Kamuzu College of Nursing

HEALTH CARE PROVIDERS' PERSPECTIVES ON FACTORS INFLUENCING PROVISION OF YOUTH FRIENDLY SEXUAL REPRODUCTIVE HEALTH SERVICES TO ADOLESCENTS IN DEDZA, MALAWI

By

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Declaration

I, **Lucy Jonas Chimera,** declare that this thesis is my own original work which has never been submitted for any other awards in the University of Malawi or any other university. All the sources of information that I have used or quoted in this thesis have been acknowledged and added to the list of references.

Lucy Jonas Chimera

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Full Name

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Signature

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Date

Certificate of approval

The undersigned approve that this dissertation represents the student's own work and has been submitted with our approval.

Signature _____ Date _____

Dr. Lucy Kululanga (PhD).

Main Supervisor

Signature_____ Date _____

Mrs. Janet Botha (MSc)

Second Supervisor

Dedication

I dedicate this thesis to my husband Aonenji Chimera who has always been supportive of my work and made me believe in myself throughout the whole research process. Thank you for the encouragement and sacrifices.

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I would like to give thanks and praise to God Almighty for the gift of life, good health, wisdom, guidance, protection, and the grace given to me during my years of study.

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Abstract

Youth Friendly Sexual and Reproductive Health Services (YFSRHS) continue to be underutilized by adolescents despite their availability in most hospitals in Malawi leading to an increase in sexual reproductive health problems among adolescents. This study explored the factors influencing provision of YFSRHS to adolescents from the providers' experiences.

This was a descriptive qualitative study conducted at Dedza District Hospital, Chitowo, and Mtakataka Health Centres. Data were collected from a purposive sample of 17 nurses, clinicians and medical assistants through in-depth interviews using a semi-structured interview guide and was analyzed using thematic analysis method. Main themes identified from the findings were; adolescents' behaviours during service delivery, views on YFSRHS utilization, motivation to provision of YFSRHS, challenges providers encounter, and suggestions on improving provision of YFSRHS to adolescents.

The study found that adolescents' behaviours, YFSRHS delivery system challenges, and health care providers' challenges negatively affect the quality of YFSRHS given to adolescents. The passion for adolescents' health and need to safeguard their future has been identified as the major motivating factor to the utilization of YFSRHS. However, health care providers reported often times finding themselves in a dilemma between fulfilling their duties and respecting their personal, religious, and moral values and beliefs in regards to provision of YFSRHS to adolescents. Therefore, interventions aimed at increasing utilization of YFSRHS by adolescents should aim at making communities aware of the availability of YFSRHS in the hospitals, addressing misconceptions associated with YFSRHS, and addressing providers' personal, religious and moral values and beliefs towards provision of YFSRHS to adolescents along with the health service delivery related improvements.

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List of Abbreviations and Acronyms

ART	Anti-Retroviral Therapy
CHAM	Christian Health Association of Malawi
DHIS 2	District Health Information System 2
DHO	District Health Office (Officer)
EMIS	Education Management Information System
FPAM	Family Planning Association of Malawi
HCP	Health Care Providers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
PMTCT	Prevention of Mother-to-Child Transmission of HIV
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
TA	Thematic Analysis
VCT	Voluntary Counselling & Testing
UNFPA	United Nations Population Fund
WHO	World Health Organization
YFHS	Youth friendly Health Services
YFSRHS	Youth Friendly Sexual and Reproductive Health Services

Operational Definitions

Adolescents: Those aged between 10 to 19 years regardless of marital, social and economic status.

Health providers' attitude: Health providers' views about the provision of YFHS to adolescents**.**

Unmet need for family planning: Women and girls are considered to have an unmet need for family planning if they wish to delay, space, or limit their next pregnancy by two years or more and are not currently using any modern or traditional method of contraception

Utilization: The ability to consume services and incorporates economics, geographic location, abundance of health services, physical and social resources or usage of the youth friendly reproductive health services.

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. The YFSRHS services that are being referred to in this document include contraceptives, sexually transmitted infections treatment, antenatal and maternity services, postabortal care and Anti-Retroviral Therapy. These services are provided in line with the minimum health package and aim at increasing acceptability and use of health services by young people.

Young people: Those aged 10 to 24 years regardless of marital, social and economic status

Youth: Those aged between 15 to 24 years regardless of marital, social and economic status.

CHAPTER 1

Introduction and Background

Introduction

Adolescence is one of the life's most fascinating and complex stage of human life and adolescents are defined as individuals in the 10-19 year age group (World Bank Group, 2016). This period is marked by enormous physical and psychological changes in an individual and he/she starts to experience changes in social expectations and perceptions (Ministry of Health, 2016). It is the time when young people take on new responsibilities and start experiencing life with independence. In the process of experiencing this independence adolescent girls and boys start having internal and external pressures, which force them to indulge in premature sex at a very young age (Kanthiti, 2007). These 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 are usually faced with a lot of problems such unplanned pregnancies, Sexually Transmitted Infections, HIV/AIDS, school dropout, early marriages and early unplanned parenthood.

The world is currently experiencing fastest population growth of young people than before (UNFPA, 2014). This rapid growth is very high in two continents; Asia and Africa (United Nations, 2015). This calls for effective and efficient interventions in order to address the Sexual and Reproductive Health (SRH) needs for the young people so as to build a better future for them. Similarly, Malawi is experiencing rapid population growth of young people as it is estimated that 66% of Malawi's population is under 25 years of age (YFHS Strategy, 2015-2020) and 64% are under the age of 15 years (Government of Malawi, 2017) which shows that most of the Malawian

population is youthful posing a greater need to protect their future through provision of effective health services.

On the other hand, in Malawi awareness about sex among adolescents aged 10-14 years is high with 76% of males and 66% females in this age group having ever heard or talked about sex and early sexual debut continues to persist among these adolescents with 20.3% boys and 5.3% girls having had sex by age 10 (Ministry of Health & Evidence to Action, 2014). Half of all young people (aged 10-24 years) have ever had sex with the likelihood of having sex increasing with age (MOH & Evidence to Action, 2014). The burden of early childbearing in Malawi is also high such that 29% of adolescents between 15-19 years have already begun childbearing (Malawi National Statistical Office, 2016). This has resulted in high school dropout especially among girls such that two in every seven primary school girls dropped out of school due to pregnancy (Ministry of Education, Science, and Technology, 2013). This also results in physical and psychosocial problems in regards to childbearing and upbringing since their bodies are immature and they are not financially stable to raise the child.

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, Mengistie, Egata, & Reda, 2012; Kapito, Kazembe, Maluwa, Malata, & Odland, 2012). In Malawi, Botha (2010) identified that knowledge on reproductive health information among adolescents was almost universal (94%); it was however revealed that although knowledge of SRH services such as contraceptives among adolescents in Malawi is universal this does not translate to use of these contraceptives (Levandowski, Pearson, Lunguzi & Katengeza, 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 the adolescents.

In order to address the sexual and reproductive health problems that adolescents and young people are facing in Malawi, Ministry of Health introduced the Youth Friendly Health Services (YFHS) program which allows the youth and adolescents to freely access reproductive health services from private and public health facilities. 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. Despite the availability of YFHS in most health facilities in all districts in Malawi, there is low utilization of these services by the adolescents. In a recent evaluation of YFHS it was revealed that only 31.7% of young people have heard about YFHS and 13% have ever used these services (Ministry of Health & Evidence to Action, 2014). Similarly, young people in Dedza do not fully utilize the YFHS; only 3% of adolescents accessed the services during January-June 2016 period (Dedza District Health Management Information System, 2016) which shows that indeed the youth are not utilizing YFHS despite their availability in the hospitals.

Utilization of YFHS in Malawi and other Sub-Saharan Africa countries is affected by several factors ranging from those arising from the youths 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 poor attitude towards the young people accessing YFHS (Chilinda, Hourahane, Pindani, Chitsulo, &

Maluwa, 2014). These attitudes range from being judgmental to adolescents, refusing to offer the services, not treating the youth nicely and friendly, providers' rudeness to adolescents and not keeping information given to them by the youth in confidence (Akinyi, 2009; Biddlecom et al., 2007; Hiwot, Reddy, & Awoke, 2016; Kamau, 2006; Kinaro, 2013; Mbeba et al., 2012; Mwenyango, 2010; & Ministry of Health & Evidence to Action, 2014). Health Care Providers (HCP) play a major role in provision and utilization of Youth Friendly Sexual Reproductive Health Services (YFSRHS) by adolescents. However, little is known in Malawi regarding factors influencing provision of YFSRHS from health care providers' perspective. Therefore, this study explored these factors with an aim of identifying the strengths and challenges providers face during provision of these services to adolescents and make appropriate recommendations in order to improve utilization of the services by the young people.

Background

Globally, young people between the ages of 10 and 24 are estimated to be 1.8 billion, and this young population is growing fastest in the poorest nations (UNFPA, 2014). Within this population are 600 million adolescent girls with specific needs, challenges, and aspirations for the future. It was estimated that 226 million people in Africa were aged between 15-24 years in 2015 (United Nations, 2015) with Sub-Saharan African countries having a proportionally large youth cohort. This poses a risk for further population growth and an increase in SRH related problems in the region in the years to come since the youth and adolescents are still in the high fertility age range and are still exploring their bodies.

Similarly, Malawi is one of the least developed countries which has a higher population of young people among the total population. However, this young generation is experiencing different SRH problems such as early marriages and teenage pregnancies such that 29% of adolescents have already started childbearing at the age of 15-19 years (Malawi National Statistical

Office, 2016) and it was revealed that 50% of young people were involved in marriages (Malawi National Statistical Office and ICF Macro, 2011) making themselves vulnerable to maternal deaths. In addition, the country currently registers a high number of adolescent pregnancies and high STI/HIV incidences among the youth. There is also a high percentage of unmet need for family planning among adolescents in the age group (15-19 years) which is estimated to be 22.2% and this is higher than the total unmet need for family planning among all childbearing age groups in Malawi which are estimated at 19% (Malawi National Statistical Office, 2016). In addition, Malawi has the highest adolescents' fertility rate as compared to other countries in Sub-Saharan Africa which has also contributed to early childbearing in the adolescents. Millennium Development Goals end line survey observed that there were 143 births for every 1,000 women occurring among the adolescents aged 15-19 years (NSO, 2014). This figure surpasses 2010 WHO African Region estimate of 118 births for every 1,000 women aged 15-19 years (Ministry of Youth and Sports, 2013). Thus on average, a Malawian adolescent girl would bear one child by the time she completes her adolescence.

Furthermore, HIV/AIDS still poses a challenge among adolescents and young people. Globally, about 2.6 million young people die every year, most from preventable causes including injury, HIV, tuberculosis, and maternal death (Patton et al., 2012). It was estimated that approximately 2.5 million new HIV infections that occurred in 2011, 40 percent occurred among youth aged 15-24 years (UNAIDS, 2012). In Malawi, youths account for approximately half of HIV new infections (UNAIDS, 2011) with a high incidence of 3,200 annually (NAC, 2013) and it further showed that 69% of sexually active young people have multiple partners (NAC, 2013).

The government of Malawi started implementing YFHS program in 2007 following a thorough needs assessment conducted in 2002 by the United Nations Children's Fund (UNICEF) which identified that young people including adolescents were not utilizing some reproductive

health services due to poor attitude of the staff (Ministry of Health & Evidence to Action, 2014). This assessment also noted that the youth were being faced with a broad range of health and sexual reproductive health problems such as STIs, HIV/AIDS, and unwanted pregnancies. YFHS are currently being implemented in all districts in Malawi, with the scope of implementation varying across districts (Ministry of Health & Evidence to Action, 2014). The variation in these services' delivery is mainly due to different donors and technical partners supporting these services in different districts. For example, some districts provide the YFHS as an integrated package with other services, other districts provide the YFHS package as a vertical programme on a specified day in a week, and others combine both approaches. These services are being offered in both public and private hospitals with support from the government, donors, and other SRH interventions implementing partners.

Young people account for 33% of the total population in Dedza district and 24% of these young people are adolescents (Dedza District Health Management Information System, 2016). There are 18 government and Christian Health Association of Malawi (CHAM) health facilities providing YFHS to young people out of the total 34 health facilities in the district. These services are provided alongside other private facilities such as Banja La Mtsogolo (BLM), Family Planning Association of Malawi (FPAM), private clinics and also Community Based Distribution Agents (CBDA) for family planning method in the district. Among the 18 government health facilities, three facilities are certified YFHS facilities because they provide full YFHS package in line with the national YFHS standards and these are the facilities that have been included in this study. Despite availability of the services in the district, only 52,940 (21%) young people utilized YFHS in a period of 6 months during January-June 2016 and among this only 3 % were adolescents (Dedza District Health Management Information System, 2016). This shows that adolescents in Dedza District are also not utilizing the YFHS concurring with the national YFHS evaluation

results. Exploring factors influencing provision of YFSRHS to adolescents will improve provision and utilization of YFSRHS to adolescents.

Problem Statement

In Dedza district, adolescents face different SRH problems such as teenage pregnancies, early marriages, and STIs including HIV/AIDS among others which results in high school dropout rates. It was revealed that in the district, 21.7% of adolescents aged 15-19 had begun childbearing (MDHS, 2010) and 2.6% of adolescents were in marriage unions before their 15th birthday (UNICEF, 2013). Among the clients that were treated for STIs in the district in the past 6 months (January- June 2016) 36% were young people and 7% of these were adolescents (Dedza District Health Management Information System, 2016). This shows that young people in the district are getting involved in risky sexual behaviours leading to different SRH problems despite YFHS being provided in 18 facilities in the district where YFSRHS can be accessed. YFHS as a whole package are also largely under-utilized by adolescents in the district such that only 3% of adolescents utilized these services between January-June, 2016 (Dedza District Health Management Information System, 2016).

Health care providers' attitude towards the youth utilizing YFHS has been revealed as one of the main factors hindering the young people from utilizing different SRH services in Malawi (Ministry of Health & Evidence to Action, 2014) along with other reasons such as long distances to the facilities, in availability of the services in health facilities, inconvenient opening hours and lack of privacy and confidentiality among others. Most studies done outside Malawi, have reported that HCP are hesitant to provide the young people with different YFSRHS based on their personal, moral and religious beliefs and values (Godia et al., 2013; Ahanonu 2014; Nalwadda 2012). In Malawi little is known in regards to factors that influence provision of YFSRHS to adolescents especially from HCP's perspectives since most studies have concentrated on assessing

factors affecting utilization of YFHS from adolescents' and community members' views. Therefore this study sought to explore the factors influencing provision of YFSRHS to adolescents in Dedza from the providers' experiences with an aim of identifying the strengths and challenges providers face during provision of these services in order to promote provision of quality YFSRHS thereby increasing utilization of these services by the adolescents.

Justification of the Study

The study sought to explore and understand the factors influencing the provision of YFSRHS to adolescents qualitatively from the providers' perspective by focusing on their experiences during service provision. It has helped in identifying new knowledge regarding strengths and challenges/barriers health providers are facing in provision of YFSRHS to adolescents, motivating factors to provision of these services to adolescents, and strategies to improve provision of these services to adolescents. Understanding these factors will help health care providers, youth friendly health services program managers, SRH interventions implementing partners, Ministry of Health and other stakeholders in instituting effective and efficient interventions to improve provision of YFSRHS in Malawi. This will contribute towards provision of quality YFSRHS to adolescent, thereby promoting maximum utilization of these services by the adolescents leading to the promotion of their wellbeing and safeguarding their future.

Objectives of the Study

Broad objective.

To explore factors influencing provision of YFSRHS to adolescents in Dedza from the HCP.

Specific objectives.

1. To explore health care providers' experiences in providing YFSRHS
2. To identify factors that motivate health care providers' provision of youth friendly sexual and reproductive health services to adolescents.
3. To identify challenges of health care providers in provision of YFSRHS.
4. To explore strategies that can enhance health care providers' provision of YFSRHS to adolescents.

CHAPTER 2

Literature Review

Introduction

This chapter presents the existing literature relevant to the current study topic. This review focuses on studies that have been conducted to assess factors influencing provision of Youth Friendly Sexual and Reproductive Health Services to adolescents. In order to identify appropriate information related to the topic under study the review of literature was guided by the following subtopics which relate to the study's objectives; health care providers' attitude and perception towards provision of YFSRHS to adolescents, challenges/barriers to provision of YFSRHS to adolescents, and strategies that enhance health care providers' provision of YFSRHS to adolescents.

A literature search was conducted using the following electronic databases: HINARI, Pubmed, Science Direct, EBSCO host, and Google Scholar. Additional articles were retrieved from published journal articles and unpublished were also retrieved and reviewed. In addition, manual search from what peers have done was done from Kamuzu College of Nursing library. This was done to explore what was already done on the topic. Terms such as " facilitators", "barriers", "sexual and reproductive health services", "adolescents," "young people," "determinants," "factors," " utilization", "provision"," health care providers", "attitudes," "perception", and "experiences" were entered separately using "AND" and "OR". The search was an open search not confined to a specific period of time; however, priority was given to articles that were not more than 10 years old. Articles from all over the world were retrieved with much

focus on those from the Sub Saharan Africa since these countries share similar health service provision structures and challenges as Malawi.

Health Care Providers' attitude and perception towards provision of YFSRHS to adolescents

Health care providers are at the centre in the provision of YFSRHS to young people hence their attitude and perception play a greater role in the way they discharge the services. Literature shows that HCP have different views in regards to provision of YFSRHS to young people and some of these views are specific to some YFSRHS such as contraceptives. These views and perceptions contribute to different attitudes that HCP have towards provision of YFSRHS to young people. Ontiri (2015) in a study in Kenya found that majority of the providers who participated in his study were not comfortable to provide contraceptives to adolescents less than 18 years while other providers did not have any problem providing such services provided they had received enough training.

Similarly, health care providers in Uganda were found to be ambivalent towards providing contraceptive counselling to sexually active young people due to societal norms and the opportunities resulting from provider realistic approach to counselling to young women (Paul, Näsström, Klingberg-Allvin, Kiggundu, & Larsson, 2016). It was identified that the existing social norms influenced some providers' decisions during contraceptive service provision to young people. In addition, misconceptions associated with the use of hormonal contraceptives by young people and lack of appropriate knowledge and skills made some providers not to provide these contraceptives to young people. Godia et al. (2013) also found that providers were supportive towards provision of some SRH such as HIV and related services but the majority were not comfortable to provide contraceptives (except condoms) due to the side effects associated with the

contraceptives. This shows that most HCP have their own personal reservations when it comes to provision of YFSRHS to adolescents based on their different views and factors and this influences how they treat adolescents coming to seek such services.

Health care providers' attitude in provision of YFSHRS to young people acts as facilitators or barriers to utilization of YFHS by the adolescents. Research has shown that health providers show poor attitude towards young people who are accessing YFHS. As a result, the youth do not want to go back for these services in future acting as a barrier for them to use the services. These attitudes range from being judgmental to the adolescents, refusing to offer the services, not treating the youths nicely and friendly, being rude to adolescents and not keeping information given to them by the youth in confidence (Akinyi, 2009; Biddlecom et al., 2007; Kamau, 2006; Kinaro, 2013; Hiwot et al., 2014; Mbeba et al., 2012; & Mwenyango, 2010).

Chilinda et al. (2014) in their systematic review of studies on providers' attitude towards sexual and reproductive health services in developing countries revealed unprofessional attitude of health care providers towards adolescents who were utilizing the SRHS. These negative attitudes were reported in a lot of studies that were reviewed and among other actions it was noted that, providers would shout and judge adolescents when they came to utilize different SRH services. Similarly, a study in Ethiopia revealed negative attitude of health workers towards unmarried adolescents who were utilizing the SRH services and some health workers agreed setting up penal rules and regulations against premarital sex which brought fear for some youths to utilize YFHS (Tilahun et al., 2012).

Health care providers often find themselves in conflict with their personal beliefs and their professional duties which contributes to how they treat adolescents who come to seek YFSRHS at their facilities. Studies have revealed that provision of YFHS such as contraceptives to the youth

often comes in conflict with their beliefs and societal norms making it difficult for providers to provide the services since these services are often associated with promotion of promiscuity among the young people. A study in Kenya reported staff being torn between their personal feelings, cultural and religious values and beliefs and their wish to respect young people's rights to accessing and obtaining SRH services when providing YFHS (Godia et al., 2013). Some staff were conservative to provide contraceptive methods to the youth. Similarly, it was also revealed that providers assume unprofessional role such as the role of parents when adolescents seek SRH services which put them in a dilemma and makes it difficult for them to effectively give these services to adolescents (Chilinda et al., 2014).

In addition, the social-cultural norms and beliefs associated with sexuality also contribute to different attitudes that providers have towards provision of YFSRHS to adolescents. Issues of sexuality in most African countries are not openly discussed with adolescents as it is believed that it promotes sexual experimentation and there is lack of appropriate language to be used during the discussion due to the age range differences (Motsomi, Makanjee, Basera, & Nyasulu, 2016). This belief also affects how providers give information in regards to sexual and reproductive health services to adolescents. Paul et al. (2016) found that providers felt uncomfortable discussing sex with young people in an appropriate way which affected how they discharged the SRH services to adolescents. Similarly, in a study in Turkey nurses said that discussing sexual issues with children is the responsibility of parents and half of the nurses who participated in the study reported difficulties in initiating a discussion about sexuality with their clients (Yigit, Rana, Kanik,Ozcan, & Yuzer, 2007). Gondwe (2008) recommended that although discussing sex is difficult considering our cultural context, it is important for parents and health care providers to listen to the sexual problems that the young people have so that they can offer proper advice.

Young people need to be treated by providers who understand their needs and are able to give them enough information regarding different YFSRHS so as to help them prevent different SRH problems hence the need for providers to have a good attitude towards these services. When the youths are treated nicely and in a friendly manner by the providers, it promotes satisfaction and services utilization. Kanthiti (2007) in her systematic review of studies on factors that facilitate the use of family planning services identified that positive attitude of service providers and friendly environment were what adolescents wanted for them to freely utilize the services. Similarly, a study with adolescents in Kenya revealed that adolescents liked a particular facility because the health care workers were nice, welcoming, friendly and not rude to them (Kamau, 2006). It further added that services provided by the youthful peer educators promoted satisfaction because they would easily discuss sexuality education in an informal language with their peer educators who were trained as providers of YFHS and this promoted satisfaction with the services.

Challenges/barriers to provision of YFSRHS to adolescents

Provision of YFSRHS is known to be affected by several factors and these act as barriers for adolescents to receive effective services when they seek these services. Studies have revealed different barriers/challenges which HCP face in provision of YFRSHS. Lack of enough human resources to provide YFRHS to young people has been identified as one of the major factors affecting provision of these services in most African countries. There is a shortage of staff in the health facilities to help in provision of YFSHS (Godia et al., 2013; Geary, Gómez-Olivé, Kahn, Tollman, & Norris, 2014). This makes health workers to have a high workload during service delivery since they are responsible for provision of several other services; as a result, they usually have limited contact time with the adolescents and do not give these adolescents all the SRH information as required. This was revealed in a study in South Africa where providers mentioned

that they sometimes concentrate on giving curative SRH services than offering preventive services to these young people due to high workload (Alli, Maharaj, & Vawda, 2013).

Along with the high workload, lack of knowledge and proper skills to competently provide the YFRSHS to adolescents has also been identified as one of the challenges health care providers are facing. Providers reported lack of appropriate skills to effectively communicate and counsel adolescents when they come to seek the YFHS (Paul et al., 2016). Similarly, Godia et al. (2013) identified limited knowledge and competency in the provision of YFSRHS to adolescents as barriers to provision of SRH services to the youth in Kenya and the study recommended training providers in provision of YFSRHS to adolescent to improve their knowledge and skills. In addition, limited knowledge on the national guidelines and policies for providing SRH services to the youth were also identified by providers as barriers to effective provision of SRH services to adolescents (Newton-Levinson, Leichliter, & Chandra-Mouli, 2016; Godia et al, 2013). Similarly in Uganda, providers revealed that they were not aware of what is stated in the guidelines and national policy on reproductive health and family planning despite these documents being available in 11% of the health facilities studied (Nalwadda, 2012). This means that providers do not know the documents guiding their work; as a result, they are not well motivated to provide the services since they do not know their targets which are usually stated in the policies.

Inconsistent and sporadic availability of medical supplies, equipment, and commodities in the health facilities has also been revealed to affect health care providers' ability to effectively provide YFSRHS to adolescents (Nalwadda, 2012). Similarly in Malawi young people mentioned stock out of commodities and difficulties in accessing sufficient family planning methods as some of the factors that influenced their choice of providers since there are frequent shortages of commodities in government (free) health facilities (Michaels-Igbokwe et al., 2015). Inadequate

supply of these commodities results in providers providing sub-standard care since providers improvise resources in order to give the services.

Lack of infrastructure to facilitate provision of YFSRHS to adolescents is also another challenge that most health care providers face. This usually results in compromising young peoples' privacy and confidentiality, making it difficult for providers to effectively deliver YFSRHS to young people. In a study in Uganda, it was identified that limited space compromised the audiovisual privacy of the adolescents who were utilizing different SRH services. Similar findings were reported in Kenya where providers reported lack of enough room and working space as having an effect on the provision of SRH services to young people (Nawladda, 2012; Godia et al., 2013). Lack of proper infrastructure to offer enough privacy to adolescents contributes to poor interaction between providers and the young people since they may not want other people to hear their problems and needs. Adolescents do not want to be known that they are seeking YFSRHS in fear of being labelled as promiscuous by the community. Therefore poor infrastructure exposes these adolescents to other clients and this makes them feel uncomfortable during service provision.

Misconceptions regarding different YFSRHS have also been identified to affect provision of YFSRHS to adolescents. Nalwadda (2012) identified that strong misconceptions associated with contraceptives affected young peoples' choice of contraceptive method during service provision. Similarly, some providers revealed that they could not provide adolescents with some contraceptives due to the effects of some hormonal contraceptive methods. However, most providers revealed that they felt comfortable providing condoms to unmarried adolescents than the other hormonal methods which have bad effects such as infertility (Godia et al., 2013; Paul et al., 2016).

Strategies that enhance Health Care Providers' provision of YFSRHS to adolescents.

Several studies have suggested how provision of YFSRHS to adolescents can be enhanced in order to improve utilization of such services by the young people. According to literature most of the suggestions are aimed at addressing the challenges which providers face during service provision so as to promote a good working environment and enhance their competency during service provision.

In many studies, providers suggested training more staff in the provision of YFRSHS as a very effective strategy to help reduce workload in the health facilities thereby allowing providers to spend more time with the young people when they access the services (Godia et al., 2013; Kamau, 2006). Considering that some providers lack skills on how to effectively communicate with adolescents when they seek different YFRSHS, providers recommended training in YFHS provision so that they can gain skills and enough knowledge to be used during service provision. Providers in India said that they would be able to offer higher quality sexual and reproductive health services if they had received better training (Jejeebhoy, Santhya, & Singh, 2014). Similarly, Alli et al. (2013) recommended that adequate training of providers in interpersonal relations can help overcome communication problems and help providers interact with young people at a more personal level which can promote effective provision of YFSRHS to adolescents.

Apart from improving understanding of the providers on adolescents' sexuality and psychology, the training of providers has also been revealed to be essential in helping to improve providers' attitude during YFSRHS provision to the youth. Warenius et al. (2006) noted that providers who received continued education on adolescent sexuality and reproduction showed a more youth friendly attitude. Similar findings were identified in a national survey in America where facilities with staff trained in provision of youth friendly services had increased rates of

discussion about contraceptives in comparison with non-youth friendly sites (Kavanaugh, Jerman, Ethier, & Moskosky, 2013).

Literature also suggests improving infrastructure as one of the strategies to enhance provision of YFSRHS. Providers in a study in South Africa recommended that creating a dedicated space for service provision would facilitate provision of YFRSHS to adolescents (Geary et al., 2014). Consistent with these findings, providers in Kenya suggested creating adequate space to be used when attending to young people and improving privacy in the service delivery rooms in order to promote effective provision of these services (Godia et al., 2013; Kamau, 2006). Improvements on infrastructure is essential in promoting privacy and confidentiality which is very important during provision of YFSRHS to adolescents since adolescents do not want to be seen by other people seeking these services in fear of stigma and discrimination. Increasing the space in the centres where reproductive health services were being provided to the youth was also recommended by providers since it was believed that it would help in reducing congestion during service delivery and allow the youth to be served with privacy with no sense of shame or intimidation (Ontiri, 2015).

Ensuring availability of adequate resources necessary for the provision of YFSRHS to adolescents in the health facilities has also been identified as one of the important strategies to help in provision of YFSRHS to adolescents (Godia et al, 2013). Community interventions such as community sensitization on availability of YFSRHS in the health facilities, addressing misconceptions associated with the use of YFSRHS, breaking the communication barrier on adolescents' sexuality and linking the hospital interventions with the communities are some of the strategies studies have suggested in the literature to enhance provision of YFSRHS to adolescents.

CHAPTER 3

Research Methodology

Introduction

This chapter explains details of the study design, study setting, sample size, sampling method, study population, recruitment criteria, data collection process, data management, data analysis, and trustworthiness of the study. It also elaborates issues to do with pre-test, dissemination of the study findings, and ethical considerations.

Study Design

Descriptive qualitative study design was used to explore factors influencing provision of YFSRHS to adolescents. Holloway (2005) explains that qualitative study approach is used to explore the behaviours, perspectives, feelings, and experiences of people and what lies at the core of their lives. Therefore the study design was the appropriate approach to this study since it assisted in exploring factors influencing provision of YFSRHS to adolescents from providers' experiences.

Study Setting

The study was conducted at Dedza district hospital which provides a wide range of SRH services in different departments. These services include the primary and secondary SRH services since it is also a referral centre for the health centres in the district. The departments that were involved in this study included Family Health Unit, female ward (gynecology ward), VCT clinic, STI clinic, ART clinic and maternity unit. It was also conducted at Mtakataka and Chitowo health centres which provide SRH to the youth. Dedza district hospital serves a total catchment population of 21,222 of which 6,791 are young people aged 10-24 years, while Mtakataka health centre serves a total catchment population of 17,035 with 5451 being the young people and Chitowo serves a total catchment population of 33,655 with 10,769 being the young people (Dedza

District Health Management Information System, 2016). These facilities were purposively chosen because they were certified to offer full YFHS package according to YFHS national standards in the district compared to other health centres that did not have the YFHS program fully operational. These chosen health facilities are under Dedza district health office hence they receive support and supervision from providers working at Dedza district hospital. YFSRHS in these health centres are provided as an integrated package with other services such as outpatient services while at the district the services are not integrated and are provided in specific rooms according to the type of the service. For example, the district hospital has specific rooms assigned for STI treatment and ART clinic. These rooms are well known for the services provided in them by the public. For instance, room 19 is well known as STI clinic room. Therefore, adolescents seeking STI and ART services are combined with other clients.

Study Population

The study involved health care providers providing different YFSRHS to young people in the following departments at Dedza district hospital: Family Health Unit, STI clinic, ART clinic, VCT clinic, Maternity Unit and female ward (gynaecology ward). These Health Care Providers included medical assistants, clinical officer, nurses and midwives who are involved in provision of SRH to adolescents. It also included participants from two health centres in Dedza district that provide YFSRHS to young people.

Sample Size

Data was collected from 17 participants after reaching data saturation where it was noted that there were repetitions of information and no new information could be obtained with further data collection. In the chosen health facilities in Dedza, there are a total of 42 health care providers who are involved in provision of YFHS and 25 have been providing SRH services to the youth for more than 2 years. The health care providers who participated in this study included 2 medical

assistants, 4 clinical officers, and 11 nurses. In qualitative studies, sample sizes are typically small and based on information needs hence this small sample size is suitable because of the potentially detailed data that can be generated from each participant (Polit & Beck, 2010). It helped gain detailed accounts of the responses concerning factors influencing provision of YFSRHS to adolescents from their experiences. However, the sample size increased to 17 at which point data saturation was achieved. Guest, Bunce, and Johnson (2006) propose that data saturation often occurs around participants in homogenous groups such as health care providers in this study.

Sampling Method

Participants who met the inclusion criteria of the study were recruited using purposive sampling technique with the help of the nurse or clinical officer in charge. This method was chosen because it helped the researcher to obtain information rich participants by selecting them on the basis of their experience in providing YFSRHS to adolescents in the health facilities. Parahoo (2006) explains purposive sampling as a method used in qualitative research and involves the researcher intentionally selecting who to include in the study on the basis that those selected can present the requisite data. In addition, this method is mostly used in qualitative research that aims at selecting information-rich respondents who have extensive knowledge about a particular behaviour, experience or phenomenon of interest (Devers & Frankel, 2000). Therefore, HCP who were actively involved in provision of YFSRHS services to the adolescents were intentionally selected to participate in the study upon consenting to participate since they were more likely to contribute rich data in terms of depth and relevance. In order to avoid bias with the purposive sampling method, the departmental/facility in charges were involved in the recruitment process of the participants. The participants who met the inclusion criteria and consented to participate in the study were then recruited as study participants.

Inclusion Criteria

The study included HCP providing YFSRHS to young people and have been providing these services for not less than 2 years. Such experience is adequate to bring about the information that the researcher was looking for because of the vast experience they may have. Nurses, midwives, clinical officers and medical assistants providing SRH services to the youth were eligible to participate in the study irrespective of their age. These health care providers were drawn from health facilities that provide YFHS within Dedza district and in communities surrounding these health facilities. These health facilities included Dedza district hospital, Mtakataka, and Chitowo health centres. In addition, only those who consented to participate were the ones that participated this study.

Exclusion Criteria

The study did not include those HCP providing SRH services to adolescents in facilities that were not targeted in this study in Dedza district. HCP who have less than 2 years' experience providing SRH services were also not be included in the study.

Data Collection Instrument

Data was collected through face to face In-depth Interviews using a semi-structured interview guide (see appendix 5 and 6; English version and Chichewa version respectively) according to the participant's comfortability with the language. This interview guide was developed by the researcher basing on the study topic, objectives, and the literature review the study type. This method explored the following aspects of YFSRHS provision: health care providers' knowledge of available guidelines and policies, experiences of HCP in provision of YFSRHS, challenges/barriers to providing YFSRHS to young people and also explored strategies to improve provision of YFSRHS to adolescents. Polit and Beck (2010), indicate that semi-

structured interviews allow the researcher to have a framework in which open-ended questions are posed to encourage the participants to talk freely about their experiences.

Data Collection Process

After obtaining ethical approval and permission from the district health officer, recruitment of participants was done in the following departments; Family Health Unit, female ward (gynecology ward), VCT clinic, STI clinic, ART clinic and maternity unit at the district hospital with the assistance from the hospital matron, chief clinical officer and nurse ward in charges. At the health centres participants were recruited with the help of the health centre in charge. The chief clinical officer, nurse ward in charges and the health centre in charges purposively identified the participants from their departments and health facilities basing on the inclusion criteria and these participants were recommended to participate in this study. The participants who met the inclusion criteria were given detailed written information about the study (Appendix 1 and 2) and the consent form to read, understand and sign to indicate their willingness to participate in the study (3 and 3).The place for the interview was agreed upon with the participants in order to maintain confidentiality and anonymity. Each interview took approximately 40 to 60 minutes to allow time for the health providers to continue with provision of different health services.

The In-depth interviews were recorded using audio-digital recorder. This assisted in capturing the factors and experiences from the HCP in their own words and increased confirmability of the data. It also assisted the interviewer to maintain eye contact which is an important listening skill in an interview. The participants were given a choice to do the interviews in the language which they were comfortable with using the interview guide (5) in English and interview guide (6) in Chichewa. This allowed the researcher to get more detailed information since they were able to freely express themselves using the most comfortable language.

Four Pretest interviews were conducted at Dedza district hospital before the actual data collection in order to test how the data collection tool was capturing the required information. These interviews were also done in order to identify questions which were not clear and these questions were rephrased for them to be clear. Redundant questions were also edited.

Data Analysis

Data were analyzed using Thematic Analysis method as described by Braun and Clarke (2006). In qualitative studies, the significance of data analysis is to discover themes and links among these themes (Polit and Beck, 2010). Therefore this method helped the researcher in identifying themes and links among these themes in the study. This method of data analysis has been associated with clinical and health research and can be used across mainstream approaches such as those assessing individual views and experiences (Guest, Macqueen, & Namey, 2012).

Using Braun & Clarke's Thematic Analysis method, data was analyzed using a six-phase process to systematically identify patterns across the data set (Braun & Clarke, 2006, 2012, 2013). After translating and transcribing the recorded data, the first stage in the analysis was for the researcher to familiarize herself with the data. It involved reading and re-reading the entire dataset to really get to know what is in the data, the semantic meanings expressed and to start analytical engagement with the data in order to start noting potential points of analytical interest. The second stage was the coding of the data in which codes were derived from the entire dataset. These codes ranged from descriptive where they summarized the semantic content of the data excerpt to more interpretative where they indicated analytical, interpretative insight on the part of the researcher.

The third stage involved searching for themes from the dataset and themes were generated from the codes identified. Different codes were then clustered together to create a potential theme and some rich codes automatically became themes. The fourth stage involved reviewing these potential themes in which quality control of the themes identified was done by checking that these

candidate themes are a good fit with the coded data thus shaping up these themes so that they describe the full story of the relevant data. In addition, this phase also involved checking back the entire dataset to ensure that these candidate themes reflect meaning across the whole dataset.

The fifth phase was to define and name the themes. This phase involved developing the overall analysis through a detailed analysis of the data in each theme and refining each theme's focus and scope and determine the story of the data. Data extracts that were presented or analyzed in the final report were presented and finally, names for each theme and sub-themes were identified. The final stage (sixth phase) was to produce the report in which the final refinement of the analytical narratives and the weaving together of data extracts, analytical narrative, and discussion of the existing scholarly literature was done.

Data Management

The electronic data was kept on the researcher's computer with a pin code which was known to the researcher only. The data files and recorder were locked in the drawer of the researcher's study table in Dedza and were only accessible by the researcher. Each interview was numbered using codes for identification and sorting to ensure anonymity.

Trustworthiness of the Research

A qualitative study is termed trustworthy when it accurately represents the experience of the study participants (Speziale & Carpenter, 2011). The researcher used a framework by Lincoln and Guba (1985) to increase the trustworthiness of this study. This framework encompasses four criteria for developing trustworthiness of a qualitative study, which includes credibility, dependability, confirmability, and transferability (Polit & Beck. 2010).

Credibility.

Credibility refers to confidence in the truth of the data and interpretations of them (Polit & Beck, 2010). The researcher used probes to ensure that participants were encouraged to give detailed information to promote the researchers' understanding. Member checking was also done by the researcher in order to validate the findings to avoid misunderstanding and misinterpreting information given by the participants. It was noted that participants recognized the findings as a true reflection of the information they had given regarding factors influencing YFSRHS provision to adolescents. Participants were also given a chance to participate or refuse to participate in order to ensure that data was only collected from those participants who were genuinely willing to participate and were prepared to answer questions freely and honestly without coercion. To ensure internal credibility, the study methodology and methods were also well elaborated in the study and reviewed by the ethics committee and continuously by the supervisor to ensure that the data collected and analyzed achieved the aim of the study.

Dependability.

Polit and Beck (2010) states that if results of a study are to be dependable they should be consistent; this means that the study should be able to give same results if repeated in a similar context. In this study, consistency was maintained in the process of data collection by the researcher by using the same main questions in the interview guide to all participants and interviews were recorded by tape and verbatim transcriptions were made for each interview. In addition, a detailed description of data collection, analysis, and interpretation methods was given in this study to show that the research can easily be replicated. Methodological experts were also used to check the research plan and implementation. Pretesting was also done to make sure that the data collection tool was able to capture the appropriate information making it easier to capture similar information if conducted in a different setting.

Confirmability.

This entails that the findings of a study need not be affected by natural biases and personal interests (Elmusharaf, 2013). Confirmability was achieved by recording all the words spoken by participants and the researcher during in-depth interviews in order to distinguish the participant's data from interviewer's view. The researcher acted as an active listener and facilitator to allow participants to give detailed information about their experience. Only words spoken by participants were analyzed to make sure that only participants' views were analyzed and direct quotations have been provided in the findings to confirm that only participants' spoken words were analyzed. In addition, an audit trail (collection of materials, description of raw data before and after analysis) was consistently shared with the research supervisor throughout the research process to determine how well the research findings supported the data collected by the researcher in order to achieve confirmability. Direct quotations were also used to ensure to conformability.

Transferability.

This refers to the extent to which qualitative findings can be transferred to (have applicability in) other settings or groups (Polit & Beck, 2010). It also entails how the findings in a particular setting can make sense in another similar setting. This was achieved through provision of detailed background information of the participants, the research context and setting for other people to judge if the study findings will apply to them or not. Furthermore, sufficient descriptive data in the research report was provided so that anyone who wants to use it can evaluate the applicability to other or similar contexts. A thick description of the phenomena under investigation was also provided to enable someone interested in using the results to reach a conclusion. In addition, participants in this study were purposively sampled to make sure that only participants who meet the inclusion criteria according to the study aims participated in this study and give the

relevant information. This enabled the findings of this study to be easily transferred to another setting that has the similar characteristics of the participants.

Dissemination of Findings

Dissemination of study findings and possible recommendations will be done locally (at the study settings), nationally, and globally. There will be a meeting that will be organized to share the results with health providers from Dedza district hospital and other health facilities involved in the study. Furthermore, the study findings will be disseminated through international and local health forums and conferences and journal publications. A thesis will be submitted to KCN library.

Ethical Considerations

Ethics is a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants (Polit & Beck, 2010). In order to ensure that ethical issues have been considered, the District Health Officer (DHO) for Dedza district was asked for permission to conduct the research in the health centres and at the district hospital. Permission was put in writing for evidence. In addition, the research proposal was reviewed by College of Medicine Research and Ethics Committee (COMREC) which approved it before data collection was initiated.

In order to respect human rights of the health care providers as study participants, much emphasis was put on the rights to self-determination, privacy, anonymity, confidentiality, fair treatment and protecting them from any harm. This was done by giving them detailed information on the aim of the study, duration of the interviews, data collection methods and procedures, benefits or risks of the study to the participants as well as the relevance of the research study to health care consumers in Malawi and worldwide. Anonymity in this study was aimed at ensuring

participants' identity confidentiality is protected and this was done by using numbers against each participant's recording instead of other identifiable information such as names or sex.

In respect of human dignity, participants were also assured that the data will be treated with strict confidentiality and that their identity will not be disclosed in the final report or publications or at any stage of the research process. They were informed that they were free to withdraw at any stage, stop an interview or not to answer questions whenever they felt like doing so and that their refusal to participate in the study would not affect their role as health service providers. Following this, participants were asked to sign a consent form to show their willingness and acceptance to participate in the study.

The principle of beneficence was applied in order to minimize physical, social and emotional harm to the participants. In this, the researcher made sure that participants were protected from harm throughout the research process and thereafter.

Conclusion

This chapter has explained the details of the study design, study setting, sample size, sampling method, study population, recruitment criteria, data collection process, pre-test, data management, and data analysis. It has also discussed and elaborated issues to do with the trustworthiness of the study, dissemination of the study findings, and ethical considerations.

CHAPTER 4

Presentation of Study Findings

Introduction

This chapter presents the findings of the study whose aim was to explore health care providers' perspectives on factors influencing provision of Youth Friendly Sexual and Reproductive Health Services (YFSRHS) to adolescents in Dedza district. The findings are presented in two sections; demographic characteristics of participants and themes identified in the study findings. The following themes were identified; adolescents' behaviours during service delivery, views on YFSRHS utilization, motivation to provision of YFSRHS, challenges health care providers encounter, and suggestions on improving provision of YFSRHS to adolescents. The verbatim quotes from the interviews have been provided to illustrate important points where applicable in the findings.

Demographic Characteristics of Participants

The study involved 17 Health Care Providers (HCP) whose ages ranged from 25 to 55 years. The majority were in the 31-35 age group while few participants were in the 36- 40 and 41-55 years age ranges as shown in table 1. Majority of the participants were Nurse-Midwife technicians (8) while (4) were clinical officers, Medical assistants (2), Registered nurses (2), and there was only (1) Senior Community Nurse Midwife Technician.

Table 1

Age group range of participants (n= 17)

Age group in years	**Number of participants**
25-30	5
31-35	7
36-40	3
41-55	2

All participants were providing different YFSRHS in the following departments: Anti-Retroviral Therapy clinic (2), Female (gynaecological) ward (3), STI clinic (1), maternity ward (3), Family Health Unit (3), Chitowo Health centre (2) and Mtakataka Health Centre (3). Majority of the participants were Christians (15) and only 2 were Muslims. In addition, the majority of the participants have been providing these YFSRHS to adolescents for 2-5 years (15) while only (2) have been providing the services to adolescents for more than 10 years.

Majority of these participants (11) have ever been trained in the provision of YFHS to young people and among those trained (8) had undergone the training in the previous 2-5 years while (1) was trained a year ago and (2) participants were trained more than 5 years ago. Among those participants that have ever been trained in the provision of YFSRHS, only (2) have ever gone for refresher training in less than two years ago. In addition, the majority of providers have been providing more than (6) types of YFSRHS while 5 have been providing 3-5 types of YFSRHS and only 1 has been providing one type of YFSRHS.

Themes identified in the Study

Table 2 below presents the five main themes and different sub-themes that were identified from the data in this study.

Table 2

Theme and Sub-themes identified in the study

Theme	Sub-themes
Theme 1: Adolescents' behaviours during service delivery	-Shyness among adolescents -Fear of being judged -Defensive behaviours
Theme 2: Views on YFHSRH utilization	-Positive factors -Negative factors -Type of service being sought
Theme 3: Motivation to provision of YFSRHS	-Passion for adolescent's health -The need to safeguard adolescent's future - Past experiences
Theme 4: Challenges HCPs encounter	-Inadequate knowledge and skills -Lack of harmonization of policies -Role conflict -Lack of motivation -Inadequate resources
Theme 5: Suggestions on improving provision of YFSRHS to adolescents	-HCPS' related improvement suggestions -YFSRHS' provision related improvement suggestions -YFSRHS' utilization improvement suggestions

Theme 1: Adolescents' behaviours during service delivery

Three sub-themes were identified relating to adolescents' behaviours during service delivery, and these were shyness among adolescents, fear of being judged, and defensive behaviours.

Shyness among adolescents

The study identified that adolescents are shy and do not want anyone to know that they are seeking YFSRHS. This is demonstrated through different behaviours such as refusing to be on the

queue to wait for their turn to be attended, wanting to be treated as fast as possible, pretending to get the service for a friend or escorting a friend, hiding their faces during examination, and returning without receiving the services as explained by one participant:

> *"From my observation, some adolescents just come and while at the door they turn back without receiving the services when they see a lot of clients at the department. Sometimes they even return home without receiving the services because they are mixed with other clients which makes them feel shy and if you do not approach them well they may tell you that they just escorted a friend but if you are friendly to them they tell you their needs or problems."(*Participant # 1).

Another participant also said:

> *"I also noticed that I usually face difficulties to examine secondary school female adolescents especially with genital examination when they come seeking STI services. When I want to examine them they hide their genital area and some cover their faces so that they do not see me during the examination."* (Participant # 12)

In the health centres it was commonly reported that adolescents usually come during awkward hours such as during the afternoon, during the weekends and sometimes when the clinic is closed in order to seek YFSRHS since they are shy to meet other older patients during clinic opening hours. One participant stated:

> "*Mostly adolescents are shy; for example students from the nearby primary and secondary schools usually come during awkward hours like during the afternoon after we have knocked off or even during weekends. If they happen to come during working hours they do not go directly to the consultation room. They usually find someone they know who*

works here like Health Surveillance Assistants to escort them to the consultation room." (Participant # 8)

Fear of being judged

The study identified that some adolescents do not want to be mixed with other clients when they are accessing some YFRSHS for fear of being judged by other clients since these services are provided in areas which are well known by the community members such as the STI clinic as narrated by one participant:

"Adolescents do not feel comfortable to be mixed with other clients. For example at our facility, they choose to queue at the laboratory queue which is near the STI clinic. They come to the STI clinic consultation room after the other patients have gone and sometimes it requires you as a provider to pick them from the laboratory queue." (Participant # 9)

Hiding information about their needs or problems has been revealed as one of the common behaviours adolescents show when they seek YFSRHS. Majority of participants reported that most of the adolescents hide or tell false information relating to their illnesses or needs to providers when they seek different YFSRHS for fear of being judged by the HCP and the community members as promiscuous while some adolescents fear the implications their actions may have especially in communities where by-laws inhibiting teenage pregnancies are in operation. One participant said:

"*Most of the times adolescents do not give enough information and sometimes they give you false information..."* (Participant # 11)

One participant added:

"... Adolescents hide information due to fears of being perceived that they are too young to start sexual activities and think things will not go well if they tell the health provider all the information." (Participant # 5)

One participant explained:

"*Existence of by-laws concerning early marriages and early childbearing make some adolescents lie about their age when they come to access pregnancy-related treatment and you tend to wonder the way that individual is looking like and the age that she has said are not adding up. I also noted that adolescents hide their age in fear of the legal implications that may come if they say their real age depending on the services being utilized and it is common when they are utilizing pregnancy-related services."* (Participant # 6)

However, it was observed that some factors such as being male and the severity of the SRH illness/problem were associated with increased chance of openness of the adolescents to the providers. Participants observed that when an adolescent's SRH condition/problem is worse or complicated, they easily open up and give full information about their condition. In addition, it was noted that male adolescents are usually free to talk about their SRH needs/problems compared to female adolescents. One participant explained:

"Most girls do not give true information in the first place unless you probe more and some do hide the information until the next visit. I can tell you that when they are seeking STI treatment, girls will not always tell you the truth during the first contact which is mostly different with the boys who say things directly during the first time." (Participant # 7)

Another participant echoed:

"I have observed that most male adolescents are free to talk about their needs when they come seeking the YFSRHS but the female adolescents mmm they do not easily open up. (Participant # 9)

Another participant explained:

"I think it depends on the type of service they are seeking; like for postabortal care they usually hide information because they feel isolated since they consider themselves that they have done something wrong but they usually say the truth when they see their condition is getting worse." (Participant # 1)

The study found out that there are several techniques that providers use in order to motivate these adolescents to open up, freely talk, and give all the necessary information concerning their needs and problems. These techniques include: assuring them of privacy and confidentiality, probing more from these adolescents in order to get all the necessary information, building of a good rapport with the adolescents, using jokes and informal language that is commonly used by the adolescents, and spending quality time with these adolescent clients to understand their problems and needs. One participant explained:

"*These adolescents mostly hide information unless you assure them of privacy and confidentiality by telling them that everything that will be discussed will end in that room that is when they start to build trust in you."* (Participant # 12)

Another participant said:

"*… when talking to them I usually use informal language which is mostly used by the youth like 'bhobho' for a greeting and 'mphasha' for clothes etc' which makes them feel*

comfortable with me and they easily open up; so I do not want to be too professional with them to avoid them hiding information." (Participant # 10)

Another participant added:

"In order to facilitate good interaction with these adolescents, we allow them to call us by our first names and we behave as peers with them which promotes good interaction during service delivery." (Participant # 16)

One participant explained that she educates the adolescents on the effects of not giving accurate information on the treatment that they will receive which makes them give all the necessary information. She explains:

"In order to motivate them to talk, I usually tell them the importance of saying everything concerning their problem/need and how that influences the treatment and vice versa after educating them of the complications associated with their illnesses." (Participant # 7)

Defensive behaviours

Defensive actions were reported as one of the behaviours adolescents show when they seek different YFSRHS. Providers observed that some adolescents are defensive and do not want to be told that whatever they did was not done in the appropriate way. They want to show the providers through their actions and arguments that they knew what they were doing when they have an SRH problem even if they did not know or have enough information which led to the current problem. One participant said:

"Some adolescents prepare themselves that despite that they have contracted an STI or are pregnant they do not want to be humiliated by the providers or other clients; so some of

them are rude and defensive to show that they knew what they were doing." (Participant # 13)

Theme 2: Views on YFSRHS utilization

Participants were asked to describe their views on factors affecting utilization of YFSRHS by adolescents because most of them mentioned that they were not satisfied with the YFSRHS utilization by adolescents since the most of these services were underutilized by adolescents in the health facilities, especially at the district hospital compared to health centres. Three sub-themes were identified on these factors, namely: positive factors, negative factors and type of services**.**

Positive factors

These are factors that facilitated utilization of the YFSRHS by adolescents in the health facilities. Majority of the participants indicated that positive attitude and friendliness of health care providers played a bigger role in increasing utilization of YFSHRS by adolescents. In facilities where providers were considered friendly, YFSRHS were more utilized by adolescents as one participant narrates:

"…. I worked at a certain facility and these providers agreed to be friendly to the youth; so I saw that the youth who were utilizing the YFSRHS at that facility were not even shy at all. They would freely come in anytime even in school uniform to access the services." (Participant # 1)

It was also observed that the flexibility of providers to provide YFSRHS at any time outside the clinic opening hours contributed to higher utilization of the services by adolescents. This was mostly the case in health centres where providers reported a higher utilization of the YFSRHS by

the adolescents as compared to the district hospital since adolescents could utilize the services outside the clinic hours or in the afternoon when other clients have gone. One participant said:

> *"I usually see that it is good to help these adolescents who need YFSRHS; so even when they come during awkward hours I am not reluctant to help them as compared to adult patients. This makes them feel free to utilize the services at this facility anytime."* (Participant # 8)

Negative factors

These factors were viewed to contribute to low utilization of YFSRHS by adolescents. Participants indicated that unsuitable opening time for YFSRHS delivery affected adolescents' ability to utilize the services since the clinics are open when adolescents are in school and by the time adolescents knock off from school the clinics are closed. This does not offer them an opportunity to utilize the YFSRHS as one participant explains**:**

> *"The other thing is that our working days and times that we provide the YFSHRS conflict with adolescents' time schedule because they are still in school."* (Participant # 3)

Some participants reported that the negative attitudes of fellow healthcare providers towards adolescents who are utilizing the YFSRHS affect adolescents' utilization of these services as one participant narrates:

> "*Our attitude as health care providers also poses a challenge to competently provide the YFSRHS to adolescents. This is because most adolescents come at the hospital while already afraid of us shouting at them, and making rude remarks; as a result, they do not feel free to tell us their problems leading to partial treatment."* (Participant # 13)

Participants also mentioned lack of privacy in the health facilities as one of the factors contributing to low utilization of the services by adolescents. This was reported to be mainly due to inadequate rooms or lack of a dedicated space for provision of YFSRHS which results in mixing adolescents with adult patients when they come to utilize the YFSRHS. This is because as described in the study setting section, YFSRHS are provided in different clinics and department such as the family health unit, outpatient department, STI, and ART clinics, especially at the district hospital. These services are provided to both adults and young people during clinic hours which results in mixing of older clients with the adolescents. One participant said:

> *"I also want to comment on privacy and confidentiality. Due to our hospital setup, maintaining privacy and confidentiality is a big challenge and I think this also contributes to why these adolescents are not utilizing our services because we combine them with other adult patients/clients. We do not have a YFSRHS corner. As a result, all the SRH services are provided in the same area to all clients/patients regardless of age which makes these adolescents uncomfortable."* (Participant # 11)

Lack of information on the availability of YFSRHS in the health facilities was also identified to be contributing to low utilization of these services by adolescents. Most of the participants stated that most adolescents show lack of knowledge concerning sexual and reproductive health problems, sexuality, and YFSRHS being offered in the health facilities which puts them at a high risk of encountering different SRH problems. This is reflected in the way they give information when they seek YFSRHS. One participant said:

> "*Most of the times these adolescents do not have enough information on how they can prevent these pregnancies…. A lot of adolescents just seek the services because they want*

them but they do not have enough knowledge and information about these services; they mostly show lack of knowledge." (Participant # 13)

Another participant explained

> "*Some adolescents do not have knowledge on the availability of the YFSRHS in the health facilities, when and how these services can be accessed. As a result, they just return home when they are not given the right directions when they come to the health facilities; and some adolescents do not access these YFSRHS at all."* (Participant # 1)

Misconceptions, cultural values, and beliefs associated with the use of YFSRHS such as contraceptives in the communities were also reported to contribute to underutilization of YFSRHS as one participant explains:

> *" The cultural beliefs and misconceptions that communities surrounding this health facility have make the youth not to utilize the YFSRHS. They believe adolescents who are not married should never use YFSRHS such as contraceptives because of different misconceptions associated with contraceptive use before marriage such as infertility. This results in teenage pregnancies, abortion related complications, and high rates of STI among adolescents*." (Participant # 5)

Another participant said:

> *"Use of YFSRHS is often associated with promiscuity especially in the rural villages as compared to the communities that are here at the township; As such, adolescents fail to use the YFSRHS because they are afraid of being labeled promiscuous"* (Participant # 3)

Type of service being sought

Utilization of the YFSRHS was also determined by the type of YFSRHS being accessed. Most participants reported that adolescents utilize curative YFSRHS more than preventive services as narrated by one participant:

> *"I am not satisfied with the way adolescents utilize the YFSRHS at this health centre. They mostly access curative services such as STI treatment, abortion care, antenatal care, labour and delivery, and ART. Family planning services are mostly accessed by married female adolescents."* (Participant # 5)

Another participant explained:

> *"I can say it is very rare to see adolescents coming to this department to get contraceptives but for postabortal services, I used to see a lot of them coming to get the services. So from the look of things, we can see that adolescents are failing to utilize preventive services yet they are coming with different complications."* (Participant # 1)

Theme 3: Motivation to provision of YFSRHS

Different perspectives were identified as factors that motivate providers to provide and support the provision of YFRSHS to adolescents. Majority of providers had more than one factor that motivated them to be giving the YFSRHS to adolescents while others did not have anything that motivated them to provide these services. The passion for adolescent health motivated some providers to be provide the YFSRHS to adolescents. Similarly, the desire to safeguard adolescents' future in order to help them have a bright future and be financially stable in future by not allowing them to be distracted by any of the SRH problem motivated majority of the participants to provide these services to adolescents. One participant said:

"It is my wish to see everyone being well educated and having something to do for himself/herself if there is that opportunity; so seeing a young person coming to access any YFSRHS especially those that are going to school, I feel good and I try to meet their needs when they find me." (Participant # 6)

Another participant said:

"It is good to provide these adolescents with different YFSRHS for their good health because if we deny them the services it means we are destroying their future as individuals and as a nation. We will end up in problems in future." (Participant # 8).

Another participant added:

"As a health provider and a parent I support the provision of YFSRHS to adolescents because if we deny them these services the problems that they encounter will come back to us and I can easily allow my child to use these services if I note that she is sexually active." (Participant # 14)

Some participants' past experiences motivated them to provide the YFSRHS to adolescents. Some participants reported to have worked with youth programs as volunteers before becoming qualified HCP and this made their passion for the youth to grow. In addition, some providers were motivated by other HCP in the past who provided them with guidance and counselling to using the YFSRHS which helped them to achieve their dreams; so the need to motivate the young people to achieve their dreams motivates some providers to provide these services to adolescents as narrated by one participant:

"I have a passion for young people; my passion grew sometime back before I became a nurse when I was involved in youth activities as a volunteer doing different youth programs

in Zomba. I became motivated during this time to become a nurse because other providers motivated us to continue with school and become what we want; so I also want to motivate others as well." (Participant # 1)

The need to prevent and reduce different SRH related complications among the adolescents which in turn reduces health care providers' workload motivated some providers to provide the services to the adolescents as narrated by one participant:

"Most of the times what motivates me is when I care for an adolescent with a complication as a result of not giving them services in good time. You will find an adolescent having an STI that was not treated well or not treated at all and has developed a complication from that condition such as infertility. This motivates me to give these YFSRHS to prevent complications. When I consider these complications I feel very bad, as a result I get motivated to give the YFSRHS at the earliest time as possible." (Participant # 4)

Another participant explained:

"I get motivated to provide preventive YFSRHS to adolescents because I know if I do not give them the services it means a lot of girls will be coming with pregnancies and complications which will increase our workload; so I provide the services to prevent high workload that can result from poor or no treatment." (Participant # 7)

Some participants indicated that the YFHS training that they had undergone motivated them to be providing the YFHSRS to adolescents because it had made them to have all the necessary knowledge and skills on how to deliver these services to adolescents. Some providers enjoyed seeing different adolescent behaviours which they had learnt during their training being portrayed and their skills being put in practice. One participant said:

"*Aaah, as for me, after being trained during the YFHS training, when I see the behaviours that these young people portray I feel good to see what I learnt during my training in a practical way; as a result, I want to provide these services always. The training also helped me to have the right knowledge, skills and even attitude useful when handling these adolescents which makes me feel comfortable to provide these services."* (Participant # 8)

Other participants reported feeling good when interacting and providing these services to adolescents which motivated them to provide such services to adolescents than adults. On the same note, another provider said that he loves hearing sexual and reproductive health stories and this motivates him to provide these services to adolescents. He said:

"I think I just love reproductive health stories; that is why I find myself giving these services to adolescents. Apart from that I am allocated to work in the department that provides YFSRHS." (Participant # 17)

The study has also further identified that some providers were not motivated to provide these services to adolescents and some providers had negative views towards providing these services to adolescents. They were found providing these services only because they were allocated to departments and health centres which required them to be providing YFSRHS to adolescents. Some participants did not support the provision of YFSRHS to adolescents because they perceived that these services promote promiscuity among the youth. One participant said:

"It is not good to provide the YFSRHS to adolescents because it is like you are encouraging them to be more sexually active since you are helping them to prevent problems associated with their sexual behaviours." (Participant # 7)

Theme 4: Challenges Health Care Providers Encounter

Several factors were reported to challenge participants' ability to effectively provide YFSRHS to adolescents**.** Majority of participants mentioned lack of knowledge and skills in the provision of YFSRHS to adolescents as a challenge affecting service provision. This is due to lack of training in the provision of SRH services to young people and providers reported that they use the previous knowledge and skills that they acquired during pre-service training which is most of the times outdated. One participant said:

> *"The first challenge is that there are a lot of new guidelines that have been developed and are being used in provision of YFSRHS to adolescents but my knowledge and skills are not updated according to the new information since I have never been trained in the provision of YFSRHS. I usually use the knowledge I acquired during my pre-service training which is outdated and this affects how I deliver the YFSRHS to adolescents*." (Participant # 2)

In addition, lack of YFSRHS guidelines, standards, policies, and protocols to act as reference documents during service provision, and lack of YFHS register or record book to help in monitoring service provision in the health facilities challenge providers to effectively provide YFSRHS to adolescents. Majority of the participants were not aware of /had never seen any YFHS protocol, policies, guidelines, and standards except for those providers working in ART clinics which have ART guidelines to be used during ART teen clubs and when attending to a young person: One participant explained:

> *"Throughout my work experience I have never seen any guidelines, standards, protocols or policies illustrating how we should treat a young person seeking different YFSRHS and I can say there are no such documents well published to be used during service delivery. I mostly use my previous pre-service knowledge*." (Participant # 11)

Another participant working at a health centre also said:

> *"Mmm!! I have never seen these documents specific for the youth; I usually use the knowledge that I acquired during my training, during my experience, and the general SRH protocols."* (Participant # 13)

Another participant explained:

> *"I have only seen ART specific guidelines to do with the young people and these are mostly used during teen clubs or when handling a young person seeking ART services."* (Participant # 16)

Lack of harmonization between education and the health sector policies in regards to access of YFSHRS by adolescents who are in schools was also reported as a challenge affecting provision of these services to adolescents and contributing to underutilization of the services by adolescents. Participants reported that the health care system policies conflict with the education sector policies regarding provision of YFSRHS especially in the schools, thereby depriving adolescents in these schools from utilizing the YFSRHS. One participant explains:

> *"One of the contributing factors I can say are the conflicting policies between the health services and the education services. For example, as health care providers we once embarked on a program where we were putting condoms in schools but the education office banned this activity."* (Participant # 1)

Most of the participants reported role conflict between provision of YFSRHS to adolescents and their personal and religious values and beliefs which challenges the YFSRHS provision to adolescents. This conflict was experienced by both Christian and Muslim providers. Participants explained that some services such as the provision of contraceptives to adolescents

conflict with their religious beliefs which puts them in a dilemma and are not comfortable to be providing such services to adolescents. One participant explained:

> "*Provision of some of these YFSRHS a lot of times conflicts with my religious beliefs as a Christian. For example this issue of providing family planning methods to adolescents for me it is like encouraging a young person to be having sexual intercourse before marriage which is a sin. As a church elder who preaches about sin, I do not feel comfortable to be encouraging the use of contraceptives before marriage and I usually have conflicting decisions whether to provide the service or not when an adolescent comes to me."* (Participant # 8)

Another participant narrated:

> *"Provision of contraceptives to adolescents conflicts with my religious beliefs because we are taught at church that if we give the contraceptives to people it means we are killing unborn babies; this brings the conflict to me. I was personally approached by a church elder who preached to me on this topic."* (Participant # 2)

Another participant added:

> *"I am a Christian and in our Christian society we say abortion is not allowed yet on the other hand as a clinician each and every day I meet adolescents with these problems and require my help. This contradicts with the religious beliefs and values."* (Participant # 4)

It was also observed that majority of the providers were not comfortable to induce an abortion in adolescents since this service highly conflicted with their values and beliefs compared to other SRH services such as contraceptives. One participant said:

"The only thing that I cannot do is to induce an abortion where it is not medically indicated. What I mostly do when I am faced with that challenge is to refer to my colleagues." (Participant # 9)

Another participant explained:

"The only one service I never provide is to induce an abortion in an adolescent, I would rather refer that adolescent to my colleague because to me this is killing the unborn child." (Participant # 13)

When asked on how they manage/deal with situations where their beliefs and values are conflicting with their duties to provide these YFSRHS, most providers reported that they compromise their beliefs and values and provide the service. They do not allow their beliefs to be imposed on the adolescents. However, most of them reported feeling bad or repenting after providing these services such that they sometimes shun away from providing such services when other providers who can provide the same service are available. One participant reported:

"Despite these conflicts I just compromise my faith and give the services. I go back home and repent to my God but I give all the services if adolescents still stand on their decision to get the service after I counsel them." (Participant # 2)

Some providers said they first counsel these adolescents on their relationship with their creator in relation to sex before marriage. They reported that they do thorough counselling and encourage these adolescents to abstain rather than using YFSRHS such as contraceptives and if the adolescents still stand on their decision to use contraceptives they give them. Some providers reported that they refer adolescents seeking some YFSRHS to their colleagues who do not have any conflict providing such services. However, one provider said he does not even refer these

adolescents to his colleagues but rather he does not provide them with the service because even when he refers it means he has contributed to that sin. Instead he counsels the adolescents about the implications and complications of the services they are seeking. He narrated:

> *"I do not refer these adolescents to my colleague for example when they are seeking termination of pregnancy because it is like I have contributed to that death just as Pirate contributed to the death of Jesus by referring him to another jury when he had found Jesus not guilty when we get to the bible."* (Participant # 7)

Lack of motivation from their employer was also mentioned as a challenge which demotivates providers to effectively provide YFSRHS to adolescents as narrated by one participant:

> "*The other challenge is lack of motivation from our employer; instead of recognizing us where we have done well they just look for mistakes and this affects our work morale in turn affecting how we deliver the YFSRHS to young people."* (Participant # 7)

Majority of the participants also mentioned inadequate resources (human and material) as a major challenge affecting provision of YFSRHS to adolescents. Material resources such as medical supplies and equipment were reported not to be available on a daily basis. This makes the adolescents not to receive the services they want or sometimes health care providers improvise the resources in order to give care to the adolescents which is mostly not according to standards. Correspondingly, high workload due to inadequate human resource was also mentioned as a challenge leading to the provision of partial care to adolescents as providers do not have enough time to sit down with the adolescents and provide comprehensive care depending on the adolescents' needs and problems

"*The other challenge is lack of adequate resources such as medical supplies and equipment. We usually lack resources on a daily basis as we give care to the clients. For example, we now do not have depo provera and yesterday an adolescent returned without getting any contraceptive since she only wanted depo provera which puts her at risk of pregnancy."* (Participant # 1)

Another participant narrated:

"The challenges which we face include high workload which compromises how we deliver YFSRHS to adolescents; we usually do not have enough time to sit down with adolescents and provide all the necessary counselling and education as required because we also want to attend to other clients." (Participant # 3)

In addition, lack of proper infrastructure to be used for YFSRHS provision in the health facilities is another challenge faced by the majority of participants. It was reported that most facilities do not have a dedicated room or space to act as a youth corner. Instead one room is multi-purposely used for the provision of different SRH services and other services which compromises adolescents' privacy and confidentiality. One participant explains:

"We also have inadequate infrastructure to be used for the provision of YFSRHS to adolescents such as counselling; as a result, we use the normal consultation rooms which compromise their privacy and that is why most adolescents opt to come in the afternoon or during the weekend when the provision of the other services has finished." (Participant #5)

Another participant said:

"In addition, the setting of our health facility is also a challenge in terms of infrastructure; we do not have a youth corner where the youth can come and do different activities while accessing YFSRHS." (Participant # 7)

Some participants also mentioned assigning of numbers to the service provision rooms as compromising the adolescents' privacy since it makes the other clients at the hospital know the YFSRHS an adolescent is seeking. In addition, provision of the YFSRHS on a daily basis and integration of these services with other services were also identified as other challenges to some providers that affected YFSRHS provision to adolescents since they felt it made them not to have enough time with the adolescents. One participant narrates:

".. the room which I use for STI clinic (room no 19) is well known by the community to be an STI clinic and it is next to the ART clinic; so when people see an adolescent coming into this room they know which services he/she is seeking which compromises their privacy. Therefore the setting and infrastructure of our facility are a challenge to the provision of YFSRHS in terms of clients' privacy." (Participant # 12)

Another participant added**:**

"*I also find giving numbers to rooms according to the services provided in those rooms humiliating and not maintaining adolescents' privacy. For example, room 19 is known as an STI clinic and adolescents do not feel free to queue at that room which affects YFSRHS delivery*." (Participant # 9)

Poor coordination and referral system among departments and providers providing YFSRHS to adolescents was also seen to challenge provision of YFSRHS to adolescents leading to poor management of adolescents with SRH needs and problems. One participant narrates:

"Our coordination as providers and departments that provide YFSRHS challenges YFSRHS provision; we may refer an adolescent from our ward to another department. Therefore instead of treating the patients they are turned back which affects the provision of quality care to these adolescents." (Participant # 4)

Unprofessional conduct of some providers such as being involved in sexual relationships with the youth peer group motivators was also identified as a challenge faced by providers. It was reported that such behaviours make adolescents to lose trust in the healthcare providers. One participant narrated:

"Some providers are involved in sexual relations with female adolescents that come to access the services here at the hospital while other providers get involved in relationships with the youth peer group motivators that are chosen in the communities. This behavior makes the community not to trust the providers and adolescents are afraid to come to get the YFSRHS in fear of being asked to be in a relationship with the providers." (Participant # 3)

Theme 5: Suggestions on improving provision of YFSRHS to adolescents

The following sub-themes emerged from this theme: health care providers' related improvement suggestions, YFSRHS' provision related improvement suggestions, and YFSRHS utilization improvement suggestions.

Health care providers' related improvement suggestions

The participants suggested the following strategies to help improve their knowledge and skills in provision of YFSRHS to adolescents: strengthening health care providers' mentorship or on job training programms in different YFSRHS provision skills, use the Continuous Professional

Development (CPD) program to allow providers identify their gaps in YFSRHS provision and helping them to meet their needs. Establishing a specialized training program where providers will specialize in YFSRHS and training more providers in the provision of YFSRHS to help ease the high workload were also suggested as a strategy to improve the provision of YFSRHS to adolescents as explained by this participant:

> *"I think introducing a specialized program where providers will be trained to provide YFSRHS to adolescents and these providers will be responsible for the provision of YFSRHS to adolescents at a health facility can help in improving provision and utilization of the YFSRHS. This is because adolescents will get used to these individuals and adolescents are free when they find a provider who they usually meet or interact with rather than letting them queue without knowing what kind of a provider they will meet."* (Participant # 11)

Another participant said:

> *"Apart from trainings and on job mentorship of providers in provision of YFSRHS, there is need to intensify use of Continuous Professional Program (CPD) following the appropriate CPD guidelines where providers will identify their gaps in provision of YFSRHS to adolescents and help them accordingly in filling their gaps. This can help to improve provision of YFSRHS to adolescents in terms of our skills and attitude."* (Participant # 14)

Training providers in customer care to help improve their attitude towards the provision of these services to adolescents, having YFSRHS provision review meetings where HCP experiences will be shared and other providers can learn from them, and employing staff motivation measures

to improve providers' morale in service provision were also recommended by the participants as stated by one participant:

> *"If we can also be having review meetings as YFSRHS providers where we can be sharing experiences, it can help improve our attitude towards adolescents accessing YFSRHS."* (Participant # 10)

YFSRHS' provision related improvement suggestions

Participants suggested the following perspectives to help in improving service provision to adolescents: ensure availability of adequate resources in the YFSRHS delivery points on a daily basis, installation and use of suggestion boxes in YFSRHS' departments to help address adolescents' complaints thereby improving providers' competence. Integrating YFSRHS with other SRH services in the health facilities, establishing quality improvement teams/meetings to monitor YFSRHS provision, improving infrastructure in order to have enough space for YFSRHS provision, and identifying a specific day for YFSRHS provision were also suggested in order to help improve YSRHS. One participant said:

> *" We really need a room or a place which can act as a youth corner with enough providers where all YFSRHS can be provided on a daily basis or else there is need to set up a day specific for provision of YFRSHS; this will promote young people's comfortability to utilize the services and thereby leading to comprehensive care."* (Participant # 10)

Another participant added:

> *"I think having a suggestion box at every department can help get the complaints that are being raised by the adolescents and then using quality improvement teams that can be established strategies can be put in place to address those complaints which can lead to*

improvement of YFSRHS provision. In addition, supervision by those in charge and program YFHS coordinator is also good to help address our challenges in the provision of YFSRHS" (Participant # 13)

YFSRHS' utilization improvement suggestions

The following strategies were suggested by the participants to improve utilization of services by adolescents: strengthening use of open days in the communities where YFSRHS will be provided, ensuring equity in motivating youth peer motivators in order to improve their commitment to their duties, choosing youth representatives to link communities and the hospital, sensitizing the communities on availability of YFSRHS in the health facilities, and addressing the beliefs/misconceptions associated with SRH services in the communities. One participant from a health centre explained:

"*At community, we need to strengthen the mass campaigns to let the young people know of the YFSRHS offered in different health facilities and address the different misconceptions concerning the use of YFRSHS such as contraceptives. This will allow the parents to understand the YFSRHS hence they easily release adolescents to utilize these services."* (Participant # 13)

Another participant added:

"*Choosing youth representatives depending on where they are coming from to act as a link between the youth, chiefs, communities and the hospitals can help improve YFRSHS utilization since they will motivate their fellow young people and act as focal persons where adolescents can come and get information concerning utilization of YFSRHS."* (Participant # 2)

Conclusion

This chapter has presented study findings in five themes, namely: adolescents' behaviours during service delivery, views on YFSRHS utilization by adolescents, motivation to provision of YFSRHS challenges health care providers encounter, and suggestions on improving provision of YFSRHS to adolescents. According to the findings, there were no any major differences in experiences between male and female providers and across all the different cadres of providers. However, there was some minor difference between health centre participants and those from the district hospital in terms of utilization of YFSRH services where it was noted that health centre participants reported utilization of services by adolescents to be better than those working at the district hospital. This is because adolescents in the health centre easily utilize the YFSRHS in the afternoon or during the weekends when other clients have gone which is different with the district hospitals where there a lot of patients throughout the day; as a result adolescents are shy to utilize these services.

CHAPTER 5

Discussion of Findings

Introduction

This chapter presents a discussion of the findings of a study which was aimed at exploring health care providers' perspectives on factors influencing provision of YFSRHS to adolescents from in Dedza district. The discussion mainly focuses on adolescents' behaviours during service delivery, utilization of YFSRHS, motivation to YFSRHS provision, challenges health care providers encounter, and suggestions on improving provision of YFSRHS to adolescents. Recommendations, areas for further research, and study limitations are also presented in this chapter.

Adolescents' behaviours during service delivery

The study has found that most adolescents show behaviours such as being shy and feeling uncomfortable during YFSHRS delivery processes while some adolescents fear being judged by both the providers and the communities surrounding them; as a result, they hide information regarding their needs and problems when they are accessing the YFSHRS. These behaviours can be attributed to their developmental stages since due to the sexual changes happening in their bodies they mostly feel uncomfortable for a stranger including health care providers to see their private parts (Arnett, 2007). Apart from the developmental effect influencing these behaviours, the setting for YFSRHS provision contributes to such behaviours since most health facilities do not have a youth corner where young people including adolescents can go and access the YFSRHS on a daily basis. This makes them access these services from different departments offering the services they are looking for within the hospital setting resulting in mixing with other older clients

which compromises their privacy. In addition, the social stigma associated with the use of YFSRHS such as being labeled as promiscuous by their community members makes most adolescents feel shy, uncomfortable to utilize the services and hide or give false information regarding their illness or needs.

These findings are consistent with the findings of a study which was done in Burkina Faso, Malawi, and Uganda where sexually active adolescents reported feeling afraid, embarrassed or shy to seek SRH services as one of the most common barriers to utilization of SRH services (Biddlecom, Munthali, Singh, & Woog, 2007). This barrier was described as being rooted in the social context surrounding adolescent sexuality (Biddlecom et al., 2007). This was echoed by another study in South Africa where providers noted that adolescents are afraid to discuss SRH issues for fear of being considered culturally disrespectful due to the age difference between the providers and young people (Alli et al., 2013). However this adolescents' behviours may be different in other settings like European and American setting due to different cultures and modernization. There is need to empower the adolescents with information on YFSRHS so that they are confident enough when utilizing these services and make the providers youth friendly to reduce the adolescents' fears which will allow the adolescents to be free with them thereby promoting provision of quality YFSRHS to adolescents.

However, the study has further identified that female adolescents hide information more than their male counterparts during service delivery. Male adolescents were reported to talk more openly about their SRH problems and needs to providers compared to female adolescents. Hiding information contributes to partial treatment of the problems presented. The societal and cultural norms practiced in Malawi regarding sexual intercourse among adolescents contributes to female adolescents' inability to open up on sexual issues to providers. In Malawi, premarital sex and

discussion of sex issues with parents are forbidden for fear of influencing young people to initiate sex at a younger age; as a result sexual discussions are culturally held in secret within families (Tavorly & Swidler, 2009). In the same way, Mwalabu, Evans, & Redsell (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. However, the above study included young women living with perinatally acquired HIV only and did not include their young men counterparts hence the results may not be conclusive but are predictive of young women's behaviours during SRH service delivery in terms of information giving.

Similar findings were observed in a qualitative study in Kenya by Hagey et al. (2015) where providers felt that female adolescents fear disclosing their sexual activity to parents and providers for fear of being perceived as promiscuous. The study also added that female adolescents' shyness in discussing contraception with providers decreases the adolescents' ability to ask for contraception when at a facility (Hagey et al., 2015). In Malawi, the YFHS Evaluation identified that the main deterrent to the sustained utilization of YFHS was low confidence and feeling shy especially among girls (Ministry of Health & Evidence to Action, 2014). This female adolescents' behaviour continues to put them at a higher risk of SRH problems and complications since they do not freely express themselves to the providers; as a result, their SRH needs are not fully met. This results in getting inappropriate information from friends and thereby exposing themselves to different problems and complications.

Furthermore, the study also observed that fear of legal implication in areas where by-laws were in operation made some adolescents to hide information for fear of being reported to the

chiefs and being made to pay the agreed fines. By-laws are very important in safeguarding adolescents' good health and giving them a chance to complete their education; however when the youth hide the necessary information during service delivery it negatively impacts on their health. The study also observed that the severity of the SRH problems and complications precipitated some adolescents to give information during service delivery despite the presence of bylaws in their communities. Hiding information from providers results in poor management and treatment which can result in complications hence there is need to increase awareness and acceptability of the YFSRHS by the community so as to improve adolescents' confidence during service provision.

It was also noted that in health centres, most adolescents seek YFSRHS during awkward hours such as when the clinics have closed, during the weekends and even during public holidays in order to avoid being seen by someone who knows them for fear of being labelled as sexually active or being reported to parents. This is because, in most societies and communities in Malawi, adolescents are not allowed to practice sexual intercourse before marriage as it is considered as culturally immoral (Tavorly & Swidler, 2009). Similar to these findings, providers in Kenya reported that adolescents wishing to seek contraceptive services discreetly come alone at the end of the day to avoid being seen by adults in their community (Hagey et al., 2015). However, these behaviours put some adolescents at risk of different SRH problems and complications since some adolescents do not want to come during these awkward hours and do not utilize the services at all. These findings suggest the need to strengthen strategies aimed at promoting the acceptability of adolescents' utilization of YFSRHS by the communities so that adolescents can easily access these services from the health facilities at any time without fear of being labelled promiscuous. In addition, establishing youth corners in the health facilities is important to promote adolescents' privacy when accessing YFSRHS.

The study also revealed defensive actions by adolescents when seeking YFSRHS more especially when they have an SRH problem such as STI or are pregnant. It was observed that adolescents want to show that they knew what they were doing despite having inadequate information through their actions and arguments with providers during service delivery. This is done to avoid being judged by the providers. It is essential for providers to understand adolescent psychology in relation to their growth and developmental stages in order to provide them with quality care since they will be able to understand the actions these young people portray and address them accordingly without judging them. Similarly, Godia et al. (2013) explained that providers' difficulties in understanding adolescents' psychology were reflected in difficulties in handling adolescents seeking different SRH services hence the need to enhance providers training to promote the effective provision of SRH services to adolescents.

Utilization of YFSRHS

The study identified several factors that promote and hinder YFSRHS utilization by adolescents. Positive attitude, flexibility, and friendliness of health care providers towards adolescents who are utilizing YFSRHS have been revealed to be associated with increased utilization of YFSRSHS by adolescents in this study. The study has found that in facilities where providers were considered friendly, showed a positive attitude, and were flexible to provide YFSRHS at any time outside the hospital/clinic opening hours, utilization of YFSRHS by adolescents was a bit higher from the providers' perspectives. This was mostly the case in health centres where providers reported a higher utilization of the YFSRHS by the adolescents as compared to the district hospital because adolescents utilize the services outside the clinic hours or in the afternoon when other clients have gone.

This flexibility allows adolescents to easily access the services during their convenient times off their school time and provides them adequate privacy since they will not have to mix with other clients who may come from their communities hence reducing their risk of stigmatization. In addition, the positive attitude of providers provides a welcoming environment which motivates them to freely utilize the services without fear of being embarrassed. These findings correspond with the findings in a study in Kenya where providers were aware that providers' attitude plays an important role in making adolescents feel comfortable to access contraceptives hence they stated that creating a welcoming and non-judgmental atmosphere for adolescents increases adolescent engagement about contraception (Hagey et al., 2015). Young people recommended that there is a need for HCP to improve their attitude and be open, friendly, and helpful in order to increase SRH utilization by them (Godia, Olenja, Hofman, & van den Broek, 2014). Similarly, in Malawi, it is recommended of providers to try their level best to make adolescents comfortable to speak/give all the necessary information using their personal skills and effective communication skills as expected by their training (Ministry of Health, 2016).

However, at the district hospital where most of the times there are a lot of clients in the YFSRHS departments it is almost impossible for the adolescents to utilize the services in the afternoon or during other awkward hours since the risk of meeting people who know them is still high. This makes some adolescents not to access the services at all contributing to low utilization of such services at district hospital level. Therefore, it is very important to employ measures that can help improve utilization of such services by young people including adolescents at district level through the establishment of youth corners or setting a specific day for provision of YFSRHS in a week to allow easy access to such services.

It was also noted during this study that utilization of the YFSRHS was dependent on the type of the services adolescents seek. The study has revealed that most adolescents utilize the curative YFSRHS more than preventive services. This shows that adolescents come to the hospital for YFSRHS when they have already encountered SRH problems or complications contributing to the poor indicators on adolescents' sexual and reproductive health in the country. These findings suggest the need to strengthen awareness, education, and counselling on the need to use preventive YFSRHS such as contraceptives, condoms, and information and counselling on SRH issues by adolescents in order to reduce different SRH problems and complications adolescent are facing.

Similar results were found in Ethiopia where high school students with reproductive health problems were more likely to utilize the SRH services than those without any problem (Abebe & Awoke, 2014). However, Abebe and Awoke (2014) conducted this study among high school students who may be considered literate and having knowledge on SRH issues but still yielded similar results to the current study which implies that the youth are accessing YFSRHS when they have a problem. Contrary, Mutai (2008) found that the youth highly utilized general counselling services, VCT, and family planning services while Antenatal care, postnatal services, and management of STIs were least consumed in a study in Kenya. These results can also be related to the health-seeking behaviours among people in the Malawian setting/societies. 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 from most Malawian health facilities. Similarly, traditional beliefs were seen to contribute to delays in seeking maternal and child care in Malawi (Chibwana, Mathanga, Chinkhumba, & Campbell, 2009; Zamawe, 2013) This belief and health-seeking behaviours might have contributed to the low utilization of these preventive services compared to curative services.

Further to that, the study has identified that YFSRHS are mostly accessed by married female adolescents as compared to male and unmarried adolescents. These findings are in line with the Malawi YFHS Evaluation Report which found that more than half of the young people who participated in the evaluation indicated that YFHS were for married people (Ministry of Health & Evidence to Action, 2014). Similarly, in Nepal, it was reported that most married female adolescents from the communities were the ones that visit the health centres for SRH services such as maternity and contraceptive services (Khanal, 2016). Correspondingly in Kenya, it was reported that more female married young people visited the health facilities for SRH services compared to males (Ontiri, 2015). These findings may be associated with the reduced stigma that married adolescents are exposed to during utilization of YFSRHS compared to unmarried adolescents since it is a norm that SRH services are to be utilized by married people compared to unmarried people in most communities in Malawi. Young people need to be sensitized on the need for both male and female whether married or unmarried adolescents to make use of YFSRHS that are available in the health facilities in order to prevent SRH problems and complications.

Conversely, the study identified several factors which hinder or act as barriers for adolescents to effectively utilize YFSRHS contributing to low utilization of YFRSHS by adolescents**.** Unsuitable opening times was reported to negatively affect utilization of YFSRHS by adolescents. This is because most clinic opening hours usually clash with adolescent's school timetable making it difficult for them to utilize the YFSRHS while very few access the services during awkward hours. This implies that most adolescents do not access the services contributing to low utilization of YFSRHS and poor SRH outcomes among school-going adolescents. Other studies have also reported similar findings. In a qualitative study with health service providers in Kenya, providers mentioned inconvenient opening hours as a barrier to utilization of YFHS by the

young people since the health facilities do not open during the weekends and adolescents are at school during the week leaving them with a low chance of accessing the services (Godia et al, 2013). Similarly, Abebe and Awoke (2014) in a study in Ethiopia found that inconvenient hours was mentioned by students as a barrier to utilization of YFHS. Likewise, the YFHS evaluation (2014) in Malawi revealed that inconvenient opening hours of YFHS sites acted as a barrier for the young people to utilize the services. There is need to develop policies and strategies that will help to bring the YFSRHS closer to the adolescents who need them and at the same time not disturbing the school activities in different educational institutions in order to reach out to the adolescents.

In addition, lack of harmonization of health and education policies has also been revealed to contribute to low utilization of YFSRHS by adolescents. The study revealed conflicting policies between the education and health department where the education policies do not allow provision of YFSRHS within the school premises especially in primary and secondary schools. According to Malawi School Health and Nutrition Guidelines (2009) adolescents are allowed to be given information regarding SRH through subjects and school-based clubs life skills, youth clubs, and Edzi Toto 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 programmes where provision of YFSRHS can also be done since there are no clinics in most primary and schools. However, provision of YFSRHS is prohibited by the education policies during these school health programs. These inconsistent policies result in low utilization of YFSRHS since most school going adolescents do not easily access the YFSRHS services putting them at a higher risk of SRH problems and complications. In view of this, there is need to develop strategies to ease access to these services for those adolescents who are in school through

strengthening mass campaigns and taking advantage of school gatherings such as during sporting activities between schools where YFSRHS can be provided thereby reaching out to those adolescents who are in school.

The study has also revealed that adolescents lack information regarding sexuality, different SRH problems, and availability of YFSRHS in the health facilities leading to low utilization of these services. This was also revealed in the Malawi national YFHS evaluation which found that only 31.7% of the youth had ever heard about YFHS and lack of knowledge about the availability of the YFHS in the health facilities was also identified as a barrier which hindered the youth from utilizing the services (Ministry of Health & Evidence to Action, 2014). Similarly, young people in Kenya reported lack of awareness of available services as one of the reasons why they did not seek SRH services (Godia et al., 2014; Mutai, 2008). These findings were echoed by Motuma, Syre, Egata, & Kenay, (2016) where lack of awareness about the location of youth friendly services was identified as a reason why most young people did not visit the YFHS. Most literature has shown that lack of basic reproductive health information, knowledge, and experience among adolescents make them feel less comfortable to access SRH services (Tilahun et al., 2012). Similarly, Newton-Levinson et al. (2016) observed that the youth have limited knowledge of SRH problems and lack understanding of the SRH services including where to go to get the services.

Along with the lack of information among the adolescents, the study has also identified that misconceptions, cultural values, and beliefs associated with YFSRHS such as contraceptives negatively affect utilization of these services by adolescents. Use of YFSRHS such as contraceptives is believed by the communities to promote promiscuity among adolescents and also subject them to side effects such as infertility. Consistent with these results were the findings of a study in Uganda which identified that strong misconceptions and cultural norms associated with

the use of contraceptives acted as obstacles for young people to access these services (Nalwadda, 2012). In this study young people believed that contraceptives interfere with their fertility; both married and unmarried adolescents believed that use of contraceptives would burn a woman's eggs and condoms were believed to accumulate in the reproductive system thereby damaging it. Cultural norms regarding the wish to have a big family also obstructed the youth from utilizing the contraceptives (Nalwadda, 2012). Similarly, in Malawi Kapito et al., (2014) identified that misconceptions and myths about contraceptives contributed to negative attitudes towards contraceptive use among adolescents. This calls for a need to educate the public at large in order to address the misconceptions and myths associated with some YFSRHS.

Negative attitude of health care providers was found to affect utilization of YFSRHS among adolescents by many participants. This study has identified that some providers are reported to be judgmental, rude, unapproachable, and harsh to adolescents resulting in low utilization of the services. Several studies have also pointed out that negative attitude of providers negatively affects provision and utilization of YFHS. Two studies in Ethiopia and South Africa had shown that providers have a negative attitude towards provision of YFHS especially to unmarried adolescents (Geary et al., 2014; Tilahun et al., 2012). Similarly, a systematic review of studies on sexually transmitted infections for adolescents and youth in low and middle-income countries revealed that some providers acknowledged that they judged or lectured youth when they came for STI/SRH care (Newton-Levinson et al., 2016). In Ghana, some health care providers reported being judgmental towards adolescents seeking reproductive health information and services (Kumi-Kyereme, Asare, & Darten, 2014). These health care providers' findings echo what the youth have been raising as barriers to utilization of YFHS in the previous studies in Africa where the negative attitude of providers was identified as a major reason they do not utilize different YFSRHS

(Chilinda et al., 2014). This negative attitude of health care providers shows that providers do not personally prioritize the SRH needs of adolescents putting them at a higher risk of SRH problems and defeating the government's efforts to increase utilization of such services by the young people.

Motivation to YFSRHS provision

The study has identified several factors that motivate providers to be providing these YFSRHS and support provision of YFRSHS to adolescents. The passion to ensure adolescents' good health and helping the adolescents have a bright future has been revealed as one of the motivating factors. Providers associated effective provision of YFSRHS to adolescents with the likelihood of adolescents having good health thereby giving them a chance to pursue their careers and be financially stable. This encourages some providers to be providing these services to adolescents. Similar to these findings, a study in Nigeria revealed that the health benefits associated with family planning services provision such as reduced mortality was identified to act as a motivation for some providers to be offering such services to young people (Hebert, Schwandt, Boulay, & Skinner, 2013).

In addition, the study has also revealed that the YFHS training that some providers underwent motivated them to be providing the YFSRHS to adolescents since most of them became confident enough to treat and counsel adolescents with different needs and problems while providers enjoyed seeing what they had learnt during the training being put into practice. The training also promoted understanding of adolescents' needs and problems among the providers thereby improving their attitude during service provision. Furthermore, the study identified that some providers enjoyed/feeling good listening to RH stories and this motivates them to be providing the services.

Contrary to the views supporting provision of YFSRHS to adolescents and the motivating factors identified, the study has also identified that most of the participants regardless of whether they were trained or not trained in YFHS provision do not personally support provision of YFSRHS to adolescents due to their religious, personal and moral values and beliefs. This demotivates them to effectively provide YFSRHS to adolescents. Most participants reported finding themselves in a role conflict between their personal values, religious beliefs and their obligation to provide some YFSRHS such as contraceptives which affect how they deliver the services to adolescents. These personal values and religious beliefs dictate that provision of YFSRHS promotes promiscuity which is a sin and morally wrong. However, this conflict was experienced by both Muslim and Christian participants interviewed in this study and this conflict may not be true to providers from other religions but gives an insight of the effect of religion in the provision of YFSRHS to adolescents. These findings echo the studies done in Nigeria and Sri Lanka where providers reported feeling uncomfortable to discuss contraception with adolescents because of their religious and ethical beliefs (Ahononu, 2014; Dawson, Wijewardena, & Black, 2014). Instead of giving them contraceptives, providers encouraged the young people to abstain from sexual intercourse till marriage (Ahononu, 2014; Paul et al., 2016). In Vanuatu, providers felt that they could not discuss sexuality with the young people due to cultural and often religious norms (Kennedy et al., 2013).

In order to deal with these conflicts, the study found that most providers compromise their beliefs and values in order to provide these YFSRHS to adolescents; however, they do not provide the quality care since they do not fully accept provision of such services to adolescents. Other providers indicated that they first counsel the adolescents about their sexuality, the need to abstain in relation to the adolescents' religious beliefs while others reported that they refer the adolescents

to their colleagues who can easily provide the services. However, the study has also revealed that some providers do not provide the service to the adolescents and send them back since referring to other providers is also a sin to them. Similarly, nurse-midwives in Kenya and Zambia indicated that their first option in dealing with an adolescent who wants contraceptives is to counsel them to abstain rather than offering them the contraceptives (Wareniuse et al., 2006). Correspondingly, in South Africa, some providers providing abortion service reported that they had made peace with their decision to provide abortion services despite being ostracized by the church (Harries, Stinson, & Orner, 2009). These findings point to the need to address the personal socio-cultural and religious beliefs and values of providers in relation to provision of YFSRHS to adolescents because they affect how they provide these services to adolescents. These role conflicts often result in poor service provision making adolescents feel uncomfortable to utilize the services again.

However, this study further revealed that some providers are more reluctant to provide some YFSRHS compared to others on the basis of their values and beliefs. For instance, compared to services such as contraceptives which most providers reported they would easily compromise their values and beliefs to provide the service to adolescents, inducing an abortion was strongly rejected by providers. Most providers reported that they can never provide such services because it is same as killing according to their personal, religious, and moral values and beliefs. This resistance has a potential of affecting the bill of legalizing abortion in Malawi since providers will not be comfortable to provide such services to adolescents due to their values and beliefs. Similarly, Rehnström Loi, Gemzell-Danielsson, Faxelid, & Klingberg-Allvin (2015), in a systematic review of studies about providers' perceptions of and attitudes towards induced abortion in Sub-Saharan Africa and East Asia identified religion as the most important factor influencing the attitude of HCP towards induced abortions.

Challenges health care providers encounter

The study has revealed lack of appropriate knowledge and skills to effectively provide the YFSRHS to adolescents due to inadequate training in provision of YFSRHS as a challenge that most health providers face during provision of YFSRHS to adolescents. Providers reported using their general SRH knowledge and experience during provision of YFSRHS to adolescents which affects how they handle these adolescents. These findings are similar to some studies that have been conducted in other countries where providers expressed 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 provision of SRH services to young people (Godia et al., 2013).

The study has also found that all the health facilities that participated in this study lacked essential documents such as YFSRHS guidelines, protocols, standards, policies, and record books which are important in the provision of quality YFSRHS to adolescents. Providers expressed lack of knowledge on the existence of these documents and reported to have never seen them throughout their working experience. This makes it difficult for them to refer to these documents when they are faced with a difficult situation/scenarios during service provision thereby affecting provision of quality YFSRHS to adolescents. Contrary to these findings, the Malawi YFHS Evaluation report (2014) indicated that more than 60% of the health facilities reported to have copies of the YFHS standards but did not have the policies and protocols. This discrepancy may be due to the differences in the type of studies since this study was qualitative and allowed individuals to fully express themselves while the YFHS evaluation used a mixed method where the participants might not have fully expressed themselves during the quantitative part of the study.

Similarly, in Kenya providers were not aware of the national guidelines for provision of YFHS and this was reported as a barrier to provision of effective SRH services to the young (Godia et al., 2013). In Uganda, very few facilities had guidelines and national policy on reproductive health and family planning and providers were not aware of these documents which acted as obstacles to the effective provision of contraceptive methods to young people (Nawaldda, 2012). It is important to ensure availability of these essential documents in all the health facilities in order to promote provision of quality YFSRHS to adolescents. It is also essential to make sure that providers are made aware of and use these guidelines because their mere availability in the health facilities does not translate to use as revealed by Motuma et al., (2016) in Ethiopia who identified that despite having the national guidelines for YFHS provision in some health institutions, only a few providers reported to be using them.

In addition, the study has also identified that providers lack resources to effectively provide the YFSRHS to adolescents. This forces providers to improvise some resources in order to deliver the services. The study has revealed that providers run out of the essential supplies such as medications on a daily basis making other adolescents return without receiving the services they were seeking, thereby putting them at risk of different SRH problems and complications. Similarly, lack of equipment was also identified as a challenge which affected utilization of YFHS to adolescents in Tanzania (Mbeba et al., 2012). Correspondingly, Nawaldda, (2012) identified that inconsistent and sporadic availability of contraceptives commodities affected contraceptive use among adolescents in Uganda. Likewise, the findings in the Malawi YFHS Evaluation (2014) reported that the youth, parents and community leaders mentioned the shortage of medicine and non-availability of some services as challenges affecting utilization of YFSRHS.

High workload has also been revealed in this study to affect provision of YFSRHS to adolescents. Due to inadequate staffing levels in the health facilities, providers provide multiple services; as a result, they end up providing poor quality care to adolescents seeking YFSRHS and most of the times they provide curative services in order to finish the numbers. This may also be a contributing a factor to the findings in this study where it was noted that adolescents utilize curative YFSRHS more than preventive services. Likewise, Alli et al. (2013) found that majority of providers reported limited contact time with young people and heavy patient loads as a challenge affecting provision of SRH services to adolescents. They further added that they dealt with patients quickly and mostly concentrated on providing curative services than preventive services due to the long queues (Alli et al., 2013). Similarly, providers in Uganda reported being too busy to provide contraceptives to young people because they had to provide other services as well (Nalwadda, 2012). High workload contributes to long waiting hours which compromises adolescents' confidentiality. It also presents missed opportunities to provide these adolescents with all the necessary information and counselling on different YFSRHS. This negatively influences adolescents' decisions to access the YFRHS in future. Michaels-Igbokwe et al (2015) found that time spent waiting to see a provider at the facility and concerns about confidentiality were considered to influence the choice of contraceptives among young people in Malawi.

Lack of motivation from the employer has also been identified as a challenge affecting provision of YFSRHS to adolescents by the participants in this study. This results in reduced morale to effectively provide the YFSRHS to adolescents. Similarly, poor staff motivation was identified as a barrier to provision of SRH to adolescents in Kenya (Godia et al., 2013). Likewise, Dagne, Beyene, & Berhanu (2015) identified that supervisor related factors in terms of relationship and supervisors' recognition and appreciation of the achievement made by providers negatively

affected staff motivation in public hospitals in Ethiopia. In addition, the study has found that lack of YFSRHS supervision from YFHS coordinators and other managers contributes to poor delivery of these services. This was also associated with low motivation of providers to effectively provide the YFSRHS since when one is supervised he/she is always conscious of his/her actions and it also provides an opportunity to address different challenges one is facing, thereby making it easy to confidently provide the service. Similarly, perceived lack of management support was identified to be a source of frustration among VCT counsellors in Ethiopia (Jacobi, 2010). This shows that supervision positively influences provision of quality YFSRHS to young people.

Perspectives on improving provision of YFSRHS to adolescents

Training providers in provision of YFRSHS has been suggested by majority of the participants in this study as a way of improving the knowledge and skills of providers in provision of YFSRHS to adolescents. This training can be done through formal in-service training, on job training and also through mentoring providers in different skills necessary for provision of YFSRHS to adolescents. This will help them gain a deep understanding of adolescents' behaviours, build their confidence, and develop a positive attitude in handling adolescents thereby contributing to quality care. Similarly, training of HCP has been recommended by providers in several studies as a way to improve provision and utilization of YFS and other SRH services (Godia et al., 2013; Jejeebhoy, 2014; Ontiri, 2015). Alli et al (2013) in their study recommended that adequate training in interpersonal relations for youth friendly services provision is essential in helping overcome communication problems and enabling providers to interact with young clients at a more personal level.

Other providers in this study also suggested establishing a specialized training program where providers would specialize in provision of YFSRHS as part of their career progression. This

will allow the health facilities to have specialized providers who can be experts in provision of YFSRHS and adolescents can easily get used to those providers. Adolescents freely utilize the YFSRHS when they meet a health service provider who is familiar with them and this can help increase utilization of these services.

In addition, strengthening the already existing strategies such as on job mentorship and use of Continuous Professional Development (CPD) to allow providers identify their own gaps in YFSRHS provision and help them meet their needs was also recommended by participants in this study. This will help improve providers' knowledge, skills, and confidence in provision of these services to adolescents. Along with training the providers in provision of YFSRHS, the participants also recommended training the providers in customer care so as to improve their attitude towards adolescents utilizing different YFSRHS in order to promote utilization of such services. Regular review meetings where providers can share their experiences and learn from others how to address the challenges they are facing in their facilities were also recommended to help enhance provision of YFSRHS. These strategies are essential in helping address several difficulties providers face during provision of YFSRHS to adolescents and also learn from fellow providers which can help improve their attitude and skills in regards to YFSRHS provision to adolescents.

Participants in this study also recommended employing more HCP to be providing different YFSRHS so as to reduce the workload and allow the providers to spend more time with the adolescents during service provision. The Malawi YFHS Evaluation report (2014) also 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, 2013). Increasing HCP will allow providers to

spend quality time with the adolescents thereby offering the providers an opportunity to provide them with all the necessary information, education, and services.

In order to improve provision of the YFSRHS to adolescents in the facilities participants in this study suggested improving infrastructure through identification of places in the health facilities which can be used as youth corner where adolescents can freely engage in different activities such sporting activities or accessing internet services while receiving the different YFSRSHS. This will ensure privacy and confidentiality to the adolescents since they will not be mixed with other older patients and hence it will make them feel free to access any service they want without fears of being labeled promiscuous. In addition, the providers suggested identifying a specific day during the week for provision of YFSRHS. This will allow providers to spend more time with adolescents since they will not be in a hurry to finish the line so that they provide other services. 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.

However, other providers also suggested integrating the YFSRHS with other services provided in the facilities in order to allow the adolescents to be free during service provision to give all the necessary information since other clients will not easily find out what service they are seeking. These findings are in line with the findings of a study in Kenya where providers recommended integrating SRH services with other services to promote utilization by the young people (Godia et al., 2013). Similarly, Hagey et al. (2015) identified that integration of contraceptive and HIV care services allows easier access to contraceptives by adolescents by removing the stigma associated with coming to the clinic for contraceptives only.

Ensuring 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 provision of quality YFSRHS to adolescents. Similarly, studies in Kenya recommended ensuring availability of essential drugs, supplies, and basic equipment for provision of YFHS as one of the strategies in improving service provision to young people (Godia et al., 2013; Kamau 2006). These resources will enable providers to provide every service that adolescents seek according to standards.

In order to improve the quality of the services provided to the adolescents, participants in this study suggested the need to have suggestion boxes in YFSRHS' departments and facilities and to periodically be reviewing the complaints raised by the adolescents. This will help providers improve their attitude and the way they deliver services and align the services according to the needs of the adolescents. In addition, establishing quality improvement teams to monitor provision of YSRHS and help address other emerging issues relating to provision of YFSRHS was also suggested. Wagner et al. (2017) in a study to determine whether continuous quality improvement improves quality of HIV testing service in Kenya recommended that quality improvement interventions are useful in improving adolescent friendly service delivery. Furthermore, this study has suggested strengthening supervision of YFSRHS in order to help to identify gaps and challenges providers are facing and come up with ways to address them. These findings are similar to the recommendation from an assessment made by African Youth Alliance (2003) in Tanzania which recommended supportive supervision of providers providing YFHS as part of capacity building to providers. Similarly, the Malawi YFHS strategy 2015-2020 has also emphasized on the need to strengthen capacity building for health workers through supportive supervision to enhance their skills in provision of YFSRHS to young people including adolescents.

Providers in this study suggested the need to sensitize the communities on the availability of YFSRHS in the health facilities, address misconceptions associated with the use of YFSRHS, and make the communities understand the importance of utilizing the YFSRHS by adolescents through the use of open day campaigns in order to improve YFSRHS utilization. This will help reduce the stigma associated with the use of YFSRHS by the adolescents. Young people in a study in Kenya similarly suggested conducting community meetings to inform parents on activities that take place at a youth centre as a way of addressing misconceptions associated with SRH utilization by young people (Godia et al., 2014). Similarly, Feleke, Koye, Demssie, & Mengesha, (2013) also recommended increasing awareness for the youth about the services available in the health facilities as an important step in improving adolescents' reproductive health service utilization.

The study also suggested choosing of youth representatives from different communities to act as a link between communities and the hospital on the issues regarding YFSRHS delivery as essential in improving utilization of the services. These individuals will act as focal people or peer educators where adolescents will seek guidance from on how to access the YFSRHS. In addition, the participants emphasized the need to ensure equity in motivating these youth peer educators/motivators in order to improve their commitment to their duties of motivating fellow young people to utilize the services. Involving young people in strategies aimed at improving YFSRHS utilization is very important since it can promote ownership of the strategies and adolescents can freely interact with these peer motivators. Similarly, a study in Ethiopia recommended that the youth should be involved in addressing their own problems in order to improve utilization of SRH services by the young people (Motuma et al., 2016). Young people in Kenya also recommended involving the youth in mobilizing other young people in order to help improve utilization of SRH services by the youth in Kenya (Godia et al., 2014).Youth participation

in provision of YFSRHS has also been prioritized in the Malawi YFHS strategy 2015-2020 in order to promote ownership and understanding of the YFSRHS. Similarly, the YFHS evaluation report (2014) reported lack of youth participation in YFHS activities and attributed the poor implementation and quality assurance in YFHS national standards in Malawi to limited meaningful participation of the youth in the program as clients and as program developers. Therefore there is the need to involve the youth in interventions aiming at promoting utilization of YFSRHS by the young people to ensure quality YFSRHS provision.

Recommendations

According to the study findings the researcher recommends the following;

YFSRHS Delivery departments and Health Facilities

Health care providers to periodically (yearly) do self-assessments to identify their personal needs in regards to provision of YFSRHS to young people and communicate with the relevant people such as in charges to facilitate how those needs are to be addressed such as through mentorship, Continous Professional Development (CPD) and through training. This will help providers to acquire the necessary knowledge, skills, and attitudes which will promote provision of quality care to adolescents utilizing YFSRHS and reduce the health care providers' knowledge and skills gaps.

Working hand in hand with the health facility management teams, there is need to identify space to be used as a youth corner where all YFSRHS can be provided on a daily basis in the facilities providing YFSRHS. Alternatively, health facilities may identify a day in a week when YFSRHS can be provided to all young people. Another approach that can be adopted is to integrate YFSRHS with the other services that are provided in the facilities depending on the health facilities' feasibility. Integration of services is believed to benefit both clients and health providers by improving the quality of care, reducing costs, helping to maximize utilization of the limited

resources and providing comprehensive client-centered care hence it has been globally promoted (Warren, Mayhew, & Hopkins, 2017). It also has been argued to help in maximizing the use of scarce health care resources by increasing both cost and technical efficiency of service delivery (Dudley & Garner, 2011). Hagey et al. (2015) observed that integration of contraceptive and HIV care services allows easier access to contraceptives by adolescents by removing the stigma associated with coming to the clinic for contraceptives only. These initiatives will help enhance privacy and confidentiality during service provision which will, in turn, promote provision of quality YFSRHS to adolescents.

There is need to establish quality improvement structures at department or health centre level such as installing suggestion boxes, establishing quality improvement teams to help in monitoring and evaluating YFSRHS provision. These will help in informing the health facilities 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 YFSRHS by health care providers and adolescents respectively. Similarly, in Kenya, quality improvement interventions were recommended to be useful in improving adolescent friendly service delivery (Wagner et al., 2017).

Management

There is a need for regular YFSRHs review meetings where HCP can share experiences and learn from each other thereby improving the attitude of providers in provision of YFSRHS to adolescents. These meetings can be conducted quarterly in coordination with the stakeholders supporting adolescent health in these facilities. In addition, there is need to identify means of recognizing those providers who have performed well in provision of quality YFSRHS to adolescents to act as a motivation to these providers.

In coordination with the stakeholders and the YFHS coordinator, there is need to intensify supportive supervision and mentorship sessions which will help in identification and addressing challenges providers face during YFSRHS provision to adolescents. In addition, there is need to conduct in-service training to providers in provision of YFSRHS to adolescents in order to improve their knowledge and skills in provision of YFSRHS. Training providers was proven to be beneficial in a study in Ethiopia where providers that had been trained in provision of YFHS reported to be confident to respond to the needs of the youth while those that had not been trained reported that they treat young people 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).

In collaboration with partners, management needs to sensitize the communities and make them aware of the availability of YFSRHS in the health facilities and address the myths and misconceptions regarding the use of YFRSHS by adolescents. This will reduce the stigma associated with utilization of YFSRHS by adolescents. Feleke, Koye, Demssie, & Mengesha, (2013) also recommended increasing awareness for the youth about the services available in the health facilities as an important step in improving adolescents' reproductive health service utilization. In addition, there is need to identify peer educators from the communities to ensure youth participation in the programs and interventions aimed at increasing utilization of YFSRHS by adolescents. Use of peer educators has been seen to improve utilization of YFHS in Zambia where it was identified that those youths who cited peer educators as their source of information about availability of the YFHS were two times more likely to utilize the services as compared to

those who cited friends, church, neighbours, and cousins as their source of information (Mushinda, 2004).

The Ministry of Health and the District Health Management Team (DHMT) need to ensure availability of all YFSRHS resources in all the health facilities and departments providing YFSRHS to adolescents. These resources include both human and material resources

The study identified that all the facilities that participated in this study did not have YFSRHS guidelines, standards, policies and protocols and providers were not aware of the existence of these documents. Therefore, in coordination with the YFHS coordinator, the DHMT should avail the guidelines, protocols, and policies pertaining to provision of YFSRHS to adolescents in all the facilities providing YFSRHS. HCP providing YFSRHS should be oriented on these policies and guidelines and these documents should be made available and pasted in easy to reach places so that they can be continually referred to during service provision.

Policy

There is need for continuous education and training of YFSRHS providers to ensure provision of quality care to adolescents and this education and training needs should be incorporated into the health care system policies for professional development such in and out of service training policies. This will help address the shortage of YFSRHS providers in the facilities revealed in this study in addition to improving the knowledge and skills of providers in the delivery of these services to adolescents. Warenius et al (2006) in a study in Kenya and Zambia noted that facilities whose providers had received continued education on adolescent sexuality and reproduction showed a more youth friendly attitude as compared to those that had never received the training.

Policy guidelines and instructions pertaining to religious, moral values and beliefs and clarifying the role of providers regarding provision of YFSRHS to both married and unmarried adolescents should be developed and communicated at hospital level. This will help address the conflict that providers face during the provision of YFSRHS to adolescents identified in this study. These policies will also help managers when allocating providers to specific work stations taking in consideration of their values and beliefs in regards to YFSRHS provision to adolescents. However, all providers are expected to provide YFSRHS to all young people irrespective of their personal and cultural beliefs.

There is need to harmonize the education and YFHS policies in regards to utilization of YFSRHS by in-school adolescents. These policies will need to be communicated to both sectors so that the adolescents are aware on how they can access YFSRHS easily despite being in school.

YFHS Education

Findings from this study show that most providers experience role conflict between their personal and religious values and beliefs and their obligation to provide YFSRHS to adolescents. Therefore there is need for YFHS training module in pre-service and in-service training to include a topic on the personal, cultural and religious beliefs of HCP that affect provision of YFSRHS. This will allow for students and providers to reflect on themselves, help each other deal with the possible dilemmas thereby preparing them to have a positive attitude towards the provision of YFSRHS to adolescents leading to provision of quality YFSRHS care.

Study Limitations

There are three main limitations in this study. Firstly, the use of purposive sampling method which enrolled participants based on their level of experience (not less than 2 years providing YFSRHS) does not guarantee that they are the ones with more rich information compared to those

with less than 2 years of experience. Therefore, it does not guarantee that all voices of YFSRHS health care providers were heard and represented in the study. Secondly, the study was conducted in three health facilities in Dedza hence the findings will be limited to these facilities only. Thirdly, the findings cannot be generalized this being a qualitative study. However, these findings may give useful insights regarding factors influencing provision of YFSRHS to adolescents from providers' perspective in facilities where YFSRHS are provided.

Areas for Further Research

The study has found that HCP are still conservative to provide YFSRHS to adolescents regardless of whether they were trained or not in provision of YFSRHS especially contraceptives and inducing an abortion to adolescents due to their socio-cultural and religious beliefs and values. Therefore there is need to explore how socio-cultural beliefs and values influence provision and utilization of YFSRHS by young people in Malawi from the perspectives of both the youth and health care providers.

YFSRHS have been revealed to be largely under-utilized in the health facilities that were involved in this study due to health worker related factors, YFSRHS delivery factors, and community related factors. However, there is need to assess the young peoples' perception of YFSRHS in regards to their SRH needs in order to get their personal views on whether the available services are able to meet their SRH needs.

Conclusion

The study has shown that the different behaviours that adolescents portray when seeking YFSRHS affect the quality of health service provision. It has revealed that most adolescents are uncomfortable to utilize the YFSRHS due to the attitude of health providers and community

perception associated with the use of YFSRHS by an adolescent. Adolescents who utilize these YFSRHS are often labelled as promiscuous by the community members and even health providers which makes them feel uncomfortable to utilize these services. However, knowledge, skills, and attitude of health providers, lack of essential YFSRHS supplies and resources, inconvenient YFSRHS provision hours, misconceptions associated with some YFSRHS such as contraceptives, and poor awareness about the availability of YFSRHS in the health facilities have been identified to negatively affect effective utilization and provision of YFSRHS to adolescents.

Health and financial benefits associated with provision of YFSRHS to adolescents, adequate knowledge and the personal interests and passion for adolescents motivated some providers to freely provide YFSRHS to adolescents. However, most providers reported finding themselves in a role conflict between their duty to provide the YFSRHS to adolescents against their personal, moral, and religious values and beliefs. This makes some providers compromise their values and beliefs in order to fulfill their duties which affects the quality of YFSRHS provided to adolescents. However, great resistance has been noted in regards to provision of some YFSRHS to adolescents especially inducing an abortion.

It is important that YFSRHS interventions should aim at making the community aware of the availability of YFSRHS in the health facilities, addressing misconceptions and stigmatization associated with the use of YFSRHS. Along with such interventions, there is need to improve infrastructure in the health facilities, address HCP knowledge and skills gap, and ensure availability of both human and materials in order to enhance provision and utilization of quality YFSRHS. In addition, it is also very important to address HCP personal conflicts associated with provision of YFSRHS to adolescents in order to promote quality YFSRHS provision.

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Appendices

Appendix 1: Information Letter to Health Care Providers in providing Youth Friendly Sexual and Reproductive Health Services to adolescents in Dedza district.

Dear participants

My name is Lucy Jonasi Chimera and I am currently registered as a student at the University of Malawi, Kamuzu College of Nursing for Master of Science degree in Reproductive Health. I am conducting a research project on "**Factors influencing provision of Youth Friendly Sexual and Reproductive Health Services to Adolescents in Dedza District from the health care providers' perspective."** and I write this letter to ask you to participate in this study**.** The aim of the study is to determine the factors influencing provision of youth friendly sexual and reproductive health services from health care providers' experiences. The findings of this study will help in identifying strengths and challenges that health care providers face during provision of YFSRHS to adolescents. Strategies on how to enhance health provider's provision of YFSRHS will also be identified which will later help to improve provision of these services to adolescents.

Participation in the study is entirely voluntary. You may choose to participate or withdraw from the study at any time, which will not have any effects on the services you give to the patients and your workplace relationship with your supervisors. Furthermore, the study does not have any foreseeable physical harm (risks); however, in cases of any emotional or psychological harm, you may forward your concern and complaints to the researcher at Kamuzu College of Nursing.

I appreciate that you will derive no benefit from participating in the study. However, the findings from this study will assist in responding to health care provider's needs to enhance provision and improve utilization of youth friendly sexual and reproductive health by the adolescents. No reports in this study will identify you in any way and results of the study will be given to you should you so wish. Should you agree to participate, I will ask you to sign a consent

form to indicate that you have accepted to be interviewed. It is anticipated that the interview will take 40 minutes to one hour of your time. The interview will be conducted at a time that is most suitable and convenient for you in a quiet environment to avoid any disturbances.

The study has been approved by College of Medicine Research and Ethics Committee (COMREC) and permission has been granted from Dedza District Health Office.

Thank you for taking time to read this information letter.

Should you require any further information regarding the study or your rights as study participant you are free to contact me on 0999076076 or The chairperson, COMREC Secretariat, P/Bag 360, Chichiri, Blantyre 3 or you may call on 01989766.

Appendix 2: Chichewa Version of Information Letter to Health Care Providers in providing YFSRHS to adolescents in Dedza district.

Kalata yofotokoza za kafukufuku wa zomwe zikulimbikitsa ndi kulepheretsa ntchito yopereka chithandizo chokhudza ubeleki ndi kugonona kwa achinyamata osaposera zaka 19 mu boma la Dedza kuchokera kwa ogwira ntchito za chipatala.

Wokondedwa wotenga mbali

Ndine Lucy Jonasi Chimera, wophunzira za unamwino kusukulu yaukachenjede ya Malawi ku Kamuzu koleji, amene ndikuphunzira zokhudza moyo wa ubeleki ndipo ndikupanga kafukufuku wofuna kudziwa **"zomwe zikulimbikitsa ndi kulepheretsa ntchito yopereka chithandizo chokhudza ubeleki ndi kugonona kwa achinyamata osaposera zaka 19 mu boma la Dedza kuchokera kwa ogwira ntchito za chipatala."**

Ndalemba kalatayi ndi cholinga chofuna kukupemphani kuti mutengepo mbali polowa nawo mukafukufukuyu. Cholinga cha kafukufukuyu ndi kufuna kupeza zomwe ogwira ntchito za chipatala amakumana nazo akamapereka chithandizo chokhudza ubeleki ndi kugonana kwa a chinyamata osaposera zaka 19 ndipo zotsatira zake zidzathandiza kupeza zomwe zimalimbikitsa komanso zovuta zomwe ogwira ntchito za chipatala amakumana nazo akamapereka chithandizochi kwa a chinyamata osaposera zaka 19. Njira zopititsira patsogolo ntchito ndi ukadaulo wa ogwira ntchitozi zidzapezekanso kudzera mu kafukufuku ameneyu. Izi zidzachititsea kuti achinyamata ambiri azikhala omasuka kulandira chithandizo chokhudza ubeleki ndi kugonana chimenechi komanso ogwira ntchito za chipatala azipereka chithandizochi mosavuta.

Dziwani kuti simukukakamizidwa kutengapo mbali komanso muli ndi ufulu ngati mukufuna kusiya nthawi imene mungafune popanda vuto lina lililonse ndipo muli omasuka kufunsa mafunso aliwonse okhudza kafukufukuyu. Mukuyeneranso kudziwa kuti mayankho anu

adzasungidwa mwachinsisi ndipo sizizadziwika kuti anayankha mafunsowa ndi ndani chifukwa mayina anu sadzayikidwa pamapepala a mafunso m'malo mwake tizagwiritsa ntchito manambala. Dziwaninso kuti palibe chiopsezo china chili chonse pakafukufukuyi. Chinaso chomwe mungadziwe ndi chakuti palibe ndalama kapena mphatso zilizonse zomwe mungalandire popeza mwatenga nawo mbali mu kafukufukuyu.

Ngati mwavomereza kutengapo mbali pakafukufukuyi muzapemphedwa kusayina fomu ndiponso kuyankhapo mafunso kwanthawi yosachepera mphindi 40 kapena ola limodzi. Kafukufukuyu wavomerezedwa ndi a komiti yaikulu yoona za kafukufuku ndi ufulu ya College of Medicine Research Ethics (COMREC) komanso office yaikulu yoona zaumoyo ya m'boma la Dedza.

Ngati pangakhale mafunso kapena nkhawa ina yiliyonse yokhudzana ndikafukufukuyu khalani omasuka ndikubweretsa madandaulo anu kwa mwini kafukufukuyu poimba telefoni pa nambala iyi 0999076076 kapena kwa wapampando, COMREC P/Bag 360, Chichiri, Blantyre 3 kapena imbani telefoni pa nambala iyi 01989766.

Appendix 3: Health Care Providers' Consent Form

Please read and sign the form if you are taking part in this study.

Informed consent for health care providers consenting to be participants for a study titled **'Factors influencing provision of Youth Friendly Sexual and Reproductive Health Services to Adolescents in Dedza District: health care providers' perspective.'**

I have read/ have had another person read to me 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 have understood 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. That is why I am voluntarily consenting to participate in the study.

…… …….

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 01989766.

Appendix 4: Chichewa Version of the Consent form

Kalata yopempha chilolezo kwa ogwira ntchito za chipatala

Werengani ndi kusayinira pa kalatayi ngati mukutenga nawo mbali mu kafukufukuyu

Kalata yovomeleza kutenga nawo mbali pa kafukufuku yemwe akufufuza za "**zomwe zikulimbikitsa ndi kulepheretsa ntchito yopereka chithandizo chokhudza ubeleki ndi kugonona kwa achinyamata osaposera zaka 19 mu boma la Dedza kuchokera kwa ogwira ntchito za chipatala."**

Ndawerenga/ ndawerengeredwa ndipo ndamvetsetsa uthenga onse uli mukalata yokhudzana ndi kafukufukuyu, komanso ndapatsidwa mwayi wofusa mafuso okhudzana ndi kafukufukuyu pomwe pamafunika kutero. Ndamvetsetsanso kuti zonse zomwe ndingafotokoze kapena kupereka zisungidwa mwa chinsisi ndipo amene angazifikile ndi mwini kafukufuku yekha kapena ena amene ali oyenera kutero. Ndikudziwaso kuti sindikuyenera kukumana ndi chiopsezo cha mtundu wina uliwonse mu nthawi ya kafukufukuyi ndipo uthenga omwe ndipereke kwa mwini kafukufukuyu sudzagwilitsidwa ntchito mondiukila m'tsogolo muno. Ndauzidwanso m'mene ndingapezere opanga kafukufukuyi ngati kuli kofunika kutero. Kotero, ichi ndi chifukwa chake ndikulora kutenga nawo mbali mukafukufukuyi mosakakamizidwa.

…… …….

Posainila otenga mbali Tsiku

……. ……..

Posainila mwini kafukufukuyu Tsiku

Ngati pangakhale mafunso kapena nkhawa iliyonse yokhudzana ndikafukufukuyu khalani omasuka ndikubweretsa madandaulo anu kwa wapampando wa COMREC pa telefoni nambala iyi 01989766.

Appendix 5: Interview Guide for a study on factors influencing provision of Youth Friendly Sexual and Reproductive Health Services to Adolescents.

Participant Number……..Date……..Time……..

Section A: Demographic data and Health Care Providers' information

1.1 Age…….

1.2 Religion……..

1.3 Department/health center/ catchment area currently working in----------

1.4 Cadre----------

1.5 How many years have you been providing Youth Friendly Sexual and Reproductive Health Services?

1.6 What sexual and reproductive health services do you offer to adolescents as part of YFHS?

1.7 Have you ever been trained in YFHS? a).Yes b).No

If yes in (1.7) when……

1.8 Have you ever had a refresher training since your initial training? a).Yes b).No

If yes in (1.8) when……

Section B: In-depth interview guide

1. Can you tell me about your experience in providing Youth Friendly Sexual and Reproductive Health Services to adolescents?

   Probes

What is your experience in terms of factors that affect YFSRHS delivery when an adolescent comes to your clinic seeking for sexual and reproductive services such as STI treatment, ART, Contraceptives, antenatal and maternity services?

Do you have anything that motivates you to be providing YFSRHS to adolescents?

What aids (protocols, guidelines, policies) do you have that facilitate your provision of YFSRHS to adolescents?

2. What are your views towards the provision of YFSRHS to adolescents?

Probes

Do you think adolescents from this facility's catchment area utilize YFSRHS services?

As compared to older patients, when adolescents access the SRH services, do you think they fully open up to give you the information you require in order to help them effectively? What is your experience on this? Do they freely communicate their needs/problems? How do you motivate them to open up?

What is your opinion towards adolescents utilizing SRH services such as contraceptives?

Does provision of YFHS to adolescents conflict with any of your personal feelings, cultural and religious beliefs and values? Are you comfortable with adolescents utilizing SRH Services?

What challenges/barriers do you face to competently and effectively provide YFRSHS to adolescents?

3. In your opinion do you think enough is being done at your health facility to enhance health providers' knowledge and skills in provision of YFRSHS to adolescents?

Probe

Can you give examples of what is being done to enhance health providers' knowledge and skills in provision of YFHSHS to adolescents?

4. According to you, what do you suggest should be done to enhance health providers' competency (knowledge and skills) in provision of YFSRHS?

5 You are free to give any comments in regards to factors influencing provision of YSRFHS to adolescents.

Thanks for your participation!

Appendix 6: Chichewa version for the Interview Guide for a study on factors influencing provision of Youth Friendly Sexual and Reproductive Health services to adolescents

Mafuso kwa ogwira ntchito za chipatala pa zomwe zikulimbikitsa ndi kulepheretsa ntchito yopereka chithandizo chokhudza ubeleki ndi kugonona kwa achinyamata osaposera zaka 19."

Nambala yachinsinsi ya wotenga mbali mukafukufukuyu……

Tsiku……. Nthawi……

Gawo loyamba (A): Mbiri ya wogwira ntchito za chipatala

1.1 Muli ndi zaka zingati?.....

1.2 Mumapemphera chipembedzo chanji?.....

1.3 Mukugwira ntchito depatimenti pa chipatala pano kapena chipatal chachong'ono chiti ……..

1.4 Mumagwira ntchito ngati ndani pa chipatala pano? .....

1.5 Mwakhala mukupereka chithandizo chokhudza ubereki ndi kugonana kwa achinyamata kwa nthawi yayitali bwanji?

1.6 Ndi chithandizo chiti kapena zithandizo ziti zokhudza ubereki ndi kugonana zomwe inuyo mumapereka nawo kwa achinyamata osaposera zaka 19 ngati mbali imodzi mwa chithandizo chomwe chimaperekedwa kwa achinyamata pa chipatala chino?

1.7 Kodi munalandirako maphunziro okhudza kaperekedwe ka chithandizo kwa achinyamata?

a). Eya b). Ayi. Ngati eya, ndi liti munalandira maphunziro amenewa? …….

1.8 Munachitako maphunziro owonjezera pa ukadaulo wanu pa kaperekedwe ka chithandizo kwa achinyamata chipangireni maphunziro anu oyamba aja? a). Eya b) Ayi

Ngati eya munachita liti maphunziro amenewa?.....

Gawo lachiwiri (B): Mafunso a kwa ogwira ntchito za chipatala

1. Mungandifotokozereko maganizo anu ndi zomwe mwakhala mukukumana nazo mukamapereka chithandizo chokhudza ubereki ndi kugonana kwa achinyamata osapyola zaka 19?

   Mafunso othandiza kupeza zambiri

   Mumatani mukakumana ndi wachinyamata wosaposeraa zaka 19 wakuti wabwera kufuna chithandizo chokhudza ubereki kapena kugonana monga; chamatenda opatsirana pogonana, mankhwala otalikitsa moyo, njira zakulera, sikelo ya amayi a pakati ndi chithandizo chofunikira pobereka? Ndi zinthu ziti zomwe mumaona kuti zkuthandizira kapena kulepheretsa kaperekedwe ka chithandizo chimenechi kwa achinyimata osaposera zaka 19 wa mukakumana nawo?

   Ndi zinthu ziti zomwe zimakupangitsani kukhala ndi chilimbikitso komanso chilakolako choti muzipereka chithandizo chokhudza ubereki ndi kugonana kwa achinyamata osaposera zaka 19 amenewa?

   Ndi zinthu ziti (ndondomeko zakaperekedwe ka chithandizo chosiyanasiyana kwa achinyamata) zomwe mulinazo zimene mumatsatira pa ntchito yopereka chithandizo cha ubereki ndi kugonana kwa achinyamata osaposera zaka 19?

2. Maganizo anu wokhudza kupereka chithandizo cha ubereki ndi kugonana kwa achinyamata osaposera zaka 19 ndi wotani?

   Mafunso othandiza kupeza zambiri

Mukuganiza kuti achinyamata osaposera zaka 19 a m'madera ndi midzi yozungulira chipatala chino amabwera kudzalandira chithandizo chokhudza ubereki ndi kugonana bwinobwino pachipatala chino?

Mukafananiza ndi anthu odutsa zaka 19 ofuna chithandizo cha ubereki ndi kugonana, mumaona ngati achinyamata osaposera zaka 19 akabwera kudzalandira chithandizo chokhudza ubereki ndi kugonana amamasuka bwanji? Kodi amafotokoza bwinobwino mavuto ndi zosowa zawo mwaufulu kuti muwathandize moyenera? Fotokozani zomwe mumakumana nazo pa izi.

Kodi maganizo anu ndi wotani okhudza kupereka chithandizo cha ubereki ndi kugonana kwa achinyamata osaposerala zaka 19 monga njira zolera?

Kodi kupereka chithandizo chokhudza ubereki ndi kugonana kwa achinyamata osaposera zaka 19 kumagwirizana kapena sikugwirizana bwanji ndi zikhulupiriro za umunthu wanu, zachipembedzo chanu komanso za chikhalidwe chanu? Muli ndi vuto lililonse kuti achinyamata osaposera zaka 19 azilandira chithandizo cha ubereki ndi kugonana?

Ndi zovuta ziti zomwe mumakuna nazo kuti mupereke mwaukadaulo chithandizo cha ubereki ndi kugonana kwa achinyamata osaposera zaka 19?

3. Mukuganiza kuti chipatala chanu chikuyesetsa chikuyesetsa bwanji kupititsa patsogolo ukadaulo wanu pa ntchito zokhudza kupereka chithandizo cha ubereki ndi kugonana kwa a chinyamata osaposera zaka 19?

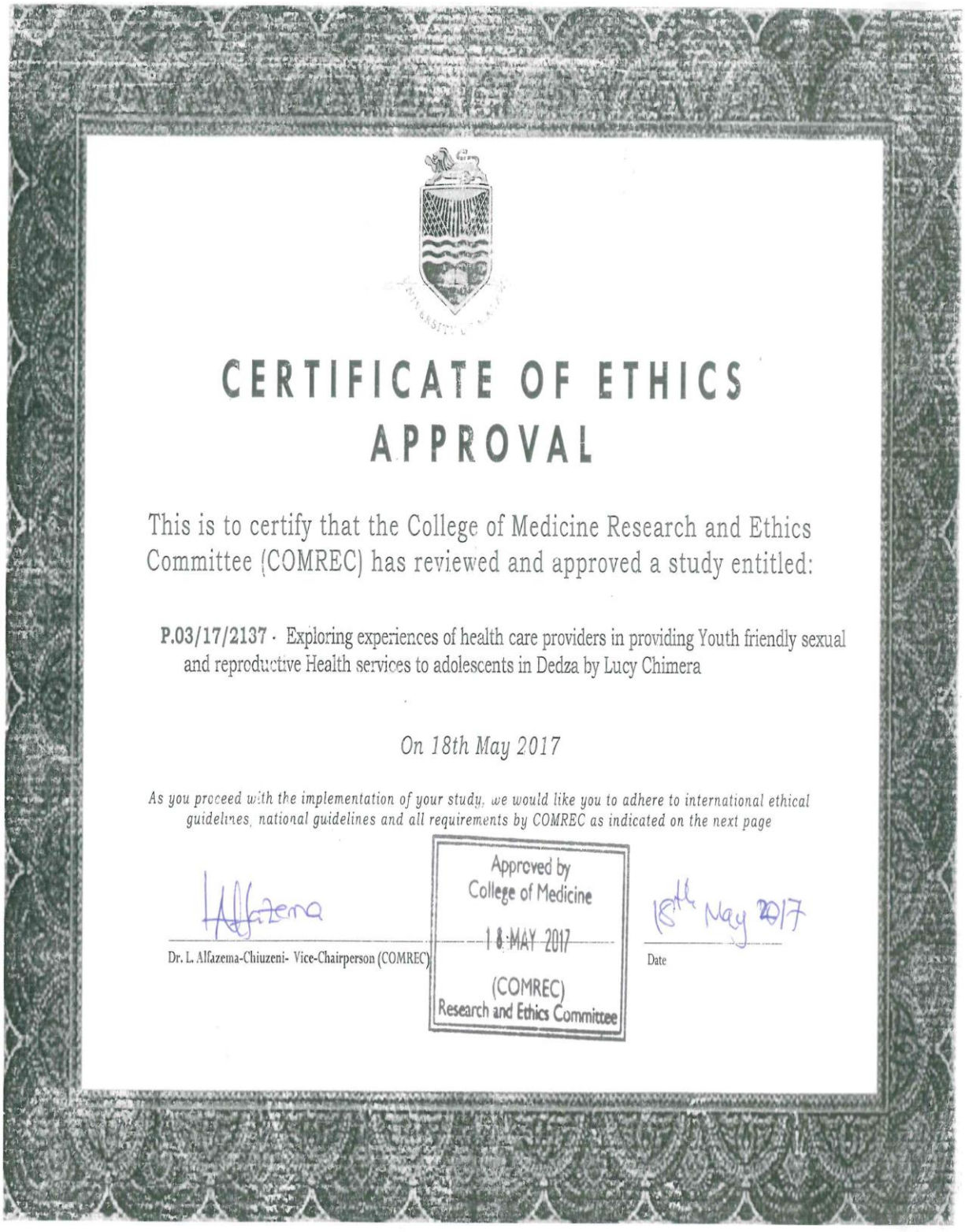
Mafunso othandiza kupeza zambiri

Mungaperekeko zitsanzo za zomwe zikuchitika polimbikitsa ogwira ntchito pa ukadaulo wawo opereka chithandizo chokhudza ubereki ndi kugwana ka a chinyamata osaposera waka 19.

4. Mwa inu nokha, mukuganiza kuti ndi zinthu ziti zomwe zingapititse patsogolo ukadaulo wanu pakaperekedwe ka chithandizo cha ubereki komanso kugonana kwa achinyamata osaposera zaka 19?
5. Mutha kuonjezerapo china chilichonse pa zomwe mwakumananazo popereka chithandizo cha ubereki ndi kugonana kwa a chinyamata osaposera zaka 19?

Zikomo potenga nawo mbali mukafukufuyu

Appendix 7: Authorization from COMREC



CERTIFICATE OF ETHICS APPROVAL

This is to certify that the College of Medicine Research and Ethics Committee (COMREC) has reviewed and approved a study entitled:

P.03/17/2137 - Exploring experiences of health care providers in providing Youth friendly sexual and reproductive Health services to adolescents in Dedza by Lucy Chimera

On 18th May 2017

As you proceed with the implementation of your study, we would like you to adhere to international ethical guidelines, national guidelines and all requirements by COMREC as indicated on the next page

Approved by College of Medicine
18 MAY 2017
(COMREC) Research and Ethics Committee

Dr. L. Alfazema-Chiuzeni- Vice-Chairperson (COMREC)

18th May 2017
Date

Appendix 8: Authorization Letter from Dedza district health officer

Dedza District Hospital

P.O. Box 136

Dedza

28th February,2016

Lucy Jonas Chimera

Kamuzu College of Nursing

P.O.Box 415

Blantyre

Dear Madam,

RE:REQUEST FOR PERMISSION TO CONDUCT A REASERCH STUDY AT DEDZA DISTRICT HOSPITAL, MTAKATAKA AND CHITOWO HEALTH CENTRES

Reference is made to your request letter dated 27th February, 2017. Be informed that your request has been accepted.

However, you will be allowed to proceed with your research study upon production of research ethics committee certificate of approval.

I wish to request you to share the results of your study for local use.

Thank you,

MINISTRY OF HEALTH
DEDZA DISTRICT HOSPITAL
DISTRICT HEALTH OFFICER
28 FEB 2017
P.O. BOX 136, DEDZA
TEL: 01 223 439

Dr Solomon Jere

District Health Officer