536 Email: doccentre@malawi.net

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E-mail: JHU@irboffice@jhu.edu

Your initials (or thumbprint/mark) on this form means:
• You have been told about the purpose, procedures, possible benefits & risks of this study.
• You have been given the chance to ask questions before you sign.
• You have voluntarily agreed to be in this study.
• You say we can record this interview.

_____________________________  ________________________
Initials of Participant          Date

Ask the participant to mark a “left thumb impression” in this box if the participant (or participant’s parent) is unable to provide a signature above.

SIGN BELOW ONLY IF THUMBPRINT USED

_____________________________  ________________________  ________________________
Name of Witness                  Signature of Witness          Date

_____________________________  ________________________  ________________________
Name of Person Obtaining Consent Signature of Person Obtaining Consent Date

Melissa Marx, FGD_femaleminorinschool_ASSENT_V2
Minor Assent – Chichewa

Study Title: Youth friendly reproductive health provision preferences among youth, parents, and health providers in Malawi

Approval Date: June 30, 2016
Approval Consent Version No.: 1
PI Name: Melissa Marx
IRB No.00007246

FGD_femaleminorinschool_ASSENT

PI Name: Melissa Marx
Study Title: Youth friendly reproductive health provision preferences among youth, parents, and health providers in Malawi
IRB No.: 7246

PI Version/Date: Version 2, July 10, 2016

Timafuna tikambirane naru za kafukuiku amene tikupenga. Kafukuiku ndi njira imene timaphunzilira zinthu zina ndi zina. Tikufunsa tifuze zambiri za nthito za uchembere wabwino wa a chinyama m'malawi muno. Timafuna tikupempheni kuti mutenga nawo mbali pa kafukuiku yu chifukwa ndinu mtsikana wa zaka za zapakati 15-17, muli pa sukulu komanso mumakhala mu dera lonwefone.

Ngati mungavomereze kutenganawo mbali pa kafukuiku yu, tikupephanzi kuti mukhale pa malo panokha (podukamphepo) pamodzi ndi anzanu amišikhu yanu omwenso aipa pa Sukulu. Tifunsu guulu lanulo zomwe mukudziwa ndi kugariza zokhudziana ndi nthito za uchembere wa bwino wa achinyama mu dera lanu lino. Tikufunsaniso mmene nthito zmenezi zingakonzedwere bwino kuti anthy ngati inu mungathe kuigungwiritsa nthito. Sitikufunsanani ngati inuyo mumagwiritsa nthito njira zmenezi. Tikufunsanani ngati anthy amišikhu yamu yamu amaigungwiritsa nthito kapena amafuna ataguwingwiritsa nthito njira zmenezi. Tikambilana zokhudziana ndi zinthu izi kwa maola awiri (2 hours)


Zmene takambilana panu zikhoza kuululika zitaapeza kuti zinthu zathu zabedwa kapena sizinasameille likuweru. Guulu imene likupanga kafukuiku ̣phunzilisa mmene lingateczere zokambiranza zathu. Akakhomera ma pepala onse komose zodabira/kutepera mawu mu chikwama ndi kusunga pa bwino kuti zisaululike.

Pailibizishandizipo thekerekera potenga nawo mbali pa kafukuiku. Koma tikuhulupili kuti zimene tiphenzire kwa inu zithandiza unduna wa za umoyo kukonzaro ndondomeko za umoyo wa anthu a misiniku yanu.


Melissa Marx, FGD_femaleminorinschool_ASSENT
Pa mapeto a zokambrana zathuza tipeleka zakumwa zoziilitsa kukhosi ndi kubweza ndalama zomwe mwayendera phwera kuwo ngati munatero. Mukhoza kulandira zakumwa zoziilitsa kukhosi ndi kubwezeredwa ndalama zomwe mwayendera ngakhale mutavomera kutenga nawo mbalu pa kafukufukuyu kensko ndi kusintha maganizo kusaptiiliza nawo kafukufukuyu.

Musanavomereze kutenga nawo mbalu pa kafukufukuyu, tikufuna tikuyankheni mafunso amene mulinawo.

Ngati mungakhle ndi mafunso panopo kapena mutameliza kafukufukuyi, muttha kulumikizana ndi Melissa Marx pa mmars@jhu.edu kapena kusimba lamya pa nambala iyi +01 410 502 1942.

Ngati mungafune kuyankhula ndi wina alyense pa chilichanse kuphatikizapo mavuta kapena nkha wa zamu, muttha kulumikizana ndi U.S. kapena Malawi Ethics Committee amene anavomereza kafukufukuyi.

Malawi Research Ethics Committee
National Health Sciences Research Committee Ministry of Health P.O. Box 30377 Lilongwe 3 MALAWI
Tel: +265 1 789400/414 Fax: +235 1 789 527/536 Email: doccentre@malawi.net

Johns Hopkins Bloomberg School of Public Health
615 N. Wolfe Street, Suite E1100 Baltimore, MD 21205
Telephone: 410-955-3193 Toll Free: 1-888-262-3242 Fax: 410-502-0584
E-mail: HHHIrroffice@jhu.edu

Kusayina kapena kudinda pa form kukutanthaaza kuti:
• Mwasuizida za cholina, ndondomeko, cholowa ndi zovuta za kafukufukuyu.
• Mwapsidwa mwayi ofunsa mafunso musanasyine.
• Mwawomera mwa ufulu kutenga nawo mbalu pa kafukufukuyu
• Mwawomera kujambudiwana mawu pa kafukufukuyu.
Ma initial a munhu mukucheza naye

Tsiku

Muuzeni munhu emene mukucheza naye kuti adinde chala chake chachikulu cha ku mazere mu box iyi
ngati sangathe kusina pamwambapo

LEMBANI ZOKHUDZA MBONI NGATI CHIDINDO CHAGWIRITSIDWA NTCHITO

Dzina ia mbon

ya mboni

Tsiku

Dzina ia munhu amene akufusa mafuso

ya munhu amene akufusa mafuso

Tsiku
Parental Consent - English

FGD_femailminorinschool_PARENTCONSENT

PI Name: Melissa Marx
Study Title: Youth friendly reproductive health provision preferences among youth, parents, and health providers in Malawi
IRB No.: 7246
PI Version/Date: Version 2, July 10, 2016

We want to talk to you about a research study we are doing. A research study is a way to learn information about something. We would like to find out more about youth friendly reproductive health services in Malawi. We are asking your daughter to join the study because she is a female between 15-17 years old, who is in school and lives in this community.

If you and your daughter agree that she can join this study, we will ask her to sit in a private place with other young women her age who are also enrolled in school. We will ask the whole group what they know and think about youth friendly reproductive health services in your community. We will also ask how these services could be improved so people like your daughter would want to use them. We will not ask your daughter if she uses these services. We will ask if people like your daughter use them or want to use them. We will talk about these things for about 2 hours.

Talking about reproductive health services in a group might make your daughter uncomfortable. She does not need to answer any question that makes her feel uncomfortable. She can say no to answering any question that we ask. Your daughter does not have to talk about anything she does not want to talk about. Your daughter can ask to leave the discussion group any time for any reason. She can just say she wants to leave.

We would like to audio record this interview. Taping it helps us remember clearly what everyone said. We will just tape your daughter’s voice. We will not ask her to give her name on tape. She can ask the interviewer to stop the tape at any time.

It is possible that your child’s privacy may be breached in the event that data is lost, stolen, or handled improperly. The study team will be trained to protect your privacy. They will lock all paper documents and recorders in a backpack and securely store all documents and files to help protect you.

Being in this study will not help your daughter directly. But we hope what we learn from her will help the Ministry of Health to improve health programs for people like her.

Your daughter does not have to join this study. It is up to you and her. You can both say yes now, and change your minds later. You or your daughter just have has to tell us. No one will be mad at you or your daughter if you or she changes your minds.

At the end of the group discussion we will give your daughter a small snack and repay travel costs if she had them. She can have snacks and transport reimbursement even if she says yes to be part of the study but changes her mind later. You can have a snack and travel costs too.

Melissa Marx, FGD_femailminorinschool_PARENTCONSENT_V2
We will tell your daughter about the study and ask her permission to participate only if you say it is okay. Before you say yes to allowing her to join this study, we want to answer any questions you have.

If you want to ask someone else questions now or after she takes part, you can contact Melissa Marx at mm Marx@jhu.edu or +41 40 952 1942.

If you want to talk to someone else about anything, including problems or concerns, you can contact the U.S. or Malawi Ethics Committees that approved this study:

Malawi Research Ethics Committee
National Health Sciences Research Committee Ministry of Health P.O. Box 30377 Lilongwe 3 MALAWI
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615 N. Wolfe Street, Suite E1100 Baltimore, MD 21205
Telephone: 410-955-3193 Toll Free: 1-888-262-3242 Fax: 410-516-0584
E-mail: JSPH.irbOffice@jhu.edu

Your initials (or thumbprint/mark) on this form means:
- You have been told about the purpose, procedures, possible benefits & risks of this study.
- You have been given the chance to ask questions before you sign.
- You have voluntarily agreed to allow your daughter to be in this study.
- You say we can record this interview if your daughter also agrees.

Initials of parent/legal guardian  Date

Ask the participant to mark a “left thumb impression” in this box if the parent is unable to provide a signature above.

SIGN BELOW ONLY IF THUMBPRESS USED

Name of Witness  Signature of Witness  Date

Name of Person Obtaining  Signature of Person Obtaining Consent  Date

Melissa Marx, FGD_femaleminorinschool_PARENTCONSENT_V2
Parental Consent – Chichewa

PI Name: Melissa Marx
Study Title: Youth friendly reproductive health provision preferences among youth, parents, and health providers in Malawi
IRB No.: 7246
PI Version/Date: Version 2, July 10, 2016

Tikufuna tikambirane nanu za kafukufuku amene tikupanga. Kafukufuku ndi njira imene timaphunzilira zinhuzi zina ndi zina. Tikufuna tifuwe zambiri za nthitho za uchembele wabwino wa a chinyamata mimalawi muno. Tikufuna tikupempheni kuti mwana wawu wa mkazi atenge nabo mambilawo mambil awo kafukufukuyu chifukwa ndi mtisika wa zaka zapa kati pa 15-17, ali pa Sukulu ndi popo amakhala mdele lino.

Ngati inu ndi mwana wawu wa mkazi mwavomera kutenga nabo mambilawi pa kafukufukuyu, timufunsu kuti akhalale pa ma ne podukanephepo pamodzi ndi atsilika amisinthu yake amenenso ali pa Sukulu. Tifunsu gulu lonse zimene akudziwa ndi kuganiza zokhutuzana ndi uchembere wabwino wa a chinyamata mu cera lanu lino. Tifunsanso mmene nthitho zimenezi zingapititsidwiwe pa tsogolo kuti anthu ngati mwana wawu angafuna kudigwiritsa nthitito. Stimufunsu mwana tambi ngati magwiritsa nthitho njira za uchembele wabwinozi. Tifunsu ngati anzake omagwiritsa nthitho njirazi kapena ngati anzakewo amafuna atagwiritsa nthitho njirazi. Zokambiranazi zitenga maola awiri (2 hours)


Zimene takambilina pano zikoza kuvela kuziterve kuti zinthu zathu zabeza kappen szizasamalilikwe mokwana. Gulu limene likupanga kafukufuku lipunziidwa mmene lingatetere zokambiranza zathu. Akakhomera na pepala osse komaso zodabira/katukera mawu ma chikwanadzi ku ngungu pa bwino kuti zisaluwile.

Palihe thandizo lopezekera tu limene mwana wawu angapeze potenga nabo mambilawi pa kafukufukuyu. Koma tikukulupilira kuti zimene tipehunziire kuchokera kwa lye yo zithandiza unduna wa za umoyo kukonzanso ndondonkwe za umoyo wa anthu a misionthu yake.

Pa mapeto a zokambirana zathu tipeleka kwa mwana wanu zakumwa zozilitsa kukhosi ndi kubweza ndalama zomwe wayendera pobwera kuno ngati anatero. Akhoza kulandira zakumwa zozilitsa kukhosi ndi kubwezeredwa ndalama zomwe wayendera ngakhale atavomera kutenga nako mbali pa kafukufukuyo kena ndi kusintha maganizo kusapitiza nako kafukufukuyo. Nanunso mulandira nako zozilitsa kukhosi ndi kubwizeledwa ndalama zomwe mwawendera.

Timufotokoza mwana wanu za kafukufukuyo ndi kumufuna kuti atenge nako mbali ngati iruyo mwavomera. Musanavomera kumulidza mwana wanu kutenga nako mbali pa kafukufukuyo, tikufuna tiyankhunzo mfunso onse amene mulawo.

Ngati mungakhale ndi mafunso panopopana kapena atamaliza kafukufukuyo, mutha kulumikizana ndi Melissa Marx pa mmarx@hsc.edu kapena kuyinka 'amwa pa rambala iyi +01 410 502 1942.

Ngati mungafune kuyankhala ndi wina alyense pa chilichonse kus-fitikizepo mavuto kapena nkha wa zani, mutha kulumikizana ndi U.S. kapena Malawi Ethics Committee amene anavomereza kafukufukuyo.

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Melissa Marx, FGD_femaleminorschool_PARENTCONSENT
Kusayine kapena kudinda pa form kukukuntha kuta kuti:

- Mwauzdwa za cholinga, ndondomeko, cholowa ndi zovuta za kafukufukuyu.
- Mwapatsiwa mwayi cfunsa mafunso musanasyine.
- Mwapomera mwa ululu mwana wamu kutenga nawo mbai pa kafukufukuyu
- Mwapomera kuti tijambule mawu pa kafukufukuyu ngati mwana wamu wawomera.

Ma Initial a kholo kapena wankulu wa panyamba

Muuzeni munthu amene mukuchena naye kuthi adinde chala chake chachikulu cha ku mazere mu box iyi ngati sangathe kusaina pamwambapo

LEMBANI ZOKHUDZA MBONI NGATI CHINDIYO CHAGWIRITSIDWA NTCHITO

Dzina la mboni

ya mboni

Tsku

Dzina la munthu amene akufusa mafuso

ya munthu amene akufusa mafuso

Tsku
<table>
<thead>
<tr>
<th>Theme</th>
<th>Code</th>
<th>Subcode</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FP Knowledge, Information, and Availability</strong></td>
<td>Method pros and cons</td>
<td>Condom Pro</td>
<td>Participants own beliefs about the pros and cons specific family methods, these can also be misconceptions.</td>
</tr>
<tr>
<td></td>
<td>Condom Con</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pill Pro</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Pill Con</td>
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<td></td>
<td>Injection Pro</td>
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<td>Injection Con</td>
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<td>Implant Pro</td>
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<td>Implant Con</td>
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<td></td>
<td>Abstinence Pro</td>
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<tr>
<td></td>
<td>Abstinence Con</td>
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<td></td>
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<tr>
<td></td>
<td>Other Con</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Pro</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contraception misconceptions</strong></td>
<td>Condom misc.</td>
<td></td>
<td>Views and opinions about specific contraceptive methods that result from a misunderstanding or inaccurate information about the method.</td>
</tr>
<tr>
<td></td>
<td>Pill misc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injection misc.</td>
<td></td>
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<tr>
<td></td>
<td>Implant misc.</td>
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<tr>
<td></td>
<td>Abstinence misc.</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Other misc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Services Availability</strong></td>
<td></td>
<td></td>
<td>The FP services that participants mentioned being available in their communities.</td>
</tr>
<tr>
<td><strong>Institutional counseling</strong></td>
<td></td>
<td></td>
<td>Youth learn about FP issues from institutional settings: schools, health workers, NGOs, and youth clubs. This is the content of the counselling they receive about FP from those sources.</td>
</tr>
<tr>
<td><strong>Medium of Communication</strong></td>
<td></td>
<td></td>
<td>How family planning messaging is delivered or should be delivered to best reach youth. For example, radio or posters.</td>
</tr>
<tr>
<td><strong>Provider/institutional barriers</strong></td>
<td>HW Treatment</td>
<td></td>
<td>The attitude of the health worker when dealing with youth. This can come from any participant’s own experiences or when someone describes</td>
</tr>
<tr>
<td><strong>Provider/institutional barriers (continued)</strong></td>
<td></td>
<td>how health workers should be/are treating youth.</td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td></td>
<td>When the cost of receiving FP methods is discussed. This can also include non-financial costs (time, sexual favors), transport costs, and other indirect costs.</td>
<td></td>
</tr>
<tr>
<td>Stock out</td>
<td></td>
<td>Stock outs of FP commodities from all perspectives.</td>
<td></td>
</tr>
<tr>
<td><strong>HW Barriers</strong></td>
<td></td>
<td>Health workers barriers to providing family planning services. These can include lack of time, busy work loads, policies, stock outs etc. It is likely other codes will overlap with this code.</td>
<td></td>
</tr>
<tr>
<td><strong>HW Training</strong></td>
<td></td>
<td>Training and supervision that health workers are receiving about family planning for youth and the kind of training/supervision that HWs need. Use this only when it is explicitly mentioned.</td>
<td></td>
</tr>
<tr>
<td><strong>Youth Barriers</strong></td>
<td><strong>Distance</strong></td>
<td>This has to do with the physical distance to services only. They may mention they prefer (location) because it is closer, in which case it should be coded as location and distance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Stigma/discrimination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Age</strong></td>
<td>Stigma/discrimination based on age</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Sex</strong></td>
<td>Stigma/discrimination based on sex</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Marriage</strong></td>
<td>Stigma/discrimination based on marriage</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Fear/exposure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other personal barriers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Societal Influences</strong></td>
<td><strong>Peer</strong></td>
<td>Youth learn about FP and FP issues from their peers. This is the content of what they learn from their peers and the role of these peer networks play.</td>
<td></td>
</tr>
<tr>
<td><strong>Societal Influences (continued)</strong></td>
<td><strong>Family and Community</strong></td>
<td><strong>Parent</strong></td>
<td><strong>Religion</strong></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>--------------------------</td>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>Youth learn about FP and FP issues from their family and community. This is the content of what they learn from their family and community and the role these networks play. This includes community based organizations and NGOS. DO NOT INCLUDE CHURCHES, SCHOOLS OR PARENTS</strong></td>
<td><strong>Parents play an important role in family planning for youth. These are the ways in which parents are supportive and unsupportive of youth accessing, utilizing, and learning about FP services. This also includes the content of that information and the role parents should play.</strong></td>
<td><strong>Religion and religious denominations play supportive and unsupportive roles in regards you youth accessing, utilizing, and learning about FP services.</strong></td>
<td><strong>Descriptions about FP or sexual and reproductive health in a school setting or ways that schools should be involved in FP.</strong></td>
</tr>
<tr>
<td><strong>HW Motivation</strong></td>
<td><strong>HW’s motivations for providing family planning services. These are from HWs only.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Norms</strong></td>
<td><strong>Gender Role</strong></td>
<td>Roles that women and men play or are expected to play in family planning decision making. Expectations for men and women in regards to family planning.</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>----------------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Family Size</strong></td>
<td></td>
<td>Preferred family size and the reasons for those preferences.</td>
<td></td>
</tr>
<tr>
<td><strong>Marriage Ages</strong></td>
<td></td>
<td>Preferred marriage ages and the reasons for those preferences.</td>
<td></td>
</tr>
<tr>
<td><strong>Birth Ages</strong></td>
<td></td>
<td>Preferred ages for first birth and the reasons for those preferences.</td>
<td></td>
</tr>
<tr>
<td><strong>Preferences</strong></td>
<td><strong>Organization Preference</strong></td>
<td>Preferences for certain organizations that provide family planning services. The characteristics of the organizations that are specifically mentioned as to why they are preferred. This could include costs, reliability, distance - often it will be double coded.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>HW Preference</strong></td>
<td>Youth's preferences for the characteristics (age, sex, etc.) of health workers. This does not have to do with HWs organization or their of youth.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Location</strong></td>
<td>The preferred location of accessing family planning services and the reasons associated with the preference. For example, they prefer hospital because it is private or they prefer in community because it is closer.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Contraceptive Preference</strong></td>
<td>Preferences for certain contraception methods and their reasons.</td>
<td></td>
</tr>
<tr>
<td><strong>Quality of care</strong></td>
<td></td>
<td>Health Workers descriptions of how they deal with clients when presented with different scenarios.</td>
<td></td>
</tr>
<tr>
<td><strong>Suggestions for improving services</strong></td>
<td></td>
<td>Ideas for improving FP utilization and access.</td>
<td></td>
</tr>
</tbody>
</table>