



Kamuzu College of Nursing

**KNOWLEDGE AND PERCEPTIONS OF ADOLESCENTS AND
COMMUNITY LEADERS ON YOUTH FRIENDLY HEALTH SERVICES: A
CASE OF SELECTED COMMUNITIES IN SALIMA**

BY

ESTHER CHILALIRE KAPALAMULA

BSC (Nursing) – University of Malawi

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Declaration

I **Esther Chilalire Kapalamula** hereby declare that this thesis is my own original work which has not been submitted for any other awards at the University of Malawi or any other University.

Esther Chilalire Kapalamula

Full Name

Signature

Date

Certificate of approval

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

Signature_____

Date_____

Abigail Kazembe, PhD (Associate Professor)

Main Supervisor

Signature_____

Date_____

Maria Chikalipo, Msc, RNM (Lecturer)

Co Supervisor

Dedication

I dedicate this paper to my dear husband, Elisha and son Elshaddai for their encouragement, prayers and standing with me which has helped to reach this far. I give them this due respect because they were always there for me in time of need. I appreciate my husband's motivation, financial support and his desire for my advancement in my studies.

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Abstract

The aim of the study was to establish the extent of knowledge on and the perception of adolescents and community leaders towards Youth Friendly Health Services (YFHS) in communities of Traditional Authorities (T/A) Maganga and Kambwiri in Salima District. This was a cross sectional quantitative study that involved 268 adolescents of which 129 were females and 139 were male, and 84 community leaders from randomly selected village heads. Data were collected by administering a structured questionnaire during face to face interviews with the participants. Statistical package for social Scientists (SPSS) version 16.0 was used to analyse data.

The study revealed the following; (a) that knowledge of YFHS as a concept is high among adolescents as well as community leaders but they both had limited information on services that are provided at delivery points and where to access the services. (b) The higher %age of adolescents and community leaders 51% and 43% respectively had positive perception towards YFHS. On the other hand there was another %age (46%) of adolescents who had negative perception towards fellow adolescents who seek YFHS and view them as prostitutes or sexually active. (c) that factors such as consent from parents to allow adolescents access the service, unfriendly services, long waiting hours, denial of services, and services offered at the delivery point influence the uptake of YFHS. (d) that community leaders have a role to play in order to promote service access.

The roles of community leaders in YFHS were found out to be promoting active participation in YFHS activities, encouraging adolescents to access the YFHS, urging parents to allow adolescents participate in YFHS activities and encouraging adolescents delay sex until maturity. Results also show that there is a need for community involvement and sensitisation and involvement in YFHS activities in order for the program to be accepted by the community. On the other hand health workers in service trainings on YFHS can help in changing their attitude towards adolescents who access the services.

Key words: *Adolescents, community leaders, youth friendly health service, service accessibility and attitudes towards services*

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
EHP	Essential Health Package
ESA	Eastern and Southern Africa
FDG	Focus Group Discussion
FGM	Female Genital Manipulation
HIV	Human Immune Deficiency Virus
HTC	HIV Testing and Counselling
MDHS	Malawi Demographic Health Survey
MOH	Ministry of Health
NAC	National AIDS Commission
NGO	Non-Governmental Organisations
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational Scientific and Cultural Organisation
YFHS	Youth Friendly Health Services

Operational Definitions

Adolescent: Young people aged from 15-19 years.

Community leaders: Are people with the following characteristics; actively involved in counselling, advising and passing cultural information related to adolescence such as chiefs and religious leaders.

Knowledge in YFHS: To have heard of YFHS and able to mention at least three of the services provided at delivery site

Youth friendly health services: Reproductive health services provided to youths in a friendly manner so as to prevent early and unplanned pregnancies, sexually transmitted infections and HIV infection among the youths

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CHAPTER ONE

INTRODUCTION

1.1 Introduction

Globally more than 2.6 million young people of ages 10 – 24 years die each year from preventable causes including reproductive health related complications [World Health Organisation (WHO), 2011]. A greater number of young people engage in behaviours that jeopardise not only their current state of health but also their health of years to come (WHO, 2011). Nearly two thirds of premature deaths and one third of the total disease burden in the adults is associated with conditions or behaviours that began in their youth including lack of physical activities, unprotected sex or exposure to violence to mention a few (WHO, 2011). About sixteen million girls aged 15– 19 give birth every year roughly representing 11% of all births worldwide (WHO, 2011). Currently only 36 % of young men and 24 % of young women have comprehensive and correct knowledge they need to protect themselves. 15– 24 year olds account for approximately 40 % of all new infections of HIV among adults worldwide (WHO, 2011).

Malawi is a youthful population with about 52% of the total population aged 18 years (Munthali, 2010). This present a huge demographic dividend and it is only when such mass can be properly managed in terms of reproductive health services that they will be a productive generation. Most young people are healthy but a greater number of these young people suffer from illnesses which hinder their ability to grow and develop to their full potential. Studies have shown that many adolescents who are

sexually active in Malawi, have unpredictable life style and are likely to have multiple sexual partners with low use of family planning methods (Botha, 2010). According to 2014 youth friendly health services evaluation report, adolescents are becoming sexually active as early as at 10 years old. It was reported that 58.7% of adolescents aged 15 – 19 had ever had sex or talk about sex which is a clear indication that adolescent are active in sex issues (MOH, 2014a). Twenty 6 % of girls became pregnant before the age of 19 and the HIV and AIDS prevalence is highest among youth aged 15– 24 years (MOH, 2014a).It is estimated that 110,000 new infections occur in the country and 46% of those infections occur among young people aged 15– 24 (MOH, 2007).

Recognising the challenges that young people are facing, the Ministry of Health implemented several health activities for young people in partnership with different Non-Governmental Organisations (NGOs) and the private sector. Health activities included provision of reproductive health services, prevention and management of sexually transmitted infections, HIV/AIDS prevention, care and support but these lacked an approach of reaching young people hence introduction of youth friendly health services (MOH, 2007). Youth friendly health services are high quality services that are relevant, easily accessible, attractive, affordable, appropriate and acceptable to young people (MOH, 2007). Health services provided to young people are within normal clinical standards and procedures as approved by Ministry of Health. It is reported that young people in Malawi do not have adequate nor equitable access to Sexual and Reproductive Health (SRH) and HIV prevention, care and support services (MOH, 2007). Lack of knowledge and skills, poor access to contraceptive methods including condoms, as well as vulnerability to coerced sex puts adolescents

at high risk of unwanted pregnancies and infections (Botha, 2010). According to Youth Friendly Health Services (YFHS) evaluation report for Malawi, awareness and use of YFHS program is low with only 13% reporting to have ever used YFHS and one third of the respondents reporting to have heard of YFHS. It also finds out that young people, parents and community leaders lack knowledge about YFHS program and young people doubt about privacy and confidentiality at delivery points hence affecting uptake of the service (MOH, 2014a). In addition a range of obstacles to utilization of health services may make it difficult for them to obtain advice and health services they need.

The aim of this study was to find out whether adolescents and community leaders of Traditional Authorities Maganga and Kambwiri have knowledge on YFHS and their perception towards the services.

1.2 Background Information

Youth Friendly Health Services are provided as a combination of clinical services and health promotion interventions for addressing health needs of young people which is referred to as a minimum package. In Malawi provision of YFHS started in 2007 (Katengeza, 2012). “Youth friendly health services are high quality services that are relevant, accessible, attractive, affordable, appropriate and accessible to young people” (MOH, 2007). The health services provided to young people are within the normal clinical standards and procedures as approved by MOH, and are in line with minimum package (a combination of clinical services and health promotion interventions for addressing the health needs of young people) as outlined in the Essential Health Care Package. Emphasis of minimum package is in three main areas which are health promotion, delivery of health care and referral and follow up provided at community, health centre and hospital levels. The services that can be

provided at community level include contraceptive services including condoms, Human Immune Virus (HIV) Testing and Counseling (HTC), and referral to health facility or other service delivery points. At health centre level services provided include all services at community plus prevention, diagnosis and management of Sexually Transmitted Infections (STI), antenatal, delivery and postnatal care, post abortion care, Prevention of Mother to Child Transmission of HIV (PMCT), treatment of sexually abused victims, referral to hospitals or other service delivery points, counseling and referral for nutrition, substance abuse and mental health. The services that are provided at hospital include all the services at other levels plus treatment of sexually abused victims including provision of Post Exposure Prophylaxis (PEP), reproductive health cancer screening and provision of antiretroviral drugs (Ministry of Health, 2009b)(MOH, 2009)

Health promotion activities and counseling are done during service delivery at all levels which include STIs, Family planning, RH Cancers, Psychosocial support to Substance abuse adolescents and young people, nutrition, HIV and AIDS, sexual abuse, maternal health care and adolescent growth and development (MOH, 2007). YFHS are those services that specifically seek to be open, suitable for young people, and are located in places where young people feel safe and comfortable accessing it. Most importantly, young clients should not face judgement or stigma from staff, and should be able to trust that their confidentiality will be respected (UNESCO, 2013).

In Malawi Youth friendly health services are provided in many service delivery points accredited by the Ministry of Health in conjunction with Reproductive Health Unit. In Salima services are provided at Salima District Hospital and five health centres including Maganga Health centre. Young people find obstacles to

access services which include lack of service providers, equipment for service delivery, poor attitude of health providers and cultural and religious beliefs (Zileni, Lungu, & Makono, 2010; and MOH, 2014a).

Community leaders cannot be left out in advancement of YFHS at all levels especially at community level. In many cases, youth behavior is controlled to different extent by adults, including parents and others who interact with youth on a regular basis (Inter Agency Working Group, 2007). The capacity of young people to act as full members of the larger community is influenced by these realities.

Since communities play a significant role in influencing youth behavior (and thus behavior change), no intervention to reach youth can be complete without considering how best to encourage dialogue and involvement of these gatekeepers in promoting positive SRH practices. The linkage between community leaders and YFHS delivery among adolescent related problems is strong. Community leaders are gatekeepers of community norms, values and beliefs; hence cooperation of community leaders is very crucial in advancement of any public health initiative (MOH, 2009). A research done by Malawi Educaids (2011) revealed that some barriers that bar adolescents from accessing SRH services at community level include strong traditional and cultural beliefs and faith in traditional health systems and strong religious beliefs contradicts modern health practices. If there is a clear linkage between health facilities, community health workers who provide YFHS and community leaders program of YFHS can make a tremendous impact on adolescents' behaviour in accessing services (Msiska et al, 2013).

Parents, teachers, traditional leaders and faith communities play an important role in supporting youth access to information and services (MOH, 2003). A culture which is conservative and slow adapting to change prevents access to health services

and facilities particularly young people including adolescents. In many situations community leader and community members are not aware of the values of providing health services to adolescents. They do not believe that adolescents should have access to reproductive health services which deter health service providers from providing services. Community leaders can be engaged in many ways such as seeking their views, providing information and involving the prioritising areas of quality improvement. Going through literature it was found to be difficult to find studies done on community leaders' knowledge on YFHS. It might be that studies are there but are not published. This prompted the researcher to conduct a study to bring in information on knowledge of community leaders on YFHS.

It is important to study knowledge of adolescent in YFHS for many reasons. Firstly adolescents experience different vulnerabilities that are unique to their age group; physiological vulnerability; high susceptibility to peer pressure; tendency to engage in risk-taking behavior; less ability to negotiate safer sex practices; and difficulty accessing reproductive health information and services (Baloyi, 2006). In addition, early pregnancy and STIs (including HIV) threaten health of adolescents more than at any other age group. Secondly, changing behavior of young people provides opportunity for intervening against STIs and AIDS. Research has shown that few countries that have successfully decreased national HIV prevalence have done so mostly by encouraging safer sexual behaviors in adolescents (Bearinger et al 2007).

In Salima adolescents as any other young people in Malawi are at risk of a broad range of health problems. Among those problems are early initiation of sexual activities, unwanted pregnancies, pregnancy related complications, unsafe abortions, STIs, HIV and AIDS (Salima District Assembly, 2011). Young people are vulnerable to these problems because they mostly engage in unplanned and unprotected sex,

some lack skills necessary to negotiate for safer sex, engage in sexual activities with multiple partners and have limited awareness of STI prevention (Pathfinder International, 2005).

One of the most important concept to protect adolescents from acquiring an STI or HIV and becoming pregnant is dual protection which has been advocated by many professionals familiar with both family-planning and HIV/AIDS-control services (Chacko, Kipp, Laing, & Kabagambe, 2007). Dual protection can be achieved through: using a male or female condom together with another contraceptive method, e.g. oral contraceptives, using a non-barrier method and mutual monogamy between HIV-negative partners, and non-penetrative sex. Knowledge about dual protection among adolescent users is generally limited (Chacko et al., 2007). According to a study done by Motuma (2012) on Youth-Friendly Services (YFS) utilization and factors in Harare, Ethiopia it was concluded that most youth had positive attitude towards YFS but had poor knowledge on the services. In Kenya youth friendly services and reproductive services face multiple challenges from the youth who have little or lack knowledge on Youth Friendly Reproductive Health Services (YFRHS), community has negative perception on youth sexuality and RHS to adolescents.

Reproductive health and HIV/AIDS for youths in Malawi have typically been found to be difficult to access because most facilities are not youth friendly and are generally geared toward adults (Pathfinder International, 2005). Family planning and reproductive health services in the past have been provided as maternal and child health services in the hospitals since their introduction. This made community members to perceive reproductive health services to be for adult women thereby creating barriers to access the services for young people.

1.3 Problem Statement

In Malawi adolescents and young people face sexual and reproductive health challenges including early unplanned pregnancies and low access to health services. Research has shown that 63.5% of female adolescents aged 15– 19 have started child bearing and 23.4% are married (Dzilankhulani, 2012). According to Malawi Demographic and Health Survey (MDHS) (2010) it was reported that Malawi has highest adolescent fertility rate in Sub Saharan Africa with adolescents (15– 19) contributing 11% of all births and for every 1000 adolescents aged 15– 19, 152 have started child bearing (National Statistical Office and ICF Macro, 2011a). This contributes to increased pregnancy related complications, and maternal and child mortality. Adolescents in Salima also face such challenges which contribute to increased rate of unsafe abortions and pregnancy related complications. According to Salima District Hospital data from January 2012 to December 2012 it revealed that out of 528 abortions cases that reported to the facility 126 were adolescents aged 15– 19 representing 24%. From February 2012 to December 2012 out of 3,801 antenatal mothers 717 were adolescents aged 15– 19 representing 8.6%. In Traditional Authority Maganga there is history of increased rate of unsafe abortions representing 23% of all abortions according to maternal and child health coordinator for Salima District Hospital. Despite the district having YFHS program, which encourages young people to go to health facilities for health promotion, education and clinical services that can help them prevent early pregnancies and STIs including HIV, adolescents do not access the services. Knowledge and perceptions of adolescents and community leaders towards YFHS in Salima are not known. This research intends to investigate the knowledge and perceptions that adolescents and community leaders have towards YFHS.

1.4 Broad Objective

The research aimed at exploring knowledge and perceptions of adolescents and community leaders on youth friendly health services in selected communities in Salima District.

1.5 Specific Objectives

The study was guided by the following specific objectives:

1. To determine knowledge of adolescents and community leaders on YFHS
2. To identify perceptions of adolescents and community leaders towards YFHS
3. To identify factors that influence adolescents access to YFHS in the area
4. To determine the roles of community leaders on YFHS in the area

1.6 Significance of Research

The study findings are important in making recommendations about YFHS which are relevant to reproductive health care for adolescents in the country. The findings will also generate information that can help in modification of existing programs in reproductive health and relevant policies that are in place to meet the health needs of adolescents.

1.7 Summary

This chapter has described the back ground of the study, the problem statement, and aim of study, specific objectives and study significance. The next chapter discusses literature review on Youth friendly health services among adolescents and community leaders.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter discusses literature review done on studies which were conducted in relation to youth friendly health services regarding knowledge and perceptions among adolescents and community leaders. Traditional review of literature was utilised to come up with related studies that were published or not. Literature search was done using library shelf text books, thesis, dissertations and electronic data bases of Google scholar, EBSCO host, HINARI and World Health Organisation. The literature search centred on English language articles published between 2004 and 2015. However some studies published before 2002 were included as they contained important information which recent articles did not have. Only articles which were peer reviewed from credible data bases were included to ensure quality of data.

Findings from Literature search revealed that different researchers have investigated different areas in adolescents' reproductive health services. Studies on knowledge and perceptions on YFHS among adolescents and community leaders have been done in other districts (Karonga, Kasungu, Lilongwe, Phalombe and Nsanje) of Malawi but not in Salima (MOH, 2014b). However most of these studies were done in other countries and very little literature was found on research done in Malawi. Most researches done in Malawi related to adolescents were on abortions, family planning, reproductive health services and not specifically on YFHS as a whole. The information gathered from the review facilitated researcher's understanding of the existing situation and identification of areas requiring further investigations and interventions in YFHS.

2.2 Knowledge of youth friendly health services

This section presents what literature is saying on knowledge of adolescents and community leaders in youth friendly health services. It focused on studies which were conducted to determine in depth knowledge among adolescents and community leaders.

2.2.1 Community leaders

Having knowledge in YFHS is of importance for community leaders as it affects service accessibility and acceptability in one way or the other. Since parents and community leaders have an influential role in seeking health care it is important to find out from them what they know about YFHS. Due to lack of knowledge some community leaders only support use of contraceptives methods among adolescents only in special circumstances. Some parents even tell their children not to take part in any activity or punish them if they hear that their children visited YFHS delivery point for services (MOH, 2014b). It was found out that community leaders have ever heard about YFHS and were only able to state some components of the program. Most respondents of focus group discussions were not able to state comprehensively what YFHS is and activities that happen there. Lack of information in YFHS issues makes community leaders have difficulties in making decision on whether to allow adolescents access the services.

2.2.2 Adolescents

Many studies have been done pertaining adolescents and sexual reproductive health. Most studies which have been done focused on either one of the component of YFHS such as knowledge on STI, HIV and AIDs, contraceptives and antenatal care (Agampodi, 2008; Chacko et al, 2007; Chinkhata, 2011; Mlingo, 2008; MOH 2014) than the program as a whole. Findings from these studies done within or outside

Malawi clearly indicate that there is limited information and access to RH and there is lack of in-depth knowledge of YFHS among adolescent widely.

There are factors that are associate with knowledge of YFHS among adolescents which include age, accessibility and acceptability etc. in the community (Akinyi, 2009). Kennedy et al (2013b) in Vanuata found out that most adolescents lack comprehensive knowledge about SRH and face significant barriers to access quality information and services. For instance in Vanuata one third of urban youth have not ever heard of family planning and 27% lack knowledge about STIs. In another study done in Nepal it was also revealed that young people lack in-depth knowledge on reproductive health though they say they have ever heard of it. This may be an indication that they are not meeting with experts in the field who can be found at YFHS delivery points.

According to 2014 National YFHS evaluations done by Ministry of Health Malawi (2014b) it was revealed that awareness and ever use of YFHS is very low as only one third of respondents accepted to have heard about it and 13% to have used YFHS. It is clear that knowledge about YFHS in Malawi is still low as evidenced by adolescents stating in the same evaluation that they could not understand why female adolescents especially those who have never been pregnant before nor had a child would use family planning methods. According to them RH services should be for those who are married. The study further revealed that knowledge differed in various regions and zones. This study used FGD to come up with results and it is difficult to generalise the findings to the country as a whole hence need for further research.

2.3 Perception on YFHS

2.3.1 Community leaders

Community leaders being the gate keepers and custodians of cultural values and norms can influence uptake of the YFH services. Throughout the world there are different cultural practices that promote transmission of sexually transmitted infections for example Male circumcision if done in unhygienic way, female genital mutilation (FGM), unprotected sex when performing some rituals like *kusasafumbi* (removing dust) in other words sex cleanser. Traditional leaders in this case need to be involved in the YFHS activities to understand the dangers of such cultural practices and look for alternatives of such activities. The community groups such as community leaders, church leaders, and community health volunteers have together created a consensus about prescriptive norms of sexuality for youth. In Malawi for example National AIDS Commission (NAC) in partnership with community leaders are encouraging sex cleansers to use condoms while carrying out such rituals in light of the risk of HIV associated with the rituals (Maleche & Day, 2011).

During an evaluation exercise for YFHS by MOH (2014b) it was revealed that parents have different reactions to their children or wards accessing RHS. Use of contraceptives for youths aged below 15 years is perceived to be culturally inappropriate. This was revealed in most parent Focus Group Discussions (FDGs) participants who were against their children use of contraceptives (MOH, 2014b). It was also revealed that many parents disapproved their children seeking RH services. There was lack of understanding among parents on why unmarried adolescents should use contraceptives. It was also found out that parents tolerate their sons who have sex to use condoms to prevent STIs but not their daughters to use contraceptives. This is

just an indication that parents including community leaders lack understanding on use of contraceptive among adolescents and misconceptions related to YFHS issues.

2.3.2 Adolescents

Perceptions of adolescents are equally important to be understood by all implementers of YFHS. Positive perception of adolescent can lead to support of the program and on the other hand negative perception can result in diminished support from adolescents towards the program. Many studies on adolescents' perception towards RH services have been done, which focused on components of YFHS not as a whole. On part of positive perceptions included availability of non-reproductive health activities, given chance to express their problem, finding providers who are their peer and warm welcome by service providers (Chacko et al, 2007; Kennedy, 2009; MOH, 2014,). The negative perceptions included misconceptions and disadvantages of contraceptives, lack of resources, long waiting hours, poor quality of care, negative attitude of service providers (Chacko et al, 2007; Kennedy, 2009; MOH, 2014,).

According to research by Kapito et al (2012) it was found out that the adolescents have positive attitude towards contraceptives for the fact that they prevent un wanted pregnancy and STIs including HIV and AIDS. On the other hand there was a negative attitude because of misinformation regarding the side effects and misconception for contraceptive use as well as beliefs and values that disapprove use of contraceptives among adolescents. Adolescent sexuality issues are attached to stigma, this promote increased opposition to youth access to SRH information and services for the fear of promoting promiscuous behaviour among the young age groups (MOH, 2003). For example Crommett (2008) in his study found out that adolescents who contract STI and access STI treatment are perceived as promiscuous

and bad person. This put the adolescents at risk of not visiting facilities when they are sick for fear of being stigmatised ending up with complications of untreated STIs.

During national evaluation of YFHS (MOH, 2014b) adolescents reported that seeking or using contraceptives gives an impression that the adolescent is ready for marriage because is already having sex which is meant for married people. There were also adolescents of the view that girls who have never become pregnant or never had children can get their wombs destroyed if they use family planning methods. Some of adolescents had a perception that their parents would not allow them access the services hence decide not to inform their parents about their intentions of accessing the service. These perceptions make them shun RH services which put them at risk of contracting some infections and unintended pregnancies. Godia et al (2014) in their study found out that girls seeking antenatal care and family planning services at a health facility perceived the services as good and staff helpful. But it was also revealed that boys perceived the services as designed for women and children and therefore feel uncomfortable seeking services at such a place.

2.4 Factors influencing YFHS access

2.4.1 Community leaders

In different societies there are some factors that can influence or hinder community leaders to allow adolescents access services at YFHS delivery point such as consent to access, community involvement, impression that community leaders have on the services and what services are provided at the service delivery point. Social-cultural norms and taboos regarding adolescents' sexual behaviour are the most significant reasons why adolescents find it difficult to access RH services (Kennedy et al., 2013b). Literature for community leaders on factors which contribute to their acceptance of the services for their adolescents was very scanty. Most

communities can be resistant to adolescents SRH services because they lack structures to effectively discuss, agree upon and carry out solutions to their problem (DSW, 2011). Some cultural values and morals hinder adolescents from accessing the services.

It was revealed in an evaluation report (MOH, 2014b) that some parents would not allow their wards to visit YFHS delivery points because at these places adolescents are provided with information that can encourage adolescents to indulge in promiscuous behaviours. But some parents stated that they can be happy to learn that their wards are going for YFHS because it prevents early pregnancies, STIs and HIV and AIDS.

2.4.5 Adolescents

It is important for program implementers to know what factors are impending adolescents access YFHS. Studies have been conducted to assess factors that promote or hinder adolescents to access services. Youth friendly health services were introduced with an aim of reaching out adolescents thereby reduce reproductive health problems such as unintended pregnancies, STIs and HIV. Literature has revealed that many studies conducted were focusing on components of YFHS such as family planning, STI, HIV not the program as a whole. Factors such as decision making regarding working hours, desire to have good life in future, stable future families, attain higher education, decoration and attractiveness of the premises, presence of younger health professionals at least at the reception and initial screening interview and providing separate entrance for adolescent client were found out to be some of the motivational factors to access the services (Abebe and Awoke, 2014). On the other hand there are factors that hinder access to services such as stigma, adolescents expectation, needs for special clinics, attitude of parents, privacy and confidentiality,

knowledge about available services and lack of services at facilities, long waiting hours, beliefs and values (Agimpodi, 2008; Chacko et al 2007; Chinkhata, 2014; Kennedy et al, 2013; Mlingo, 2007; Moya, 2012).

In their study Abebe and Awoke (2014) found out that some of the barriers to YFHS access include inconvenient hours, fear of being seen by parents or people whom they know. Health service provider's reception, facial expression, simple greetings, being given a chance to express themselves and explain their problem were some of the factors that were found to be affecting uptake of the services in Kenya among adolescents (Godia et al., 2014). It was also revealed in the same study that majority of boys and girls were concerned about long queues that were present at facilities. This makes adolescents fear of being found by their parents or people they know while waiting for the service.

2.6 Role of community leaders in YFHS

It is clear that the needs and issues that influence the use of services by unmarried and married young people are very different. Premarital sex remains a taboo in many societies in the world and sensitization and involvement of the wider community is particularly key if an acceptance of their needs for contraceptives and services is to be established (WHO, 2009). Community and adolescents involvement in the design, implementation and evaluation can help ensure that programs are being accepted in the community. Dealing with adolescents in isolation is not helpful and there is need to involve adults around them in programs. There is evidence that broader community mobilisation activities can help gather even wider support from community leaders for youth SRH programs and can ease some of barriers to adolescents accessing services (WHO, 2005). Through community mobilisation

community leaders gain more information there by promoting their role in SRH activities because they know what they are doing.

Community leaders have a role in encouraging their children to avoid early sex, pregnancies and related problems, asking those in intimate relationships to end the relationships when they become aware of it and helping adolescents to get care for SRH care problems (Biddlecom, 2007; Kumi- Kyereme, Awusabo-Asare, 2007).

However looking at this literature many studies were done outside Malawi and they were focusing on either one component of YFHS. Evaluation of YHFS looked at almost all areas of YFHS in some districts in Malawi excluding Salima. All these statistics gave the researcher an insight of an area that needs to be researched on in Salima and check if the results will be similar to those of the other studies.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the methods and procedures used to find out the knowledge and perceptions of adolescents and community leaders on YFHS in Salima District. The chapter includes study design, setting, sampling, data collection and analysis, validity and reliability of tools and ethical consideration.

3.2 Research design

The research was a cross sectional design employing a quantitative data collection and analysis method to find out knowledge and perceptions of the adolescents and community leaders on youth friendly health services in some communities in Salima. Quantitative research is a broad, umbrella term for research that uses methods that collect evidence that can be transformed into numerical data (Gerrish & Lacey, 2010).

3.3 Research setting

This study was conducted in Tradition Authorities of Maganga and Kambwiri in Salima District. TA Maganga was chosen because of the reports that many adolescents were reporting to the district hospital with history of unsafe abortions, teenage pregnancies and pregnancy related complications. On the other hand TA Kambwiri which is an area also along lakeshore as the same as Maganga but very few cases of teen age pregnancies and abortion were reported at the hospital.

3.4 Target population

Population is the entire aggregation of cases in which a researcher is interested in (Polit & Beck, 2003). The study population included female and male adolescents in TA Kambwiri and TA Maganga communities. The target population in this study was all adolescents not less than 15 years and not more than 19 years old and community leaders who are influential figures (chiefs, and church leaders) from Traditional Authorities Maganga and Kambwiri. The community to be studied was randomly selected to represent adolescents in Salima on their knowledge and perceptions towards YFHS.

3.5 Inclusion and exclusion criteria

3.5.1 Inclusion criteria for adolescents

The research study included adolescents aged 15– 19 from the two Traditional Authorities who were able to communicate in Chichewa or English and willing to participate in the study.

3.5.2 Exclusion criteria for adolescents

The study excluded adolescents aged below 15 and above from traditional authorities area under study. The study also excluded adolescents who were not able to communicate in Chichewa or English. Not willing to participate in the study

3.5.3 Inclusion criteria for community leaders

The study included community leaders from the two traditional authorities under study who stay in the community and willing to participate in the study. It also included community leaders who were able to communicate in Chichewa or English.

3.5.4 Exclusion criteria for community leaders

The study excluded community leaders not from the two traditional authorities under study who do not stay in the community and not willing to participate. The

study also excluded those who were not able to communicate in Chichewa and English.

3.6 Sampling and sample size

3.6.1 Adolescents

The sample for the study was drawn from two Tradition Authorities of Maganga and Kambwiri in Salima district using random sampling technique. Random sampling is the least biased of all sampling techniques, there is no subjectivity- each member of total population has an equal chance of being selected (Creswell, 2009). A sample frame was generated where names of all adolescents aged 15-19 from the study were registered and numbers allocated to them. A sample frame was developed from which 268 random numbers were to be selected. Pieces of papers bearing numbers of all adolescents were put in a box and mix them thoroughly then they were drawn one by one without replacement until a sample of 268 adolescents were picked. After an adolescent has drawn a number was assessed for inclusion and exclusion criteria. If one had drawn an expected number and fail to meet the criteria another number from sample frame was drawn until the required sample was reached.

3.6.2 Community leaders

Random sampling was used to get Community leaders with the following characteristics; actively involved in counselling, advising and passing cultural information related to adolescence (chiefs and religious leaders) in the community and were available at the time of study. A sample frame was generated where names of all community leaders were registered and numbers allocated to them. Thereafter a list of random numbers was generated and each random number was matched to its corresponding number on a sample frame. Eighty four random numbers were selected. Simple random sampling was done by putting pieces of papers bearing

numbers of all community leaders in a box mixing them thoroughly and drawing them one by one without replacement to select 84 community leaders. Those community leaders who picked the selected numbers were assessed for inclusion and exclusion criteria. If one picked an expected number and failed to meet the criteria another number from sample frame was drawn until the required sample was reached.

Sample size

Random sampling of subjects, without replacement, was done from a finite population of adolescents, and community leaders in the targeted areas of T/A Maganga and T/A Kambwiri. Thus, in order to determine the sample size for the estimation of the proportion of those that have knowledge in YFHS, the Finite Population Correction Factor (PCF) was supposed to be taken into account. Therefore sample size determination using the finite population correction factor was done using the following formula:

$$n = \frac{n_0 N}{n_0 + (N - 1)} \quad (\text{Cochran, 1977})$$

Where, n = Sample size; and N = Finite population size. The value of n_0 is calculated using the formula:

$$n_0 = \frac{z^2 \times p \times (1 - p)}{E^2} \quad (\text{Cochran, 1977})$$

Where,

z = value corresponding to the confidence level (1.96 for a confidence level of 95%);

p = proportion of those that have knowledge, in this case, 0.5;

E = Bound on the error of estimation or acceptable margin of error in estimating p .

The value of p has been chosen to be 0.5 to make sure that the dominance of attributes of interest is not biased.

The Value of E has been chosen to be 0.083 due to availability of the resource for the study, but also considering that it is still within the acceptable error limit that can give unbiased sample size.

With $z = 1.96$; $p = 0.5$; and $E = 0.083$, the value n_0 is computed as follows:

$$n_0 = \frac{1.96^2 \times 0.5 \times 0.5}{0.083^2} = 139.4107$$

This means that $n_0 = 140$ after rounding up.

Adolescents Sample Size

According to National Statistical Office (2013), T/A Maganga had a population of adolescent aged 15-19 of 4,930 out of the entire population of 47,498 while T/A Kambwiri had adolescent population of 2,580 out of entire population of 27, 114. Using the above formula the sample size for adolescents to be interviewed for the study is 268, which is broken down as 136 from T/A Maganga and 132 from T/A Kambwiri.

Community leaders sample size

According to Salima District Council (2014), T/A Kambwiri had 70 Village heads and 12 different church leaders (pastors) while T/A Maganga had 54 village heads and 10 different church leaders (pastors). Using the same formula to derive the sample size, the study was to interview 96 leaders. Shared as follow for the two areas,

T/A Kambwiri 52, while T/A Maganga 44. For the adolescent and community leaders sample size detailed calculations please refer to appendixes VII

3.7 Data Collection

3.7.1 Data collection instrument

The data collection instrument was a structured questionnaire containing responses for the researcher to tick appropriate response. There were two questionnaires one for adolescents which had 4 sections and the other for community leaders and had five sections. The questionnaires sections included section A, demographic characteristics, section B, knowledge on youth friendly health services, section C, perceptions towards services, section D, factors that affect service delivery and section E, the role of community leaders in YFHS (Appendix I and III). The questionnaire was prepared in English and then translated into Chichewa (Appendix II and IV)

Data collecting instrument was pre tested at Maganga Health Centre Youth Friendly Health Clinic where 10 female adolescents were asked to answer the questionnaire. For community leaders questionnaire pre testing was conducted at Chitedze Village where 5 community leaders were approached to answer the questionnaire. The purpose of pre testing was to check the feasibility of the study in terms of resources, time, availability of subjects for the study (Polit & Hungler, 2004) and necessary amendments on the data collecting instruments were made in consultation with experts in the field.

3.8 Validity

Validity is the degree to which an instrument measures what it is supposed to measure (Polit & Beck, 2010) the data collection instruments was reviewed by experts before being used to ensure validity. Experts (included research supervisor and Kamuzu

College of Nursing research director) in research, adolescent health, reproductive health and health education were consulted for review. The instruments was also pre tested by collecting data from ten adolescents and 5 community leaders in order to determine if the questionnaire will collect the data that the researcher was looking for in the study. This was done before actual collection of data.

3.9 Reliability

Reliability refers to the consistency with which an instrument measures the attribute (Polit & Beck, 2010). The importance of research instrument to be reliable is that the researcher is confident that the instrument is going to produce similar results if someone else used the same instrument time and again (Maltby, Williams, McGarry, & Day, 2010). The instrument is said to be more reliable and accurate if it has less variations of results of the instruments after testing several times. This was achieved by conducting a pre-test of the questionnaire. Using questionnaire intended for the study, the researcher interviewed 10 adolescents and 5 community leaders from different community in order to determine if the instrument would collect stable and constant information from the entire subject interviewed. The pre testing process was done by the researcher herself for easy identification of problems with the questionnaires.

3.10 Variables

A variable is any entity that can take on different values (Trochim, 2006). Dependent variable is the variable that is presumed to be influenced by one or more independent variable (Trochim, 2006). Utilisation of YFHS is our dependent variables in this study. Independent variable is presumed to cause change to occur in another variable, which is what you manipulate. Having knowledge and the perceptions towards youth friendly health services were our independent variables

3.11 Data collection process

3.11.1 Ethical clearance

Research proposal was reviewed and approved by College of Medicine Research and Ethics Committee at University of Malawi for implementation approval. Permission to conduct study was granted from Salima District Health Office and from Traditional Authorities. District Youth Coordinator was informed of the study before it commenced. Each participant was informed of the purpose of the study and their human rights upheld in course of study as they were given an opportunity to ask questions concerning the study. Once a participant was satisfied with the requirements of study, a written consent form was signed. For adolescents aged 15 – 17 the researcher asked the guardian if they could give consent on behalf of the adolescents since the owners would not be allowed to provide consent due to their age constraints. Guardians who accepted to provide consent for their adolescents were asked to sign consent and the adolescent were asked to assent in order to be recruited in the study. The consent outlined the purpose of the study, its voluntary approach, right to withdraw at any time without penalty and an assurance that all information provided will be treated with utmost confidentiality and will not be traced back to them. Participant and researcher all signed consent form. For confidentiality purposes participants were identified on interview transcript by a numerical number and their names were not needed.

3.11.2 Access to community

Permission was sought from the traditional authorities and chiefs before conducting study. Message was sent chiefs to inform them of the research team coming to the village and female adolescents and community leaders were called to the chiefs ground. The research purpose was explained to the community and method of sampling was explained. Papers with numbers for random sampling were

distributed to all adolescents and community leaders only those who got the required digits and met the required criteria were asked to stay the rest allowed to go. Before interviews informed consent was obtained from each adolescent and community leader. Interviewers for adolescents were young, aged 18 -25 and were assigned to interview adolescents of the same sex because of the personal nature of the topic. Community leaders were interviewed by the researcher .This was to make sure that the community leaders are handled respectfully since issues around sexuality more sensitive, if respondents are not handled well they would be reluctant to talk.

Four people were employed and oriented as data collectors to ensure their understanding of the content and methodological issues of the study. They were introduced to study objectives and trained on how to conduct interviews especially listening skills and how to administer questionnaire.

Participants were helped by the interviewer in responding to questions by ticking the appropriate response following questioner or if the participant needed to respond to questionnaire at a convenient time questionnaires were distributed. Interviews were conducted in places where there was only the interviewer and respondent to assure privacy for adolescents and community leaders. The rationale was that the presence of particular people wandering about or sitting within hearing distance during interview could influence responses.

3.8 Data management and analysis

The data was checked for completeness and accuracy at the end of every data collection day and before storage. Data from completed questionnaires was entered into a computer in a designed template using a statistical package for the social sciences (SPSS) version 16. Descriptive statistics was computed for the data set on

participants' knowledge and perception of health adolescents and community leaders.

The results were presented as means, frequencies and %ages in tables and figures.

CHAPTER FOUR

RESEARCH FINDINGS

4.1 Chapter Overview

This chapter presents the results of the study according to the following objectives: to determine the knowledge of adolescents and community leaders on YFHS, to identify perceptions of adolescents and community leaders towards YFHS, to identify factors that influence adolescents' access to YFHS in the area and to determine roles of community leaders towards YFHS in the area. A total of 268 adolescents and 84 community leaders took part in the study.

4.2 Demographic summary of the participants

The adolescents' demographic characteristics are presented in Table 1. The majority 71% (n=191) of the adolescents were aged between 15 and 17 years. The majority 91% (n=245) of participants were single. On education, 80% (n=218) attained education up to standard 8. On ethnic background, 58% (n=156) were Chewa and 38% (n=100) were Yao. The data further shows that 50% (n=133) were Moslems while the remaining %age were Christians. On occupation it was found out most of the adolescents 68% (n= 182) were still at school.

Table 1: Demographic characteristics of adolescents

Characteristics	Options	Adolescents				Aggregate	
		Male		Female			
		(n)	(%)	(n)	(%)	(n)	(%)
Age range	15 – 17	97	70	94	72	191	71
	18- 19	41	30	36	28	76	29
Marital status	Married	7	5	14	11	21	9
	Single	132	95	113	87	245	91
	Divorced	0	0	0	1	1	0
	Widowed	0	0	0	0	0	0
	Separated	0	0	0	1	1	0
Occupation	Farming	24	17	32	25	56	21
	Business	15	11	13	10	28	10
	Employed	2	1	0	0	2	1
	Still at school	98	71	84	65	182	68
Ethnicity	Yao	52	37	48	37	100	38
	Chewa	83	60	73	57	156	58
	None	4	3	8	6	12	4
Education	None	2	1	2	2	4	1
	Std 1 – 8	114	82	104	80	218	80
	JCE	14	10	19	14	33	12
	MSCE	9	7	9	6	18	7
Religion	Catholic	25	17	21	17	46	17
	Islam	73	52	60	48	133	50
	Pentecostal	9	5	7	5	16	6
	CCAP	28	20	21	16	49	18
	SDA	1	0	4	4	5	2
	Others	10	6	9	8	19	7

The results show that 38% (n=23) of the community leaders were aged 60 years and above. The majority 64% (n=54) of participants were married. On education, 54% (n=44) attained education up to standard 8. On ethnic background, 53% (n=44) were Chewa and 33% (n=28) were Yao. The data further shows that 63% (n=53) were Moslems while the remaining %age were Christians. On occupation it was found out most of the community leaders 76% (n= 64) were farmers.

Table 2: Demographic characteristics of community leaders

Characteristics	Options	Community leaders		Aggregate			
		Male		Female			
		(n)	(%)	(n)	(%)	(n)	(%)
Age range	20 – 29	3	8	5	10	8	9
	30 – 39	2	7	7	13	9	11
	40 – 49	7	22	6	12	14	17
	50 – 59	8	25	13	25	21	25
	>60	12	38	21	40	23	38
Marital status	Married	25	79	29	55	54	64
	Single	1	4	10	18	11	13
	Divorced	2	7	3	6	5	6
	Widowed	3	10	7	13	10	12
	Separated	0	0	4	8	4	5
Occupation	Farming	25	78	39	74	64	76
	Business	1	4	4	8	5	6
	Employed	4	14	5	9	9	11
	None	1	4	5	9	6	7

Ethnicity	Yao	15	46	28	54	44	53
	Chewa	12	38	17	33	28	33
	None	5	16	7	13	12	14
Education	None	6	19	21	40	27	32
	Std 1 – 8	19	60	25	49	44	54
	JCE	1	4	0	0	1	1
	MSCE	5	17	5	11	10	13
Religion	Catholic	4	14	7	13	11	13
	Islam	20	63	33	62	53	63
	Pentecostal	1	3	2	4	3	4
	CCAP	5	17	5	9	10	12
	SDA	0	0	0	0	0	0
	Others	1	3	6	11	7	8

4.3 Knowledge of adolescents and community leaders on YFHS

The study investigated the knowledge of community leaders and adolescents on the YFHS concept, package, nearest health facility where adolescents access YFHS, services provided and who provide the services at the facility.

4.3.1 YFHS concept

The study revealed that 77% (n=207) of adolescents reported to have ever heard of YFHS. With 43% (n=90) Chewa ethnic background indicated to have heard of YFHS as opposed to 22% (n=46) from Yao tribe (Figure 1). Majority 80% (n=67) of community leaders have ever heard of YFHS. In terms of ethnic group, 55% (n=37) of Yao community leaders and 30% (n=20) from the Chewa tribe indicated to have heard of YFHS (Figure 1).

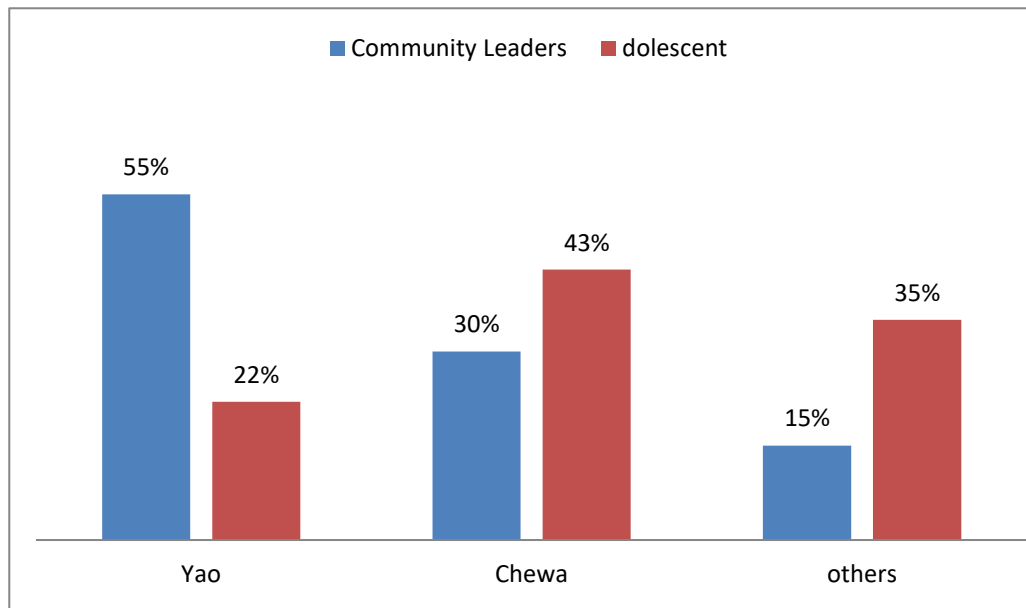


Figure 1: Community leaders and adolescents awareness of YFHS concept

4.3.2 YFHS package

The participants' knowledge about YFHS package knowledge is presented in Table 3. There was awareness of YFHS amongst adolescents as 61% (n=165) of the respondents indicated to be conversant with at least three services that are in YFHS package which included PAC, ARVs, STI management, HTC, contraceptives, ANC delivery and postnatal care. In terms of gender composition slightly more male adolescents 65% (n=174) were more knowledgeable than their female counterparts 58% (94) (Table3)

Table 3: Adolescents knowledge on YFHS

Options	Male		Female		Total	
	(n)	(%)	n	(%)	n	(%)
Contraceptives	11	8	12	9	23	9
Contraceptives and HTC	38	27	42	33	80	30
Contraceptives, HTC, ANC, delivery and postnatal care, STI management, Management of sexually abused victims, PAC and ARVs	81	58	59	46	140	52
Contraceptives, HTC and ARVs	9	7	16	12	25	9
Total	139	100	129	100	268	100

4.3.3 Knowledge of YFHS package by T/A

There was high awareness of YFHS package in T/A Maganga 63% (n=53) as opposed to T/A Kambwiri 43% (n=31) (Table 4). The knowledge in T/A Kambwiri was also high on contraceptives and contraceptives and HTC (Table 4).

Table 4: Knowledge of YHFS package by T/A

Variable	Kambwiri		Maganga	
	(n)	(%)	(n)	(%)
Contraceptives	16	12	7	5
Contraceptives and HTC	59	45	44	32
Contraceptives, HTC,ANC, delivery and postnatal care, STI management, Management of sexually abused victims, PAC and ARVs	57	43	85	63
Total	132	100	136	100

4.3.4 Adolescents' and community leaders' knowledge on YFHS delivery points

The most commonly mentioned delivery point by community leaders was health centre 57% (n=48). For the adolescents, 51% (n=137) indicated that they also

accessed YFHS services at health centre. However, there were 11% (n=29) of adolescents that accessed the services from youth clubs. The results are summarized in Figure 2.

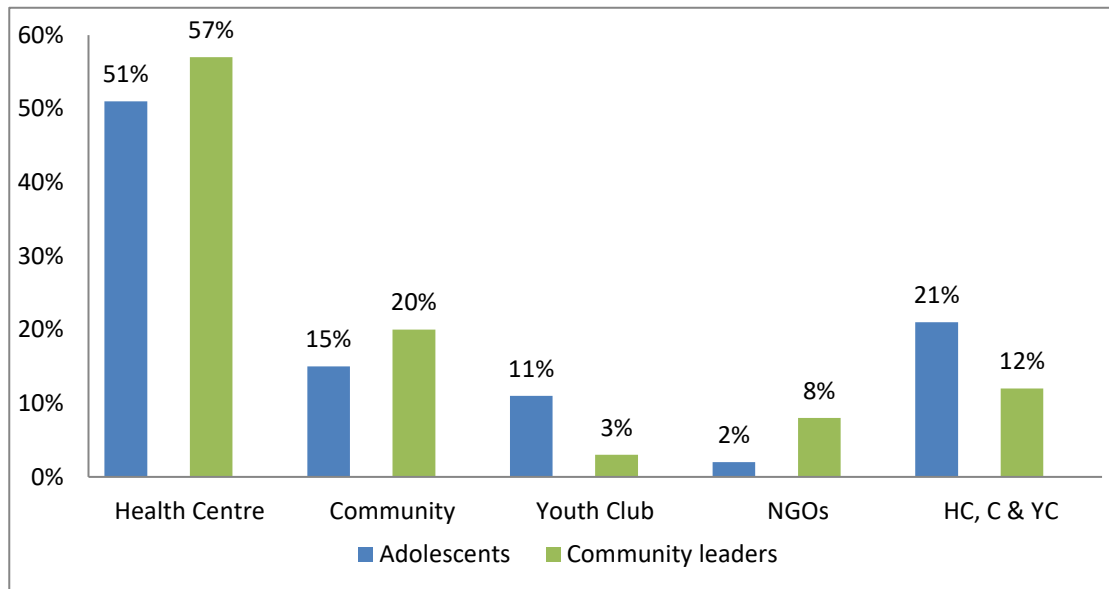


Figure 2: Knowledge of YFHS delivery points

4.3.5 YFHS providers

There were 42% (n=35) of community leaders and 56% (n=150) of adolescents respectively that indicated Health Surveillance Assistants (HSAs) as providers of YFHS. On the same, only 3% (n=8) and 6% (n=5) of adolescents and community

leaders respectively mentioned clinicians. Figure 3 below summarizes the results:

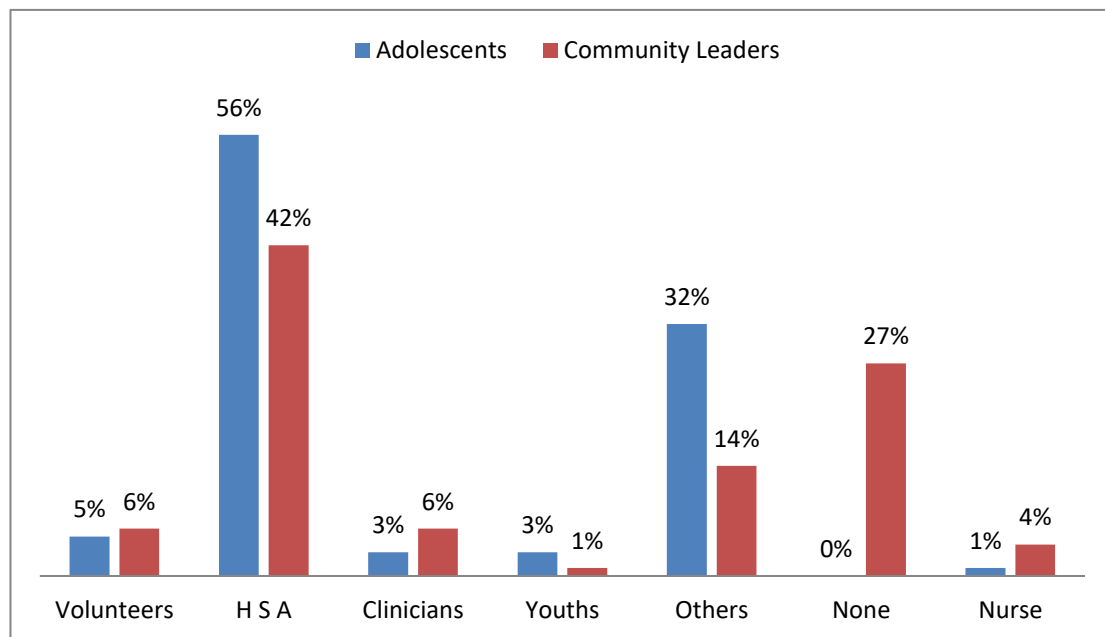


Figure 3: Providers of YFHS

4.3.6 Services provided at nearest health facility

The findings also show that 50% (n=42) of community leaders and 35% (n=94) of adolescents indicated that YFHS involves provision and distribution of contraceptives, HTC, general counselling, prevention, diagnosis and management of STIs. On the same, 15% (n=13) and 19% (n=51) of community leaders and adolescents respectively held the view that YFHS entails provision and distribution of contraceptives, HTC and general counselling. The community leaders and adolescents knowledge on services offered is summarised in Table 5.

Table 5: Adolescents and community leaders knowledge on services provided at nearest YFHS delivery points

Option	Community leaders				Adolescents			
	Male		Female		Male		Female	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Provision/distribution of contraceptive methods	0		2	4	6	4	6	5
HIV testing and counselling	6	19	6	11	18	13	21	16
Provision and distribution of contraceptive, HTC, general counselling, prevention, diagnosis and management of STIs	12	39	30	57	45	32	49	38
Provision and distribution of contraceptives , HTC and general counselling	5	16	8	15	30	22	21	16
Prevention, diagnosis and management of STIs	1	3	0		3	2	1	1
Provision and distribution of contraceptives & HTC	5	16	6	11	26	19	19	15
Never heard	2	7	1	2	11	8	12	9
Total	31	100	53	100	139	100	129	100

4.3.7 Knowledge of contraceptive methods offered at YFHS delivery points

The findings show that there was relatively low knowledge of contraceptive methods that are offered at YFHS delivery points as 52% (n=139) of adolescents were able to mention at least more than three contraceptives namely; condoms, injectables, oral contraceptive pills and implants as services offered. More female adolescents 57% (n= 137) were slightly more knowledgeable than their male counterparts 47% (n=131). It further revealed that 29% (n=78) of adolescents mentioned condoms as the only service offered.

4.4 Source of first information on YFHS

The different sources of first information for the participants are shown in

Table 6. The commonest source of first information on YFHS was the radio for 31% (n=82) while the least was HSA 1% (n=3).

Table 6: Adolescents source of first information YFHS

Options	Male		Female		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Health care delivery systems	17	12	26	20	43	16
Radio	50	36	32	25	82	31
News paper	12	9	11	9	23	9
School/ clubs	9	6	19	14	28	10
Internet	4	3	5	4	9	3
HAS	2	1	1	1	3	1
Community members	1	1	5	4	6	2
Health care delivery systems, radio, newspaper, school/clubs, friends, internet, HAS and community members	44	32	30	23	74	28
Total	139	100	129	100	268	100

4.5 Source of messages on YFHS

The commonest source of messages for adolescents include radio, health centre, newspaper, school, friends and parents representing 38% (n=103) of adolescents while community leaders, their source of messages included radio, health centre, newspaper, school and friends representing 37% (n=31) of community leaders. The radio was the commonest source of messages for both adolescents (24%, n=64) and community leaders representing (21%, n=18). Table 7 summarises sources of messages of YFHS.

Table 7: Source of message on YFHS

Options	Community leaders						Adolescents					
	Male		Female		Total		Male		Female		Total	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Health centre	5	16	13	25	18	21	10	7	13	10	23	9
Radio	7	22	11	21	18	21	33	23	31	24	64	24
Newspaper	0	0	1	1	1	1	1	1	4	3	5	2
School	1	3	1	1	2	3	14	10	5	4	19	7
Friends	4	13	4	8	8	10	3	2	2	1	5	2
Parents	0	0	0		0	0	0	0	5	4	5	2
All of above	12	39	19	36	31	37	54	39	49	37	103	38
Radio, newspaper, school, friends & parents	2	7	4	8	6	7	22	16	22	17	42	16
Total	31	100	53	100	84	100	139	100	129	100	268	100

4.6 Perceptions of community leaders and adolescents on YFHS

This section presents the findings on perception of adolescents and community leaders towards YFHS as regards to their participation, seeking and access of YFHS service.

4.6.1 Perceptions of community leaders towards adolescents who seek YFHS

The perception of community leaders towards adolescent who seek YFHS are presented in Table 8. The findings show that 43% (n=36) of community leaders perceive adolescents who sought YFHS as responsible.

Table 8: perception of community leaders towards adolescents who sought YFHS

Options	Male		Female		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Prostitute	4	13	12	23	16	19
Responsible	15	49	21	40	36	43
Unstable	1	3	1	1	2	2
Sexually active	7	23	8	15	15	18
Shameless	0	0	4	8	4	5
Prostitute, sexually active & unstable	0	0	4	8	4	5
Responsible and shameless	2	6	0	0	2	2
Sexually active and prostitute	2	6	3	5	5	6
Total	31	100	53	100	84	100

4.6.2 Adolescents' perception towards fellow adolescents who seek Family planning services

There were 51% (n=137) of adolescents who perceived their fellow adolescents who go for family planning services at health facilities as responsible individuals. The study also shows that 19% (n=51) of adolescents perceive such adolescents as sexually active and 10% (n=27) branded them as sexually active, shameless, unstable and prostitutes. The results are summarised and presented in Table 9.

Table 9: Perception of adolescents to fellow adolescents who seek family planning services

Options	Male		Female		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Prostitute	9	7	13	10	22	9
Shameless	7	5	5	4	12	5
Sexually active	22	16	29	22	51	19
Responsible	76	55	61	47	137	51
Unstable	2	2	2	2	4	1
Sexually active and responsible	7	5	6	5	13	5
Sexually active, shameless, unstable and prostitute	14	10	13	10	27	10
Total	139	100	129	100	268	100

4.6.3 Adolescents perception towards fellow adolescents who seek STI treatment

The study revealed that adolescents who sought STI treatment were perceived as unstable representing 46% (n=123) and only 4% (n=11) perceive them to be responsible persons. Table 10 presents the summary of the results.

Table 10: Perception of adolescent towards fellow adolescents who seek STI treatment

Options	Male		Female		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Prostitute	29	21	38	29	67	25
Shameless	6	4	11	9	17	6
Sexually active	8	6	9	7	17	6
Responsible	7	5	5	4	12	4
Unstable	72	52	51	40	123	46
Sexually active, prostitute and unstable	14	10	7	5	21	9
Responsible, shameless, and sexually active	3	2	8	6	11	4
Total	139	100	129	100	268	100

4.6.5 Access to YFHS

There were 49% (n=131) of adolescents that found easy access to YFHS (Figure 5) and only 5% (n=13) indicated that it was very difficult to access YFHS services. The findings are summarised in Figure 4.

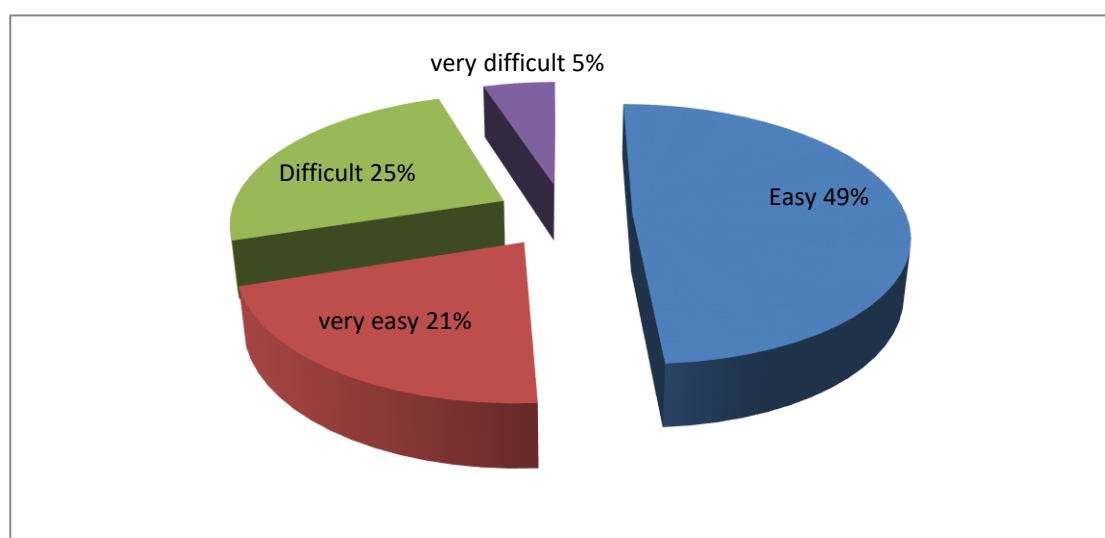


Figure 4: Access to YFHS

4.6.6 Services ever accessed at YFHS delivery points

The most commonly accessed YFHS were family planning, STI treatment, health education and VCT for 33%, n=89 of the study participants (Table 10). It revealed that 20% (n=65) of adolescents reported that VCT is the only service accessed at YFHS delivery point (Table 11).

Table 11: Services accessed at YFHS delivery points

Options	Male		Female		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Family planning	13	9	9	7	22	8
STI treatment	10	7	10	8	20	8
Health education	19	14	19	14	38	14
Voluntary counselling and testing	29	21	36	28	65	24
Family planning, STI treatment, health education and VCT	47	34	42	33	89	33
STI treatment, health education and VCT	21	15	13	10	34	13
Total	139	100	129	100	268	100

4.6.7 Openness in discussing YFHS issues

There were 76% (n=64) of community leaders who reported to be comfortable to talk or discuss SRH issues with adolescents. In terms of gender, 87% (n=27) of male and 70% (n=37) of female community leaders could ably discuss with adolescents SRH issues. On the part of adolescents it was revealed that 74% (n=198) of adolescents feel comfortable discussing SRH issues with their friends and parents. Out of all male participants 76% (n=98) and 72% (n=100) of all female adolescents said they were comfortable to discuss YFHS issues with fellow adolescents and their parents.

4.7 Factors influencing access of YFHS in the area

The study assessed factors that affect access of YFHS in the study area. To assess this, the respondents were asked to state if adolescents are allowed to access YFHS, if they are allowed which services should be provided. The respondents were also asked to explain their first experience at delivery point and ways that can be followed to influence adolescents' access services.

4.7.1 Giving consent to access YFHS

There were 74% (n=62) of community leaders that would allow their adolescents to go for YFHS and 75% (n=200) of adolescents reported that their parents would allow them to go for YFHS.

4.7.2 Participation in YFHS

On participation in YFHS activities it was revealed that 50% (n=133) of adolescents and 45% (n=38) of community leaders were involved in YFHS activities such as dramas, sports (football and netball), HIV testing and counselling (Figure 2). In terms of gender composition, more male adolescents 55% (n=147) were involved than female adolescents 46% (n=121). The opposite was true with community leaders as 47% (n=25) of female community leaders as opposed to 42% (n=10) of male community leaders were involved in YFHS activities. The results of participants' involvement in YFHS are presented in Figure 5.

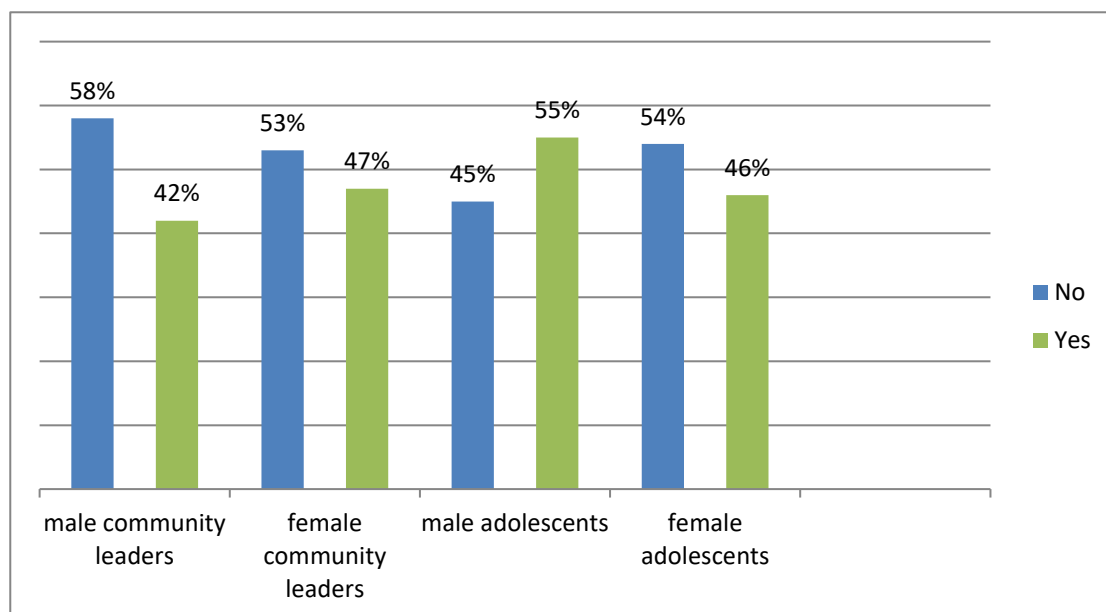


Figure 5: Participation of adolescents and community leaders in YFHS activities

The study results further show that there is higher participation 51% (n=71) in TA Maganga than TA Kambwiri 49% (n=68). And participation in YFHS according to this study it high on the part of Chewa 58% (n=81) as opposed to Yao 37% (n=51).

4.7.3 Services that should be provided at YFHS delivery point

There were 57% (n=48) and 32% (n=87) of community leaders and adolescents respectively reported that contraceptives and HTC only should be provided to adolescents. However, 37% (n=100) and 31% (n=26) of the adolescents and community leaders respectively mentioned contraceptive, HTC, prevention, diagnosis and management of STIs antenatal, delivery and postnatal services, provision of PEP and ARVs. The results are summarized in (Table 12).

Table 12: Services that are expected to be found at YFHS

Options	Community leaders						Adolescents					
	Male		Female		Total		Male		Female		Total	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Contraceptives	1	3	0	0	1	1	10	7	5	4	15	6
HIV testing & counselling	1	3	8	15	9	11	20	14	22	17	42	15
Prevention, diagnosis & management of STI	0	0	0	0	0	0	8	6	6	4	14	5
Antenatal, delivery and postnatal services	0	0	0	0	0	0	0	0	1	1	1	1
Treatment of sexually abused victim	0	0	0	0	0	0	0		1	1	1	1
Post abortion care	0		0				0		0	0	0	
Provision of ARVs	0		0				4	3	4	3	8	3
Contraceptives & HTC	17	55	31	58	48	57	46	33	41	32	87	32
Contraceptive, HTC, prevention diagnosis & management of STI, antenatal, delivery & postnatal services, PEP & ARVs	12	39	14	27	26	31	51	37	49	38	100	37
Total	31	100	53	100	84	100	139	100	129	100	268	100

4.7.4 First experience at YFHS delivery point

The participants accessed various services at the YFHS delivery point. There were 77% (n=205) of adolescents whose first experience included unfriendly service, long waiting time and denial of the service. The concerns of the adolescents on YFHS are summarized in Table 13.

Table 13: Experiences of adolescents on first visit to YFHS delivery point

Options	Male		Female		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Unfriendly services	30	22	30	23	60	23
Long waiting time	7	5	13	10	20	7
Denial of service	3	2	5	3	8	3
Lack of privacy	11	8	7	5	18	7
Poor attitude of health workers	11	8	6	5	17	6
Unfriendly service, long waiting time and denial of services	77	55	68	53	145	54
Total	139	100	129	100	268	100

4.7.5 Ways of influencing access of YFHS amongst adolescents

Over a quarter of the adolescents (28%, n=75) indicated the need for sensitization (Figure 6). The need for privacy was mentioned by 10 % (n=26) of adolescents while 9% (n=23) and 7% (n=18) stated that services should be accessed and there has to be community support respectively. On the other hand, 14% (n=37) and 20% (n=53) of adolescents were of the view that there ought to be community sensitization, privacy, accessibility and community support in order for YFHS to be easily accessed (Figure 6).

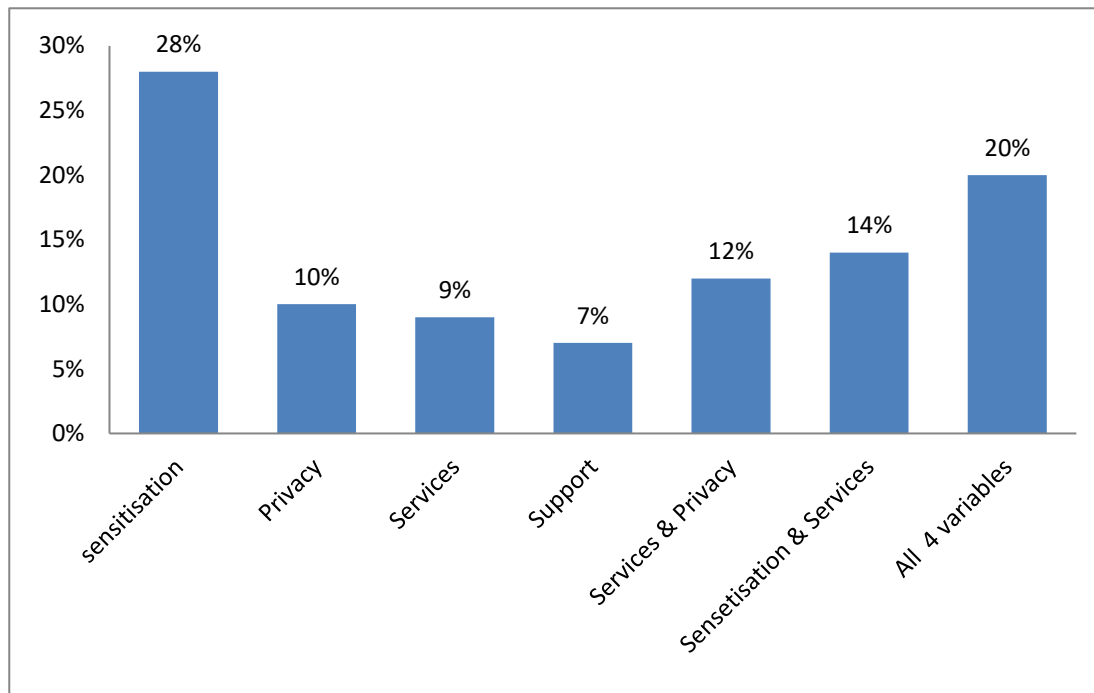


Figure 6: Ways of enhancing access of YFHS amongst adolescents

4.8 The role of community leaders in YFHS

Just over half of the participants 56%, (n=47) said that community leaders were supposed to encourage adolescents access YFHS, urge parents to allow adolescents participate in YFHS activities and, encourage adolescents delay sexual debut until mature. On the other hand, 44% (n=37) of the participants had little understanding of the roles which need to be played in promoting YFHS activities as 15% (n=13) and 6% (n=5) argued that community leaders encourage adolescents to access YFHS and encourage parents to allow adolescents to access YFHS respectively while 5% (n=4) indicated that community leaders were of the view that they are supposed to encourage adolescents to delay sex until they were mature (Table 14).

Table 14: Role of community leaders in YFHS

Options	Male		Female		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Encourage adolescents to access YFHS	4	13	9	18	13	15
Encourage parents to allow adolescents to access YFHS	3	10	2	3	5	6
Participating in YFHS activities in the community	4	13	11	21	15	18
Encourage adolescents to delay sex until they are mature	2	6	2	3	4	5
Encourage adolescents to access YFHS and urge parents to allow adolescents participate in YFHS activities and encourage adolescents delay sex until mature	18	58	29	55	47	56
Total	31	100	53	100	84	100

4.8.1 Community leaders' understanding on promotion of YFHS

The results show that 60% (n=51) of community leaders were of the view that they ought to be involved in YFHS activities (Table 15). While 12% (n=10) were of the view that the age at which adolescent can receive the services should be well defined (Table 15).

Table 15: Community leaders understanding on promotion of YFHS

Options	Male		Female		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Community leaders involvement	20	65	31	58	51	60
Selected services should be provided	3	10	5	10	8	10
Age young people receive services to be defined	4	12	6	11	10	12
Community leaders involvement & define age for access	3	10	6	11	9	11
Community leaders involvement, selected services to be provided & define age for access	1	3	5	10	6	7
Total	31	100	53	100	84	100

4.11 Summary

This chapter the findings of the study have been presented clearly. The next chapter discusses the findings and conclusion made on the findings. Some recommendations will also be presented in the following chapter.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This quantitative descriptive study examined the knowledge and perceptions of youths and community leaders on youth friendly health services in TA Maganga and TA Kambwiri of Salima District. The objectives of the study were to determine the knowledge of adolescents and community leaders on YFHS, identify perceptions of adolescents and community leaders towards YFHS, identify factors that influence adolescents access YFHS in the area and determine roles of community leaders towards YFHS in the area. This chapter interprets and discusses the study results, presents recommendations, implication of study findings and study limitation

5.2 Knowledge on YFHS among adolescents and community leaders

To maximise access and use of reproductive health services adolescents need to be aware of services offered, where to get the services, and have a positive perception of the service as beneficial in terms of meeting their RH needs and be satisfied with the quality of services provided. This section discuss what adolescents know about YFHS, package of YFHS, and where adolescents access the services and utilisation of the service.

Adolescents

The findings of this study suggest that 77% of adolescents have ever heard of YFHS, and 61% were able to state at least three or more services of YFHS package. The present findings are different to findings done elsewhere by many researchers who found out that knowledge among adolescents in YFHS is low (Agampodi, 2008; Chacko et al, 2007; Chinkhata, 2011; Mlingo, 2008; and MOH, 2014,). This means that adolescents in the area of study have knowledge on YFHS as a concept and

package. Having knowledge among adolescents can help them to access the service there by putting adolescents at safer side in unplanned pregnancies thereby reducing incidences of abortions and STIs among them.

The results of the present study also suggest that only 52% of adolescents were able to mention more than three contraceptives. These findings are consistent to findings of study done by Agampodi (2007) and Munthali et al (2004) that there is a wide range of reproductive services offered in YFHS delivery points but many adolescents are not aware of the range of services available. This means that adolescents know that there is YFHS but not knowing what it is all about in terms of services offered at YFHS delivery points. If adolescents do not have information on contraceptives/ services they can access at delivery point their chances of visiting the facility for service are more likely to reduce. Adolescents need to know the wide range of services that are offered so that they can make informed choices when they encounter sexual and reproductive health problems and this can be accomplished if various stakeholders in coordination with community health workers can intervene with projects aimed at promoting adolescents' reproductive rights and access to services (Munthali et al., 2004, Biddlecom et al, 2007; and Ndyabangi and Kipp, 2013).

The study also revealed that 63% of adolescents from T/A Maganga were aware of YFHS as opposed to 43% from TA Kambwiri. The difference in awareness is attributed to distance to health facility. In T/A Maganga the health facility which provides the service is within the community while for adolescents from T/A Kambwiri find the service from far facility in a distance not less than 20 kilometres. These findings are in consistent with findings by Abebe and Awoke(2014) who reported that some adolescents have knowledge but do not utilise services because the

services are provided near their homes. Young people do not want to run into family members and neighbours when entering, utilising or leaving sexual health facilities. However many youths have difficulties travelling very far away to access services unless public transport is available (Abebe & Awoke, 2014).

Community leaders

On part of community leaders 80% reported to have heard of YFHS and female participants were more knowledgeable than male counterparts represented by 66% of females and 34% males. The findings of this study is consistent with findings by MOH (2014) evaluation which revealed that community leaders have ever heard about YFHS and were only able to state some components of the program. Most respondents in that study's focus group discussions were not able to state comprehensively what YFHS is and activities that happen there.

The study suggest that 57% of community leaders indicated that adolescents access YFHS services at health centre and Health Surveillance Assistants (HSAs) were the commonly mentioned as providers of YFHS. On the same only 6% of community leaders mentioned clinicians and nurses as providers of YFHS. The findings clearly show that nurses and clinicians are not putting much effort in provision of YFHS though they are the leading champions in health service delivery. Youth clubs were also found to be not active in the study area which is a disadvantage to adolescents for this is where they could mostly meet with peers to discuss sexual and reproductive issues.

5.3 Source of information on YFHS

This study indicates that 31% of adolescents got their first information on YFHS from radio. Similarly in a study by WHO (2009) in Kenya it was found out that over half of youths listened to a Youth Variety Show and 40% listened to drama which improved the awareness of the service and knowledge of and use of condoms. In contrast the study by Bankole et al (2007) and evaluation of YFHS (MOH, 2014) indicated that friends are considered to be a key source of information as majority of the respondents mentioned this source. Furthermore, Bankole et al (2007) found out that health facilities and professionals are also considered to be a major source of reproductive health information among Malawi adolescents with 50% of males and 36% of females mentioning these sources. Radio has a wide audience that it can reach a big population at once. Most programs on RH are broadcasted in vernacular which makes it easier for all individuals to be communicated to unlike other sources such as internet and newspaper which are not locally found. However, radio as source of information has its own limitation as information is only basic and adolescents are not given a chance to ask for clarification ending up with many questions unanswered. The most reliable source of information are health workers because they have time for questions, clarification and be able to provide context examples.

5.4 Perception of adolescents and community leaders on YFHS

This section focuses on perceptions of adolescents and community leaders towards YFHS, adolescents who access STI service and contraceptives.

5.4.1 Community leaders

This study finding suggests that 43% of the community leaders regard those adolescents who sought services like family planning and STI treatment as responsible. The research finding in an evaluation of YFHS (MOH, 2014b) also found out that some parents would be happy to know that their children are using something to prevent themselves from HIV and pregnancy. On the same note, some parents stated that they actually encourage their children to use contraceptives. The two studies are similar in that if community leaders are of the view that those adolescents who go for STI treatment are responsible they are more likely to be happy seeing their wards accessing the service.

It was, also found out that some community leaders had a negative perception towards adolescents who go for services at YFHS as they view them not only as sexually active but also prostitutes. Perception of community leaders and adolescents towards adolescent receiving YFHS play a key role in determining adolescents' access to service that allow them safely manage their sexual and reproductive health. Attitude and perception of community leaders towards adolescents who seek YFHS could influence patronage in the centres in one way or another.

5.4.2 Adolescents

The results of this study indicated 51% of the adolescents had positive attitude towards fellow adolescents who seek family planning services as they are perceived responsible. Data on how adolescents perceive fellow adolescents who access family planning or YFHS was scanty. If adolescents view fellow adolescents who access family planning services as responsible they are in position to encourage one another access the service.

This present study also found out that 46 % of adolescents had negative perception as they described them as unstable. This is consistent with past study findings by Crommett et al (2008) in Ghana where it was revealed that 64% of respondents believed that a person infected by STIs was promiscuous; nearly half believed that the infected was a bad person while 34% were of the view that the person was a prostitute. Such adolescents would be discouraged from seeking the services again thereby being at a high risk of contracting STI and HIV since there is high likelihood of shunning YFHS centres because of fear or embarrassment. It shows that there is a serious problem in the manner in which adolescents perceive persons who seek STI treatment or services.

The findings of the present study also suggest that 70% of adolescents find YFHS easy access with no obstacles. The finding of the present study contradict findings by Munthali et al (2004) who found out that 78% of the respondents indicated there was lack of family planning methods which leads to teenage pregnancies found to be common in their areas. In terms of gender composition, there were minor variations as female adolescents 75% found access to YFHS services slightly easier than their male counterparts 67%. When RH services are easy to find adolescents acquire valuable services such as condoms and other contraceptives which are vital in HIV prevention and teenage pregnancies.

Despite having easy access to YFHS the study results has revealed low utilisation of the services as only 33% of respondents indicated to have accessed at least three or more services. The findings are similar to research findings in 2004 National representative surveys of 12 – 19 years old in Malawi, Burkina Faso, Uganda and Ghana which found out that contraceptive, STI services and HIV testing

services are still underutilised by the young generation because a proportion of sexually active adolescents do not know sources where to obtain contraceptives or get STI treatment. This present study findings are similar to MOH (2014b) evaluation of YFHS which revealed that there was low use of YFHS in Malawi with only 13% of the respondents reported to have ever used YFHS.

There are contributing reasons to underutilisation of the services among adolescents such as fear of parents, fear of side effects and misconception about the services provided (Kaphagawani, 2006). The facilities being in the community also acts as barrier as some adolescents narrated that they fear run into family members or neighbours coming from YFHS delivery points and be a talk of community (Moya, 2002, Abebe & Awoke, 2014). It is very important to encourage use of YFHS amongst adolescents as there is evidence to suggest that there is an increase in promiscuous behaviour and sexual intercourse amongst adolescents (Chitwere & Msiska, 2015). In terms of gender composition, female adolescents 75% found access to YFHS services slightly easier than their male counterparts 67%. When RH services are easy to find adolescents acquire valuable services such as condoms and other contraceptives which are vital in HIV prevention and teenage pregnancies.

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There are contributing reasons to underutilisation of services among adolescents such as fear of parents, fear of side effects and misconception about services provided (Kaphagawani, 2006). Health facilities being in the community also acts as barrier as some adolescents narrated that they fear run into family members or neighbours coming from YFHS delivery points and be a talk of community (Abebe & Awoke, 2014; Moya, 2002). The results of the present study show that family planning, STI treatment, Health education and VCT are the services which were commonly mentioned to be ever accessed. The finding of the present study is consistent with findings of past study by Kennedy et al. (2013a) who found out that most adolescents accessed information or advice on SRH. While some group value SRH services because they access testing or care for STI and pregnancy in order to prevent illness and unwanted pregnancies. The findings show that there is selection of services access among adolescents. Provision of appropriate RH services is important to adolescents in case of STI and unintended pregnancies.

This study finding further revealed that 76% of community leaders feel comfortable to discuss with adolescents SRH issues. This contradicts findings of evaluation of YFHS (MOH, 2014) which reported that most parents feel uneasy to discuss with their children sexual related issues hence they invite others to do it for them. In another study by Adedimeji (2005) it was reported that parents shy away from discussing sex related issues with their children but adolescents expressed a strong desire for parents to be involved in providing sex education to them. In this study it was revealed that 74% of adolescents find it comfortable discussing with fellow adolescents and their parents on SRH issues. However, interestingly the

finding contradict finding by Agampodi et al. (2008) and Kumi- Kyereme (2007), who found out that adolescents would rather prefer discuss RH issues with friends than their parents. In another study Ndyabangi and Kipp (2013), it was also revealed that most of the respondents (young people) found it difficult to discuss with their parents sexual issues. Some reported that their parents fear that if they talk about sex they make their children more interested in exploring and practicing sex. On the other hand young people fear introducing this issue to their parents because parents can interpret it as an evidence of sexual involvement. Similar to the present study Adedimeji (2005) found out that girls and boys discuss issues with their parents. In the same it was revealed that girls were disappointed that their mother only inform them on changes that they expect to see at puberty and warn them to stay away from boys and men leaving them curious and desirous of information from available resources. On the other hand boy found their fathers unsympathetic as it is impossible to engage them into discussion of sexual issue and their mothers only tell them to be careful and not impregnate girls or catch a disease. Community leaders, parents and adolescents need to break this silence if the battle of accessing YFHS is to be won. Discussions between parents and adolescents is of importance because it makes it easy for parents to advise their young ones on means of preventing unintended pregnancy and STIs including HIV.

5.5 Factors influencing uptake of YFHS in the area

This section discusses on the findings on factors that affects implementation of YFHS.

5.5.1 Adolescents

The findings show that majority 75% of adolescents responded that their parents would allow them access YFHS. These findings are contrary to those reported by the YFHS national evaluation of YFHS (2014) that revealed that the majority of

parents could not allow their children access the services except in special circumstances. By virtue of parents allowing their adolescents to access YFHS it means that they understand its importance in preventing HIV, STIs and unwanted pregnancies among adolescents.

The study results show that 54 % of adolescents' mentioned unfriendly service, long waiting time and denial of the service as what they experienced the first day they visited the facility. These findings are similar to the findings by Agimpodi (2008); Moya (2012); and Kennedy et al (2013) which revealed that adolescents encountered with negative attitude providers, waited long to get services and some were told that services are out of stock. The first impression at health facility matters, as it affects how one will perceive the service and determine follow up visits. In such cases adolescents give up on utilizing SRHS and contraceptive and condom use to protect themselves from unintended pregnancy and STIs including HIV.

The study also revealed that 37% of adolescents think that if services such as contraceptive, HTC, prevention, diagnosis and management of STIs, antenatal, delivery and postnatal services, provision of PEP and ARVs are found at facilities, it would easily meet their reproductive health needs. It was impressive to find out that most adolescents would like many services offered at YFHS delivery points and if such services are present it is more likely that the adolescents are going to access one or two services because it is what they want.

The study also found out that community sensitization and support in, privacy, and accessibility of YFHS were mentioned by adolescents as factors that can contribute to easy access of services. The results are similar to findings by Kibombo (2008) who find out that there is need for community sensitisation, education and

guidance in order for our adolescents have good access to reproductive health services.

5.5.2 Community leaders

This study indicates that 74% of community leaders would allow adolescents access YFHS. The reasons for allowing adolescents included that they do not listen when advised to change their sexual behaviours, therefore, they would allow them to go to YFHS so that they can prevent themselves from STIs, HIV and unwanted pregnancies. At least 62% of Community leaders complained about behaviour among trainee soldiers in T/A Maganga, who pursue their adolescent girls and engage in sexual relationships. This leads to unwanted pregnancies which are always denied by the responsible men and gives the girl no choice but to abort the pregnancy so as to be accepted in the community. The presents study results are different to national evaluation of YFHS (2014b) which find out that parents reacts differently to whether adolescents should be allowed to access RH services or not. Most of the parents suggested that they were free to send adolescents to access non contraceptive methods except under special circumstances (e.g. PEP after being raped) they would allow them access the rest. Despite the fact that parents responded that they could allow their adolescents to seek YFHS, still there is little or underutilisation of the services in the health facility.

The research revealed that 57% of community leaders would need contraceptives and HTC only to be services that adolescents can find at YFHS delivery points. It is counterproductive that community leaders only want contraceptives and HTC as services that should be provided to adolescents at YFHS delivery point. Community leaders are more likely to discourage adolescents access

the services for fear of having access to services they would not want adolescents access.

Community leaders also concurred with adolescents as 28% of them reported that there was need for community sensitization and emphasise on privacy when services are being provided to youths. These findings are similar to the findings of 2004 national representative surveys which revealed that proportion of sexually active adolescents do not know sources to obtain contraceptives or get STI treatment which lead to underutilisation of services (Biddlecom et al., 2007). If the community itself accept to have little knowledge is of advantage in that when the messages are brought to them they are going to listen.

The significance of privacy and confidentiality need not to be over – emphasised as adolescents just as any other human being have a right to privacy even during the time they are accessing RHS. A study based on data from 10–19 year olds in Kenya and Zimbabwe by Biddlecom et al (2007), showed that adolescents considered youth-only services, youth involvement in services and young staff to be the least important characteristics of YFH services while characteristics such as confidentiality and privacy, short waiting time, low cost and friendly staff were rated as the most important. Agampodi et al. (2008) also found out that adolescents lack confidence to access HR services due to inadequate privacy and confidentiality given by health care providers, teachers and parents for these issues. Kennedy et al. (2013a) found out that due to lack of privacy and confidentiality majority of adolescents fear to access SRH services for fear of being teased or be part of community gossip.

5.7 Role of Community leaders in promoting YFHS

Community leaders have a role to play in YFHS. The roles of community leaders differ depending on the culture of a particular society. This section discusses findings on the roles of community leaders in relation to YFHS.

Community leaders' involvement in various YFHS activities was the commonly mentioned (60%) if the goal of preventing STIs and unwanted pregnancies was to be attained in YFHS centres. This study found out that community leaders have a role to encourage adolescents' access YFHS, urge parents to allow adolescents participate in YFHS activities and, encourage adolescents delay sexual debut until mature. These findings are similar to results for the studies which were conducted elsewhere by Biddlecom (2007); Kumi- Kyereme, Awusabo-Asare (2007); and MOH, 2014.

The findings show that community leaders could play a pivotal role in influencing adolescents seek YFHS if they are involved in the activities because this can help their understanding of the service. This perhaps could help in breaking barriers in accessing YFHS since parents are likely to be advised by community leaders on the importance of YFHS. On the same, community leaders are highly respected and have a commanding voice which could be tapped lure parents and even adolescents in YFHS activities. Increasing body of knowledge of adults' perspective on adolescents' SRHS allows individuals interested in influencing debate on opportunities to better address concerns.

5.8 Conclusion

Many adolescents are being involved in sexual relationships but they underutilise the YFHS hence missing out skills and services that may help them prevent unwanted pregnancies and STIs including HIV. Adolescents and community leaders in this study had knowledge of YFHS as a concept but lacked in depth

information on what really happens at these delivery points in terms of services offered and where the services are provided. Efforts should aim at enhancing activities and programs that would lead to provision of adequate information about YFHS. Adolescents should be empowered with information on the benefits YFHS, where they can access services and of what type which would assist them focus on their future. Factors such as long waiting hours, unfriendly services and denial of services affect adolescents' patronage in YFHS. Involvement and sensitization of community leaders in YFHS activities contribute significantly on improving adolescents' utilisation of services since they are gate keepers and they ably know how best sexuality issues are communicated to adolescents in their community.

5.9 Limitation of the study

Due to sensitivity of the topic of sexual and reproductive health and is perceived as a private or personal issue, it is possible that some adolescents who are sexually active and utilising the services did not want to disclose their status because of shame and stigma hence affecting the results on utilisation. The study only focused only on two TAs out of 11 T/As in Salima hence the results cannot be concluded for the entire district or country but it is a true reflection of the two TAs studied. However the results can be used in order to reflect on how adolescents perceive YFHS in Malawi in absence of such country studies.

5.10 Recommendations

5.10.1 Practice

Managers of health institutions should be empowered to provide supportive supervision to health care providers and ensure YFHS are being provided in health facilities. Providers need to be encouraged to have positive attitude toward YFHS to adolescents, hence promoting attendance to delivery points.

Interventions aimed at accelerating adoption and usage of YFHS ought to be considered to bridge the utilisation gap through trainings and awareness campaigns to community members in the studied area. This would perhaps enable adolescents gain understanding on the roles played by YFHS. There is need to orient adolescents and even community leaders on providers of YFHS and this can be attained through trainings in YFHS centres.

Training on health care workers in YFHS should be improved through in service trainings to all health care providers in health facilities to promote their understanding in the importance-of YFHS. Focus of education this study recommends an emphasis on consequences of poor YFHS practices among providers.

Health workers should improve on service delivery to adolescents so as to promote service accessibility.

5.10.2 Research

Study should be done to find out sexual behaviours on adolescents in Salima district.

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APPENDICES

Appendix i: Questionnaire for adolescents English version

RESERCH TITLE: Knowledge and perceptions of adolescents and community leader on youth friendly health services: A case of some communities in Salima District

DATE OF INTERVIEW / (Day, month)

TIME OF INTERVIEW : (24 HOUR Time

INTERVIEWER'S NAME.....

RESPONDENT ID

PLACE OF INTERVIEW.....

SECTION A: DEMOGRAPHIC DATA

NO	QUESTION	RESPONSE	COD E
A1	What is your gender?	Male	1
		Female	2
A2	How old are you?	15- 17	1
		18-19	2
A3	What is the highest level of education did you attain?	None	1
		Std 1- Std 5	2
		Std 6- Std 8	3
		JCE	4
		MSCE	5
		Others	6
A4	What is your marital status?	Married	1
		Single	2
		Divorced	3
		Separated	4
		Widowed	5
		Others specify	6
A5	Which church do you belong?	Catholic	1
		Islam	2
		Pentecostal churches	3
		CCAP	4
		SDA	5
		Others specify	6
A6	What is your tribe	Yao	1
		Chewa	2
		Others specify	3
A7	What is your occupation	Farming	1
		Businessman/woman	2
		Employed	3
		Others specify	4

SECTION B: ADOLESCENTS KNOWLEDGE AND USE OF YFHS

NO	QUESTION	RESPONSE	CODE
B1	Have you ever heard about YFHS	Yes []	1
		No []	2
B2	What do you know about YFHS?	Provision/ distribution of contraceptive methods	1
		HIV testing and counselling	2
		Contraceptive counselling	3
		General counselling	4
		Prevention, diagnosis and management of	5

		STIs	
		Others specify	6
B3	Have ever participated in any YFHS activities?	Yes []	1
		No []	2
B4	What contraceptive methods are offered at YFHS delivery points?	Male condoms	1
		Injectables	2
		Female condoms	3
		Oral contraceptive pills	4
		Implants	5
		IUD	6
		Others specify	7
B5	Can you tick any youth friendly health services you know?	Contraceptives including condoms	1
		HIV testing and counselling	2
		Prevention, diagnosis and management of STI	3
		Ante natal, delivery and post natal services	4
		Treatment of sexually abused victims (including PEP)	5
		Post abortion care	6
		Provision of ARVs	7
		Others specify	8
		Right here in the community	2
		Youth clubs	3
		Others	4
B6	Who are the champion providers of the services in your community?	Health surveillance assistants	1
		Volunteers	2
		Nurses	3
		Clinicians	4
		Youth club members	5
		Others	
B7	Which is the closest YFHS delivery point in or closest to your community?	Health centre	1
		Right here in the community	2
		Youth clubs	3
		Others	4
B8	Where can you get messages on YFHS in this community?	Health Centre	1
		Radio	2
		News papers	3
		School	4
		Friends	5
		Parents	6

		Others	7
B9	Where did you get the information about youth friendly health services?	Health care delivery system	1
		Radio	2
		News paper	3
		School/social groups/ clubs	4
		Friends/peers	5
		Internet	6
		Parents	7
		HSA	8
		Community members	9
		Youth clubs	10
		Others	11

SECTION C: ADOLESCENTS PERCEPTION ON YFHS

NO	QUESTION	RESPONSE	CODE
C1	How easy is it to access YFHS in your community?	Easy	1
		Very easy	2
		Slightly easy	3
		Not easy at all	4
C2	Tick examples of the services you have ever accessed easily (you can tick more than one)	Family planning methods	1
		Sexually transmitted infections treatment	2
		Health education	3
		Voluntary counselling and testing	4
		Others	5
C3	Do you think YFHS are important to adolescents?	Yes []	1
		No []	2
C4	How do you perceive adolescents who go for family planning services?	Sexually active	1
		Shameless	2
		Unstable	3
		Prostitute	4
		Responsible	5
		Others specify	6
C5	How do you look at an adolescent who go for STI treatment at the hospital?	Prostitute	1
		Sexually active	2
		Responsible	3
		Shameless	4
		Unstable	5

		Others	6
C6	How comfortable are you talking about youth friendly health services with friends?	Comfortable	1
		Not comfortable	2
		A little comfortable	3
		We do not talk about it	4
		Others	5
C7	How comfortable are you in accessing YFHS?	Comfortable because I want to prevent early pregnancy	1
		Not comfortable because am still in school	2
		Not comfortable because it would destroy my womb	3
		Not comfortable because they cause cancer	4
		Not comfortable because it may cause delay in getting pregnancy when I want to	5
		Not comfortable because my parents would not allow me	6
		Others	7
C8	Can your parents allow you to go for any youth friendly health services?	Yes []	1
		No []	2
C9	If yes explain		1
C10	If no explain		1

SECTION D: FACTORS AFFECTING YFHS ACCESSIBILITY

NO	QUESTIONS	RESPONSE	CODE
D1	What was your first experience when you visited YFHS delivery point?	Unfriendly services	1
		Long waiting time	2
		Denial of services	3
		Lack of privacy	4
		Poor attitude of health workers	5
		Others specify	6
D2	What do you think needs to be done so that adolescents could go for youth friendly health services?	Community sensitisation	1
		Privacy should be emphasised	2
		Should be accessible	3
		Community support for youth to use YFHS	4
D3	What health services would you want health facilities to provide specifically	Contraceptives including condoms	1
		HIV testing and counselling	2

	for the adolescents?	Prevention, diagnosis and management of STI	3
		Ante natal, delivery and post natal services	4
		Treatment of sexually abused victims (including PEP)	5
		Post abortion care	6
		Provision of ARVs	7
		Others specify	8
D4	Do you have any comments on youth friendly health services?		1

Appendix ii: **Questionnaire for adolescents Chichewa version**

**MUTU WA KAFUKUFUKU: Kufufuza kuti tidziwe ngati achinyamata ndi
atsogoleri ammudzi amadziwa za zithandizo za achinyamata ndi momwe
amazonera**

Tsiku lakafukufuku :/..... (Day/month)

Nthawi yakafufuku : (24 hours)

Nambala ya chinsinsi:

Dzina la ofunsa: -----

Dzina la dera: -----

GAWO A: MBIRI YANU

NO	MAFUNSO	MAYANKHO/RESPONSES	CODE
A1	Kodi ndinu ndani	Mwamuna []	1
		Mkazi []	2
A2	Muli ndi zaka zingati	15- 17 []	1
		18- 19 []	2
A3	Maphunziro muna fika pati?	Sindidaphunzireko	1
		Std 1- Std 5	2
		Std 6- Std 8	3
		JCE	4
		MSCE	5
		Zina fotokozani	6
A4	Muli pa banja	Ndili pa banja	1
		Sindili pa banja	2
		Banja li datha	3
		Tidasiyana ukwati	4
		Mwamuna/mkazi anamwalira	5
		Zina fotokozani	5
A5	Mumapemphera mpingo wanji ?	Katolika	1
		Chisilamu	2
		Pentekosite	3
		CCAP	4
		SDA	5
		Ina fotokozani	6
A6	Mumagwira ntchito yanji ?	Ulimi	1
		Bizinesi	2
		Yolembedwa	3
		Zina	4
A7	Ndinu ntundu wanji wa anthu	Yao	1
		Chewa	2
		Ina	3

GAWO B: ZOMWE MUKUDZIWA

NO	MAFUNSO	MAYANKHO	CODE
B1	Munayamba mwamvapo za zithandizo zaumoyo zoyanjana ndi achinyamata?	Eya []	1
		Ayi []	2
B2	Mumadziwapo chiyani pa za zithandizo zaumoyo zoyanjana ndi achinyamata?	Amapereka njira zakulera	1
		Kuyesa magazi ndi kupereka uphungu wa HIV	2
		Uphungu wa zakulera	3
		Mauphungu a za umoyo	4
		Zithandizo zamatenda opatsirana pogonana	5
		Zina fotokozani	6
B3	Mudayamba mwatengako mbali muzochitika chitika za zithandizosi?	Eya []	1
		Ayi []	2
B4	Ndizithandizo ziti zakulera zomwe mungazipeze kumalo opereka zithandizo zoyanjana ndi achinyamata?	Makondomu aabambo	1
		Jakisoni	2
		Makondomu aamayi	3
		Mapilitsi	4
		Inipulantsi	5
		IUD	6
		Zina	7
B5	Kodi ndizithandizo ziti zomwe zimapezeka Chongani chithandizo chomwe mukuchidziwa mmusimu	Njira zolera kuonjezapo makondomu	1
		Uphungu wa ndi ku yezetsa HIV	2
		Chithandizo cha matenda opatsilana pogonana	3
		Sikelo ya amayi oyembekezera, kubadwitsa ndi chithandizo cha amayi akachila	4
		Chithandizo kwa anthu omwe agwiriridwa (kuphatikizapo PEP)	5
		Chithandizo kwa amene mimba	6

		yachoka	
		Kupereka ma ARV	7
		Zina fotokozani	8
B6	Amapereka zithandizo za achinyamata mdera muno ndi ndani?	Azaumoyo	1
		Mavulontiya	2
		Anamwino	3
		Adokotala	4
		Magulu a chinyamata	5
		Ena	6
B7	Kodi ndi malo ati apafupi mungapezeco zithandizo zokomera achinyamata?	Health centre	1
		Mdera mwathu mommuno	2
		Magulu a achinyamata	3
		Kwina tchulani	4
B8	Mauthenga a zaumoyo oyanjana ndi achinyamata mumawapeza kuti?	Health centre	1
		Pawayilesi	2
		Nyuzipepala	3
		Kusukulu	4
		Kwa anzathu	5
		Kwa makolo	6
		Ena	7
B9	Uthenga wa zithandizo zokomera achinyamata munaumva kuchokera kuti?	Njira za kuchipatala zo falitsira uthenga	1
		Pa wailesi	2
		Mabungwe a achinyamata	3
		Nyuzi pepala	4
		Sukulu / timagulu/ kumasewero	5
		Anzathu	6
		Intaneti	7
		Makolo	8
		A zaumoyo	9
		Anthu amudzi mwathu	10
		Zina fotokozani	11

GAWO C: MALINGALIRO

NO	MAFUNSO	MAYANKHO	CODE
C1	Nkwapafupi bwanji kupeza njira zoyanjana ndi achinyamata mdera lino?	Nkwapafupi	1
		Nkwapafupi kwambiri	2
		Nkovuta	3
		Nkovuta	4
C2	Tchulani zithandizo zaumoyo zoyanjana ndi achinyamata zomwe mudalandilapo (chongani)	Njira zakulera	1
		Chithandizo cha matenda opatsilana poganana	2
		Ziphunzitso zaumoyo	3
		Uphungu ndi ku yezetsa magari	4
		Zina	5
C3	Mukuganiza kuti zithandizo za achinyamatazi nzofunikira?	Eya []	1
		Ayi []	2
C4	Kodi achinyamata omwe amalandira njira zakulera mumaona bwanji?	Amapanga zogonana	1
		Opanda manyazi	2
		Osakhazikika	3
		Oyendayenda	4
		Odzisamalira	5
		Zina	6
C5	Kodi achinyamata omwe amakalandira chithandizo chamatenda opatsirana pogonana mumawaona bwanji?	Amapanga zogonana	1
		Opanda manyazi	2
		Osakhazikika	3
		Oyendayenda	4
		Odzisamalira	5
		Zina	6
C6	Mumakambirana bwanji za zaumoyo zoyanjana ndi achinyamata ndi anzanu?	Timakambirana momasuka	1
		Timakambirana momasuka pang'no	2
		Timakambirana koma sitimamasukirana	3
		Sitikambirana	4
		Zina	5
C7	Kodi ndinu omasuka bwanji	Ndine omasuka chifukwa	1

	kukatenga njira zaumoyo zoyanjana ndi achinyamata?	sindifuna kutenga pakati mwansanga	
		Ndine osamasuka chifukwa ndikadali wamng'ono	2
		Ndine osamasuka ndimaopa zingadzandiononge chiberekero	3
		Ndine osamasuka chifukwa zimapangitsa khansa	4
		Ndine osamasuka chifukwa zitha kudzandichedwetsa kukhala ndi pakati pamene ndi dzafune kutero.	5
		Ndine osamasuka chifukwa makolo anga sangandilore kutero	6
		Zina fotokozani	7
C8	Makolo anu anga kuloreni ku kalandira zaumoyo zoyanjana ndi achinyamata?	Eya []	1
		Ayi []	2
C9	Ngati eya fotokozani		1
C10	Ngati ayi fotokozani		2

**GAWO D: ZOPANGITSA KUTI A CHINYAMATA ASAMAKATENGE
ZITHANDIZO ZOKOMELA A CHIMATA**

NO	MAFUNSO	MAYANKHO	CODE
D1	Kodi chithandizo chanu choyamba ku chipatala pokapeza chithandizo choyanjana ndi achinyamata chinali chotani?	Ndinadikira nthawi yayitali	1
		Zithandizo sizinali zoyanjana ndi achinyamata	2
		Anandikana kundipatsa chithandizo	3
		Kunalibe chinsisi	4
		Ogwira ntchito sanandi yankhule bwino	5
		Zina fotokozani	6
D2	Mukuganiza tingatani kuti achinyamata azipita kukalandira zithandizozi?	Kudziwitsa anthu onse za zaumoyo zoyanjana ndi achinyamata	1
		Zidzikhala zachinsinsi	2

		Zidzippezeka mosavuta	3
		Anthu onse adzithandizapo achinyamata kugwiritsa ntchito zithandizo zokomera achinyamata	4
D3	Ndi zithandizo ziti mwa zithandizo zoyanjana ndi achinyamata zomwe zidziperekedwa makamaka kwa achinyamata?	Njira zolera kuonjezapo makondomu	1
		Uphungu wa ndi ku yezetsa HIV	2
		Chithandizo cha matenda opatsilana pogonana	3
		Sikelo ya amayi oyembekezera, kubadwitsa ndi chithandizo cha amay akachila	4
		Chithandizo kwa anthu omwe agwiridwa (kuphatikizapo PEP)	5
		Chithandizo kwa amene mimba yachoka	6
		Kupereka ma ARV	7
D4	Muli ndi zoonjezera zina zilizonse?		

RESEARCH TITLE: Knowledge and perceptions of adolescents and community leader on youth friendly health services: A case of some communities in Salima district

PLACE OF INTERVIEW.....

SECTION A: DEMOGRAPHIC INFORMATION

NO	QUESTION	RESPONSE	CODE
A1	What is your gender?	Male	1
		Female	2
A2	How old are you?	20- 29	1
		30- 39	2
		40- 49	3
		50-59	4
		60 and above	5
A3	What is the highest level of education did you attain?	None	1
		Std 1- Std 5	2
		Std 6- Std 8	3
		JCE	4
		MSCE	5
		Others	6
A4	What is your marital status?	Married	1
		Single	2
		Divorced	3
		Separated	4
		Widowed	5
		Others specify	6
A5	Which religion do you belong?	Catholic	1
		Islam	2
		Pentecostal churches	3
		CCAP	4
		SDA	5
		Others specify	6
A6	What is your tribe	Yao	1
		Chewa	2
		Others specify	3
A7	What is your occupation	Famer	1
		Businessman/woman	2
		Employed	3

		Others specify	4
--	--	----------------	---

SECTION B: KNOWLEDGE OF COMMUNITY LEADERS ON YFHS PROGRAM

NO	QUESTION	RESPONSE	COD E
B1	Have you ever heard anything about youth friendly health services?	Yes []	1
		No []	2
B2	Have you ever been involved in any of the YFHS interventions?	Yes []	1
		No []	2
B3	What do you know about YFHS?	Provision/ distribution of contraceptive methods	1
		HIV testing and counselling	2
		Contraceptive counselling	3
		General counselling	4
		Prevention, diagnosis and management of STIs	5
		Others	6
B4	Which YFHS do you know?	Contraceptives including condoms	1
		HIV testing and counselling	2
		Prevention, diagnosis and management of STI	3
		Ante natal, delivery and post natal services	4
		Treatment of sexually abused victims (including PEP)	5
		Post abortion care	6
		Provision of ARVs	7
		Others	8
B5	Who provide such services in your community?	Health surveillance assistants	1
		Volunteers	2
		Nurses	3
		Clinicians	4
		Youth club members	5
		Others	6
B6	Where do adolescents find YFHS in	Health Centre	1

	this community?	Right here in the community	2
		Youth Clubs	3
		Others specify	4
B7	Where do adolescents get messages on YFHS	Health Centre	1
		Radio	2
		News paper	3
		School	4
		Friends	5
		Parents	6
		Others specify	7

SECTION C: PERCEPTION OF COMMUNITY LEADERS ON YFHS

NO	QUESTION	RESPONS	CODE
C1	How do you perceive an adolescent who go for services like family planning, STI treatment?	Prostitute	1
		Sexually active	2
		Responsible	3
		Unstable	4
		Shameless	5
		Others	6
C2	Can you discuss with adolescents on YFHS	Yes	1
		No	2
C3	Would you allow adolescents to go for YFHS services	Yes []	1
		No []	2
C4	How comfortable are you talking about YFHS services with adolescents?	Comfortable	1
		A little bit comfortable	2
		Not comfortable	3
		We do not talk	4
		No []	2
C5	If yes give a reason		1

C6	If no give a reason		1

SECTION D: FACTORS AFFECTING YFHS

NO	QUESTION	RESPONSE	CODE
D1	What do you think needs to be done so that adolescents could go for health services?	Community leaders involvement	1
		Selected services should be provided	2
		The age at which young people receive the services should be well defined	3
		Others	4
D2	What health services would you want health facilities to provide specifically for the adolescents?	Contraceptives including condoms	1
		HIV testing and counselling	2
		Prevention, diagnosis and management of STI	3
		Ante natal, delivery and post natal services	4
		Treatment of sexually abused victims (including PEP)	5
		Post abortion care	6
		Provision of ARVs	7
		Others	8

SECTION E: ROLE OF COMMUNITY LEADERS

NO	QUESTION	RESPONSE	CODE
E1	What roles do community leaders have in youth friendly health services?	Encouraging adolescents to access YFHS	1
		Encouraging parents to allow adolescents to access YFHS	2
		Participating in YFHS activities in the community	3
		Encouraging adolescents to delay sex until they are mature	4
		Others explain	5

E2	Do you have any comments on youth friendly health services?		1
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Appendix iv: Questionnaire for community leaders Chichewa version

MUTU WA KAFUKUFUKU: Kufufuza kuti tidziwe ngati achinyamata ndi atsogoleri amudzi amadziwa za zithandizo za achinyamata ndi momwe amazionera: Mmadera ena a mboma laSalima

Tsiku lakafukufuku :/..... (Day/month)

Nthawi yakafufuku : (24 hours)

Nambala ya chinsinsi:

Dzina la ofunsa: -----

Dzina la dera: -----

GAWO A: MBIRI YANU

NO	MAFUNSO	MAYANKHO/RESPONSES	CODE
A1	Kodi ndinu ndani?	Mwamuna	1
		Mkazi	2
A2	Muli ndizaka zingati?	20- 29	1
		30- 39	2
		40- 49	3
		50- 59	4
		60 kapena kuposelapo	5
A3	Maphunziro muna fika pati?	Sindidaphunzireko	1
		Std 1- Std 5	2
		Std 6- Std 8	3
		JCE	4
		MSCE	5
		Zina fotokozani	6

A4	Muli pa banja?	Ndili pa banja	1
		Sindili pa banja	2
		Banja li datha	3
		Tidasiyana ukwati	4
		Mwamuna/mkazi anamwalira	5
		Zina fotokozani	6
A5	Mumapemphera mpingo wanji?	Katolika	1
		Chisilamu	2
		Pentekosite	3
		CCAP	4
		SDA	5
		Ina fotokozani	6
A6	Mumagwira ntchito yanji?	Ulimi	1
		Bizinesi	2
		Yolembedwa ya pa mwezi	3
		Zina	4
A7	Ndinu ntundu wanji wa anthu?	Yao	1
		Chewa	2
		Ina	3

**GAWO B: ZOMWE MUKUDZIWAPO PAZAZITHANDIZO ZOKOMERA
ACHINYAMATA**

NO	MAFUNSO	MAYANKHO	CODE
B1	Munayamba mwamvapo za zithandizo za umoyo zoyanjana ndi achinyamata?	Eya []	1
		Ayi []	2
B2	Mudayamba mwatengako mbali	Eya []	1

	muzochitika chitika za zithandizozi?		
		Ayi []	2
B3	Mukudziwapo chiyani pa zithandizo zoyanjana ndi achinyamata?	Kupereka/kugawa njira zakulera	1
		Uphungu wa ndi ku yezetsa HIV	2
		Uphungu wa zakulera	3
		Uphungu wa zones	4
		Chithandizo cha matenda opatsilana pogonana	5
		Zina fotokozani	6
B4	Ndizithandizi ziti zoyanjana ndi achinyamata mukuzidziwa?	Njira zolera kuonjezapo makondomu	1
		Uphungu wa ndi ku yezetsa HIV	2
		Chithandizo cha matenda opatsilana pogonana	3
		Sikelo ya amayi oyembekezera, kubadwitsa ndi chithandizo cha amayi akachila	4
		Chithandizo kwa anthu omwe agwiriridwa (kuphatikizapo PEP)	5
		Chithandizo kwa amene mimba yachoka	6
		Kupereka ma ARV	7
		Zina fotokozani	8
B5	Amapereka zithandizo zaachinyamata mdera muno ndi ndani?	Azaumoyo	1
		Mavulontiya	2
		Anamwino	3
		Adokotala	4
		Magulu a chinyamata	5
		Ena	6
B6	Zithandizo zokomera achinyamata zimapezeka kuti mdera muno?	Health centre	1
		Mdera mwathu mommuno	2
		Magulu achinyamata	3

		Kwina tchulani	4
B7	Mauthenga a zaumoyo oyanjana ndi achinyamata mumawapeza kuti?	Health centre	1
		Pawayilesi	2
		Nyuzipepala	3
		Kusukulu	4
		Kwa anzathu	5
		Kwa makolo	6
		Ena	7

GAWO C: MALINGALIRO

NO	MAFUNSO	MAYANKHO	CODE
C1	Kodi achinyamata omwe amalandira njira zakulera ndi chithandizo cha matenda opatsirana pogonana mumaona bwanji?	Oyendayenda	1
		Amapanga zogonana	2
		Odzisamalira	3
		Osakhazikika	4
		Opandamanyazi	5
		Zina	6
C2	Kodi munga kambirane ndi achinyamata za zaumoyo zoyanjana ndi achinyamata?	Eya []	1
		Ayi []	2
C3	Kodi munga lore kuti achinyamata akalandire zithandizo zoyanjana ndi achinyamata?	Eya []	1
		Ayi []	2
C4	Kodi ndinu omasuka bwanji kukambirana ndi achinyamata za zithandizo zaumoyo zoyanjana ndi achinyamata?	Ndine omasuka	1
		Ndine omasuka pang'ono	2
		Ndine osamasuka	3
		Sitimakambirana	4
C5	Ngati eya fotokozani		1
C6	Ngati ayi fotokozani		1

**GAWO D: ZINTHU ZOMWE ZIMAPANGITSA KUTI ACHINYAMATA
ASAMAKONDE ZITHANDIZO ZOKOMERA ACHINYAMATA**

NO	MAFUNSO	MAYANKHO	CODE
D1	Mukuganiza tingatani kutiachinyamata azipita kukalandira zithandizozi?	Atsogoleri a mmaderaadzitengapo mbari	1
		Njira zowerengeka zokha zidziperekedwa kwa a chinyamata	2
		Zina mwanjirazi zisamaperekedwe kwa achinyamata akhazikitsidwe zaka zokhazikika za a chinyamata oyenera kulandira zithandizozi.	3
		Zina	4
D2	Ndi zithandizo ziti mwa zithandizo zoyanjana ndi achinyamata zomwe zidziperekedwa makamaka kwa achinyamata?	Njira zolera kuonjezapo makondomu	1
		Uphungu wa ndi ku yezetsa HIV	2
		Chithandizo cha matenda opatsilana pogonana	3
		Sikelo ya amayi oyembekezera, kubadwitsa ndi chithandizo cha amayi akachila	4
		Chithandizo kwa anthu omwe agwiridwa (kuphatikizapo PEP)	5
		Chithandizo kwa amene mimba yachoka	6
		Kupereka ma ARV	7
		Zina	8

GAWO E: UDINDO WA ATSOGOLERI AMMUDZI

NO	MAFUNSO	MAYANKHO	CODE
E1	Kodi udindo wanu ngati atsogoleri a mmdera ndi chani pa zithandizo zaumoyo zo yanjana ndi achinyamata? (fotokozani)	Kulimbikitsa achinyamata kukapeza zithandizo zoyanjana ndiachinyamata	1
		Kulimbikitsa makolo kulola achinyamata kukatenga zithandizo zoyanjana ndi a chimyamata	2
		Kulimbikitsa a chinyamata kudikila mpaka atakhwima kuti ayambe zogonanana	3
		Kutengako mbali muzo chitikachitika za zithandizo zoyanjana ndi achinyamata mdera.	4
		Zina fotokozani	5
E2	Muli ndi zoonjezera zina zilizonse?		1

Appendix v: Consent form English version

Title of Study: Knowledge and perceptions of adolescents and community leaders on youth friendly health services: Case of selected communities in Salima

Investigator: Esther Chilalire Kapalamula

I am a student pursuing a Master of Community Health Nursing at Kamuzu College of Nursing. As part of the academic requirements, I am conducting this study to find out whether adolescents and community leaders have knowledge on and their perceptions towards youth friendly health services. I will ask questions to adolescents and community leaders in the sampled traditional authorities' villages.

What you need to do for this study

If you decide to participate in the study, you will be required to give your personal data and answer questions on a questionnaire.

How will your privacy be maintained?

The information will be accessed by me and people who are directly involved in the study. Records will be kept safe in a lockable drawer. Codes will be used instead of names. After the study, your records will be destroyed.

Voluntary participation and your right to refuse

You have the right to withdraw from the study at any time if you wish to do so and you will not be penalized.

Are there any risks involved in this study?

There are no known risks associated with taking this study.

Whom to contact if any question, concern or complaints on this study

If you have additional questions, concerns or complaints pertaining to your participation in the study about this study please do not hesitate to contact

Esther Chilalire Kapalamula,

Salima District hospital,

Post Office Box 53,

Salima.

Cell: 0884743543/ 0999103255

Who has given permission for me to go ahead with the study?

The College of Medicine Research and Ethics Committee, Ministry of Health and Salima District assembly and Health Office. If you have any worries or queries, contact the chairperson of the Research and Ethics Committee.

Thank you for taking the time to read or listen to the information sheet

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

I have read the attached information sheet for this study and have understood the purpose of the study. I agree to voluntarily participate in the study, to be questioned and provide answers to the best of my knowledge. I understand that I am free to withdraw any time without giving reasons. I understand that my information will be kept in confidential and will only be accessed by the researcher or those people directly concerned with this study.

I.....voluntarily agree to participate in this research.

.....		
Participants name	Signature	Date
.....		
Researchers Name	Signature	Date

Thank you for participating in this study.

Appendix vi: Consent form Chichewa version

Mutu wa kafukufuku: Kufufuza kuti tidziwe ngati achinyamata ndi atsogoleri ammudzi amadziwa za zithandizo za achinyamata ndi momwe amazionera

Wotsogolera Kafukufuku: Esther Chilalire Kapalamula

Ndine mwana wasukulu ya anamwino (Kamuzu College of Nursing). Mwazofunikira zina pamaphunziro anga azaumoyo ndikuchita kafukufuku kuti ndidziwe ngati achinyamatakomanso atsogoleri ammudzi akudziwa za zithandizo zokomera achinyamata za umoyo. Ndidzinka nafunsa mafunso ndikucheza ndi achinyamata komanso atsogoleri a mmudzi mumidzi imene yasankhidwa.

Zofunika kuti inu muchite mukafukufukuyu

Ngati mwalola kulowa mukafukufuku mudzafunsidwa kupereka uthenga wokhudzana ndiinu monga zaka ndikumene mukuchokera ndi zina. Mudzafunsidwa mafunso panokha.

Kusunga chinsisi chanu

Ine ndidzasunga chinsisi chazonse zimene mudzandiuze kwaine ndekha kapena kupatsa okhao akukhudzidwa ndi kafukufukuyu. Sikofunika kuti mutiwuze dzina lanu chifukwa tigwiritsa ntchito manambala wosati maina kuti tikusungileni chinsisi. Kafukufuku akatha, uthenga wokudzana ndiinu zidzawonongedwa kuti wina aliyence asadzazione.

Ufulu wanu kulola kapena kusalola kulowa mukafukufuku

Muli ndiufulu kusapitiliza ndikafukufuku panthawi yili yonse pamene mwafuna kutero ndipo simudzayimbidwa mlandu.

Pali zovuta zina zilizonse zokhudzana ndikafukufukuyu?

Ayi palibe zovuta zina zilizonse zokhudzana ndi kafukufukuyu.

Ngati ndili ndi chidandaulo kapena mafunso ndingafunse ndani?

Munthu amene mungafunse china chili chonse chokhudzana ndi sekafukufuku.

Esther Chilalire Kapalamula

Salima District Hospital

P. O. Box 53

Salima

Foni: 0884743543/ 0999103255

Kalata yachilolezo

Ndawerenga kalata yolongosola za kafukufuku ali pamwambayi ndipo ndamvetsa cholinga cha kafukufukuyu ndi zovuta zake. Ndavomereza kutenga mbali pa kafukufukuyu mosaumirizidwa, ndikafunsidwa mafunso ndiyankha mmene ndimadziwira. Ndamvetsanso kuti ndili ndi ufulu kusiya nthawi ina iliyonse popanda chifukwa. Ndamvetsetsa kuti zonse zomwe ndichite ndi kuyankhula mu kafukufukuyu zidasungidwa mwa chinsinsi ndi kugwiritsidwa ntchito ndi anthu omwe akupanga kafukufukuyu ndi ena omwe akukhudzidwa.

Ine Ndavomereza kutenga nawo mbali pa kafukufukuyu mwakufuna kwanga ndi popanda kuumirizidwa.

.....		
Dzina la otenga mbali	Chitsindikizo	Tsiku
.....		
Mboni	Chitsindikizo	Tsiku
.....		
Mwini wa kafukufukuyu	Chitsindikizo	Tsiku

ZIKOMO KWAMBIRI

Appendix vii: Calculation of sample size

Adolescents

T/A Maganga

Area of T/A Maganga has a total population of 47498 and the targeted population which is adolescents aged 15-19 is 4930 (National Statistical Office, 2013).

Taking $n_0 = 140$, and $N = 4930$, the sample size, n , for adolescents in the TA Maganga is

$$n = \frac{n_0 N}{n_0 + (N - 1)}$$
$$n = \frac{140 \times 4930}{140 + (4930 - 1)}$$
$$n = 136$$

T/A Kambwiri

In the T/A Kambwiri total population is 27114 and the targeted population which is adolescents aged 15-19 is 2580 (National Statistical Office, 2013). Setting $z = 1.96$; $p = 0.5$; $E = 0.083$; $n_0 = 140$ and $N = 2580$, the sample size, n , for adolescents in the T/A Kambwiri is

$$n = \frac{n_0 N}{n_0 + (N - 1)}$$
$$n = \frac{140 \times 2580}{140 + (2580 - 1)}$$
$$n = 132$$

Community Leaders

T/A Kambwiri

According to Salima District council (2014), T/A Kambwiri has 70 village heads and 12 different Church leaders (pastors) giving a total of 82 Community leaders. Setting $z = 1.96$; $p = 0.5$; and $E = 0.083$; $n_0 = 140$ and $N = 82$, the sample size, n , for community leaders in the T/A Kambwiri is

$$n = \frac{n_0 N}{n_0 + (N - 1)}$$

$$n = \frac{140 \times 82}{140 + (82 - 1)}$$

$$n = 52$$

T/A Maganga

According to Salima District council (2014), T/A Maganga has 54 village heads and 10 different Church leaders (pastors) giving a total of 64 Community leaders. Setting $z = 1.96$; $p = 0.5$; and $E = 0.083$, $n_0 = 140$ and $N = 64$, the sample size, n , for community leaders in the T/A Maganga is

$$n = \frac{n_0 N}{n_0 + (N - 1)}$$

$$n = \frac{140 \times 64}{140 + (64 - 1)}$$

$$n = 44$$

Therefore the total sample size for Community Leaders is $44+52= 96$.

University of Malawi,
Kamuzu College of Nursing,
P. Bag 1,
LILONGWE.
29th July, 2014.

The District Health Officer,
Salima District Hospital,
P.O. Box 53,
SALIMA.
Dear Sir,

PERMISSION TO CARRY OUT A RESEARCH STUDY

I write to request for your permission to carry out a research study at Traditional Authority Maganga and Kambwiri. I am a registered nurse currently pursuing a Master of Science Degree in Community Health Nursing at Kamuzu College of Nursing. In partial fulfilment for the degree I am supposed to carry out a research study related to community health nursing practice. The title of the study is: knowledge and perceptions of adolescents and community leaders on youth friendly health services: a case of some communities in Salima.

I look forward to your favourable response to my request.



Yours sincerely

ESTHER CHILALIRE KAPALAMULA (Mrs).