



KAMUZU COLLEGE OF NURSING

**PERCEPTIONS OF HEALTHCARE PROVIDERS ON THE PROVISION OF
CONTRACEPTIVES TO ADOLESCENTS AT MITUNDU COMMUNITY HOSPITAL,
LILONGWE**

MSc (REPRODUCTIVE HEALTH) THESIS

BY

Linda Kachigamba Chimbalanga

(BSc & UCM, UNIMA)

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requirement of the Master's Degree in Reproductive Health

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Declaration

I, **Linda Kachigamba Chimbalanga**, hereby declare that this thesis is my own original work which has not been submitted for any other awards to the University of Malawi or any other University for similar purposes. Acknowledgements have been made where other people's work has been used.

LINDA KACHIGAMBA CHIMBALANGA

Full legal name

Signature

Date

Certificate of Approval

The undersigned certify that this thesis represents the student's own work and effort and has been submitted with our approval.

Signature _____ Date _____

Dr. E. Mkwinda

Main supervisor

Signature _____ Date _____

Mrs. Annie Namathanga

Second Supervisor

Dedication

To my lovely husband, Yohane, and kids for your love, support, and for trusting in me.

To my dearest parents, Alick and Elizabeth, thank you very much for your endless support and encouragement throughout my school life.

May Jehovah continue blessing you all!

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Abstract

Contraceptive use among adolescents is still low in Malawi and Mitundu community hospital catchment population is not an exception. This has contributed to increased adolescent pregnancy rate which contributes to obstetric complications and high abortion rates among adolescents. Several barriers are contributing to adolescents' underutilization of contraceptive methods and one of them is unfriendly attitudes of healthcare providers in the provision of contraceptives to adolescents. The purpose of this study was to explore the perceptions of healthcare providers on the provision of contraceptives to adolescents at Mitundu community hospital. The following were the objectives of the study; to explore healthcare providers' views towards the provision of contraceptives to adolescents and to identify challenges that healthcare providers encounter in the provision of contraceptives to adolescents.

A qualitative descriptive study was conducted among healthcare providers who are working at Mitundu community hospital. The study recruited 10 participants through purposive sampling method. A semi-structured interview guide was utilized to collect data which was analyzed using thematic analysis. The findings revealed that most of the healthcare providers were uncomfortable to provide contraceptives to adolescents due to various perceptions which they hold. Some of the perceptions established were contraceptive provision influences adolescent sexual behavior, fear of contraceptives side effects, and the idea that condoms only and not hormonal contraceptives are for adolescents. This posed a dilemma among providers to balance their personal beliefs and professional roles hence they prescribed condoms and abstinence to adolescents who went to the hospital seeking contraceptive methods. Despite this, healthcare providers face different challenges when providing contraceptives to adolescents, and these include lack of privacy, shortage of staff, and unavailability of hormonal contraceptives. As such,

the researcher recommends that Reproductive Health Directorate and District management organize training on Youth Friendly Health Services for nurses and the clinical team. It is also important that they should provide supportive supervision and get regular updates on adolescents' uptake of contraceptives. It is also necessary that Mitundu Community Hospital management should lobby for more staff to work in the youth centre. The study findings may provide a basis to carry out a similar study in a similar setting on a larger scale to make the transferability of the findings possible.

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List of Abbreviations

COMREC: College of Medicine Research Ethics Committee

MDHS: Malawi Demographic Health Survey

HMIS: Health Management Information System

KCN: Kamuzu College of Nursing

WHO: World Health Organization

YFHS: Youth Friendly Health Service

SRH Sexual Reproductive Health

DMPA Depomedroxyprogesterone Acetate

Operational definitions

Healthcare provider: Healthcare worker who was trained in providing contraceptives to adolescents.

Adolescents: In this study, is a young person in the process of developing from childhood to adulthood within the age ranges of 10 to 19 years.

Obstetric complications: Conditions or pathological processes associated with pregnancy. They can occur during pregnancy, delivery, or after delivery. They range from minor discomforts to serious diseases that require medical interventions.

Perceptions: The way of understanding, interpreting, and conceptualizing or viewing a phenomenon. In this study, perceptions entail how healthcare providers understand, interpret, or view the provision of contraceptives to adolescents.

Contraceptive: A device or drug serving to prevent pregnancy. In this study, contraceptives focus on hormonal and long-acting contraceptive methods.

Youth Friendly Sexual and Reproductive Health Services (YFSRHS): High-quality Sexual and Reproductive Health services that are relevant, accessible, attractive, affordable, appropriate, and acceptable to the young people.

CHAPTER 1

Introduction and Background

1.1 Introduction

Adolescents constitute a large and growing segment of many societies. According to the World Health Organization (WHO), adolescents are individuals between the ages of 10 and 19 years (World Health Organisation, 2017). Adolescents experience a period of transition from childhood to adulthood, which is characterized by dramatic biological and social changes. Among the biological changes, adolescents start feeling the urge to have sex as early as 10 to 15 years when they are still at school. As a result, they usually face a lot of problems such as unplanned pregnancies, Sexually Transmitted Infections, HIV/AIDS, school dropouts, and early marriages.

Therefore, increased attention on their development is essential as it relates to their sexual and reproductive health (Bankole & Malarcher, 2010; Patton & Viner, 2007). However, despite adolescents' acute need to access comprehensive sexuality information and health services, resistance to providing adolescents with sexual and reproductive services by the healthcare providers continues in many countries. This results in an increased risk of unintended pregnancies among adolescents (Bankole & Malarcher, 2010).

Adolescent pregnancy remains a major contributor to maternal deaths, child mortality, and poverty. Worldwide, about 16 million adolescents aged 15 to 19 years and 1 million girls under 15 years give birth every year (World Health Organisation, 2014). Among these adolescents, 95 percent live in the developing world and the highest number being Sub-Saharan Africa (World Health Organisation, 2008; Tilahun et.al., 2012a). Malawi has the highest adolescent fertility rate as compared to other countries in Sub-Saharan Africa which has also

contributed to early childbearing among adolescents. Millennium Development Goals end line survey indicated that there were 143 births for every 1,000 women occurring among the adolescents aged 15-19 years (NSO, 2014). This figure surpasses the 2010 WHO African Region estimate of 118 births for every 1,000 women aged 15-19 years (Ministry of Youth and Sports, 2013). Babies who are being born from these adolescents are at a higher risk of dying than those born from women who are 20 years and above due to premature delivery. Adolescents may also develop obstetric complications due to delay in antenatal and intrapartum care (World Health Organisation, 2018). The obstetric complication which they experience includes unsafe abortion, obstructed, and prolonged labour which may lead to vaginal and rectal fistulas (World Health Organisation, 2014).

Addressing adolescent sexual reproductive needs remains an important challenge to prevent unsafe and risky behaviors among adolescents which may result in unwanted pregnancies. The provision of contraceptive methods to adolescents has several benefits such as reducing the risk of Sexually Transmitted Infections (STIs) and unintended pregnancies which promote a healthy transition to adulthood. Despite the benefits of contraceptive use in adolescents, there is still underutilization of the contraceptive methods by adolescents in most African countries (Tilahun, et al., 2012). In Malawi, the current use of contraceptive methods among unmarried adolescents aged 15 to 19 is 30 percent (Ministry of Health, 2016). In contrast, Mitundu rural hospital has been reporting high teenage pregnancies with fewer adolescents utilizing contraceptive methods. According to the Mitundu Health Information System report (2016), about 16,124 teenage pregnancies were reported with 221 teenagers who accessed contraceptives in that year. Mitundu has a total teenage population of 63,840. This shows that most adolescents who are sexually active were not using contraceptives. This study

focused on the perceptions of healthcare providers on the provision of hormonal contraceptive methods which are mostly used by the girls and accessed at the hospital. Some adolescent boys access condoms at the facility but it is difficult to explore perceptions of healthcare providers since they mostly access them through non-healthcare providers or collect them from strategic areas where they are placed around the hospital premises.

Active participation of healthcare providers in provision of contraceptives may assist sexually active adolescents to use contraceptive methods due to youth-friendly services which may be offered to adolescents that help them to access the services without fear. Despite healthcare workers being expected to guide the sexually active adolescents in the utilization of contraceptive services, studies have shown that healthcare providers are some of the barriers to adolescents in accessing contraceptive methods (Calhoun et al., 2013; Chilinda et al., 2014; Hagey et al., 2015; Tilahun et al., 2012b). Mitundu community hospital has the infrastructure for providing Youth Friendly Health Service (YFHS). In spite of this, healthcare providers from Mitundu reported that they were not using it to provide services and adolescents were accessing contraceptive services in the same room and at the same time with older women.

Healthcare providers seem to have their own beliefs about contraceptives for adolescents that they can promote promiscuity among adolescents (Calhoun et al., 2013). Therefore, the perceptions, beliefs, and attitudes of healthcare providers may influence the care they provide to adolescents (Breheny & Stephens, 2007). There is a need to support healthcare providers by equipping them with knowledge and skills for them to address adolescent reproductive health needs.

Despite the above information on the negative attitudes of healthcare providers in most African countries, there is a knowledge gap on the perceptions of healthcare providers on the

provision of contraceptives to adolescents in Mitundu, Lilongwe. Hence the study explored the perceptions of healthcare workers on the provision of contraceptives as this can affect utilization of the services by the adolescent population.

1.2 Background

Healthcare providers are considered to be the source of scientific information on sexual and reproductive health issues. They deal directly with the public and have power in determining how policies and guidelines are implemented. Healthcare providers are usually involved in contraceptive method selection for adolescent clients by making decisions on the type of contraceptive methods to take despite being eligible for all contraceptive methods as they often feel shy, embarrassed, anxious, and socially vulnerable (Olivari et al. 2015).

Adolescents are still facing challenges in contraceptive use despite available policies, trained providers, and standards (Biddlecom et al., 2007; Jayachandran, Chapotera & Stones, 2016; World Health Organization, 2012). Utilization of contraceptives among adolescents in Malawi and other Sub-Saharan Africa countries is affected by several factors ranging from those arising from the adolescents themselves, coverage of YFHS, infrastructure, societal beliefs and norms, health providers' attitude, and the way the activities are run at a particular health facility. Most of the studies have shown that health providers show a poor attitude towards young people accessing YFHS (Chilinda et al., 2014). These attitudes range from being judgmental to adolescents, refusing to offer the services, unfriendly healthcare providers, providers' rudeness to adolescents, not keeping information given to them by the youth in confidence and lack of privacy (Biddlecom et al., 2007; Calhoun et al., 2013; Jayachandran et al., 2016; Mwenyongo, 2010; Mbeba et al., 2012).

Due to the national increase of teenage pregnancies rate, the Malawi Ministry of Health and Population decided to make reproductive health services youth-friendly (Bearinger, Sieving, Ferguson & Sharma, 2007). In 2002, the Malawi Ministry of Health launched a new national Reproductive Health Program with the goal of promoting accessible reproductive health services through informed choice and safer reproductive health practices for young people and also to increase the use of high-quality reproductive health services. As part of formalizing the initiative, the Malawi government formalized the guidelines for healthcare (Bearinger et al. 2007; Ministry of Health, 2014). To continue supporting the healthcare providers to provide youth-friendly health services, the government of Malawi in 2007 launched the youth friendly health service program where most of the healthcare providers were trained on youth friendly services (Jayachandran et al., 2016). Youth Friendly Health Services are defined as high-quality services that are relevant, accessible, attractive, affordable, appropriate, and acceptable to young people (Ministry of Health, 2007). Sexual and reproductive health services included in the YFHS package include; provision of contraceptives, management, and treatment of STIs, provision of Post Exposure Prophylaxis, HIV Counselling, and Testing, Peer education on HIV/AIDS and other SRH problems affecting them, Anti-Retroviral Therapy (ART), Prevention of Mother To Child Transmission of HIV (PMTCT), Nutrition Education Information and Counselling, Childbirth and postnatal care, Post abortal care, and Antenatal Care.

In spite of the stipulated efforts of them healthcare in YFHS, healthcare providers seem to have negative attitudes in providing services to adolescents. This was reflected in assessment findings of YFHS in Malawi which indicated that healthcare providers who were not trained in Youth Friendly services were more able to provide quality youth-friendly healthcare to the adolescents than those who were trained (Jayachandran et al., 2016). This was evidenced in the

number of adolescents who reported having been encouraged to ask questions during consultations by untrained healthcare providers (Jayachandran et al., 2016). In contrast, Godia, et al., (2013) found that youth-friendly trained nurses and midwives disapprove of premarital sex, and the use of contraceptive methods among adolescents. This shows that training does not have much impact on healthcare providers' attitudes.

Healthcare providers are reluctant to provide contraceptives to adolescents due to their religious and ethical beliefs (Ceva & Moratti, 2013; Trenholm et al., 2008). Most of the healthcare providers would propose and sometimes impose sexual abstinence before marriage in support of their beliefs (Ceva & Moratti, 2013). However, research evidence has found that condoms and contraceptives education are more effective in reducing premature sexual activity among sexually active adolescents than abstinence-only education (Trenholm et al., 2008).

Healthcare providers seem to be torn between personal values, beliefs, and their wish to respect young people's rights to accessing and obtaining SRH services (Godia, et al., 2013). Literature pointed out that healthcare providers showed unfavorable attitudes towards the provision of contraceptives for adolescents. Two studies carried out in Nigeria and Sri Lanka found that healthcare providers feel uncomfortable to discuss contraception with adolescents because of their religious and ethical beliefs (Dawson et al. 2014; Nalwadda, et al., 2010). In addition to this, in Sierra Leone, Uganda, Lesotho, and urban Uttar in India, healthcare providers were uncomfortable providing contraceptives to adolescents under the age of 18 as they believed that adolescent contraceptive use may lead to promiscuity. As a restrictive measure, adolescents were asked to report to the hospital with their parents or sexual partners (Ahanonu, 2014).

Both doctors and nurses were practicing restriction of adolescent contraception. Calhoun et al. (2013) found that almost 50 percent of the doctors and 70 percent of the nurses respectively

restricted the adolescents use of pills, condoms, and IUCD and the age range for the provision of contraceptive methods was from 18 to 21 years (Calhoun et al., 2013). Judgmental views by contraceptive service providers coupled with the lack of privacy inhibit adolescents from seeking contraceptive services or using contraceptive methods (Nalwadda et al., 2010). Sexually active adolescents are still at an increased risk of early and unwanted pregnancies due to the low utilization of contraceptives.

Healthcare providers are placed to guide policies and ensure contraceptive provision for all people who have unmet needs. Most of the studies which were done in Africa were on healthcare providers' attitudes towards contraceptive use among adolescents. Healthcare providers' unfriendly attitudes may exist at Mitundu which may have contributed to fewer adolescents utilizing contraceptive methods resulting in increased adolescent pregnancy rates. This study was aimed at exploring the healthcare providers' perceptions on the provision of contraceptives to adolescents.

Perceptions is the way of understanding, interpreting, and conceptualizing or viewing a phenomenon (Collins & Quan-Haase, 2012). In this study, perceptions entail how healthcare providers understand, interpret, or view the provision of contraceptives to adolescents.

1.3 Problem statement

Despite the Malawi government's Ministry of Health efforts in introducing Youth Friendly Health Services (YFHS) in most of the health facilities, there is still under-utilization of contraceptives among adolescents. Nationally, 33.7 percent of sexually active adolescents are currently using contraceptive methods (National Statistical Office, 2017). Mitundu Rural Hospital has been reporting high numbers of adolescent pregnancies from its catchment area. According to Mitundu HMIS reports (2016); 16,124 adolescent pregnancies were reported and

221 adolescents accessed contraceptive methods in that year (Mitundu HMIS, 2016). There are several factors which could be barriers towards adolescents' utilization of contraceptive methods and one of them is unfriendly attitudes of healthcare providers in the provision of contraceptive methods to adolescents (Calhoun et al., 2013; Chilinda et al., 2014; Hagey et al., 2015). Most of the studies conducted focused on attitudes of healthcare providers towards the provision of contraceptives to adolescents but their perceptions have not been adequately explored. This study intended to cover the gap by exploring perceptions of healthcare providers on the provision of contraceptives to adolescents at Mitundu community hospital as their perceptions may affect their attitudes in the provision of services.

1.4 Justification of the study

In this study, new knowledge on the perceptions of healthcare providers has been generated. In clinical practice, the knowledge gained would influence healthcare providers to offer evidence-based services to adolescents. Healthcare providers' knowledge of their perceptions may influence good practices in provision of contraceptives to adolescents. There has been wide literature search on adolescent contraceptive use and recommendations have been made based on findings. This will assist the healthcare providers to have good perceptions of adolescent contraceptives.

The study findings would also influence Reproductive Health Directorate to include issues on perceptions of healthcare providers as barriers in provision of contraceptives to adolescents when developing policies. This, in turn, can also influence the healthcare providers' practices and assist in promoting the provision of contraceptive services to adolescents in a friendly manner.

In education, the knowledge gained may be used when developing a new curriculum for healthcare providers in their respective training institutions. The nursing and medical curricula have the aspect of YFHS but they do not specifically include information on the perceptions of healthcare providers and how such perceptions influence the provision of contraceptives to adolescents by the healthcare providers.

The challenges faced by healthcare providers have been explored and addressed. This may also assist in improving adolescents' uptake of contraceptives. Therefore, utilization of the contraceptives by adolescents will assist in the prevention of unwanted adolescent pregnancies and obstetric complications which in return contribute to the reduction of maternal and neonatal deaths in Malawi. Since limited research has been done in Malawi in this area, this study findings may provide a basis where people can carry out a similar study in another setting on a larger scale.

1.5 Broad Objective

The main objective of this study was to explore perceptions of healthcare providers on the provision of contraceptives to adolescents at Mitundu community hospital in Lilongwe, Malawi.

1.5.1 Specific Objectives.

- To explore healthcare providers' views towards the provision of contraceptives to adolescents.
- To identify challenges that healthcare providers encounter in the provision of contraceptives to adolescents.

CHAPTER 2

Literature Review

2.1 Introduction

This chapter presents a review of literature pertaining to the study on perceptions of healthcare providers on the provision of contraceptives to adolescents. The review was done in line with the study objectives. It focuses on the scope of the literature review, the search engines used, and the type of literature review. This is a narrative literature review with a critical analysis of the perceptions of healthcare providers on the provision of contraceptives to adolescents. Data were searched from relevant published books, electronic and paper-based journals. Hence, it was selective in the materials used. The reviewed period span was from 2008 to 2019. This was done to capture relevant and recent literature that would determine the relevance of the present study.

The following search engines were used to access literature; EBSCO Host, Google Scholar, HINARI, Pub Med, WHO database, and full free PDF for free scientific publications. Articles that were identified were used to retrieve other related published articles through their reference lists. In this literature search, the researcher also included studies done on attitudes of healthcare providers in the provision of contraceptives to adolescents because their results were also indicating the perceptions of healthcare providers as only a few studies were found to be strictly on perceptions of healthcare providers.

2.2 Adolescent pregnancies and contraceptive use

The young generation is experiencing different sexual and reproductive problems such as early marriages and adolescent pregnancies. Adolescent pregnancies are a global problem that occurs in high, middle, and low-income countries (World Health Organisation, 2018). Adolescent

birth rates range from as high as 115 births per 1000 adolescents in West Africa, 64 births per 1000 adolescents in Latin America and Caribbean, 45 per 1000 adolescents in the southeastern Asia, to 7 per 1000 adolescents in western Asia (World Health Organisation, 2014). In Malawi, 29 percent of the adolescents have already started childbearing at the age of 15-19 years (National Statistical Office, 2017). Malawi has the highest adolescent fertility in sub-Saharan Africa which has contributed to early childbearing in adolescents. According to the Millennium development goals end line survey, 143 births for 1000 women occur among the adolescents aged 15 to 19 years (“Malawi MDG Endline Survey 2014). Pregnancy rate among adolescents in developed countries is low due to high contraceptive use. The contraceptive prevalence rate among adolescents is highest in Latin America and the Caribbean at 51 percent, East Asia and the Pacific is at 38 percent and is lower in the west and central Africa at 7 percent (UNFPA, 2013). Similarly, Malawi registers high number of adolescent pregnancies among the youth. There is high percentage of unmet needs for family planning among adolescents aged 15 to 19 years estimated at 22 percent which is higher than the total unmet needs for family planning among childbearing groups in Malawi estimated at 19 percent (National Statistical Office, 2015) However, adolescents who are pregnant encounter different challenges as their bodies are still growing. They are at risk of anaemia, malaria, depression, postpartum hemorrhage, and obstetric fistula. Most women who develop an obstetric fistula (9 to 86 percent) develop the condition in adolescence as a complication of teenage pregnancy (Morris & Rushwan, 2015a).

Although there seems to be increased usage of contraceptives among adolescents in developed countries than in developing countries, there are discrepancies in developed countries due to differences in the use of long-term contraceptive methods. For instance, in the United States, 42 percent of adolescents aged 15 to 19 years who had sexual intercourse reported having

used some methods of contraception during their life time (Curtis, 2012). Despite the use of contraceptives during adolescence, adolescent pregnancies continue to increase in the United States than in other developed countries like France and the United Kingdom (Winner et al., 2012). One of the contributing factors is the inability to use effective long-acting reversible contraceptives (LARC) methods such as implants and IUCD which are proven to be the most effective pregnancy prevention options for women of all ages (Winner et al., 2012). Adolescents do not routinely use LARC methods due to health provider counseling and access barriers. Furthermore, there is a lack of clinician training and comfort in placing these devices for adolescent clients.

In Malawi, 68.8 percent of unmarried and sexually active adolescent girls report wanting a child in the next 2 years and only 37.0 percent of them are currently using contraceptive methods to prevent pregnancy (Bankole & Malarcher, 2010). Most of the literature has shown that adolescents often lack basic reproductive health information, knowledge, experience, and are less comfortable accessing Sexual Reproductive Health (SRH) services than adults (Tilahun et al., 2012; Kapito et al., 2012). Botha (2010) identified that knowledge on reproductive health information among adolescents in Malawi was almost universal; it was however revealed that although knowledge of SRH services such as contraceptives among adolescents in Malawi is universal this does not translate into the use of these contraceptives (Levandowski et al. 2012). This shows that knowledge about reproductive health information and existing SRH services does not guarantee access to these services but a combination of several factors act as facilitators to the utilization of SRH services by adolescents. Adolescents face barriers in accessing the contraceptives and one of them is the discriminatory behavior of healthcare providers. Studies were done in Kenya, Laos, and Zambia found one-half to two-thirds of providers unwilling to provide contraceptives to adolescents (Bankole & Malarcher, 2010). Worldwide healthcare

providers affect adolescents' utilization of contraceptives (Curtis, 2012). In Africa, providers have a negative attitude on the use of all hormonal contraceptive methods and long-acting contraceptives unlike in developed countries where provider barrier is on long term contraceptive methods (Winner et al., 2012)

2.3 Youth Friendly Health Services

Youth Friendly Health Services (YFHS) are services that are accessible, acceptable, and appropriate for adolescents and youths (Ministry of Health, 2016). In Malawi, YFHS are a key component of Malawi National Sexual and Reproductive Health Program and helps facilitate the attainment of family planning commitment to achieve a 60 percent contraceptive prevalence rate with a focused increase among ages 15 to 24 years by the year 2020 (Ministry of Health, 2016). The program was launched to promote high quality Sexual and Reproductive Health services among young people in Malawi in light of increased adolescent pregnancies. Despite the availability of YFHS in most health facilities in all districts in Malawi, there is low utilization of these services by adolescents. Additionally, negative attitudes of Healthcare Providers (HCP) who play a major role in the provision and utilization of Youth Friendly Sexual Reproductive Health Services (YFSRHS) by adolescents.

The evaluation results of 2013-2014 by Malawi Ministry of Health Reproductive Health Directorate (MOH-RHD) with assistance from USAID supported evidence to action project and the Centre for Social Research of the University of Malawi on YFHS facilities revealed that only 64 out of 266 sites assessed were ready for accreditation (USAID, 2014). It was revealed that only 31.7% of young people have heard about YFHS and 13% have ever used these services (Malawi Government 2014). Further findings point to the negative attitudes of providers as some of the reasons for discontinued use of the health services by adolescents. In spite of the negative attitudes

of healthcare providers, the findings established that most of the healthcare providers were trained in youth friendly health services; about 68 percent from health centers and 73 percent in hospitals reported to have been trained to offer YFHS. Similarly, Mitundu Hospital which has the infrastructure for youth-friendly services and some trained healthcare providers but the center is usually closed and is sometimes open with no trained health provider to offer services.

Literature indicates that most healthcare providers have knowledge in regard to youth friendly health services though they demonstrate different attitudes to adolescents' contraceptive provision. While this information was obtained regarding healthcare providers, there was no information on providers' perspectives as it was essential to learn from them since they were trained in the provision of youth friendly services but were not providing youth friendly health services.

2.4 Healthcare providers' attitude towards adolescent contraceptive use

A range of people have an influence on adolescent access to information and services including peers, parents, family members, teachers, and healthcare workers. Some argue that the single most important barrier to adolescent reproductive care is healthcare providers' attitude (Morris & Rushwan, 2015a). Many healthcare providers deter adolescents from accessing contraceptives because of a lack of respect or not taking their clients seriously (Blanc et al., 2009). Healthcare providers act as a barrier to care by failing to provide adolescents with supportive, non-judgmental, youth appropriate services (Morris & Rushwan, 2015a). Healthcare providers may affect the utilization of reproductive health services and quality of the care through their behavior and attitudes which they may display when providing care to adolescent groups (Jonas et al., 2017). As a result, adolescents choose not to access sexual reproductive health services in the future (Regmi et al., 2010).

Despite healthcare providers' attitudes towards adolescent contraception, research suggests that current contraceptive use prevents approximately 272, 000 maternal mortalities per year and if current family planning needs are met another 104,000 adolescent lives would be saved (Morris & Rushwan, 2015b). One major outcome of unmet needs of contraceptive use is unwanted pregnancy and consequently high levels of unsafe abortions and complications from pregnancy and childbirth which are the leading cause of deaths in girls aged 15 to 19 years in Low and Medium Income Countries (LMIC) (Chandra-Mouli et al., 2014a).

Healthcare providers seem to have different beliefs about adolescent contraceptive use which also affects their provision of care. Misperceptions and continued adherence to traditional norms influenced their ambivalence (Xiaowen & Nian, 2008). The social-cultural norms and beliefs associated with sexuality also contribute to different attitudes that providers have towards the provision of YFSRHS to adolescents. Issues of sexuality in most African countries are not openly discussed with adolescents as it is believed that discussion of such promotes sexual experimentation and there is lack of appropriate language to use during the discussion due to the age range differences (Motsomi et al., 2016). This belief also affects how providers give information in regards to sexual and reproductive health services to adolescents. Gondwe, (2008) recommended that although discussing sex is difficult considering our cultural context, it is important for healthcare providers to listen to the sexual problems that young people have so that they can offer proper advice. Mwalabu et al. (2017) observed that majority of young women living with perinatally acquired HIV in Malawi were not open to talk about their sexual issues to providers for fear of being discovered to be sexually active and did not disclose their sexual information. Instead, some pretended to conform to societal expectations since they knew that service providers disapproved of their sexual activity.

Chilinda et al. (2014) in their systematic reviews of studies on healthcare providers' attitudes towards sexual and reproductive health services in developing countries revealed that healthcare providers felt that the early sexual debut of the adolescents is due to the easy availability of contraceptives in the clinics. Healthcare providers were denying adolescents Sexual and Reproductive Health Services and were being told to be accompanied by their parents to access the services. Another study done in Calaba alluded that 75.8 percent of healthcare providers had a positive attitude in the provision of contraceptives to adolescents (Samson-Akpan & Ahanonu, 2009). Despite being in support of adolescent use of contraceptives, they had their restrictions in practice such as saying that adolescents should abstain from sexual intercourse, adolescents age should determine the need for contraception, providing contraceptives promotes promiscuity and unmarried adolescents need parental consent (Samson-Akpan & Ahanonu, 2009). This brought fear in adolescents to access sexual and reproductive services. Despite the different attitudes that providers have against the use of contraceptives by the adolescents, adolescents have a right to access Sexual and Reproductive Health Services and they should not be denied the services. Many studies linked adolescents' on-use of SRH services to social, structural, economic, and psychological factors. However, these factors tend to differ from the perspective of adolescents and service providers. Seventeen studies from the review of the literature identified social barriers as one of the obstacles to adolescents' access to SRH services. A cross-sectional study that compared the views of sexual health service providers with those of adolescents themselves found that service providers always feel confidentiality, lack of awareness of available SRH services, cost of treatment, geographical location, hours of service operation as a hindrance for them to access sexual healthcare (Agyemang, et al., 2019). Therefore, healthcare providers' negative

attitudes in the provision of contraceptives to adolescents could be influenced by their perceptions towards adolescent contraceptive use.

2.5 Perceptions of healthcare providers on adolescent contraceptive use

Perception has been defined as the way a person understands or interprets something (Collins & Quan-Haase, 2012). Literature has described how healthcare providers perceive the provision of contraceptives to adolescents in different countries other than Malawi. The following are some of healthcare providers' perceptions towards provision of contraceptives to adolescents.

2.5.1 Contraceptives promote promiscuous behavior

Healthcare providers feel that the provision of contraceptives to adolescents promotes promiscuous behavior (Ahanonu, 2014; Leonard et al., 2015). Therefore, increasing contraceptive access would lead young people to taking more sexual risks. This will inevitably lead to more pregnancies and abortions because it will cause more sexual activity (Dreweke, 2019). Healthcare providers would therefore not want to provide information on contraceptives rather abstinence-only education in fear of promoting promiscuous behavior among adolescents. However, scientific literature strongly rebuts this narrative.

Lindberg et al. (2018) found that a decline in adolescent pregnancy risk during the 2007-2014 period was entirely attributable to better contraceptive use. Likewise, controlled trials of the advanced provision of emergency contraception to women aged 24 years and younger, found no increase in risky sexual behaviors among adolescents who accessed the emergency contraceptives (Atkins & Bradford, 2015).

Another study that evaluated the effectiveness of comprehensive sexual and abstinence-only to reduce adolescent sexual behavior found different results. The study participants included 450 adolescents aged 12 to 14 years. The findings indicated that adolescents who receive

abstinence education only are at greater risk of engaging in unprotected sex than those who were taught both abstinence and contraceptive methods use (Shepherd, et al., 2017). Adolescents need to be given full information regarding sexual and reproductive health services so that they can make informed decisions to prevent unwanted pregnancies and Sexually Transmitted Infections.

2.5.2 Age restriction on contraceptive use

Healthcare providers have a minimum age limit which they feel comfortable providing hormonal contraceptive methods to adolescents (Calhoun et al., 2013; Chilinda et al., 2014; Nalwadda et al., 2011; Sidze et al., 2014). Calhoun et al., (2013) conducted a study in Urban Uttar Pradesh, India, and found that healthcare providers have an average minimum age for the provision of pills, IUCD and condoms to adolescents and the recommended age was 19 to 22 years. Nurses were found restricting adolescents to access contraceptives based on age than doctors and clinicians. This could be due to differences in knowledge and skills in the provision of contraceptives between nurses on one hand and doctors and clinicians on the other. This study used mixed methods to explore socially and culturally imposed restrictions on hormonal contraceptive method provision and the findings may be applicable in African countries like Malawi as they have a similar social environment with limited resources.

Another study in Senegal found no difference among healthcare providers working in the private and public sector as they both restricted the provision of contraceptives and required the client to be at least 18 years and it was more common among nurses than healthcare providers of other cadres (Sidze et al., 2014). Due to age restriction in the provision of contraceptive methods, adolescents were labeled and perceived as “children”. This inflicted role conflict among nurses as they regarded adolescents as their children and culturally they were not free to provide condoms and hormonal contraceptives to adolescents (Chilinda et al., 2014). Consequently, adolescents are

forced to seek care from nonmedical professionals and this may have serious consequences to their lives which may lead to unwanted pregnancies and unsafe abortions.

2.5.3 Contraceptive provision is against personal / religious beliefs

Despite healthcare providers' knowledge that in principle they should not deny young people any of the Sexual Reproductive Services (SRH), their personal values and beliefs sometimes take precedence. Healthcare providers are also torn between their personal beliefs, feelings, cultural, religious values and their wish to respect young people's rights (Chilinda et al., 2014; El-Damanhoury & Abdelhameed, 2013; Godia et al. 2013; Paul et al 2016; Sidze et al., 2014). A study in Swaziland showed that healthcare providers did not provide contraceptives to adolescents as it was against their religious beliefs for youths to indulge in sex (Mngadi et al., 2008). This showed that their values and beliefs played a key role. In addition, emergency contraceptives were only provided to adolescents if only they were brought by the police (Mngadi et al., 2008). They also echoed society norms that respectable young women should avoid premarital sex.

Society norms/culture on premarital sexual intercourse may influence healthcare providers' perceptions. For example, Nigerian culture discourages premarital sex. A study done in Nigeria found that more than half of the providers perceived the provision of contraceptives to unmarried adolescents as promoting sexual promiscuity (Leonard et al., 2015). However, their belief was not in line with realities of adolescents' sexual activities as reflected by high rates of unplanned pregnancies and Sexually Transmitted Infections among the group. Similarly, Mitundu registered more adolescent pregnancies and low contraceptive use. The healthcare providers may have similar cultural beliefs discouraging sex before marriage which could influence their perceptions on the provision of contraceptives to adolescents. This made it necessary to explore

the perceptions of healthcare providers as they may be influenced by their cultural beliefs (Leonard et al., 2015).

2.5.4 Fear of side effects

Healthcare providers are not comfortable providing contraceptives like Depo Provera, implants, and IUCD to young girls as it may affect their ability to conceive (Paul et al., 2016). On the other hand, others feel that contraceptives may lead to the development of cancer (El-Damanhoury & Abdelhameed, 2013; Godia et al. 2013; Håkansson et al.2018). Healthcare providers' lack of knowledge on the mode of action on different contraceptive methods and outdated protocols on contraceptive use in adolescents may affect their provision of contraceptives. A study done in Egypt revealed that healthcare providers were unwilling to provide services to unmarried adolescents due to moral doubt, negative attitude, and ethical dilemma towards the sensitive reproductive health issues of the youths in the absence of guidelines and protocols (El-Damanhoury & Abdelhameed, 2013). Similarly, Tyler et al., (2012) found that healthcare providers perceived IUCD and lenovo4gestrel – releasing IUCD as being very unsafe while some were not sure if they are suitable for nulliparous women.

Healthcare providers' lack of knowledge on the mode of action on different contraceptive methods in adolescents has been shown to affect both nursing and medical practice. A study on challenges in translating evidence into practice on the provision of intrauterine contraception found fewer than half of physicians who felt that nulliparous women or teenagers were appropriate candidates for IUCDs (Harper et al., 2008). Healthcare providers believe that adolescents were more likely to become impatient with side effects and discontinue Long-Acting Reversible Contraceptives (LARC). However, other research findings have indicated that adolescents are no more likely to discontinue LARC than their adult counterparts and that continuation rates for

adolescents are higher with LARC than short-term contraceptive methods (Mermelstein & Plax, 2016). Furthermore, current IUCDs are not tied to an increased risk of Pelvic Inflammatory Disease or ectopic pregnancies (Russo et al., 2013).

Misconceptions transform into fear of being held responsible for causing infertility hence healthcare providers prefer to advise nulliparous adolescents to abstain or to provide condoms if they insist to use contraceptives (Godia et al., 2013; Håkansson et al., 2018). Healthcare providers also use contraceptive side effects to dissuade clients from accessing contraceptives. They expressed concern about the loss of fertility among unmarried women who use hormonal contraceptives. The methods which are recommended for unmarried adolescents include condoms, emergency contraception, and pills (Sieverding et al., 2018). Therefore, the healthcare providers' bias in the provision of contraceptives to adolescents may affect the quality of care and method choice. The perceptions of healthcare providers in different countries and health facilities within Africa may also apply to Malawi as we have a similar culture and lifestyle. Hence, there was a need to know Mitundu healthcare providers' perception of the provision of contraceptives to adolescents.

Adolescents may not access contraceptives but would report to the hospital to seek antenatal and delivery services. For example, in Ethiopia, high school students with reproductive health problems were more likely to utilize sexual and reproductive services than those without any problem (Abebe & Awoke, 2014). Abebe and Awoke (2014) conducted the study among high school students who may be considered literate and having knowledge of sexual and reproductive issues but results imply that the youth are accessing YFSRHS when they have a problem. In Malawi, it is mostly when one is sick that they go to the hospital to get treatment unlike seeking disease preventive measures and routine physical examination and this contributes to delays in

seeking care (Chibwana et al., 2009; Zamawe, 2013). This belief and health-seeking behaviour might have contributed to the low utilization of these preventive services compared to curative services. Therefore, healthcare providers need to have good attitudes that will help adolescents to seek preventive services.

2.6 Challenges faced by healthcare providers in the provision of contraceptives to adolescents.

Healthcare providers experience different challenges that affect their provision of services to adolescents. There are service-related barriers that affect the provision of contraceptives among adolescents such as the lack of essential equipment and supplies (medication and contraceptives), lack of anonymity, privacy, and high workload (El-Damanhoury & Abdelhameed, 2013; Godia et al., 2013; Kennedy et al., 2013; Nalwadda et al., 2011). Healthcare providers may have limited time to spend with adolescents during consultation time due to pressure of work and lack of knowledge on youth friendly services (Brittain et al., 2015; El-Damanhoury & Abdelhameed, 2013; Geary et al. 2014). Furthermore, there is also a shortage of healthcare providers to help in the provision of YFHS in the facilities (Geary et al., 2014; Godia et al., 2013a). Providers are also required to provide several other services; as a result, they have a high workload during service delivery and limited contact time with the adolescents hence there is a missed opportunity to provide information and counseling on sexual and reproductive health. Therefore, healthcare providers are more concerned with giving curative services than preventive services to young people due to workload (Alli et al., 2013).

Lack of service delivery guidelines is one of the institutional factors that affect the provision of contraceptives to adolescents (Godia, Olenja, Lavussa, Quinney, Hofman, & Van Den Broek, 2013). Lack of knowledge and proper skills to competently provide YFHS to adolescents is another

challenge that healthcare providers are facing. Healthcare providers reported lacking appropriate skills to effectively communicate and counsel adolescents when they come to seek YFHS (Paul et al., 2016). Kennedy et al. (2013) found that training that addresses the knowledge, attitudes as well as communication and counseling skills (including confidentiality) can improve healthcare providers' performance. Hence, continuing education can more likely have a positive impact on healthcare providers' attitudes. In contrast to these findings Godia et al. (2013) found that youth friendly policies and healthcare providers' training alone may not improve services but also addressing the cultural, religious and traditional value system.

Furthermore, poor infrastructure with limited space in which to offer both auditory and visual privacy during client consultation is another challenge in the provision of contraceptives to adolescents, making it difficult for providers to effectively deliver YFHSS to adolescents (Geary et al., 2014; Nalwadda et al., 2011). In a study done in Uganda, limited space compromised the audiovisual privacy of adolescents who were utilizing different SRH services (Nalwadda et al., 2011). Similar results were found by Geary et al. (2014) who conducted a study on challenges and facilitators of youth-friendly health program in rural South Africa where it was revealed that young people receiving contraceptive services together with older clients with chronic health conditions which demotivated them from accessing contraceptive services (Geary et al., 2014).

It has also been noted that lack of method mix and equipment to meet young people's needs and preferences affect healthcare providers' ability to effectively provide YFSRHS to adolescents (Nalwadda et al., 2011). Stock out of commodities and difficulties in accessing sufficient family planning methods are some of the factors that influenced adolescents' choice of service site since there are frequent shortages of commodities in government (free) health facilities (Michaels-Igbokwe et al., 2015).

Healthcare providers' religious beliefs and personal values have also been identified as affecting contraceptive provision to adolescents. Healthcare providers' beliefs about contraceptive methods influence their contraceptive counseling practices (Akers et al., 2010). Service providers frequently identified structural barriers, confidentiality, and lack of awareness of SRH services as barriers for young people seeking SRH care. Young people also reported that structural factors such as transport, cost, and service operating hours were important; however, they placed greater value on personal attributes of service providers, particularly welcoming and non-judgmental attitudes (Johnston et al., 2015). Adolescents placed greater importance on the personal attributes of service providers.

Healthcare providers' beliefs influence the content of their contraceptive discussion with adolescents. A nurse lamented in a study on providers' perceptions of challenges to contraceptive counselling in primary care setting "we discourage the patch because of excessive hormones that students don't need". Healthcare providers also highlighted the lack of adolescent sexual and reproductive competencies included in current nursing curricula and limited in-service training opportunities. Lack of training has been associated with negative attitudes towards adolescent sexual reproductive health (Kennedy et al., 2013).

2.7 Summary

The reviewed literature shows that despite all adolescents being entitled to free contraceptive services whenever they want them, providers have different views. Most healthcare providers have negative attitudes in the provision of contraceptives to adolescents. They seem to have different perceptions which may influence their attitudes in providing services to adolescents. There is low contraceptive use in both the developed and developing countries among adolescents leading to high teenage pregnancy rates. However, most of these studies have been conducted

outside Malawi and their main focus is on the attitude of healthcare providers. It was imperative therefore that this study be conducted in Malawi at Mitundu hospital to know the perceptions of healthcare providers on the contraceptive provision to adolescents.

CHAPTER 3

Methodology

3.1 Introduction

This chapter discusses the type of research study, setting, study population, inclusion, and exclusion criteria of participants, sampling method, sample size, data collection, management, and analysis. Furthermore, issues pertaining to pre-testing of data collection tools, ethical consideration, limitations of the study, and dissemination of study findings have also been elaborated.

3.2 Study design

This study used a descriptive qualitative study design to explore the perceptions of healthcare providers at Mitundu Community Hospital. The descriptive qualitative study design recommends that inquiry be done in a natural set up without manipulation (Neergaard et al 2009). Studies are also conducted when little is known about the phenomenon as a result they assist the researcher to discover new meaning, describe and categorize information (Grove et al., 2013). Therefore, descriptive qualitative design was chosen in this study because little is known about the perceptions of healthcare providers. Hence, using the design assisted to find out new knowledge about the phenomenon. Furthermore, it also assisted the researcher to collect relevant information on the perceptions of healthcare providers as it was conducted at the duty station of healthcare providers. Inductive approach was used as a research paradigm so that a theory be developed after data collection and analysis.

3.3 Study setting

The setting is the physical location where study participants live, experience life, and where data collection takes place (Polit & Beck, 2010). The study setting was Mitundu Community

Hospital in the family planning clinic, Maternity, and Outpatient department. The hospital offers Family planning, Outpatient, Maternity, under-five clinics, and ART. Mitundu Community Hospital is under Lilongwe District Health Office. It is located 26 kilometers from Lilongwe city. It has a catchment population of 532, 000, women of reproductive age 220,000, and 63,840 teenagers (Mitundu HMIS, 2016). The site was chosen because the hospital registered an increased number of teenage pregnancies in 2016 with low utilization of contraceptive use. Additionally, the hospital does not provide YFHS despite having a youth friendly infrastructure. The study was conducted at Mitundu in the family planning clinic, maternity, and outpatient department because it is where adolescents access contraceptive methods and (or) counseling services. Therefore, the researcher was able to obtain the required information.

3.4 Study population

The study population is referred to as the entire population in which a researcher is interested and to which the researcher would generalize the results (Polit & Beck, 2010). The study involved healthcare providers who are involved in the provision of family planning to adolescents. These healthcare providers included nurses, medical assistance, and clinical technicians (Clinical Officers) at Mitundu hospital. The total population was 32 nurses, 1 medical assistant, and 5 clinical technicians. The clinical technicians and the medical assistants also provide family planning counseling, manage contraceptive side effects, and provide long-acting contraceptive methods to both adults and adolescents. Therefore, these healthcare providers were selected because they provide the services to the adolescents and were knowledgeable on the subject matter. Hence, they provided rich information on their perceptions towards the provision of contraceptives to adolescents.

3.5 Sampling method

Purposive sampling was used to select the participants among those who met inclusion criteria with the help of the nurse and clinical technician in charge. Purposive sampling is based on the belief that a researcher's knowledge about a population can be used to select sample members (Polit & Beck, 2014). Therefore, the researcher recruited healthcare providers that were actively involved in the provision of contraceptive services to adolescents although they were working in different departments other than family planning clinic because they were likely to give accurate data in terms of relevance and depth. At Mitundu, healthcare providers rotate to different departments including the family planning clinic after 6 months and are all involved in providing adolescent contraceptive services in the other departments they are currently working. Some of the services they provide include counseling on contraceptive use and management of side effects. Participants of different cadres were interviewed to have a broader understanding of healthcare providers' perceptions regarding provision of contraceptives to adolescents.

3.5.1 Inclusion criteria.

To be eligible for the study, the participants were expected to meet the following inclusion criteria;

- Nurse, clinical technician, or medical assistant working full time at Mitundu Community hospital.
- One year of working experience in the family planning clinic at Mitundu Community Hospital.
- Willing to participate.
- Trained in providing contraceptive services

3.5.2 Exclusion criteria.

- Healthcare providers that are not nurses, clinical technicians, or medical assistants.
- Healthcare providers with less than one-year working experience in the family planning clinic.
- Healthcare providers that are working on part-time basis.
- Healthcare providers not trained in provision of contraceptives.

3.6 Recruitment process

After obtaining ethical approval from the College of Medicine Research and Ethics Committee, the authorization to conduct the study at Mitundu was sought from the Lilongwe District Health office. The researcher then went to Mitundu Community hospital where permission was sought from the facility in charge to recruit participants who met the inclusion criteria. The researcher explained her intention to conduct the study at the facility. Ethical approval obtained from the College of Medicine and an approval letter from the District Health Office were shown to the Mitundu Community Hospital in-charge. The facility in-charge introduced the researcher to the facility matron who introduced the researcher to the nurse in-charge and clinical technician. Recruitment of the participants was done with the help of the nurse in-charge and the clinical technician. The researcher purposively selected nurses and clinical technicians to participate in the study based on the inclusion criteria. The participants who met the inclusion criteria were given detailed written information about the study and a consent form to read and were asked to sign to show that they had understood and were willing to participate in the study (Appendix 1&2). The times for interviews were discussed and this prevented inconveniences like clients being delayed to be assisted. Most participants preferred to be interviewed in the afternoon after assisting the clients except those who were off duty.

3.7 Sample size

The planned minimum sample size for this study was 15 participants. However, data saturation was achieved with a sample size of 10. The following were interviewed; 1 nursing officer, 1 community health nurse, 4 nursing midwifery technicians, 1 medical assistant, and 3 clinical technicians. At the time of the interviews the participants were allocated in the following departments; 1 nursing officer and 1 nursing midwifery Technician in the maternity unit, 1 community health nurse and 1 nursing midwifery technician in the family planning clinic, 1 nursing midwifery technician in the ART clinic, 1 nursing midwifery technician, 1 medical assistant and 1 clinical officer in Outpatients' Department, 2 clinical technicians maternity and family planning. The common range of sample size in qualitative research is usually between 8 to 15 participants but this can vary depending on data saturation (Annells & Whitehead, 2007). The small sample size is suitable because of the potentially detailed data that can be generated from each participant (Polit & Beck, 2014). The sample size of 10 helped to gain detailed information on the responses concerning the perceptions of healthcare providers on the provision of contraceptives to adolescents.

3.8 Pretesting of the interview guide

The interview guide was pretested at Kawale Health Centre in Lilongwe among healthcare providers in order to assess the clarity of the questions and to evaluate the content of the interview. The pre-test interviews were conducted in June 2017 where 5 healthcare providers were interviewed. These included 1 clinical technician, 1 medical assistant, and 3 nursing midwifery technicians. According to (Polit & Beck, 2010), a pre-test study improves the research project as it assists to refine the data collection instruments, determines the feasibility of the study, gives the researcher experience with the subjects, and refines the methodology. The interview guide was

modified by eliminating other questions that seemed vague to participants and questions were refined.

3.9 Data Collection

The participants who met the inclusion criteria were given detailed written information about the study and a consent form to read and were asked to sign to show that they have understood and were willing to participate in the study (Appendix 1&2). The times for interviews were discussed and this prevented inconveniences like clients being delayed to be assisted. The place for the interview was agreed upon with the participants. Data was collected through face-to-face in-depth interviews using a semi-structured interview guide (Appendix 3). The development of the interview guide was guided by the objectives of the study. Semi-structured interview guide allowed the participants to respond to questions in their own words and also assisted the researcher to probe and get more information on their perceptions on the provision of contraceptives to adolescents. Semi- structured interview guide also allowed the researcher to guide participants towards an area of focus (Polit & Beck, 2014). Interviews were conducted at the facility in English since healthcare providers can communicate in English. Therefore, they were able to express their views and share experiences freely without language being a barrier. Furthermore, the interviews were recorded using a digital tape recorder and this assisted the researcher to maintain eye contact which is an important listening skill in an interview. Field notes were also taken on each interview to ensure that accurate participants' body language, tone, and emotions were observed and recorded in the researcher's journal. Each interview lasted approximately 45 minutes.

3.10 Trustworthiness of the Research

To ensure the trustworthiness of the study, the researcher used Lincoln and Guba's (1985) framework for assessing trustworthiness. This was done to ensure that the findings on the ground reflect the perceptions and also to ensure the accuracy and honesty of the data. This framework encompasses five criteria for developing trustworthiness in qualitative research (Polit & Beck, 2014). These have been elaborated in the following paragraphs.

3.10.1 Credibility.

Credibility refers to the confidence in the truth value of the data and interpretations. In addition, the study needs to enhance the believability of the findings so that it should be credible to the external readers (Munhall & Chenail, 2008; Polit & Beck, 2014). To achieve credibility, the researcher used interview guides that were developed from the objectives of the study to avoid misleading the researcher during interviews. She also took field notes and used a tape recorder to ensure that the collected data was complete. Literature was also reviewed extensively in order to acquire adequate knowledge about the phenomenon under study.

3.10.2 Dependability.

This is the consistency of the research process which indicates that the data should be able to give the same results if it were repeated in a similar context (Polit & Beck, 2014). To achieve consistency, the same interview guides were used on all participants, interviews were tape-recorded and were all transcribed verbatim. Furthermore, audit trails were used where the researcher kept a record of all processes taken within the study which include a detailed description of data collection, analysis, and interpretation methods to show that the research can easily be replicated. Data was also checked with some participants to ensure that data which was collected reflected participants' views. Pretesting of data collection tool was done to ensure that the tool

captures appropriate information making it easy to capture similar findings if conducted in another setting

3.10.3 Conformability.

Conformability is the potential congruency in data accuracy, relevance, and meaning (Polit & Beck, 2014). It ensures that data reflects the perceptions of the participants. The researcher had to distinguish her personal values and perspectives from those of participants. In this study, conformability was achieved by the use of a tape recorder where words spoken by the participants were recorded to make sure that during analysis it was their views that were analyzed and not the researcher's views. In addition to this, the researcher acted as an active listener and facilitator to allow participants to give detailed information. Member checking of the data with some participants was done and direct quotations were also used to ensure conformability.

3.10.4 Transferability.

Transferability is the extent to which qualitative findings can be transferred to other settings or groups (Polit & Beck, 2014). Research findings need to ably apply to other settings. In this study, transferability was achieved by providing a detailed explanation of the study which includes background information, research context, setting, sample size, data collection methods, and use of participants' quotations when presenting results for other people to judge if the study findings can apply to them or not. Furthermore, participants were purposively selected to participate in the study in order to make sure that only those that meet inclusion criteria were recruited in order to give relevant information. This enabled the study findings to be transferred to another setting with similar characteristics of the study participants.

3.10.5 Authenticity.

This is the extent to which researchers fairly and faithfully show a range of participants' lives as they are lived (Polit & Beck, 2010). A study has authenticity if it invites readers into a vicarious experience of the lives being described and also enables readers to develop a heightened sensitivity to the issues being depicted (Polit & Beck, 2014). Therefore, in this study authenticity was achieved by selecting a suitable method of data analysis, accurate interpretation of the study findings, and use of participants' quotations which provided a true reflection of participants' perceptions in the readers.

3.11 Data management

The data files and recorder were locked in a drawer of the researcher's study table and were only accessible by the researcher. The electronic data was kept in the researcher's computer with a password that was known to the researcher only.

3.12 Data Analysis

In qualitative studies, the significance of data analysis is to discover themes and links among the themes (Polit & Beck, 2010). After the interviews, the researcher used guidelines for thematic data analysis by Braun and Clarke (2006) to analyze the data. Braun and Clarke described six phases of qualitative data analysis which were used in this study; familiarizing with the data, generating initial codes, searching for themes, reviewing themes, defining themes, and producing a report.

3.12.1 Familiarizing with the data.

This phase involves repeated reading of data in order to immerse oneself in the data to the extent that one is familiar with the content. Braun and Clarke (2006) further indicated that verbal data needs to be transcribed into written form in order to conduct a thematic analysis. In this study, the in-depth interview recordings were listened to several times so as to extract meaning from them. They were then transcribed verbatim. After which the transcribed data was read several times to gain familiarity with the ideas presented.

3.12.2 Generating initial codes.

According to Braun and Clarke, (2006) this phase involves the production of initial codes from the data. Codes identify features of data that appear meaningful regarding the phenomenon. In this study, data was broken down into smaller units where initial codes were given to sentences in the data set with similar meaning. Codes were compared across the whole data set to identify any similarities, differences, and their linkages. This also involved naming the units according to the content they present and grouping coded material into categories based on the shared concepts.

3.12.3 Searching for themes.

According to Braun and Clarke, (2006) this phase begins when all data has been initially coded and collated. The phase involves sorting codes into potential themes and collating all the relevant coded data extracts within the identified themes. In this study, codes were combined to come up with categories. The researcher validated the categorization of the findings after which she developed main themes and subthemes regarding perceptions of healthcare providers.

3.12.4 Reviewing themes.

According to Braun and Clarke, (2006) this phase involves reviewing and refining the themes to ascertain whether the themes match with the data set. In this study, the researcher refined the themes to ensure that they were clear and they matched with the data that supported them. The researcher re-read the entire data set to make sure that the themes matched the collected data.

3.12.5 Defining themes.

According to Braun and Clarke, (2006), phase five involves defining and further refining the themes. This means identifying the essence of what each theme is about and determining what aspect of data each theme captures. This is done by going back to data extracts for each theme and organizing them into a coherent and internally consistent account with an accompanying narrative. In this study, the researcher identified themes, subthemes, and meaning that each theme carried and selected the data which participants provided under each theme.

3.12.6 Producing the report.

According to Braun and Clarke, (2006) this phase involves final analysis and write-up of the final report to tell the story of the data in a way that convinces the reader of the merit and validity of the analysis. In this study, the themes and subthemes, and supporting narratives were fully polished in line with the study objectives, and the report of the results was written.

3.13 Ethical Consideration

Ethics is a system of moral values that is concerned with the degree to which research procedures adhere to the professional, legal, and social obligation to the study participants (Polit & Beck, 2014). To ensure that ethical issues have been considered in this study, the research proposal was submitted to the College of Medicine Research and Ethics Committee (COMREC) through Kamuzu College of Nursing for approval. After approval, permission was solicited from

the Lilongwe District Health Office (Appendix 4) to carry out pre-test interviews at Kawale Health Centre and to conduct the study at Mitundu Community Hospital.

The researcher also sought voluntary participation of the healthcare providers working at Mitundu Community Hospital while respecting their human rights. Participants' human rights emphasis was on right to self-determination, privacy, anonymity, confidentiality, fair treatment, and protecting them from harm. This was done by providing them with an information sheet that provided detailed information on the aim of the study, duration of the interviews, data collection methods, benefits or risks of the study to participants as well as the relevance of the study to adolescents in Malawi. Permission was sought from participants to use a digital recorder during the interview. They were also asked to sign a consent form to show their willingness and acceptance to participate in the study (Appendix 2).

All participants were assured that data was to be treated with strict confidentiality and to ensure this, no names were attached to the data. Only codes were used, and the identities of the participants would not be disclosed in the final report or publications. To ensure autonomy, the emphasis was placed on their freedom to participate or withdraw at any stage or stop an interview if they felt like doing so. Participants were informed that they did not have to answer any questions that they felt uncomfortable answering. They were also told that refusal to participate in the study would not affect their work in any way. Privacy was ensured by allowing the participants to propose their convenient time and place for the interviews. Anonymity in this study was achieved by ensuring that participants' identities were protected by using numbers against each participant's recording instead of other identifiable such as cadre, sex, or names.

CHAPTER 4

Research Findings

4.1 Introduction

This chapter presents the findings of the study conducted at Mitundu Community Hospital whose aim was to explore perceptions of healthcare providers (HPs) in the provision of contraceptives to adolescents. Demographic characteristics are presented first followed by the themes that emerged from the data analysis. The planned sample size was fifteen participants but data saturation was reached at 10. Data was collected at Mitundu Community Hospital among healthcare providers through in-depth interviews using a semi-structured interview guide. The results are expressed using direct quotations from participants to illustrate important points of their perceptions.

4.2 Demographic Characteristic of the Participants

Ten healthcare providers participated in the study and their ages were; 1 was 25 years, 4 were 36 years, 4 were 39 years and 1 was 45 years. Among the 10 participants, 6 were females and 4 were males. There was no difference regarding the views between male and female healthcare providers. All the participants were Christians who belonged to different religious denominations and the most popular denomination was CCAP followed by Seventh-day Adventist. Participants included nurses, medical assistants, and clinical technicians (previously were called clinical officers). The following cadres were included from the nursing profession, registered nurse midwives, nursing midwifery technicians, and community health nurses. Table 1 below describes the demographic characteristics of the participants.

Table 1: Demographic characteristics of the healthcare providers

Demographic characteristics	
<hr/>	
Age(years)	
25	1
36	4
39	4
45	1
Religious belief	
CCAP	4
Seventh-Day Adventist	2
Roman Catholic	1
New Apostolic	1
Church of Christ	1
Assemblies of God	1
Training in youth-friendly service	
Trained	5
Not trained	5
Professional qualification	
Registered Nurse Midwife	1
Community Health Nurse	1
Nurse Midwife Technicians	4
Clinical Officers (Clinical Technician)	3
Medical Assistant	1

4.3 Qualitative Data Findings

The findings from qualitative data have been presented on two main themes: beliefs on the contraceptive provision and challenges to contraceptive provision. The subthemes under beliefs on contraceptive provision were contraceptives influence sexual behavior, fear of contraceptive side effects and condoms are for adolescents. The following subthemes were on challenges to contraceptive provision; lack of privacy, shortage of trained staff, and negative attitudes of healthcare providers, adolescent contraceptives not considered a priority, and unavailability of contraceptives. These themes and subthemes have been summarized in Table 2 below.

Table 2: Summaries the themes and the subthemes

Main theme	Subtheme
1. Beliefs on the contraceptive provision.	<ul style="list-style-type: none"> <li data-bbox="735 1035 1284 1119">➤ Contraceptives influence sexual behavior <li data-bbox="735 1171 1203 1203">➤ Fear of contraceptive side effects <li data-bbox="735 1255 1154 1283">➤ Condoms are for adolescents
2. Challenges to contraceptive provision	<ul style="list-style-type: none"> <li data-bbox="735 1335 987 1367">➤ Lack of privacy <li data-bbox="735 1388 1284 1472">➤ Shortage of trained staff and negative attitudes of healthcare providers <li data-bbox="735 1493 1284 1577">➤ Adolescent contraceptive not considered a priority <li data-bbox="735 1608 1195 1640">➤ Unavailability of contraceptives

4.4 Beliefs on the contraceptive provision

During the interviews, participants expressed a positive attitude in the provision of contraceptives to adolescents and gave reasons for supporting their decisions. However, it was discovered that in practice most of the healthcare providers had different beliefs associated with the provision of contraceptives to adolescents. The healthcare providers' responses are presented according to the following subthemes: contraceptives influences sexual behavior, fear of contraceptive side effects, condoms are for adolescents, and challenges to contraceptive provision.

4.4.1 Contraceptives influence sexual behavior.

Most of the participants felt that they are encouraging/influencing premarital sexual activities among adolescents in providing contraceptives to them. In addition, they felt that the provision of contraceptives increases immoral behavior in adolescents due to the knowledge that they can easily be assisted at the hospital after indulging in unprotected sex. Some participants also felt that the provision of contraceptives to adolescents has a bearing on the number of times the adolescents engage in sexual behavior as expressed by the following quotations:

I feel like when I am providing the services to the adolescents, am encouraging them to practice premarital sex. We are encouraging them to use different contraceptive methods when they are sexually active. Their feeling that they are fully protected from getting unwanted pregnancies and STI's can influence them to do sexual intercourse with anyone (P1).

The provision of contraceptives to adolescents increases their sexual behaviour as they think that they are protected so they would rather do sexual intercourse on a daily basis at any time they want (P7).

Some providers viewed premarital sex as a sin against God. Their religious beliefs influenced their counseling to adolescents on contraceptive methods. Adolescents seeking contraceptive methods were being told that sex before marriage is a sin against God and God will punish them if they continue having sexual intercourse while not married. Another participant narrated:

When providing contraceptive services & counsel, them that if they are doing sexual intercourse outside marriage, it is a sin, and if they do not repent God will punish them (P7).

4.4.2 Fear of Contraceptive side effects.

Some of the healthcare providers were uncomfortable providing contraceptives for fear of side effects. They expressed that the use of contraceptives at a tender age may cause serious side effects. The majority of the participants were uncomfortable providing contraceptives to adolescents who are less than 18 years old. Participants felt that adolescents who are below 18 years are too young to use contraceptives. The most mentioned side effect was infertility due to the use of depo Provera as a contraceptive method. The providers were also afraid of causing stress and anxiety in adolescents due to other contraceptive side effects which they may experience like missed menstrual periods and prolonged vaginal bleeding as expressed in the following quotations;

When people use Depo Provera for a long period of time they take long to conceive after discontinuing the method while others can conceive immediately. Therefore, for adolescents to use the method for a long period of time they may develop infertility since the hormones will accumulate in their body due to long period of use (P5).

I do not feel comfortable to provide contraceptives to adolescents who are 10-13years because I feel that they are very young, they have to abstain. Currently, I haven't met them in family planning clinic but in the labour ward. Right now we have a 13-year-old girl in the labour ward and she is going for a caesarian section. (P1).

I feel comfortable to counsel the adolescents when they come seeking contraceptives on the use of condoms than hormonal methods as they can develop side effects like missed menstrual periods or prolonged menses which may cause anxiety and stress. Other hormonal contraceptives like Depo Provera also cause infertility if the adolescents start using the methods at a tender age (P1).

The results showed that other providers seem not to have enough knowledge on contraceptive side effects in adolescents but were still using knowledge which they heard from colleagues in their practice. Therefore, they would rather counsel them on abstinence, and if they insist on the use of contraceptives, they would give condoms and not hormonal methods as narrated in the following quotations:

I prefer providing contraceptive methods to only those adolescents who seem to think in a mature way like those who are 18 years and above. Adolescents who are 14 years and below, we counsel on abstinence because most of the contraceptive methods require someone who is matured enough; for example, pills, they need to remember to take every day (P2).

For those adolescents who are 18 years and above I feel comfortable to provide contraceptives but for those who are below that age I think twice about it. I have no experience with adolescents less than 18 years coming to access contraceptive methods

but if I meet them, I would rather counsel them and provide them with condoms only than hormonal contraceptives (P4).

This study has also shown that some providers were also not afraid of side effects of contraceptives to adolescents despite others being afraid of the effects. Participants' comfortability to provide contraceptives was based on the fact that benefits emanating from the use of contraceptives outweigh the side effects, which in most cases are case-specific. Furthermore, the knowledge that every drug has got its side effects compelled some healthcare providers to provide the service as narrated in the following quotations:

I feel it is better that adolescents should be given contraceptive methods than leaving them for fear of side effects, as those effects are minor as compared to the benefits gained in using contraceptives (P5).

Most of the time adolescents experience vaginal bleeding and hormonal imbalance, but this doesn't affect me in the provision of the services as every drug has its side effects (P10).

I am comfortable to provide the contraceptives to the adolescents after explaining the side effects of the method and they should decide. Most of the adolescents are mature enough to use contraceptives and if we become afraid of the side effects and not give them when they have sexual intercourse they can get pregnant leading to obstetric complication; so it is better to provide the contraceptives (P7).

4.4.3 Condoms are for adolescents.

The study has established that most healthcare providers took condoms as a good contraceptive method for adolescents despite adolescents seeking hormonal contraceptive methods at the clinic as narrated in the following quotations:

I think these young adolescents are not mature in their thinking, so when they take contraceptives, they just think that they cannot get pregnant. Their thinking capacity is low, unlike older women who are also mature in their thinking. The best way for adolescents is abstinence and the last resort if they can't manage are condoms (P8).

To me it is too early to provide hormonal contraceptive methods to those adolescents and I cannot be comfortable to provide the services (P10).

4.5 Challenges to Contraceptive Provision

Participants said that they face various challenges in the provision of contraceptives to adolescents. The following were challenges that were commonly stated: lack of privacy, shortage of staff, and negative attitudes of healthcare providers, adolescent contraceptives not considered a priority, and unavailability of contraceptives.

4.5.1 Lack of privacy.

Most of the participants explained that there was lack of privacy in the provision of contraceptives to adolescents as there was no separate clinic for the adolescents to access contraceptives. Contraceptive services for older women and adolescents are provided in the same room and at the same time. Participants felt that adolescents get frustrated to access contraceptive services with older women. Adolescents queue together with older women which takes much of

their time and also compromises privacy. As a result, those who access the services do not return for follow up while others do not go at all as expressed in the following quotations:

We do not have enough space for providing contraceptives to adolescents; we conduct a contraceptive clinic in the same room with older women so for adolescents who put privacy as their priority cannot come directly to access the services as they are afraid of meeting people whom they know and can report to their guardians (P5).

Few adolescents are accessing the services. This could be due to lack of adolescent contraceptive clinics because during the training in college when we were taught about youth-friendly care. They said that youths have to be provided all their services whilst at the place where they meet like the youth centre. They said that the adolescents have their own convenient time to access the services while as for older women is in the morning (P4).

Our services are not open enough to the adolescents, much as there is a program of the youth friendly services, the question is, are we having a clinic specifically for adolescents? And in our case, it is not there and you find adolescents coming only to find services that are combined with other clients and we are talking of adolescents who are mostly going to school. Adolescents have to stay on the queue for so long and at the end of the day, they get frustrated and never return which affects the provision of contraceptive services (P9).

Participants are aware of the effects of combining family planning clinics for adolescents and older women. Most of them felt that adolescents are not comfortable to access the services with older women because they are shy to meet with their mothers or relatives which can inform people from their community about their sexual life. Furthermore, they also said that this prevents them from accessing the services as they are afraid of being labelled promiscuous which

consequently predisposes them to more teenage pregnancies. Participants, therefore, suggested opening an adolescent contraceptive planning clinic in order to deal with the stated problems as expressed below:

I think the best way would be to provide those services to adolescents right at the youth centre and not that they should queue with older women. I think some adolescents can meet friends with their parents and may ask them why they are accessing contraceptive methods since they are not married and still in school (P10).

We have space at the youth centre where we can provide services and there are trained healthcare providers in youth-friendly services that can rotate in providing the services to the adolescents. But we just have to organize ourselves as a hospital (P1).

4.5.2 Shortage of staff and negative attitudes of trained providers

The majority of the participants acknowledged that they have a youth centre. However, they indicated that it is closed most of the time and there are no health personnel to assist the adolescents when they go there. This was also evident when the researcher went to collect data at the facility where she found the youth centre closed on all the days when she was available at the facility. However, participants explained that this is a missed opportunity between the adolescents and healthcare providers where information sharing on contraceptives and provision of contraceptives in a friendly environment would have been done, as stated in the quotation below:

I feel our youth centre is not active to provide information and services to adolescents as most of the times it is locked and I do not see trained healthcare providers going there to assist the adolescents (P6).

Participants said that they have a challenge in operating the youth friendly centre due to a shortage of staff and negative attitudes of trained healthcare providers. Participants said that 5 healthcare providers were trained in youth-friendly services but they are few since they are also required to do other duties in different departments. Those few providers who were trained in youth friendly services are assigned by the coordinator to work at the youth centre but most of them do not adhere to their duty roster. Due to such attitudes, the centre is usually manned by Health Surveillance Assistant, evidenced by the narrations below;

I do not know the reason why providers are not found at the youth centre; maybe there is no schedule but most of the time adolescents are with HSAs which compromises sexual and reproductive information gained. Trained healthcare providers are available but are busy in other departments (P3).

Those people who were trained in youth friendly services are not actively involved in the provision of the services to the adolescents. We used to have a roster for those who were trained in youth-friendly and we could meet but we stopped. I think it is because of the negative attitude of healthcare providers. People would not just feel like going there and the department is located away from other departments/clinics and just to chat with adolescents... (P7).

To have a fully functional youth centre, participants suggested allocation of staff at the youth centre to assist the adolescents as expressed in the following statements:

I think the availability of healthcare providers at the youth centre is the most important thing. The availability of the healthcare providers will help the adolescents to have first-

hand information from the healthcare providers on contraceptives without the message being distorted by third parties (P4).

I think the best way is to improve the services at the youth center because some adolescents cannot be comfortable to come and access contraceptives at the family planning clinic; so the development can help a lot of adolescents (P5).

Most participants indicated that there is also a shortage of staff in the provision of contraceptive services to adolescents especially in the contraceptive clinic and youth centre. However, despite the combination of both adults' and adolescents' family planning services, there is only one nurse allocated to the department. Some participants also reported that the nurse fails to provide comprehensive individualized care to adolescents due to pressure of work as narrated in the following quotations:

Here at Mitundu in a contraceptive clinic, there is one nurse assigned to conduct clinics and for her to assist all the people who come to access the services is a challenge. The hospital in-charge can also not ask providers working in other departments because there is also a shortage of staff (P2).

The study established that the shortage of staff is also contributing to lack of separate clinics for adolescents. The hospital cannot manage to assign one healthcare provider to conduct adolescent contraceptives clinic hence they would rather combine them with adults when conducting the clinics as narrated below;

We have a youth centre where space is available which we can use to provide contraceptive services to adolescents but it is used as a library for adolescents. The allocation of a

healthcare provider to provide contraceptives is not possible due to a shortage of staff (P 6).

The majority of the participants suggested that healthcare providers should be trained and have a chance of being allocated to a family planning clinic or youth corner where they could provide the care to adolescents. Participants also feel that those few healthcare providers who have been trained in youth friendly services must make an effort to provide the services to the adolescents as expressed below:

I think there is a need for training of healthcare providers on youth friendly health services as most of the healthcare providers provide contraceptive methods but they need training on how to provide contraceptive services to youths in a friendly manner. Some healthcare providers are still discriminating against adolescents against accessing contraceptives services as they think that they are still young. Furthermore, some feel like they are promoting premarital sexual behavior by providing services to adolescents. This negative attitude can be improved with training (P1).

There is a need for training in youth friendly services because those who were trained are not in most cases found in the family planning clinic. Due to a shortage of staff, the few providers can be allocated to other departments that affect the provision of services to adolescents. Therefore, I feel everyone should be trained and be ready to provide the services when assigned to work in a family planning clinic. Some of us just provide the services; going for training can improve our knowledge and skills in offering services to the adolescents correctly (P 2).

Training helps the healthcare providers to be committed to their work but also to change their attitude towards the provision of contraceptives to the adolescents (P3).

4.5.3 Adolescent contraceptive services not considered a priority

Adolescent contraceptive services are not considered as a priority by the healthcare providers as well as the hospital management team. Most of the participants said that hospital management does not consider healthcare providers who were trained in youth friendly services when allocating staff to the family planning clinic. The facility has got 5 trained healthcare providers in youth friendly service. In spite of this, the hospital management reallocates staff every 6 months in various departments regardless of their knowledge and expertise. Therefore those who are trained are all allocated in other departments as expressed in the quotations below:

We have healthcare providers who were trained in youth friendly care but few considering the demand we have and other services we are providing. I remember 5 people plus were trained in youth friendly health services but they are also required to provide services in other important programmes which we have compared to youth friendly health service program (P9).

Youth-friendly service healthcare providers are available but as a facility, we have many departments; so providers are allocated to general wards, outpatient departments, or labour ward so for them to work in family planning becomes a challenge. They only allocate one nurse to a family planning clinic but also it's not a guarantee that she or he can be youth friendly health service provider as mostly they are family planning providers (P4).

I am a clinician but we are allocated to a number of departments in a day like a theatre, obstetric clinic, outpatient clinic youth-friendly inclusive. Therefore, we tend to prioritize other departments than the youth centre as they are considered to be of life-threatening (P9).

The findings also established that there is poor coordination of youth-friendly activities at the facility which include the provision of contraceptives to adolescents. There is poor coordination between the hospital in-charges and youth friendly health providers in running the program. In addition, the focal person of youth-friendly services is usually allocated to another department which makes her busy hence difficult to supervise and take charge of the program as evidenced by the following narrations;

Youth-friendly centre does not work at this facility despite having trained healthcare providers. The facility management has its known providers whom they can assign to work there but they also don't provide the services. Therefore, those of us who were trained while working at another facility we are not recognized (P 5).

A nurse who is a focal person for youth friendly services is also allocated to another department and most of the time adolescents are not attended to by healthcare providers and are not given information (P5).

4.5.4 Unavailability of contraceptives.

Most of the participants reported that there is a shortage of hormonal contraceptives at the facility and this affects the provision of contraceptives to the adolescents as the preferred hormonal contraceptive, Depo Provera is usually out of stock or in short supply. Despite the health facility ordering contraceptives through their pharmacy technician from the District Health Office (DHO)

pharmacy, the supplies seem to be in short supply at DHO pharmacy stores as well, and this is explained below:

There is a shortage of contraceptive methods, out of which the most chosen method depo provera has not been in stock for the past 6 months; so, adolescents go back without contraceptive methods (P5)

For the whole of 2 weeks we did not have stocks of implants, Depo Provera, pills and it is only last week that we had a supply of Depo Provera only although in short supply as well (P4).

The pharmacy technician orders contraceptive methods from the District Health Office pharmacy but sometimes they are told that contraceptives are also out of stock (P 2).

Participants recommended that the health facility should also request other organizations to assist with the procurement of contraceptives for the adolescents in times when the District Health Office pharmacy has run short of the contraceptive supplies as narrated below:

Apart from ordering only from the District Health Office pharmacy if we can have other non-governmental organizations who can assist us with contraceptives in time of stock-outs that will help us (P4).

4.6 Summary

This chapter has presented the findings according to study objectives and the themes that emerged from the study objectives. It has revealed the perceptions of health-care providers on the provision of contraceptives to adolescents. Some of the perceptions of healthcare providers are; contraceptives influence sexual behavior, contraceptives have negative side effects and condoms

are for adolescents. Healthcare providers encounter the following challenges when providing contraceptives to adolescents; lack of privacy, shortage of staff, adolescent contraceptive services not considered a priority, and unavailability of contraceptives.

CHAPTER 5

Discussion of Research Findings

5.1 Introduction

This chapter discusses the findings on perceptions of healthcare providers and the challenges encountered in provision of contraceptives in line with the literature, and the study's main objective which was to explore the perceptions of healthcare providers on the provision of contraceptives to adolescents at Mitundu community hospital in Lilongwe. The chapter will also address the limitations of the study, areas for further research, recommendations as well as implications of the study findings and conclusions.

5.2 Perceptions of Healthcare Providers

The study revealed that many healthcare providers were not comfortable with providing contraceptives to adolescents. This was a result of various perceptions which they hold towards the provision of the service. There was no difference in the perceptions among providers who were trained or not trained in YFHS. The following perceptions were among the factors influencing their provision of contraceptives to adolescents: contraceptives influence sexual behavior, fear of contraceptive side effects and condoms are for adolescents.

5.2.1 Contraceptives influence adolescent sexual behavior.

The study discovered that participants felt that they were encouraging premarital sexual activities, and also enhancing immoral behavior among adolescents when providing contraceptives. In addition, participants felt that adolescents' knowledge that they can easily access contraceptive methods at the hospital influences them to indulge in premarital sex. The results of this study are similar to other studies that found that more than half of the providers perceived the provision of contraceptives to unmarried adolescents as promoting promiscuity (Ahanonu, 2014;

Leonard et al., 2015; Lo, Vo, Ouj, Oe, & Fa, 2015). In support of their disapproval, healthcare providers were encouraging adolescents who seek contraceptives to abstain rather than providing them with contraceptives (Ahanonu, 2014; Leonard et al., 2015; Lo et al., 2015). Similarly, another study indicated that healthcare providers were reluctant to teach adolescents on contraceptive methods as it was perceived as leading adolescents into promiscuous behavior instead of healthy behavior (Enuameh et al., 2014). Healthcare providers feared that knowledge of contraceptives could corrupt adolescents to become promiscuous.

Healthcare providers' perceptions and barrier factors are important in influencing contraceptive use among adolescents. Higher knowledge of how to use a contraceptive method is associated with higher levels of contraceptive use. Adolescents develop values and knowledge from their immediate physical and social environment, which in turn influences service seeking behaviour. However, barriers encountered during the process of seeking services affect contraceptive use, and the experiences adolescents obtained in the external environment during the period of seeking services influence perceptions on use. The results from the study showed that even if an adolescent had a positive perception of contraceptive use, barriers experienced in the process of obtaining services would influence use (Kinaro et al. 2015). Therefore, healthcare providers who show negative attitudes when adolescents are seeking contraceptive methods affect the adolescents' future utilization of the services hence few adolescents accessing contraceptives services from the clinics and Mitundu is one of the facilities which has been affected.

Scott et al. (2011) found that there is a very strong relationship between the number of sexual encounters and the use of contraceptives. One's perception of a high degree of risk is likely to influence them to take precautions due to higher perceived need. The number of sexual partners increases the perceived risk, and hence the perceived need for contraceptives. On the other hand,

contraceptives may not influence the number of sexual partners (Scott et al., 2011). In contrast, in this study providers perceived that the use of or any information on contraceptives to adolescents may influence them to indulge in premarital sexual intercourse.

Secura et al. (2014) also found little evidence to support concerns of increased sexual risk-taking behavior after greater access to no-cost contraceptives among adolescents. Instead, it resulted in greater use of the most effective contraceptive methods among adolescents. Furthermore, similar findings were found in a study on adolescents above 16 years with improved access to emergency contraceptive methods more frequently when needed which showed no increase in their sexual behavior (Harper et al., 2010).

In this study, healthcare providers associated the provision of contraceptives with an increased number of times the adolescent engages in sexual behavior. This perception of healthcare providers may affect the provision of contraceptives to adolescents hence denying them the services which may predispose them to unwanted pregnancies and obstetric complications. In spite of national efforts to address the health sector response for adolescents by producing global standards for quality healthcare service for adolescents and competencies in adolescent's health and development, primary healthcare providers still have personal perceptions which affect provision of contraceptives to adolescents (Calhoun et al., 2013; Nalwadda, et al., 2011; Tilahun et al., 2012).

Healthcare providers in this study were uncomfortable providing contraceptives to adolescents who were less than 18 years old. They strongly believed that adolescents were too young to use contraceptives as such they would advise them on abstinence, and when they insist, they provide condoms and not hormonal contraceptives. This finding is in tandem with other study findings which showed that healthcare providers have minimum age restriction in the provision of

contraceptives to adolescents especially when providing hormonal contraceptive methods (Calhoun et al., 2013; Chilinda et al., 2014; Nalwadda et al., 2011; Sidze et al., 2014). Calhoun et al., (2013) found that healthcare providers have an average minimum age for the provision of pills, IUCD, and condoms to adolescents which was 19 to 22 years. Nurses were found to be more restricting than doctors and clinical officers, due to differences in knowledge and skills. However, this study did not show differences in the provision of contraceptives services between medical and nursing professionals.

In another study, providers were labeling adolescents as “children” (Chilinda et al., 2014). This inflicted role conflict among nurses as they regarded adolescents as their children and culturally were not free to provide condoms and contraceptives to youths. There was also a lack of consistency on acceptable age at first use of contraception and that may have direct implications for access, autonomy in decision making, and consent for young people (Sedekia et al., 2017). Age restriction has been identified as a prevalent barrier to contraceptive use in Kenya, Senegal, and Tanzania (Tumlinson et al., 2015). Providers were not providing injectable contraceptives to women younger than twenty years while some reported that they do not offer to women without at least one child. Healthcare providers fears of contraceptive inducing infertility contribute to their age biases. Fertility is incredibly important in their societal norms and infertility is associated with a life of no value. Therefore, healthcare providers fear that they will be accused of causing infertility during the adolescent period (Schwandt, 2017). Similarly, this study’s findings alluded that some healthcare providers were afraid of providing contraceptives to adolescents for fear of side effects. The healthcare providers could therefore be sharing perceptions with other healthcare providers from other African countries who treasure children and are afraid of been held responsible for someone’s infertility.

The findings also show that providers were more comfortable to provide condoms than hormonal contraceptive methods to adolescents. Similarly, Nalwadda et al. (2011) found that healthcare providers considered short term methods to be acceptable for adolescents. To restrict access to the hormonal contraceptive they requested parental or spousal consent for an adolescent who is less than 18 years of age. Different negative attitudes that are demonstrated by healthcare providers are also noted by adolescents and this affects future utilization of contraceptive services. Adolescents indicated that service providers discriminate against them on account of age and in some facilities providers demanded national identification cards just to discourage them from seeking contraceptive services (Kinaro et al., 2015). Providers' attitude is prediction for the use of contraceptives. A study on contraceptive use and associated factors among sexually active female adolescents in Ghana found that 72 percent of participants who were accessing contraceptive methods admitted that providers of contraceptive services were friendly to them and 75 percent also stated that providers encouraged them to use contraceptives (Agyemang et al., 2019). The findings differ with most of the study results discussed on the attitude of healthcare providers on adolescent contraceptive use which showed negative attitudes of healthcare providers.

Scientific literature and several rigorous studies have shown that a more comprehensive approach to educating adolescents about contraceptives, which includes dispensing condoms and hormonal contraceptives is superior to abstinence-only education at reducing sexual risk behaviors and outcomes (Harper et al., 2010). Therefore, educating adolescents who are already sexually active and seeking contraceptives methods may not be effective and may predispose them to unwanted pregnancies. On the other hand condom use requires the ability to communicate and negotiate with a partner, admit to the risk of STI acquisition, and initiate use at the time of coitus, which can be challenging for adolescents (Williams & Fortenberry, 2011). Furthermore, dual

method use which involves pairing condoms with more effective contraceptive methods to protect against STIs and unwanted pregnancy is the ideal contraceptive practice for adolescents. Therefore healthcare providers who restrict the use of hormonal contraceptive methods to sexually active adolescents and encourage the use of condoms put the adolescents at greater risk of contracting sexually transmitted infections but also unwanted pregnancies if they fail to negotiate with their partners. Most of the times the adolescent girls are faced with challenges to negotiate partner use of condoms as they are shy, afraid, and sometimes lack empowerment from older people.

Furthermore, WHO medical recommendation for the provision of contraceptives does not restrict adolescents based on age, parity, and marital status (World Health Organisation, 2015). Adolescents are eligible to use all methods of contraception (Curtis, 2012). All methods that are appropriate for healthy adults are also potentially appropriate for healthy post-pubertal adolescents (World Health Organisation, 2015). Therefore, once puberty has been reached, methods that are physiologically safe for adults are also physiologically safe for adolescents. Despite this, there seems to be a high prevalence of minimum age restriction on contraceptives at Mitundu catchment area but also low turn up of adolescents at family planning clinic. This could lead to maternal complications as a result of giving birth at tender ages as has been shown in the study where 13 to 14 years old adolescents were accessing antenatal services.

Barriers that adolescents are facing due to lack of support and negative attitude of the healthcare providers may force them not to access contraceptives from the hospitals. According to another study done in South Africa, the majority of school-going adolescents felt that bringing contraceptive services to school premises would help to overcome health services and structural barriers that adolescents are facing (Jonas et al., 2020). However, there is a lack of harmonization of health and education policies in regard to the provision of contraceptives on school premises.

There are conflicting policies between the education and health department where the education policies do not allow the provision of contraceptives within the school premises, especially in primary and secondary schools. According to Malawi Government (2010) adolescents are allowed to be given information regarding contraceptives through subjects and school-based clubs and access the actual services from the nearby health facilities. On the contrary, the health sector wants to scale up utilization of these services through the use of school health programs where the provision of YFSRHS can also be done since there are no clinics in most primary and secondary schools. However, the provision of contraceptives is prohibited by the education policies during these school health programs. These inconsistent policies result in low utilization of contraceptives since most school-going adolescents do not easily access the services putting them at a higher risk of unwanted pregnancy and complications. In view of this, there is a need to improve service providers' attitudes and skills on quality adolescent sexual and reproductive health services that are youth-friendly as hospital facilities remain as a convenient place to access contraceptives by adolescents.

5.2.2 Contraceptive side effects.

In this study, healthcare providers were uncomfortable providing contraceptives to adolescents for fear of causing infertility due to side effects especially when using the Depo Provera contraceptive method. However, most adolescents who wanted a hormonal contraceptive method to choose DMPA injection (Depomedroxyprogesterone Acetate) as their method. Similar to this study's findings, healthcare providers in another study felt that the provision of contraceptives to adolescents may lead to the development of cancer and also difficulties in conceiving (Paul et al., 2016). Therefore, healthcare providers prefer to advise adolescents on abstinence or provide condoms if they still insist on the use of hormonal contraceptives (Godia et

al., 2013; Håkansson et al., 2018). However, another study in Tanzania found that the use of modern contraceptives was acceptable among unmarried students and people in unstable relationships (Sedekia et al., 2017). In spite of this, long-acting reversible methods were perceived as inappropriate methods for delaying first birth, partly because of fear around the delayed return of fertility, which may sometimes permanently limit future fertility (Sedekia et al., 2017).

Similarly, another study established that 80 percent of gynecologists did not offer the Intrauterine Device (IUD) to nulliparous and adolescents (Olivari et al., 2015). Intrauterine Device use was linked with the risk of Pelvic Inflammatory Disease (PID). Contrary to these findings, in Italy, healthcare providers thought that it is fundamental for their work and practice to adopt a non-judgmental attitude towards adolescents who were asking for contraceptive methods by trying to understand their reasons and to answer their needs (Olivari et al., 2016). In addition, they strongly believed that their role requires the ability to distance themselves from their personal and moral beliefs because working with adolescents means to be welcome and open-minded. Contraceptive counseling programs that engage adolescents in shared decision making show high levels of Long-Acting Reversible Contraceptive method selection which are most effective in the prevention of unwanted pregnancies among adolescents (Eliscu & Burstein, 2016).

Studies have shown that both adolescents and older women have an equal chance of experiencing side effects due to contraceptive use (World Health Organisation, 2015). The use of progesterone-containing injectable contraceptive methods, DMPA may lead to loss of bone mineral density in both adults and adolescents but the mass is regained after discontinuing the injection (World Health Organisation, 2015). Injectable contraception (DMPA) has a convenient dosage schedule, which makes it a good method for many adolescents. When cost and access barriers are eliminated, women who received repeat injections of DMPA within the recommended

3-month period have very low pregnancy rates, similar to those of Long-Acting Reversible Contraceptive methods (Hubacher et al. 2017). Losses in bone mineral density appear to be fully reversible and do not contribute to fracture risk. Concerns about bone mineral density prompted caution against the use of the method beyond 2 years unless no other contraceptive method is acceptable. However, evidence suggests that DMPA may be used indefinitely by adolescents or older women (Committee Opinion No. 602, 2014). Similarly, a study on IUCD found that the risk of pregnancy, infection, and perforation are low among IUD users of any age. Heavy bleeding or removal with bleeding does not seem to be associated with age (World Health Organisation, 2015). Like other hormonal contraceptive methods, combined hormonal contraceptives contain estrogen and progestin and include OCPs and patch. Although they have a higher failure rate than LARC methods or DMPA, combined hormonal contraceptives have a beneficial effect on a number of conditions that can affect an adolescent's quality of life, including dysmenorrhea, benign breast disease, iron deficiency anemia, acne, and menstrual irregularity (Martinez & Abma, 2015). Therefore, healthcare providers need not to restrict contraceptive use in sexually active adolescents due to side effects as the side effects are equally the same as in adults and some contraceptive methods can improve quality of life in sexually active adolescences in the course of using them.

In contrast, other study findings indicate that healthcare providers sometimes encourage adolescents to use condoms due to inadequate knowledge in regards to modern contraceptive methods. In this study providers' knowledge and confidence in the provision of modern or long-term contraceptive methods were not explored but could be another contributing factor for restriction of the methods. Similarly, a study in Botswana on knowledge, attitudes, and practice of healthcare providers regarding contraceptive use in adolescents indicated that three-quarters of the

participants strongly agree that they were comfortable with prescribing contraceptives to adolescents. However, only 23 percent of the respondents very much prescribed contraceptives or always prescribed contraceptives to adolescents. Most healthcare providers prescribed contraceptives irregularly and this could be attributed to limited knowledge about newer methods, safety concerns, and limited counselling skills (Tshitenge et al., 2018). Therefore, there is a need to explore healthcare providers' knowledge regarding long-term and new contraceptive methods at Mitundu hospital as this may also affect their provision of services to adolescents.

5.3 Challenges encountered in provision of contraceptives

Healthcare providers experience different challenges that may affect their provision of services to adolescents. These challenges may include service-related factors that affect the provision of contraceptives like lack of essential equipment and supplies (El-Damanhoury & Abdelhameed, 2013; Godia et al., 2013; Kennedy et al., 2013; Nalwadda et al., 2011). In this study, participants' challenges were; lack of privacy, shortage of trained staff, and unavailability of hormonal contraceptives.

Healthcare providers are key to ensuring that young people access, adopt, and continue the use of contraceptive methods. Therefore, the healthcare providers' biases and restrictions may hamper young people's access and use of the contraceptives. Healthcare providers may encourage adolescents to abstain from sex than providing them with knowledge of available contraceptive methods and how to access them which may affect the utilization of reproductive health services. In this study, it was noted that there was a lack of privacy in contraceptive provision for adolescents. They were accessing contraceptive methods together with other older women. This is in tandem with a study on barriers and facilitators to the provision of youth-friendly health service program in rural South Africa which found a lack of dedicated space for young people in four of

the eight facilities which did not uphold the right of the young people to access healthcare independently (Geary et al., 2014). There was a breach of confidentiality to young people in accessing the services. Lack of space that provides auditory and visual privacy to clients may affect service delivery for all ages (Geary et al., 2014; Nalwadda et al., 2011). This may discourage adolescents from accessing contraceptive methods for fear of being labelled promiscuous by the community members and parents whom they may meet at the hospital.

The study findings showed that the youth-friendly center was nonfunctional. Adolescents need a dedicated space where sexual and reproductive services are offered. Youth-friendly health service centers for young people have a significant role in disseminating sexual health information and delivering the services (Ochako et al., 2015). Youth-friendly services may improve reproductive health outcomes for young people and identifies service characteristics that might increase their receptivity to use the service (Brittain et al., 2015). Adolescent Centres outside the hospital environment could encourage more adolescents to utilize such facilities (Chandra-Mouli, et al., 2014b). Similarly, a study by Hagey et al. (2015) recommended that adolescent days can help adolescents to access the contraceptive services without fear of older people seeing them and can also create a more comfortable setting for adolescents seeking contraceptive services.

The study findings showed that there was a shortage of staff at the facility which also contributed to lack of separate clinics for adolescents and also youth-friendly centres being nonfunctional. Despite combing the adolescent and older contraceptive clinics, there was still the pressure of work for providers as a result they fail to provide individualized comprehensive care to adolescents. Furthermore, the providers are expected to provide multiple services and as a result, they end up providing poor quality care to adolescents who are seeking contraceptive services. Likewise, Alli et al. (2013) found that the majority of the providers reported limited contact time

with young people and heavy workload as a challenge affecting the provision of contraceptive services to adolescents. It was further said that they deal with patients quickly and mostly concentrated on the provision of curative than preventive services (Alli et al., 2013).

Providers reported using their general Sexual and Reproductive Health knowledge and experience during the provision of contraceptives to adolescents which affects how they handle the adolescents. These findings are similar to some studies that have been conducted in other countries where providers expressed a lack of knowledge on how to provide YFHS to the youth and reported to be using their past experience which made them feel uncomfortable and unable to meet the needs of the youth (Motuma et al., 2016). In Kenya, providers reported limited knowledge and competency as barriers to the provision of SRH services to young people (Godia et al., 2013b). Youth-friendly services are designed to make health services accommodate the unique needs of the youth. Therefore, providers who get youth-related services information from different sources and are knowledgeable about the services increase the utilization of the services by the adolescents. The Malawi YFHS Evaluation report (2014) recommended training more staff to be providing YFHS in order to improve service utilization. These findings echo a study in Kenya where providers suggested improving staffing levels as one way of improving YFHS provision (Godia et al., 2013a). Increasing HCP will allow providers to spend quality time with the adolescents thereby offering the providers an opportunity to provide the adolescents with all the necessary information, education, and services. This will improve the utilization of contraceptive services and continuation due to a good understanding of side effects as there is more information shared with adolescents about contraceptive methods and services.

In addition to inadequate staffing, there is also a high workload for the providers working in the contraceptive clinic. High workload contributes to long waiting hours for adolescents which

compromises their confidentiality. Michaels-Igbokwe et al. (2015) found that time spent waiting to see a provider at the facility and the concerns about confidentiality were considered to influence the choice of contraceptives among adolescents. In this study, it was discovered that for most female adolescents who accessed contraceptive methods, Depo Provera was their method of choice. This might be the case due to less time taken to access the method, unlike the long term family planning methods.

The study revealed that there is usually a shortage of hormonal contraceptives at the facility and this affects the provision of contraceptives to the adolescents as the preferred hormonal contraceptive, Depo Provera is usually in short supply. It has also been noted that lack of method mix and equipment to meet young people's needs and preferences affects healthcare providers' ability to effectively provide YFSRHS to adolescents (Nalwadda et al., 2011). Stock out of commodities and difficulties in accessing sufficient contraceptive methods are some of the factors that influenced adolescents' choice of the service site. Due to frequent shortages of commodities in government (free) health facilities adolescents prefer to access services from private clinics of none health professionals (Michaels-Igbokwe et al., 2015). This also affects their reproductive health as they cannot also afford to pay for the services.

Ensuring the availability of adequate resources in YFSRHS, delivery points on a daily basis has also been suggested in this study as one of the strategies to promote the provision of quality YFSRHS to adolescents. Similarly, studies in Kenya recommended ensuring the availability of essential drugs, supplies, and basic equipment for the provision of YFHS as one of the strategies in improving service provision to young people (Godia et al., 2013). These resources will enable providers to provide every service that adolescents seek according to standards.

5.4 Recommendations

Recommendations have been made following the results of the study in order to address some challenges that affect the provision of contraceptives to adolescents by healthcare providers. These have been categorized under practice, management, policy, and education.

5.4.1 Practice

Healthcare providers are required to do self-assessments yearly to identify their personal needs in regards to the provision of contraceptives to adolescents and communicate with the relevant people such as in charges or CPD focal person or YFHS coordinator to facilitate how those needs are to be addressed such as through mentorship, Continuous Professional Development (CPD) and training. This will help providers to acquire the necessary knowledge, skills, and attitudes which will promote the provision of quality care to adolescents utilizing contraceptive services and reduce the healthcare providers' knowledge and skills gaps.

Mitundu hospital management team should allocate nurses, clinicians, or both at the youth centre to provide sexual and reproductive health services to adolescents so that adolescents can easily access contraceptives and other services. It will also be necessary to consider opening the clinic during weekends and time should also be convenient for the adolescents. Alternatively, the health facility may identify a day in a week when contraceptives can be provided to all adolescents at the youth centre. This will help in maintaining confidentiality as adolescents are afraid to access contraceptive services for fear of meeting their relatives but also being labelled as promiscuous by the community members. Clinics are also usually open when the adolescents are engaged with academic activities hence, they find clinics closed when they want to access the services.

Trained youth-friendly service providers at Mitundu should provide youth-friendly services at the youth center. Trained providers will give detailed and appropriate information to adolescents as the most active adolescents' source of information are healthcare providers hence the need for accurate information which will help them to utilize sexual and reproductive health services. This will help them to prevent unwanted pregnancies, sexually transmitted infections, and obstetric complications.

Mitundu should lobby for more healthcare providers from the District Health Office to have full-time healthcare service providers who can provide youth-friendly services inclusive of contraceptives. There is a need to establish quality improvement structures at the department or health centre level such as installing suggestion boxes, establishing quality improvement teams to help in monitoring and evaluating contraceptive provision. This will help in informing the health facility on how the services are being provided to adolescents, identifying areas that require improvement, and instituting different interventions to enhance provision and utilization of quality contraceptive services by providers and adolescents respectively. Similarly, in Kenya, quality improvement interventions were recommended for the improvement of adolescent-friendly service delivery (Wagner et al., 2017).

There is a need for regular YFHS review meetings where healthcare providers can share experiences and learn from each other how services are being offered at their facility and other facilities within the Lilongwe district. In addition, there is a need to recognize outstanding performing healthcare providers in providing Youth Friendly Services such as contraceptives as this will act as a motivation.

5.4.2 Management

District Health and Social Services and reproductive directorate should be providing in-service training on adolescent contraception to update healthcare providers on adolescent contraceptives in order to improve their knowledge and skills thereby preventing contraceptive access barriers due to lack of knowledge and negative attitudes. In coordination with the stakeholders and the YFHS coordinator, there is a need to intensify supportive supervision and mentorship sessions which will help in identifying, and addressing challenges providers face during contraceptive provision to adolescents.

In addition, there is a need to conduct in-service training for providers in the provision of contraceptives to adolescents. Training providers were proven to be beneficial in a study in Ethiopia where providers that had been trained reported to be confident in responding to the needs of the youth while those that had not been trained reported that they treat adolescents as adults (Motuma et al., 2016). Similarly, a national survey in America found increased rates of discussions about contraceptives and increased contraceptive provision including long-acting contraceptives to adolescents in public-funded family planning facilities which had staff trained in youth-friendly services as compared to non-youth friendly sites (Kavanaugh et al., 2013).

Reproductive health directorate should organize more regular follow up and updates on adolescent contraception for example adolescents' age and contraceptive use through forums or seminars with the healthcare providers for them to have updated knowledge on adolescent contraception. This will help the providers to have knowledge and skills on current practices thereby improving their attitudes and perception in the provision of contraceptives to adolescents and in return, more adolescents will be accessing contraceptive methods.

The Ministry of Health and the District Health Management Team (DHMT) needs to ensure the availability of all YFSRHS resources at Mitundu hospital and in all health facilities providing YFSRHS to adolescents. These resources include both human and material resources such as contraceptive methods. Similarly, studies in Kenya recommended ensuring the availability of essential drugs, supplies, and basic equipment for the provision of YFHS as one of the strategies in improving service provision to adolescents (Godia et al., 2013a).

5.4.3 Policy

Youth-friendly policies should influence someone's perceptions on the provision of comprehensive sexual and reproductive services to adolescents. Policy guidelines and instructions pertaining to religious, moral values and beliefs should be developed and communicated at the hospital level.

The policy should clarify the role of providers regarding the provision of hormonal contraceptives to both married and unmarried adolescents. This will help address the conflict that providers face during the provision of contraceptives to adolescents identified in this study. These policies will also help managers when allocating providers to specific workstations taking into consideration their values and beliefs in regards to the provision of contraceptives to adolescents. However, all providers are expected to provide contraceptives to all adolescents who are sexually active and are seeking condoms or hormonal contraceptive methods irrespective of their personal and cultural beliefs.

There is a need for continuous education and training of YFSRHS providers to ensure the provision of quality care to adolescents. The education and training needs should be incorporated into the healthcare system policies for professional development such as in and out of service training

policies. This will help address the shortage of YFSRHS providers in the facilities revealed by this study in addition to improving the knowledge and skills of providers in the delivery of the services to adolescents.

Education

Findings from this study show that most providers experience role conflict between their personal beliefs and their obligation to provide contraceptives to adolescents. Therefore training packages of pre-service and in-service healthcare providers should be comprehensive and should include both technical and interpersonal relations of healthcare providers that affect the provision of contraceptives to adolescents. Providers' training places much emphasis on technical issues at the expense of interpersonal aspects which is equally essential to enable providers to interact with the young clients at a more personal level.

Healthcare providers' training needs to address the cultural, religious, and traditional values system as they may influence someone's perceptions on the provision of comprehensive sexual and reproductive services to adolescents. This will also allow students and providers to reflect on themselves and help each other deal with the possible dilemmas thereby preparing them to have a positive attitude towards the provision of quality sexual reproductive care to adolescents.

Study Limitations

The study has three main limitations; firstly the study results cannot be generalized to the general population as it used qualitative methods. However, the study findings may provide useful insights regarding the perceptions of healthcare providers on the provision of contraceptives to adolescents in other facilities. Secondly, the study was done at one facility in Mitundu community hospital and the findings will only apply to that setting. Thirdly the study used purposive sampling to recruit

participants who have worked for more than 1 year at Mitundu community hospital. This does not guarantee that they gave rich information as compared to those with less than a year of experience working in family planning at Mitundu community hospital. Therefore the study does not guarantee that all voices of healthcare providers were heard and represented in the study.

Areas for further research

This study concentrated on healthcare provider perceptions of the provision of contraceptives to adolescents. However is important to explore the determinants of contraceptives use in both males and females as this may also affect their utilization of contraceptive services.

There could also be a study on perceptions of adolescents towards healthcare providers' provision of contraceptives to adolescents. This is on the understanding that the current study mainly focused on the healthcare providers and it would be interesting to explore the perceptions of the adolescents as well.

Another study could be conducted on knowledge and practices of healthcare providers on hormonal contraceptives/long term contraceptive methods. This study looked into the perceptions of health providers but it is also important to explore their knowledge and practices in contraceptives as this may also affect the provision of contraceptive services to adolescents.

5.5 Conclusion

It is widely acknowledged that healthcare providers play an important role in the provision of quality sexual and reproductive health services. Despite playing such an important role, this study has shown that healthcare providers hold different perceptions towards the provision of contraceptives to adolescents. It has revealed that most healthcare providers are uncomfortable

providing contraceptives to adolescents due to fear that contraceptive use influences adolescent sexual behavior, fear of contraceptives' side effects, condoms are for adolescents and premarital sex is a sin against God. Healthcare providers who are comfortable to provide contraceptives prefer to counsel adolescents who are seeking contraceptives more on abstinence and condom use than hormonal contraceptives. However, lack of privacy when providing contraceptive services to adolescents, shortage of trained staff, and negative attitudes of healthcare providers, and unavailability of hormonal contraceptives have also been identified to negatively affect the provision of contraceptives to adolescents. Healthcare providers' perceptions and challenges affect the provision and accessibility of contraceptive services for adolescents. Interventions must aim at making providers more aware of adolescent contraceptives and also clear misconceptions regarding contraceptive use among adolescents. There is a need for in-service training on adolescent contraception to update healthcare providers. There is also a need for regular follow-ups and updates on adolescent contraception. The issue of lack of privacy in the provision of the services can be dealt with by ensuring that the provision of contraceptives to adolescents is done separately from elder women. Furthermore, there is a need to ensure the availability of both human and material resources to enhance the provision and utilization of contraceptive services to adolescents. There is also a need to address personal conflicts of healthcare providers in the provision of contraceptives to adolescents to improve quality YFHS provision.

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Appendices

Appendix 1: Participants information sheet

Dear participant,

My name is Linda Kachigamba Chimbalanga, currently registered as a student at the University of Malawi, Kamuzu College of Nursing for a Master of Science degree in Reproductive Health. I am conducting a research project on **“Perceptions of healthcare providers on the provision of contraceptives to adolescents at Mitundu rural hospital, Lilongwe”** as part of the partial fulfillment of the requirement of the master’s degree. I would like to ask you to participate in my study. Participation in the study is entirely voluntary. You will be interviewed using an interview guide, which has been developed by the researcher. This interview will take 30 minutes to 45 minutes of your time but it will start at your convenient time, which you may propose.

The study aims to explore the perceptions of healthcare providers who are working at Mitundu on the provision of contraceptives to adolescents. Participating in the study is freely and there no immediate benefits apart from the study findings at the end of the study. Exploring the perceptions of healthcare providers on the provision of contraceptive methods will assist in the planning of healthcare providers and adolescent contraception programs and also assist in rectifying some of the problems encountered by the health providers in providing contraceptives to adolescents. You may choose to participate or withdraw from the study at any time, which will not have any effects on your current job or any benefits you receive. Furthermore, the study does not have any foreseeable physical risks, emotional or psychological harm you may encounter. However, if you happen to have encountered any of the mentioned risks you may choose to withdraw from the study at any point.

No names will be used and the individual responses will be encoded to be kept confidential. Reports in this study will not identify you in any way and the results of the study will be given to you should you wish so. Should you agree to participate, I will ask you to sign a consent form to indicate that you have accepted to be interviewed.

Participants signature.....Date.....

The study has been approved by the College of Medicine Research Ethics Committee (COMREC) and Lilongwe District Health Office.

Thank you for taking the time to read this information letter.

Should you require any further information regarding the study or your rights as a study participant you are free to contact me on the following number:

Linda Chimbalanga on 0999453448 or The chairperson, COMREC Secretariat, P/Bag 360, Chichiri, Blantyre 3 or call on 01871911, extension 334.

Appendix 2: Informed Consent form

PLEASE READ AND SIGN THE FORM IF YOU ARE TAKING PART IN THIS STUDY

I..... (Name), voluntarily give permission to participate in the study.

I have read and understood the content of the information letter and I have been given the opportunity to ask questions, where deemed necessary, about the study.

I understand that the information I give will be kept confidential and will only be accessed by the researcher and/or those people who are directly concerned with the study

I know that I do not have to suffer any injury or harm during the research process and the information that I will give to the researcher will not be used against me in future.

.....

Participant’s Signature Date

.....

Researcher’s Signature Date

Should you have any further inquiries please contact: The Chairperson, COMREC Secretariat
P/Bag 360, Chichiri, Blantyre 3 or you may call on 01871911.

Appendix 3: Semi- Structured Interview Guide

SECTION A.

Interview guide number.....

Date of the interview.....

Name of the interviewer.....

DEMOGRAPHIC CHARACTERISTICS

Age

1. 20-25 years

2. 25-35 years

3. 35-45 years

4. 45 and above

Sex

1. Male

2. Female

Religious belief

1. Jehovah's witness

2. Roman Catholic

3. CCAP

4. Muslims

5. Others specify.....

Professional qualification:

1. Clinical Officer

2. Medical Assistant

3. Nurse

If a nurse; nursing Cadre

1. Registered nurse

2. Nurse midwife Technician

3. Enrolled Nurse Midwife

Work experience in family planning clinic

1. 1 year

2. More than one year.

Trained in youth friendly health services

1. Yes

2. No

SECTION B: In-depth interview guide.

1. Tell me about your views towards the provision of contraceptives to adolescents

Probes

- Knowledge of adolescent contraceptives
- Side effects of contraceptives to adolescents
- Religious beliefs
- Adolescent behavior and contraceptive use
- Age and contraceptive use

2. Would you tell me the challenges that you encounter when providing contraceptives to adolescents?

Probes

- Lack of knowledge among adolescents
- Availability of space
- Human resource
- Clinical resource

3. What would you suggest to be done to improve the provision of contraceptives to adolescents?

- Training/in-service training on youth friendly services

- Resources
- Sensitization to the adolescents
- Community involvement.

4. Tell me any other information that you would like to explain the provision of contraceptives to adolescents.

Thank you for your participation!

Appendix 4: Letter to Lilongwe District Health Officer

University of Malawi

Kamuzu College of Nursing

Private Bag 415

BLANTYRE

10th May 2017.

District Health Officer,

Lilongwe District Health Office,

Private Bag 1274,

LILONGWE 3.

Dear Madam/ Sir,

PERMISSION TO CONDUCT A RESEARCH STUDY

I write to seek permission to conduct a research study at Mitundu rural hospital and pre-test interview at Kawale health centre. I am a student currently pursuing a Master of Science degree in reproductive health at the above-mentioned institution. In partial fulfillment for the master's degree is a requirement to carry out a study related to reproductive health. The title of the study is **“Perceptions of healthcare providers on the provision of contraceptives to adolescents at Mitundu rural hospital, Lilongwe.”**

Evidence has shown that healthcare providers are barriers to adolescent contraceptive use due to their unfriendly attitudes and lack of privacy when providing the services. This has resulted in low utilization of contraceptive services among adolescents, which has caused an increased number of unwanted pregnancies, obstetric complications, and neonatal deaths. Mitundu rural hospital is unexceptional with increased teenage pregnancies and low contraceptive use among teenagers. Therefore it is important to conduct a research and explore the perceptions of the healthcare providers. The knowledge gained will assist in improving the access of contraceptive methods among adolescents.

Enclosed is the proposal.

Looking forward to your favorable consideration

Yours faithfully,

Linda Kachigamba Chimbalanga.

Appendix 5: Certificate of approval



Ref. No.:
Telephone No.: **265 726 466/464**
Telefax No.: **265 727817**
Telex No.:
E-Mail: **lilongwedho@malawi.**



In reply please quote NO DZH/MALAWI,
Lilongwe District Health Office
P.O. Box 1274
Lilongwe
Malawi

COMMUNICATIONS TO BE ADDRESSED TO:

3rd July, 2017

The In-charge, Mitundu Community Hospital
The In-charge, Kawale Health Centre
Sir/Madam

PERMISSION TO CONDUCT RESEARCH STUDY IN LILONGWE DISTRICT

Approval has been granted to the bearer of this letter: **Linda Kachigamba, from Kamuzu College of Nursing**, to conduct a research study at Mitundu Rural Hospital and pre-test interviews at Kawale Health Centre, in Lilongwe.

" Perceptions of health care providers in provision of contraceptives to adolescents at Mitundu rural hospital, Lilongwe"

Any assistance rendered would be appreciated.

Ministry of Health & Population
Lilongwe District Health Office
DISTRICT MEDICAL OFFICER
Dr. E. Rambika
2017
DISTRICT MEDICAL OFFICER-LL
Lilongwe