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RESEARCH DISSERTATION

Title: Applying a gender lens in cervical cancer programming: the assessment of sexually active young men involvement in cervical cancer preventive efforts

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DECLARATION

I Chimwemwe Nyambose Nkosi, hereby declare that this dissertation is my original work and has not been presented for any other awards at the University of Malawi or any other University.

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March 2020

DEDICATION

I dedicate this dissertation to my beloved sister, Madalo Nyambose. Your character and support keep challenging me and that has been my inspiration in my studies towards this degree as well. May God continue blessing you.

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My heart felt gratitude should go to the study subjects and key informants who participated in this study, without your support and cooperation this study would not have taken place. To Lilongwe DHO, thanks for allowing me to conduct the study in your catchment area and the entire staff and Management of Bwaila and Kawale health facilities, I salute you. To my research assistants, Coletta Libale and Louise Kwenda, thanks a lot for your tireless support during data collection and analysis of the study. May the Almighty God keep blessing you. My special gratitude also goes to my supervisor, Dr. Fresier Chidyaonga-Maseko for the guidance and advice on my thesis proposal and healthy comments and suggestions that led to the completion of a full Master's Thesis.

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ACRONMYS

CECAP:	Cervical Cancer Control Programme
COMREC:	Collage of Medicine Research Ethics Committee
DHO:	District Health Officer
DHS:	Demographic Health Survey
FPAM:	Family Planning Association of Malawi
HBM:	Health Belief Model
HPV:	Human Papillomavirus
IPV:	Intimate Partner Violence
MoH-RHD:	Ministry of Health-Reproductive Health Directorate
NHS:	National Health Service
PMTCT:	Prevention of Maternal to Child Transmission
SRH:	Sexual Reproductive Health
STI:	Sexually Transmitted Infection
VAWG:	Violence Against women and Girls
VIA:	Visual Inspection with Acetic acid
VMMC:	Voluntary Medical Male Circumcision
WHO:	World Health Organisation

ABSTRACT

Introduction: Cervical cancer remains a public health concern across the world especially in developing countries including Malawi. Much as country's policies calls for male involvement in sexual reproductive health, their involvement in cervical cancer prevention is still not clear. Sexually active young men are usually left behind despite their important role in its prevention.

Objectives: The study's main objective was to assess the involvement of sexually active young men in cervical cancer preventive efforts in Lilongwe Urban.

Methodology: This was mixed methods study. A sample of 196 randomly selected study participants and 10 key informants were interviewed. Inclusion criteria were sexually active young men aged 15 to 24 patronising Bwaila and Kawale health centres. Thematic analysis was used for qualitative data and analysed using NVivo 7.4 software. Quantitative data was analysed using STATA version 14 statistical program.

Results: The study findings suggest knowledge of causes of cervical cancer, partner's risks and whether one is circumcised or not as having a significant impact on young men involvement in cervical cancer preventive efforts. Their non-involvement is attributed to a number of factors which includes structural barriers in terms of access to cervical cancer information and services, lack of a standalone policy, lack of access points of the services such as youth friendly health corners. Culturally, the misconception that cervical cancer is a feminine disease and men as sole decision makers also deters them from assessing the services.

Conclusion: The study findings suggest low involvement of sexually active young men in cervical cancer prevention despite their willingness and their important role in the disease prevention. Deliberate efforts therefore have to be put in place to involve them if the disease is to be contained. The study suggests their involvement in policy and programme formulation as well as implementation and integration of cervical cancer in youth friendly health services as some of the strategies that could be employed to increase their involvement.

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CHAPTER 1: INTRODUCTION AND STUDY OBJECTIVES

1.1 Cervical Cancer Health Burden

Cervical cancer remains a public health concern across the world especially in developing countries. It is the fourth most common cancer among women worldwide and remains one of the most important area of action in cancer control programmes worldwide [1]. In 2012, statistics shows that 528,000 new cases were diagnosed across the globe and about 70% of these were recorded in developing countries out of which 266,000 women diagnosed with the disease die annually [2]. Malawi is one of the low-income countries in Sub Saharan Africa hit hard by the disease due to its high incidence and mortality rates. The country is ranked second on the world ranking on cervical cancer incidence rate and first in Eastern African region. It registers about 3,684 incidences of cervical cancer annually out of which 2,314 die representing one of the highest incident rates in the region [1]. This is despite the fact that the disease is preventable in its early stages of diagnosis.

1.2 Causes of Cervical Cancer

Cervical cancer is highly associated with the Human Papillomavirus (HPV) which is the major cause of cervical cancer and other cancers. HPV infection is one of the most common sexually transmitted infection (STI) worldwide, and the majority of sexually active individuals, both males and females, acquire it at some point of their lives [2]. The virus is spread through sexual intercourse and globally, its external genital prevalence is higher in males than cervical infections in females though its persistence in the former is unlikely [1]. HPV is responsible for 99.7% of cervical cancer and about 530,000 new cases globally every year.

HPV is also highly associated with HIV and AIDS. Both HIV infection and HPV infection are sexual transmitted disease and they often are found together [1]. Studies shows that women

living with HIV are more likely to develop persistent HPV infections at an earlier age and to develop cancer sooner [3]. The 2016 Malawi Cervical Cancer Control Programme annual report for instance, recorded more HIV positive women tested VIA positive at 6.8% against 3.3% for HIV negative women [4]. Another study in Rwanda among HIV infected and unaffected women also showed higher HPV prevalence among HIV-positive women in all age groups at 69% for HPV type, 46% for a carcinogenic HPV type, and 10% for HPV-16 than among HIV negative women [5]. The increased susceptibility to HPV infection leads to among others: a greater risk of pre-cancer and cancer at younger ages, which increases with the degree of immunosuppression; an increased risk of developing invasive disease up to 10 years earlier than in women not infected with HIV; and more frequent presentation with advanced disease with smaller chance of survival for five years [3].

High parity rate which is high in most African countries including Malawi, is another recognised HPV-related co-factor for the development of cervical cancer [6]. In Malawi, the current wanted fertility rate within the age group of 15 to 49 years is at 3.4 children against the actual total fertility rate of 4.4 children which indicates that on average women in Malawi have one more child than they have wanted. Furthermore, women in Malawi are more likely to have more children than men which according to DHS data is at 49% of women against 43% for men. This is also exacerbated by early marriages which is common in the country. According to DHS data, the current mean age at first marriage for females is at 18.2 as compared to 23.0 for men [7]. Early marriages also contribute to high parity and early age at first sexual intercourses among the adolescent which are also some of the risk factors for cervical cancer and other related diseases.

Besides, HPV causing cancer, there is also growing evidence that HVP is a causality factor for other anogenital cancers such as penile, anal, vulva and other cancers of the neck and head [1] [8] which are also on the rise and affect males more than females. For instance, a study conducted in the UK on "Attitude towards and knowledge about HPV and the HPV vaccination in parents of teen age boys in UK" quoting Denny L, indicates that neck cancer which is attributed to HPV 16 and 18 in Europe is five folds higher in men than women, thus 12,707 versus 2,531 respectively new recorded cases yearly [9]. In addition, though the prevalence rate for these cancers are low compared to cervical cancer globally, their strong association with HPV makes them important as HPV also causes cervical cancer which is on the rise worldwide. Research also suggests that HPV could as well be preventable using the same strategies as that of cervical cancer with young men at the centre of high risk behaviours that leads to HPV transmission [1].

1.3 Cervical Cancer Programming in Malawi

Following World Health Organization's (WHO) recommendations for cervical cancer control in resource poor countries, Malawi through its Ministry of Health-Reproductive Health Directorate (MoH-RHD) adopted a cost-effective strategy for cervical cancer prevention and control. The Ministry introduced a Cervical Cancer Control Programme (CECAP) which started cervical cancer screening program using Visual Inspection with Acetic acid (VIA) and cryotherapy in 2004 after a pilot phase between 1999 and 2001 by Project Hope in selected health facilities in Blantyre and Mulanje districts. Since then, the program has scaled up to all districts and central hospitals in the country [10] . According to Ministry of Health statistics, by 2011 Malawi had a total of 81 health facilities providing cervical cancer services (50 VIA only, 29 VIA and cryotherapy and 2 VIA, cryotherapy, loop electrosurgical excision procedure (LEEP) and major surgery) through which a total of 59,217 women have been screened of

which 5,744 were VIA positive [11]. Despite this progress, the country still registers low usage of the screening services [12] which is an indication that there could be more cases which go un recorded.

According to Malawi National Cervical Cancer Strategy of 2016, the recommended screening age is 30 to 49 years [13]. However, there have been studies which have reported cases of cervical cancer outside this age band which collarets to more cases going unreported. A study by Ministry of Health in 2011, for instance, indicated that 12% of the women diagnosed with cervical cancers were aged between 20 and 29 years and 32% were older than 50 years which suggest that about 44% of women are left out from screening programmes [11]. A draft report by the Malawi National Cervical Cancer Control Programme also collarets with this. The report indicates that 5% (504) of those screened during other hospital visits (10,114) with VIA positive results were women aged less than 25 and 0.4% (36) registered suspected cancer [4]. In addition, a study by Msyamboza also indicates that out of a total of 145,015 women who were screened 7,349 (5.1 %) and 6,289 (4.3 %) were VIA positive and suspected cancer respectively out of which 28.1 % of the diagnosis was in women aged 29 or less [11]. Though not age specific, this age range may include young women which further indicate that there are cases of cervical cancer among this age group. All this call for age tailored preventive interventions which targets these age ranges together with their male counterparts who could be carriers of HPV.

1.4 Cervical Cancer Prevention Efforts in Malawi

Cervical cancer is preventable if diagnosed in its early stages. Research has shown that the disease can largely be prevented through screening and HPV vaccine [1] in addition to other protective sexual reproductive health related behaviours which reduces chances of contracting

HPV. However, most interventions of the disease targets females than their male counterparts whose involvement have also not been adequately documented [14].

The National Cervical Cancer Strategy also include male circumcision and use of condoms as some of the strategies for cervical cancer prevention. Malawi introduced Voluntary Medical Male Circumcision (VMMC) program in the late 2011 and was formally launched in 2012 along with the national VMMC policy. Although VMMC is identified as a priority HIV prevention intervention in key HIV policy documents such as the National Strategic Plan for HIV and AIDS (2015–2020) [15], it is also regarded as one of the protective strategy for cervical cancer [10]. However, recent data from DHS 2015/16 shows that 70.7% of young men aged between 15 to 24 have not been circumcised yet [7], a practise that still leaves women at risk of HPV transmission which could later develop into cervical cancer. In Malawi, condom use is also low among females and males, thus 27% and 30% respectively for those that have more than one partners [7]. This practise puts both sexes at risk of contracting HPV among other STIs including HIV. Furthermore, some studies have reported use of violence for not using condoms by male partners which further predisposes girls for STIs which include HPV [16].

Another prevention strategy which has been introduced is the HPV vaccine. However, not much progress has been registered in Malawi [1]. Preliminary research findings on HPV vaccination in Malawi suggest the vaccine as one of the strategies in cancer prevention efforts [17]. The vaccine however has only been recommended for girls aged between 9 to 13 [18] [13] leaving out the boys who could also be symptomatic carriers on HPV. This is not only the case in Malawi as it is the same in many countries including in the UK where the National Health Service (NHS) has introduced free HPV vaccination for girls aged 12 to 13 and not boys

who can only access the vaccine through private means [9]. The rationale behind this is that vaccinated girls will provide herd immunity to boys. However, this leaves out young men who have sex with girls who have not been vaccinated or those having sex with older women and those that are bi-sexual.

1.5 Gender and Cervical Cancer

Cervical cancer like many STIs wears a gender lens. Gender differences exist in its epidemiology, etiology, diagnosis, screening, treatment as well as its consequences on both the patient as an individual and people surrounding them. Gender refers to sociocultural concepts of femininity and masculinity, which can vary between cultures [19]. The society perceives women and men having different gender roles which determines their way of live. Besides their biological differences related to the reproductive roles of men and women, the differences also occur because women have less power over sexual activities than men. According to Littlefield, gender roles refer to beliefs regarding division of specific tasks and differences in behaviour, ability and personalities that society expects from men and women. Traditional gender roles suggest that men hold masculine attributes such as independence, perseverance, confidence and decisiveness while women as holding feminine characteristics such as warmth, understanding, sensitivity to others' needs, and awareness of feelings [20].

Studies have revealed several gender related risk factors to contracting HPV and promote the oncogenic effect of the virus. These factors that are mostly perpetuated be men due to their masculinities include early exposure to sexual intercourse, multiple sexual partners and non-use of condoms when having sex intercourse [1]. These high risk factors not only lead to high risk of cervical cancer but also HIV and AIDS which in Malawi is currently at 4.9% and 1% among young women and men aged 15 to 24 respectively [7]. Literature shows that it is mostly boys

who initiates early sexual activity and determines how to have it (use condom or not) which puts both sexes at risk of contracting STIs more especially girls who lacks negotiating power for safe sex [21]. According to data from HPV information centre, 22.2% of boys against 12.8% for girls aged 15 have been engaged in sexual intercourse [1]. DHS 2015-16 data also indicate more young men engaging in sexual activities with multiple partners with a mean number of sexual partners at 3.9 against that of female of 1.9. [7]. All this indicate more boys (15 to 24) practising sexual behaviours that may put girls more at risk of contracting HPV and other STIs which are associated with cervical cancer.

In Malawi, the power imbalances between men and women make men more superior than women which extends to decision making in the home including those pertaining to their spouse's sexuality. For instance, research shows that, in most African countries, for women to go for cervical cancer screening or any other sexual reproductive health services, they need to get permission from their male spouses [22]. A practise that either denies them from accessing the services or delays them in accessing the services which in return increases the disease burden on health. Emerging literature also suggests that violence against women and girls (VAWG) particularly sexual violence increases the risk of acquiring STIs including those associated with cervical cancer [23].. According to WHO, VAWG is defined as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life'' [24].

1.6 Problem statement and justification of the study

Malawi as many other countries adopted WHO's recommendation to involve men in all health programmes including cervical cancer after realising their important role in public health [25].

WHO further recommends for outreach strategies that not only reach out and engage young girls and women as direct beneficiaries of cervical cancer preventing efforts, but also reaching out to boys and men as some of the key stakeholders in the fights against the disease [3]. A number of studies on male involvement in cervical cancer have also recommended for different strategies for different subgroups in order to tackle HPV infection [21] [22]. True to this, the National Sexual Reproductive Health Policy recognises the need for involvement of men in cervical cancer prevention efforts [26]. However, despite all these efforts the majority of men are still lagging behind [22] and young people are generally underserved. Conversely, the major focus of most studies done in this area has been on married men leaving out the young men who are mostly involved in sexual behaviours that perpetuate the disease [13].

This therefore calls for early engagements of young men who are not only symptomatic carriers of HPV but also interested party in HPV infections. In addition, it is the belief of the researcher that if men are reached at an early stage, they would be able to make informed decisions about their lives and that of their spouses hence effectively contributing to the reduction of the disease burden in public health. It is therefore for this reason this study was proposed to assess the involvement of men in cervical cancer preventive efforts particularly the forgotten group of sexually active young men of 15 to 24 years of age. The findings will inform cervical cancer prevention programming in Malawi and beyond.

1.7 Conceptual Framework

This study was based on the Health Belief Model (HBM) conceptual framework as illustrated in figure 1 below. The model suggests that individuals weigh the potential benefits of the recommended action against the psychological, physical and financial costs of the action which they have to take. Using this model, the involvement of sexually active young men in cervical

cancer preventive efforts can be explored within the six domains of the model, thus, perceived susceptibility, perceived seriousness, perceived benefits, perceived barriers, perceived threats and cues to action [27]. According to Rosentock, the combination of perceived susceptibility and seriousness provides motivation for action [28]. The comparison of perceived benefits to perceived barriers provides the pathway to action. Thus, the stronger the perceptions of seriousness, susceptibility and benefits, the weaker the perception of barriers and the greater the likelihood of engaging in a health promotion behavior. The findings of the study therefore are expected to contribute to building young men's self-efficacy to actively participate in cervical cancer preventing efforts with the view to lessen the burden it currently has on health outcomes.

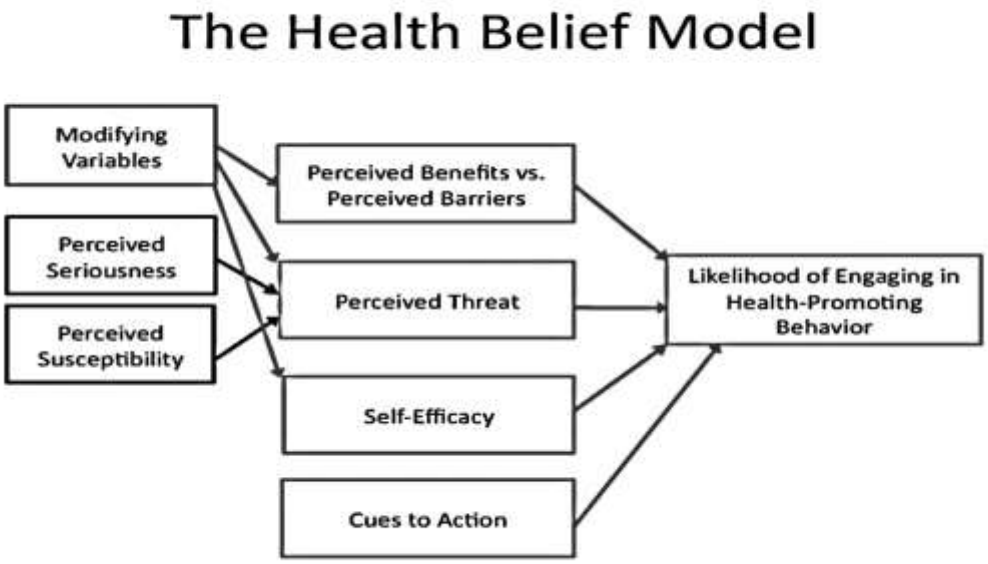

Figure 1: Health Belief Model

1.8 Objectives of the study

Broad Objective: To assess the involvement of sexually active young men in cervical cancer preventive efforts in Lilongwe Urban

Specific Objectives

1. To explore determinants of the involvement[1] of young men aged between 15 and 24 in cervical cancer preventive efforts in Lilongwe urban
2. To identify facilitators and barriers to sexually active young men involvement in cervical cancer prevention efforts in Lilongwe urban
3. To suggest strategies on how best sexually active young men could be involved in cervical cancer programming in Malawi

[1] Sexually active young men involvement in this study is an outcome variable referred to as "men role". The involvement in this case could be change of sexual behaviours that promote the spread of HPV, going for circumcision and support decision making for their female counterparts in cervical cancer prevention.

Chapter II: LITERATURE REVIEW

2.1 Introduction

This session outlines a search of the literature related to sexually active young men involvement in cervical cancer prevention efforts. A systematic review approach was used to get relevant articles for the review. The researcher used PubMed, Google Scholar, Research gate, MEDLINE and Research4life literature search engines to get articles. The key words used to guide the literature review search were; gender, cervical cancer, cervical cancer programming, sexually active young men, adolescent boys, cervical cancer prevention, male involvement, barriers and facilitators. A total of 139 articles were screened and assessed. All articles without key words in the abstract, those written before 2009, those not in English language and duplicates were excluded. Out of these, 20 full articles which provided relevant information on the subject matter were included as presented in figure 2 below.

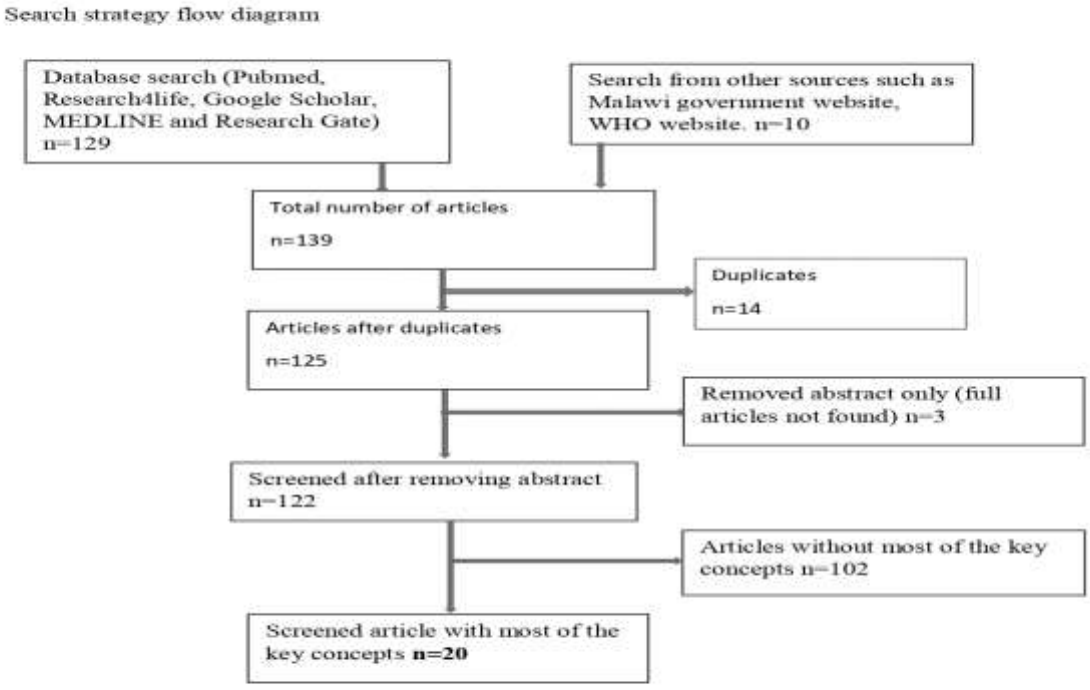

Figure 2: Search Strategy flow diagram

2.2 Men as Decision Makers in Cervical Cancer Preventive Efforts

Generally, literature reveals low involvement of men in cervical cancer prevention efforts regardless of the potential the strategy have on reducing the disease burden [29] [30]. Furthermore, the few studies done mostly targeted adult married men (above 24 years of age) and not the sexually active young men who are at the helm of risky behaviours that promote the disease. This is also contrary to the African context where most decisions including those on health care are made by men [31], the situation which makes women assess to cervical screening services difficult. Furthermore, leaving the young men who are, in the near future, expected to be making such important decisions may also be a recipe for a vicious cycle of the disease burden in future. In a study by Mthepheya on "Knowledge and Practices of Cervical Cancer among Married Men in Rural Phalombe", 71.7% of the men interviewed acknowledged that decisions for women to access screening services or not, lies with them in as much as they are not fully involved [22].

The low involvement of men has conversely contributed to low uptake of cervical cancer services globally. For instance, in the same study by Mthepheya, when asked what men would do if their spouse was found cervical cancer positive, 1.5% of men interviewed indicated that they would go for divorce, 67.9% said they would be sad about the results and only 30.6% pledged their support to their spouses [22]. This situation is likely to put women at a fix whether to go for screening or not as they are not sure how their spouse would react if found positive. A similar study in Kenya on "Men's knowledge and attitudes about cervical cancer screening", also found similar results i.e. 1.8% of the respondents saying they would let go of the married and 2.7% expressed concerns about treatment costs which they felt would be expensive and 20.9% expressed negative emotions [32]. In a study which aimed at analysing the role of several social and cultural factors in relation to early detection of cervical cancer in

Mexico, it was also reported that women feared to be abandoned by the partners when diagnosed with cervical cancer [33]. The negative emotions and sentiments in this case could easily lead to emotional violence to the patient and other people involved which in the long run would make women not to go for screening services for fear of being judged.

Culture also plays avital role in determining health seeking behaviours including cervical cancer screening. A study in State of Micronesia which aimed at understanding cervical cancer prevention and screening in Chuukese women, noted that culturally women showing their genitals to anyone apart from their husband is a taboo and a sign of disrespect to their husbands. Some husbands also do not allow their spouses to go for screening for fear of doctors to see their wives' nudity [34]. Similarly, another study in Kenya by Lunsford et al on "Environmental and Psychosocial Barriers to and benefits of Cervical Cancer Screening" found that men usually do not allow their spouses going for screening for fear of another man seeing their wives body. Conversely, the study also reported that in some cases it is the doctors themselves who refuse to test women without their husband's consent. For the women who sneak out without husbands approval risk to loss their marriages as the act could be perceived as being deceptive and "disobedient" [35]. All this, limits women cervical cancer screening uptake which if men get involved at an earlier stage will find it easier to allow their spouses and daughters to go for screening services.

A study by Nyambe et al which aimed at addressing the question, what is the relationship between knowledge about cervical cancer, attitudes, self-reported behaviour, and immediate support system, towards screening and vaccination of cervical cancer of Zambian women and men, found a strong association between respondents awareness of cervical cancer and support provided by partners of the respondents thus, allowing them to go for screening [36]. Targeting

young sexually active men in this case would prepare them to make informed decisions in support of their partners now and in future. Knowledge of causes and prevention of cervical cancer among both men and women of all ages is therefore important in combating the disease.

Other studies have also suggested interpersonal interactions between men and women as having great impact on practicing prevention behaviours including making decisions on vaccination of daughters for HPV. The same study by Nyambe *et al*, for instance, found that the majority of the population that is aware of cervical cancer and its prevention services will vaccinate their children regardless of sex if given a chance in the future [36]. A study in Bangalore in India on HPV vaccine acceptance among young male patients seeking care in some health facilities (ART clinic and general dermatology) 68% and 42% of the young men with knowledge on vaccine safety and side effects respectively are likely to accept the vaccination. Ninety three percent (93%) were also in favour of vaccinating their own children [37]. The study findings show the power of knowledge to self-vaccination as well as decisions to vaccinate others. For the young men, this could also have both short- and long-term effects on vaccinating themselves and in the long-term making decisions to vaccinate their daughters which would ultimately help reduce the disease prevalence in the near future.

2.3 Gender Related Risk Factors

Some studies also noted that gender roles and women overall subordinate position in families and societies impacts on women ability to access cervical cancer screening services. For instance, a descriptive qualitative study which aimed at investigating men's perception and specific views about women's cervical cancer in Korea, men expressed dis-interest in knowing about women health including cervical cancer. The men indicated that the disease is for women and some wondered why they should be involved. The study considered age dispersion of men in the sample selection thus 20 to 58 under the assumption that generational differences might

reflect Korean men's awareness of their participants [30]. This shows the power of patriarchy which needs to be deconstructed if the disease is to be contained. Women access to health services largely depends on men who if are aware of the disease impact on their families they would easily support women decision to access health services including that of cervical cancer. The awareness of HPV as a virus that also cause other cancers in males may also be a motivation factor for men to get involved in the disease prevention efforts. A study among young men in India for instance found that 89% of the respondents reporting self-protection from other cancers caused by HPV as a motivating factor to the vaccine [37]. Much as this could be seen as benefiting the men themselves, it may still help in reducing the disease burden in their female counterparts as they will both be protected from the virus it may still help in reducing the disease burden in their female counterpart as they will both be protected from the virus.

A study by Nguyen on "Gender Roles and Acculturation: Relationships with Cancer Screening Among Vietnamese American Women" also found that traditional masculine gender roles as being positively associated with cancer screening variables unlike the traditional feminine gender roles [38]. The study findings support the need for male involvement in cervical cancer prevention efforts through which women would also be empowered to embrace masculine characters which would help them improve their health seeking behaviours without being dependent on men.

Burden of care work for women have also been noted as some of the barriers for women access to screening services. A study in Mulanje, Malawi, which aimed at getting a better understanding of the complex barriers that prevent women from getting early cervical cancer screening, for instance, cited time factor coupled with child care burden as one of the

determining factors for women to go for screening services. The research team also observed children of varying ages with almost every woman of childbearing age which suggests that this experience was not unique among most women [39]. The burden of care work emanates from the socialisation processes which suggests gender as one of the factors to be considered in cervical cancer programming. Early stages of human development in this case are very crucial in the socialisation processes and determines the characters of adulthood [40]. In which case when boys and young men are sensitised in their early years, they would easily support their spouses when they grow up.

Some studies have also suggested cervical cancer being highly associated with VAWG especially sexual violence which perpetuates transmission of HPV. Some forms of VAWG that perpetuate the disease include girls exposed to sexual abuse which increase the risk of substance abuse, child pregnancies and subsequent sexual risk behaviours which increases chances of acquiring HPV [41]. A study by Coker on "Intimate Partner Violence (IPV) and Women's Cancer Quality of Life" found the positive relationship between IPV and cancer in most women including cervical cancer. Amongst the interviewed subjects, 37.3% of the participants disclosed experiences consistent with lifetime IPV: 33.6% scored as ever experiencing psychological IPV, 24.5% as physical IPV and 10.6% as sexual IPV. The study further found that that the adjusted prevalence rates of IPV were significantly higher among the 354 women who had also experienced childhood sexual abuse (17.7%) compared with the 2924 never experiencing childhood sexual abuse (7.3%). The study was aimed at determining the role of intimate partner violence, by timing and form, on cancer related quality of life as defined by how well women function within 12 to 18 months following diagnosis using the completed sample of 3,278 women recently diagnosed with cancer [42].

2.4 Cervical Cancer Prevention Efforts

Malawi just as many African countries have adopted a number of strategies to prevent cervical cancer incidence rate, however most prevention efforts target female than male except for male circumcision which have also been rolled out in the country. The HPV vaccine for instance only targets girls and not boys. Studies however have shown that when vaccinated, participants consider themselves to be more aware of the disease and less likely to engage in risky behaviour that may result in acquiring the disease than their peers who have not been vaccinated. In a qualitative study in Sweden by Oscarsson *et al* on "Attitude of cervical cancer screening and sexual behaviour among HPV vaccinated young women", for instance the study participants considered themselves less likely to engage in risk behaviours to contracting HPV than their peers [43]. In which case boys in Malawi are left out and are unlikely to be aware of the disease hence indulge in risky sexual behaviours which increases the risk to acquiring HPV which could be passed on to their female counterpart. Similarly, the current cervical cancer screening programme also target women only leaving out the men who are the most decision makers in the homes.

Furthermore, studies elsewhere have also shown that there is generally low level of knowledge on HPV as a cause for cervical cancer and other cancers which also affect uptake of HPV vaccine. A study in Germany on HPV awareness, knowledge and vaccine acceptance among students (both males and females) of 18 to 25 years of age, for instance, found that 95% of the women and 80% of the men were aware of the vaccine against cervical cancer but only half of the women and 25% of the men had heard of HPV. Furthermore, only 51% of the women and 42% of the men thought that only women can be infected with HPV and the majority did not know that HPV is sexually transmitted [44]. Such knowledge gaps on both the HPV and HPV vaccine including misinformation of HPV infections could somehow explain the low male

involvement in cervical cancer programming which have a huge stake on the disease prevention strategies.

Mthepheya study also reported VMMC programme as one of the opportunity windows to reach out to men with reproductive health information including that of cervical cancer. It is reported that the men who go through this process are counselled on the benefits of the procedure including prevention of cervical cancer. However, it seems, the information given during VMMC concerning cervical cancer is inadequate and that very few males (about 29% of the young men) have undergone the procedure at present meaning that most of them have not had the opportunity yet to access the information through the programme [22].Therefore, there is need for more information on the benefits, especially on prevention of cervical cancer considering that there is a clear relationship between VMMC and cervical cancer.

2.5 Male Involvement in Sexual Reproductive Health

Generally, literature show low involvement of men in sexual reproductive health care despite the call for male involvement in health care services. Though not much has been documented on male involvement in cervical cancer, the strategies have worked in other health related issues which also suggest benefits in cervical cancer programming. For instance, a study by Ditekemena et al which aimed at identifying determinants of male partners' involvement in Mother to Child Transmission activities, focusing specifically on HIV Prevention of Maternal to Child Transmission (PMTCT) in sub-Saharan Africa found that male involvement in child bearing decision positively impact on acceptability of PMTCT interventions. Firstly, when men are well-informed, they are more likely to participate positively in the decision making for the well-being of the family. Secondly, women with supportive partners will be more motivated to undergo HIV testing, to return for the HIV test result and to disclose the HIV result to their

partner. Thirdly, well-informed couples are more likely to adopt a low risk sexual behaviour and increase mutual support, regardless of the test result [45].

However, in addition to cultural barriers to male involvement in sexual reproductive health services in Malawi such as male masculinities and lack of knowledge on the impact of the disease as discussed above, literature has also documented structural barriers which may need to be addressed to ensure their full involvement. First and far most as noted by Maseko at el, the country does not have a stand-alone policy on cervical cancer which does not reflect the importance of the disease in the country despite its huge health burden on the country. The disease is covered under the SRHR policy and fails short of its conclusive coverage [46]. The same author with others in his article on "Health systems challenges in cervical cancer prevention program in Malawi", noted that only few health facilities offer cervical cancer services. Out of the 21 health facilities included in the study only 7 provided both screening and treatment of cervical cancer and patients were reported to be referred from those facilities with no treatment equipment to the districts or central hospitals when they have been diagnosed with cervical cancer. Furthermore, only one health facility was open throughout the week and six opened from Mondays to Fridays for cervical cancer screening while the rest opened once a week for cervical cancer screening while eight opened twice [47]. These barriers, apart from barring women from accessing the services they are also likely to deter men from getting involved. Lack of service provision in some facilities would also entail difficulties in access information on the same for both women and men including young men who could be carriers of HPV.

Cervical cancer screening is key for secondary prevention of the disease, thus detection of grade 2 or 3 which are considered to be true precancerous lesion. Understanding the barrier

that hinders women from screening services and treatment is therefore essential to national health systems in the country [48]. However, it is apparent that for the women to do this they would need support from their male counterparts including young sexually active young men who are not only carriers of HPV but also future decision makers. Their active involvement in both the design and implementation of cervical cancer prevention strategies is thus of paramount importance for effective cervical cancer control programs that can attract more women (both old and young) for screening and treatment. This would also not only help reduce cervical cancer burden but also other cancers that affect both males and female.

Chapter III: METHODOLOGY

Research methodology is a technique used to identify, select, process and analyze information about a topic [49]. It is the plan that guides the researcher. It involves a research design, sampling methods, data collection methods and analysis, as well as ethical considerations. The study employed HBM as conceptual framework. The study participants were assessed according to their perceived susceptibility and seriousness to the problem and their perceived benefits and barriers to cervical cancer prevention efforts.

3.1 Type of Research study

This is a mixed methods study which employed both qualitative and quantitative methods of data collection and analysis. The approach was chosen because it describes the situation as it exists. It allows one to discover new meaning, describing what exist and determining the frequency with which something occurs [50]. In this study both outcomes and exposures do not follow temporal sequence and participants were chosen based on the inclusion and exclusion criteria as set by the study. Furthermore, the design is relatively faster and inexpensive [51], which made it easier for the researcher to conduct the study within the specified time frame with minimal costs.

3.2 Study Place

The study was conducted in Lilongwe urban targeting Bwaila and Kawale health facility catchment areas. These two health facilities were chosen because of their robust youth friendly health services, which made it easier for the researcher to recruit the study participants.

3.3 Study population:

Study population corresponds to the entire set of subjects whose characteristics are of interest to the researcher [52]. In this study, the study population were sexually active young men aged 15 to 24 in Lilongwe urban.

3.4 Study period

The study was conducted for a period of 18 months. Thus, from August 2018 to August 2019. This involved preparation of the proposal, submission and approval, training of research assistants, pretesting (of the questionnaire), data collection, data analysis, report preparation, and dissemination of the findings.

3.5 Sample size

Sampling is referred to as the process through which individuals or sampling units are selected from the sampling frame [52]. In this study, both probability and nonprobability sampling techniques were used in identifying study participants. Purposive sampling technique was used for the key informants and simple random sampling for the young men patronising youth friendly health centres at Bwaila and Kawale health facilities. A sample size of 196 study participants was interviewed using sample calculation below [53].

$$n = Z_{1-\alpha/2}^2 P(1-P)/d^2$$

where:

$Z_{1-\alpha/2}^2$ is standard normal variate at 5% type 1 error ($P<0.05$) which is 1.96

P is expected proportion of sexually active young men aged 15 to 24 based on previous studies on the same age group of young men of 15%

D is absolute error or precision set at 0.05

For the key informant interviews, 10 health workers and experts in cervical cancer were interviewed before reaching a saturation point. Saturation point is when the respondents begin to give all most the same responses to the questions being asked [54].

3.6 Data Collection

3.6.1 Study Preparation

Before the actual data collection, authorisation was sought from Lilongwe DHO and respective heads of health facilities for Kawale and Bwaila. Then the questionnaire was piloted at Bwaila health facility from which no changes were depicted. Recruitment of two assistant researchers was also done to help with data collection and entry. The two were briefed about the study and trained in data collection and management accordingly.

3.6.2 Enrolment of Study Participants

Study participants were randomly selected using Excel RAND command. A list of sexually active young men within the age bracket of 15 to 24 was obtained from the two health facilities youth friendly corners. The names were assigned numbers which were used in the excel sheet to pick on the study participants. Before asking questions, the researcher explained the consent form in either Chewa or English depending on one's preference. For the subjects under 18 years of age the assent form was read out to them after getting the permission from their parents or guardians. This meant following up the study subjects to their homes to get the parental consent. Once consent was obtained, the subjects and/or the parents signed the forms. Both the consent and assent forms described the objectives of the study, the procedures undertaken, the risk and benefits of participating in the study and clearly stated that participation in the study was entirely voluntary. This process took an average of 15 minutes per individual.

3.6.3 Data collection

The study used semi structured questionnaire with both open and closed questions to collect data from the study participants (refer appendices 1 and 2 for English and Chewa version of the questionnaire). Some of the closed questions were followed with further probing questions to get the in depth understanding of the responses. The open-ended questions further helped to explore participant's level of involvement and barriers in cervical cancer preventive efforts while the closed questions mainly explored determinants for their involvement. The findings at this level were complemented by key informant interviews with relevant stakeholders which included health workers at both Kawale and Bwaila health facilities, experts at Family Planning Association of Malawi (FPAM) and MoH RHD. Interviews with key informants also helped in getting information on how the young men have been involved and recommendations on how best they could be involved in preventing efforts of the disease. A checklist was used to get this data (appendix 3).

3.7 Data Management and analysis

To conceal the names of respondents, codes were used and data collected were kept in a lockable drawer which was only accessed by the researcher. Excel data base with a password was used to keep electronic data. Quantitative and qualitative data were analysed separately using STATA software version 14 and NVivo version 7.4 respectively. The former was used to analyse data on the determinants of sexually active young men involvement under objective 1 of the study. Statistical significance tests at 95% confidence interval and a p-value of 0.05 was used to determine the association of the outcome variable, thus, young men involvement [prescribed as men's role] and the response variables as described in the results section below. Qualitative data on the other hand was obtained from the study subjects and key informants in respond to objectives 2 of the study which is on the facilitators and barriers to sexually active

young men involvement in cervical cancer prevention. Proposed strategies for their involvement were also determined using the qualitative data analysis responding to objective 3.

For the quantitative data, descriptive statistics was first conducted on frequencies for the key demographic variables of the study subjects such as age, education levels, employment status and circumcision. This was done to check whether there is correlation between the variables with their responses to questions on facilitators and barriers to sexually active young men involvement in cervical cancer preventive efforts. The data was then run through the normality test using skewness and kurtosis test. This was done to determine whether the data was normally distributed or not which further informed the data analysis tests for the study. After running this test, skewness p-value was 0.0000 and kurtosis p-value was 0.0000 and thus the data showed that it was not normally distributed, as such nonparametric tests such as chi-square was used in the analysis.

To determine the association between the outcome variable and response variables, chi-square test was used. After running the data through this test, those that were found to be associated were further run through the bivariate analysis to determine their significance level of association on each other. Only those variables found to be associated with young men role in the bivariate analysis were fitted into a logistic model to find variables that have strong association with the outcome variable. Multiple regression technique was used to come to the final significance model. The process fitted 3 models, dropping one variable at each level.

For the qualitative data, thematic analysis method was found to be most appropriate for the study. According to Savin-Baden and Major, thematic analysis is a method of identifying,

analysing and describing patterns or themes for a particular data set. It enables the researcher to easily interpret complex and large data through aligning the data into themes. This involved a rigorous process of data familiarisation, data coding and themes development. All the six steps in thematic analysis were followed starting with the researcher familiarising herself with the data through reading the data again and again while noting down the initial list of ideas. Then, the generation of initial codes was done. This involved assigning the coded interesting features of the data in a systematic fashion across the entire data set while collating data relevant to each code. All the codes emerged from the data that was collected and no pre- set of themes was done. This was to avoid the information bias in analysing the data by the researcher. The coded data was then collated into potential themes. The themes were checked if they were working in relation to the coded extracts and the entire data set. The themes were then defined and named. In the process, the specific themes were refined to determine what the aspect of the data each theme captures. Lastly, the report was produced where the analysed selected extracts as they relate to the research objectives and literature review were outlined [55]. The data was transcribed into Microsoft word document which was then imported into NVivo 7.4 software for analysis.

3.8 Ethical considerations

The researcher got the approval for the study and permission from Collage of Medicine Research Ethics Committee (COMREC), (appendix 4) and Lilongwe District Health Office to carry out the study in its catchment area (appendix 5**).** To ensure confidentiality, data was removed from audio recorders after transcription and all completed questionnaires were destroyed. Given the observational nature of the study, there were limited potential risks. However, since the study involved human subjects the major risks foreseen included embarrassment and breach of privacy and confidentiality. To ensure there was no breach of

privacy, all interviews were conducted in private spaces. The two research assistants who were recruited also went through a training on how to collect the data taking into consideration of the ethical issues surround the research. Codes were also used to conceal the identity of the identified participants in data analysis.

Participation in the study was voluntary and informed consent was sort from the study participants over 18 years of age and assent from those below the age of 18 years before interviewing them. Every participant was informed of their right to refuse to participate or withdrawal from the study. All those who accepted to be interviewed signed informed consent and assent forms which were in English and Chewa (appendices 6,7,8, 9,10 and 11).

3.9 Study constraints

Being a study targeting young men, it was difficult to get most of them at the centres as planned. To address this, the researcher made prior bookings through the hospital youth officers to alert the participants about the study and data collection dates which were agreed upon. In some cases, some participants had to be followed wherever they were with the aid of the Health Surveillance Assistants. This was further exacerbated by the 2019 general election campaign activities and the post-election violence which attracted the attention of most youths in te country including some study participants. The latter also halted some activities including mobility and accessibility of some places including the study sites. This to a greater extent contributed to the unexpected delays in completion of the study than was planned.

Chapter IV: STUDY RESULTS

4.1 Introduction

This chapter presents findings of the study from the 196 study subjects interviewed and 10 key informant interviews conducted. The first part presents basic characteristics of study participants and findings from quantitative data analysis. The characteristics of the study participants are explored to lay the foundation for further analysis. The section also looks at the statistical associations between the outcome variables and response variables and then the amongst the response variables themselves. The second part presents the analysis of the qualitative findings responding to objective 2 and 3 of the study. The findings have been discussed according to the themes that emerged in reflection to the research objectives. The study was carried out to assess the involvement of sexually young men in cervical cancer preventive efforts in Lilongwe Urban.

4.2 Analysis of the quantitative data

Table 1: Basic Characteristics of the study subjects

Age category	**n**	**Percent**	
15-19	92	47	196
20-24	104	53	196
Marital status			
not married	195	99	196
married	1	1	196
Level of Education			
no formal education	3	2	196
primary education	11	6	196

secondary level	106	54	196
tertiary level	76	39	196
Employment status			
employed	2	1	196
not employed	194	99	196
Have children			
yes	2	1	196
no	194	99	196
Society			
patrilineal	118	60	196
matrilineal	78	40	196
Circumcision			196
circumcised	112	57.14	196
Not circumcised	84	42.86	196

From table 1 above, 53% of the study subjects were aged 20 to 24 years of age and only 1 participant was married and 1 had children. In term of education level, more than 50% of the study population were in secondary school and above. The table further indicates that all most 60% of the study participants were from the patrilineal society (the family relationships by line of descent from a person male ancestor). For circumcision, almost 60% had been circumcised by the time the study was undertaken.

4.2.1 Associations between explanatory variable and response variable

The study outcome variable was young men involvement in cervical cancer preventive efforts and the rest were the explanatory variables. Table below shows the association between the outcome variable and the response variables after running chi-square tests.

Table 2: Summary results of the association between the involvement of sexually active young men in cervical cancer prevention effort and its response variables using Chi-square

VARIABLE[2]	n	CHI-SQUARE VALUES	Df	P-value
Partner Risk	196	152.96	16	0
Age	196	37.43	36	0.403
Marital Status	196	0.56	4	0.968
Have children	196	4.27	4	0.371
Level of Edu	196	23.81	12	0.02
Employment status	196	4.95	4	0.292
Tribe	196	17.65	20	0.611
Society	196	2.82	4	0.588
Region	196	6.59	8	0.581
Circumcised	196	24.53	4	0
Know HPV	196	13.68	4	0.008
Know HPV Transmission	196	2.16	4	0.707

[2] The variables referred here are the response variables which have been analysed against the outcome valuable (men role)

Know CC	196	3.82	4	0.496
Knowledge of cause of CC	196	16.23	4	0.003
HPV causes CC	196	8.62	4	0.071
HPV causes other cancers	196	9.39	4	0.052
CC preventable	196	5.8	4	0.214
Screening tests	196	7.41	8	0.493
Source of Information	196	16.2	20	0.704
Spouse screening	196	11.36	8	0.182
Perceived Risk	196	18.26	16	0.308
CC affected	196	6.76	4	0.149
Efforts	196	4.45	4	0.348

The results in table 2 shows the association between sexually active young men involvement in cervical cancer prevention with the following response variables: Partner Risk[3] (χ^2=152.96 p-value=0.000), Level of Education (χ^2=23.81, P-value=0.02), Circumcision (χ^2=24.53, P-value=0.000), Knowledge of HPV (χ^2=13.68, P-value=0.008), and Knowledge of cause of cervical cancer (χ^2=16.23, P-value=0.003). The remaining variables have a P-value of greater than or equal to 0.05 hence do not show any associations with young men involvement.

Further analysis of the data collected showed that amongst those circumcised (about 60%), about 78% strongly agreed that young men have a role in cervical cancer preventive efforts against a lower percentage of those not circumcised (46%) as illustrated in figure 3 below. Only about 3% of those circumcised and a higher percentage (about 18%) strongly disagreed on young men involvement in cervical cancer preventive efforts.

[3] Partner's risk refers to willingness of the respondent to change his behaviour based on the risks it poses on his partner. In this case the risk involves acquiring HPV which causes cervical cancer

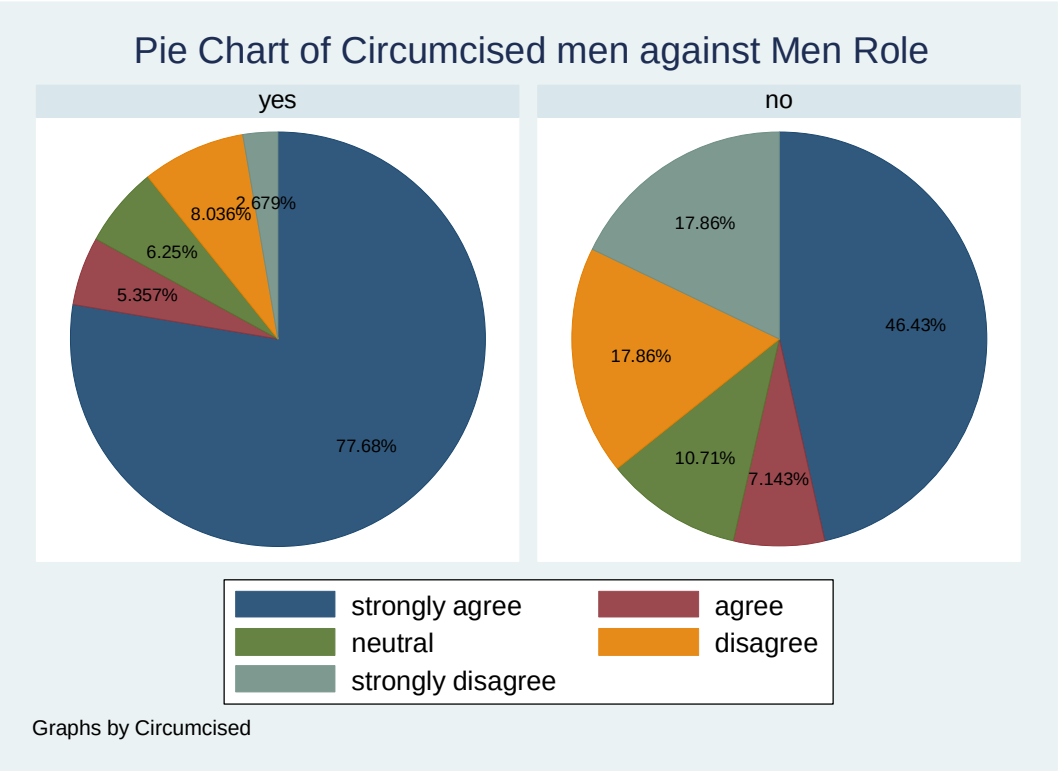

Figure 3: Circumcised and men's role

4.2.2 Associations between explanatory variables

Table 3: Summary results of the association between the response variables using Chi-Square test[4]

VARIABLES	CHI SQUARE VALUE	P-VALUE	Df
Partner Risk			
Level of education	18.78	0.094	12
Circumcised	17.45	0.002	4
Knowledge of HPV	16.88	0.002	4
Knowledge of cause of HPV	19.28	0.001	4

[4]These response variables showed an association with the outcome variable (P value of less than 0.05)

Level of Education			
Circumcised	3.10	0.377	3
Knowledge of HPV	1.56	0.668	3
Knowledge of Cause of HPV	9.28	0.026	3
Circumcised			
Knowledge of HPV	1.6	0.202	1
Knowledge of Cause of CC	1.2	0.256	1
Knowledge of HPV			
Knowledge of Cause of CC	6.68	0.010	1

The results in table 3 above suggests that partner risk is closely related with circumcision (χ^2=17.45 P-value=0.002), Knowledge of cervical cancer (χ^2=16.88 P-value = 0.002) and Knowledge of Cause of cervical cancer (χ^2 = 19.28 P-value = 0.001). Level of education is related with Knowledge of cause of cervical cancer (χ^2 = 9.28 P-value = 0.026) and Knowledge of HPV is related with Knowledge of cause of cervical cancer (χ^2= 6.68, P-value=0.010).

The study findings further show a higher percentage of respondents that strongly agreed that their partner was at risk (70.54%) were also circumcised, seconded by those that agreed at 15.18%, then those that were neutral about their partner's risk at 8.04% then those that disagreed (4.46%) and those that strongly disagreed at 1.79%. Sixty-four percent of those that know about HPV strongly agreed that their partners were at risk and 66% of those that know the cause of cervical cancer also strongly agreed that their partners were at risk. Fifty-nine percent of those who went up to secondary level knew the cause of cervical cancer and 82% of those that knew cause of cervical cancer knew about HPV. The study further found that about

64% of the study subjects acknowledged that they have a role in cervical cancer preventive efforts if the disease has to be contained.

4.1.3 Multivariate analysis

Table 4 below shows the results from the first model and the significant (final) model of the logistic process. The values given in the tables are; the P>t-value, and coefficient of that particular variable/variable category (β).

Table 4: Modelling using the multivariate analysis

VARIABLE	**MODEL 1**	**MODEL 2**	**MODEL 3**
	P>t{β}	**P>t{β}**	**P>t{β}**
Perceived Partner Risk	0.000{0.759}	0.000{0.762}	0.000{0.739}
Education level	0.448{-0.682}	0.469{-0.078}	Dropped
Knowledge of HPV	0.528{0.107}	Dropped	Dropped
Circumcised	0.004{0.427}	0.004{0.431}	0.003{0.436}
Knowledge of causes of cervical cancer	0.067{0.293}	0.050{0.309}	0.049{0.310}

After running the third model, our Prob>F value was 0.000 and R-squared 0.547 which shows that the regression model had some explanatory power suggesting that this is a better model

for our data. From the table, the first model contained all the five explanatory variables as indicated in the table. The variables: Knowledge of HPV (P-value=0.528) and Level of Education (P-value=0.469) were dropped from models 1and 2 respectively, since they all had P-values greater than 0.05 hence were considered insignificant in influencing sexually young men involvement. The results obtained from this analysis were those fitted in a linear regression and it was observed that Knowledge of HPV(P>t=0.528) and Education level(P>t=0.448) were not significant predictors of young men involvement in cervical cancer prevention. Rather, perceived partner risk, knowledge of cause of cervical cancer and whether one was circumcised or not showed that they had significant impact on sexually active young men involvement in cervical cancer prevention.

4.3 Analysis of qualitative data

4.3.1 Facilitators of young men involvement in cervical cancer programming

4.3.1.1 Willingness of the young men in cervical cancer programming

Most of the young men interviewed expressed that they would be willing to talk to others about the disease so they can help stop its spreading. Others felt that there was need to promote preventive efforts so that the disease is contained. Some indicated the use of condoms as one way of preventing the disease from spreading to their female counterparts.

> "*I will try my best to follow all the procedures which can be used to avoid transmission of HPV" BW 009*
>
> *"Since am aware that HPV causes other cancers, I should take part in civic educating other people who are not aware about HPV or cervical cancer."KW007*

4.3.1.2 Roles of young men in addressing the disease burden

The data established that most of the young men feel that they have a role in addressing the challenges that young women face while accessing cervical cancer services. Most of them mentioned that men need to encourage their spouses to go for screening and also accompany them when going there. Others also said young men need to go for circumcision as one way of reducing the disease burden. However, some felt that there is nothing a man can do to address the challenges.

> *"Men are the heads of the households so if they give the information to their wives or girlfriends the women can be encouraged to go for screening. So, it is the responsibility of every man to tell his spouse or relatives to go for screening because it is so deadly if not treated."* KII006
>
> *"Most men including young men when told about cervical cancer, they feel is a woman's disease and have nothing to do with them. Perhaps it is the way messages are designed which makes them feel that way"* KII004

4.3.1.3 Cervical cancer policies and strategies.

The study established that there is no standalone policy for cervical cancer in Malawi, rather cervical cancer is embedded in the sexual reproductive health policy. During the key informant interviews majority of the participants indicated that there are guidelines that are used in the health facilities for prevention which they still felt was not enough. Those who are found positive for HPV are referred for care.

> *"We have the National Cervical Cancer Control Strategy (2016 to 2020) strategy which guides the implementation of cervical cancer services. However, this is not enough as*

there is no standalone policy on the disease as it is with other equally important diseases" KII 005.

4.3.1.4 Progress in the implementation of policies and strategies.

Responding to the question on progress in terms of implementation of the related policies and strategies on cervical cancer prevention, most respondents noted that there isn't much progress because there are still few women access screening services. However, some felt that there is progress in as much as the concentration has been in urban centres and that men and boys have not been involved. While some respondents indicated an improvement in terms of availability of screening equipment in most health facilities in Malawi some still said some health facilities lacks equipment and medical suppliers for screening.

"There isn't much progress here in Malawi because we are very backward when it comes to technological issues to the extent that we refer minor cases to India or South Africa. Our Labs do not have the equipment to deal with trivial cases of cervical cancer" KII010

"in as much as we have not done a comprehensive assessment in term of progress yet, but we feel there is progress in as much as our concentration have been in urban centres unlike rural areas. At least we have provided the training for all service providers [health staff for cervical cancer], and through Global Fund we also have procured and distributed equipment in almost all health facilities. With all this we feel we should have a drop in terms of incidence rate by now" KII005

"we should really admit that we have not been involving young men in cervical cancer programming in as much as they are the ones who harbours HPV and that their sexual behaviour put girls at risk of contracting the virus. We really have never thought about this. But there is need to involve them if we are to deal with this disease" KII005

4.3.2 Barriers to sexually active young men involvement in cervical cancer preventive efforts

4.3.2.1 Barriers that young men face in accessing HPV and cervical cancer services

When asked about the barriers that young men face in accessing HPV and cervical cancer services most of them talked about lack of information and shortage of medical personnel in most public health facilities which make it difficult for them to access the services. Other young men felt that the distance from home to health facilities is also one of the barriers that makes men not to access the services. Other barriers included lack of preventive measures like condoms and shortage of youth friendly centres. Some also noted that the disease is rarely discussed during their interactions at the youth centres which they felt is a lost opportunity to reach out to them.

"*Young people face challenges because they don't know what cancer is. Like here [at this centre] we don't see organizations coming and talking to us about cervical cancer, you are the first people to come here. Even in our communities we haven't had any organizations that talk about cervical cancer. So, it is the lack of information which the youths face" KW005*

"I rarely patronise the youth friendly corner because where I live is far from the health facility. Besides, I have never heard anything on HPV or cervical cancer during the days I have participated"BW009

"I often participate in the meetings at the youth corner but we have never discussed anything on HPV not even cervical cancer. The only time I was introduced to this topic was when I attended a training workshop organised by RDH when the HPV vaccines was being introduced" KW008

4.3.2.2 Barriers that young women face in accessing HPV and cervical cancer services

Most of the young men felt that young women face the same barriers which the young men face which are lack of information in cervical cancer and poor technology in hospitals. However, others also felt that some women are shy to go for cervical screening (probably because screening involves being undressed), others are deterred by bad attitude from health care providers and culture.

4.3.2.3 General challenges for male involvement.

The study established that most men don't like going to the clinic because they are busy with other things and some of them just don't like accompanying their partners to the clinic. However, it was noted that there have not been deliberate efforts to involve young men in the cervical cancer programming and that information on cervical cancer is given on a case by case basis but not strategically.

"the challenge mostly has been that men in general don't like coming to clinics even when they know they are supposed to come. We talk about cervical cancer at ANC clinics mostly and at Under-five clinics but almost 96% of those that we meet there are

women and young men are not usually there. In which case we need to have deliberate programmes targeting them" KII 006

4.3.3 Suggested strategies on how best sexually active young men could be involved

4.3.3.1 Sexually active young men involvement in policy formulation

The study revealed that most of the respondents felt that the government needs to involve them in making policies and designing of interventions on cervical cancer prevention mainly through consultation and information sharing. Most of them expressed that government needs to empower them so they can sensitize other young people in their communities to prevent the spread of HPV infection. The empowerment in this case could be training on HPV and cervical cancer and supporting them with reference materials. Others felt that government needs to put more effort on youth friendly services where young people can access cervical cancer services and start creating an HPV-free generation by encouraging girls to get vaccinated.

"*They need to involve them when developing the policies and strategies in cervical cancer programming so that they can help in prevent themselves and their female counterparts from contracting HPV and encourage their female relations and girlfriends to go for screening as well as access HPV vaccines."* KII004

4.3.3.2 Suggested strategies for male involvement

Data from the study showed that sensitizing young men on HPV and cervical cancer can help to deal with the challenges that are currently there. Most of the respondents noted that using radio, TV and community sensitizations would bring a positive change.

"I will give an example, we had circumcision campaign in the past. During that time very few used to come for circumcision but we had a campaign going into villages, posting posters and telling people the benefits of circumcision and if you can come now you will see a lot of men that come for circumcision. So I believe if we do the same with cervical cancer screening and other preventive strategies, announcing on the radios, TV and social media about the benefits of preventing the disease, I believe there can be a positive change." KII001

Furthermore, while integration of the cervical cancer services has been done with other reproductive health services such as family planning, ART and ant-natal, the study found out that the major focus still remains on the women and girls themselves and not their male counterparts. It was therefore recommended that deliberate efforts need to be made to include cervical cancer information including screening services within the sexual reproductive package.

"Pregnant women are encouraged to be accompanied by their partners whether they are married or not to the antenatal clinic. So, if we can capitalize on the time they come to the clinic to inform them about the benefits of cervical cancer screening and the dangers of cervical cancer. Then we would trap them in the process and make them know about this disease." KII 005

CHAPTER V: DISCUSSION OF THE STUDY FINDINGS

5.1 Introduction

The aim of the study was to assess the involvement of sexually active young men in cervical cancer prevention efforts in Lilongwe urban. This is following the policy recommendations on male involvement in sexual reproductive health interventions [14]. This is one of the very first studies in Malawi where male involvement is assessed in as far as assessment of sexually active young men involvement in cervical cancer prevention is concerned. This chapter, therefore, presents discussion of the study findings. The study findings have been discussed in relation to the study objectives, Conceptual framework (HBM) and reviewed literature on sexually active young men involvement in cervical cancer preventive efforts.

5.2 Determinants of sexually active young men involvement in cervical cancer preventing efforts

The study findings indicate knowledge of causes of cervical cancer, partner's risks and whether one was circumcised or not as having a significant impact on young men involvement in cervical cancer preventive efforts. The study also found that knowledge of the causes of cervical cancer is also associated with levels of education. About 70% of the study participants who indicated having knowledge of the causes of cervical cancer, 59% went up to secondary education level and 82% of those that knew cause of cervical cancer also knew about HPV. This might be the case because at secondary schools there are considerable talks about cervical cancer and HPV compared to primary schools. It is also easier for secondary school students with their older age than those in primary school to access health facilities (health workers) where information of cervical cancer is readily available. The study also noted lack of functional youth friendly health corners in most health facilities which negatively impacts on accessibility and patronage of the facilities. This is also in line with some policy reviews on

challenges of young people accessing youth friendly health services which pointed the unavailability and non-functionality of some of these centres in most health facilities in the country [56]. Furthermore, a higher percentage (64%) of those that know about HPV also strongly agreed that their partners were at risk. Their knowledge about HPV and what causes cervical cancer in this case could be one of the reasons why they believed their partners were also at risk of cervical cancer.

The study findings further show a higher percentage of respondents that strongly agreed that their partner was at risk (70.54%) were also circumcised. This could be the case because at the circumcision sites they also talk about cervical cancer and it's causes [22]. However, while acknowledging the role that service providers play in educating those going for circumcision on cervical cancer and the importance of the disease, the researchers view is that the primary drivers for young men to get circumcised or not may not necessarily be on cervical cancer prevention rather it could be as a result of other drivers such as HIV and AIDs prevention, cultural requirements and religious identity as also noted by other researchers such as Sahay *et al* [57]. Circumcision is also meant to prevent women from sexually transmitted diseases including HPV [58]. There is therefore need for further research on primary drivers for male circumcision in relation to cervical cancer prevention.

Furthermore, in as much as the study found no association between young men involvement in cervical cancer prevention efforts and their perceived risk to HPV (with p-value of 0.308), the researcher is of the view that this may be the case due to lack of knowledge of other cancers HPV causes in both males and females. This is the case following the health belief model which suggests that if people feel they are at risk due to their behaviour or actions, they quickly adjust to prevent themselves from being hurt. In the same vein, it is in the researcher view that

if young men are made aware of effects of HPV on their health they would want to be involved, the action which will not only protect them but their female counterparts as well from cervical cancer which is causing a lot of harm among women in Malawi and the world at large. In which case, their perceived risks to HPV together with the risk of their partners (which have been found to be strongly associated with young men involvement), they would be more willing to be involved and probably encourage their partners and female relations to go for screening and other preventive interventions.

Culturally, in Africa including Malawi men are the most decision makers in any household transactions including decisions to access health services for their household members and community at large [22]. This corresponds to the study findings where both the study subjects (about 64%) and key informants strongly agreed and acknowledged the important role men play in the society which can also be applied in cervical cancer prevention efforts through encouraging their spouses to go for screening. This could also motivate them to go for circumcision among others with the view to prevent the transmission of HPV. It is further the researcher's view that if young men are targeted in their young age, they may be able to make informed decisions for their spouses and daughters to access cervical cancer preventive services now and in future when they get married.

5.3 Barriers of sexually active young men involvement in cervical cancer preventive efforts

The study has revealed that despite having an established cervical cancer prevention program in the country, there is low involvement of sexually active young men in cervical cancer prevention efforts. As with previous studies, sexually active young men involvement in sexual reproductive health have not been adequately studied. Furthermore, the few studies conducted on barriers to male involvement in cervical cancer have also been on married men and not the

young men who may be asymptomatic carriers of HPV and whose sexual behaviours puts young women at risk of contracting HPV that causes cervical cancer [30].

This could be true due to a number of factors as also highlighted in this study. One is that structurally there has been no deliberate efforts to involve sexually active young men including all other men in cervical cancer preventing efforts despite policy calls for male involvement in sexual reproductive health services. Some of the key informants also confirmed this as they clearly noted that there have not been deliberate efforts to include young men in the preventive efforts despite the important role, they play in transmitting HPV and decision making in as far as access to health services is concerned. Furthermore, due to the current health financing constraints the country is facing, HPV vaccines in Malawi for instance only targets girls and not boys [18] and that sensitisation of the same only talks of girls and women and not boys and men as alluded to by some study subjects and key informants. In the researcher's view point this may also have contributed to low male involvement as the disease is perceived as feminine. Kim *et al* in their qualitative study on "Men awareness of cervical cancer" also reported men as having nothing to do with cervical cancer as it seems to be a women's disease [30]. On the other hand, male circumcision whose primary roles it to reduced transmission of STI including HPV, its association with cervical cancer prevention as one of the primary drivers of circumcision is however not known as it has also been noted in the study.

The study has also revealed that in the youth centres, issues of cervical cancer are hardly discussed as may be perceived except in cases where some organisations have conducted a training which also is rarely done as reported by some study subjects. According to the country's current youth friendly health strategy, youth centres are supposed to provide all relevant sexual reproductive health knowledge and services including that on cervical cancer

and HPV among other sexual reproductive health services such as family planning and HIV and AIDs. These centres are also supposed to be accessible and affordable to all the young people [56]. However, this is not the case as noted in the study. One, the study established difficulties in accessibility of the services in terms of distances to the health facilities as well as inadequate coverage of cervical cancer and HPV issues in the youth friendly services. Most of the study subjects noted that cervical cancer is hardly talked about in most youth friendly health centres. To the researcher's knowledge, there is also limited literature on the extent to which cervical cancer is discussed in the youth friendly health sessions which suggests areas for further research. However, this could be the lost opportunity for reaching out to young sexually active men in cervical cancer preventive efforts. Youth friendly health services have proved to provide a conducive environment for young men to access sexual health reproductive services.

The absence of a standalone policy on cervical cancer may also have contributed to the low male involvement as the disease may have not be given adequate attention as may be required for its effective programming as also noted by Maseko e*t al* in their study on "Cervical cancer control and prevention in Malawi - need for policy improvement". Maseko *et al* noted that cervical cancer which is covered under SRH policy does not give some important directions in cervical cancer programming such as age and frequency for screening, policy implications on service provision among others [46]. Similarly, in the study, some respondents indicated lack of appropriate equipment and medical supplies for cervical cancer prevention services such as VIA kits as one of the barriers to women accessing cervical cancer services. Such stock outs may discourage men from escorting their partners to access screening services or even supporting them in terms of costs that may be involved resulting from several visits the women have to go the health facilities to get assisted.

Furthermore, research also has it that men usually lacks health seeking behaviour. similarly, the study has also established lack of the same amongst young men as one of the barriers to their involvement in cervical cancer preventive efforts. This could be the case due to among others the misconception that cervical cancer is feminine disease hence no need for their involvement, lack of knowledge of the impact HPV and cervical cancer have on their wellbeing and that of the spouses, lack of deliberate efforts to involving them in the disease prevention initiative and lack of a stand-alone policy of cervical cancer which could provide policy direction in cervical cancer programming as also have been revealed in the study.

Chapter VI: CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

The study suggests that the involvement of sexually active young men in cervical cancer preventive efforts is generally low. The study findings indicate knowledge of cause of cervical cancer, partner's risks and whether one was circumcised or not as having a significant impact on young men involvement in cervical cancer preventive efforts. According to the study findings, their non-involvement is attributed to a number of factors which includes structural barriers to access cervical cancer information which include among others lack of a standalone policy, lack of access points of the services such as youth friendly health corners. Culturally, the feeling that cervical cancer is feminine disease and have nothing to do with men also deters them from assessing the services. However, when informed of the HPV on them, the risk to their partners, and their roles as men in decision making, all the study subjects expressed willingness to get involved which is a great opportunity to address the disease burden.

6.2 Recommendations

6.2.1 Need for a standalone policy

Considering the disease burden on the health sector and women's health in particular in Malawi, for cervical cancer to get much attention and support in its programming, there is need for a standalone policy which would provide the much needed policy direction as it is with other diseases such as HIV and AIDS. It should however be noted that having a standalone policy does not necessary negates integration of SHR services. Rather, it is there to provide the detailed policy direction on the disease considering its importance in health as is the case with other diseases such as HIV and AIDS.

6.2.2 Involvement of the young men in policy development and strategies on cervical cancer prevention

There is need to involve sexually active young men in development of policies and designing of interventions on cervical cancer prevention. This could either be through consultations as the policies and programmes are being developed and sharing of information of the processes involved so that all the parties are satisfied with the outcome. Their involvement in this case would also encourage them to be supportive to their female counterparts in as far as cervical cancer prevention is concerned. There is also need to make deliberate efforts to sensitise the young men on HPV and its association with cervical cancer to enable them make informed decisions now and in future.

6.2.3 Incorporation of cervical cancer in youth health friendly services

There is also need to put more effort on youth friendly health services where young people can access cervical cancer services and start creating an HPV-free generation by encouraging girls to get vaccinated and practise safe sex to avoid transmission of HPV. Deliberate efforts also have to be made to ensure cervical cancer is also included in the youth friendly health services. This could be done through among others building the capacity of the health workers in these facilities with knowledge and skills on cervical cancer prevention.

6.2.4 Targeting sexually active young men in cervical cancer prevention

According to the study findings, young men feels left out in most cervical cancer preventive efforts in as much as they harbour HPV and that HPV also causes other cancers that attack them. However, due to financial constraints the government have prioritised girls for the HPV vaccine which they feel is discriminatory to some extent. The government should therefore consider expanding the vaccine campaign to boys as well. Leaving them outside the equation

is somewhat un ethical and discriminatory. There is also need to encourage young men to go for circumcision as one way of preventing HPV transmission.

6.3 Areas for further research

- The study did not go further to establish primary drivers for male circumcision in relation to cervical cancer prevention. The study only established that due to cervical cancer talks that take place during hospital circumcision procedure, more men tends to be aware of HPV and cervical cancer than those who have not undergone the procedure. But whether one would still opt for circumcision just to prevent transmission of STIs including HPV have not been established yet hence need for further research.

- In as much as the study established that HPV is not discussed much in youth friendly health centres as one of the STIs, it has not established the extent to which the disease is discussed during their routine activities. Further research is therefore needed to establish the extent to which HPV and cervical cancer in general have been mainstreamed in youth friendly health services as the policy requires.

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Appendix 1: QUESTIONAIRE FOR THE STUDY SUBJECTS IN ENGLISH

Institution……. Record No……

SECTION A: PERSONAL AND DEMOGRAPHIC DETAILS

1. Age:

15-19

20-24

2. Marital Status

No married

Married

3. Do you have children?

YES

NO

If yes, how many and how old?

4. Level of education

No formal education

Primary level

Secondary level

Tertiary level

5. Employment status

Employed

Unemployed

Others (specify)

6. Tribe

Chewa

Tumbuka

Yao

Ngoni

Lomwe

Others (specify)

7. District of origin

NAME:

8. Are you from a patrilineal or matrilineal society?
    1. Patrilineal
    2. Matrilineal
9. Have you been circumcised?

YES

NO

If yes, when?

SECTION B: KNOWLEDGE ON HPV

10. Do you know what HPV is?

YES

NO

If yes, explain what you know about it?

11. Do you know how HPV is transmitted?

YES

NO

If yes, explain how

If no, explain to the respondent how HPV is transmitted and then ask the Q 12 below

12. How do you think HPV infections can be reduced?

SECTION C: KNOWLEDGE ON CERVICAL CANCER AND ITS LINKAGES WITH HPV

13. Do you know what cervical cancer is?

YES

NO

If yes, what is it?

14. Do you know what causes cervical cancer?

YES

NO

If yes explain?

15. Are you aware that HPV causes cervical cancer? If not mentioned in Q 13 above
16. Do you know that HPV also causes other cancers that affect both male and female?

YES

NO

If yes, name the type of cancers

If no, then explain to the respondent then ask Q 17 below

17. Now that you know that HPV also causes cervical cancer and other cancers, how willing are you to be engaged in its programming
18. What other determinants can influence your (male) involvement in cervical cancer prevention efforts?

19. Do you know that cervical cancer is preventable?

YES

NO

I don't know

If yes, explain how

20. What tests for screening cervical cancer do you know?

21. What was the source of information for the screening tests mentioned in Q10 (tick what is relative to you)
    Health workers
    Friend/relative
    Media
    Others
22. Based on the information you have [been given], do you think you can allow your spouse (now or in future) or friend or relative to go for screening services
    YES
    NO
    Please Explain your answers
23. What are some of the barriers that women face in accessing cervical cancers services?
24. Do you think men have a role in address these challenges?
    YES
    NO
    If yes, explain the roles
    If no explain why

SECTION D: ATTITUDE ON CERVICAL CANCER

25. Do you see yourself as being at risk of HPV?
    YES
    NO

26. Do you see your partner (girlfriend or wife) as being at risk of HPV and cervical cancer?
    YES
    NO
27. Do you know anyone who have ever suffered from cervical cancer?

YES

NO

If yes, who are they to you

If yes, what was your feeling about them?

28. Now that you know what cervical cancer is, what is your feeling now?

SECTION E: ROLES IN CERVICAL CANCER PREVENTION

29. In general, what activities are you involved as a member of the youth friendly corner at this health facility
30. Have you ever been involved in cervical cancer preventive efforts?

YES

NO

If yes, what was it? And what was your role?

31. What other roles do you think you can play in cervical cancer prevention?
32. How do you think the country's strategies/policies should incooperate young men involvement in cervical cancer prevention efforts?
33. What are some of the barriers that young men face in accessing HPV and Cervical Cancer information?
34. How could these barriers be addressed?

THE END

Appendix 2: QUESTIONAIRE FOR THE STUDY SUBJECTS IN CHEWA

Bungwe/Chipatala ..... No .....

CHIGAWO A: ZINTHU ZOPHUNZIRA NDI ZOPHUNZIRA

1.

Zaka:

15-19

20-24

2. Banja

wosakwatira

Wokwatirana

3. Kodi muli ndi ana?

Inde

Ayi

Ngati inde, ndi angati ndipo ali ndi zaka zingati?

4. Mndandanda wa maphunziro

Sanaphunzilero

Pulaimale

Secondary

Maphunziro apamwamba

5. Ntchito?

Ali pantchito

Osagwira ntchito

Ena (Tchulani)

6. Fuko

Chewa

Tumbuka

Yao

Ngoni

Lomwe

Ena (tsankhu)

7. Boma lochokela

Dzina:

8. Kodi mchikhalidwe chakwanu mumasatila mwambo uti waukwati?

1. Chikamwini

2. Chitengwa

9. Kodi mudadulidwa?

Inde

Ayi

Ngati inde, liti?

CHIGAWO B: KUDZIWA PA HPV

10. Kodi mukudziwa kuti HPV ndichiani?

Inde

Ayi

Ngati inde, fotokozani kuti ndi chiani?

11. Kodi mukudziwa momwe HPV imafalitsira?

Inde

Ayi

Ngati inde, fotokozani

Ngati ayi, afotokozereni wofunsidwa momwe HPV imafalitsira kenako kufunsani funso 12 pansipa

12. Kodi mukuganiza kuti HPV ikhachepetsedwe bwanji?

CHIGAWO C: KUDZIWA ZA KHANSA YAKHOMO LACHIBEREKERO CHA AMAYI NDIMOMWE ZIMAKHUNZIRANA NDI HPV

13. Kodi mumadziwa za khansa yap homo lachiberekelo cha mayi?

Inde

Ayi

Ngati inde, ndi chiyani?

14. Kodi mukudziwa chomwe chimachititsa khansa ya pachibelekero?

Inde

Ayi

Ngati inde afotokoze?

15. Kodi mukudziwa kuti HPV imayambitsa kansa ya pachibelekero? (Ngati siinatchulidwe pa funso13 mwambamu)

16. Kodi mukudziwa kuti HPV imayambitsanso khansa zina zomwe zimakhudza onse amuna ndi akazi?

Inde

Ayi

Ngati inde, tchulani

Ngati ayi, ndiye afotokozereni wofunsayo kenako funsani funso 17 pansipa

17. Tsopano mmene mwadziwa kuti HPV imayambitsanso khansara ya chiberekero ndi khansa zina, chidwi chanu ndichotani pa matendawa?

18. Ndi ndiziyenereza zina ziti zomwe zingachitise amuna (abambo) kutengapo gawo popewa matendawa?

19. Kodi mukudziwa kuti khansa ya pachibelekero imachizidwa?

Inde

Ayi

Sindikudziwa

Ngati inde, afotokozani

20. Ndi njila ziti zimene mumadziwa zoyenzela matendawa?

21. Munanvera kuti njila zimenezi mwatchulazi?

Kwa anthu ogwira ntchoto ku chipatala

Amene anadwalako mthendayi

Mnzanga / wachibale

Media

Ena

22. Malinga ndi zomwe mwapatsidwa, kodi mukuganiza kuti mungalole kuti okondedwa wanu kaya wachibale kapena nzanu kuti apite kukayezesa matendawa ku chipatala

Inde

Ayi

Chonde Fotokozani mayankho anu

23. Ndi zina ziti zomwe zimalepheretsa amayi kupeza mauthenga kapena upangili /chithandizo cha matendawa?

24. Kodi mukuganiza kuti abambo angathandiza kuthetsa mavutowa?

Inde

Ayi

Ngati inde, afotokozani mbali imene angatengepo

Ngati palibe kufotokoza chifukwa chake

CHIGAWO D: MAGANIZIDWE ANU PA MATENDAWA

25. Kodi mumadziona kuti muli pachiopsyezo cha HPV?

Inde

Ayi

26. Kodi mukuwona mnzanu (chibwenzi kapena mkazi wanu) ali pachiosyezo chotenga HPV komanso khansa lapakhomo lachiberekero?

Inde

Ayi

27. Kodi mumadziwa wina aliyense yemwe adadwalapo matendawa?

Inde

Ayi

Ngati inde, ndi ndani kwa inu?

Ngati inde, mumamva bwanji za iwo?

28. Tsopano kuti mukudziwa chomwe khansara ya chiberekero ili, mukunva bwanji tsopano?

CHIGAWO E: GAWO LA ACHINYAMA POTETEZA MATENDAWA

29. Mwachidziwikire, ndi mbali ziti zomwe mumagwirapo ngati membala wachinyamata ku chipatala chino

30. Kodi munayamba mwatengapo mpali pa zochitikachitika zokhuza kapewedwe ka mtenda ya khansa yakhomo la chiberekero?

Inde

Ayi

Ngati inde, chinali chiyani? ndipo udindo wanu unali chiyani?

31. Ndi maudindo ena ati omwe mukuganiza kuti mungathe kuchita potetezamatendawa?

32. Mukuganiza kuti ndondomeko za dzikoli ziyenera kugwirizanitsa bwanji anyamata kutengapo gawo pa kuthandiza kuchepesa matendawa?

33. Ndi zina zotani zomwe anyamata akukumana nazo pakupeza uthenga wa HPV ndi Khansa ya Chiberekero?

34. Zingathetsere bwanji izi?

KUMAPETO

Appendix 3: CHECKLIST FOR THE KEY INFORMANTS

Name:

Level of Education:

Institution:

Position:

1. Explain your work in cervical cancer prevention effort? And what is your major role?
2. How do you involve young men in cervical cancer programming in your work? And general cervical cancer services?
3. How has cervical cancer been incorporated in the Malawi policies and strategies? What about male involvement?
4. What do you think is the progress in terms of implementation of the policies/strategies mentioned above?
5. What are the general challenges in cervical cancer programming in as far as male involvement is concerned?
6. What can be done to address these challenges?
7. How best do you think young men should be involved?

THE END

Appendix 4: CERTIFICATE OF APPROVAL COMREC

CERTIFICATE OF ETHICS APPROVAL

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

P.11/18/2524 - Applying a gender lens in cervical cancer programming: the assessment of sexually active young men involvement in cervical cancer preventive efforts. Version 1.4 by Chimwemwe Nkosi

On 28-Feb-19

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

28-Feb-19

Dr. YB. Mlombe - Chairperson (COMREC) — Date

Appendix 5: PERMISSION LETTER TO CONDUCT THE STUDY IN LILONGWE DISTRICT

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

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

COMMUNICATIONS TO BE ADDRESSED TO:

11thSeptember, **2018**

College of Medicine Research Ethics Committee
Privata Bag 360
Chichiri
Blantyre 3

Dear Sir/Madam

PERMISSION TO CONDUCT RESEARCH STUDY IN LILONGWE DISTRICT

Approval has been granted to the bearer of this letter: Chimwemwe Nkosi, from College of Medicine to conduct a research study in Lilongwe.

" applying a gender lens in cervical cancer programming: assessing the involvement of sexually active young men in cervical cancer prevention effert"

Any assistance rendered would be appreciated.

MINISTRY OF HEALTH & POPULATION
LILONGWE DISTRICT HEALTH OFFICE
DHO
11 SEP 2018

Dr. Ethel Rambiki Kajawo OFFICER
SENIOR MEDICAL OFFICER - LL

Appendix 6: INFORMED CONSENT FOR ADULT YOUNG MEN (18 TO 24 YEARS) FORM IN ENGLISH

Informed Consent Form for young men aged between 18 and 24 years who are invited to participate in an academic research titled *"Applying a gender lens in cervical cancer programming: the assessment of sexually active young men involvement in cervical cancer preventive efforts"*

Name of Principle Investigator: Chimwemwe Nyambose Nkosi

Name of Organization: College of Medicine – Masters in Public Health

Name of Project and Version: Applying a gender lens in cervical cancer programming: the assessment of sexually active young men involvement in cervical cancer preventive efforts.

Part I: Information Sheet

Introduction: I am Chimwemwe Nkosi, a student at College of Medicine doing Master of Public Health (MPH). I am doing research on **"**Applying a gender lens in cervical cancer efforts: the assessment of sexually active young men involvement in cervical cancer preventive efforts". I am going to give you information and invite you to be part of this research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research. This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can always ask me and I will respond accordingly.

Purpose of the research: Cervical cancer is a public health concern across the world especially in developing countries including Malawi which registers high incidence and mortality rates. This is despite the fact that the disease is preventable in its early stages of diagnosis. We want to find out how sexually active young men are involved in the fight against the disease. We believe that you can help us by telling us what you know both about the disease and how best you can help fight the disease. We want to learn how young men are involved in the prevention efforts of the disease. We believe this will help in cervical cancer programming in Malawi which will in the long run help reduce the burden.

Type of Research Intervention: This research will involve your participation in a one on one discussion that will take about 30 minutes.

Participant Selection: You are being invited to take part in this research because we feel that your roles and responsibilities as young men can contribute to the reduction of the disease incidences which will eventually help reduce the disease burden.

Voluntary Participation: Your participation in this research is entirely voluntary. It is your choice whether to participate or not and your name will not appear in the report.

Procedures: We are asking you to help us learn more about young men involvement in cervical cancer prevention efforts in Lilongwe urban. We are therefore inviting you to take part in this research project. If you accept, you will be asked to take part in responding to some questions on what you know about cervical cancer and its causes, your general feeling about the disease and how young men are involved and how best you think you [and young men in general] can be involved in prevention efforts of the disease. We will not ask you to share personal practices or stories and you do not have to share any knowledge that you are not comfortable sharing. The discussion will take place at a comfortable place at the health facility. If it is better for you, the interview can take place in your home or a friend's home. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. No one else but the interviewer will be present unless you would like someone else to be there. The information recorded is confidential, and no one else except me and my academic supervisor will have access to the information documented during your interview. The information recorded is confidential.

Duration: The research takes place over a period of 10 months in total. During that time, we will only interview you once for a period of about 30 minutes.

Risks: There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. However, we do not wish for this to happen. You do not have to answer any question or take part in the interview if you feel the question(s) are too personal or if talking about them makes you uncomfortable.

Benefits: There will be no direct benefit to you, but your participation is likely to help us find out more about how to prevent cervical cancer which continues to be a health burden in Malawi and Africa as a whole.

Reimbursements: Your participation in this study is voluntary. However, you will be given $10 (at a current exchange rate of $1 = MK750.00) as compensation for your participation in the study.

Confidentiality: The research being done in the community may draw attention and if you participate you may be asked questions by other people in the community. We will not be sharing information about you to anyone outside of the research team. The information that we collect from this research project will be kept private. Any information about you will have a code on it instead of your name. Only the researchers will know what your number is and we will lock that information up with a lockable drawer. It will not be shared with or given to anyone.

Sharing the Results: Nothing that you tell us today will be shared with anybody outside the research team, and nothing will be attributed to you by name. Being an academic research, the key findings of the study will be submitted to College of Medicine Library and College of Medicine Research Ethics Committee. The findings will also be disseminated through local and international conferences and we will also publish the results so that other interested people may learn from the research.

Right to Refuse or Withdraw: You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your participation in health related interventions or any other interventions in in any way. You may stop participating in the interview at any time that you wish I will give you an opportunity at the end of the interview/discussion to review your remarks, and you can ask to modify or remove portions of those, if you do not agree with my notes or if I did not understand you correctly.

Who to Contact: If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact any of the following: Chimwemwe Nkosi, C/O MHRRC, P.O Box 891, Lilongwe. Tel: 265888903710, Email: chimwemwenkosi@gmail.com or Dr Frezier Chidyaonga Maseko, University of Malawi, College of Medicine, P/Bag 360. Blantyre.

This proposal has been reviewed and approved by College of Medicine Ethics Research Committee (COMREC), which is a committee whose task it is to make sure that research

participants are protected from harm. If you wish to find about more about the COMREC, contact the Chairman COMREC Secretariat, College of Medicine, P/Bag 360. Blantyre. Tel: 265 1 871 911/334.

Part II: Certificate of Consent

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant_____
Signature of Participant _____
Date _____
Day/month/year

If illiterate [5]

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____ **Thumb print of part**
Signature of witness _____
Date _____
Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands the information described in this document and freely consents to participate

[5] A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.

A copy of this ICF has been provided to the participant.

Print Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____

Day/month/year

Appendix 7: INFORMED CONSENT FORM FOR ADULT YOUNG MEN (18 TO 24 YEARS) IN CHEWA

Fomu yolandira chidziwitso kwa anyamata a zaka zapakati pa 18 ndi 24 omwe akuitanidwa kutenga nawo mbali pa kafukufuku wokhuza Kutengapo mbali kwa a nyamata pa kuteteza amayi ku kansa yakhomo lachiberekero.

Dzina la Wofufuza Wamkulu: Chimwemwe Nyambose Nkosi

Dzina la Bungwe: College of Medicine

Dzina la Project: Kutengapo mbali kwa a nyamata pa kuteteza amayi ku kansa yakhomo lachiberekero.

Gawo I: Za muchipepalamu

Mau oyamba: Ine ndine Chimwemwe Nkosi, wophunzira ku College of Medicine ndipo ndikuphunzira Master of Public Health (MPH). Ndikuchita kafukufuku pa " Kutengapo mbali kwa a nyamata pa kuteteza amayi ku kansa yakhomo lachiberekero." Ndikukuitanani kuti mukhale mbali ya kafukufukuyu. Simukuyenela kulola lero kutengapo mbali pa kafukuku ameneyu, ngati ndikofunika kaye kuyakhulana ndi aliyense amene mumakhala womasuka nawo za kafukufuku, mukhoza kutero. Fomuyi ikhoza kukhala ndi mawu omwe simumamvetsa, chonde ndipempheni kuti ndiyimire kuti ndifotokoze kaye. Ngati muli ndi mafunso mtsogolo, mutha kundifunsa ndipo ndikuyankha moyenela.

Cholinga cha kafukufuku: Matenda a pakhomo la chiberekero cha amayi ndiovuta kwambiri padziko lonse lapansi makamaka m'mayiko osauka kuphatikizapo Malawi lomwe lili ndi anthu ambili odwala mtendayi ndipo ambili afanso nayo. Izi zili choncho ngakhale kuti matendawa ndiochizika akayamba kumene. Tikufuna kupeza momwe anyamata angathandizira polimbana ndi matendawa. Timakhulupirira kuti mutha kutithandiza potiuza zomwe mukudziwa zokhudza matendawa ndi momwe mungathandizire kuthana nawo. Tikufuna kuphunzira momwe anyamata akukhudzidwira mu ntchito yothandizira matendawa. Tikukhulupirira kuti izi zidzathandiza pa mapulogalamu a kansa ya mchiberekero zomwe zingathandizile kuchepetsa vutoli.

Kutengapo gawo kwanu pa kafukufukuyu: mukuyembekezeka kutenga nawo gawo pa zokambirana zomwe zingatenge pafupifupi pindi makumi atatu ndipo zokambilanazi zizachitipa pa nokha.

Kusankhidwa ka otengapo gawo: Mukuitanidwa kukachita nawo kafukufukuyu chifukwa timaganiza kuti maudindo anu monga anyamata angathe kuthandizira kuchepetsa matendawa.

Kutengapo gawo mwaufulu: Kutengapo gawo kwanu mu kafukufukuyu ndi mwaufulu kwathunthu. Ndiyo kusankha kwanu ngati kutenga nawo mbali kapena ayi komanso dzina lanu silidzawoneka mu lipoti la kafukufukuwu.

Ndondomeko: Tikukupemphani kuti mutithandize kuphunzira zambiri zokhudza anyamata omwe amagwira nawo ntchito yothandizira kuchepesa khansa ya mchiberekero mumzinda wa Lilongwe. Choncho tikukupemphani kuti mutenge nawo gawoli. Ngati mukuvomereza, mudzafunsidwa kutenga nawo mbali pa kuyankha mafunso ena pa zomwe mumadziwa zokhudza matendawa ndi zomwe zimayambitsa, momwe mumamvera za matendawa ndi momwe anyamata akukhudzidwa ndi momwe mukuganizira kuti [ndi anyamata ambiri] akhoza kutenga nawo mbali pochepesa matendawa. Sitifunsani kuti mugawane nafe chidziwitso chilichonse chimene simumasuka kugawana nafe. Zokambiranazi zidzachitika pamalo abwino pa chipatala pano angakhala malo ena amene mungamasuse nawo. Ngati simukufuna kuyankha mafunso aliwonse, mukhoza kunena choncho ndipo wofunsayo adzapitiriza ndifunso lotsatira. Palibe wina koma wofunsayo amene angakhalepo pokhapokha ngati mukufuna kuti wina akhalepo. Zomwe zalembedwazo ndizobisika, ndipo palibe wina kupatula ineyo ndi woyang'anira maphunziro anga amene angaone zomwe zalembedwa. Chidziwitso cholembedwa ndi cha chinsinsi.

Nthawi

Kafukufukuyu achitikira kwa miyezi khumi. Panthawi imeneyi, tidzangokambirana nawo kamodzi kwa mphindi makumi atatu okha.

Chiopsezo: Pali chiopsezo kuti mutha kugawana mwatsatanetsatane zachinsinsi kapena kuti simungakhale womasuka kunena za zina mwaizo. Komabe, sitikufuna kuti izi zichitike. Simusowa kuti muyankhe funso lirilonse kapena kutenga nawo mbali mufunsoli ngati mukumva kuti mafunsowa ndi enieni kapena ngati kuyankhula za iwo kumakupangitsani kukhala osasangalala.

Ubwino: Kutenga nawo mbali kungatithandizire kuti tipeze zambiri za momwe tingapewere matenda a kansa ya chiberekero yomwe ikupitirizabe kukhala yovuta mudziko lathu lino komanso maiko ena mu Africa muno.

Cholowa: Kutengapo mbali kwanu mukafukufuku ameneyi ndi kwaufulu ndipo muzapasidwa cholowa chokwana MK7,500 potengapo mbali pa kafukuku ameneyi.

Chinsinsi: Kafukufuku omwe akuchitika mderalo akhoza kukuthandizani ndipo ngati mutenga mbali mungayambe kufunsidwa mafunso ndi anthu ena ammudzi. Sitizanena inu kwa wina aliyense kunja kwa gulu lakafukufukuyu. Chidziwitso chirichonse cha inu chidzakhala ndi nambala ya chinsinsi m'malo mwa dzina lanu. Ofufuza okha ndi omwe angadziwe kuti nambala yanu ndi yotani.

Kufalisa Zotsatira: Palibe chimene mutiwuze lero chidzagawidwa ndi wina aliyense kunja kwa gulu lofufuza, ndipo palibe chomwe chidzatchulidwe ndi dzina lanu. Pokhala kafukufuku wamaphunziro, zofunikira za phunziroli zidzaperekedwa ku College of Medicine Library ndi College of Ethics Research Ethics Committee komanso misokhano ina mudziko muno ngakhalenso amaiko ena kuti zotsatilazi zikathandizenso ena.

Ufulu Wokana ketengapo gawo: Simuyenera kutenga nawo mbali mukafukufukuwa ngati simukufuna, ndipo kusankha kutenga nawo gawo sikukhuza kutenga nawo mbali kwanu pazochitika zina. Mutha kusiya kuyakha nthawi iliyonse yomwe mukufuna ndipo mukhoza kupempha kusintha kapena kuchotsa magawo ena ngati simukugwirizana nawo kapena ngati sindinakumvetse bwino.

Amene mungayakhule nawo ngati muli ndifunso: Ngati muli ndi mafunso, mukhoza kuwafunsa panopa kapena mtsogolo. Ngati mukufuna kufunsa mafunso mtsogolo, mutha kulankhulana ndi Chimwemwe Nkosi, C / O MHRRC, P.O Box 891, Lilongwe. Tel: 265888903710, Email: chimwemwenkosi@gmail.com kapena Dr Frezier Chidyaonga Maseko, University of Malawi, College of Medicine, P / Bag 360. Blantyre.

Cholinga ichi chafotokozedwa ndikuvomerezedwa ndi College of Medicine Ethics Research Committee (COMREC), yomwe ndi komiti yoonetsetsa kuti anthu ochita kafukufuku akutetezedwa ndi kusachitilidwa khanza. Ngati mukufuna kupeza zambiri za COMREC,

funsani wa pampando Secretariat COMREC, College of Medicine, P / Bag 360. Blantyre. Tel: 265 1 871 911/334.

Gawo 2: Kalata ya Chivomerezo

Ndawerenga chipepalachi, kapena chawerengedwa kwa ine. Ndakhala ndi mwayi wofunsa mafunso okhudza izi ndipo mafunso alionse omwe ndapemphedwa ayankhidwa moyenela. Ndinagwirizana ndi mtima wonse kuti nditengepo gawo pa kafukufukuyi.

Sindikizani Dzina la ofunsidwa: _____

Chizindikiro cha ofunsidwa _____

Tsiku _____

Tsiku / mwezi / chaka

Ngati osaphunzira

Ndawona kuweredwa kwa chipepalachi kwa omwe angathe kutenga nawo mbali, ndipo munthuyo anali ndi mwayi wakufunsa mafunso. Ndikutsimikizira kuti munthuyo wapereka chilolezo momasuka.

Dzina mboni_____ Poika chala

Chizindikiro cha umboni _____

Tsiku _____

Tsiku / mwezi / chaka

Ndemanga ya wofufuzira / munthu wobvomerezana

Ndaphunzira mwatsatanetsatane pepala lodziwitsira kwa omwe angathe kutenga nawo mbali, ndipo mwa kukhoza kwanga kulimbikitsa kuti ofunsidwayo amvetsetse zomwe zafotokozedwa m'nyuchipepalayi ndipo amavomereza kuti atenge nawo mbali

Kope ya ICF iyi yaperekedwa kwa ofunsidwa.

Sindikizani Dzina la munthu wotenga chilolezo_____

Chizindikiro cha munthu otenga chilolezo_____

Tsiku _____

Tsiku / mwezi / chaka

Appendix 8: PARENTS WRITTEN INFORMED CONSENT FORM IN ENGLISH

Parents informed consent form for young adolescent men aged between 15 and 17 years who are invited to participate in an academic research titled *"Applying a gender lens in cervical cancer programming: the assessment of sexually active young men involvement in cervical cancer preventive efforts"*

Name of Principle Investigator: Chimwemwe Nyambose Nkosi

Name of Organization: College of Medicine – Masters in Public Health

Name of Project: Applying a gender lens in cervical cancer programming: the assessment of sexually active young men involvement in cervical cancer preventive efforts.

Part I: Information Sheet

We are asking your child to help us learn more about young men involvement in cervical cancer prevention efforts in Lilongwe urban. We are therefore inviting him to take part in this research project. If you accept, he will be asked to take part in responding to some questions on what he knows about cervical cancer and its causes, his general feeling about the disease and how young men are involved and how best he thinks he [and young men in general] can be involved in prevention efforts of the disease. We will not ask him to share personal practices or stories which he is comfortable sharing. The discussion will take place at a comfortable place at the health facility. No one else but the interviewer will be present unless he like someone else to be there. The information recorded is confidential, and no one else except me and my academic supervisor will have access to the information documented during your interview.

The research is for a period of 10 months in total. During that time, we will only interview your child once for a period of about 30 minutes. His participation in this study is voluntary and will not harm him in anyway. However, he will be given $10 (at a current exchange rate of $1 = MK750.00) as compensation for his participation in the study.

Do you understand? Would you like to participate Yes/No?

Part II: Certificate of Consent

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been

answered to my satisfaction. I consent voluntarily for my child to be a participant in this study

Print Name of Participant_____

Signature of Participant _____

Date _____

Day/month/year

If illiterate [6]

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____ **Thumb print of part**

Signature of witness _____

Date _____

Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands the information described in this document and freely consents to participate

A copy of this ICF has been provided to the participant.

Print Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____

Day/month/year

[6] A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.

Appendix 9: PARENTS WRITTEN INFORMED CONSENT FORM IN CHEWA

Fomu yolandira chidziwitso kwa makolo kapena oaimilila a anyamata a chichepele (zaka zapakati pa 15 ndi 18) omwe akuitanidwa kutenga nawo mbali pa kafukufuku wokhuza Kutengapo mbali kwa a nyamata pa kuteteza amayi ku kansa yakhomo lachiberekero.

Dzina la Wofufuza Wamkulu: Chimwemwe Nyambose Nkosi

Dzina la Bungwe: College of Medicine

Dzina la Project: Kutengapo mbali kwa a nyamata pa kuteteza amayi ku kansa yakhomo lachiberekero.

Ndondomeko: Tikukupempha chilolezo choti mwana wanu nyamata wachichepere kuti atithandize kuphunzira zambiri zokhudza anyamata omwe amagwira nawo ntchito yothandizira kuchepesa khansa ya mchiberekero mumzinda wa Lilongwe. Ngati mukuvomereza, mwanayu adzafunsidwa kutenga nawo mbali pa kuyankha mafunso ena pa zomwe amadziwa zokhudza matendawa ndi zomwe zimayambitsa, momwe amamvera za matendawa ndi momwe anyamata akukhudzidwa ndi momwe akuganizira kuti [ndi anyamata ambiri] akhoza kutenga nawo mbali pochepesa matendawa. Zokambiranazi zidzachitika pamalo abwino pa chipatala chaku delali angakhale malo ena amene angamasuse nawo. Palibe wina koma wofunsayo amene angakhalepo pokhapokha ngati inuyo kapena mwini wake akufuna kuti wina akhalepo. Zomwe zalembedwazo ndizobisika, ndipo palibe wina kupatula ineyo ndi woyang'anira maphunziro anga amene angaone zomwe zalembedwa.

Kafukufukuyu achitikira kwa miyezi khumi. Panthawi imeneyi, tidzangokambirana nawe kamodzi kwa mphindi makumi atatu okha. Kutengapo mbali kwanu mukafukufuku ameneyi ndi kwaufulu ndipo kulibe chiopsezo chilichonse. Mwanayu azapasidwa cholowa chokwana MK7,500 potengapo mbali pa kafukuku ameneyi.

Gawo 2: Kalata ya Chivomerezo

Ndawerenga chipepalachi, kapena chawerengedwa kwa ine. Ndakhala ndi mwayi wofunsa mafunso okhudza izi ndipo mafunso alionse omwe ndapemphedwa ayankhidwa moyenela. Ndinagwirizana ndi mtima wonse kuti nditengepo gawo pa kafukufukuyi.

Sindikizani Dzina la ofunsidwa: _____

Chizindikiro cha ofunsidwa _____

Tsiku _____

Tsiku / mwezi / chaka

Ngati osaphunzira

Ndawona kuweredwa kwa chipepalachi kwa omwe angathe kutenga nawo mbali, ndipo munthuyo anali ndi mwayi wakufunsa mafunso. Ndikutsimikizira kuti munthuyo wapereka chilolezo momasuka.

Dzina mboni_____ Poika chala

Chizindikiro cha umboni _____

Tsiku _____

Tsiku / mwezi / chaka

Ndemanga ya wofufuzira / munthu wobvomerezana

Ndaphunzira mwatsatanetsatane pepala lodziwitsira kwa omwe angathe kutenga nawo mbali, ndipo mwa kukhoza kwanga kulimbikitsa kuti ofunsidwayo amvetsetse zomwe zafotokozedwa m'nyuchipepalayi ndipo amavomereza kuti atenge nawo mbali
Kope ya ICF iyi yaperekedwa kwa ofunsidwa.
Sindikizani Dzina la munthu wotenga chilolezo_____
Chizindikiro cha munthu otenga chilolezo_____

Tsiku _____

Tsiku / mwezi / chaka

Appendix 10: ASSENT FORM FOR OLDER ADOLESCENT BOYS IN ENGLISH

Assent Form for young adolescent men aged between 15 and 17 years who are invited to participate in an academic research titled *"Applying a gender lens in cervical cancer programming: the assessment of sexually active young men involvement in cervical cancer preventive efforts"*

Name of Principle Investigator: Chimwemwe Nyambose Nkosi

Name of Organization: College of Medicine – Masters in Public Health

Name of Project and Version: Applying a gender lens in cervical cancer programming: the assessment of sexually active young men involvement in cervical cancer preventive efforts.

Part I: Information Sheet

We are asking you to help us learn more about young men involvement in cervical cancer prevention efforts in Lilongwe urban. We are therefore inviting you to take part in this research project. If you accept, you will be asked to take part in responding to some questions on what you know about cervical cancer and its causes, your general feeling about the disease and how young men are involved and how best you think you [and young men in general] can be involved in prevention efforts of the disease. We will not ask you to share personal practices or stories and you does not have to share any knowledge that you are not comfortable sharing. The discussion will take place at a comfortable place at the health facility. If it is better for you, the interview can take place in your home or a friend's home. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. No one else but the interviewer will be present unless you would like someone else to be there. The information recorded is confidential, and no one else except me and my academic supervisor will have access to the information documented during your interview. The information recorded is confidential.

The research takes place over a period of 10 months in total. During that time, we will only interview you once for a period of about 30 minutes. Your participation in this study is voluntary and this will no harm you in anyway. However, you will be given $10 (at a current exchange rate of $1 = MK750.00) as compensation for your participation in the study. You can ask questions if you do not understand any part of the study.

Do you understand? Would you like to participate Yes/No?

Part II: Certificate of Consent

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant_____

Signature of Participant _____

Date _____

Day/month/year

If illiterate [7]

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____ **Thumb print of part**

Signature of witness _____

Date _____

Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands the information described in this document and freely consents to participate

A copy of this ICF has been provided to the participant.

Print Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____

Day/month/year

[7] A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.

Appendix 11: ASSENT FORM FOR OLDER ADOLESCENT BOYS IN CHEWA

Fomu yolandira chidziwitso kwa anyamata a zaka zapakati pa 15 ndi 17 omwe akuitanidwa kutenga nawo mbali pa kafukufuku wokhuza Kutengapo mbali kwa a nyamata pa kuteteza amayi ku kansa yakhomo lachiberekero.

Dzina la Wofufuza Wamkulu: Chimwemwe Nyambose Nkosi

Dzina la Bungwe: College of Medicine

Dzina la Project: Kutengapo mbali kwa a nyamata pa kuteteza amayi ku kansa yakhomo lachiberekero.

Ndondomeko: Tikukupemphani kuti mutithandize kuphunzira zambiri zokhudza anyamata omwe amagwira nawo ntchito yothandizira kuchepesa khansa ya mchiberekero mumzinda wa Lilongwe. Choncho tikukupemphani kuti mutenge nawo gawoli. Ngati mukuvomereza, mudzafunsidwa kutenga nawo mbali pa kuyankha mafunso ena pa zomwe mumadziwa zokhudza matendawa ndi zomwe zimayambitsa, momwe mumamvera za matendawa ndi momwe anyamata akukhudzidwa ndi momwe mukuganizira kuti [ndi anyamata ambiri] akhoza kutenga nawo mbali pochepesa matendawa. Sitifunsani kuti mugawane nafe chidziwitso chilichonse chimene simumasuka kugawana nafe. Zokambiranazi zidzachitika pamalo abwino pa chipatala pano angakhala malo ena amene mungamasuse nawo. Ngati simukufuna kuyankha mafunso aliwonse, mukhoza kunena choncho ndipo wofunsayo adzapitiriza ndifunso lotsatira. Palibe wina koma wofunsayo amene angakhalepo pokhapokha ngati mukufuna kuti wina akhalepo. Zomwe zalembedwazo ndizobisika, ndipo palibe wina kupatula ineyo ndi woyang'anira maphunziro anga amene angaone zomwe zalembedwa.

Kafukufukuyu achitikira kwa miyezi khumi. Panthawi imeneyi, tidzangokambirana nawo kamodzi kwa mphindi makumi atatu okha. Kutengapo mbali kwanu mukafukufuku ameneyi ndi kwaufulu ndipo palibe chiopsezo china chili chonse. Pakutha kwa kucheza kwathu muzapasidwa cholowa chokwana MK7,500 potengapo mbali pa kafukuku ameneyi.

Gawo 2: Kalata ya Chivomerezo

Ndawerenga chipepalachi, kapena chawerengedwa kwa ine. Ndakhala ndi mwayi wofunsa mafunso okhudza izi ndipo mafunso alionse omwe ndapemphedwa ayankhidwa moyenela. Ndinagwirizana ndi mtima wonse kuti nditengepo gawo pa kafukufukuyi.

Sindikizani Dzina la ofunsidwa: _____

Chizindikiro cha ofunsidwa _____

Tsiku _____

Tsiku / mwezi / chaka

Ngati osaphunzira

Ndawona kuweredwa kwa chipepalachi kwa omwe angathe kutenga nawo mbali, ndipo munthuyo anali ndi mwayi wakufunsa mafunso. Ndikutsimikizira kuti munthuyo wapereka chilolezo momasuka.

Dzina mboni_____ Poika chala

Chizindikiro cha umboni _____

Tsiku _____

Tsiku / mwezi / chaka

Ndemanga ya wofufuzira / munthu wobvomerezana

Ndaphunzira mwatsatanetsatane pepala lodziwitsira kwa omwe angathe kutenga nawo mbali, ndipo mwa kukhoza kwanga kulimbikitsa kuti ofunsidwayo amvetsetse zomwe zafotokozedwa m'nyuchipepalayi ndipo amavomereza kuti atenge nawo mbali

Kope ya ICF iyi yaperekedwa kwa ofunsidwa.

Sindikizani Dzina la munthu wotenga chilolezo_____

Chizindikiro cha munthu otenga chilolezo_____

Tsiku _____

Tsiku / mwezi / chaka