Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls Project
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Evaluation of Youth-Friendly Health Services in Malawi

June 2014

E2A Overview

The Evidence to Action Project (E2A) is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and leading the scale-up of best practices that improve family planning services. A five-year Cooperative Agreement awarded in September 2011, E2A is led by Pathfinder International in partnership with the African Population and Health Research Center, ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.

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Abbreviations

APHRC	African Population and Health Research Centre
ARV	Anti-retroviral
AYSRH	Adolescent and Youth Sexual and Reproductive Health
BLM	Banja La Mtsogolo
BCC	Behavioral Change Communications
CBDA	Community Based Distribution Agent
CHAM	Christian Health Association of Malawi
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CSR	Centre for Social Research
DD	Demographic Dividend
DHO	District Health Officer
DYFHSC	District Youth Friendly Health Services Coordinator
E2A	Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Girls Project
FGD	Focus Group Discussion
FP	Family Planning
FPAM	Family Planning Association of Malawi
FP/RH	Family Planning and Reproductive Health
GOM	Government of Malawi
HC	Health Center
HEU	Health Education Unit
HF	Health Facility
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistants
HTC	HIV Testing and Counseling
IEC	Information, Education and Communication
IUD	Intra Uterine Devise
LAM	Long-Acting Method
MDHS	Malawi Demographic and Health Survey
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
MOH/RHU	Ministry of Health's Reproductive Health Unit
NGO	Nongovernmental organization
PMTCT	Prevention of Mother to Child Transmission of HIV
PAC	Postabortion Care
PEP	Post-Exposure Prophylaxis
RHD	Reproductive Health Directorate
RHU	Reproductive Health Unit
SBCC	Social and Behavior Change Communication
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
YCBDA	Youth Community Based Distribution Agents
YFHS	Youth Friendly Health Services

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Foreward

The provision of youth-friendly health services started in 2000, and since then no comprehensive evaluation of the program has been done to look at the quality of these services compared to the standards that were developed. Furthermore, no evaluation or assessment has been done to look at effectiveness of the youth-friendly health services models (approaches) and strategies currently in use by the Ministry of Health and non-governmental organizations to inform future programming or to change the approach to respond to the needs of youth.

More importantly, the voices of youth are lacking from any document that assesses the current state of youth-friendly health services, which are crucial for ensuring that health services respond to the needs of youth from a youth perspective.

The Demographic Health Survey of 2010 revealed that young people are sexually active; 26 percent of girls became pregnant before the age of 19 and the HIV and AIDS prevalence is highest among youth aged 15-24 years. Previous assessments conducted by WHO, UNFPA, and other stakeholders revealed that young people still face challenges in accessing comprehensive health and sexual and reproductive health services, despite availability of enabling policies, trained providers and standards. If Malawi is to increase its contraceptive prevalence rate from 42 percent and reduce its high fertility rate of 5.7, adolescents and youth must have their rights to sexual and reproductive health services and health protection, and their right to decide when and how many children to have, strengthened and prioritized.

Meeting the reproductive health needs of the youth is one important strategy in addressing the social and economic implications of a rapidly growing population and managing development. It is in view of these facts that the Ministry of Health decided to carry out a comprehensive evaluation of youth-friendly health services program to assess the scope, quality, and outcomes of efforts by the Ministry of Health and other implementing partners.

The Reproductive Health Department of the Ministry of Health identified the need for this program evaluation, and received technical support from USAID/Malawi for the administration of the process of evaluation. The Reproductive Health Department and USAID were joined by UNFPA, WHO, UNICEF/Malawi, the E2A Project, and CSR to carry out this program evaluation.

Chris V. Kang'ombe
Secretary for Health

Executive Summary

Youth aged 10-24 constitute more than one-third of the population in Malawi. Recognizing that this significant population of young people are exposed to a broad range of sexual and reproductive health (SRH) challenges that include unwanted pregnancies, sexually transmitted infections (STIs), and HIV/AIDS, in 2007, the Government of Malawi, with support from the United Nations Population Fund (UNFPA), the United Nations Children's Fund, the World Health Organization (WHO), and other stakeholders, began implementing the Youth-Friendly Health Services (YFHS) program as a strategy to make all health services more acceptable, accessible, and affordable to young people.

The Ministry of Health (MOH) developed a technical working group to create a set of YFHS standards that defined the minimum package of services to be offered to young people by level of care, using the WHO international standards as a guide. Despite the efforts to scale up YFHS across the country, a monitoring exercise conducted in 2010 revealed that only 64 of 266 sites assessed (24 percent) were ready for accreditation. Since 2007, no comprehensive assessment has been conducted to examine program coverage, the extent to which services align with standards, what works, and the barriers to implementation and uptake of YFHS package. The MOH therefore decided to carry out a comprehensive evaluation of the YFHS program to assess coverage, quality, and achievements.

The specific objectives of the evaluation, conducted by the USAID-funded Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls Project, USAID, the Centre for Social Research, UNFPA, WHO, and Malawi's MOH were to:

1. Assess the extent to which YFHS standards and the minimum package of YFHS have been implemented.
2. Examine factors that influence uptake of YFHS at the district and zonal levels.
3. Determine the coverage of YFHS.

Methodology

The evaluation had two components: the qualitative component that focused on gaining deeper understanding of facilitators and barriers to uptake of YFHS in Malawi, and the quantitative component that focused on coverage of the YFHS program, uptake of YFHS, adherence to standards, and satisfaction with YFHS services provided. The quantitative component was conducted in 10 districts selected from the 5 zones of Malawi: Mzimba and Karonga (North), Dowa and Kasungu (Central East), Lilongwe and Ntcheu (Central West), Mangouchi and Phalombe (South East), and Nsanje and Chiradzulu (South West). The qualitative data were collected in 5 of the 10 districts (1 district per zone).

For the qualitative component, focus group discussions (FGDs) were conducted with two groups of respondents: youth in the community and parents of youth. FGDs were conducted in both urban and rural sites, with males and females. Each FGD consisted of eight to ten members and the discussions were facilitated by trained persons using pretested guides. The FGD participants were recruited with support from health surveillance assistants[1] using age and gender criteria.

The quantitative component consisted of a community survey with 2,033 young people to determine their knowledge and use of YFHS; exit interviews with 589 young clients at health facilities to determine their satisfaction with services; interviews with 30 hospital- and 87 health center-based service providers

[1] Health surveillance assistants are the lowest cadre of health workers in Malawi's health system, based at community level and mainly responsible for preventive and promotive health services. They are responsible for a population of 1,000 people. They are attached to a health facility.

to determine the quality and breadth of the services they offer as well as any challenges they face; interviews with 67 peer educators and 86 community-based distribution agents (CBDAs) to determine how they conduct outreach and offer services, among other activities; interviews with NGO staff to identify their YFHS-related activities; interviews with 61 health facility management staff/senior YFHS providers and 11 district health officers to determine adherence to YFHS standards; interviews with 11 district YFHS coordinators to determine successes and barriers to implementation of YFHS; interviews with community leaders to assess their perceptions of young people, particularly with regard to SRH; and a review of service statistics from the four quarters preceding the evaluation to assess YFHS uptake.

The evaluation highlighted strengths and weaknesses in the current YFHS program, information which can be used to inform new strategies. Evaluation results are expected to guide future YFHS, including HIV programming in Malawi.

Key Findings

The key findings are presented in the table below. The findings are organized by the three evaluation objectives and represent overall percentages among the populations interviewed. For the majority of the findings, however, there were vast variations by zones. Those variations are presented in the corresponding chapters of this report. Specifically for findings related to health facilities implementing the Government of Malawi's Standards for YFHS, there were not only zonal variations, but also variations between health facilities that were implementing YFHS and those that were not. A national dissemination workshop will be conducted to share findings with key stakeholders. The study results will also be presented at national, regional, and international meetings.

Objective 1: Implementation of YFHS & Standards
Training & Supervision of Providers
- About half of community-based distribution agents and 64% of peer educators reported being trained in YFHS, including counseling on contraception, HIV/AIDS, and STIs, and information about condoms and condom distribution. Both groups reported supervision from higher-ranking officers as generally weak. - 68% of health center providers and 73% of those in hospitals said they had been trained to offer YFHS, with varying percentages trained in the aforementioned counseling services as well as prevention of mother-to-child transmission of HIV, and treatment and care for adolescents living with HIV. Some health center providers had been trained to provide antenatal care and treat abortion complications. *See **Chapter 4** for more details, including variations by zone.*
NGO Support
- More than half of NGOs reported to support YFHS at both the community and health facility levels. One-quarter of NGOs reported supporting programs in either communities *or* facilities. - At health facilities, NGOs reported to support activities including supply of IEC materials, and commodities and equipment. At the community level, NGOs reported supporting the training of YFHS providers, supply of contraceptives and IEC materials, and provision of space for youth to meet. - Of the five approaches to delivering YFHS identified in this report, the most widely applied approach is the integrated one (see ***Section 1.4*** for a description of the five service delivery approaches). *See **Chapter 4** for more details, including variations by zone.*

Implementation of Standards

- Evaluators rated the implementation of the government's five YFHS standards as medium;[1] however, this evaluation demonstrates vast variation among the five zones in terms of scope of implementation and which standards and elements are implemented.

- Of the eight Standard 1 elements, implementation was low for two, medium for three, and high for three; Of the five Standard 2 elements, implementation was low for three and high for two; Of the seven Standard 3 elements, implementation was low for four and medium for three; Of the eighteen Standard 4 elements, implementation was low for twelve, medium for three, and high for three; Of the nine Standard 5 elements, implementation was low for five, medium for one, and high for three.

- More than 60% of health facilities reported to have copies of the YFHS standards on-site; less than one-third of health facilities reported to have a clear sign advertising YFHS, provide outreach services specific to youth, have trained providers on the YFHS Standards, and have youth-specific IEC materials; about half of health facilities have organized community meetings to provide information on YFHS; less than 40% reported disaggregating data by age, sex, school and marital status—information that can inform service provision based on where young people are in their lifecycle stages.

*See **Chapter 5** for more details, including variations by zone.*

[1]Implemenatation of a standard element was rated low if less than 50% of health facilities reported to be implementing it; medium, if between 50 and 75% were implementing; and high, if more than 75% were implementing.

Objective 2: YFHS Program Coverage

- Awareness and ever use of the YFHS program is low in Malawi, with less than one-third of community youth survey respondents reporting to have heard about YFHS and 13% reporting to have ever used a YFHS.

- Those living in communities where health facilities offer YFHS report knowing more about YFHS than those living in communities where facilities do not; about 35% versus 25%, respectively. However, ever use of YFHS does not vary by whether or not community has a facility that offers YFHS.

- Knowledge and use of YFHS varied by districts and zones as well as the age, sexual experience, and school attendance status of the young people being interviewed. Sexually experienced youth, those who were out of school, and those who were older more often accessed YFHS than their counterparts, suggesting that where young people are in their lifecycle plays a significant role in their knowledge and use of YFHS.

- The majority of young people who reported visiting YFHS did so for the first time in the 12 months prior to our interviews with them, conveying that the YFHS program has gained more prominence over the last year or two. Most of those who had accessed YFHS expressed satisfaction with the services they received.

- More than 60% of those who reported accessing YFHS went to government health facilities for those services. Among young people interviewed, misconceptions about who should benefit from YFHS are evident, with more than half saying that YFHS are only for married youth.

*See **Chapter 6** for more details, including variations by zone.*

Objective 3: Factors Influencing Uptake of YFHS
- Young people, parents, and community leaders lack knowledge about the YFHS program, and young people's doubts about privacy and confidentiality in the YFHS provided inhibit the uptake of YFHS. - Some young people interviewed pointed out that when service providers require youth to undergo an HIV test before being offered other health services, they become discouraged from visiting the facility. - Other factors impeding the use of YFHS include inadequate outreach to young people in communities surrounding the YFHS; low self-confidence among clients and the tendency to be 'shy,' particularly with girls; weak parental and community support for young people seeking SRH services; long commutes and inadequate transport to facilities offering YFHS; and contradictory religious beliefs. *See **Chapter 7** for more details, including variations by zone.*
Other Findings: Sexual and Reproductive Health
- Awareness about sex is high, even among the youngest age group—those 10-14 years old. More than 76% of males and 66% of females in this age group had heard or talked about sex. - Half of all young people (aged 10-24) who reported knowing about sex had actually had sex, with the likelihood of reporting to have had sex increasing with age. Of the sexually experienced youth, more than 85% of males and about 75% of females expressed the intention to use contraception during future sex; there was a strong preference among males for use of condoms. - Most young people preferred to get their contraceptives from public health facilities. - 72% of sexually experienced females had been pregnant, with the tendency to report pregnancy increasing with age; around 43% reported to want the last pregnancy while 31% said they did not. *See **Chapter 3** for more details, including variations by zone.*

Recommendations to the Government of Malawi's YFHS Program

- Train all youth service providers in YFHS and ensure that designated officers monitor the quality of services through supportive supervision.
- Work with stakeholders to develop strategies for implementation and monitoring of the Government of Malawi's YFHS standards, support these efforts with adequate resources, and ensure engagement of district YFHS coordinators in monitoring efforts.
- Strengthen the quality of monitoring and use of data to improve services for young people and inform future programming.
- Develop appropriate strategies to create awareness about the YFHS program, particularly in catchment areas surrounding YFHS, including the package of services offered, and the program benefits and its intended beneficiaries; gain the support of parents and community leaders for YFHS; reach young persons at their different lifecycle stages with information and services that meet their needs; and address health providers' attitudes towards youth.
- Have peer educators, CBDAs, and providers assist with developing and implementing programs that address young people's misconceptions about SRH services.

- Address personal, social, and structural barriers that hamper access to and use of services by youth.
- Focus on the involvement of village chiefs and parents in YFHS program activities, especially with regard to their role in promoting YFHS and access to SRH services for young people.
- Coordinate with NGOs to streamline the different approaches to YFHS applied in Malawi.
- Review the content of sex education to ensure 10-14 year olds, in particular, are getting the information they need about sex, contraception, and pregnancy.
- Leverage the opportunity to disseminate accurate SRH information through peers, the most commonly cited source of information on YFHS among young people.
- Increase access to contraceptives by making them more affordable and attractive to youth, particularly at private and NGO facilities.

1. Background to the Evaluation

1.1. Context

Young persons aged 10-24 constitute more than 30 percent of Malawi's population. The 2008 census showed that 32 percent (31.6 percent of males and 32.5 percent of females) were young persons aged 10-24.[2] The 2010 Malawi Demographic and Health Survey (MDHS) showed that the percentage of all household members aged 10-24 is 32.3 (33.3 percent of males and 31.4 percent of females)[3] Because of the relative size of the young population, significant improvements in their health conditions will translate to significant improvements in the population's health indices and vice versa. Despite this prospect, sexual and reproductive health (SRH) services in Malawi have been generally unfriendly to young people, leading to high proportions of young people not motivated to seek/access them.[4] A 2002 needs assessment conducted by the United Nations Children's Fund (UNICEF)[5] conveyed that service providers were often negative and judgmental, opening hours were at odds with preferred/convenient times for young people to access services, and unaffordable costs were institutionalized in high user fees.

The findings of the 2002 needs assessment prompted the Government of Malawi (GOM) to begin thinking about instituting a youth-friendly health services[6] (YFHS) program. The government recognized that young people in Malawi were exposed to a broad range of health and SRH problems that include unwanted pregnancies, sexually transmitted infections (STIs), and HIV/AIDS. Results from the 2004 MDHS, 2004 National Survey of Adolescents[7], and later the 2006 Multiple Indicator Cluster Survey[8]confirmed government concerns about SRH among young people, revealing high rates of sex and childbearing among adolescents, low rates of contraceptive use at first sex, a considerable unmet need for family planning (FP) to space births, high-risk behaviors such as having sex with multiple partners and the prevalence of HIV and STIs (see 2004 MDHS and 2004 National Survey of Adolescents for specific figures).

These and many other similar findings contributed to the GOM's resolve to identify and pay more attention to the specific health needs of youth, including implementing services and strategies that address those needs within the health system. Guided by the 2004 young people's health strategy and implementation framework[9] and the 2006 National Reproductive Health Strategy[10], the GOM, through the Ministry of Health's (MOH) Reproductive Health Unit (RHU), started implementing the YFHS program in 2007 as a strategy to make all health services more acceptable, accessible, and affordable to

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[2] National Statistical Office of Malawi, 2008 Population and Housing Census.

[3] National Statistical Office, Malawi and ICF Macro, Malawi Demographic and Health Survey (Calverton, Maryland, DHS, September 2011).

[4] The 2007 YFHS manual defines young people as those aged between 10 to 24 years regardless of marital, social, and economic status; however, the revised National Youth Policy defines youth as those aged between 10 to 29 years. For this evaluation, youth will refer to those aged 10-24 years.

[5] UNICEF, YFHS Needs Assessment: How friendly are they to Young People? (2002).

[6] The 2007 National Standards of Youth Friendly Health Services defines youth-friendly health services as high-quality services that are relevant, accessible, attractive, affordable, appropriate and acceptable to young people. The services are provided in line with a minimum health package that aims to increase acceptability and use of health services by young people.

[7] Alister Munthali, Eliya M. Zulu, Nyovani Madise, Ann M. Moore, Sidon Konyani, JamesKaphuka and Dixie Maluwa-Banda, *Adolescent Sexual and Reproductive Health in Malawi: Results from the 2004 National Survey of Adolescents, Occasional Report No. 2* (2006).

[8] National Statistical Office, United Nations Children's Fund, Multiple Indicator Cluster Survey (Malawi, 2006).

[9] Ministry of Health (RHU), *Young People's Health Strategy and Implementing Framework* (2004).

[10] Ministry of Health (RHU), *National Reproductive Health Strategy 2006-2010,* (2006).

young people. The RHU, with support from the United Nations Population Fund (UNFPA), the World Health Organization (WHO), UNICEF, and other stakeholders, reviewed Malawi's Sexual and Reproductive Health & Rights Policy in 2009, recommending the inclusion of standards that would specifically ensure the provision of health services to young people as part of the government's minimum health package of services. That minimum package of services would focus on STIs, HIV and AIDS, FP information and services, nutrition, sexual abuse, adolescent and youth pregnancy, and psychosocial support. Using the WHO international standards as a guide, a technical working group (TWG) then developed a set of YFHS standards that defined the minimum package of services to be offered to young people by level of care.

According to MOH guidelines, the minimum package is a combination of clinical services and health promotion interventions that address the health needs of young people. Three areas of the minimum package are emphasized: health promotion, delivery of health services, and referral and follow-up. Although health services are provided to young people within the original clinical standards and procedures approved by the MOH and supported by WHO guidelines,[11] they are not provided in a youth-friendly manner; that is, in ways that are acceptable, accessible, appropriate, convenient, and affordable to young people.

As described in Chapter 4 of this report, there are five standards for the Malawi YFHS program, each of which contains criteria/elements for tracking performance:

Standard 1: Health services are provided to young people according to existing policies, procedures, and guidelines at all service delivery points.

Standard 2: Young people are able to obtain health services that include preventive, promotive, curative, and rehabilitative health services appropriate to their needs.

Standard 3: All young people are able to obtain health information (including SRH and HIV) relevant to their needs, circumstances, and stage of development.

Standard 4: Service providers at all delivery points have the required knowledge, skills, and positive attitudes to effectively provide YFHS.

Standard 5: Health information related to young people is collected, analyzed, and utilized in decision making at all levels.

The YFHS standards require that clinical services are delivered at three levels as follows:[12]

Community Level:

- Contraceptive services, including condoms
- HIV testing and counseling (HTC)

[11] World Health Organization, Reproductive Health and Research and Child and Adolescent Health and Development Departments, *Policy Brief 4 – Implementing the reproductive health strategy* (Geneva: World Health Organization, 2006).

[12] Health services in Malawi are delivered mostly through MOH facilities (about 60%) with the Christian Health Association of Malawi as the largest partner (about 38%). The other providers include private and NGO facilities. Static and outreach services are provided at three levels: primary, consisting of health centers and outreach sites; secondary, consisting of district hospitals; and tertiary, consisting of central hospitals.

- Referral to health facility or other service delivery points

Health Center Level:

- Contraceptive services, including condoms
- Prevention, diagnosis, and management of STIs
- Antenatal, delivery, and postnatal care services
- Prevention of mother to child transmission of HIV (PMTCT)
- HTC
- Treatment of sexual abuse victims
- Referral to hospitals or other service delivery points

Hospital Level:

- Postabortion care (PAC)
- Contraceptive services, including condoms
- Prevention, diagnosis, and management of STIs
- Antenatal, delivery, and postnatal care services
- PMTCT
- HTC
- Provision of antiretrovirals (ARVs)
- Treatment of sexual abuse victims (including post-exposure prophylaxis (PEP))
- Referral to hospitals or other service delivery points

Health promotion and counseling during service delivery at all levels address:

- STIs
- HIV/AIDS
- Contraceptives to prevent unwanted pregnancies
- Nutrition
- Sexual abuse
- Maternal and neonatal health care
- Adolescent growth and development
- Psychosocial support

The development of the YFHS standards was informed by the need to have performance benchmarks for all donors and partners implementing YFHS. For this evaluation, the standards were used to:

- Assess the youth friendliness of service delivery points providing services to young people.
- Identify gaps between required performance and actual performance at different levels of the health system—community, health facility, district, and national.
- Identify and address causes of observed gaps between required and actual performance.
- Appraise performance of service providers together with existing clinical standards.
- Accredit service delivery points.

Underlying the standards are the following key principles:

- Active participation of young people in the planning, implementation, and monitoring of health services according to their level of capacity.
- Provision of services based on the development and health needs of young people.
- Community participation in development and provision of services.
- Provision of YFHS by trained health workers and community volunteers.
- Accreditation and certification of all facilities providing YFHS.

Since the development of the YFHS standards, the government and NGOs, with support from development partners, have trained staff in YFHS to ensure provision of services accordingly. Supervision visits are being conducted to ensure that trained service providers are implementing standards. In addition, the government and NGOs have provided programmatic support to districts in the implementation of the YFHS program. Since 2007, the MOH has made efforts to scale up YFHS across the country. In 2010, a national monitoring exercise of YFHS in Malawi[13] showed that 1,122 providers had been trained. The exercise also revealed that only 64 of 266 sites surveyed were ready for accreditation, implying that only a few facilities were implementing YFHS standards. Additionally, the report reveals that:

- IEC materials targeting young people are not available at most of the sites and for those that have them, less than 50 percent have them available for young people to take home.
- Only 30 percent of the sites had at least the two required providers trained in YFHS.
- Data utilization among service delivery points for programming was reported at less than 47 percent; only 40 percent of the sites involved young people in supporting activities at YFHS.

1.2. Rationale/Justification for this Evaluation

Since the provision of YFHS started in 2007, no comprehensive assessment has been conducted to examine program coverage, the extent to which services align with established standards, and the barriers to implementation and uptake of the YFHS package. Furthermore, no assessment has been undertaken to examine the implementation of the different YFHS approaches and strategies currently applied by the MOH and NGOs to inform future programming. Likewise, youth and community involvement in planning, implementing, and monitoring YFHS has not been adequately documented, even though it is widely accepted that youth voices are crucial for ensuring that health services respond to the needs of youth.

Assessments conducted elsewhere by WHO, UNFPA, and other stakeholders reveal that young people still face challenges accessing comprehensive health and SRH services despite availability of enabling policies, trained providers, and standards. If Malawi is to increase its contraceptive prevalence rate from 42 to 60 percent by 2020 and reduce its high total fertility rate of 5.7, adolescents and youth must exercise their rights to health services and protection, and be able to decide when and how many children they have. Meeting the SRH needs of youth is an important strategy for addressing the social and economic implications of a rapidly growing population and managing development. It is in view of these facts that the MOH decided to carry out a comprehensive evaluation of YFHS to assess coverage, quality, and achievements of YFHS in Malawi. The present evaluation conducted by the USAID-funded Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls Project (E2A), with support from USAID, the Centre for Social Research, UNFPA, WHO, and Malawi's MOH, was therefore undertaken to examine the proportion of youth in the catchment areas of service delivery points that have accessed YFHS and the extent to which services are performed in accordance with standards.

[13] National Youth Council of Malawi, *Report of the 2010 Youth Friendly Health Services (YFHS) National Monitoring* (2010).

1.3. Literature Review

In 2010, there were 1.8 billion young people between 10 and 24 years old, representing one-quarter of the world's population.[14] Approximately 85 percent of them lived in developing countries where poverty remains high and resources scant. In Malawi, an estimated one-third of all household members are aged 10-24.[15] Although the government, since the MDHS was published in 2004, has focused on implementing a YFHS program to address the SRH of this large population, six years later, when data for the 2010 MDHS were collected, not much had changed in the SRH behaviors of young people. As of 2010, the MDHS revealed that:

- Among never-married young people aged 15-19, 53.1 percent of males and 24.1 percent of females had had sex.
- Among never-married young people, 78 percent of males and 57 percent of females had had sex.
- 25.6 percent of females 15-19 and 86.9 percent of those aged 20-24 had started childbearing.
- 17 percent of sexually active young women 15-19 and 22 percent of those aged 20-24 were using contraceptives.
- 0.4 percent of sexually experienced males and 0.7 percent of sexually experienced females 15-19 reported having had STIs; among 20-24 year-olds, the figures are 2.1 percent for males and 1.4 percent for females.
- Among those aged 15-19, 1.3 percent of males and 4.1 percent of females were HIV infected; among those aged 20-24, the corresponding figures are 2.8 percent for males and 6.4 percent for females.
- 48.3 percent of females aged 15-19 and 79.7 percent of those aged 20-24 visited a health facility for care in the year preceding the survey.

Globally, about 2.6 million young people die every year, most from preventable causes including injury, HIV, tuberculosis, and maternal death.[16] Young women aged 15-19 are twice as likely as adult women to die in childbirth. Young people are also more prone to HIV infection; of the approximately 2.5 million new HIV infections that occurred in 2011, 40 percent occurred among youth aged 15-24 years.[17] In Malawi, young people (10-24) account for approximately half of new infections.[18] Efforts to improve the health conditions of young people informed the development of both the YFHS strategy in Malawi and similar efforts around the world.

Responding to the health needs of adolescents and youth requires the concerted effort of multiple ministries/sectors. However, the health sector has usually assumed the responsibility of expanding coverage and improving the quality of health services for adolescents and youth, with a view to improving health outcomes and attaining the demographic dividend (DD). The economic benefits of the

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[14] United Nations Population Division, *World population prospects: the 2008 revision* (2009), accessed at: http//www.un.org/esa/population/publications/wpp2008/wpp2008_highlights.pdf.Accessed Dec_2012.

[15] National Statistical Office Malawi and ICF Macro, *Malawi Demographic and Health Survey 2010* (Calverton, Maryland, September 2011).

[16] Patton, G et al (2012) Health of the world's adolescents: a synthesis of internationally comparable data, Lancet vol 379 April 2012: 1665-1675

[17] UNAIDS (2010) UNAIDS World AIDS Day Report 2012. Geneva: UNAIDS Available at http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/jc2434_worldaidsday_results_en.pdf., ccessed March 2014.

[18] UNAIDS (2011). Malawi HIV and AIDS monitoring and evaluation report: 2008-2009. http://www.unaids.org/es/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/file.

DD can be attained through reductions in birth and child death rates. Preventing unintended pregnancies among young people through increased voluntary use of contraception paves the way for attainment of the DD by reducing maternal mortality, unsafe abortions, and contributing to a shift in the age structure of the population in favor of the more productive segment of the population.[19]

In the past four years, there have been several policy documents and briefs, publications in peer-reviewed journals, and syntheses of research findings on adolescent and youth sexual and reproductive health (AYSRH). The UNICEF report entitled *Adolescence – An Age of Opportunity* [20] calls attention to the need to invest in adolescents, outlining not only the risks and vulnerabilities, but also the opportunities such investments can offer to build a better future for humanity. During the July 2012 FP Summit in London, WHO released the brief, *WHO: From Evidence to Policy: Expanding Access to Family Planning*, which summarizes the latest evidence on FP. The brief, *Expanding Access to Contraceptive Services for Adolescents,*[21] presents FP as a critical health and development issue and a key intervention for the survival of women and children. The brief recommends enacting policies that require the provision of accurate, age-appropriate comprehensive sexuality education to eliminate social and non-medical restrictions on the provision of contraceptives to adolescents. Enactment of policies that enable adolescents to obtain a full range of contraceptive methods and services through delivery mechanisms that are appropriate and acceptable to them was also recommended.

USAID released the Youth in Development Policy in October 2012.[22] The goal of the policy is to improve the capacities and aspirations of youth so that they can contribute to and benefit from more stable, democratic, and prosperous communities and nations. Young people are seen as a driving force in global development and promoting youth participation as partners and leaders is a central element. Reviewing and following up on the implementation of the Programme of Action of the International Conference on Population and Development beyond 2014, the Bali Global Youth Forum produced important recommendations to advance AYSRH.[23] These policies draw attention to the fact that despite all the efforts that have been made, young people still face considerable social and economic barriers to accessing reproductive health (RH) information and services. In response to the urgent needs to meet AYSRH needs, the *Lancet* dedicated a special edition to adolescent health in 2007. In the edition, Tylee et al[24] discussed key approaches of youth-friendly health service provision and reviewed evidence on the effects of such approaches on young people's health. Despite limited evidence, the authors concluded that "enough is known to recommend that a priority for the future is to ensure that each country, state, and locality has a policy and support to encourage provision of innovative and well-assessed youth-friendly services." Also, based on a 2007 impact evaluation of the African Youth Alliance Program in Ghana, Tanzania, and Uganda,[25] it was suggested that multicomponent programs that combine strategies

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[19] James N Gribble and Jason Bremmer, "Achieving a Demographic Dividend," *Population Bulletin* 67, no.2 (2012).
[20] UNICEF, "The State of the World's children 2011, Adolescence An Age of Opportunity," accessed December 2012 at: http://www.unicef.org/sowc2011.
[21] WHO, "Evidence to Policy: Expanding Access to Family Planning - Improving contraceptive services for adolescents," accessed at: http://apps.who.int/iris/bitstream/10665/75160/1/WHO_RHR_HRP_12.21_eng.pdf.
[22] USAID, Youth in Development Realizing the Demographic Opportunity," accessed at http://transition.usaid.gov/our_work/policy_planning_and_learning/documents/Youth_in_Development_Policy.pdf.
[23] UNFPA, "Bali Global Youth Forum Declaration," accessed January 2012 at: http://icpdbeyond2014.org/about/view/13-icpd-global-youth-forum.
[24] Tylee, A. et al., "Youth-friendly primary-care services: how are we doing and what more needs to be done?," *Lancet Series* 369 (2007): 1565-73.
[25] Williams, T et al., "Evaluation of the African Youth Alliance Program in Ghana, Tanzania, and Uganda. (2007), http://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=INTL&id=4645&thisSection=Resources.

and are culturally appropriate and youth sensitive can be an effective approach for addressing young people's SRH needs. In 2010, WHO supported a review[26] that acknowledged the failure of approaches focusing solely on improving SRH service provision (quality, availability, acceptability, and accessibility) to youth. The results indicated that the "involvement of key community gatekeepers is vital and that a combined multicomponent approach seems most promising." These findings confirm the impact evaluation of YFHS projects in Lusaka, Zambia,[27] which showed an improvement in the clinic experience of adolescents and an increase in service utilization. The findings also show that "community acceptance of reproductive health services for youth may have a larger impact on the health-seeking behavior of adolescents." Over time, other program approaches to address AYSRH needs were examined with improved accuracy. The examination of YFHS approaches led to the conclusion that interventions which train service providers and make facilities more youth friendly, coupled with activities in the community, and involvement of other sectors to link or refer young people to health services[28];[29];[30];[31] ;[32] show the strongest evidence of effectiveness. Unfortunately these studies often lack details on specificities of YFHS implementation, making it difficult to identify best practices in YFHS and the type of YFHS approach used to achieve key results. What the evidence does show is that for YFHS to have a significant impact, they have to be implemented over a sustained period of time and at significant scale.[33] The evidence further shows that making services friendly to young people can be done using a range of different models and approaches—there is no approach that fits all contexts.[34]

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[26] Kesterton, A & Cabral de Mello, M., "Generating demand and community support for sexual and reproductive health services for young people: a review of the Literature and Programs," *Reproductive Health* 7 (2010):25, accessed December 2012 at: http//www.reproductive-health-journal.com/content /7/1/25.

[27] Mmari, K et al., "Does Making-Clinic-based Reproductive Health Services more youth-friendly increase services use by adolescents? Evidence from Lusaka, Zambia," *Journal of Adolescent Health* 33 (2003): 259-270.

[28] Dick B. Fergunson J, Ross DA, eds., Preventing HIV/AIDS in young people –a systematic review of the evidence from developing countries, accessed October 2012, at http://www.who.int/child-adolescent-health/publications/ADH/ISBN 92 4 1209380.htm.

[29] Kesterton, A & Cabral de Mello, M., "Generating demand and community support for sexual and reproductive health services for young people: a review of the Literature and Programs," *Reproductive Health* 7 (2010):25, accessed December 2012, at http//www.reproductive-health-journal.com/content /7/1/25.

[30] Sawyer, S et al., "Adolescence: a foundation for future health," *Lancet* (2012).

[31] Ringheim, K &Gribble, J., *Improving the Reproductive Health of Sub-Saharan Africa's Youth: A route to achieve the Millennium Development Goals* (Population Reference Bureau, 2010).

[32] Mavedzenge, Sue N, Doyle A & Ross D., HIV prevention in young people in sub-Saharan Africa: A systematic review, accessed September 2012 at http://www.schoolsandhealth.org/Documents/HIV%20prevention%20in%20young%20people%20in%20sub-Saharan%20Africa%20A%20Systemic%20Review.pdf.

[33] Renju, J. et al., "A process evaluation of the scale up a youth-friendly health services initiative in northern Tanzania," *Journal of the International AIDS Society* 13 (2010):32, accessed December 2012, at: http://jiasociety.org/content/13/1/31.

[34] WHO, Adolescent-friendly Health Services in the South-East Asia Region report, accessed October 2012 at: http://hpe4.anamai.moph.go.th/hpe/data/yfhs/AFHS_SEA.pdf.

1.4. Approaches to Delivering Youth-Friendly Health Services in Malawi

Following the development of the MOH YFHS guidelines and standards, and with the support of donors and implementing partners, YFHS are currently implemented in all districts in Malawi, with the scope of implementation varying across districts. The involvement of different donors and technical partners has resulted in some variation in the way services are provided. In July 2013, staff of the MOH, USAID, and E2A visited YFHS delivery points to gain better insight into how services are delivered. The site visits, coupled with a mapping of service delivery activities by different implementing partners and a pilot exercise carried out in November 2013, showed that there are five basic approaches (or combination of elements) in Malawi. The assessment examined uptake of YFHS through these approaches in an effort to highlight the most efficacious approach(es) applied in Malawi. The five approaches are:

1: Delivery of clinical and non-clinical health services in stand-alone YFHS delivery points (clinics or youth drop-in centers that offer counseling, contraceptive distribution, STI/HTC, and PAC services only to youth). The service providers include clinical service providers (in average-sized clinics), youth peer educators, and peer counselors. Members of community youth clubs meet at these centers for counseling and education on SRH issues as well as for recreational activities.

2: Delivery of YFHS in health facility rooms designated for only youth activities. Unlike the stand-alone centers, the facilities provide services to other segments of the population—children and adults; however, clinical and non-clinical services are delivered to youth at regular health facility opening hours in rooms reserved for youth activities by trained YFHS providers, including clinicians and peer educators.

3: Delivery of YFHS as highlighted in approach 2, but combined with community activities led by peer educators. The peer educators educate and recruit youth who are then referred to the youth-designated service delivery points at the health facility.

4: This is a modified version of approach 3 where services are provided on specified days of the week.

5: This is an integrated approach in which health services are provided to youth and other segments of the population at the same time and location within the health facility; that is, services for youth are provided in the same room where health services to adults are provided. Clients aged 10-24 are given immediate attention once they are identified by trained YFHS providers.

1.5. Evaluation Objectives

The evaluation sought to determine the integrity of YFHS program implementation, program achievements, and barriers to program implementation and uptake of services. The assessment is meant to inform appropriate strategies that can be developed to improve program implementation and uptake of services in Malawi. The specific objectives were to:

Assess the extent to which YFHS standards and the minimum package of YFHS have been implemented:

- Examine the implementation of YFHS (that is, determine the extent to which the YFHS standards have been met) at the service delivery points.
- Examine the implementation of YFHS at the district level.
- Highlight implementation gaps with a view to addressing them in the process of scaling up the YFHS program.

Examine factors that influence uptake of YFHS at the district and zonal levels.

- Examine parents' and community leaders' knowledge of and their support for their wards' use of YFHS.
- Examine youth/adolescents' perceptions of their health needs, acceptability and accessibility of YFHS, and the extent to which YFHS meet their health needs.

Determine the coverage of YFHS.

- Determine, at the community level, young people's awareness and acceptance of, access to, and utilization of YFHS.
- Examine utilization of YFHS by approaches and strategies currently in use in Malawi.
- Examine the extent to which health providers work with communities and youth-serving institutions/organizations (e.g., schools, NGOs, youth clubs) to promote utilization of YFHS.
- Recommend an efficient YFHS model or a combination of models for Malawi.

Table 1.1: Evaluation Objectives and Assessment Tools

Evaluation Objectives	Assessment tools
1. **Assess the extent to which YFHS standards and minimum package of YFHS have been implemented.**	
• Examine the implementation of YFHS (that is, determine the extent to which the YFHS standards have been met) at the service delivery points.	• Health center standards questionnaire • Hospital standards questionnaire • Health facility service provider questionnaire • CBDA and peer educator questionnaire
• Examine the implementation of YFHS at the district level.	• District health office standards questionnaire
• Highlight implementation gaps with a view to addressing them in the process of scaling up the YFHS program.	• Comparison of observed implementation practices with expected/guidelines
2. **Examine factors that influence uptake of YFHS at the district and zonal levels.**	
• Examine parents' and community leaders' knowledge of and their support for their wards' use of YFHS.	• FGDs among parents • In-depth interviews among community leaders
• Examine youth/adolescents' perceptions of their health needs, acceptability and accessibility of YFHS, and the extent to which YFHS meet their health needs.	• FGDs among youth • Some sections of community survey of youth
3. **Determine the coverage of YFHS.**	
• Determine, at the community level, young people's awareness, acceptability, accessibility and utilization of YFHS.	• Community survey of youth • Client exit interviews • FGDs among youth
• Examine utilization of YFHS by approaches and strategies currently in use in Malawi.	• Community survey of youth • Client exit interviews • FGDs among youth • Service provider questionnaire
• Examine the extent to which health services providers work with communities and youth-serving institutions/organizations (for example,	• Service provider questionnaire • FGDs among parents and youth

schools, NGOs, youth clubs) to promote utilization of YFHS.	
• Recommend an efficient YFHS model or a combination of approaches for Malawi.	• Analysis of data on service provision by approach to service delivery.

Chapter 2: Methodology

2.1. Evaluation Sites

The evaluation was conducted in 10 districts selected from the five health zones of Malawi. These districts were Mzimba and Karonga (North), Lilongwe and Ntcheu (Central West), Dowa and Kasungu (Central East), Nsanje and Chiradzulu (South West), and Mangochi and Phalombe (South East). The selection of the districts was based on several factors. First, in order to have evaluation sites that reflect differences among the districts in YFHS outputs, two districts (one low-performing and the other medium- to high-performing) were selected from each of the five health zones. The MOH grouped the districts in each zone into low-, medium-, and high-performing districts on the basis of data on uptake of RH and HIV services, the volume of YFHS activities, and investments in terms of partner organization presence and timeliness and accuracy of reporting. In selecting the districts, efforts were made to ensure that different YFHS delivery approaches[35] were represented across districts to ensure we were able to assess the utilization of health services by approach.

Once the districts were identified, the MOH compiled a list of health facilities from the selected districts and divided them into four groups by location (urban-rural) and whether or not they were implementing YFHS. The four groups were urban implementing YFHS; urban not implementing YFHS; rural implementing YFHS; and rural not implementing YFHS.[36] Two health facilities were selected from urban areas that were implementing YFHS and one from urban facilities not implementing YFHS. Similarly, two health facilities were selected from the rural health facilities that were implementing YFHS and one from the rural health facilities not implementing. A total of six health facilities were selected in each district. Once they were selected, their catchment areas were identified with the help of health facility staff. All interviews and focus group discussions (FGDs) were conducted in the identified catchment areas of selected health facilities.

2.2. Sample Size Estimation for the Community Survey Component of the Evaluation

The following formula was used to calculate sample size for this evaluation.

$$n = D\frac{\left[\sqrt{2P(1-P)}Z_{1-\alpha} + \sqrt{P_1(1-P_1)+P_2(1-P_2)}Z_{1-\beta}\right]^2}{\Delta^2}$$

D = design effect **(1.5)**;
P1 = the assumed baseline value of the indicator of interest (in our case, the proportion of youth accessing youth health services) at the time of starting the YFHS program (**0.17**);

[35] An integrated approach was added after the pilot in November 2013.

[36] Facilities not implementing YFHS were selected to serve as comparison group for assessment of the quality of care services, including clients' satisfaction with services provided. They were not intended to be used as comparison for assessment of coverage or of implementation of Standards.

P2 = the expected value of the indicator of interest at the time of the survey *(0.37)* such that the quantity (P2 - P1) is the size of the magnitude of change we desire to detect **(0.20)**;
P = (P1 + P2) / 2 = **((0.17 + 0.37)/2);**

Z1-α = the z-score corresponding to the probability with which it is desired to be able to conclude that an observed change of size (P2 - P1) would not have occurred by chance; and,

Z1-β = the z-score corresponding to the degree of confidence with which it is desired to be certain of detecting a change of size (P2 - P1) if one actually occurred.

α = 0.05 (Z1-α = 1.65) β=0.20 (Z1-β=0.84)

To determine sample size for the community youth survey undertaken as part of this evaluation, the primary indicator of interest was the percentage of youth accessing YFHS. For this survey, the baseline value of this indicator was set at 17 percent, while the expected change in coverage between the time the YFHS were initiated and the time of the evaluation was set at 20 percent.[37] Because a cluster rather than a simple random design was used, a design effect of 1.5 was applied. The level of precision was set at 95 percent. The application of the above formula yielded a minimum sample size of 90 youth from the rural catchment areas and 90 youth from the urban catchment areas in each district in order to detect a significant change in coverage over the baseline value, or a significant difference between the urban and rural coverage levels. However, because not all youth approached will agree to be interviewed, the sample size was adjusted by a factor that represented the expected refusal rate. By setting the refusal rate at 10 percent, the desired sample size of 90 was adjusted upward to the effective sample size of 99, which was rounded up to 100. Consequently, in each district, attempts were made to interview 200 youth aged 10-24. Since there are three age groups of youth (10-14, 15-19, and 20-24) none of which had up to 100 youth, this sample size might not yield significant differences among the age groups.

2.3. Components of the Evaluation

The evaluation had two components: the qualitative component which focused on gaining deeper understanding of facilitators and barriers to uptake of YFHS in Malawi, and the quantitative component, which focused on coverage of YFHS program, uptake of YFHS, adherence to standards, and satisfaction with YFHS provided. The qualitative component was implemented in 5 of the 10 districts (1 district per zone). Three of the districts were regarded as medium to high performing, while two were regarded as low performing. These districts were Karonga, Kasungu, Lilongwe, Phalombe, and Nsanje. The FGD participants were recruited with the help of Health Surveillance Assistants (HSAs) and community leaders.

For the qualitative component, FGDs were conducted with two groups of participants:

1. **Youth in the community**: The FGDs with youth focused on determining their awareness of YFHS programs, expectations from the YFHS program, attitudes to utilization of YFHS, perceptions of the benefits of YFHS programs, and the challenges youth face in accessing YFHS. For the FGDs, six separate groups of youth were identified by age (10-14, 15-19, and 20-24) and sex (male and female). Since the plan was to conduct four FGDs with youth in each district, it

[37] At the Stakeholder TWG meeting of June 28, 2013, it was decided to assume a baseline coverage value of 17-20% and an increase of 15-20% in coverage between the time the YFHS program started and the time of evaluation. These assumptions were used to generate different sample size estimates that permit a comparison between rural and urban facilities

was not feasible to conduct FGDs with all the six groups in each district. Consequently, in each district, four groups were identified for FGDs in such a way that across the five districts; a minimum of three FGDs would have been conducted with each of the six groups. Table 2.2 shows the categories of youth with whom FGDs were conducted in each district. Each FGD consisted of 8-10 members and discussions were facilitated by trained data collectors.

2. **Parents of youth**: The FGDs with parents focused on what parents perceived to be the major health issues among youth in their community, what they do to address these health issues, their awareness and acceptability of YFHS programs, how the YFHS complement/contradict what they (parents) normally do to address health issues among youth, and their attitudes to their children accessing YFHS. Two separate groups of parents were identified by sex (male and female). In each district, four FGDs (two in urban—one male, one female; two in rural—one male, one female) were conducted. Each FGD consisted of 8-10 members and discussions were again facilitated by trained persons.

The quantitative component was implemented in all 10 selected districts and consisted of the following:

1. **A community survey of young people 10-24 years to determine level of coverage of the YFHS program.** A structured questionnaire was administered among randomly selected youth in the catchment area of each selected health facility to determine their knowledge and use of YFHS. The recruitment process guaranteed that male and female, and in- and out-of-school youth of different age groups (10-14, 15-19, and 20-24) were represented in the sample. Prior to data collection, the number of youth to interview in each catchment area was determined and a decision was taken to interview equal numbers of youth (and equal numbers of males and females) in each age group. In addition, a decision was taken to not interview more than one young person in each household. Each research assistant was assigned the number of respondents to interview by age and sex.[38] Research assistants worked closely with the HSA who led them to the households where interviews were conducted. The research assistants moved from one identified household to another until the quota for that catchment area was met or until they could find no more youth to interview.[39] A total of 2,040 questionnaires were completed, but our analysis was based on information from 2,033 respondents who met the age requirements.

   Clients' interviews to determine young people's satisfaction with YFHS. The interviews were conducted as the clients left the health facilities. Where there were many clients, those interviewed were systematically selected[40] until a maximum of 10 was reached. With the low turnout of clients in some facilities, we had no choice but to interview all clients that came to the facilities on the day(s) of the interview. In a few facilities, we were unable to reach the maximum number of 10 clients. Of the target 600 clients, we interviewed 593. In addition to collecting information on a few background characteristics—age, sex, education, marital status, and number of children—each client was asked to provide information on services received at the health facility, familiarity with the different YFHS offered at the center,

[38] Unfortunately, it was challenging recruiting the 10-14 year olds, a lot of whom were reluctant to participate in the evaluation, even after parental assent had been obtained.

[39] The target of 200 per district could not be reached in Lilongwe and Nsanje districts.

[40] The sampling interval depended on the volume of clients available on the day of the interview. In most of the facilities, the clients were few and consequently all of them were interviewed. In some facilities, it was impossible to get enough clients to interview.

how they knew about the services, satisfaction with the services received, and adequacy of the services in meeting their health needs. Efforts were made to interview youth of both sexes and of different age groups.

2. **Interviews with service providers.** These interviews were conducted to determine: the types of YFHS offered at the facility; where and when the services are offered; what has been done to make the community aware of the services offered (including community mobilization activities); volume of clients; attitude to young people accessing YFHS; referral activities; perceptions of the adequacy of the services offered in meeting the needs of youth; the challenges faced in the implementation of the YFHS program activities; what could be done to overcome the challenges; and how they use service data to inform services. Information on the service provider's age, sex, education, training in YFHS, number of years on the job, position in the health facility, and association with youth clubs in the community was also collected. In facilities with more than one male and one female provider, two of them (one male and the other female) were randomly selected and interviewed. Of the 120 health facility-based service providers that we planned to interview, we were able to interview 113. In the evaluation design, it was specified that only two service providers could be interviewed in any facility; consequently the research team could not interview more than two at any facility with two or more providers.

3. **Interviews with peer educators**. The peer educators constitute the link between the community (and sometimes the youth clubs from which youth are recruited into the YFHS program) and the facility. In many instances, they operate within the health facility to provide education and counseling services and refer clients to appropriate places for clinical services. Interviews with peer educators focused on determining what they do (the types of services offered), how they locate/recruit youth for the YFHS program, where and when they offer services, how they record and report their activities, whether and how they use the data they collect to inform their activities, what they perceive to be working well in the YFHS program, the challenges they face in the implementation of their activities, and what they think could be done to overcome the challenges. Information on the peer educator's age, sex, education, marital status, number of children, training in YFHS, how they were recruited, how long they have worked as peer educators, by whom they are supervised, how they are remunerated, and their workload was also collected. Although the plan was to interview 120 peer educators, we were able to interview only 69 because they were not available at several evaluation sites.

4. **Interviews with youth community-based distribution agents (CBDAs)**. This group of providers works at the community level to mobilize young people to access YFHS. They educate and counsel on RH and HIV issues, distribute condoms and oral pills, and refer clients to health facilities for services they cannot offer. As with the peer educators, interviews with CBDAs sought to determine the services they offer (which may differ from one place to another depending on who is coordinating their activities), how and when they offer these services, how they record and report their activities, what works well in the YFHS program, the challenges they face in the implementation of their activities, and what they think could be done to overcome the challenges. Information on each CBDA's age, sex, education, marital status, number of children, training in YFHS, how they were recruited as CBDAs, how long they have worked as a CBDA, who supervises their work, how they are remunerated, and workload was also obtained. We were able to interview 87 of the 120 planned.

5. **Interviews with NGO staff**. Interviews with NGO staff were conducted to determine their YFHS activities in the district where they work, who they support to implement YFHS, the service delivery approach they apply, their level of investment in YFHS, how they are linked to

the public health sector, and the challenges they face in the implementation of their activities. Twenty NGO staff members were interviewed.

6. **Interviews with health facility management staff to determine adherence to health facility-level YFHS standards.** A checklist of YFHS program standards at the facility level was used to collect information from health facility staff on what they do in relation to each of the standards. Information on what works well and the challenges faced in the implementation of these standards was collected.

7. **Interviews with district health officers (DHOs) to determine adherence to district-level YFHS standards**. A checklist of YFHS program standards at the district level was used to collect information from the DHO on what they do in relation to each of the standards. Information on the success of YFHS programs, barriers to implementation and use of YFHS, and what should be done to make the YFHS program more effective was collected from each DHO. Eleven DHOs were interviewed.[41]

8. **Interviews with district youth-friendly health services coordinators (DYFHSCs) to determine success of the YFHS program and barriers to its implementation in the district.** Interviews with DYFHSCs focused on their activities implementing the YFHS program (including support to youth clubs), donor and government support to the implementation of the YFHS program in the district, YFHS program achievements (in terms of coverage and uptake of the services), adequacy of the program in meeting the health needs of youth in the district, how they work across ministries (e.g., education, youth) to develop programs that meet needs of young people, what works well in the YFHS program, and the challenges in the implementation of the program in the district. For the same reason that we interviewed 11 district health officers, 11 DYFHSCs were also interviewed.

9. **Interviews with community leaders** to assess their perceptions of youth's major health issues and needs, their awareness and acceptability of the YFHS program, how the YFHS complement/contradict what the community has usually done to ensure young people are healthy, and their attitudes to young people accessing YFHS.

10. **Review of service statistics.** A service statistics form was used to collect data on uptake of YFHS in the four quarters preceding the interviews at the district level. Unfortunately the forms were inadequately completed by the DYFHSCs.

2.4. Data Collection Methods

The quantitative data were collected through face-to-face interviews using standardized, pre-coded questionnaires that covered all issues examined in the evaluation. The interviews were conducted by trained individuals. The FGDs were facilitated by trained facilitators using guides and the discussions were recorded with consent from participants. All the questionnaires and FGD guides were pilot tested to ensure they were culturally appropriate and able to capture the information required to answer the evaluation questions. The research instruments were translated from English to Chichewa and Tumbuka and then translated again from Chichewa/Tumbuka to English to determine accuracy of the initial translation. Table 4.1 presents a summary of the different instruments that were administered, the

[41] Because of its large size, Mzimba district has two district health officers and both were interviewed.

target numbers as specified in the proposal, and what was achieved. Table 4.2 shows the number of FGDs conducted by age, sex, and district.

Table 2.1: Summary of Instruments Administered

Respondent	Interview Type	Target Number per District	Total Number Targeted	Total Number Achieved	Comments
Community youth survey questionnaire (10-24)	Structured questionnaire (to determine coverage)	200 per district (35 per health facility (HF) catchment area)	2,000	2,040	Exceeded target but could not reach a target of 200 in Lilongwe (194) and Nsanje (172) districts; some questionnaires were discarded for missing information leaving us with 2,033
Client exit interviews (10-24)	Structured questionnaire (to determine satisfaction with services received)	60 (10 per HF)	600	593	Low turnout of youth at HFs
YFHS providers at the HF	Structured questionnaire	12 (2 per HF)	120	113	Highly dependent on having 2 or more YFHS providers at the facility on the interview day(s). Some facilities had only one YFHS provider
Peer educators	Structured questionnaire	12 (2 per HF/catchment area)	120	69	Peer educators were not available at some HFs/catchment areas
Community-based distribution agent (CBDA)	In-depth interviews	12 (2 per HF catchment area)	120	87	CBDAs were not available in some communities
NGO staff	Key informant interviews	2-3 depending on # NGO	20-30	20	-
HF standards	Checklist on HF standards	6 (1 per HF)	60	60	One was discarded – looks like a duplicate
District health office standards	Checklist on standards	1	10	11	Mzimba is a large district with 2 district health officers - both were interviewed
District YFHS coordinator	Semi-structured interviews on district support for YFHS, facilitators, and barriers to utilization of YFHS	1	10	11	Mzimba is a large district with 2 district YFHS coordinators - both were interviewed
Community leaders	Semi-structured interviews	2 per district (5 districts)	15	14	

Table 2.2: FGDS Conducted by District and Age

District	Age Range	Number of FGDs in Urban		Number of FGDs in Rural		Total
		Female	Male	Female	Male	
Karonga	10-14	1				1
	15-19	1			1	2
	20-24			1		1
	Total	**2**		**1**	**1**	**4**
	FGDs parents	1	1	1	1	4
Kasungu	10-14			1		1
	15-19		1	1		2
	20-24		1	1		2
	Total		**2**	**3**		**5**
	FGDs parents	1	1	1	**1**	**4**
Lilongwe	10-14	1				1
	15-19	1			1	2
	20-24				1	1
	Total	**2**			**2**	**4**
	FGDs parents	1	1	1	**1**	**4**
Phalombe	10-14				1	1
	15-19		1	1		2
	20-24					
	Total		**1**	**1**	**1**	**3**
	FGDs parents	1	1	1	**1**	**4**
Nsanje	10-14		1			1
	15-19	1			1	2
	20-24	1				1
	Total	**2**	**1**		**1**	**4**
	FGDs parents	1	1	1	1	4

2.5. Training of Field Workers

All fieldworkers—supervisors, data monitors, interviewers, FGD facilitators, and note takers—were trained to have a clear understanding of the evaluation objectives, data collection instruments, their roles in the evaluation, the need for good quality data, and the principles and procedures related to human subject research. E2A staff, CSR, UNFPA, and the MOH conducted a10-day training, from October 28 to November 8, 2013, in Zomba, Malawi. During the training, there were plenary discussions, role-plays, pretests, and revision of the data-collection instruments. The training sought to achieve the following objectives:

- Develop a common understanding of the objectives of the Malawi YFHS evaluation.
- Become more familiar with the data-collection instruments and the type of data collected; relate instruments to evaluation objectives and revise draft instruments as needed.
- Review evaluation processes; identification and recruitment of respondents and administration of survey instruments.
- Develop a shared understanding of the ethical and confidentiality issues involved in conducting the evaluation.
- Develop a shared understanding of the roles of field workers (managers, supervisors, and interviewers).
- Provide an opportunity to rehearse/pilot test the interview techniques.
- Share information and learn from each other about how best to conduct the evaluation.

2.6. Data Quality Assurance

Several quality-assurance measures were adopted to ensure that data were of high quality. In addition to the training described above, a staff of CSR, E2A, the MOH, as well as a UNFPA-funded consultant monitored the fieldwork to ensure homogeneity, completeness, accuracy, and consistency of data, and ensure adherence to the protocol as approved by the National Health Sciences Committee. Field teams met at the end of each day to review activities and achievements, discuss problems and challenges, explore ways to improve data-collection activities, and plan work for the following day.

2.7. Data Management and Analysis

Data-entry templates were developed in CSPro by CSR and shared with E2A. Data-entry screens were made to mirror the questionnaires to facilitate speedy and accurate data entry. All questionnaires were checked for completeness by supervisors and data monitors, CSR, and a UNFPA local consultant. Questionnaires were then sent to CSR periodically for editing and data entry. The data manager registered all the questionnaires and assigned them serial numbers. The data monitors ensured all questionnaires were complete.

E2A conducted the data analysis in collaboration with the UNFPA consultant and CSR. A data-analysis plan was developed, which outlined the type of analysis to be conducted. A two-week data analysis workshop was held between February 17, 2013 and March 1, 2013 in Zomba for E2A, CSR staff, and the UNFPA consultant for preliminary data analysis, discussion of findings, and harmonization of the interpretation of preliminary findings. Some preliminary results were presented to stakeholders at the end of the two-week workshop. Frequency tables were generated, which showed the distribution of respondents by variables of interest (i.e., sex, age, urban/rural residence, district and health zone). A bivariate analysis explored relationships between variables.

All FGDs were conducted in the local language, recorded, and transcribed and translated into English. The data were analyzed using content analysis. The transcripts were read and re-read several times and recurring themes were identified. For purposes of this report, the analysis focused on the following issues: (i) parents' perceptions about youth; (ii) youth's and parents' knowledge about YFHS; (iii) community perceptions about youths who access YFHS; (iv) health problems affecting youth; (v) barriers and facilitators to accessing YFHS among youth; and, (vi) youth's and parents' suggestions about how barriers accessing YFHS by youth can be addressed.

2.8. Report Writing

The writing of this report was a joint exercise between E2A and CSR staff. The draft report was sent to USAID/Malawi, the MOH, UNFPA/Malawi, WHO/Malawi, and RESPOND/Malawi for comments. Comments from stakeholders were incorporated after which a final report was sent to USAID/Malawi and the MOH.

2.9. Dissemination of Results

A national dissemination workshop will be conducted to share findings with key stakeholders, including youth organizations. As indicated above, a written report was provided to the MOH, USAID/Malawi, and other relevant ministries and stakeholders. Prior to the national dissemination workshop and finalization of the evaluation report, the MOH and evaluation TWG held a meeting to discuss, verify, and validate the draft evaluation results. The suggestions from the verification meeting were then incorporated into the final report. On approval by the GOM, the study results will be presented at national, regional, and international meetings.

2.10. Limitations of the Evaluation

A major limitation of this evaluation is the potential not to have valid comparisons among different subgroups of youth defined, for instance, by age, sex, marital status, and education due to sample size limitations. For instance, the current sample size may not yield statistically significant differences among youth, even when such differences exist in the population. To obtain sufficient cases in each youth subgroup for valid comparison, the sample size would have to increase astronomically (with an attendant increase in costs). Since the sample was not drawn randomly from a national frame, but rather, from catchment areas of selected facilities, estimates of coverage may differ from actual district or national level coverage. In addition, unless we assume young people's knowledge, attitudes, and utilization of YFHS in the selected districts mirror adequately the situation in the non-selected districts in each zone, estimates of zonal coverage from the selected districts might differ from what would have been obtained had all districts in the health zone been sampled. However, we believe this evaluation will yield adequate data to answer all pertinent evaluation questions.

Although data collection for this evaluation went well, some challenges included:

- Unavailability of respondents such as peer educators, CBDAs, and NGO staff in some areas.
- Difficulty reaching target number of client exit interviews per facility due to low client turn-out.
- Confusion about whether a facility was implementing YFHS or not.
- New officials at facilities who could not provide the required information on YFHS statistics.
- Expectation of a field allowance among HSAs, chiefs, and other personnel for escorting the team to data-collection sites; after explaining the purpose of this study, however, they understood and supported the process.

2.11. Ethical Considerations

The protocol for this evaluation was submitted to the National Health Sciences Research Committee for ethical approval. It was only after obtaining this approval that training and subsequent data collection took place. The MOH Reproductive Health Directorate wrote to the appropriate district health offices to inform them of the evaluation. On arrival in the districts, the data-collection teams paid courtesy calls to the DHOs to inform them of their presence in the districts and met with the DYFHSCs.

At the community level, the teams met with the village headmen to ask for permission to collect data in their communities. All survey respondents and FGD participants were briefed on the objectives of the evaluation, their roles and rights, and were assured of confidentiality. The different categories of respondents and FGD participants were allowed to participate in the study only after they had given consent. Participation in the evaluation was strictly voluntary. For participants aged younger than 18 years of age, assent was sought from their parents and they also had to give consent before being interviewed, even after their parents had consented.

Chapter 3: Background Characteristics of Survey Respondents and Sexual and Reproductive Health Experience of Youth

In this chapter, we will examine the background characteristics of surveyed youth and key service providers. This examination is based on the assumption that while the demographic and socioeconomic background of a youth defines their lifecycle stage and consequently their need for information and services, as well as exposure to information about and use of YFHS, the background characteristics of service providers may influence their attitude to youth and consequently the way they provide services to them. The demographic characteristics also provide information on the extent to which different sub-groups of youth were involved in the evaluation. This chapter is divided into five sections. The first two sections describe the demographic and socioeconomic characteristics of youth respondents; first, the community youth survey respondents, and secondly, the client exit interview respondents. The third section examines the demographic profile of health facility- and community-based service providers, peer educators, and CBDAs. The fourth section examines sexual experience of youth, and the fifth section examines pregnancy and childbearing among the youth.

3.1. Community Survey Respondents (Youth)

Table 3.1 shows the distribution of community youth survey respondents aged 10-24 in the five zones by background characteristics. The table shows that:

- The modal[42] age group of community youth survey respondents in all zones is 15-19, and the median age is 17 years. It is worth noting that all three age groups are adequately represented in the study.
- At the national (total sample) level, males and females were equally represented in the survey. However, at the zonal level, it was difficult to have equal representation of males and females. In the North, Central East, and Central West, slightly more males were interviewed, and in the two southern zones, slightly more females were interviewed.
- More than half (58.8 percent) of all respondents were drawn from rural areas, mainly because more facilities with catchment areas from which youth were selected are rural.[43] But there is variation by zone. While in the North, Central East, and South East more youth were interviewed in the rural areas, in the Central West and South West, more youth were interviewed in urban areas.
- Half of community youth survey respondents reported having had sex, with slight variations across zones. Having information on sexual experience was considered important as it could help to explain differences among youth in their motivation to seek YFHS. For instance, sexually experienced youth, particularly those never married and previously married, may be more motivated to seek health services to prevent pregnancy and contraction of STIs.
- 59 percent of community youth survey respondents were attending school at the time of the survey, and 38.6 percent were former pupils/students out of school; 2.3 percent had never been to school. For both current and former pupils, the modal highest level of educational is primary in all the zones. Examining school attendance status is important as it helps to differentiate levels of exposure to health information and services. While in-school youth may be exposed to both school-based and community/health facility-based information and services, out-of-school youth may be exposed only to community/health facility-based information and services.

[42] Throughout this report, modal is defined as the frequency stated by the highest number of respondents.

[43] This also should be expected as Malawi is predominantly rural.

- 78.5 percent of all interviewed youth had never been married, though there are variations by zone. The percentage never married is lowest in the South East where it is 68.5 and highest in the North where it is 84.7. 17.8 percent of the youth were married at the time of the survey while 3.8 percent were previously married (separated, divorced, or widowed). Among married youth, the modal age group at marriage is 18-19.
- 82.8 percent of community youth survey respondents were not working at the time of the survey. With about 60 percent of the youth in school at the time of the survey, it should be expected that a high percentage of them would not be working. Employment status was examined because of the potential to influence exposure to SRH information and services, with employed youth having an advantage.
- Although there are slight variations by zone, almost half of all respondents had lived in their places of interview for 10-19 years (25.1 percent of the 10-14 year-olds and 24.2 percent of the 15-19 year-olds). About one-quarter of the youth had resided in their place of interview for less than five years. We examined length of stay at the place of interview with the assumption that exposure to YFHS related information and services available in the community will increase as length of stay in the community increases.
- 58.5 percent of the community youth survey respondents are Protestants; 22.6 percent are Catholics, 10.5 percent are Muslims, and 8.4 percent are of other religions. We examined distribution of the population by religion to assess the heterogeneity of the population, which has been identified in some studies as one of the factors that may influence the uptake of SRH services, particularly when those services include distribution of contraceptive methods.
- The highest proportion of the youth are Chewa (31.1 percent) followed by Lomwe (16.7 percent), and Tumbuka (16.2 percent).
- 33.7 percent of youth listen to the radio almost every day while 11.7 percent listen to radio less than once a week. A significant percentage (22.8 percent) of youth reported to not listen to radio at all. With respect to watching television, over half (51.6 percent) have never watched a TV, 12.9 percent watch it almost every day, and 20.2 percent at least once a week. If information on YFHS is disseminated through the radio or television, then listening to radio or watching the television increases the chance of having access to this information.
- Use of Internet is extremely low—only about 8 percent of the community youth respondents have ever used the Internet, with more youth having used the Internet in the North (19.1 percent) than any other zone.

Table 3.1: Percentage Distribution of Community Survey Respondents (Youth) by Background Characteristics

Characteristic	North	Central East	Central West	South East	South West	All
Age:						
10-14	29.5	29.8	31.0	29.2	29.3	29.8
15-19	39.2	42.7	40.1	35.7	41.9	39.8
20-24	31.5	27.6	29.0	35.1	28.8	30.4
Number of cases	403	410	397	445	375	2030
Median	17	17	17	18	17	17
Sex:						
Male	51.2	57.8	51.5	41.2	49.2	50.0
Female	48.8	42.2	48.7	58.8	50.8	50.0
Number of cases	402	410	394	43.4	374	2014
Type of residence:						
Urban	30.8	27.3	51.4	45.6	51.5	41.2
Rural	69.2	72.7	48.6	54.4	48.5	58.8
Number of cases	403	410	397	445	375	2030
Sexual experience:						
Never had sex	57.9	52.3	47.5	44.0	48.8	50.0
Ever had sex	42.1	47.7	52.5	56.0	51.2	50.0
Number of cases	404	411	398	445	375	2033
School attendance status:						
Out of school	33.3	35.4	43.6	41.2	39.7	38.6
In school	65.8	63.9	55.7	53.6	56.5	59.0
Never attended school	1.0	0.7	0.8	5.2	3.7	2.3
Number of cases	403	410	397	444	375	2029
Education:						
None	1.0	0.7	0.8	5.2	3.7	2.3
Primary	58.1	70.5	66.8	66.5	61.5	64.7
Secondary & above	40.9	28.8	32.5	28.3	34.9	33.0
Number of cases	403	410	397	445	375	2030
Marital status:						
Never married	84.7	83.5	78.1	68.5	78.4	78.4
Currently married	11.1	14.4	19.6	24.9	18.1	17.8
Previously married	4.2	2.2	2.3	6.5	3.5	3.8
Number of cases	404	411	398	445	375	2033
For those ever married, age at first marriage:						
<10	0.0	1.5	0.8	0.0	0.0	0.4
10-14	7.2	6.4	10.1	4.1	9.0	7.2
15-17	21.7	20.5	32.8	36.5	41.0	32.1
18-19	40.6	41.0	39.5	42.6	28.0	38.5
20-24	30.4	30.8	16.8	16.9	22.0	21.8
Number of cases	69	78	119	148	100	514
Work to earn						

Characteristic	North	Central East	Central West	South East	South West	All
money:						
Yes	9.9	18.3	22.9	18.5	16.0	17.2
No	90.1	81.7	77.1	81.5	84.0	82.8
Number of cases	403	410	397	444	374	2028
Length of stay (at place of interview):						
Less than 1 year	7.6	6.2	10.1	4.1	5.4	6.6
1-4 years	22.7	19.5	23.8	18.3	13.6	19.6
5-9 years	13.9	9.6	10.9	9.2	6.0	9.9
10-14 years	25.7	24.4	20.7	26.3	28.5	25.1
15-19 years	19.1	28.1	21.0	23.1	29.9	24.2
20 and above	11.1	12.3	13.5	19.0	16.6	14.5
Number of cases	397	406	386	437	368	1994
Religion:						
Catholic	29.5	27.6	20.7	13.6	22.2	22.6
Protestant	59.8	68.0	71.5	28.3	68.7	58.5
Muslim	2.5	0.5	5.3	35.8	5.6	10.5
Other	8.2	3.9	2.5	22.2	3.5	8.4
Number of cases	403	409	396	441	374	2023
Ethnic group:						
Chewa	8.9	81.7	39.8	14.0	10.4	31.1
Tumbuka	64.8	10.7	4.0	0.9	0.8	16.2
Yao	1.5	0.5	6.5	36.7	9.3	11.4
Other	5.2	0.0	0.5	1.1	0.5	1.5
Lomwe	1.0	0.5	4.0	43.2	33.3	16.7
Ngoni	5.2	5.9	43.3	3.6	3.5	12.1
Sena	0.0	0.2	0.8	0.2	39.5	7.5
Tonga	2.5	0.2	0.8	0.2	0.3	0.8
Ngonde	10.9	0.0	0.3	0.0	0.0	2.2
Mang'anja	0.0	0.2	0.0	0.0	2.4	0.5
Number of cases	403	410	397	442	375	2027
Frequency of listening to radio:						
Almost everyday	40.0	34.7	31.7	27.7	35.0	33.7
At least once a week	30.0	38.9	33.5	25.5	32.1	31.9
Less than once a week	8.2	7.6	17.4	14.9	9.9	11.7
Never	21.8	18.7	17.4	32.0	23.0	22.8
Number of cases	403	406	397	444	374	2024
Frequency of watching TV:						
Almost everyday	22.6	7.4	16.1	7.0	12.0	12.9
At least once a week	26.8	22.4	17.1	13.3	22.4	20.2
Less than once a week	13.9	12.3	20.9	16.6	12.8	15.3
Never	36.7	58.0	45.8	63.1	52.8	51.6
Number of cases	403	407	397	445	375	2027
Frequency of using Internet:						

Characteristic	North	Central East	Central West	South East	South West	All
Almost everyday	5.7	1.2	2.5	2.0	1.1	2.5
At least once a week	7.9	2.7	3.8	1.5	1.1	3.3
Less than once a week	5.5	1.2	2.5	0.9	1.5	2.3
Never	80.9	94.9	91.2	95.7	96.5	91.9
Number of cases	403	410	397	445	375	2030

3.2. Client Exit Interview Respondents

This section describes the demographic and socioeconomic profile of exit interview respondents. The respondents were interviewed shortly after they received services at the surveyed health facilities. The demographic characteristics, which were examined with a view to determining the categories of youth who access youth health services including age, sex, type of residence, educational status, marital status, age at marriage, and number of living children at the time of the survey. We also examined the type of facility in which they were interviewed, including whether the facility was implementing YFHS or not, and the kind of service delivery approach adopted. The distribution by selected background characteristics are presented in Table 3.2. Graph 3.2 presents information on the kind of service delivery approach adopted in the facility in which the clients were interviewed.

Table 3.2 shows that:

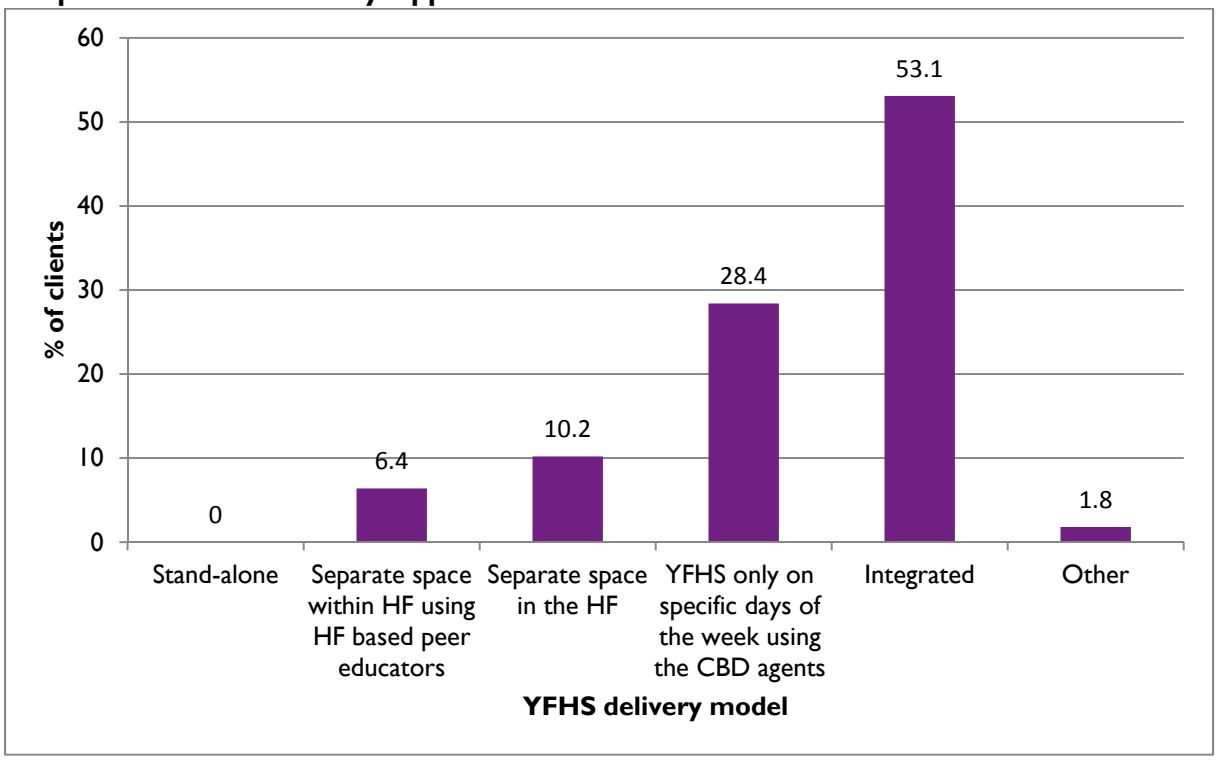
- The modal age group for all exit interview respondents is 20-24 (44.2%), with some variations by zone. While in the North, Central East and South West, the modal age group is 20-24, in the Central West and South East, the modal age group is 15-19. With a median age of 19 years, the client exit interview respondents are older than their community youth survey respondents whose median age was 17 at the time of the survey.
- Forty-six percent of all clients interviewed were males and 54% were females. The percentage of interviewed clients that were females is highest in the North (63.2%) and lowest in the South East (50%). Although our plan was to interview equal numbers of male and female clients, the fact that we ended up interviewing more females shows that females, particularly those aged 20 and above, were more likely to access youth health services.[44]
- In each zone, more respondents were interviewed in the rural than urban areas. The percentage of clients from rural areas ranges from 50.9 in the South West where it is lowest to 59.2 in the Central East where it is highest.
- Except in Central East, the interviewed clients consisted more of youth who were no longer attending school (out of school) at the time of the survey (53.3 percent overall; 72.6 percent in the North, 45.5% in the Central East, 56.2 percent in Central West, 47.4 percent in South East, and 46.6 percent in South West). In-school youth constituted 41.1 percent and youth who have never attended school constituted 5.4 percent.
- Although the modal highest level of education for all clients is primary (51.6 percent), it is secondary or higher in the North (50.9 percent) and Central East (55.3 percent).
- Except in the North, the interviewed clients consisted more of never-married youth than currently or previously married youth. Overall, never-married youth constituted 53.9 percent of the interviewed clients and currently married and previously married youth constituted 42.2

[44] There were no reports of male clients refusing to be interviewed; the interviewers could just not find enough male clients to interview.

percent and 4 percent, respectively. The percentage of interviewed clients who were never married ranges from 40.4 percent in the North to 68 percent in the Central East.

- For clients who were married, the median age at first marriage was 18. The modal age group at first marriage is 18-19 in all the zones.
- More than two-thirds (69.7 percent) of interviewed clients had no living children at the time of the survey. Although all types of health facilities in Malawi were included in this survey—public, private, and NGO managed—about 67 percent of interviewed clients were drawn from government hospitals (16.7 percent) or health centers (50.2 percent). About one-fifth (20.2 percent) of the clients were interviewed in Christian Health Association of Malawi (CHAM) health facilities (7.1 percent in hospitals and 13.1 percent in health centers). About 8 percent of the clients were interviewed in private hospitals and 4 percent in Banja La Mtsogolo (BLM) health facilities.
- Over three-quarters (78 percent) of the client exit interview respondents were interviewed at the health facilities implementing YFHS. By design, facilities offering YFHS should constitute about two-thirds of all facilities selected for the evaluation.
- More than half (53.3 percent) of the client exit interview respondents received services and were interviewed at the health facilities implementing the integrated service delivery approach. With the integrated approach, health services are provided to youth and other segments of the population at the same locations within the health facility with clients aged 10-24 being given immediate attention on identification by trained YFHS providers.
- Over half (57.9 percent) of the clients came to the health facilities on the day of interview to seek treatment for what they described as general body pain. Other services sought by significant proportions of the clients on the day of the interview include malaria treatment (15.9 percent), HIV testing (14.4 percent), prenatal care (13 percent), procurement of contraceptive methods (6.5 percent), and contraceptive counseling (6.2 percent)

Graph 3.2: Service Delivery Approaches at Facilities Where Clients Were Interviewed [a]



[a] Facilities providing stand-alone services were not found among the sampled facilities.

Table 3.2: Percentage Distribution of Client Exit Interview Respondents (Youth) by Background Characteristics*

Characteristic	North	Central East	Central West	South East	South West	All
Age:						
10-14	8.8	15.5	17.0	19.9	22.4	16.9
15-19	37.7	35.9	42.0	40.4	37.9	38.9
20-24	53.5	48.5	41.1	39.7	39.7	44.2
Number of cases	114	103	112	136	116	581
Median age	20.0	19.0	19.0	19.0	18.0	19.0
Sex:						
Male	36.8	48.5	44.6	50.0	49.1	45.9
Female	63.2	51.5	55.4	50.0	50.9	54.1
Number of cases	114	101	112	136	116	579
Location of health facility (HF):						
Rural	58.8	59.2	52.7	55.9	50.9	55.4
Urban	41.2	40.8	47.3	44.1	49.1	44.6
Number of cases	114	103	112	136	116	581
School attendance status:						
Out of school	72.6	45.6	56.2	47.4	46.6	53.5
In school	25.7	52.4	41.1	42.2	44.8	41.1
Never attended school	1.8	1.9	2.7	10.4	8.6	5.4
Number of cases	113	103	112	135	116	579
Education:						
None	1.8	1.9	2.7	11.0	8.6	5.5
Primary	47.4	42.7	56.2	49.3	62.1	51.6
Secondary & above	50.9	55.3	41.1	39.7	29.3	42.9
Number of cases	114	103	112	136	116	581
Marital status:						
Never married	40.4	68.0	50.9	51.5	60.3	53.9
Currently married	54.4	30.1	44.6	44.1	36.2	42.2
Previously married	5.3	1.9	4.5	4.4	3.4	4.0
Number of cases	114	103	112	136	116	581
For those ever married, age at first marriage:						
>10	2.7	0.0	1.8	0.0	0.0	1.1
10-14	1.4	0.0	7.1	6.3	2.1	3.6
15-17	32.9	24.3	26.8	28.6	31.9	29.3
18-19	34.2	40.5	33.9	38.1	46.8	38.0
20-24	28.8	35.1	30.4	27.0	19.1	27.9
Number of cases	73	37	56	63	47	276
Median age at first marriage	18	18	18	18	18	18
Have living children?						
Yes	31.6	28.7	31.2	27.2	32.2	30.1
No	68.4	71.5	68.8	72.8	67.8	69.9
Number of cases	114	101	112	136	115	578
Number of living children:						
0	68.4	70.9	67.9	72.1	69.0	69.7

Characteristic	North	Central East	Central West	South East	South West	All
1	20.2	18.4	19.6	14.7	19.8	18.4
2	9.6	8.7	10.7	9.6	8.6	9.5
3 or more	1.8	1.9	1.8	3.7	2.6	2.4
Number of cases	114	103	112	136	116	581
Type of facility where interview took place:						
Public Health Facilities:						
Government hospital	23.7	20.4	17.0	7.4	17.2	16.7
Government health center	42.1	43.7	50.9	54.1	58.6	50.2
Other public facilities	0.0	0.0	0.0	0.0	0.9	0.2
CHAM/MISSION:						
Hospital	9.6	9.7	0.0	7.4	8.6	7.1
Health center	15.8	0.0	16.1	23.7	6.9	13.1
PRIVATE SECTOR:						
Hospital/clinic/doctor	0.0	17.5	16.1	0.0	7.8	7.8
Other private medical	0.0	1.0	0.0	0.0	0.0	0.2
Banja La Mtsogolo	8.8	7.8	0.0	7.4	0.0	4.8
Number of cases	114	103	112	135	116	580
Is facility implementing YFHS?						
Yes	75.2	75.5	77.1	85.0	75.4	77.9
No	24.8	24.5	22.9	15.0	24.6	22.1
Number of cases	113	102	109	133	114	571
YFHS approach adopted in the facility where interviewed:						
Only YFHS in the center (stand-alone)						
Separate space within HF using HF-based peer educators	8.1	2.5	18.4	3.5	0.0	6.4
Separate space in the HF (using HF-based peer educators) combined with community activities (using CBDA)	39.5	13.9	1.1	0.0	0.0	10.2
YFHS only on specific days of the week using the CBD agents (Specific youth days/activities+ CBD youth activities	0.0	30.4	33.3	39.5	35.7	28.4
Integrated (services provided to all clients at the same place but clients 10-24 are offered YFHS package on identification	52.3	53.2	47.1	57.0	54.8	53.1
Other	0.0	0.0	0.0	0.0	9.5	1.8
Number of cases	86	79	87	114	84	450
Service sought on the day of interview						
Contraceptive counseling	13.6	3.7	5.3	5.2	2.7	6.2
Contraceptive purchasing	5.9	5.6	14.2	3.7	3.5	6.5
Prenatal care	26.3	2.8	4.4	19.4	9.7	13.0
Postnatal care	3.4	2.8	4.4	0.7	0.0	2.2
Counseling about nutrition	5.1	4.7	1.8	0.7	0.9	2.6
Pregnancy test	3.4	4.7	2.7	2.2	0.0	2.6
STI screening	3.4	0.0	0.0	0.0	0.0	0.7
STI treatment	2.5	0.0	1.8	0.7	3.5	1.7

Characteristic	North	Central East	Central West	South East	South West	All
HIV test	28.0	10.3	9.7	15.7	7.1	14.4
Gynecological exam	0.0	1.9	1.8	3.7	0.0	1.0
Peer counseling	3.4	0.0	0.0	1.5	0.0	1.0
Abortion-related services	0.8	0.0	0.0	0.0	0.0	0.2
Infertility-related consultation	0.8	0.0	0.0	0.7	0.0	0.3
Maternal/neonatal health care	5.9	0.9	17.7	0.7	5.3	6.0
Other (general body pain)	26.3	71.0	49.6	68.7	74.3	57.9
Other (malaria treatment)	6.8	15.9	12.4	8.2	38.1	15.9
Number of cases	118	107	113	134	113	585

* **We also included data on type of facility and services sought by clients**

3.3. Characteristics of Service Providers: Health Facility and Community-Based Providers

This section describes the background characteristics of health facility and community-based youth service providers. The characteristics examined were age, sex, marital status, number of living children, professional status, and length of service. Graph 3.3 at the end of this section depicts the percentage of CBDAs and peer educators operating in each zone

3.3.1. Health Facility-Based Service Providers

The distribution of the health facility-based service providers by selected background characteristics are displayed in Table 3.3.1. The table shows that:

- In all the zones, the modal age of service providers is 30 years and above (65.5 percent all; 77.3 percent in the North, 77.3 percent in Central East, 65 percent in Central West, 50 percent in South East, and 60.9 percent in South West).
- 54.9% of all interviewed health facility-based service providers were males while 45.1percent were females. These figures may not reflect the actual sex composition of facility-based youth health service providers in the country or in the survey zones, but, rather, they are a reflection of the sex composition of those that were there the day of interview.
- Although the rural-urban composition of the facility-based service providers varies by zone, overall, the service providers were almost equally divided between rural and urban health facilities (50.4 percent rural and 49.6 percent urban). In the North, Central East, and South East, more rural health providers were interviewed, and in Central West and South West, more urban service providers were interviewed.
- Except in the North, the modal level of education for the facility-based service providers is post-secondary. The percentages with post-secondary education are North (31.8 percent), Central East (77.3 percent), Central West (100 percent), South East (53.8 percent), and South West (63.6 percent). These percentages show that majority of the service providers have basic post-secondary trainings required for adequate performance of their duties as nurses, midwives, medical doctors, among others.
- The majority of the service providers were married at the time of the survey (76.1 percent all; 95.5 percent North; 77.3 percent Central East; 60 percent Central West; 69.2 percent South East; and 78.3 percent South West.
- Over three-fifths of the facility-based service providers reported not having children aged 10-24. The percentage of service providers with children 10-24 is highest in Central East (50 percent) and lowest in South East (23.1 percent). Examining the distribution of service providers by whether or not they have children 10-24 was initially premised on the idea that having adolescent children of their own might influence their attitude to youth and consequently inform

the way they provide services. Unfortunately, because we did not have information on all youth service providers in each facility and because different questionnaires were administered among service providers and client exit interview respondents, it was difficult to examine the level of client satisfaction by the characteristics of the providers.

- The nurse midwives constitute the largest single group of the facility-based youth service providers in Malawi (32.7 percent). The percentage of service providers who are nurse midwives varies by zone: North (18.2 percent), Central East (50 percent), Central West (45 percent), South East (26.9 percent), and the South West (26.1 percent). Other service providers include medical doctors and nurses.
- Almost one-third (31.9 percent) of the facility-based service providers became health professionals within the year preceding the survey and are relatively new on the job. The percentage that is new on the job ranges from 4.5 in the Central East to 65.4 in the South East. In between these two are the South West (17.4), Central West (20) and North (45.1). Almost one-fifth (19.5 percent) of the service providers became health professionals one to four years before the survey, and another 28.3 percent became health professionals five to nine years before the survey.
- About three-quarters of service providers have been in their current service station for less than a year and are thus new in their work station.
- The service providers are located in different departments of the health facilities, with those in the FP, maternal and child health department (36.1 percent), constituting the largest group. Other departments where significant percentages of the service providers work include Environmental Health (16.7) and HIV prevention and treatment (13.9). The percentage of service providers working in these departments varies by zone.
- As was observed among the exit interview clients, slightly above two-thirds (67.3 percent) of the service providers work in public (government) health facilities: 17.7 percent I n government hospitals, 48.7 percent in government health centers, and 0.9 percent in government health posts. About 17 percent of the service providers work in CHAM health facilities, 8.9 percent in private health facilities, and 5.3 percent in BLM facilities.
- 79.3 percent of the service providers work in health facilities that offer YFHS, and the modal approach adopted is the integrated approach.

Table 3.3.1: Percentage Distribution of Health Facility-Based YFHS Providers by Background Characteristics*

Characteristic	North	Central East	Central West	South East	South West	All
Age:						
15-19	0.0	0.0	0.0	3.8	0.0	0.9
20-24	4.5	4.5	20.0	7.7	17.4	10.6
25-29	18.2	18.2	15.0	38.5	21.7	23.0
30 and above	77.3	77.3	65.0	50.0	60.9	65.5
Number of cases	22	22	20	26	23	113
Median age	33.0	34.5	30.0	29.5	32.0	32.0
Sex:						
Male	59.1	54.5	45.0	53.8	60.9	54.9
Female	40.9	45.5	55.0	46.2	39.1	45.1
Number of cases	22	22	20	26	23	113
Type of Residence/locality:						
Rural	54.5	54.5	45.0	53.8	43.5	50.4
Urban	45.5	45.5	55.0	46.2	56.5	49.6
Number of cases	22	22	20	26	23	113
Education:						
Primary	0.0	4.5	0.0	0.0	0.0	0.9
Secondary	68.2	18.2	0.0	46.2	36.4	35.1
Higher (above secondary)	31.8	77.3	100.0	53.8	63.6	64.0
Number of cases	22	22	19	26	22	111
Marital status:						
Never married	4.5	13.6	30.0	23.1	21.7	18.6
Currently married	95.5	77.3	60.0	69.2	78.3	76.1
Previously married	0.0	9.1	10.0	7.7	0.0	5.3
Number of cases	22	22	20	26	23	113
Number of living children 10-24:						
0	59.1	50.0	65.0	76.9	60.9	62.8
1	13.6	27.3	15.0	7.7	21.7	16.8
2	13.6	13.6	15.0	11.5	4.3	11.5
3 or more	13.6	9.1	5.0	3.8	13.0	8.8
Number of cases	22	22	20	26	23	113
Current professional status:						
Nurse midwife	18.2	50.0	45.0	26.9	26.1	32.7
Professional nurse	4.5	0.0	0.0	7.7	0.0	2.7
Social worker	0.0	0.0	5.0	0.0	0.0	0.9
YFHS provider	9.1	4.5	5.0	7.7	4.3	6.2
Community health Worker	13.6	0.0	5.0	0.0	0.0	3.5
Other	54.5	45.5	40.0	57.7	69.6	54.0
Number of cases	22	22	20	26	23	113
How long provider						

Characteristic	North	Central East	Central West	South East	South West	All
has been a health professional:						
Less than 1 year	45.5	4.5	20.0	65.4	17.4	31.9
1-4 years	4.5	27.3	25.0	3.8	39.1	19.5
5-9 years	36.4	31.8	35.0	15.4	26.1	28.3
10-14 years	9.1	9.1	5.0	7.7	4.3	7.1
15-19 years	0.0	9.1	10.0	3.8	13.0	7.1
20 and above	4.5	18.2	5.0	3.8	0.0	6.2
Number of cases	22	22	20	26	23	113
How long provider has been a working in the surveyed health facility (HF):						
Less than 1 year	70.0	100.0	100.0	68.4	60.0	75.6
1-4 years	0.0	0.0	0.0	21.1	40.0	13.3
5-9 years	20.0	0.0	0.0	0.0	0.0	4.4
10-14 years	10.0	0.0	0.0	0.0	0.0	4.4
15-19 years	0.0	0.0	0.0	10.5	0.0	4.4
Number of cases	10	5	6	19	5	45
Unit/department where YFH service provider works:						
Family Planning (maternal and child health)	20.0	50.0	47.4	23.1	43.5	36.1
HIV Prevention and Treatment	15.0	10.0	21.1	15.4	8.7	13.9
STI Prevention and Treatment	5.0	10.0	5.3	0.0	0.0	3.7
YFHS	15.0	5.0	0.0	7.7	4.3	6.5
Clinical Department	0.0	10.0	0.0	3.8	13.0	5.6
Environmental Health	30.0	0.0	5.3	30.8	13.0	16.7
OPD	0.0	5.0	5.3	11.5	8.7	6.5
Other	15.0	10.0	15.8	7.7	8.7	11.1
Number of cases	20	20	19	26	23	108
Type of HF where interview took place:						
Public HFs:						
Govt. hospital	22.7	18.2	20.0	11.5	17.4	17.7
Govt. health center	31.8	40.9	50.0	57.7	60.9	48.7
Govt. health post/outreach	4.5	0.0	0.0	0.0	0.0	0.9
has	4.5	0.0	0.0	0.0	0.0	0.9
CHAM/MISSION:						
Hospital	4.5	9.1	5.0	7.7	8.7	7.1
Health center	22.7	0.0	5.0	15.4	4.3	9.7

Characteristic	North	Central East	Central West	South East	South West	All
PRIVATE SECTOR:						
Hospital/clinic/doctor	0.0	18.2	15.0	0.0	8.7	8.0
Private/medical	0.0	4.5	0.0	0.0	0.0	0.9
Banja La Mtsogolo	9.1	9.1	0.0	7.7	0.0	5.3
Youth drop-in center	0.0	0.0	5.0	0.0	0.0	0.9
Number of cases	22	22	20	26	23	113
Is HF implementing YFHS?						
Yes	63.6	77.3	94.4	84.6	78.3	79.3
No	36.4	22.7	5.6	15.4	21.7	20.7
Number of cases	22	22	18	26	23	111
YFHS approach adopted in HF:						
Separate space within HF using HF-based peer educators	18.2	0.0	66.7	0.0	0.0	16.7
Separate space in the HF (using HF based peer educators) combined with community activities (using CBDA)	36.4	0.0	0.0	0.0	0.0	16.7
YFHS only on specific days of the week using the CBDAs (specific youth days/activities+ CBDA youth activities	9.1	44.4	33.3	0.0	100.0	29.2
Integrated (services provided to all clients at the same place but clients 10-24 are offered YFHS package on identification)	36.4	55.6	0.0	0.0	0.0	37.5
Number of cases	11	9	3	0	1	24

*Information also included on type of health facility.

3.3.2. Peer Educators

Table 3.3.2 conveys the distribution of peer educators by selected background characteristics, showing the following.

- The peer educators were slightly older than their potential/actual clients—the community survey and client exit interview respondents; one-third of the peer educators were aged 25 years or older at the time of the survey. Although the plan was to interview peer educators younger than 25 years, they were difficult to find in some places. The percentage of peer educators above age 24 (that is, older than the youth they serve) varies across zones (from 0 percent in Central East to 68.8 percent in the North). However, caution must be exercised in interpreting the zonal differences as the number of cases is small, particularly in Central East with only five peer educators.
- There were more male than female peer educators. Sixty-five percent of the peer educators were males and the percentage of male peer educators ranges from 50 percent in Central West to 73.9 percent in Central East. Regarding location, almost two-thirds (63.2 percent) of the peer educators were located in the rural areas. It is only in Central West that more urban peer educators were interviewed.
- In all the zones, the modal highest level of education is secondary school (80.9 percent) and the percentage with secondary school education ranges from 62.5 percent in the North to 100 percent in Central East. With 11.8 percent having post-secondary education, the data show that almost 93 percent of peer educators have secondary or higher education. This figure shows that overwhelming majority of peer educators have some basic education upon which RH education can be built through training.
- Over half (53.6 percent) of the peer educators were not married at the time of the survey. Except in the North, there were more never-married peer educators than ever-married peer educators (currently or previously) s. The percentage of peer educators who have never been married varies across zones (from 37.5 percent in the North to 63.6 percent in Central West).
- Almost half (49.1 percent) of the peer educators have worked in that capacity for four or more years, implying a good mixture of old (experienced) and new (less experienced) individuals who could learn from one another. Only one in five peer educators started in the year preceding the survey. Furthermore, the data suggest that the majority of peer educators must have gained a deep understanding of the health condition in their communities having lived there for five or more years. Over two-thirds of the peer educators reported to have lived in the communities where they offer services for five or more years; 20.3 percent have lived in the communities for five to nine years and 47.8 percent have lived in the communities for ten or more years.

Table 3.3.2: Percentage Distribution of Peer Educators by Background Characteristics

Characteristic	North	Central East	Central West	South East	South West	All
Age:						
Below 19	6.3	0	27.3	21.7	21.4	17.4
20-24	25.0	100.0	54.5	52.2	50.0	49.3
25 years and above	68.8	0	18.2	26.1	28.6	33.3
Number of cases	16	5	11	23	14	69
Sex:						
Male	68.8	60.0	63.6	73.9	50.0	65.2
Female	31.3	40.0	36.4	26.1	50.0	34.8
Number of cases	16	5	11	23	14	69
Type of residence/locality:						
Rural	75.0	80.0	40.0	60.9	64.3	63.2
Urban	25.0	20.0	60.0	39.1	35.7	36.8
Number of cases	16	5	10	23	14	68
Education:						
Primary	6.3	0	0	13.8	7.1	7.4
Secondary	62.5	100.0	90.9	77.3	92.9	80.9
Above secondary	31.3	0	9.1	9.1	0	11.8
Number of cases	16	5	11	23	14	69
Marital status:						
Never married	37.5	60.0	63.6	60.9	50.0	53.6
Currently married	53.6	20.0	36.4	20.4	35.7	37.7
Previously married	6.3	20.0	0	8.7	14.3	8.7
Number of cases	16	5	11	23	14	69
How long respondent has been working as a peer educator:						
Less than 1 year	18.8	0	22.2	17.6	37.5	20.0
2-3 years	37.5	40.0	33.3	29.4	12.5	30.0
4 years and above	43.8	60.0	44.4	52.9	50.0	49.1
Number of cases	16	5	9	17	8	55
Length of stay in survey community:						
1-4 years	50.0	0	27.3	17.4	50.0	31.9
5-9 years	18.8	20.0	18.2	26.1	14.3	20.3
10 years and above	31.3	80.0	54.5	56.5	35.7	47.8
Number of cases	16	5	11	23	14	69

3.3.3. Community-Based Distribution Agents

Table 3.3.3 shows the distribution of CBDAs by selected background characteristics.

- The CBDAs were generally much older than their potential/actual clients—the community survey and client exit interview respondents; almost three-quarters (73.6 percent) were aged 25 years and above at the time of the survey. As with the peer educators, the plan was to interview CBDAs below age 25, but they were difficult to find in some survey sites. The percentage of CBDAs above age 24 varies across zones (from 53.3 percent in Central East to 95.2 percent in the North). The CBDAs were also generally older than the peer educators.
- There were slightly more male than female CBDAs—52.9 percent of all CBDAs were males, and across zones the percentage ranges from 42.1 percent in South East to 66.7 percent in Central West. Regarding location, 62.1 percent of CBDAs were located in rural areas (from 50 percent in Central West to 81 percent in the North).
- About 70 percent of CBDAs had secondary school education and the percentage having secondary education ranges from 40 percent in Central West to 81.8 percent in South West. Compared to the peer educators, the CBDAs were less educated. While 92.6 percent of peer educators reported to have secondary or post-secondary education, the corresponding figure for CBDAs is 75.6 percent.
- Almost three in four (73.6 percent) CBDAs were married at the time of the survey. The percentage married ranges from 59.1 percent in the South West to 86.7 percent in Central East.
- Almost half (48.1 percent) of CBDAs have worked in their capacity for four or more years, implying, as we noted for the peer educators, a good mixture of old (experienced) and new (less experienced) individuals who could learn from one another. Only 11.9 percent of CBDAs started working as CBDAs in the year preceding the survey. The data in the last panel of Table 3.3.3 suggest that majority of CBDAs might have gained a fairly deep understanding of the health conditions in their communities having lived in these communities for five or more years. Almost three-quarters (72 percent) of CBDAs reported to have lived in the communities where they offer services for five or more years; 17.1 percent have lived in the communities for five to nine years and 54.9 percent have lived in the communities for ten or more years.

Table 3.3.3: Percentage Distribution of CBDAs by Background Characteristics

Characteristic	North	Central East	Central West	South East	South West	All
Age:						
20-24	4.8	46.7	10.0	31.6	36.4	26.4
25 years and above	95.2	53.3	90.0	68.4	63.6	73.6
Number of cases	21	15	10	19	22	87
Sex:						
Male	52.4	66.7	50.0	42.1	54.5	52.9
Female	47.6	33.3	50.0	57.9	43.5	47.1
Number of cases	21	15	10	19	22	87
Type of Residence/locality:						
Rural	81.0	60.0	50.0	57.9	54.0	62.1
Urban	19.0	40.0	50.0	42.1	45.5	37.9
Number of cases	21	15	10	19	22	87
Education:						
Primary	33.3	20.0	60.0	22.2	4.5	24.4
Secondary	61.9	73.3	40.0	77.8	81.8	69.8
Above Secondary	4.8	6,7	0	0	13.6	5.8
Number of cases	21	15	10	18	22	86
Marital status:						
Never married	4.8	6.7	10.0	26.3	36.4	18.4
Currently married	85.7	86.7	80.0	63.2	59.1	73.6
Previously married	9.5	6.7	10.0	10.5	4.5	8.0
Number of cases	21	15	10	19	22	87
How long respondent has been working as a CBDA:						
Less than 1 year	9.5	14.3	11.1	0	22.2	11.7
2-3 years	28.6	42.9	0	46.7	66.7	40.3
4 years and above	61.9	42.9	88.9	53.3	11.1	48.1
Number of cases	21	14	9	15	18	77
Length of stay in survey community:						
1-4 years	23.8	33.3	33.3	17.6	35.0	28.0
5-9 years	28.6	13.3	0	23.5	10.0	17.1
10 years and above	47.6	53.3	66.7	58.8	55.0	54.9
Number of cases	21	15	9	17	20	82

3. 4. Sexual Experience of Youth Aged 10-24

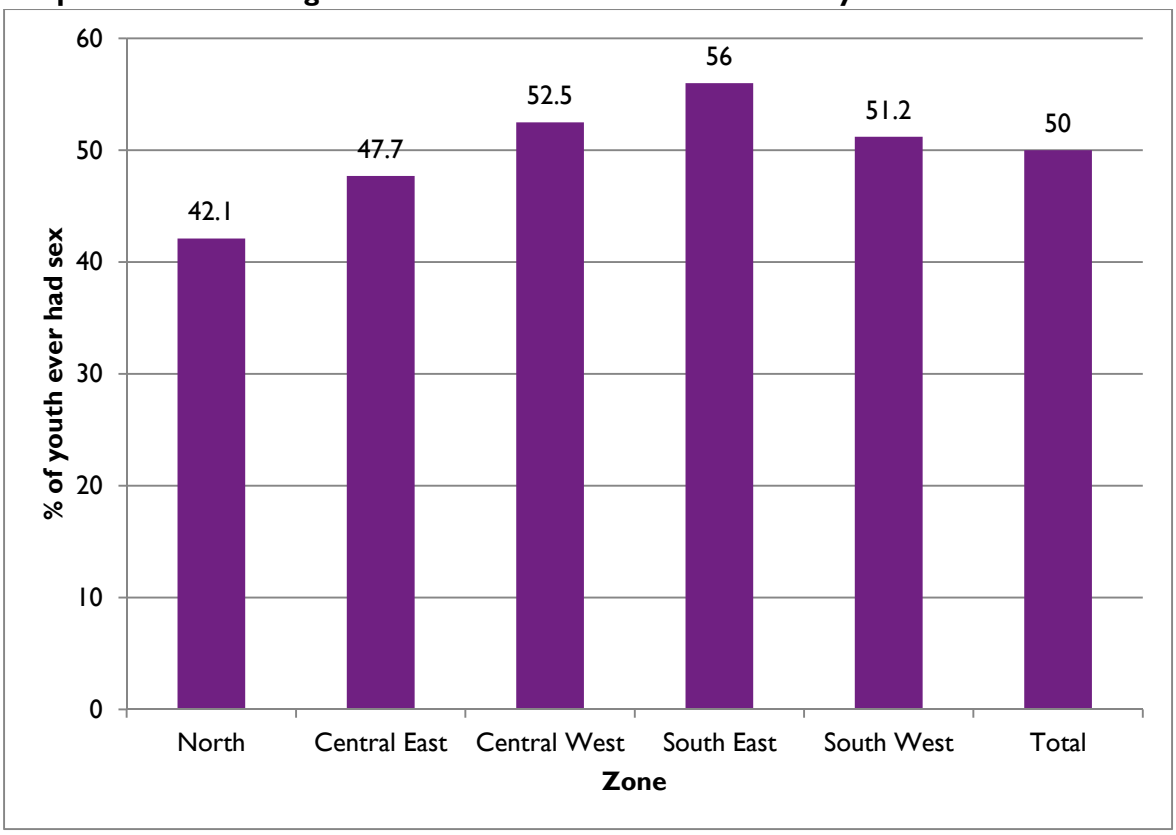
3.4.1. Ever Had Sex

Information on sexual experience was collected from the youth to highlight their SRH needs and to inform the modification of existing programs to meet their health needs. For example, findings showing a significant percentage of youth, aged 10-14, as sexually active might encourage policymakers to consider including information about the consequences of unprotected sex in RH education materials for this age group. This section describes the sexual experience of youth aged 10-24. Table 3.4.1 depicts data for males and females, Table 3.4.2 for males only by zone, and Table 3.4.3 for females only by zone. Graph 3.4.1 depicts the percent of youth who have ever had sex by zone, while Graph 3.4.2 shows young people who have ever had sex by age and sex.

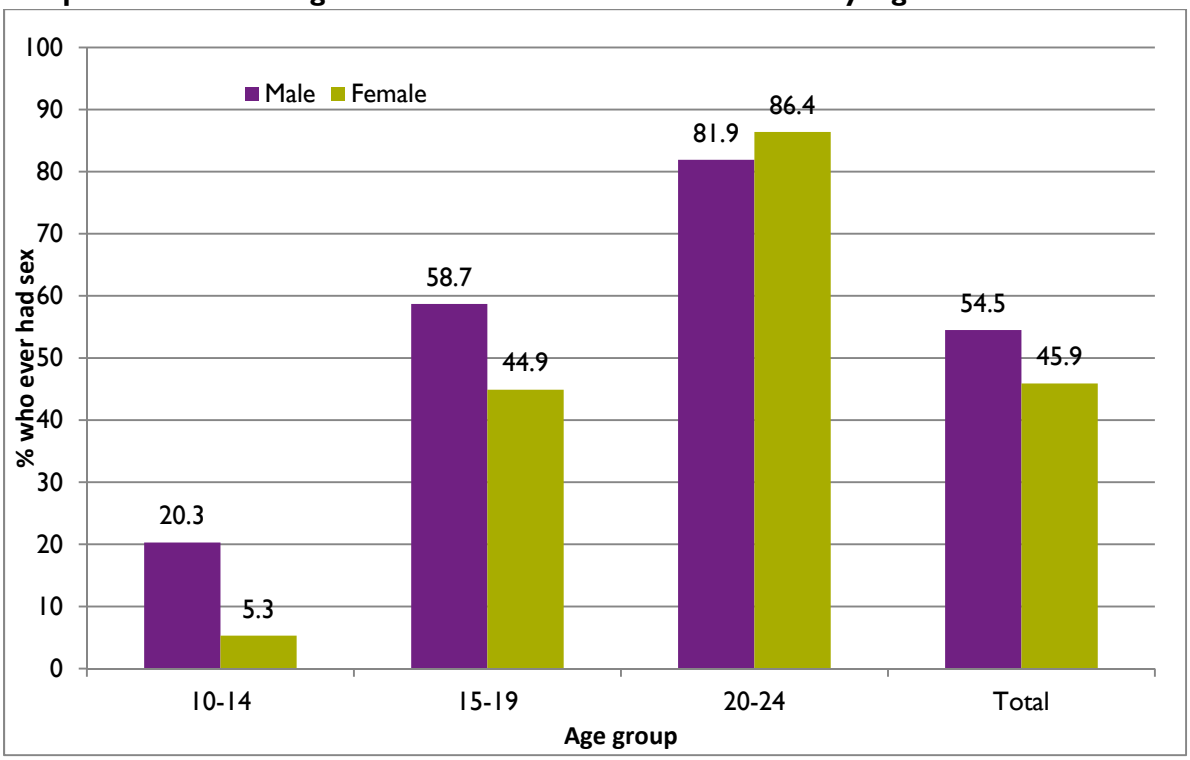
- About 72 percent of adolescents (76.5 percent of males and 66.3 percent of females) aged 10-14 have heard or talked about sex. The percentage of male adolescents aged 10-14 who have heard or talked about sex ranges from 58 percent in the South East to 91 percent in Central East. Among females aged 10-14, the percentage reporting to have heard or talked about sex ranges from 47.4 percent in the South West to 96.3 percent in Central East. Seventy-six percent (80.7 percent of males and 71.4 percent of females) reported to know someone of their age who has had sex. Again, there are zonal variations with the percentage indicating if the respondents knew someone who has had sex, ranging from 65.6 percent in Central East and 87.8 percent in South West for males, and 57.6 percent in Central West to 84.6 percent in Central East for females. Higher percentages of males 10-14 reported to have heard about sex or know someone who has had sex.
- Half of youth aged 10-24 reported to have had sex at the time of the survey, and the likelihood of reporting to have had sex increases with age (12.6 percent of those aged 10-14, 51.9 percent of those 15-19 and 84 percent of those aged 20-24). Among males 10-24, 54.5 percent reported to have had sex at the time of the survey, with the percentage reporting to have ever had sex increasing with age (20.3 percent of youth 10-14[45], 58.7 percent of those 15-19, and 81.9 percent of those 20-24). Males in the North were least likely to report ever having sex (47.3 percent) while those in the Central West were most likely to report ever having sex (59.1 percent). In addition, males in rural areas were more likely to report ever having sex—57.2 percent for rural vs. 50.4 percent for urban. Among females, 45.9 percent (5.3 percent of those aged 10-14, 44.9 percent of those aged 15-19, and 86.4 percent of those aged 20-24) reported to have ever had sex. There are also variations by zone, with females in the North least likely to report ever having sex (36.2 percent) and those in the South East most likely to report ever having sex (54.5 percent). In addition, sexual experience does not appear to vary significantly by rural/urban residence. The median age of sex for both male and female respondents is 16 years. Overall, a higher percentage of males reported to have had sex.

[45] For the age group 10-14, the denominator for the percentage of adolescents reporting to have ever had sex is the number who reported to have heard or talked about sex Those who reported to have not heard about sex were not asked whether they have ever had sex.

Graph 3.4.1: Percentage of Youth Who Have Ever Had Sex by Zone



Graph 3.4.2: Percentage of Youth Who Have Ever Had Sex by Age and Sex



- While 87 percent of male respondents reported to have sexual partners that were either younger or of the same age, only 34.5 percent of female respondents reported sexual partners who were younger or of the same age with them; 63 percent of females reported that their sexual partners were older than them. For both male and female respondents, the percentages reporting sexual partners that are younger, of the same age, or older than them vary significantly by zones. The patterns reflect the traditional practice of males wanting to have a sexual relationship with females who are younger or of the same age and females wanting to have a relationship with older men or males of the same age.
- Among those who reported that their partners were either younger or older than them, 16.9 percent (4.8 percent of males and 28 percent of females) reported that their partners were five or more years older than them; 46 percent (25.5 percent of males and 64.3 percent of females) reported that their partners were less than five years older than them. And 30.6 percent (60.1 percent of males and 4.6 percent of females) reported that their partners were less than five years younger than them. Again, there are variations across zones.
- Almost half (48.1 percent) of sexually experienced youth (52.4 percent of males and 42.2 percent of females) reported to have used a contraceptive method during first sex. The percentages reporting use of contraception vary by zone (from 31.4 percent in the South East to 66.3 percent in the North for males, and from 34.1 percent in the South West to 56.3 percent in the North for females). The dominant contraceptive method reported to have been used is the male condom (94.4 percent of all respondents, 97.5 percent of males, and 90.3 percent of females). About 3 percent (0.7 percent of males and 5.6 percent of females) reported to have used injectable contraceptives, with the North reporting highest level of injectable contraceptives use among females (12.5 percent). The major sources of contraceptive methods used during first sex (which is mainly male condom) are the government health facilities—hospitals, health centers, outreach posts, HSAs, and CBDAs. Fifty-four percent of male and female respondents reported to have received their methods from these public facilities. About 25 percent of respondents also reported to have received methods from a market or shop.

Table 3.4.1: Sexual Experience of Youth 10-24 Years Old: Ever Had Sex

	Total	N
Percent of youth 10-14 who have ever heard or talked about sex	71.8	594
Know people of same age having sex (10-14)	75.6	425
Percent who have ever had sex by:		
1. Age:		
10-14	12.6	604
15-19	51.9	811
20-24	84.0	618
All (10-24)	50.0	2,033
Median age ay first sex	16.0	1,002
2. Residence:		
Rural	51.5	1,197
Uban	47.8	836
Percent of sexually experienced who are:		
Same age with partner at first sex	40.5	
Older than partner at first sex	22.4	
Younger than partner at first sex	35.0	
Don't know age of partner at first sex	2.2	
Number of cases	1,006	
Difference between age of respondent and partner:		
More than 10 years younger than partner at first sex	2.4	
5-10 years younger than sex partner at first sex	14.5	
Less than 5 years younger than partner at first sex	46.0	
Less than 5 years older than partner at first sex	30.8	
5 years or more older than partner at first sex	3.1	
No response	0.3	
Don't know	2.8	
Number of cases	574	
Percent using contraception at the time of first sex	48.1 (1,002)	
Method used at first sex		
Oral contraception pill	0.8	
Intrauterine device	0.2	
Injectables	2.7	
Implants	0.2	
Male condom	94.4	
Female condom	1.7	
Number of cases	481	
Source of contraceptive methods at first sexual encounter		
Public sector government hospital	9.0	
Public sector government health center	30.8	
Public sector government health post or outreach	2.1	
Public sector government mobile clinic	0.2	
Public sector government health surveillance assistant	3.5	
Public sector government community-based distribution agent (CBDA) door to door	7.5	
Public sector government other	1.0	

CHAM/mission hospital	0.4
CHAM/mission health center	2.9
CHAM/mission mobile clinic	0.2
CHAM/mission CBDA door to door	0.4
Private sector private hospital/clinic/doctor	1.9
Private sector pharmacy	0.8
Private sector mobile clinic	0.2
Private sector CBDA door to door	1.0
Private sector other private medical	2.1
Banja La Mtsogolo	1.5
Macro	1.7
Youth drop-in center	1.0
Other source: market/shop	24.8
Other source: church	0
Other source: friends/relatives	3.5
Other source: other	5.2
Number of cases	478

Table 3.4.2: Sexual Experience of Male Youth 10-24 Years: Ever Had Sex

	North	Central East	Central West	South East	South West	All
Percent of youth 10-14 who have ever heard or talked about sex	61.3 (62)	91.0 (67)	89.7 (58)	58.0 (50)	78.8 (52)	76.5 (289)
Know people of same age having sex (10-14)	84.2 (38)	65.6 (61)	83.0 (53)	83.3 (30)	87.8 (41)	80.7
Percent who have ever had Sex by:						
Age:						
10-14	9.5 (63)	17.9 (67)	26.2 (61)	21.6 (51)	28.3 (53)	20.3 (295)
15-19	50.6 (81)	61.3 (106)	62.2 (82)	65.1 (63)	55.0 (80)	58.7 (412)
20-24	81.0 (63)	78.5 (65)	88.3 (60)	83.1 (65)	78.4 (51)	81.9 (304)
All (10-24)	47.3	53.5	59.1	58.9	54.1	54.5
Number of cases	**207**	**238**	**203**	**179**	**184**	**1,011**
Residence:						
Rural	50.0 (142)	54.3 (173)	64.4 (101)	58.4 (101)	64.8 (90)	57.2 (607)
Urban	41.5 (65)	52.3 (65)	53.9 (102)	59.5 (78)	43.6 (94)	50.4 (404)
Percent of sexually experienced who are:						
Same age with partner at first sex	42.9	59.5	33.9	54.3	49.0	48.3
Older than Partner at first sex	48.0	24.6	51.3	34.3	37.8	38.7
Younger than partner at first sex	9.2	15.1	13.9	3.8	13.3	11.2
Don't know age of partner at first sex	0.0	0.8	0.9	7.6	0.0	1.8
Number of cases	**98**	**126**	**115**	**105**	**98**	**542**
Difference between age of respondent and partner						
More than 10 years younger than partner at first sex	1.8	0.0	0.0	0.0	3.9	1.1
5-10 years younger than sex partner at first sex	0.0	10.0	1.4	2.4	5.9	3.7
Less than 5 years younger than partner at first sex	21.4	36.0	36.0	22.0	21.6	25.5
Less than 5 years older than partner at first sex	69.6	44.0	57.5	63.4	66.7	60.1
5 years or more older than partner at first sex	5.4	6.0	13.7	5.4	0.0	6.3
No response	0.0	0.0	0.0	0.0	2.0	0.4
Don't know	1.8	4.0	1.4	9.8	0.0	3.0
Number of cases	56	50	73	41	51	271
Percent using contraception at the time of first sex	66.3 (98)	54.4 (125)	52.2 (115)	31.4 (105)	59.2 (97)	52.5 (540)
Method used at first sex						
Oral contraception pill	1.5	0.0	1.7	0.0	0.0	0.7

	North	Central East	Central West	South East	South West	All
Intrauterine device	0.0	1.4	0.0	0.0	0.0-	0.7
Injectables	0	1.4	0.0	3.0	0.0	0.7
Implants	0.0	0.0	0.0	0.0	0.0	0.0
Male condom	98.4	95.7	98.3	97.0	98.2	97.5
Female condom	0.0	1.4	0.0	0.0	1.8	0.7
Lactational amenorrhea method	0.0	0.0	0.0	0.0	0.0	0.0
Emergency contraception	0.0	0.0	0.0	0.0	0.0	0.0
Withdrawal	0.0	0.0	0.0	0.0	0.0	0.0
Standard Days Method	0.0	0.0	0.0	0.0	0.0	0.0
Number of cases	**65**	**68**	**60**	**33**	**58**	**284**
Source of contraceptive methods at first sexual encounter						
Public sector government hospital	9.5	5.9	5.1	6.1	12.5	7.9
Public sector government health center	27.0	19.1	28.8	30.3	38.6	28.2
Public sector government health post or outreach	0.0	5.9	6.8	3.0	0.0	3.2
Public sector government mobile clinic	0.0	0.0	1.7	0.0	0.0	0.4
Public sector government health surveillance assistant	6.3	7.4	5.1	6.1	0.0	5.0
Public sector government community-based distribution agent (CBDA) door to door	9.4	10.3	1.7	18.2	7.0	8.5
Public sector government other	1.6	2.9	0.0	0.0	0.0	1.1
CHAM/mission hospital	0.0	0.0	0.0	3.0	0.0	0.4
CHAM/mission health center	3.1	1.5	6.8	9.1	1.8	3.9
CHAM/mission mobile clinic	0.0	0.0	1.7	0.0	0.0	0.4
CHAM/mission CBDA door to door	0.0	1.5	0.0	0.0	0.0	0.4
Private sector private hospital/clinic/doctor	0.0	0.0	8.5	0.0	1.8	2.1
Private sector pharmacy	0.0	0.0	1.7	0.0	0.0	0.4
Private sector mobile clinic	0.0	0.0	0.0	3.0	0.0	1.4
Private sector CBDA door to door	1.6	1.5	3.4	0.0	0.0	1.4
Private sector other private medical	6.2	5.9	1.7	0.0	0.0	3.2
Banja La Mtsogolo	1.6	1.5	0.0	0.0	0.0	0.7
Macro	9.4	0.0	1.7	0.0	0.0	2.5
Youth drop-in center	0.0	1.5	0.0	0.0	1.8	0.7
Other source: market/shop	18.8	20.6	26.7	12.1	28.1	22.0
Other source: church	0.0	0.0	0.0	0.0	0.0	0.0
Other source: friends/relatives	1.6	7.4	10.0	3.0	5.3	5.7
Other source: other	6.2	8.8	1.7	6.1	3.5	5.3
Number of cases	**63**	**68**	**59**	**33**	**56**	**279**

Table 3.4.3: Sexual Experience of Female Youth 10-24 Years: Ever Had Sex

	North	Central East	Central West	South East	South West	All
Percent of youth 10-14 who have ever heard about or talked about sex	65.5 (55)	96.3 (54)	56.9 (58)	67.1 (76)	47.4 (57)	66.3 (300)
Know people of same age having sex (10-14)	66.7 (36)	84.6 (52)	57.6 (33)	68.6 (51)	74.1 (27)	71.4 (199)
Percent who have ever had Sex by:						
Age:						
10-14	3.6 (56)	5.5 (55)	3.4 (59)	6.5 (77)	7.0 (57)	5.3 (304)
15-19	26.0 (77)	34.3 (70)	48.7 (78)	58.7 (92)	53.2 (77)	44.9 (394)
20-24	77.8 (63)	85.4 (48)	89.1 (55)	93.0 (86)	83.9 (56)	86.4 (308)
All (10-24)	36.2 (196)	41.0 (173)	46.4 (192)	54.5 (255)	48.4 (190)	45.9 (1011)
Residence:						
Rural	40.6 (138)	36.6 (131)	45.3 (92)	58.4 (137)	50.5 (91)	46.2 (589)
Urban	25.9 (58)	53.2 (47)	47.0 (100)	50.0 (118)	46.5 (99)	45.5 (422)
Percent of sexually experienced who are:						
Same age with partner at first sex	19.7	32.8	29.9	35.2	33.7	31.2
Older than Partner at first sex	2.8	4.5	4.6	2.6	2.2	3.3
Younger than partner at first sex	77.5	61.2	64.4	55.6	63.0	63.0
Don't know age of partner at first sex	0.0	1.5	1.1	6.3	1.1	2.6
Number of cases	71	67	87	142	92	459
Difference between age of respondent and partner						
More than 10 years younger than partner at first sex	2.7	0.0	5.0	2.4	6.8	3.6
5-10 years younger than sex partner at first sex	35.2	18.2	25.0	14.3	32.2	24.3
Less than 5 years younger than partner at first sex	57.4	81.8	60.0	67.9	55.9	64.3
Less than 5 years older than partner at first sex	1.9	0.0	6.7	9.5	1.7	4.6
5 years or more older than partner at first sex	0.0	0.0	0.0	1.2	0.0	0.3
No response	1.9	0.0	0.0	0.0	0.0	0.3
Don't know	0.0	0.0	3.3	4.8	3.4	2.6
Number of cases	54	44	60	84	59	301
Percent using contraception at first sex	56.3 (71)	49.3 (67)	41.4 (87)	37.3 (142)	34.1 (92)	42.2 (459)
Method used at first sex						
Oral contraception pill	2.5	0.0	2.8	0.0	0.0	1.0
Intrauterine device	0.0	0.0	0.0	0.0	0.0	0.0

	North	Central East	Central West	South East	South West	All
Injectables	12.5	0.0	0.0	7.5	6.5	5.6
Implants	0.0	0.0	0.0	0.0	0.0	0.0
Male condom	82.5	100.0	91.7	92.5	83.9	90.3
Female condom	2.5	0.0	5.6	1.9	9.7	3.1
Number of cases	40	35	36	53	31	195
Source of contraceptive methods at first sex						
Public sector government hospital	7.5	16.7	16.7	3.8	12.9	10.8
Public sector government health center	37.5	19.4	30.6	34.6	58.1	35.4
Public sector government health post or outreach	2.5	0.0	0.0	0.0	0.0	0.5
Public sector government mobile clinic	0.0	0.0	0.0	0.0	0.0	0.0
Public sector government health surveillance assistant	5.0	0.0	0.0	1.9	0.0	1.5
Public sector government community-based distribution agent (CBDA) door to door	2.5	2.8	5.6	9.6	6.5	5.6
Public sector government other	0.0	2.8	0.0	1.9	0.0	1.0
CHAM/mission hospital	0.0	2.8	0.0	0.0	0.0	0.5
CHAM/mission health center	2.5	0.0	2.8	1.9	0.0	1.5
CHAM/mission mobile clinic	0.0	0.0	0.0	0.0	0.0	0.0
CHAM/mission CBDA door to door	0.0	0.0	0.0	1.9	0.0	0.5
Private sector private hospital/clinic/doctor	0.0	2.8	0.0	0.0	3.2	1.0
Private sector pharmacy	0.0	2.8	2.8	0.0	3.2	1.5
Private sector mobile clinic	0.0	0.0	0.0	0.0	0.0	0.0
Private sector CBDA door to door	0.0	2.8	0.0	0.0	0.0	0.5
Private sector other private medical	0.0	0.0	2.8	0.0	0.0	0.5
Banja La Mtsogolo	2.5	2.8	2.8	3.8	0.0	2.6
Macro	2.5	0.0	0.0	0.0	0.0	0.5
Youth drop in center	0.0	0.0	0.0	3.8	3.2	1.5
Other source: market/shop	37.5	25.0	33.3	28.8	12.9	28.2
Other source: church	0.0	0.0	0.0	0.0	0.0	0.0
Other source: friends/relatives	0.0	0.0	0.0	1.9	0.0	0.5
Other source: other	0.0	11.1	5.6	5.8	3.2	5.1
Number of cases	**40**	**36**	**36**	**52**	**31**	**195**

3.4.2. Sexual Experience in the 12 Months Preceding the Survey

Tables 3.4.4 and 3.4.5 show the percentage of community youth survey respondents who reported having had sex in the 12 months preceding the survey, using a contraceptive method at last sex, and obtaining contraceptive methods from different sources. The data on male sexual experience are presented in Table 3.4.4 and the female data are presented in Table 3.4.5.

Sexually active female youth reported higher levels of sexual activity in the 12 months preceding the survey than their male counterparts. While 59 percent of sexually active males reported having had sex in the 12 months preceding the survey, the corresponding figure for females is 66.7 percent. For males, the percentage having had sex in the 12 months preceding the survey ranges from 51.2 percent in Central East to 67.3 percent in the South West. For female youth, the percentage ranges from 57.7 percent in the North to 80.5 percent in Central West. The majority of youth who reported having had sex in the 12 months preceding the survey had sex in the month preceding the survey.

The percentages of youth who reported using a contraceptive method during last sex vary by sex (67.6 percent of males vs. 54 percent of females) and by zone. For males, contraceptive use at last sex was lowest in the Central West (57.7 percent) and highest in the North (81.4 percent), and for females contraceptive use at last sex was lowest in the South East (46.9 percent) and highest in the North (66.1 percent). Male and female youth also tended to use different contraceptive methods at last sex: 86% of male youth reported using condoms, while females, condoms (41.6 percent) and injectable contraceptives (41.6 percent) were most frequently mentioned. There are also variations across zones in the percentage of contraceptive users reporting each method.

Both males (25.7 percent) and females (46.4 percent) most frequently got their contraceptive methods from government health centers. They also frequented markets/shops. Males also went to government hospitals (10.6 percent) and CBDAs (11.1 percent) for contraceptives.

Table 3.4.4: Sexual Experience of Male Youth 10-24 in the Year Preceding the Survey

	North	Central East	Central West	South East	South West	All
Percent having sex in the 12 months preceding survey by age:						
10-14	16.7 (5)	41.7 (12)	56.2 (16)	63.6 (11)	53.3 (15)	50.0 (60)
15-19	53.7 (41)	39.3 (62)	43.8 (49)	53.7 (41)	65.1 (43)	50.0 (236)
20-24	70.6 (51)	68.6 (51)	68.0 (50)	69.8 (53)	74.4 (39)	70.1 (244)
All (10-24)	60.2 (98)	51.2 (125)	55.7 (115)	62.9 (105)	67.3 (98)	59.0 (540)
Percent who used contraception at last sex	81.4 (59)	67.7 (65)	57.7 (64)	65.2 (66)	67.2 (66)	67.6 (320)
Contraceptive method used at last sex						
Oral contraception pill	2.2	6.8	0.0	0.0	0.0	1.9
Intrauterine device	0.0	0.0	2.7	0.0	2.2	0.9
Injectables	0.0	18.2	8.1	14.0	4.4	8.8
Male condom	97.8	70.5	89.2	79.1	93.3	86.0
Female condom	0.0	2.3	0.0	2.3	0.0	0.9
Withdrawal	0.0	2.3	0.0	0.0	0.0	0.5
Other	0.0	0.0	0.0	2.3	0.0	0.5
Don't know	0.0	0.0	0.0	2.3	0.0	2.3
Number of cases	46	44	37	43	45	215
Source of contraceptive method at last sex						
Public sector government hospital	8.5	17.8	2.7	14.3	8.7	10.6
Public sector government health center	19.1	20.0	24.3	31.0	32.6	25.3
Public sector government health post or outreach	0.0	0.0	5.4	0.0	0.0	0.9
Public sector government mobile clinic	0.0	0.0	2.7	2.4	0.0	0.9
Public sector government health surveillance assistant	6.4	4.4	0.0	7.3	0.0	3.7
Public sector government community-based distribution agent (CBDA) door to door	14.9	4.4	10.8	24.4	2.1	11.1
Public sector government other	2.1	4.4	0.0	0.0	0.0	1.4
CHAM/mission hospital	4.3	2.2	0.0	0.0	0.0	0.9
CHAM/mission health center	4.3	0.0	2.7	0.0	0.0	1.4
Private sector private hospital/clinic/doctor	0.0	0.0	10.8	0.0	0.0	1.9
Private sector CBDA door to door	2.1	4.4	0.0	0.0	4.3	2.8
Private sector other private medical	4.3	0.0	0.0	0.0	0.0	0.9
Banja La Mtsogolo	4.3	2.2	2.7	0.0	0.0	1.9
Macro	6.4	0.0	2.7	0.0	0.0	1.9
Other source: market/shop	21.3	8.9	32.4	12.2	32.6	21.3
Other source: church	0.0	4.4	0.0	12.2	2.1	3.7
Other source: friends/relatives	2.1	2.2	5.4	2.4	2.2	2.8
Other source: other	4.3	15.6	0.0	0.0	2.2	4.7
Number of cases	**47**	**45**	**37**	**41**	**46**	**216**

Table 3.4.5: Sexual Experience of Female Youth 10-24 in the Year Preceding Survey

	North	Central East	Central West	South East	South West	All
Percent having sex in the 12 months preceding survey by age:						
10-14	0.0 (2)	50.0 (2)	50.0 (2)	80.0 (5)	25.0 (4)	46.0 (15)
15-19	65.0 (20)	50.0 (24)	75.0 (36)	65.5 (55)	52.5 (40)	62.3 (175)
20-24	57.1 (49)	65.9 (41)	85.7 (49)	70.0 (80)	73.9 (46)	70.6 (265)
All (10-24)	57.7 (71)	61.1 (72)	80.5 (87)	68.6 (140)	62.2 (90)	66.7 (460)
Percent who used contraception at last sex	66.1 (43)	69.6 (42)	52.1 (71)	46.9 (98)	47.4 (57)	54.0 (311)
Contraceptive method used at last sex						
Oral contraception pill	3.6	71	2.7	2.2	7.4	4.2
Intrauterine device	0.0	0.0	0.0	0.0	0.0	0.0
Injectables	21.4	39.3	51.4	45.7	44.4	41.6
Implants	10.7	10.7	16.2	4.3	11.1	10.2
Male condom	60.7	42.9	29.7	43.5	33.3	41.6
Female condom	3.6	0.0	0.0	0.0	0.0	0.6
Withdrawal	0.0	0.0	0.0	0.0	3.7	0.6
Source of contraception at first sexual encounter						
Public sector government hospital	14.3	21.4	32.4	6.5	14.8	17.5
Public sector government health center	42.9	39.3	40.5	50.0	59.3	46.4
Public sector government mobile clinic	0.0	3.6	2.7	0.0	0.0	1.2
Public sector government health surveillance assistant	10.7	0.0	0.0	8.7	3.7	4.8
Public sector government community-based distribution agent (CBDA) door to door	3.6	0.0	0.0	4.3	0.0	1.8
Public sector government other	0.0	0.0	0.0	2.2	0.0	0.6
CHAM/mission hospital	0.0	3.6	0.0	0.0	0.0	0.6
CHAM/mission health center	3.6	0.0	5.4	4.3	0.0	3.0
CHAM/mission CBDA door to door	0.0	7.1	0.0	0.0	0.0	1.2
Private sector private hospital/clinic/doctor	0.0	0.0	2.7	0.0	7.4	1.8
Banja La Mtsogolo	0.0	3.6	2.7	4.3	0.0	2.4
Youth drop in-center	0.0	0.0	0.0	2.2	0.0	0.6
Other source: market/shop	21.4	25.0	16.2	15.2	7.4	16.9
Other source: friends/relatives	0.0	0.0	0.0	0.0	0.0	0.0
Other source: other	3.6	0.0	0.0	0.0	0.0	1.8
Number of cases	**28**	**28**	**37**	**46**	**27**	**166**

3.4.3. Future Use of Contraception Among Youth

Tables 3.4.6 and 3.4.7 show the percentages of sexually experienced male and female youth, respectively, who expressed intention to use contraception during future sex. The tables also show the preferred methods and where they hope to obtain the methods. For those not interested in using contraception during future sex, their reasons for not intending to use a method are highlighted.

High percentages of sexually experienced youth expressed intention to use contraception during future sex (85.2 percent of males, and 74.7 percent of females). Higher proportions of male youth expressed intention to use a contraceptive method during future sex. While the percentages of male youth intending to use contraception in the future vary widely across zones (from 79.8 percent in Central West to 93.9 percent in the South West), there are little zonal variations for females (from 71.8 percent in Central East to 77.3 percent in Central West).

For those not intending to use contraception during next sex, the dominant reasons among males are the desire to have partner his become pregnant (30.9 percent) and the difficulty in obtaining a method (10.3 percent). For females, the dominant reasons are the desire to become pregnant (24.4 percent) and fear of side effects (16.3 percent). There are zonal variations which must be interpreted with caution due the small number of cases; for example, in South West for males and Central East for females.

Youth who expressed the desire to use a contraceptive method during the next sex were asked to state their method of choice. Among male youth, 85.7 percent expressed preference for condoms and 8.7 percent for injectable contraceptives. Among females, 40.4 percent expressed preference for injectable contraceptives and 36.6 percent would like to use condoms; another 4.7 percent would like oral pills. The percentages of male and female youth expressing preference for each method vary by zone.

Regarding where the youth intend to obtain contraceptive methods, the majority of them said public health facilities (government hospitals and health centers); 55 percent of males and 72 percent of females. The other major source of the commodities is the market/shop; 25.7 percent of males and 13.5 percent of females.

Table 3.4.6: Use of Contraception During Next Sex, Male Youth 10-24

	North	Central East	Central West	South East	South West	All
Percent planning to use contraception during next sex	85.7 (98)	86.5 (126)	79.8 (114)	81.0 (105)	93.9 (97)	85.2 (540)
Reasons for not using contraception						
Fear of side effects	0.0	0.0	5.3	0.0	0.0	1.5
Stigma	0.0	0.0	0.0	5.3	0.0	1.5
Hard to get methods	14.3	16.7	5.3	10.5	0.0	10.3
Community disapproval	7.1	0.0	5.3	5.3	0.0	4.4
Want partner to get pregnant	28.6	41.7	15.8	31.6	75.0	30.9
Other	50.0	41.7	68.4	47.4	25.0	51.5
Number of cases	**14**	**12**	**19**	**19**	**4**	**68**
Type of contraception for those planning to have sex again						
Oral contraception pill	1.2	3.5	1.1	0.0	1.1	1.5
Intrauterine device	0.0	0.9	1.1	0.0	0.0	0.4
Injectables	3.6	13.5	6.5	8.3	9.9	8.7
Implants	0.0	2.6	2.2	0.0	1.1	1.3
Male condom	94.0	76.6	88.2	84.5	87.9	85.7
Female condom	0.0	0.9	0.0	2.4	0.0	0.6
Withdrawal	0.0	0.0	0.0	1.2	0.0	0.2
Standard Days Method	0.0	0.0	0.0	1.2	0.0	0.2
Other	1.2	0.9	1.1	0.0	0.0	0.9
Don't know	0.0	0.9	0.0	2.4	0.0	0.6
Number of cases	**83**	**111**	**93**	**84**	**91**	**462**
Source of contraception at next sex						
Public sector government hospital	15.5	13.0	7.7	14.1	15.6	13.1
Public sector government health center	29.8	37.6	46.2	43.5	54.9	42.3
Public sector government health post or outreach	1.2	0.9	3.3	0.0	0.0	1.1
Public sector government mobile clinic	0.0	0.9	0.0	0.0	0.0	0.2
Public sector government health surveillance assistant	7.1	7.3	3.3	4.7	1.1	4.8
Public sector government community-based distribution agent (CBDA) door to door	10.7	3.7	2.2	7.1	1.1	4.8
Public sector government other	0.0	3.7	0.0	1.2	0.0	1.1
CHAM/mission hospital	1.2	4.6	0.0	1.2	4.4	2.4
CHAM/mission health center	1.2	0.9	6.6	4.7	4.4	3.5
CHAM/mission CBDA door to door	0.0	0.0	0.0	2.4	0.0	0.4
Private sector private hospital/clinic/doctor	1.2	2.8	8.8	0.0	1.1	2.8
Private sector CBDA door to door	4.8	2.8	4.4	1.2	3.3	3.3
Private sector other private medical	2.4	1.8	0.0	1.2	0.0	1.1
Banja La Mtsogolo	6.0	4.6	2.2	1.2	1.1	3.1
Macro	9.5	4.6	0.0	0.0	0.0	2.8
Youth drop-in center	1.2	0.0	0.0	0.0	0.0	0.2

	North	Central East	Central West	South East	South West	All
Other source: market/shop	27.4	14.7	33.0	21.2	34.1	25.7
Other source: church	0.0	0.9	3.3	4.7	2.2	2.2
Other source: friends/relatives	2.4	0.9	9.9	1.2	1.1	3.1
Other source: other	4.8	7.3	4.4	0.0	3.3	4.1
Number of cases	**84**	**109**	**91**	**85**	**90**	**459**

Table 3.4.7: Use of Contraception during Next Sex, Female Youth 10-24

	North	Central East	Central West	South East	South West	Total
Percent planning to use contraception during next sex	76.1 (71)	71.8 (66)	77.3 (88)	72.5 (142)	76.9 (91)	74.7 (463)
Reasons for not using contraception						
Fear of side effects	26.7	11.1	0.0	18.2	17.6	16.3
Hard to get methods	6.7	0.0	8.3	0.0	0.0	2.3
Community disapproval	6.7	0.0	0.0	0.0	0.0	1.1
Want to get pregnant	26.7	22.2	33.3	24.2	17.6	24.4
Other	33.3	66.7	58.3	57.6	64.7	55.8
Number of cases	**15**	**9**	**12**	**33**	**17**	**86**
Type of contraception for those planning to have sex again						
Oral contraception pill	3.6	1.8	8.5	2.8	6.9	4.7
Intrauterine device	0.0	0.0	0.0	1.9	1.4	0.8
Injectables	32.1	30.9	45.1	42.1	47.2	40.4
Implants	7.1	23.6	9.9	10.3	11.1	11.9
Male condom	51.8	40.8	32.4	38.3	23.6	36.6
Female condom	0.0	1.7	2.8	0.9	4.2	1.9
Withdrawal	1.8	0.0	0.0	0.0	0.0	0.3
Other	3.6	1.8	1.4	2.8	4.2	2.8
Don't know	0.0	0.0	0.0	0.9	1.4	0.6
Number of cases	**56**	**55**	**71**	**107**	**72**	**361**
Source of contraception at next time when having sex						
Public sector government hospital	24.5	12.0	24.6	10.5	22.2	18.1
Public sector government health center	45.3	52.0	50.7	61.9	52.8	53.9
Public sector government health post or outreach	1.9	0.0	0.0	0.0	0.0	0.3
Public sector government mobile clinic	0.0	2.0	1.4	0.0	0.0	0.6
Public sector government HAS	3.8	0.0	0.0	4.8	1.4	2.3
Public sector government CBDA door to door	1.9	2.0	1.4	3.8	1.4	2.3
CHAM/mission hospital	0.0	2.0	1.4	0.0	0.0	0.6
CHAM/mission health center	3.8	0.0	4.3	3.8	6.9	4.0

Private sector private hospital/clinic/doctor	0.0	8.0	1.4	0.0	6.9	2.9
Private sector CBDA door to door	1.9	0.0	0.0	1.0	0.0	0.6
Private sector other private medical	0.0	2.0	0.0	0.0	0.0	0.3
Banja La Mtsogolo	0.0	2.0	1.4	1.9	0.0	1.1
Macro	0.0	2.0	0.0	0.0	0.0	0.3
Other source: market/shop	18.9	12.0	17.4	13.3	6.9	13.5
Other source: church	0.0	0.0	0.0	0.0	1.4	0.3
Other source: friends/relatives	0.0	0.0	0.0	0.0	1.4	0.3
Other source: other	1.9	7.4	0.0	0.0	1.4	1.7
Number of cases	**53**	**50**	**69**	**105**	**72**	**349**

3.5. Pregnancy and Childbearing among Youth

Information was also collected on pregnancy and childbearing experiences of sexually active respondents or their partners (in the case of males). Table 3.5.1 shows data on the pregnancy and childbearing experiences of the partners of male respondents and Table 3.5.2 shows data on the pregnancy and childbearing experiences of female respondents.

About 17 percent of sexually active male respondents reported that their sexual partners have ever been pregnant. The percentage of male youth reporting that their partners have ever been pregnant increases with age (1.7[46], 9.5, and 29.8 percent among the 10-14, 15-19 and 20-24 year olds, respectively) and varies slightly across zones (from 13.3 percent in the North to 22.1 percent in the South East). Among sexually active female respondents, 72.4 percent reported having been pregnant. The percentage reporting having ever been pregnant also increases with age (20, 60.3, 83.4 percent among the 10-14, 15-19 and 20-24 year olds, respectively) and varies across zones (from 62.9 percent in Central East to 81.3 percent in South West)

Among youth who reported that they or their partners have been pregnant, the modal number of times they or their partners have been pregnant is 1 (74 percent of males and 62.9 percent of females). The percentage of females reporting two or more pregnancies is significantly higher than the males (37.1 percent of females vs. 26 percent of males). The lower number of pregnancies reported by male youth could be due to the fact that their sexual partners were generally younger than the interviewed females. As was observed earlier, most men had sexual partners that were much younger than them; consequently, since the interviewed males and females were of the same age, then, the sexual partners of the interviewed men were much younger than the interviewed females. There are slight variations across zones in the percentages reporting the number of times they or their partners have been pregnant.

The modal number of living children reported by male respondents is 0 (51.2 percent) and among female respondent the modal number is 1 (55.1 percent). Female respondents reported more living children than the males; while 9.7 percent of males reported 2 or more children, the corresponding

[46] It's only in the South East where a few male respondents aged 10-14 reported to have partners who have ever been pregnant.

figure for females is 28.2 percent. The lower number of living children reported by male youth could also result from their sexual partners being younger than the female respondents.

As to whether the last pregnancy was wanted or not, 43.4 percent of female respondents reported to want the last pregnancy, while 31 percent did not want the pregnancy at all and 9 percent wanted to wait until a later time before becoming pregnant. That 40 percent of the youth did not want the pregnancy or wanted it at a later time reinforces the need to make FP accessible and feasible to adolescents to avoid unwanted pregnancy.

Reports from both male and female respondents show that women who have never been pregnant have a high demand for children. Among males, 81 percent would like their sexual partners who have never been pregnant to have a child. Among females who have never been pregnant, 82.1 percent expressed the desire to have a child. There are variations across zones (from 58.8 percent in the North to 91.6 percent in the South West for males, and from 56.2 percent in the South West to 93.5 percent in Central West for females).

Regarding the ideal numbers of children for men and women in their communities, male youth gave a mean of 4 for both men and women. There are some variations across zones: for women, the ideal mean number ranges from 3.42 in the North to 4.46 in South West and for men, the mean number ranges from 3.55 in the North to 4.43 in the South West. Female respondents also gave 4 (3.96) as the mean ideal number of children for both men and women. Also, there are variations across zones: for women, the mean ideal number ranges from 3.39 in the North to 4.48 in the South West and for men it ranges from 3.52 in the North to 4.48 in the South West.

Both male and female youth would like men to have their first child at an older age than women. While the male youth suggested 20 as the mean ideal age at first birth for women, they suggested 22.58 years for men. The female youth suggested 19.97 as the mean ideal age at first birth for women and 22.36 for men. The mean ideal ages vary by zone but does not vary significantly between male and female youth.

Table 3.5.1: Pregnancy and Childbearing Among Partners of Male Youth, 10-24 Years

	North	Central East	Central West	South East	South West	All
Percent of male youth whose partner has ever been pregnant	13.3 (98	20.8 (125)	15.5 (116)	22.1 (104)	16.5 (96)	17.8 (539)
By age:						
10-14	0.0 (6)	0.0 (12)	0.0 (16)	9.1 (11)	0.0 (15)	1.7 (60)
15-19	9.8 (41)	9.8 (62)	4.2 (49)	7.5 (40)	16.7 (42)	9.5 (234)
20-24	17.6 (51)	39.2 (51)	31.4 (51)	35.8 (53)	23.1 (39)	29.8 (245)
Number of times partner has been pregnant:						
1	100	73.1	68.4	54.5	87.5	74.0
2	0.0	26.9	26.3	31.8	12.5	21.9
3	0.0	0.0	5.3	13.6	0.0	4.2
Number of cases	13	26	19	22	16	96
Number of living children the partner has:						
0	46.2	28.6	47.8	36.0	85.3	51.2
1	53.8	64.3	43.5	32.0	14.7	39.0
2-3	0.0	7.1	8.6	32.0	0.0	9.7
Number of cases	13	28	23	25	34	123
Percent of respondents whose partners have never been pregnant who said they wanted to have a child	58.8	94.4	78.6	75.9	91.6	81.0
Mean number of children a woman should have	3.42	4.01	3.98	4.31	4.46	4.02
Mean number of children a man should have	3.55	4.05	3.81	4.28	4.43	4.01
Mean age at which a woman should have her first child	19.80	20.64	20.03	19.46	20.46	20.11
Mean age at which a man should have his first child	22.12	23.20	22.43	21.83	23.19	22.58

Table 3.5.2: Pregnancy and Childbearing Among Female Youth, 10-24 Years

	North	Central East	Central West	South East	South West	All
Percent of respondents, 10-24, who have ever been pregnant	67.6 (71)	62.9 (66)	67.4 (89)	76.8 (142)	81.3 (91)	72.4 (459)
By age:						
10-14	0.0 (2)	0.0 (2)	0.0 (2)	20.0 (5)	50.0 (4)	20.0 (15)
15-19	50.0 (20)	37.5 (24)	50.0 (38)	73.7 (57)	70.0 (40)	60.3 (179)
20-24	77.6 (49)	80.0 (40)	83.7 (49)	82.5 (80)	93.6 (47)	83.4 (265)
Number of times partner or respondent has been pregnant						
1	56.2	57.8	66.7	63.3	66.7	62.9
2	33.3	33.3	28.3	23.9	24.0	27.3
3-5	10.4	8.9	5.0	12.9	9.3	9.7
Number of cases	48	42	60	109	75	334
Number of living children						
0	4.1	10.9	11.7	17.3	21.2	14.5
1	61.2	54.3	61.7	50.0	53.8	55.1
2	28.6	28.3	25.0	22.7	18.8	23.0
3	6.1	6.5	1.7	7.3	3.8	5.2
Number of cases	**49**	**42**	**60**	**110**	**80**	**341**
Desire to have last pregnancy						
Wanted to be pregnant	57.8	32.5	49.1	39.1	41.5	43.4
Wanted to wait	2.2	7.5	5.7	20.7	3.1	9.3
Did not want to be pregnant	24.4	37.5	30.2	27.6	36.9	31.0
Did not think of it	15.6	22.5	15.1	12.6	18.5	16.2
Number of cases	**45**	**40**	**53**	**87**	**65**	**290**
Proportion of respondents who have never been pregnant who wanted to have a child	65.4	87.8	93.5	89.2	56.2	82.1
Mean number of children a woman should have	3.39	4.06	3.83	4.04	4.48	3.96
Mean number of children a man should have	3.52	3.97	3.73	4.12	4.48	3.96
Mean age at which a woman should have her first child	20.39	20.07	20.05	19.76	19.66	19.97
Mean age at which a man should have his first child	23.29	22.51	23.01	21.65	21.62	22.36

Chapter 4: Implementation of the Youth-Friendly Health Services

Chapter 1 describes how the MOH guidelines define the minimum package of YFHS: a combination of clinical services and health promotion interventions delivered at three levels of health care to address the health needs of young persons. According to the guidelines, it is expected that youth will have access to the following at the different levels of care:

- **Community**: contraceptive services including condoms, HTC, referral to a health facility or other service delivery points.
- **Health Center**: contraceptive services including condoms; prevention, diagnosis, and management of STIs; antenatal, delivery, and postnatal care services; PMTCT; HTC; treatment of sexual abuse victims; referral to hospitals or other service delivery points.
- **Hospital:** PAC; contraceptive services including condoms; prevention, diagnosis, and management of STIs; antenatal, delivery, and postnatal care services; PMTCT; HTC; provision of ARVs; treatment of sexual abuse victims (including PEP); referral to hospitals or other service delivery points.

The guidelines specify that health promotion and counseling services be provided at all levels of care to address the following health issues: STIs, HIV and AIDS, contraceptives to prevent unwanted pregnancies, nutrition, sexual abuse, maternal and neonatal health care, adolescent growth and development, and psychosocial support. The delivery of these services requires the combined efforts of community and health facility-based service providers.

This next section examines the roles of different categories of service providers—CBDAs, peer educators, and facility-based service providers—in the implementation of the YFHS package. District support is also examined. The number of service providers to be interviewed in or around a health facility was determined *a priori* and was not in any way related to the number of service providers in a health facility. Up to two CBDAs, two peer educators, and two hospital or health center service providers in or around a selected health facility were interviewed. In any hospital or health center with two or more male and/or female youth providers, one male and one female provider were randomly selected for interviews. The same procedure was applied for the selection of CBDAs and peer educators. Unfortunately, interviewers could not find CBDAs or peer educators in a few facilities in Central East and Central West zones.

4.1. CBDAs, Peer Educators and Health Facility-Based Service Providers

Peer educators and CBDAs constitute a major link between the community and health facilities. The CBDAs provide counseling and limited commodity distribution services at the community level and refer health issues they cannot address to health centers. The peer educators function at both the community and facility levels to promote the health of youth through counseling, educational and commodity distribution activities. Though often supported by NGOs, they work closely with health center- and hospital-based service providers. The facility-based service providers are of different cadres.

The extent to which the CBDAs and peer educators are able to perform their expected roles depends on how well they are prepared or equipped with the skills to do so as well as the amount of supervision they receive from higher level officers. Standard 4 of the YFHS standards requires that all *service providers in all service delivery points have the required knowledge, skills, and positive attitudes to effectively provide YFHS.* It is also expected that *service providers are trained and oriented on the YFHS standards.* Training not only enhances the capacity of health workers to provide quality services, it also helps to

shape their attitudes toward the clients and minimize provider bias. Besides serving as on-the-job training for providers, supervision helps to monitor adherence to standards and make immediate corrections as needed. Interviewed service providers were asked a series of questions related to training in YFHS and the type and level of supervision they receive from their supporting NGO officials, health center or hospital staff.

4.1.1. Training of CBDAs and Peer Educators

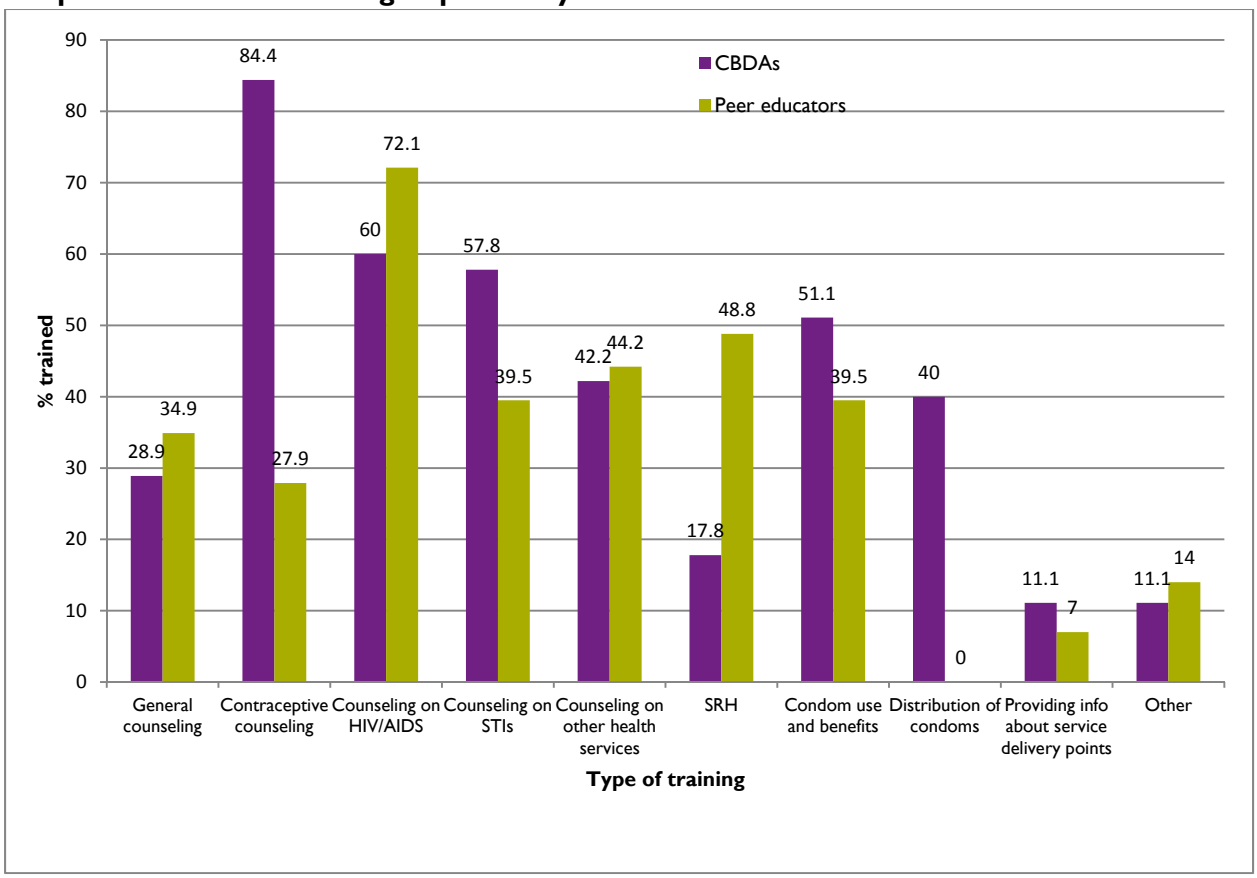
Table 4.1 shows the percentage of interviewed CBDAs and peer educators who had received training in one or more YFHS areas. Panel A1 of the table shows that about half of interviewed CBDAs reported to have received training in YFHS and that the percentage trained ranges from 40 percent in Central West, where it was difficult for interviewers to locate CBDAs, to 61.1 percent in the South East. By MOH guidelines, these percentages are low and unacceptable. Without training, the CBDAs would not have an adequate understanding of the YFHS program and their roles, and would find it difficult to mobilize community youth for the program. Their ability to provide educational and counseling services would also be limited. Although the evaluation team recognized that the results might reflect a general rapid turnover of trained CBDAs, efforts should be made to monitor turnover and train replacements immediately. Data on YFHS areas in which the CBDAs have received training shows that majority of them have been trained in areas correlated with their expected roles in community health promotion, awareness generation, counseling, and commodity distribution.

Panel B1 of Table 4.1 shows that although almost two-thirds (64.2 percent) of interviewed peer educators reported having received training in YFHS, the percentage trained ranges from 33.3 percent in Central East where it was difficult for interviewers to locate the peer educators to 72.7 percent in Central West. Although the overall percentage of peer educators trained is higher than that of CBDAs, efforts should be made to train all peer educators in YFHS. Without adequate training, the peer educators would not have an adequate understanding of the YFHS program and their roles and would find it difficult to mobilize youth for services at the community and facility levels. Their ability to function as expected depends on their understanding of the program and their expected roles. The areas of training reported for both CBDAs and peer educators are depicted in Graph 4.1.

Table 4.1: Percent of CBDAs and Peer Educators Who Received YFHS Training

A. CBDAs	**North**	**Central East**	**Central West**	**South East**	**South West**	**All**
1. Percent of interviewed CBDAs trained in YFHS	52.4 (21)	53.2 (15)	40.0 (10)	61.1 (18)	50.0 (22)	52.3 (86)
2. Of the number trained, percent trained in:						
General counseling	45.5	37.5	25.0	9.1	27.3	28.9
Contraceptive counseling	100.0	75.0	75.0	81.1	81.1	84.4
Counseling on HIV and AIDS	72.7	62.5	25.0	54.5	63.6	60.0
Counseling on sexually transmitted infections (STIs)	63.6	25.0	50.0	54.5	81.8	57.8
Counseling on other health issues	54.5	25.0	25.0	36.4	54.5	42.2
Sexual and reproductive health	18.2	12.5	25.0	9.1	27.3	17.8
Condom use and benefits	63.6	50.0	75.0	54.5	27.3	51.1
Distribution of condoms	63.6	25.0	25.0	54.5	18.2	40.0
Providing information about service delivery points	0.0	12.5	0.0	18.2	18.2	11.1
Other	9.1	12.5	0.0	18.2	9.1	11.1
Number trained	**11**	**8**	**4**	**11**	**11**	**45**
B. Peer educators						
1. Percent of interviewed peer educators trained in YFHS	**56.3 (16)**	**33.3 (3)**	**72.7 (11)**	**69.6 (23)**	**64.3 (14)**	**64.2 (67)**
2. Of the number trained, percentage trained in:						
General counseling	22.2	-	37.5	31.2	44.4	34.9
Contraceptive counseling	0.0	0.0	37.5	31.2	44.4	27.9
Counseling on HIV and AIDS	66.7	0.0	87.5	75.0	66.7	72.1
Counseling on STIs	66.7	0.0	50.0	18.8	44.4	39.5
Counseling on other health issues	22.2	-	50.0	37.5	66.7	44.2
Sexual and reproductive health	22.0	0.0	50.0	68.8	44.4	48.8
Condom use and benefits	44.4	0.0	37.5	37.5	44.4	39.5
Providing information about service delivery points	0.0	100.0	0.0	6.2	11.1	7.0
Other	11.1	0.0	0.0	18.8	22.2	14.0
Number trained	**9**	**1**	**8**	**16**	**9**	**43**

Graph 4.1: Areas of Training Reported by CBDAs and Peer Educators



4.1.2. Training of Health Facility-Based Service Providers

Like the CBDAs and peer educators, health facility-based providers need training to enhance their technical skills, acquire a deep understanding of YFHS issues, and gain exposure to up-to-date information about how services should be provided in a friendly manner. In addition, training affords the service providers opportunities to learn from one another. Youth service providers at the health centers and hospitals were asked to state whether they had been trained in YFHS, and if so, the areas in which they were trained. Related data are presented in Table 4.2.1.

Compared with the CBDAs and peer educators, higher percentages of health facility-based service providers reported that they had been trained in YFHS: 68.4 percent of health center-based youth service providers and 73.3 percent of hospital-based youth service providers. The percentage of health center-based providers trained ranges from 40 percent in the North to 80 percent in Central East. For the hospital-based providers, the percentage trained ranges from 57.1 percent in Central West to 100 percent in South West. To ensure service providers offer good-quality services in accordance with MOH guidelines/standards, all service providers should be trained in YFHS.

The health facility-based youth service providers received training in several areas that reflect the types of YFHS they are expected to provide. Although the percentage of service providers who had received training in each service area varies by zone and type of facility, the major service areas of training include: general counseling (54.5 percent of hospital-based providers and 77.5 percent of health center-based providers); HIV and AIDS counseling (54.5 percent of hospital-based providers and 70.7 percent of health center-based providers), contraceptive counseling (54.5 percent of hospital providers and 62.5 percent of health center-based providers); distribution of contraceptives (50 percent of hospital-based

providers and 60 percent of health center providers); HIV testing (50 percent of hospital providers and 48.7 percent of health center providers); PMTCT (50 percent of hospital-based providers and 36.6 percent of health center-based providers); treatment and care for adolescents living with HIV (36.4 percent of hospital-based providers and 34.1 percent of health center-based providers); and postnatal care (31.8 percent of hospital-based providers and 32.5 percent of health center- based providers).

Table 4.2.1: Percent of Health Facility-Based, Youth-Focused Service Providers Trained in YFHS

	Hospital	Heath Center
Percent of Health Facility Service Providers Trained	**73.3 (30)**	**68.4 (57)**
Of the number trained, percent trained in:		
General counseling	54.5	77.5
Contraceptive counseling	54.5	62.5
Distribution of contraceptives	50.0	60.0
Antenatal care	22.7	37.5
Delivery	18.2	25.0
Postnatal care	31.8	32.9
Treatment of abortion complications	31.8	37.5
HIV and AIDS counseling	54.5	70.7
HIV testing	50.0	48.7
Treatment and care for adolescents living with HIV	36.4	34.1
Prevention of mother-to-child transmission of HIV	50.0	36.6
Sexually Transmitted Infection services	50.0	58.0
Child/Adolescent immunization	4.5	12.8
Child/Adolescent growth & development monitoring	18.2	20.5
Curative services for women	9.1	10.3
Curative services for children	4,5	7.7
Nutrition	22.7	2.6
Monitoring & support for sexual abuse	22.7	13.1
Psychosocial support	18.2	12.8
Emergency contraception	29.3	15.4
Referral to health facility/other service delivery point	18.2	1.1
Referral for social services/psychosocial services	4.5	12.8
Other	22.7	7.7
Number trained	**22**	**39**

Table 4.2.2: Percent Health Facility-Based, Youth-Focused Service Providers Trained in YFHS by Zone & Health Facility Type

	North Zone		Central East Zone		Central West Zone		South East Zone		South West Zone	
	Hospital	**Health center (HC)**	**Hospital**	**HC**	**Hospital**	**HC**	**Hospital**	**HC**	**Hospital**	**HC**
% trained	**66.7 (6)**	**40.0 (10)**	**83.3 (6)**	**80.0 (10)**	**57.1 (7)**	**75.0 (8)**	**60.0 (5)**	**76.5 (17)**	**100.0 (6)**	**75.0 (12)**
Of the number trained, percentage trained in:										
General counseling	50.0	75.0	40.0	77.8	50.0	66.7	100.0	76.9	50.0	77.8
Contraceptive counseling	75.0	75.0	40.0	77.8	25.0	33.3	66.7	61.5	66.7	55.6
Distribution of contraceptives	50.0	75.0	20.0	66.7	50.0	16.7	0.0	61.5	100.0	66.7
Antenatal care	25.0	25.0	0.0	66.7	25.0	33.3	0.0	23.1	50.0	33.3
Delivery	25.0	25.0	0.0	33.3	25.0	0.0	0.0	23.1	33.3	33.3
Postnatal care	25.0	25.0	20.0	44.4	50.0	16.7	0.0	30.8	50.0	33.3
Treatment of abortion complications	25.0	25.0	40.0	55.6	25.0	33.3	0.0	30.8	50.0	33.3
HIV and AIDS counseling	75.0	75.0	20.0	77.8	50.0	66.7	33.3	69.2	83.3	66.7
HIV testing	75.0	25.0	20.0	55.6	50.0	50.0	33.3	38.5	66.7	55.6
Treatment and care for adolescents living with HIV	25.0	50.0	20.0	66.7	25.0	16.7	0.0	30.8	83.3	11.1
Prevention of mother-to-child transmission of HIV	50.0	25.0	20.0	33.3	50.0	50.0	33.3	30.8	83.3	44.4
STI services	25.0	50.0	60.0	66.7	50.0	66.7	66.7	38.5	50.0	77.8
Child/adolescent immunization	0.0	0.0	0.0	11.1	0.0	0.0	33.3	23.1	0.0	11.1
Child/Adolescent growth & development monitoring	0.0	0.0	40.0	33.3	0.0	66.7	66.7	23.1	0.0	11.1
Curative services for women	0.0	0.0	20.0	22.2	0.0	0.0	33.3	7.7	0.0	11.1

Curative services for children	0.0	0.0	0.0	11.1	0.0	0.0	33.3	15.4	0.0	0.0
Nutrition	0.0	0.0	40.0	0.0	25.0	0.0	33.3	7.7	16.7	0.0
Monitoring & support for sexual abuse	75.0	100.0	40.0	0.0	25.0	16.7	0.0	7.7	16.7	11.1
Psychosocial support	0.0	0.0	20.0	11.1	0.0	16.7	33.3	15.4	33.3	11.1
Emergency contraception	0.0	25.0	40.0	11.1	0.0	0.0	66.7	23.1	33.3	11.1
Referral to health facility/other service delivery point	25.0	0.0	20.0	11.1	0.0	0.0	33.3	7.7	16.7	0.0
Referral for social services/psychosocial services	0.0	25.0	20.0	33.3	0.0	0.0	0.0	0.0	0.0	11.1
Other	25.0	25.0	20.0	0.0	25.0	16.7	0.0	0.0	33.3	11.1
Number trained	**4**	**4**	**5**	**8**	**4**	**5**	**3**	**13**	**6**	**9**

4.2. Supervision of Service Providers

Supportive supervision applies a practical system of objective measures to foster improvements in the procedures, personal interactions, and management of primary health care facilities. It helps program managers apply corrective measures before problems occur. In recognition of the important role of supervision in ensuring services are performed according to guidelines, Malawi YFHS Standards list four criteria related to supervision and feedback:

- Facility provides supportive supervision to peer educators.
- Facility provides supportive supervision to community-based service providers.
- Facility provides feedback to service providers/community-based service providers.
- Facility provides recognition to service providers/community-based service providers who provide high-quality YFHS.

4.2.1. Supervision of CBDAs and Peer Educators

To assess the extent to which services provided by CBDAs and peer educators are monitored for quality and adherence to standards by different categories of designated supervisors—CBDA/peer educator supervisors, health facility YFHS providers, sponsoring NGO officers, YFHS coordinators—CBDAs and peer educators were asked to state whether they are usually supervised, who supervises them, and the frequency of supervision.

Table 4.3 shows that 95 percent of CBDAs reported to have been supervised, with little variation among zones. However, the data show almost all supervisors performed below expectation. Each CBDA is expected to be supervised by different categories of supervisors to ensure that different aspects of their activities are adequately monitored; approximately 59 percent of the CBDAs reported to be supervised by a CBDA supervisor, with zonal variation from 45.5 percent in the South West to 88.2 percent in the South East. Since all CBDAs are expected to be supervised by their supervisors to ensure adherence to service standards, the data reflect low supervision performance on the part of the CBDA supervisors. Reports from CBDAs also indicate that other designated supervisors[47]have performed significantly below expectation. Less than 20 percent of CBDAs reported to have been supervised by a health facility YFHS provider, sponsoring NGO officer, or YFHS coordinator.

The modal frequency of supervision reported by about half of the CBDAs is monthly: 47.4 percent in the North, 40.4 percent in Central East, 44.4 percent in Central East, 71.4 percent in South East and 59.1 percent in South West. Other reported frequencies of supervision are: twice a month (19 percent); once every three months (11.4 percent); once a year (6.3 percent) and once a week (2.5 percent)[48]. There is no difference between the percentages of CBDAs who are supervised in the urban (95.3 percent) and rural (96.5 percent) areas. Graph 4.3 depicts the percentages of CBDAs and peer educators supervised by the different categories of supervisors.

[47] For both CBDAs and peer educators, reported supervisors grouped together in the 'other' category include medical assistants, health supervisors, district health officers, and focal coordinators.

[48] For both CBDAs and peer educators, reported frequencies grouped together in the 'other' category are: whenever need arises and three times a month.

Graph 4.3: CBDAs/Peer Educators Supervised by Different Categories of Supervisors

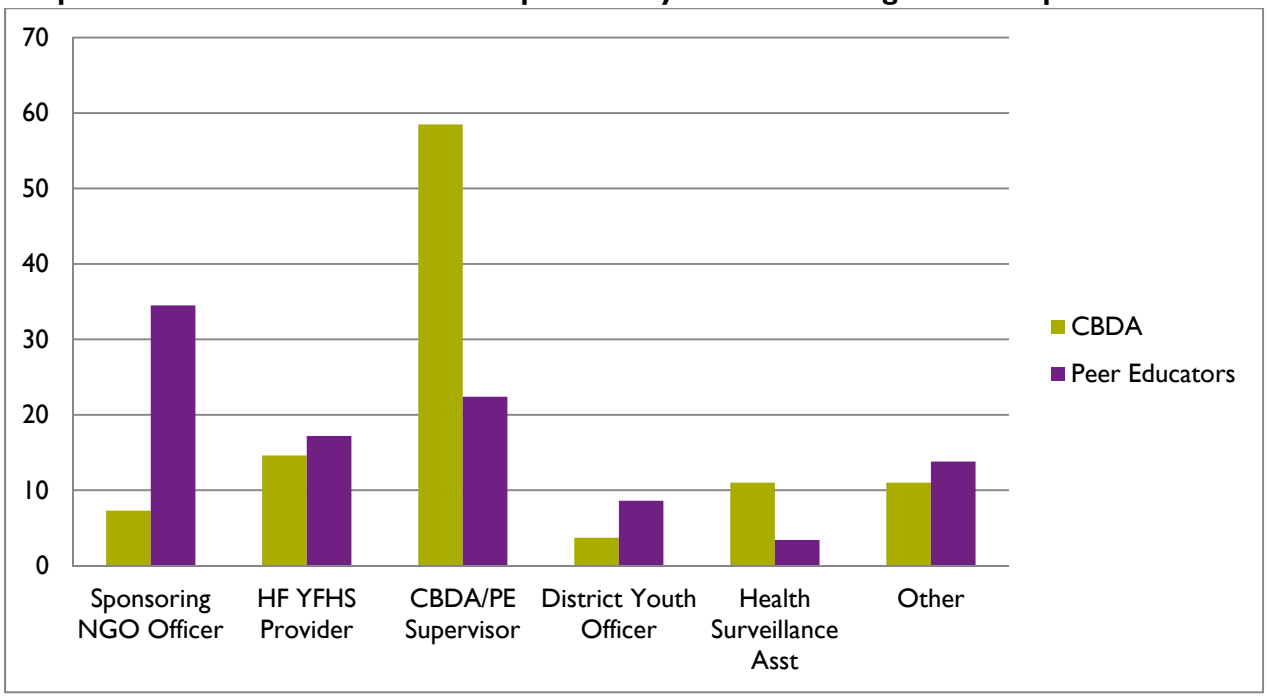


Table 4.3: Percentage of CBDAs Who Reported Being Supervised, Who Supervised Them, and Frequency of Supervision

	North	Central East	Central West	South East	South West	All
1. Percentage of CBDA who reported being supervised	90.5 (21)	100.0 (15)	90.0 (10)	94.4 (18)	100.0 (22)	95.3 (86)
2. Of those supervised, percent who reported being supervised by:						
Sponsoring NGO officer	15.8	6.7	22.2	0.0	0.0	7.3
Health facility YFHS provider	16.7	41.7	8.3	16.7	16.7	14.6
CBDA supervisor	52.6	46.7	66.7	88.2	45.5	58.5
Health surveillance assistant	0.0	20.0	0.0	5.9	22.7	11.0
YFHS coordinator	0.0	0.0	0.0	0.0	13.7	3.7
Other	21.1	13.3	0.0	5.9	9.1	11.0
3. Frequency of supervision						
Once a week	0	6.7	0.0	7.1	0.0	2.5
Twice a month	5.3	26.7	33.3	14.3	22.7	19.0
Every month	47.4	40.0	44.4	71.4	59.1	53.2
Once every three months	15.8	13.3	11.1	0.0	4.5	11.4
Once a year	15.8	0.0	11.1	0.0	4.5	6.3
Other	15.8	13.3	0.0	0.0	4.5	7.6
Number supervised	**19**	**15**	**9**	**17**	**22**	**82**
4. Location of CBDAs						
Urban	75.0	100.0	80.0	100.0	100.0	95.3
Rural	94.1	100.0	100.0	90.9	100.0	96.3

About 86 percent of all interviewed peer educators reported being supervised: 75% in the North, 100% in Central East, 90% in Central West, 82.6% in South East, and 85.7% in South West. Compared with a CBDA, a peer educator was less likely to have been supervised. Like the CBDAs, the reports from peer educators indicate that designated supervisors did not perform sufficiently. Contrary to expectation, the percentages of all peer educators who reported to have been supervised by the different categories of supervisors are: sponsoring NGO officer (34.5 percent); health facility YFHS provider (17.2 percent); peer educator supervisor (22.4 percent); district youth officer (8.6 percent); and HSA (3.4 percent), with slight variations by zone.

The modal frequency of supervision reported by about 46 percent of the peer educators is monthly (66.7 percent in the North, 40 percent in Central East, 54.5 percent in Central West, 42.1 percent in South East and 25.0 percent in South West). Other reported frequencies of supervision are: twice a month (16.9 percent); every week (13.6 percent); once every three months (8.7 percent) and once a year (1.7 percent).

Table 4.4: Percentage of Peer Educators Who Reported Being Supervised, Who Supervised Them, and Frequency of Supervision

	North	**Central East**	**Central West**	**South East**	**South West**	**Total**
Percentage of peer educators who reported being supervised	75.0 (16)	100.0 (5)	90.0 (11)	82.6 (23)	85.7 (14)	85.5 (69)
Of those who reported being supervised, percent who reported being supervised by:						
Sponsoring NGO	41.7	40.0	63.6	16.7	25.0	34.5
Health facility YFHS provider	25.0	0.0	9.1	16.7	25.0	17.2
Peer educator supervisor	16.7	40.0	9.1	33.3	16.7	22.4
District youth officer	0.0	0.0	0.0	11.1	25.0	8.6
Health surveillance assistant	8.3	0.0	0.0	5.6	0.0	3.4
Other	8.3	20.0	18.2	16.7	8.3	13.8
Frequency of supervision:						
Once a week	8.3	20.0	18.2	15.8	8.3	13.6
Twice a month	0.0	0.0	18.2	15.8	41.7	16.9
Every month	66.7	40.0	54.5	42.1	25.0	45.8
Once every three months	8.3	40.0	0.0	5.3	8.3	8.5
Once a year	0.0	0.0	0.0	0.0	8.3	1.7
Other	0.0	9.1	21.1	8.3	13.6	16.7
Number supervised	**12**	**5**	**11**	**18**	**12**	**58**
Location of peer educators						
Urban	50.0	100.0	100.0	77.8	100.0	84.0
Rural	83.3	100.0	100.0	85.7	77.8	86.0

4.3. Services Offered by CBDAs and Peer Educators

In order to determine alignment between the services in which CBDAs and peer educators were trained, those that they provide to youth, and the extent to which the services provided respond to the needs of youth, the CBDAs and peer educators were asked to list the services they offer. Table 4.5 shows the services youth request from CBDAs and peer educators, the services CBDAs and peer educators provide, and the services on which they spend most of their time. The data in the table suggest that the services provided align with or are informed by requests from the youth. For the CBDAs, the top six requested and provided services are: providing information about service delivery points (60.9, 72.4 percent)[49], counseling on HIV and AIDS (60.9, 65.5 percent), contraceptive counseling (49.9, 54.0 percent), distribution of condoms (35.6, 39.1 percent), counseling on STIs (35.6, 44.8 percent), and general counseling (20.7%, 35.6 percent). Of these six, the top four on which the CBDAs spend most of their time are: providing information about service delivery points (60.9 percent), counseling on HIV and AIDS (26.4 percent), condom distribution (17.2 percent), and contraceptive counseling (14.9 percent). For the peer educators, the top six requested and provided services are: condom distribution (63.8, 62.3 percent), counseling on HIV and AIDS (62.3, 69.6 percent), providing information about condoms (46.4, 46.4 percent), counseling on STIs (46.4, 40.6 percent), contraceptive counseling (46.4, 37.7 percent), and general counseling (42, 44.9 percent). The top four services on which the peer educators spend most of their time are: condom distribution (36.2 percent), counseling on HIV and AIDS (24.6 percent), information on SRH (15.9 percent), and information about condoms (13 percent). These services align with their expected roles under the YFHS program.

Table 4.5: Services Offered by CBDAs and Peer Educators

	CBDA			**Peer Educators**		
Services	**Services youth normally request**	**Services normally provided**	**Services spend most time on**	**Services youth normally request**	**Services normally provided**	**Services spend most time on**
General counseling	20.7	35.6	8.0	42.0	44.9	13.0
Contraceptive counseling	49.9	54.0	14.9	46.4	37.7	4.3
Counseling on HIV and AIDS	60.9	65.5	26.4	62.3	69.6	24.6
Counseling on STIs	35.6	44.8	8.0	46.4	40.6	5.8
Counseling on other health issues	19.5	24.1	2.3	27.5	27.5	8.7
Information on sexual and reproductive health	8.0	9.2	4.6	34.8	37.7	15.9
Information about condoms	17.2	19.5	2.3	46.4	46.4	13.0
Distribution of condoms	35.6	39.1	17.2	63.8	62.3	36.2
Information about service delivery points	60.9	72.4	60.9	8.7	7.2	1.4
Other	3.4	2.3	1.1	10.1	11.6	4.3
Number of providers	**87**	**87**	**87**	**69**	**69**	**69**

[49] For services requested and provided, the first percentage in the parentheses after a service refers to the percentage of providers who reported that youth usually request the service while the second is the percentage of providers reporting that they provide the service.

4.4. NGO-Supported Services

The extent to which services are adequately provided and reach a considerable proportion of the target population depends not only on the service providers, but also on the technical, logistics and/or financial support the program receives from other key players; for instance, NGOs, district officials, and donors. These key players have supported the YFHS program in Malawi. To assess the level of their support, NGOs were asked to provide information on the type of support provided. Although our plan was to interview a maximum of three NGOs in each district where there were three or more NGOs (for a maximum of six NGOs per zone), we were unable to reach six in any zone. The number of NGOs we were able to locate and interview ranges from three in Central East to five in the North. In Central West, South East, and South West, four NGOs were located and interviewed.

Table 4.6 shows that the majority of NGOs support the YFHS program at both the community and health facility levels (55 percent), while 20 percent of NGOs interviews support only community- based programs and 25 percent support only health facility-based programs. All five service delivery approaches (see page 18) were supported, with the modal service delivery approach being the integrated approach (services are provided to all clients at the same place, but clients aged 10-24 years are offered YFHS package upon identification). Twenty percent of NGOs support the "stand-alone" YFHS center approach in which only YFHS are provided to youth, and another 20 percent support the approach of providing YFHS in health facilities only on specific days of the week through the engagement of CBDAs. Fifteen percent support the approach in which YFHS are provided as a part of health facility services, with designated space for YFHS and the engagement of health facility-based peer educators and CBDAs. Ten percent support the approach in which YFHS s are provided as a part of health facility services with designated space for YFHS and engaging health facility-based peer educators.

A high percentage of NGOs provide support to health facility-based service providers (75 percent), peer educators (75 percent), and CBDAs (65 percent). At the facility level, several activities are supported by NGOs: training of YFHS providers (55 percent); supply of information, education and communication (IEC) materials (50 percent); supply of commodities/medicines (40 percent); supply of equipment (35 percent), and provision of recreational materials (35 percent). The other activities in the other category includes organization of special events, conducting outreach programs, seconding their staff to the facilities, providing supervision and transportation. At the community level, support for YFHS program includes: support to YFHS providers (60 percent); supply of contraception (60 percent); provision of space for youth to meet for YFHS (40 percent); and supply of IEC materials (40 percent).

Table 4.6: Nature of NGO Support

	N=20
1. Percent of NGOs supporting services at:	
Health facility level	20.0
Community-level support	25.0
Both health facility and community	55.0
2. Type of YFHS delivery approach supported by NGO	
Centers that provide only YFHS (Stand-alone center)	20.0
YHFS provided as a part of health facility services, with designated space for YFHS and using HF-based peer educators (separate space within health facility)	10.0
YFHS as a part of health facility services, with designated space for YFHS and engaging facility-based peer educators and community-based agents (separate space plus community activities)	15.0
YFHS provided only on specific days of the week and engaging CBDAs (specific youth days/activities + CBDA youth activities)	20.0
Integrated (services provided to all clients at the same place, but clients aged 10-24 are offered YFHS package on identification)	39.0
No response	5.0
3. Type of service provider supported by NGO	
Health facility-based service provider	75.0
Peer educators	75.0
Community-based distribution agents	65.0
Health surveillance assistant	15.0
Other	25.0
4. Type of support given to health facility to implement YFHS	
Supply of equipment	35.0
Supply of commodities/medicines	40.0
Supply of IEC materials	50.0
Provision of recreation materials	35.0
Support of YFHS provider (training)	55.0
Other	50.0
5. Type of support NGO gives toward implementation of YFHS at the community level/percent of NGOs supporting:	
Supply of IEC materials	40.0
Provision of space for youth to meet for YFHS	40.0
Supply of contraceptives	60.0
Support to YFHS provider	60.0
Other	10.0

Table 4.7 shows that the health service providers supported by NGOs offer a wide variety of YFHS and that the number of services supported varies by zone (lowest in the North and South West and highest in the South East). Although there are slight zonal variations in the percentages of NGOs reporting each service offered by the service providers they support, the leading services reported are: contraceptive counseling (80 percent); distribution of contraceptive methods free or at cost) (75 percent); HIV testing and counseling (70 percent); general counseling (60 percent); and prevention, diagnosis, and management of STIs (45 percent).

Table 4.7: YFHS Provided by NGO-supported Health Service Providers

	North Zone	**Central East Zone**	**Central West Zone**	**South East Zone**	**South West Zone**	**Total**
Percent of NGOs[50] supporting						
General counseling	60.0	100.0	75.0	25.0	50.0	60.0
Contraceptive counseling	100.0	100.0	75.0	100.0	25.0	80.0
Obtain/buy contraceptive methods/services	60.0	100.0	100.0	100.0	25.0	75.0
HIV testing and counseling	60.0	100.0	25.0	100.0	75.0	70.0
Referral to health facility/other service delivery points	60.0	33.3	50.0	25.0	25.0	40.0
Prevention, diagnosis and management of STIs	20.0	100.0	25.0	75.0	25.0	45.0
Antenatal , delivery and postnatal care services	20.0	33.3	50.0	25.0	50.0	35.0
Prevention of mother-to-child transmission of HIV	40.0	0.0	50.0	50.0	25.0	35.0
Treatment of sexual abuse (including PEP)	0.0	0.0	25.0	25.0	0.0	10.0
Post abortion care	0.0	0.0	0.0	50.0	0.0	10.0
Provision of ARVs	0.0	33.3	0.0	0.0	0.0	5.0
Other	0.0	33.3	0.0	25.0	0.0	10.0
Number of NGOs	**5**	**3**	**4**	**4**	**4**	**20**

[50] Because the low number of cases, we will like to ask that the percentages are interpreted with caution.

4.4. Support from District Youth-Friendly Health Service Office

The DYFHSCs are expected to be key players in the implementation of the YFHS program. At the district level, they are expected to provide logistics, training, and supervision support to the YFHS program. As a part of this evaluation, the DYFHSCs were interviewed to determine (from their own perspective) how they have supported the implementation of YFHS in their districts. The only major type of crosscutting support provided across all the zones is the supply of commodities/medicines, as reported by one or the two coordinators from the zone. Other types of support were provided by different combinations of coordinators from two to three zones. It should be noted DYFHSCs from the Northern zone provide support in more areas than their counterparts from other zones. They are closely followed by DYFHSCs from the Central East.

Table 4.8: Type of Support Provided to Health Facilities by DYFHSCs to Implement YFHS

Type of support provided	North Zone	Central East Zone	Central West Zone	South East Zone	South West Zone
Supply of equipment	X	X			X
Supply of commodities/medicines	X	X	X	X	X
Renovation of building to create space for YFHS		X			
Supply of Information, Education and Communication materials	X			X	
Provision of recreational materials	X		X		X
Support to YFHS providers	X	X			X
Other	X	X	X	X	

X represents an activity supported by one or all of the DYFHSCs in the zone

Chapter 5: Implementation of Standards and Minimum Package of Youth-Friendly Health Services

A major objective of the YFHS program is to provide quality health services to young persons in a friendly manner; that is, in an acceptable, accessible, and feasible way. To ensure YFHS, providers must adhere to a set of standards developed by the MOH.[51] This section focuses on implementation of the YFHS Standards and addresses one of the major objectives of this evaluation: examine the extent to which YFHS Standards and minimum package of YFHS have been implemented. In line with this evaluation objective, we assess the extent to which the YFHS Standards have been met at different levels of health care and service delivery points and highlight implementation gaps, with a view to addressing them in the process of scaling up the YFHS program.

In tandem with recommendations of the 1994 International Conference on Population and Development[52] as well as the United General Assembly Special Session on HIV and AIDS of June 2001[53], the Malawian MOH developed five YFHS National Standards[54] listed below:

Standard 1: Health services are provided to young people according to existing policies, procedures, and guidelines at all service delivery points.

Standard 2: Young people are able to obtain health services that include preventive, promotive, curative, and rehabilitative health services appropriate to their needs.

Standard 3: All young people are able to obtain health information (including SRH and HIV) relevant to their needs, circumstances, and stage of development.

Standard 4: Service providers in all delivery points have the required knowledge, skills, and positive attitudes to effectively provide YFHS.

Standard 5: Health information related to young people is collected, analyzed, and utilized in decision making at all levels.

The key guiding principles of these standards include the following: (i) active participation of young people in the planning, implementation and monitoring of health services according to their level of capacity; (ii) provision of services based on the development and health needs of young people; (iii) community participation in activities and services provision; (iv) provision of YFHS by trained health worker and community volunteers; and (v) accreditation and certification of all facilities providing YFHS. The Standards are to be implemented at the different levels of the health care system—community, health center, hospital, district and national. Operational indicators were used to assess the application of each Standard as presented in the subsequent sub-sections.

For this evaluation, we assessed the implementation of the YFHS Standards at the health center, hospital, and district levels. Information on the implementation of the standards was obtained through

[51] As indicated in Chapter 1, the MOH standards were informed by the WHO standards. Using WHO international standards, a technical working group developed a set of youth-friendly health standards that defined the minimum package of services to be offered to young people by level of care.

[52] United Nations, *Report on the Cairo International Conference on Population and Development* (United Nations: New York, 1994).

[53] United Nations General Assembly Special Session on HIV/AIDS, *Keeping the Promise: Summary of the Declaration of Commitment on HIV/AIDS, Joint United Nations Program on HIV/AIDS* (UNAIDS: New York, 2001).

[54] Ministry of Health (Reproductive Health Unit), National Standards: Youth Friendly Health Services (Government of the Republic of Malawi, Lilongwe, 2007).

the questionnaires administered at the health facility and district levels. For this analysis, level of implementation was defined as the percentage of health facilities reporting to be implementing a Standard element. The numerator for the percentage is the number of health facilities that reported to be implementing a Standard element/criterion and the denominator is the total number of facilities/districts where the standards questionnaires were administered whether or not the element/criterion was implemented.[55] Although the questionnaires were administered in all the surveyed health centers and hospitals, we focus more on the discussion of findings from the health facilities that reported to be implementing the YFHS at the time of the survey. In order to determine the implementation of some Standards' elements by health facilities that reported not to be implementing YFHS at the time of the survey, data are provided on the extent to which they have implemented elements of the Standards in comparison to facilities that reported to be implementing YFHS.

It should be borne in mind that unlike many evaluations, there were neither baseline values nor target levels of implementation against which to compare observed levels of implementation of the YFHS Standard elements[56]. Consequently, it would not be possible to determine how effective the different levels of health care (health center, hospital, and district health office) have been in the implementation of the YFHS program. In the absence of baseline or target values of implementation to compare with, a decision was taken, in consultation with the MOH/RHD to develop a scale to classify observed levels of implementation as high, medium and low. For this evaluation, the implementation of a Standard element was considered:

- Low, if less than 50 percent of health facilities reported to be implementing it at the time of the survey.
- Medium, if between 50 and 75 percent of health facilities reported to be implementing it at the time of the survey.
- High, if more than 75 percent of health facilities reported to be implementing it at the time of the survey.

These classifications will be applied throughout this chapter.

5. 1. Standard 1: Health services are provided to young people according to existing policies, procedures, and guidelines at all service delivery points.

Table 5.1.1 shows the percentage of health facilities that reported to be implementing Standard 1 elements by type of health facility (health center or hospital) and by location of facility (urban or rural). At the health facility level, implementation of Standard 1 was assessed according to eight elements. Three of the elements were examined only at the hospital level—*availability of copies of RH and youth policy documents at all service delivery points (element 2); availability of YFHS standards at all service delivery points in the hospital (element4); and, administration of exit interviews (element 8)*. Element 5— *dissemination of YFHS information to the community*—was assessed only at the health center level. Table 5.1.1 shows that, overall, implementation was low for two, medium for three, and high for three elements, using the classification criteria above.

An examination of levels of implementation by type of health facility (hospital or health center) shows:

- Of the five Standard 1 elements assessed at the health center level, implementation is high for three, medium for one, and low for one. The Standard 1 elements for which implementation is

[55] The numerator consists of verified and unverified responses. Verified responses are those backed by documents while unverified are those not backed by documents.

[56] There were no target values set for the YFHS program regarding the desired percentages of health facilities/service delivery points that should be implementing the Standard elements at specified time interval. Although it is expected that Standard elements would be implemented by all service delivery points, no time frame was specified.

high at the health center level are: *measures put in place to ensure that YFHS providers provide services according to YFHS standards* (100 percent)[57]; *dissemination of YFHS information in the community* (97 percent); and, *training/orientation of service providers in YFHS standards* (78.8 percent). Of the remaining two Standard 1 elements assessed at the health center level, implementation is medium for one—*availability of the YFHS standards document* (57.6 percent)—and low for *availability of the National Sexual Reproductive Health & Rights Policy documents* (48.5 percent).

- Of the seven Standard 1 elements assessed at the hospital level, implementation is high for two, medium for three, and low for twp. The two Standard 1 elements for which implementation is high at the hospital level are: *availability of copies of the National Sexual & Reproductive Health & Rights Policy documents* (100 percent), *and training/orientation of service providers in YFHS standards* (80 percent). The three elements for which implementation is medium are: *availability of the National Sexual & Reproductive Health & Rights Policy documents* (50 percent), *availability of the YFHS standards document* (70 percent), *and, measures put in place to ensure that YFHS providers provide services according to YFHS standards* (60 percent). The two for which implementation is low are: *availability of YFHS standards at all service delivery points in the hospital* (40 percent) and *administration of exit interviews* (40 percent).
- Of the four Standard 1 elements assessed at both the health center and the hospital levels, implementation is higher at the health center level for one element (*measures put in place to ensure that YFHS providers provide services according to YFHS standards*) and at the hospital level for two (*availability of the National Sexual & Reproductive Health & Rights Policy documents* and *availability of the YFHS standards document).*

In terms of location of facility (rural or urban), the results presented in the second half of Table 5.1.1 show that: Among the rural facilities, implementation of the eight Standard 1 elements is high for four (50 percent), medium for two (25 percent), and low for two (50 percent). Among the urban facilities, implementation of the Standard 1 elements is high for two (25 percent), medium for four (50 percent), and low for two (25 percent). The results tend to suggest that implementation of Standard 1 elements is higher among rural facilities.

Implementation of Standard 1 elements was also examined by zone in order to determine zonal differentials. With the number of hospitals per zone so small (from one in Central West to three in South West), we do not discuss zonal differentials in elements that were assessed only at the hospital level. We focus more on examining zonal differentials in elements assessed at both the health center and hospital levels. Table 5.1.2 shows wide zonal variations in the implementation of some Standard 1 elements. For example:

- Implementation of element 1—*availability of copies of the National Sexual and Reproductive Health & Rights Policy*—varies from low (33.3 percent) in the South East to high (100 percent) in Central West.
- The percentage of health facilities reporting to *have a copy of the YFHS standards* (element 3) is highest in Central East and Central West (80 percent) and lowest in the South East (33.3 percent).
- The proportion of facilities reporting to *have trained service providers on YFHS standards* (element 6) ranges from 55.6 percent in the North to 90 percent in the South West.
- The proportion of facilities reporting to have *put in place measures to ensure YFHS providers offer services according to YFHS standards (*element 7) ranges from 80 percent in the Central West to 100 percent in the South East.

[57] Where provided, the percentage of facilities that reported to be implementing a Standard element is indicated in parenthesis after the element.

Table 5.1.1: Percent of Health Facilities Implementing YFHS Standard 1 by Type of Health Facility and Place of Residence

Elements of Standard 1	Type of health facility (HF)		Type of residence		All HFs	ALOI[d] (All HFs)
	Health Center	Hospital	Rural[c]	Urban[c]	%	
1. Facility has a copy of the National Sexual Reproductive Health & Rights Policy and National Youth Policy	48.5	100.0	57.1	59.1	58.1	**Medium**
2. Reproductive health and youth policy documents are made available to all service delivery points in the hospital (departments/wards) [b]	-	50.0	0.0 (2)	50.0 (8)	50.0 (10)	**Medium**
3. Facility has copies of the YFHS standards	57.6	70	66.7	54.5	60.5	**Medium**
4. YFHS standards are made available to all service delivery points in the hospital (departments/wards) [b]	-	40.0	0.0 (2)	40.0 (8)	40.0 (10)	**Low**
5. Facility disseminates information about YFHS to the community [a]	97.0	-	94.7 (19)	100.0 (14)	97.0 (33)	**High**
6. Service providers have been trained/oriented on the YFHS standards	78.8	80.0	85.7	72.7	79.1	**High**
7. Measures put in place by the hospital/health center to ensure YFHS providers provide services according to YFHS standards	100.0	60.0	100.0	81.8	90.7	**High**
8. The facility administers exit interviews [b]	-	40	50.0 (2)	37.5 (8)	40.0 (10)	**Low**
Number of cases	**33**	**10**	**21**	**22**	**43**	

[a] Data collected from health centers only; [b] Data collected from hospitals only; [c] When a criterion applies to only the hospital or health center and the denominator is not the total number of health facilities in urban or rural areas, the denominator for the percentage is enclosed in parentheses. Otherwise the denominator is the total number of cases at the bottom of each table. This applies to Tables 5.1.1, 5.3.1, and 5.4.1; [d]ALOI stands for Assigned Level of implementation for all Chapter 5 tables.

Table 5.1.2: Percent of Health Facilities Implementing YFHS Standard 1 by Zone

Elements of Standard 1	North[c]	Central East	Central West	South East	South West
1. Facility has copies of the National Sexual Reproductive Health & Rights Policy and National Youth Policy	44.4	70.0	100.0	33.3	60.0
2. Reproductive health and youth policy documents are made available to all service delivery points in the hospital (departments/wards) [b]	50.0 (2)	100.0 (2)	0.0 (1)	0.0 (2)	66.7 (3)
3. Facility has copies of the YFHS standards	55.6	80.0	80.0	33.3	60.0
4. YFHS standards are made available to all service delivery points in the hospital (departments/wards) [b]	50.0 (2)	50.0 (2)	0.0 (1)	0.0 (2)	66.7 (3)
5. Facility disseminates information about YFHS to the community	100.0 (7)	100.0 (8)	100.0 (4)	100.0 (7)	85.7 (7)
6. Service providers have been trained/oriented on the YFHS standards	55.6	80.0	80.0	88.9	90.0
7. Measures put in place by the hospital/health center to ensure YFHS providers provide services according to YFHS standards	88.9	90.0	80.0	100.0	90.0
8. The facility administers exit interviews [b]	50.0 (2)	50.0 (2)	100.0 (1)	50.0 (2)	0.0 (3)
Number of cases	**9**	**10**	**5**	**9**	**10**

[a] Data collected from health centers only; [b] Data collected from hospitals only.
[c] When an element applies to only the hospital or health center and the denominator is not the total number of health facilities in the zone, the denominator for the percentage is enclosed in parentheses. Otherwise the denominator is the total number of cases at the bottom of each table. This applies to tables 5.1.2, 5.3.2, and 5.4.2.

Table 5.1.3 shows the percentage of health centers[58] that reported to be implementing Standard 1 elements by YFHS-implementing status at the time of the survey. The table shows that of the five Standard 1 elements examined, levels of implementation are much higher among health centers implementing for three. For the remaining two elements, levels of implementation are similar between the YFHS- implementing and YFHS non-implementing health centers.

Table 5.1.3: Percent of Health Centers Implementing Standard 1 Elements by YFHS-Implementing Status at the Time of the Survey

Elements of Standard 1	YFHS-Implementing Health Center	YFHS Non-implementing Health Center	Difference between (1) and (2)
	(1)	(2)	(3)
1. Facility has a copy of the National Sexual Reproductive Health & Rights Policy and National Youth Policy	48.5	6.7	+
2. Facility has copies of the YFHS standards	57.6	13.3	+
3. Facility disseminates information about YFHS to the community [a]	97.0	100.0	=
4. Service providers have been trained/oriented on the YFHS standards	78.8	40.0	+
5. Measures put in place by the hospital/health center to ensure YFHS providers provide services according to YFHS standards	100.0	100.0	_
Number of cases	**33**	**15**	

+ signifies level of implementation is higher among YFHS implementing facilities;
= signifies level of implementation is equal between YFHS implementing and YFHS non-implementing facilities;
- Signifies that the level of implementation is lower among YFHS implementing facilities

At the district health office level, six Standard 1 elements were examined. The levels of implementation are shown in Table 5.1.4.[59] Of the six elements assessed, implementation is:

- High for 1 *(Service providers in the district have been trained on how to provide YFHS*).
- Medium for four (*Facilities were provided with copies of the National Sexual Reproductive Health & Rights Policy and National Youth Policy; District health office facilitates the distribution of reproductive health and youth policy documents to all levels of health service delivery points; Monitoring and supervisory measures have been put in place to ensure service providers provide YFHS according to policies and guidelines;* and *Health facility in the district were provided with guidelines for provision of quality YFHS*).
- Low for one (*Support staff in the district have been trained on YFHS*).

[58] For all elements, the analysis of differentials in levels of implementation by YFHS-implementing status is undertaken only among health centers; only one hospital was not implementing YFHS at the time of the survey.
[59] At the district level, we show the breakdown of responses by verified and unverified. By unverified is meant that no documents (for example, copies of national policies, training report, IEC materials, etc.) were produced to support the respondent's claims. For our discussion, we will focus on total response (verified + unverified responses).

Table 5.1.4: Percent of Health Districts Implementing YFHS Standard 1

Elements of Standard 1	Report status		Total	RLOI
	Verified	Not verified		
1. Facilities were provided with copies of the National Sexual Reproductive Health & Rights Policy and National Youth Policy	36.4	18.2	54.5	**Medium**
2. District health office facilitates the distribution of reproductive health and youth policy documents to all levels of health service delivery points	27.3	27.3	54.5	**Medium**
3. Health facility in the district were provided with guidelines for provision of quality YFHS	27.3	45.5	72.7	**Medium**
4. Service providers in the district have been trained on how to provide YFHS	27.3	63.6	90.9	**High**
5. Support staff in the district have been trained on YFHS	9.1	18.2	27.3	**Low**
6. Monitoring and supervisory measures have been put in place to ensure service providers provide YFH services according to policies and guidelines	36.4	18.2	54.5	**Medium**
Number of cases	**11**	**11**	**11**	

5.2. Standard 2: Young People are Able to Obtain Health Services that Include Preventive, Promotive, Curative, and Rehabilitative Health Services Appropriate to Their Needs

Table 5.2.1 shows the percentage of health facilities that reported to be implementing Standard 2 elements by type and location of health facility. Five Standard 2 elements were examined. The table shows that, overall, the implementation of Standard 2 elements can be rated as medium. Besides element 1—*Facility is providing the minimum package of YFHS to young people*—which is a criterion for classifying a health facility as implementing YFHS in the first place, the other Standard 2 element for which implementation is high is: *Facility has adequate space for the provision of YFHS* (84 percent). Implementation is low for the other three: *Facility has a clearly displayed sign that shows available YFHS, location, and hours of operation* (27.9 percent); *Facility provides outreach services specific to youth* (32.6 percent); an *Outreach services are being provided according to schedule* (14 percent). This overall pattern of implementation is reflected among urban and rural facilities and health centers.

Table 5.2.1: Percent of Health Facilities Implementing YFHS Standard 2 by Type of Health Facility and Place of Residence

Elements of Standard 2	Type of health facility (HF)		Type of residence		All HFs	ALOI (All HFs)
	Health Center	Hospital	Rural	Urban	%	
1. Facility is providing the minimum package of YFHS to young people	100.0	90.0	100.0	95.4	97.6	**High**
2. Facility has adequate space for the provision of YFHS	100.0	40.0	95.2	77.3	86.0	**High**
3. Facility has a clearly displayed sign that shows available YFH services, location, and hours of operation	21.2	50.0	19.0	36.4	27.9	**Low**
4. Facility provides outreach services specific to youth	33.3	30.0	38.1	27.3	32.6	**Low**
5. Outreach services are being provided according to schedule	15.2	10.0	9.5	18.2	14.0	**Low**
Number of cases	**33**	**10**	**21**	**22**	**43**	

The percentage of health facilities in each zone that reported to have implemented the Standard 2 elements are shown in Table 5.2.2. The table shows some variations across zones in the implementation of four of the five elements:

- The percentage of health facilities that reported to have adequate space for the provision of YFHS is highest in the North (100 percent) and lowest in the Central West (80 percent).
- In the Central East, 40 percent of health facilities reported to have clearly displayed signs that show available YFHS, location, and hours of operation; the corresponding figure for Central West is 20 percent.
- The percentage of health facilities that reported to have provided outreach services specific to youth is highest in Central West (60 percent) and lowest in Central East (10 percent).
- The percentage of health facilities that reported to provide outreach services according to schedule ranges from 0 in Central East to 40% on Central West.

The percentage of health centers that reported to be implementing Standard 2 elements are presented in Table 5.2.3 by their YFHS-implementing status at the time of the survey. The table shows that of the four Standard 2 elements on which the two groups of facilities could be compared, the level of implementation is much/slightly higher among YFHS-implementing HFs for two elements. For the remaining two, the level of implementation is equal in one and higher among YFHS non-implementing health centers in one.

Table 5.2:2: Percent of Health Facilities Implementing YFHS Standard 2 by Zone

Elements of Standard 2	North	Central East	Central West	South East	South West
1. Facility is providing the minimum package of YFHS to young people	100.0	100.0	100.0	100.0	100.0
2. Facility has adequate space for the provision of YFHS	100.0	90.0	80.0	88.9	80.0
3. Facility has a clearly displayed sign that shows available YFH services, location, and hours of operation	25.0	40.0	20.0	22.2	30.0
4. Facility provides outreach services specific to youth	37.5	10.0	60.0	55.6	20.0
5. Outreach services are being provided according to schedule	12.5	0.0	40.0	33.3	10.0
Number of cases	**9**	**10**	**5**	**9**	**10**

Table 5.2.3: Percent of Health Centers Implementing Standard 2 Elements by YFHS-Implementing Status at the Time of the Survey

Elements of Standard 2	YFHS Implementing facility	YFHS Non-implementing facility	Difference between (1) and (2)
	(1)	(2)	(3)
1. Facility is providing the minimum package of YFHS to young people[a]	100.0	-	
2. Facility has adequate space for the provision of YFHS	100.0	100.0	=
3. Facility has a clearly displayed sign that shows available YFH services, location, and hours of operation	53.9	0.0	+
4. Facility provides outreach services specific to youth	34.4	13.3	+
5. Outreach services are being provided according to schedule	45.5	100.0	-

[a] Not used for comparison; this is the element that defines whether a facility is implementing YFHS or not.

At the district health office level, eight Standard 2 elements were examined. Levels of implementation are shown in Table 5.2.4. The table shows that at the district level, the implementation of Standard 2 is fairly high. Of the eight Standard 2 elements, implementation is high for five, medium for two, and low for only one. The low implementation of element 7, *District Health Office facilitates the development of sign posts for all types of facilities providing YFHS*, should be addressed. The YFHS guidelines require every YFHS implementing facility to have signposts displaying their hours of service and the services provided. Without signposts, access to YFHS may be limited.

Table 5.2.4: Percent of Health Districts Implementing YFHS Standard 2 (n=11)

Elements of Standard 2	Report status		Total	RLOI
	Verified	Not verified		
1. District health office provides essential medicines to all service delivery points	72.7	27.3	100.0	**High**
2. District health office provides equipment to all service delivery points	45.5	45.5	90.9	**High**
3. District health office provides supplies to all service delivery points	45.5	54.5	100.0	**High**
4. District health office provides contraceptive commodities to all service delivery points	54.5	45.5	100.0	**High**
5. District health office ensures that skilled staff are deployed equitably across the facilities in the district	72.7	18.2	90.9	**High**
6. District health office mobilizes and allocates funds for YFHS improvements	45.5	18.2	63.6	**Medium**
7. District health office facilitates the development of sign posts for all types of facilities providing YFHS	36.4	0.0	36.4	**Low**
8. District health office ensures that transportation and other resources for outreach services from YFHS facilities are facilitated	45.5	9.1	54.5	**Medium**

5.3. Standard 3: All Young People are Able to Obtain Health Information (including SRH and HIV) Relevant to Their Needs, Circumstances, and Stage of Development

At the health facility level, the implementation of seven Standard 3 elements was assessed. Table 5.3.1 shows the percentages of health facilities that reported to implement each element by type (hospital or health center) and location (urban or rural). Overall, the implementation of Standard 3 elements is low. Of the seven elements assessed, implementation is medium for three and low for the remaining four. It is only at the hospital level and among the urban health facilities that implementation is high for one of the elements. The three elements for which implementation is medium are: *Facility has established linkages with other organizations/institutions in the area that are providing information, counseling, and education on health for young people including sexual and reproductive health* (72.1 percent overall; 63.6 percent health center; 100 percent hospitals; 61.9 percent rural health facilities; and 81.8 percent urban health facilities)*; Facility has organized community meetings to provide information about YFHS* (51.2 percent overall; 48.5 percent health center; 60 percent hospitals; 61.9 percent rural health facilities; and, 45.4 percent urban health facilities); and *Service providers from the facility conduct community meetings to discuss the value and availability of health services for—measured only at the health center level* (60.5 percent overall; 60 percent rural health centers, and 61.5 percent urban health centers). A consistent pattern of difference in levels of implementation does not emerge between health centers and hospitals or between rural and urban health facilities.

Table 5.3.2 shows that while the implementation of element 6 does not vary significantly by zone and no meaningful zonal comparison could be made on element 3 because of small number of cases, there are significant zonal variations in the implementation of other elements. For instance:

- While 80 percent of health facilities in the Central West have IEC materials that target young people, only 22.2 percent o in the North reported having those materials.
- While no health facilities in the South East reported having youth-specific and appropriate IEC materials on display for young people to take away, 60 percent of facilities in Central West reported having those IEC materials.
- The percentage of health facilities that reported established linkages with other organizations/institutions providing information, counseling, and education on health for young people ranges from 40 percent in Central West to 90 percent in Central East.
- The percentage of health facilities that reported their service providers conducting community meetings to discuss the value and availability of health services for adolescents/youth with community members ranges from 42.8 percent in the South West to 85.7 percent in the North.

The percentage of health centers that reported to be implementing Standard 3 elements are presented in Table 5.3.3 by their YFHS-implementing status at the time of the survey. The table shows that the implementation of each element is slightly higher among YFHS-implementing health centers than among YFHS non-implementing health centers.

Table 5.3.1: Percent of Health Facilities Implementing YFHS Standard 3 Elements by Type of Health Facility and Place of Residence

Elements of Standard 3	Type of health facility (HF)		Type of residence		All HFs	ALOI (All HFs)
	Health Center	Hospital	Rural	Urban	%	
1. Facility has information, education, and communication (IEC) materials that target young people	42.4	60.0	38.1	54.5	46.5	**Low**
2. Facility has youth specific and appropriate IEC materials on display for young people to take away	64.3	10.0	19.0	27.3	23.2	**Low**
3. Facility distributes IEC materials [b]	-	30.0	50.0 (2)	25.0 (8)	30.0 (10)	**Low**
4. Facility has established linkages with other organizations/institutions in the area that are providing information, counseling, and education on health for young people (including sexual and reproductive health)	63.6	100.0	61.9	81.8	72.1	**Medium**
5. Facility has organized community meetings to provide information about YFHS	48.5	60.0	61.9	45.4	51.2	**Medium**
6. Facility has organized community meetings to provide information about Adolescent Youth Sexual Reproductive Health and Rights	36.4	40.0	38.1	36.4	37.2	**Low**
7. Service providers from the facility conduct community meetings to discuss the value and availability of health services for adolescents/youth with community members [a]	66.7	-	78.9 (19)	50.0 (14)	66.7 (33)	**Medium**
Number of cases	**33**	**10**	**21**	**22**	**43**	

[a] Data collected from health centers only; [b] Data collected from hospitals only.

Table 5.3.2: Percent of Health Facilities Implementing YFHS Standard 3 by Zone

Elements of Standard 3	North	Central East	Central West	South East	South West
1. Facility has information, education, and communication (IEC) materials that target young people	22.2	50.0	80.0	44.4	50.0
2. Facility has youth specific and appropriate IEC materials on display for young people to take away	11.1	40.0	60.0	0.0	30.0
3. Facility distributes IEC materials[b]	0.0 (2)	50.0 (2)	0.0 (1)	0.0 (2)	66.7 (3)
4. Facility has established linkages with other organizations/institutions in the area that are providing information, counseling, and 5. education on health for young people (including sexual and reproductive health)	77.8	90.0	40.0	55.6	60.0
5. Facility has organized community meetings to provide information about YFHS	33.3	50.0	60.0	66.7	50.0
6. Facility has organized community meetings to provide information about Adolescent Youth Sexual Reproductive Health and Rights	33.3	40.0	40.0	33.3	40.0
7. Service providers from the facility conduct community meetings to discuss the value and availability of health services for adolescents/youth with community members[a]	85.7 (7)	75.0 (8)	75.0 (4)	57.1 (7)	42.8 (7)
Number of cases	**9**	**10**	**5**	**9**	**10**

[a] Data collected from health centers only; [b] Data collected from hospitals only.

Table 5.3.3: Percent of Health Centers Implementing Standard 3 Elements by YFHS-Implementing Status at the Time of the Survey

Elements of Standard 3	YFHS Implementing Health Center	YFHS Non-implementing Health Center	Difference between (1) and (2)
	(1)	(2)	(3)
1. Facility has information, education, and communication (IEC) materials that target young people	42.4	20.0	+
2. Facility has youth specific and appropriate IEC materials on display for young people to take away	27.3	6.7	+
3. Facility has established linkages with other organizations/institutions in the area that are providing information, counseling, and education on health for young people (including sexual and reproductive health)	63.6	40.0	+
4. Facility has organized community meetings to provide information about YFHS	48.5	20.0	+
5. Facility has organized community meetings to provide information about Adolescent Youth Sexual Reproductive Health and Rights	36.4	13.3	+
6. Service providers from the facility conduct community meetings to discuss the value and availability of health services for adolescents/youth with community members	66.7	20.0	+
Number of cases	**33**	**15**	

Four Standard 3 elements were examined at the district health office level. Table 5.3.4 shows that implementation of Standard 3 elements is fairly high: the percentages of district health offices that reported to have implemented the elements range from 63.6 percent for those facilitating *the mobilization and distribution of IEC materials on YFHS to service delivery points* to 81.8 percent for facilitating *the establishment of linkages and partnerships with organizations in this area*.

Table 5.3.4: Percent of Health Districts Implementing YFHS Standard 3 (n=11).

Elements of Standard 3	Report status		Total	RLOI
	Verified	Not verified		
1. District health office facilitates the mobilization and distribution of IEC materials on YFHS to service delivery points	63.6	0.0	63.6	**Medium**
2. District health office facilitates the establishment of linkages and partnerships between service delivery points	27.3	45.5	72.7	**Medium**
3. District health office facilitates the establishment of linkages and partnerships with organizations in this area	36.4	45.5	81.8	**High**
4. District health office facilitates advocacy and social mobilization activities on YFHS through District Assembly structures	18.2	54.5	72.7	**Medium**

5.4. Standard 4: Service Providers in all Delivery Points have the Required Knowledge, Skills, and Positive Attitudes to Effectively Provide YFHS

Determining the extent to which service delivery points have providers with the required knowledge, skills, and positive attitude to effectively provide YFHS requires examining the percentage of health facilities that implement each of the 18 Standard 4 elements. Table 5.4.1 shows the percentages of health facilities that reported to have implemented each of the 18 elements by type (health center or hospital) and location (urban or rural). Three of the 18 elements were assessed only at the health center level: *Referral system was developed in collaboration with the community; Facility provides supportive supervision to peer educators;* and *Facility provides supportive supervision to community-based service providers.* Five other elements were assessed only at the hospital level: *Facility provides/organizes training for service providers in YFHS; Facility has a resource directory of organizations providing health services not provided at the health facility; Facility has a functional one-way referral system with other facilities delivering RH services; Facility has functional back-referral system with other facilities delivering RH services;* and *Facility provides in-house supervision of YFHS*.

Table 5.4.1 shows that, overall, the implementation of Standard 4 elements is rated as low. Of the 18 Standard 4 elements:

- There are only three elements for which implementation is high: *Facility has service providers who have been trained in YFHS* (81.3 percent overall; 81.8 percent health center; 80 percent hospital; 85.7 percent rural health facility; 73.9 percent urban HF); Facility refers young people to other health facilities (76.7 percent overall; 81.8 percent health center; 60 percent hospital; 81 percent rural health facility; and, 69.6 percent urban health facility); Facility has a way for young people to provide feedback on their satisfaction with YFHS (95.3 percent overall; 97 percent health center; 90 percent hospital; 95.4 percent rural health facility; and, 95.3 percent urban health facility).
- There are three elements for which implementation is medium: *Facility has Standard Operating Procedure or clinical management guidelines for service providers to provide health services to adolescents and youth as per the recommended package* (62.8 percent overall; 63.6 percent health center; 60 percent hospital; 66.7 percent rural health facilities; and, 56.5 percent urban health facilities); *Facility provides supportive supervision to community-based service providers* (66.7 percent all health centers; 68.4 percent rural health centers; 64.3 percent urban health centers); and *Facility provides feedback to service providers/community based service providers* (55.8 percent overall; 54.5 percent health center; 40 percent hospital; 57.1 percent rural health facilities; and, and 54.5 percent urban health facilities).
- For 12 of the Standard 4 elements, implementation is low (2, 3, 6, 7, 8, 9, 10, 11, 12, 16, 17, 18).

Although implementation is low, some rural/urban differentials exist with respect to the percentage of health facilities that reported to analyze and use feedback data to improve services for young people (43.5 percent urban vs. 29.6 percent rural) and give recognition to health facility-/community-based service providers who provide high-quality YFHS (30.4 percent urban vs. 7.4 percent rural). It is worth noting that very few health facilities have a plan in place and associated resources to train service providers and conduct in-house supervision of service providers, or have support staff and a functional referral system, where other facilities are offering RH services. Non-implementation of these elements could hinder the ability of service providers to provide services in friendly and effective ways.

Because the implementation of the majority of Standard 4 elements is low, there are zonal variations in only a few of the elements. Significant zonal variations exist for elements 1, 4, 5, 12, and 14.[60] For example:

[60] As indicated above, analysis of zonal differentials is limited to elements assessed at both health center and hospital level.

- While all health facilities in the South West reported to have service providers who have been trained in YFHS (element 1), in the North, only 55.6 percent of health facilities reported to have trained YFHS providers.
- The percentage of health facilities that reported to have Standard Operating Procedure or clinical management guidelines for service providers (element 4) in the Central East and Central West (80 percent) is almost twice that of South East (44.4 percent).
- The percentage of health facilities that reported to refer young people to other health facilities (element 5) ranges from 60% percent in Central West to 90 percent in the South West.
- While the percentage of health facilities that reported to be analyzing and using data on feedback to improve services for young people (element 12) is 60 percent in Central West and South West, in the North it is only 11 percent.
- The percentage of health facilities that reported to provide feedback to service providers (element 14) ranges from 50 percent in Central East to 100 percent in Central West.

The percentage of health centers that reported to be implementing Standard 4 elements are presented in Table 5.4.3 by their YFHS-implementing status at the time of the survey. The table shows that except for element 7, the implementation of the elements is slightly higher among YFHS-implementing health centers than among YFHS non-implementing health centers.

Table 5.4.1: Percent of Health Facilities Implementing YFHS Standard 4 by Type of Health Facility and Place of Residence

Elements of Standard 4	Type of health facility (HF)		Type of residence		All HFs	ALOI (All HFs)
	Health Center	Hospital	Rural	Urban	%	
1. Facility has service providers who have been trained in YFHS	81.8	80.0	85.7	73.9	81.3	**High**
2. Facility has support staff (e.g., pharmacy attendants, laboratory attendants and hospital attendants) trained in YFHS	12.1	10.0	9.5	13.0	11.6	**Low**
3. Facility provides/organizes training for service providers in YFHS [b]	-	10.0	0.0 (2)	12.5 (8)	10.0 (10)	**Low**
4. Facility has Standard Operating Procedure or clinical management guidelines for service providers to provide health services to adolescents and youth as per recommended package	63.6	60.0	66.7	56.5	62.8	**Medium**
5. Facility refers young people to other health facilities	81.8	60.0	81.0	69.6	76.7	**High**
6. Referral system was developed in collaboration with the community [a]	18.2	-	15.8 (19)	21.4 (14)	18.2 (33)	**Low**
7. Facility has a resource directory of organizations providing health services not provided at the health facility [b]	-	10.0	0.0 (2)	12.5 (8)	10.0 (10)	**Low**
8. Facility has a functional one way referral system with other facilities delivering RH services [b]	-	30.0	50.0 (2)	37.5 (8)	40.0 (10)	**Low**
9. Facility has functional back referral system with other facilities delivering RH services	-	0.0	0.0 (2)	0.0 (8)	0.0 (10)	**Low**
10. Facility initiated/conducted exit interviews with young people in the last quarter	18.2	10.0	9.5	22.7	16.3	**Low**
11. Facility has a way for young people to provide feedback on their satisfaction with YFHS	97.0	90.0	85.7	95.4	95.3	**High**
12. Facility analyzes and utilizes data on feedback to improve services for young people	42.4	40.0	33.3	50.0	41.9	**Low**
13. Facility provides supportive supervision to peer educators [a]	36.4	-	31.6 (19)	42.8 (14)	36.4 (33)	**Low**
14. Facility provides supportive supervision to community based service providers [a]	66.7	-	68.4 (19)	64.3 (14)	66.7 (33)	**Medium**
15. Facility provides feedback to service providers/community based service providers	54.5	40.0	57.1	54.5	55.8	**Medium**
16. Facility gives recognition to service providers/community based service providers who provide high quality	21.2	0.0	4.8	27.3	16.3	**Low**

Elements of Standard 4	Type of health facility (HF)		Type of residence		All HFs	ALOI (All HFs)
	Health Center	Hospital	Rural	Urban	%	
YFHS						
17. Facility provides in-house supervision of YFHS [b]	-	30.0	100.0 (2)	12.5 (8)	33.3 (10)	**Low**
18. Facility is accredited in providing YFHS	45.4	10.0	38.1	36.4	37.2	**Low**
Number of cases	**33**	**10**	**21**	**22**	**43**	

[a] Data collected from health centers only; [b] Data collected from hospitals only.

Table 5.4.2: Percent of Health Facilities Implementing YFHS Standard 4 by Zone

Elements of Standard 4	North	Central East	Central West	South East	South West
1. Facility has service providers who have been trained in YFHS	55.6	90.0	60.0	88.9	100.0
2. Facility has support staff (e.g., pharmacy attendants, laboratory attendants and hospital attendants) trained in YFHS	22.2	10.0	0.0	0.0	20.0
3. Facility provides/organizes training for service providers in YFHS [b]	0.0 (2)	50.0 (2)	0.0 (1)	0.0 (2)	0.0 (3)
4. Facility has Standard Operating Procedure or clinical management guidelines for service providers to provide health services to adolescents and youth as per recommended package	55.6	80.0	80.0	44.4	60.0
5. Facility refers young people other health facilities	66.7	80.0	60.0	77.8	90.0
6. Referral system was developed in collaboration with the community [a]	0.0 (7)	0.0 (8)	25.0 (4)	14.3 (7)	57.1 (7)
7. Facility has a resource directory of organizations providing health services not provided at the health facility [b]	0.0 (2)	(0.0) (2)	0.0 (1)	0.0 (2)	33.3 (3)
8. Facility has a functional one way referral system with other facilities delivering RH services [b]	0.0 (2)	0.0 (2)	100.0 (1)	50.0 (2)	66.7 (3)
9. Facility has functional back referral system with other facilities delivering RH services [b]	0.0 (2)	0.0 (2)	0.0 (1)	0.0 (2)	0.0 (3)
10. Facility initiated/conducted exit interviews with youth in last quarter	33.3	10.0	40.0	0.0	10.0
11. Facility has a way for young people to provide feedback on their satisfaction with YFHS	100.0	100.0	80.0	88.9	100.0
12. Facility analyzes and utilizes data on feedback to improve services for youth	11.1	50.0	60.0	33.3	60.0
13. Facility provides supportive supervision to peer educators [a]	42.8 (7)	25.0 (8)	50.0 (4)	28.6 (7)	42.8 (7)
14. Facility provides supportive supervision to community-based service providers [a]	71.4 (7)	50.0 (8)	100.0 (4)	71.4 (7)	57.1 (7)
15. Facility provides feedback to providers	44.4	40.0	60.0	77.8	50.0
16. Facility provides recognition to service providers who provide high-quality YFHS	0.0	0.0	40.0	33.3	10.0
17. Facility provides in-house supervision of YFHS [b]	0.0 (2)	0.0 (2)	0.0 (1)	50.0 (2)	66.7 (3)
18. Facility is accredited in providing YFHS	44.4	30.0	60.0	44.4	20.0
Number of cases	**9**	**10**	**5**	**9**	**10**

[a] Data collected from health centers only; [b] Data collected from hospitals only.

Table 5.4.3: Percent of Health Centers Implementing Standard 4 Elements by YFHS-Implementing Status at the Time of the Survey

Elements of Standard 4	YFHS Implementing Health Center	YFHS Non-implementing Health Center	Difference between (1) and (2)
	(1)	(2)	(3)
1. Facility has service providers who have been trained in YFHS	81.8	33.3	+
2. Facility has support staff (e.g., pharmacy attendants, laboratory attendants and hospital attendants) trained in YFHS	12.2	6.7	+
3. Facility has Standard Operating Procedure or clinical management guidelines for service providers to provide health services to adolescents and youth as per recommended package	63.6	20.0	+
4. Facility refers young people to other health facilities	81.8	80.0	=
5. Referral system was developed in collaboration with the community	18.2	6.7	+
6. Facility initiated/conducted exit interviews with young people in the last quarter	18.2	0.0	+
7. Facility has a way for young people to provide feedback on their satisfaction with YFHS	97.0	100.0	=
8. Facility analyzes and utilizes data on feedback to improve services for young people	42.4	13.3	+
9. Facility provides supportive supervision to peer educators	36.4	13.3	+
10. Facility provides supportive supervision to community based service providers	66.7	40.0	+
11. Facility provides feedback to service providers/community based service providers	60.6	33.3	+
12. Facility provides recognition to service providers/community based service providers who provide high quality YFHS	15.2	13.3	=
13. Facility is accredited in providing YFHS	45.4	6.7	+
Number of cases	**33**	**15**	

Sixteen Standard 4 elements were examined at the district health office level. Table 5.4.4 shows low implementation for 10 (62.5 percent) of them. The low level of implementation should be addressed as the elements have direct influence on the ability of service providers to adequately provide services. The elements relate to mobilization of resources for training and service provision, training and supervision of service providers and support staff, adequate supply of essential tools and development of referral system. The implementation of almost all elements related to training of service providers and support staff (elements 3-10) is low. Without adequate training and supervision of service providers or essential tools with which to work, the quality of services might be compromised. District health offices have significant room for improvement in the implementation of Standard 4 elements.

Table 5.4.4: Percent of Health Districts Implementing YFHS Standard 4 (n=11)

Elements of Standard 4	Report status		Total	RLOI
	Verified	Not verified		
1. District health office mobilizes resources for trainings on YFHS	54.5	18.2	72.7	**Medium**
2. District health office mobilizes resources for YFH service provision	54.5	18.2	72.7	**Medium**
3. District health office trains DHMTs in YFHS	0.0	45.5	45.5	**Low**
4. District health office trains service providers on adolescent and young people's health	9.1	36.4	45.5	**Low**
5. Recommended training manuals on adolescent and young people's health are utilized for the trainings	9.1	27.3	36.4	**Low**
6. District health office trains service providers on the YFHS standards	18.2	27.3	45.5	**Low**
7. Recommended training manuals on the YFHS standards utilized for the trainings	18.2	27.3	45.5	**Low**
8. Service providers have adequate tools so they can apply training within clinic settings (e.g., job aids, policy guidance)	9.1	9.1	18.2	**Low**
9. District assesses provider knowledge/skills	27.3	9.1	36.4	**Low**
10. District health office facilitates the training of support staff (e.g., laboratory attendants, pharmacy attendants from service delivery points) on the YFHS standards	0.0	27.3	27.3	**Low**
11. District health office provides supportive supervision to service providers	27.3	45.5	72.7	**Medium**
12. District health office developed a referral system in collaboration with health centers and communities	18.2	63.6	81.8	**High**
13. District health office conducts coordination meetings with stakeholders	45.5	36.4	81.8	**High**
14. District health office provides feedback to service providers	27.3	36.4	63.6	**Medium**
15. District health office provides recognition to service providers who perform well	0.0	36.4	36.4	**Low**
16. District health office facilitates refresher courses on AYSRHR	0.0	36.4	36.4	**Low**

5.5. Standard 5: Health Information Related to Young People is Collected, Analyzed, and Utilized in Decision Making at all Levels

Table 5.5.1 shows the percentage of health facilities that reported to have implemented each of the nine Standard 5 elements by type and location of facility. The nine elements were assessed at the health center and hospital levels. Table 5.5.1 portrays uneven implementation of the Standard 5 elements. Of the nine elements:

- Implementation is high for three: F*acility monitors and supervises HSAs* (86 percent); *Facility compiles HSA data* (79.1 percent); and *Facility submits quarterly reports to the district health office/national level* (88.4 percent).
- Implementation is medium for one: *Facility participates in HMIS reviews to ensure AYSRH data and indicators are included* (65.1 percent).
- There are five for which implementation is low: *Facility has disaggregated data for young people's profiles in the catchment area—age, sex, school status, and marital status* (37.2 percent); *Facility has a service register/reporting form to record the age of the adolescents/youth separately and compile the data in age categories—10-14, 15-19, 20-24* (32.6 percent); *Service providers at the facility analyze and utilize data for planning purposes* (32.6 percent); *Facility identifies best practices at the community level* (56 percent); and *Facility provides feedback on data at the community level* (44.2 percent).

The table also draws attention to the need to develop and implement strategies to improve data collection, analysis, and utilization at all levels of health care. Regardless of facility type and location, the majority of health facilities did not report having: (i) disaggregated data for young people's profiles in the catchment area (age, sex, school status, and marital status); (ii) a service register to record the age of the adolescents/youth separately and compile the data in age categories (10-14, 15-19, 20-24); and (iii) service providers at the health facility to analyze and utilize data for planning purposes. However, most of the health facilities reported monitoring and supervising HSAs and compiling HSA data.

Table 5.5.2 shows the percentage of health facilities that reported implementing the nine Standard 5 elements by zone. There are variations (wide and slight) in levels of implementation of the element by zone. Variations in implementation are wide for elements 1, 2, 3, 7 and 8. For example:

- While 77.8 percent of health facilities in the North reported to *have disaggregated data for young people's profiles in the catchment area—age, sex, school status, and marital status*— (element 1), the corresponding figure for South East is 11.1%.
- While no health facility in the South East reported *to have service registers to record the age of the adolescents/youth separately and compile it in age categories (element 2)*, about two in three health facilities in the North reported to have such registers.
- The percentage of health facilities that reported that *service providers at the facility analyze and utilize data for planning purposes (element 3)* ranges from 11.1 percent in the South East to 66.7 percent in the North.
- The implementation of element 7—*facility provides feedback on data at the community level*—is lowest in Central East (10 percent) and highest in Central West and South West (60 percent).
- The percentage of health facilities that reported to have *identified best practices at the community level* (element 8) varies from 11.1 percent in the North to 70 percent in the South West.

Table 5.5.1: Percent of Health Facilities Implementing YFHS Standard 5 by Place of Residence

Elements of Standard 5	Type of facility		Type of residence		All HFs	ALOI (All HFs)
	Health Center	Hospital	Rural	Urban	%	
1. Facility has disaggregated data for young people's profiles in the catchment area (age, sex, school status, and marital status)	39.4	30.0	28.6	45.4	37.2	Low
2. Facility has a service register/reporting form to record the age of the adolescents/youth separately and compile it in age categories (10-14, 15-19, 20-24)	33.3	30.0	19.0	45.4	32.6	Low
3. Service providers at the facility analyze and utilize data for planning purposes	36.4	20.0	23.8	40.9	32.6	Low
4. Facility monitors and supervises Health Surveillance Assistants (HSAs)	84.8	90.0	85.7	86.4	86.0	High
5. Facility compiles HSA data	78.8	80.0	81.0	77.3	79.1	High
6. Facility submits quarterly reports to the district health office/national level	87.9	90.0	90.5	86.4	88.4	High
7. Facility provides feedback on data at the community level	27.3	60.0	28.6	40.9	34.9	Low
8. Facility identifies best practices at the community level	45.4	40.0	47.6	40.9	44.2	Low
9. Facility participates in HMIS reviews to ensure AYSRH data and indicators are included	63.6	70.0	57.1	72.7	65.1	Medium
Number of cases	**33**	**10**	**21**	**22**	**43**	

Table 5.5.2: Percent of Health Facilities Implementing YFHS Standard 5 by Zone

Elements of Standard 5	North	Central East	Central West	South East	South West
1. Facility has disaggregated data for young people's profiles in the catchment area (age, sex, school status, and marital status)	77.8	30.0	60.0	11.1	20.0
2. Facility has a service register/reporting form to record the age of the adolescents/youth separately and compile it in age categories (10-14, 15-19, 20-24)	66.7	30.0	60.0	0.0	20.0
3. Service providers at the facility analyze and utilize data for planning purposes	66.7	20.0	60.0	11.1	20.0
4. Facility monitors and supervises Health Surveillance Assistants (HSAs)	88.8	80.0	100.0	66.7	100.0
5 Facility compiles HSA data	88.8	70.0	100.0	55.6	90.0
6. Facility submits quarterly reports to the district health office/national level	88.8	80.0	80.0	88.9	100.0
7. Facility provides feedback on data at the community level	22.2	10.0	60.0	33.3	60.0
8. Facility identifies best practices at the community level	11.1	50.0	60.0	33.3	70.0
9. Facility participates in HMIS reviews to ensure AYSRH data and indicators are included	55.6	80.0	80.0	66.7	50.0
Number of cases	**9**	**10**	**5**	**9**	**10**

The percentage of health centers that reported to be implementing Standard 5 elements are presented in Table 5.5.3 by their YFHS-implementing status at the time of the survey. The table shows that except for elements 1 and 2, for which implementation is slightly higher among YFHS-implementing health facilities, the levels of implementation of the other elements are equal for both groups of health facilities.

Table 5.5.3: Percent of Health Centers Implementing Standard 5 Elements by YFHS-Implementing Status at the Time of the Survey

Elements of Standard 5	**YFHS Implementing Health Center**	**YFHS Non-implementing Health Center**	**Difference between (1) and (2)**
	(1)	(2)	**(3)**
1. Facility has disaggregated data for young people's profiles in the catchment area (age, sex, school status, and marital status)	39.4	26.7	**+**
2. Facility has a service register/reporting form to record the age of the adolescents/youth separately and compile it in age categories (10-14, 15-19, 20-24)	33.3	20.0	**+**
3. Service providers at the facility analyze and utilize data for planning purposes	36.4	33.3	**=**
4. Facility monitors and supervises Health Surveillance Assistants (HSAs)	84.8	86.7	**=**
5. Facility compiles HSA data	78.8	86.7	**=**
6. Facility submits quarterly reports to the District Health Office	87.9	93.3	**=**
7. Facility provides feedback on data at the community level	27.3	20.0	**=**
8. Facility identifies best practices at the community level	45.4	53.3	**=**
9. Facility participates in HMIS reviews to ensure AYSRH data and indicators are included	63.6	66.7	**=**
Number of cases	**33**	**15**	

Table 5.5.4 also shows uneven implementation of the Standard 5 elements at the district office level. While all the district health offices reported to have participated in HMIS reviews to ensure inclusion of YFHS data and indicators, less than 50 percent reported to have implemented the following elements: *Train all HSAs on village health registers to ensure youth-specific data are collected* (45.5 percent); *provide copies of data to district youth officer* (45.5 percent); *Document best practices and share information with all relevant stakeholder* (45.5 percent). Furthermore, only 54.5 percent of the district health offices reported *to have supervised the monitoring and evaluation of data on youth from the health facilities*. For adequate implementation of the YFHS program, high-quality data must be collected, managed, and used at different levels. The data in Table 5.5.5 point to gaps in data collection and use of data to identify best practices.

Table 5.5.4: Percent of Health Districts Implementing YFHS Standard 5 (n=11)

Elements of Standard 5	**Report status**		**Total**	**RLOI**
	Verified	**Not verified**		
1. District health office trains all HSAs on village health registers, to ensure youth specific data is collected	18.2	27.3	45.5	**Low**
2. District health office supervises the monitoring and evaluation of data on youth from health facilities	27.3	27.3	54.5	**Medium**
3. District health office compiles and analyzes data on youth from all service delivery points	54.5	18.2	72.7	**Medium**
4. District health office submits data to zonal and national levels	36.4	54.5	90.9	**High**
5. District health office provides copies of data to the DYO	18.2	27.3	45.5	**Low**
6. District health office provides feedback to all service delivery points	45.5	27.3	72.7	**Medium**
7. District health office distributes registers/data collection tools to all service delivery points	36.4	54.5	90.9	**High**
8. District health office documents best practices and shares information with all relevant stakeholders	27.3	18.2	45.5	**Low**
9. District health office participates in HMIS reviews to ensure AYSRH data and indicators are included	63.6	36.4	100.0	**High**

Table 5.6 and the graph below display a summary of the implementation of the five standards. Overall, the level of implementation is rated as low-medium.

Graph 5.6: Summary of the Implementation of the Standards Elements

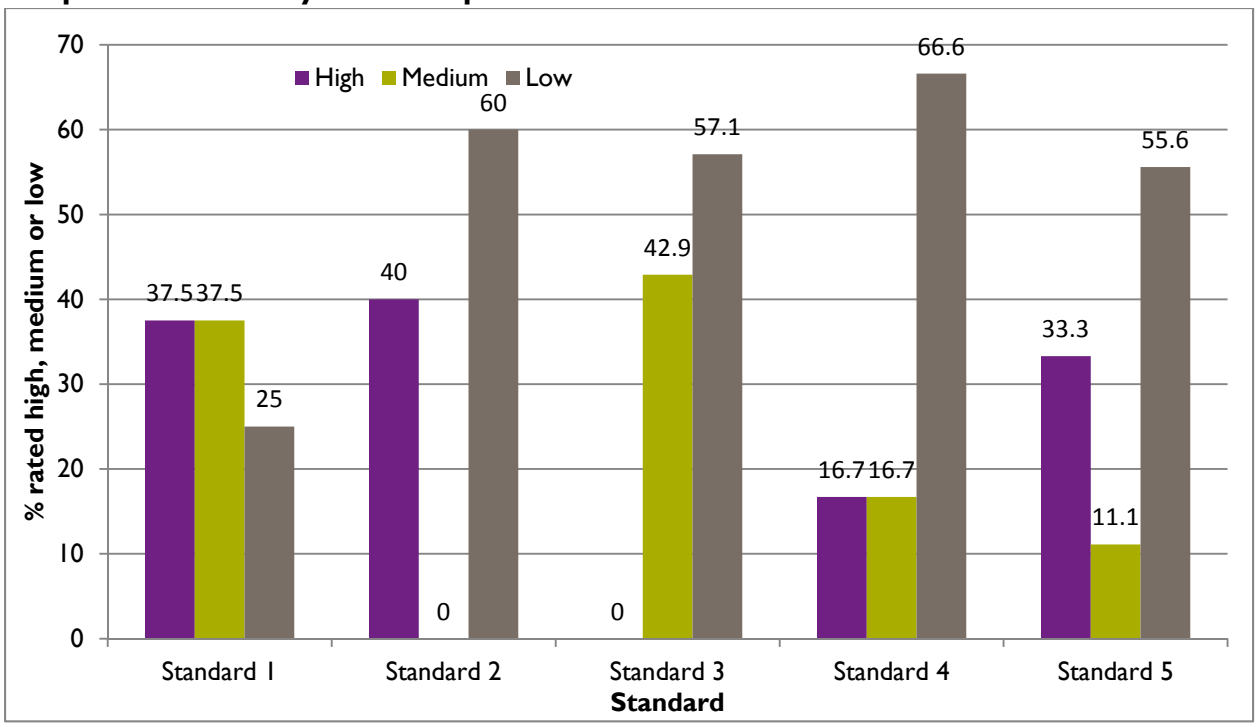


Table 5.6: Summary of the Implementation of the Standards Elements

Standard	Number of Elements	Number and percentage of elements with implementation rated as:			Overall Rating
		High	Medium	Low	
Standard 1: Health services are provided to young people according to existing policies, procedures, and guidelines at all service delivery points	8	3 (37.5%)	3 (37.5%)	2 (25%)	Medium - High
Standard 2: Young people are able to obtain health services that include preventive, promotive, curative, and rehabilitative health services appropriate to their needs	5	2 (40%)	0	3 (60%)	Low-Medium
Standard 3: All young people are able to obtain health information (including SRH and HIV) relevant to their needs, circumstances, and stage of development	7	0	3 (42.9%)	4 (57.1%)	Low
Standard 4: Service providers in all delivery points have the required knowledge, skills, and positive attitudes to effectively provide YFHS	18	3 (16.7%)	3 (16.7%)	12 (66.6%)	Low
Standard 5: Health information related to young people is collected, analyzed, and utilized in decision making at all levels	9	3 (33.3%)	1 (11.1%)	5 (55.6%)	Medium

Chapter 6: Coverage of Youth-Friendly Health Services

6.1. Awareness and Use of YFHS

A major objective of this study is to determine the coverage of the YFHS program, defined here as the percentage of the young persons aged 10-24 accessing YFHS. To maximize use/access and consequent benefits from the YFHS program, young people must be aware of the services offered, perceive the services to be beneficial in terms of meeting their health needs, have physical and financial access to the services, and be satisfied with the quality of services provided. In this section, we determine, at the community level and among health facility clients, young people's awareness and acceptance of, access to, and utilization of YFHS.

For this evaluation, awareness of the YFHS program was measured through a community survey of young persons aged 10-24 years and supplemented by exit interviews with young persons in that same age range who had received services from the health facilities selected for this evaluation on the day of interview.[61] The community survey respondents were asked what they had heard and understood about the YFHS program and how they had obtained information. Utilization was determined by a positive response to the question "Have you ever been to a youth-friendly health service delivery point?" with the word 'been' interpreted as 'sought services.' This question was asked only of those who reported to have heard about the YFHS program. Table 6.1.1 shows the percentage of community youth survey respondents who reported knowing that a health facility that offers services to youth, having heard about the YFHS program, knowing a service delivery point offering YFHS, and having accessed a YFHS. In the table, the responses to those questions are organized by whether the respondents lived in a community with a health facility that reported to be implementing YFHS.[62] Graph 6.1.1 shows awareness and use of YFHS as reported by community survey respondents and disaggregated by those who live in communities with YFHS-implementing facilities and those who do not. Findings include:

- A high percentage of community survey youth respondents (69.7 percent of all youth; 69.7 percent of youth in communities with YFHS-implementing health facility; and 69.9 percent of youth in communities without YFHS-implementing health facilities) reported knowing a place offering services to youth. Knowledge of a place offering services does not vary between youth living in communities with YFHS-implementing health facilities and their counterparts who lived in communities without YFHS-implementing health facilities.
- Only 31.7 percent (34.5 percent of youth in communities with YFHS-implementing health facilities and 24.5 percent of those in communities without YFHS-implementing health facilities) reported having ever heard of the YFHS program. That is, 54.5 percent[63] of youth (50.5 percent of those living in communities with YFHS-implementing health facilities and 65 percent of those living in communities without YFHS-implementing health facilities) who reported to know a place where youth can receive services have not heard about the YFHS program. The table shows that significantly higher percentages of youth who lived in communities with YFHS-

[61] The evaluation team avoided the temptation of assuming that all young persons who received services from a YFHS implementing health facility know about YFHS and that they were aware the facility was implementing the YFHS package.

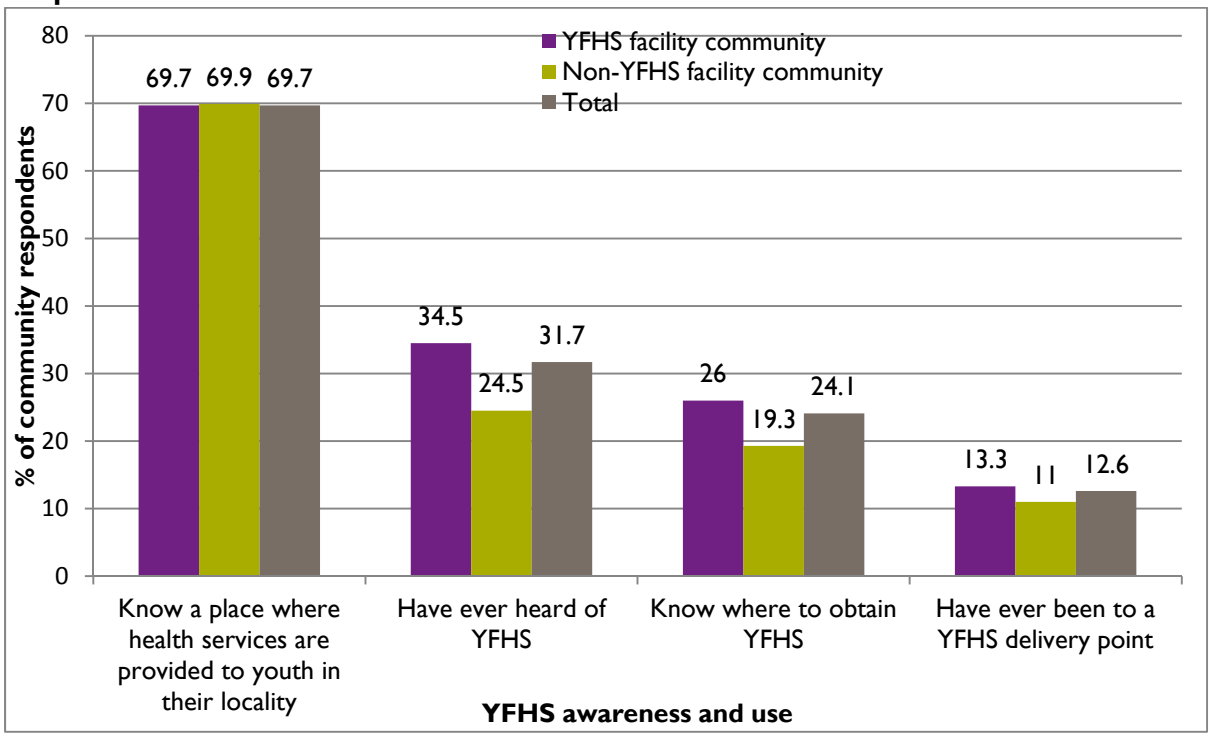
[62] The district health office classified the health facilities (HFs) in their districts as implementing or not implementing YFHS. Based on their classification, a few HFs were selected as implementing YFHS and others as not implementing YFHS. Unfortunately some of the HFs selected as implementing YFHS reported not to be implementing YFHS during the survey. Similarly, a few HFs, classified as not implementing YFHS reported to be implementing YFHS. Overall, the number of HFs classified as not implementing YFHS that reported to be implementing YFHS was greater than the number classified as not implementing YFHS that reported to be implementing. Consequently, we surveyed fewer numbers of HF not implementing YFHS than we planned to survey.

[63] 54.5% was obtained as ((69.7-31.7)/69.7)

implementing health facilities had heard about YFHS. The percentages who had heard about YFHS also vary by zone.

- About 24 percent of all surveyed youth (26 percent of those in communities with YFHS-implementing health facilities and 19.3 percent of those in communities without YFHS-implementing health facilities) reported knowing a service delivery point where YFHS could be obtained. The figures show that a significantly higher percentage of youth who lived in communities with YFHS-implementing health facilities reported knowing a service delivery point where youth can obtain YFHS, probably due to their proximity to a YFHS delivery point. The percentage knowing a place where youth can obtain YFHS also varies by zone.
- About 13 percent of all surveyed youth (13.3 percent of those living in communities with YFHS-implementing health facilities and 11 percent of those living in communities without YFHS-implementing health facilities) reported having ever accessed any YFHS. Ever use of a YFHS is much lower than assumed[64] and does not vary by whether respondents live in communities with YFHS-implementing health facilities. That the percentage of respondents who have ever accessed a YFHS is significantly lower than the percentage who reported knowing a place where services can be obtained shows that knowledge of the YFHS program does not automatically translate to utilization of services. Besides need, several factors influence uptake of services. Only about 52 percent of all youth (51.1 percent of youth who lived in communities with YFHS-implementing health facilities and 57 percent of those who lived in communities without YFHS-implementing health facilities) who reported to know a YFHS delivery point had ever accessed any of the services.

Graph 6.1.1: Awareness and Utilization of YFHS as Reported by Community Survey Respondents



[64] Although there were no baseline values, it was generally assumed at the planning stage of this evaluation that about 35% of youth would have accessed the YFHS services. The sample size estimate for the community survey was based on an assumed baseline value of 17-20% and a coverage level of about 35% at the time of the survey.

Table 6.1.1: Awareness and Utilization of YFHS by Whether Surveyed Respondents Lived in Communities with YFHS Implementing-Health Facility

Percentage of all interviewed youth who:	Community is around YFHS Implementing Health Facility (HF) (IMP)	Community is around YFHS Non-Implementing HF (NIMP)	All
1. Know a place where health services are provided to youth in their locality	69.7	69.9	69.7
2. Have ever heard of YFHS	34.5*	24.5	31.7
3. Know where to obtain YFHS	26.0*	19.3	24.1
4. Have ever been to a YFHS delivery point	13.3	11.0	12.6
Number of cases	**1462**	**571**	**2033**

Zone and type of community	North		Central East		Central West		South East		South West	
Percentage of all interviewed youth who:	YFHS IMP[a]	YFHS NIMP[b]	YFHS IMP	YFHS NIMP	YFHS IMP	YFHS NIMP	YFHS IMP	YFHS NIMP	YFHS IMP	YFHS NIMP
1. Know a place where health services are provided to youth in their locality	63.1	69.2	77.3	74.5	64.1	74.2*	71.2	70.3	71.2	70.3
2. Have ever heard of YFHS	41.0*	27.8	35.5	25.5	27.0*	13.3	27.3	18.8	43.9	37.8
3. Know where to obtain YFHS	28.0*	18.0	28.4*	18.4	17.8*	10.2	19.5	16.8	37.9	34.2
4. Have ever been to a YFHS delivery point	17.0	11.3	15.3	13.3	9.6	5.5	8.1	7.9	17.4	18.0
Number of cases	**271**	**133**	**313**	**98**	**270**	**128**	**344**	**101**	**264**	**111**

[a.] Surveyed community is around HF-implementing YFHS; b. Surveyed community is around HF not implementing YFHS; * p<=0.05

Assessment of district-level data shows that no districts qualify as a high performing. Ever use of YFHS ranges between 7.8 percent in Ntcheu to 23.8 percent in Nsanje with seven of the districts below 15 percent. Table 6.1.2 shows significant differences between awareness (percentage ever heard about YFHS) and ever use of YFHS.

Table 6.1.2: Awareness and Use of YHFS by District

District	Ever heard about YFHS	Ever Used YFHS	Number of Cases
Karonga	37.3	19.1	204
Mzimba	36.0	11.0	200
Kasungu	38.6	19.5	210
Dowa	27.5	10.0	200
Lilongwe	23.7	8.8	194
Ntcheu	21.6	7.8	204
Mangochi	26.9	8.0	238
Phalombe	23.6	8.2	209
Chiradzulu	34.5	12.3	203
Nsanje	51.2	23.8	172
All	31.7	12.6	2,033

Individual background characteristics and community and policy issues can influence access to information and services. In order to understand the background characteristics of survey respondents that might influence their access to information and use of services (with a view to addressing them), awareness and uptake of YFHS were examined by background characteristics, with the examination of awareness and utilization of services conducted separately to account for factors that influence access to use versus those that influence access to information. Understanding the relationships between background variables and information and use variables helps to develop programs that target the needs of people at different lifecycle stages. Table 6.1.2 shows that awareness and utilization of YFHS varies by background characteristics.

6.1.1. Knowledge of a Health Service Delivery Point Where Youth Can Obtain Services

The second column of Table 6.1.3 shows the percentage of community youth survey respondents who reported knowing a health service delivery point where youth can receive health services. This column shows that knowledge of a health service delivery point that offers services to youth increases with age, and is significantly higher among male respondents, sexually experienced youth, those who have attained secondary or higher education, youth who work for money, those who reside in Central East zone, those who have lived at the place of interview for 20 or more years, and youth who and have access to radio, television, and Internet at least once a week.[65]

6.1.2 Awareness of YFHS

All community youth survey respondents were asked if they have ever heard of YFHS specifically. Utilization of services is a function of awareness; people can only use what they know. As indicated above, less than half of those who reported knowing a place where youth could obtain health services reported having ever heard about the YFHS program. Column 3 of Table 6.1.3 shows that awareness of

[65] The individual effects of the background characteristics cannot be determined with precision at this stage as some of them are highly correlated with age. For instance, sexually active youth, those who have attained secondary or higher education, youth who work for money or have resided in their places of residence for 20 or more years are much older than their respective counterparts. This note applies to all bivariate relationships examined in this report.

YFHS varies by background characteristics: Older, sexually experienced, and previously married[66] youth as well as those who have attained secondary or higher education, who have lived 20 or more years in the place of interview, and listen to radio, watch television, or access Internet at least once a week are more likely than their respective counterparts to have heard about YFHS.

6.1.3. Knowledge of a YFHS Delivery Point

All community youth survey respondents who reported having heard about YFHS were asked to state whether they know YFHS delivery points. As shown in column 4 of Table 6.1.3, knowledge of a service delivery point providing YFHS also varies by background characteristics: Older youth 15 years and above, those who are sexually experienced or previously married, youth who have obtained a secondary or higher education, those in reside in the South West, youth who work for money, youth who have resided in their place of interview 20 years or more, and those who use the Internet occasionally were more likely than their respective counterparts to report knowing where YFHS are offered.

6.1.4. Utilization of YFHS

Table 6.1.3, column 5, shows that only about one-eighth of all young people have ever accessed YFHS. As with the knowledge variables, the probability that a young person would have accessed youth-friendly clinical, health promotion, and counseling services offered at the community, health center, and hospital levels[67] varies significantly among subgroups of youth defined by categories of background characteristics. Accessing YFHS increases with age and is higher among males, sexually experienced youth, out-of-school youths, those who have obtained secondary or higher education, those who reside in the South West zone, young people who have lived in the place where they were interviewed for 20 or more years, and young people who have listened to the radio, watched television, or accessed the Internet at least once a week.

[66] The previously married group consists of separated, divorced or widowed youth.

[67] As noted in Chapter 1, the YFHS Standards require that clinical services are delivered at the community, health center, and hospital levels.

Table 6.1.3: Awareness and Utilization of YFHS by Selected Background Characteristics

Background characteristic	Percentage of All interviewed Youth who:				Number of cases
	Know a place where health services are provided to youth in their locality	Have ever heard of YFHS	Know where to Obtain YFHS	Have ever been to a YFHS delivery point	
(1)	(2)	(3)	(4)	(5)	(6)
1. **Age:**					
10-14	60.4	16.9	12.9	4.6	604
15-19	70.9	36.7	74.1*	14.4	811
20-24	77.3*	39.6*	67.3	18.1*	618
2. **Sex:**					
Male	76.5*	32.4	24.5	14.7*	1011
Female	63.3	31.2	23.8	10.6	1006
3. **Sexual experience:**					
Ever had sex	77.9*	39.6*	32.1*	19.5*	1016
Never had sex	61.7	23.9	16.1	5.8	1017
4. **Marital status:**					
Never married	69.0	29.9	22.4	11.3	1595
Currently married	72.0	36.3	29.9	16.6	361
Previously married	74.0	48.1*	32.5*	22.1*	77
5. **Current school attendance status:**					
Out of school	73.2*	34.6	27.2	15.8*	786
In school	67.7	29.9	21.9	10.6	1199
Never attended school	66.0	31.9	29.8*	12.8	47
6. **Education:**					
None	66.0	31.9	29.8	12.8	47
Primary	64.9	25.5	18.9	9.3	1316
Secondary & above	79.6*	44.0*	33.9*	19.3*	670
7. **Type of residence**:					
Rural	68.8	32.2	24.8	12.4	1197
Urban	71.1	31.0	23.1	13.0	836
8. **Zone:**					
North	65.1	36.6	24.8	15.1	404
Central East	76.6*	33.1	26.0	14.8	411
Central West	67.3	22.6	15.3	8.3	398
South East	68.8	25.4	18.9	8.1	445
South West	70.0	42.1*	36.8*	17.6*	375
9. **Work to earn money:**					

Background characteristic	Percentage of All interviewed Youth who:				Number of cases
	Know a place where health services are provided to youth in their locality	Have ever heard of YFHS	Know where to Obtain YFHS	Have ever been to a YFHS delivery point	
(1)	(2)	(3)	(4)	(5)	(6)
Yes	77.1*	37.8*	30.1*	19.2*	349
No	68.3	30.5	22.9	11.3	1683
10. **Length of stay at place of interview:**					
Less than 1	65.2	23.5	15.2	6.8	132
1-4 years	67.6	34.7	24.7	13.3	392
5-9 years	71.9	33.7	25.6	16.6	199
10-14 years	62.5	22.5	17.1	7.4	502
15-19	73.9	36.1	27/2	15.4	482
20 and above	80.7*	41.0*	35.5*	17.9*	290
Don't know	55.6	13.9	5.6	0.0	36
11. **Frequency of Listening to the Radio:**					
Almost everyday	76.0*	37.1*	28.4*	15.5*	682
At least once a week	71.6	33.5	25.3	13.8	647
Less than once a week	75.4	30.5	23.3	9,3	236
Never	55.3	22.0	16.5	8.5	468
12. **Frequency of watching the TV**:					
Almost everyday	73.6	37.5*	26.4	17.2*	261
At least once a week	74.1*	35.4	26.3	15.4	410
Less than once a week	73.1	33.0	26.0	12.5	312
Never	66.1	28.5	22.1	10.5	1050
13. **Frequency of using Internet**:					
Almost everyday	78.4	49.0	39.2	27.5*	51
At least once a week	86.8*	50.0	36.8	22.1	68
Less than once a week	78.3	52.2*	45.7*	19.6	46
Never	68.7	30.1	22.7	11.7	1868
14. **Religion:**					
Catholic	71.1	34.6	26.0	14.4	457
Protestant	70.2	31.7	24.6	13.1	1225
African Church	55.6	44.4	44.4	22.2	9
Muslim	77.4	30.2	21.7	10.4	212
Other	49.6	25.2	16.3	5.7	123
All	69.7	31.7	24.1	12.6	2033

(*) Indicates that at least one of the groups is different from the others with respect to the variable under discussion (p=0.05)

6.2. Awareness of YFHS by Zone and Background Characteristics

A major sub-objective of this evaluation is an examination of zonal differentials in the coverage of YFHS as well as the factors that influence coverage. It is not uncommon for the relationships between variables to differ in different settings. What is an important determinant of access to information and services in one setting (and which needs urgent attention in that setting) may not be important in another setting. Examination of the relationships between background characteristics and awareness and use of YFHS at the zonal level helps to highlight important issues that must be addressed in each zone. Thus, for this evaluation, awareness and utilization of YFHS are examined by zone and background characteristics. We will use the community youth survey data, and where relevant, the exit interview data and information from focus group discussions among youth.

6.2.1. Community Survey Respondents

Besides showing that knowledge of YFHS is generally low, as indicated above, Table 6.2.1 shows significant differences among zones:[68] Awareness was highest in the South West (42.1 percent[69]) and lowest in Central West (22.6 percent) (See Graph 6.2.1). In the North, Central East, and South East, the percentages of youth who reported to have ever heard of YFHS are 36.6, 33.1 and 25.4, respectively. Furthermore, in each zone, awareness varies by some background characteristics. In all the zones, awareness increases with age and is higher among sexually experienced youth (who probably seek services to prevent pregnancy and contraction of STIs) and more educated youth (particularly those with secondary or higher education). Variations in awareness among sub-population groups, defined by other background characteristics, differ across zones and include the following:

- Awareness does not differ by sex, except in the South West.
- Awareness is highest among previously married youth in the North and among never-married youth in the South West. In the three other zones, awareness does not differ by marital status.
- Awareness differs between in- and out-of-school youth only in the North and Central West, where higher percentages of out-of school youth reported to have heard about YFHS.
- Awareness differs between rural and urban residents only in the South East, where it is higher among youth residents in the rural areas.
- Higher percentages of youth who work for money reported to have heard about YFHS in the North and Central East; in the other zones, awareness does not differ by employment status.
- Awareness is higher among youth who listen to the radio at least once a week in the Central East, South East, and South West.
- Although the percentage of youth who watch television at least once a week is generally low, in the North and Central East, higher proportions of youth who watch television at least once a week reported awareness compared to those who do not watch the television. In the other zones, awareness does not differ significantly by whether or not youth watch television, but it is not clear whether those who watch television have an advantage because programs related to the YFHS programs are not aired on television.

[68] The lower part of Table 1.1.1 shows that within each zone, awareness differs significantly between youth who lived in communities with YFHS implementing HFs and those who lived in communities without YFHS implementing HF only in the North and the Central West zones.

[69] The percentages here are weighted averages of the percentages shown in Table 6.1.1 for communities with YFHS-implementing health facilities and those without YFHS-implementing health facilities.

Graph 6.2.1: Awareness of YFHS by Zone, Community Survey Respondents

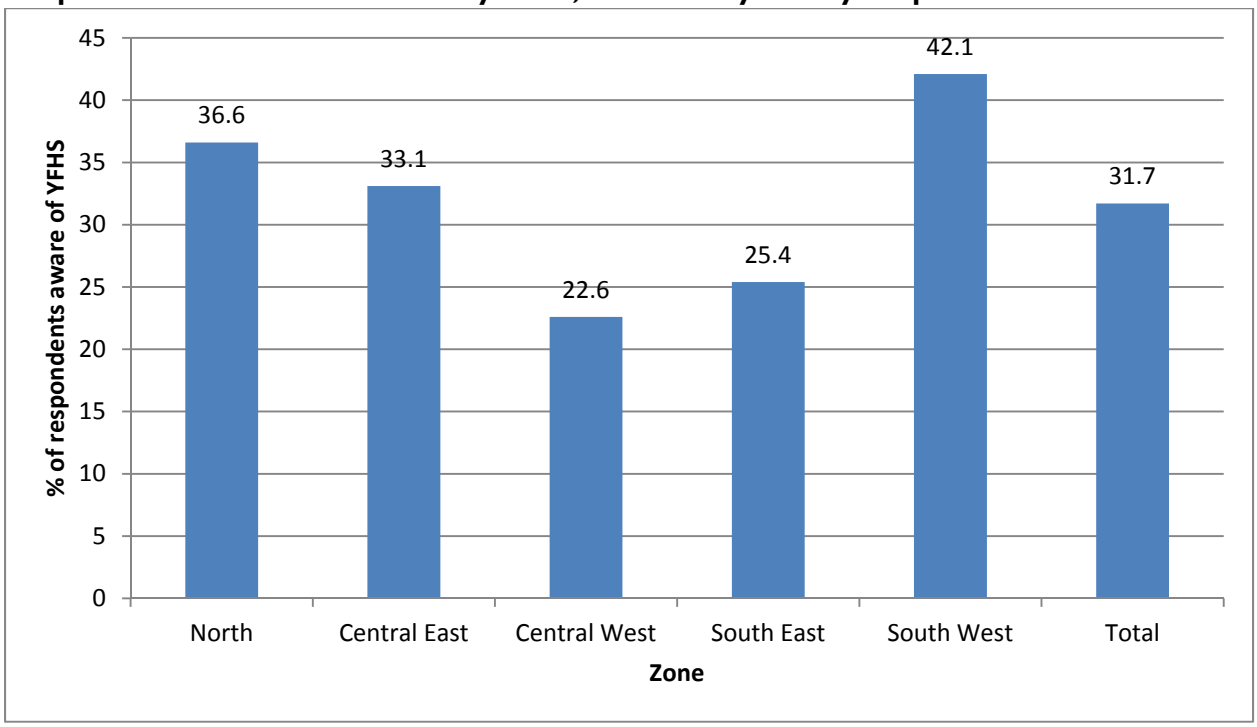


Table 6.2.1: Percentage of Community Survey Respondents (Youth) in Each Zone Who Reported to Have Heard of Youth-Friendly Health Services by Selected Characteristics

Characteristic	Percentage of Respondents who have ever heard of YFHS in the:					
	North	Central East	Central West	South East	South West	All
Age:						
10-14	11.8 (119)	20.5 (122)	11.4 (123)	12.3 (130)	30.0 (110)	16.9
15-19	41.5 (159)	39.8* (176)	25.1 (160)	28.3 (157)	48.4* (157)	36.7
20-24	54.0* (126)	36.3 (113)	30.4* (115)	33.3* (158)	45.4 (108)	39.6
Sex:						
Male	33.8 (207)	32.4 (238)	25.6 (203)	17.9 (178)	52.7* (184)	32.4
Female	39.3 (196)	34.1 (173)	19.8 (192)	31.0# (256)	32.1 (190)	31.2
Sexual experience:						
Ever had sex	50.6* (170)	43.9* (196)	30.1* (209)	30.1* (249)	47.9* (192)	39.6
Never had sex	26.5 (234)	23.3 (215)	14.3 (189)	19.4 (196)	36.8 (183)	23.9
Marital status:						
Never married	31.9 (342)	32.4 (343)	19.6 (311)	22.3 (305)	43.5* (294)	29.9
Currently married	53.3* (45)	33.9 (59)	34.6 (78)	31.5 (111)	36.8 (68)	36.3
Previously married	88.2 (17)	55.6 (9)	22.2 (9)	34.5 (29)	38.5 (13)	48.1
Current school attendance status:						
Out of school	52.6* (135)	35.2 (145)	28.7* (174)	25.1 (183)	36.2 (149)	34.6
In school	28.7 (265)	32.3 (263)	18.1 (221)	23.9 (238)	47.2 (212)	29.9
Never attended school	25.0 (4)	- (3)	- (3)	43.5 (23)	28.6 (14)	31.9
Education:						
None	25.0 (4)	- (3)	- (3)	43.5 (23)	28.6 (14)	31.7
Primary	29.5 (234)	28.3 (290)	18.0 (266)	17.6 (296)	36.5 (230)	25.5
Secondary & above	47.0* (166)	45.8* (118)	32.6* (129)	40.5* (126)	53.4* (131)	44.0
Type of Residence:						
Rural	36.1 (280)	31.4 (299)	23.7 (194)	29.8* (242)	40.1 (182)	32.2
Urban	37.9 (124)	37.5 (112)	21.6 (204)	20.2 (203)	44.0 (193)	31.0
Work to earn money:						
Yes	60.6* (40)	45.3* (75)	27.2 (92)	23.2 (82)	50.0 (60)	37.8
No	34.1 (364)	30.4 (336)	21.2 (306)	26.0 (362)	40.6 (315)	30.1
Length of stay at place of interview:						
Less than 1 year	43.3 (30)	16.0 (25)	17.9 (39)	16.7 (18)	20.0 (20)	23.5
1-4 years	40.0 (90)	35.0 (80)	30.4 (92)	27.5 (80)	44.0 (50)	34.7
5-9 years	34.5 (55)	33.3 (39)	18.6 (43)	32.5 (40)	63.6 (22)	33.7
10-14 years	19.4 (103)	23.2 (99)	13.8 (80)	18.3 (115)	36.2 (100)	22.5
15-19 years	44.7 (76)	39.5 (114)	21.0 (81)	28.7 (101)	44.5 (110)	36.1
20 and above	56.8* (44)	44.0* (50)	34.6* (52)	30.1 (83)	47.5* (61)	41.0
Don't know	16.7 (6)	25.0 (4)	9.1 (11)	- (5)	28.6 (7)	13.9
Frequency of listening to the radio:						
Almost everyday	41.6 (161)	43.3* (141)	28.6 (126)	28.5 (123)	41.2 (131)	37.1

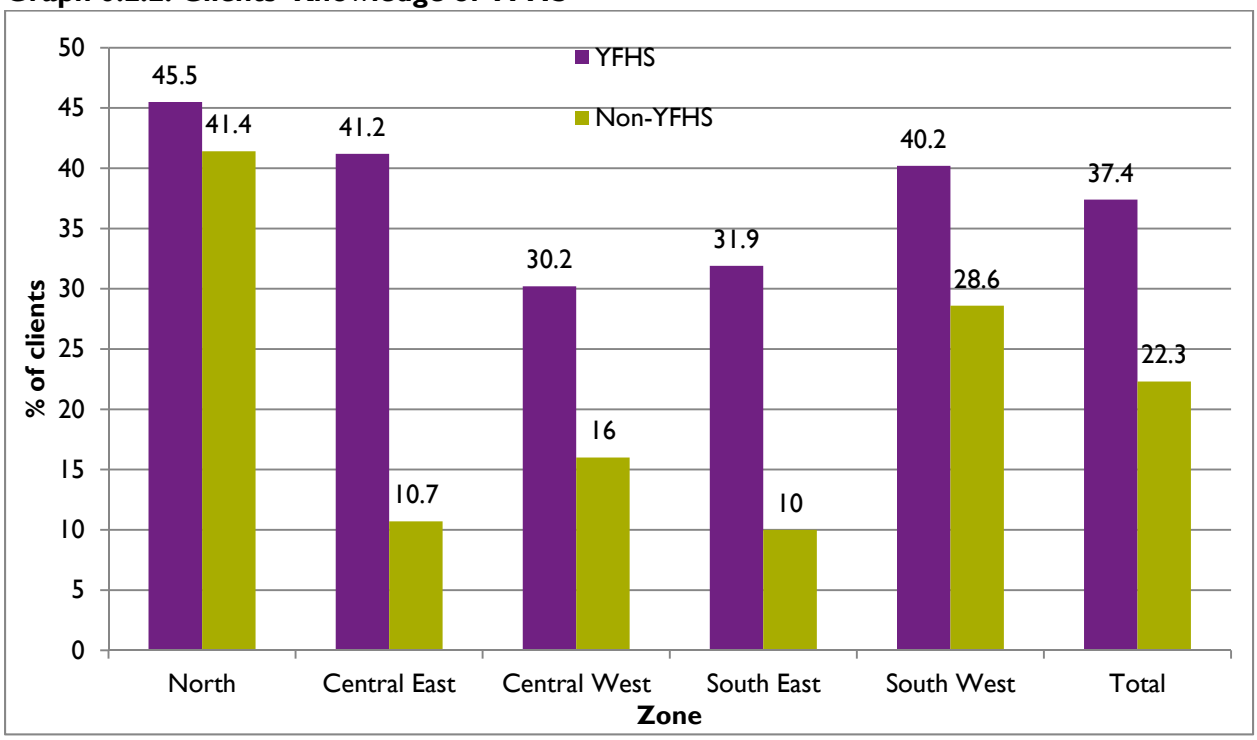
Characteristic	Percentage of Respondents who have ever heard of YFHS in the:					
	North	**Central East**	**Central West**	**South East**	**South West**	**All**
At least once a week	36.9 (122)	31.0 (158)	20.9 (134)	30.1* (113)	50.8* (120)	33.5
Less than once a week	36.4 (33)	25.8 (31)	23.2 (69)	24.2 (66)	54.1 (37)	30.5
Never	27.3 (88)	22.2 (81)	14.5 (69)	19.6 (143)	26.4 (87)	22.0
Frequency of watching the TV:						
Almost everyday	44.0 (91)	23.3 (30)	32.8 (64)	35.5 (31)	42.2 (45)	37.5
At least once a week	28.7 (108)	49.5* (91)	19.1 (68)	16.9 (59)	54.8 (84)	35.4
Less than once a week	44.6* (56)	40.0 (50)	25.0 (84)	27.0 (74)	35.4 (48)	33.0
Never	34.9 (149)	26.7 (240)	19.2 (182)	25.6 (281)	38.4 (198)	28.5
Frequency of using Internet:						
Almost everyday	43.5 (23)	20.0 (5)	80.0 (10)	44.4 (9)	- (4)	49.0
At least once a week	50.0 (32)	36.4 (11)	46.7* (15)	50.0 (5)	- (4)	50.0
Less than once a week	54.5 (22)	80.0 (5)	30.0 (10)	- (4)	80.0 (5)	52.2
Never	33.6 (327)	32.6 (390)	19.8 (363)	24.6 (426)	40.9 (362)	30.1
Religion:						
Catholic	46.2 (119)	31.9 (113)	23.2 (82)	28.3* (60)	37.3 (83)	34.6
Protestant	31.5 (248)	33.8* (278)	21.4 (285)	26.0 (154)	44.2* (260)	31.7
African church	-	- (2)	- (2)	- (3)	42.9 (21)	44.4
Muslim	59 (10)	- (2)	38.1* (21)	26.6 (158)	30.0 (10)	30.2
Other	36.0 (25)	33.3 (15)	14.3 (7)	19.7 (66)		25.2
All	36.6 (404)	33.1 (411)	22.6 (398)	25.4 (445)	42.1 (375)	31.7 (2,033)

(*) Indicates that at least one of the groups is different from the others with respect to the variable under discussion (p=0.05)

6.2.2. Exit Interview Respondents

As indicated above, knowledge of YFHS was assessed among randomly[70] selected youth who received services at the surveyed health facilities on the day of interview. The health facilities were classified into different categories by whether or not they had started implementing the YFHS[71] package and type (hospital or health center). The interviewed clients were asked to state whether they knew of the YFHS program and the type of services provided within the YFHS package. The results are presented in Table 6.2.2. The graph below summarizes clients' knowledge of the YFHS by whether they had obtained services at a YFHS-implementing or non-implementing facility.

Graph 6.2.2: Clients' Knowledge of YFHS



The fact that less than half of clients in YFHS-implementing facilities in any zone reported knowing about the YFHS program highlights a serious gap in awareness generation. The YFHS guidelines recommend that health facilities should generate awareness of the program through communication activities that include distribution of pamphlets or erecting YFHS sign posts that indicate the availability of YFHS services at the facility. For all clients, awareness does not seem to differ significantly between hospital and health center clients. However, in North and Central East, slightly higher percentages of health center clients reported to have heard of YFHS, and in the South West, slightly higher percentage of hospital clients reported to have heard of YFHS.

In order to determine what they knew about the facility where they had received services, exit interview respondents who reported to have heard about the YFHS program were asked to state

[70] Random selection took place only when there were more clients than the target number of 10. In many cases where it was even difficult to meet the sample size, we interviewed all youth clients who received services on the day of survey.

[71] We would like to emphasize that all facilities provide services to youth, whether or not they have started implementing the YFHS package. The YFHS package only recommends what should be provided at each level of care and how they should be provided. Unless adequately implemented, clients may not see any differences between facilities that reported to be implementing YFHS and those that reported not to be implementing YFHS in the way services are offered.

whether the health facility where they had just received services offers YFHS. Less than three-fifths (56.5 percent) of clients from facilities that implement YFHS recognized that those facilities offer YFHS (panel 2 of Table 6.2.2)[72]. This result suggests one or all of three things: (i) The clients do not understand the features of the YFHS package. (ii) The health facility has not generated adequate awareness of its YFH services among clients and community members. (iii) The clients could not see any differences between the health facility where they had just received services and other facilities regarding the way services are provided to youth. Whatever the reason, health facilities need to create more awareness of their services and offer them in ways that make them attractive to youth.

Table 6.2.2: Clients' Knowledge of YFHS

		YFHS-Implementing Status		**All**		**Facility Type**		**All**	
		YFHS-impl. facility	**YFHS non-impl. facility**	**%**	**n**	**Hospital**	**Health center**	**%**	**n**
1. Percentage ever heard of YFHS:									
North		45.5	41.4	44.4	117	40.0	46.2	44.1	118
Central East		41.2	10.7	33.3	108	27.5	38.6	33.3	108
Central West		30.2	16.0	27.0	111	27.8	26.3	26.8	112
South East		31.9	10.0	28.6	133	25.0	28.7	28.1	135
South West		40.2	28.6	37.4	115	43.6	35.1	37.9	116
Total	**%**	**37.4**	**22.3**	**34.1**	**-**	**33.3**	**34.2**	**34.0**	**-**
	n	**454**	**130**	**-**	**584**	**186**	**403**	**589**	**589**
2. Of those who have ever heard of YFHS, percent reporting that YFHS are provided in the facility where they were interviewed		56.5	24.1	51.8		54.8	50.4	51.8	
Number of cases		**170**	**29**	**199**		**62**	**135**	**197**	

[72] That some clients from health facilities that are supposedly not implementing YFHS considered those facilities as implementing YFHS suggests either lack of clarity on the part of the clients about what the YFHS package entails – in terms of services to be offered and how they should be offered – or that the services offered to youth in those facilities are as good as those offered elsewhere with the result that they considered them as YFHS implementing facilities.

6.2.3. Focus Group Discussions

Although there was no plan to determine level of awareness of YFHS through focus group discussions, we nevertheless wanted to gauge people's awareness of the program. Since parents play an influential role[73] in seeking health care for their children, it was considered appropriate to seek information about what they know about YFHS.[74] Consistent with the community youth survey and exit interview data, information from focus group discussions among youth and parents shows low/inadequate knowledge of YFHS, as reflected in the excerpts below.

> "We don't know that the YFHS are available here. Maybe it is because they have not been publicized by the health personnel effectively" (P7, FGD with female youth, Kasungu).

> "I have never heard anything about the youth-friendly health services. I hear this from you because many projects like these are found in big health centers, for those of us in the remote areas, we are ignored" (P6, FGD with male parents, Lilongwe).

In some FGDs where parents reported having heard about YFHS, they did not give a comprehensive picture of YFHS. Instead they talked about some elements of YFHS program.

> "I heard that youth are told that if they can't abstain they should use condoms and they are also encouraged to pursue their studies" (P4, FGD with male parents, Kasungu).

> "Yes I heard something about that, mainly about condoms. I heard about that from my friends, but I don't know much details" (P3, FGD with male parents, Lilongwe).

In a few FGDs with parents, participants reported that boys are given condoms and girls injections to prevent pregnancy under the YFHS program. Some parents confused YFHS with the work being done by youth clubs where young people discuss their future.

6.3. Sources of Information about YFHS

Obtaining information from youth about how they know about the YFHS program serves two purposes: First, it helps implementing organizations assess the effectiveness of the channels of communication they have adopted to reach youth. Secondly, it helps to direct attention to common sources of information among youth and how those sources could be strengthened to more effectively reach youth. Obtaining information about what they know about the YFHS program helps to assess the accuracy of information the youth have with a view to developing strategies to address misconceptions.

6.3.1. Community Survey Respondents

The community youth survey respondents who reported having heard about YFHS were asked to state their source of information and what they know about the YFHS. Data on sources of information about YFHS and what the youth know about the services are presented in Tables 6.3.1 and 6.3.2, respectively. In Table 6.3.1, the source of information was provided in three ways to assess variations by zone and the type of community respondents lived in (whether the community has YFHS-implementing health facility or not). The table shows little variations in source of information by type of community. The Overall, prominent sources of information, though with slightly varying degree of significance across zones, are:

[73] It should be noted that where parents seek health care for their wards will be influenced by how they perceive the appropriateness and efficacy of alternative preventive and curative approaches/regimes.
[74] A more comprehensive analysis of the qualitative data is undertaken in Chapter 7.

- Friends/peers: About two-fifths (39.3 percent) of youth receive information about YFHS from their friends/peers, and the percentage does not vary significantly by zone: 36.6 percent in the North, 40.7 percent in the Central East, 37.8 percent in Central West, 34.5 percent in South East, and 44.9 percent in South West.
- The radio, which through announcements and special programs, provides information to almost one-fifth (19.3 percent) of youth who have heard of YFHS—22.8 percent in the North, 17.8 percent in the Central East, 26.7 percent in the Central West, 11.8 percent in the South East, and 18.4 percent in the South West.
- The health care delivery system, which through health facility sign posts, posters/bill and other materials, provides information to about one-fifth (20.5 percent) of youth who have heard about YFHS—18.6 percent in the North, 23 percent in the Central East, 18.9 percent in the Central West, 25.5 percent in the South East, and 17.7 percent in the South West.
- School social groups/clubs, which through drama and other activities provide information to about 13 percent of youth who have heard about YFHS—11.7 percent in the North, 15.6 percent in the Central East, 11.1 percent in the Central West, 11.8 percent in the South East, and 14.6 percent in the South West.
- Local media, which through special programs and announcements, provides information to about one-tenth (9.9 percent) of youth—14.5 percent in the North, 8.9 percent in the Central East, 13.3 percent in the Central West, 5.5 percent in the South East and 7.6 percent in the South West.
- Community members, who through word of mouth, provide information to about 13 percent of youth who have heard about YFHS—6.5 percent in the North, 20.7 percent in the Central East, 14.4 percent in Central West, 17.3 percent in the South East, and 8.9 percent in the South West.

Other less pronounced sources of information include community-based/youth organizations (which assume some prominence in the South West), pamphlets, parents, CBDAs, and the church/mosque. When asked whether they have ever received print materials that provide detailed information on the YFHS program, including information on services provided, target beneficiaries, and benefits, 17-21 percent of youth who had heard about YFHS reported to have received such printed materials—19.1 percent in the North, 19.4 percent in the Central East, 16.7 percent in the Central West, 18.2 percent in the South East and 21.4 percent in the South West (see panel 2 of Table 6.4).

Table 6.3.1: Source of Information for Community Survey Respondents Who Have Heard About YFHS

	Type of community:		
Percentage who obtained information about YFHS from:	**Community is around YFHS Implementing Facility**	**Community is around YFHS Non-Implementing Facility**	**All**
Local media	11.0	5.8	9.9
Pamphlets/Posters	2.6	4.3	3.0
Friend/Peers	40.8	34.1	39.3
Community members	13.2	11.6	12.9
Parents	3.6	2.9	3.4
School Social groups/clubs	13.0	13.8	13.2
Health care delivery system	19.0	26.1	20.5
Radio	18.6	21.7	19.3
HSA	1.4	2.2	1.6
Internet	0.2	0	0.2
Community-based/youth organizations	7.6	6.5	7.4

Church/Mosque	4.0	3.6	3.9
Other	2.8	2.2	2.7
Number of cases	**500**	**138**	**638**

Percentage who obtained information about YFHS from:	**Zone**					
	North	Central East	Central West	South East	South West	All
Local media	14.5	8.9	13.3	5.5	7.6	9.9
Pamphlets/Posters	6.2	2.2	1.1	1.8	2.5	3.0
Friend/Peers	36.6	40.7	37.8	34.5	44.9	39.3
Community members	6.5	20.7	14.4	17.3	8.9	12.9
Parents	2.8	4.4	1.1	2.7	5.1	3.4
School Social groups/clubs	11.7	15.6	11.1	11.8	14.6	13.2
Health care delivery system	18.6	23.0	18.9	25.5	17.7	20.5
Radio	22.8	17.8	26.7	11.8	18.4	19.3
has	2,1	0.7	0	0.9	3.2	1.6
Internet	0.7	-	-	-	-	0.2
Community based/youth organizations	5.5	3.7	4.4	8.2	13.3	7.4
Church/Mosque	9.0	3.0	2.2	1.8	2.6	3.9
Other	3.4	4.4	3.3	1.8	0.6	2.7
Number of cases	**145**	**135**	**90**	**110**	**158**	**638**

Percentage who obtained information about YFHS from:	**Zone and Type of Community**									
	North		**Central East**		**Central West**		**South east**		**South West**	
	YFHS IMP	**YFHNIMP**	**YFHS IMP**	**YFHNIMP**	**YFHS IMP**	**YFHNIMP**	**YFHS IMP**	**YFHNIMP**	**YFHS IMP**	**YFHNIMP**
Local media	14.5	14.3	10.8	0	15.1	5.9	5.5	5.3	9.6	2.3
Pamphlets/posters	5.5	8.6	0.9	8.3*	1.4	0	2.2	0	2.6	2.3
Friend/peers	40.0	25.7	37.8	54.2	38.4	35.3	38.5	15.8	47.8	37.2
Community members	5.5	5.7	18.9	29.2	15.1	11.8	20.9*	0	7.8	11.6
Parents	3.6	0	3.6	8.3	1.4	0	3.3	0	5.2	4.7
School Social groups/clubs	12.7	8.6	12.6	29.2	8.2	23.5	12.1	10.5	17.4	7.0
Health care	15.5	28.6	23.4	20.8	20.5	11.8	17.6*	63.2	19.0	26.1

delivery system										
Radio	21.8	25.7	15.3	29.2	27.4	23.6	11.0	15.8	19.1	16.3
has	1.8	2.9	0.9	0	0	0	0	5.3	3.5	2.3
Internet	0.9	0	0	0	0	0	0	0	0	0
Community-based/youth organizations	7.3	0	4.5	0	5.5	0	9.9	0	10.4	0
Church/Mosque	8.2	11.4	3.6	0	1.4	5.9	2.2	0	3.5	0
Other	3.6	2.9	3.6	8.3	4.1	0	2.2	0	0.9	0
Number of cases	110	35	111	24	73	17	91	19	115	43

6.3.2. What the Survey Respondents Know About YFHS

One of the ways in which the evaluation helps program implementation is by drawing attention to what youth know, including their knowledge about who the intended beneficiaries of the YFHS program are. The first panel of Table 6.3.2 shows that about half (49.1 percent) of respondents accurately identified intended beneficiaries—unmarried and married males and females aged 10-24. Programs seeking to promote better utilization of YFHS should address gaps in knowledge related to intended beneficiaries.

Of those who had heard of YFHS, 72 percent—64.1 percent in the North, 74.1 percent in the Central East, 71.1 percent in the Central West, 69 percent in the South East, and 79.2 percent in the South West —were able to identify one or more YFHS offered across different levels of health care (see Table 6.3.2, panel 2). Prominent among the services mentioned (Table 6.3.2, panel 3) were:

- Provision/distribution of contraceptive methods (56.6 percent of all youth; 54.8 percent in the North, 53 percent in the Central East, 50.7 percent in the Central West, 55.1 percent in the South East, and 65.1 percent in the South West)
- HIV testing and counseling (53.4 percent of all youth; 43 percent in the North, 55 percent in the Central East, 54.7 percent in the Central West, 47.4 percent in the South East, and 62.7 percent in the South West).
- Contraceptive counseling (46 percent of all youth; 25.8 percent in the North, 44 percent in the Central East, 45.3 percent in the Central West, 53.8 percent in the South East, and 57.9 percent in the South West).
- General counseling (46 percent of all youth; 43 percent in the North, 41 percent in the Central East, 43.8 percent in the Central West, 64.1 percent in the South East, and 60.2 percent in the South West).
- Prevention, diagnosis and management of STIs (21.9 percent of all youth; 16.1 percent in the North, 17.6 percent in the Central East, 20.3 percent in the Central West, 24.4 percent in the South East, and 29.4 percent in the South West).

In line with government and donor interest in preventing teenage pregnancy and contraction of STIs, surveyed youth who reported knowing about YFHS were asked whether they knew the contraceptive methods offered at the YFHS delivery points; 72 percent reported to know the contraceptive methods offered (see Table 6.3.2, panel 4). The contraceptive methods identified are presented in panel 5. Prominent among the methods mentioned are:

- Male condom (85.1 percent all youth; 89.7 percent in the North, 87.1 percent in the Central East, 81.8 percent in the Central West, 77 percent in the South East, and 86.4 percent in the South West).
- Injectables (56.9 percent of all youth; 55.7 percent in the North, 54.8 percent in the Central East, 42.4 percent in the Central West, 67.6 percent in the South East, and 60.6 percent in the South West).

- Female condom (47.5 percent of all youth; 68% in the North, 46.2% in the Central East, 42.4% in the Central West, 54.1 percent in the South East, and 32.6 percent in the South West).
- Oral contraceptive pill (48.3 percent of all youth; 36.1 percent in the North, 33.3 percent in the Central East, 39.4 percent in the Central West, 73 percent in the South East, and 40.9 percent in the South West).
- Implants (27.3 percent of all youth; 17.5 percent in the North, 38.1 percent in the Central East, 21.2 percent in the Central West, 41.9 percent in the South East, and 27.3 percent in the South West).
- IUD (11.3 percent of all youth; 11.2 percent in the North, 15.1 percent in the Central East, 9.1 percent in the Central West, 13.5 percent in the South East, and 8.3 percent in the South West).

A major sub-objective of this study is to determine whether youth who reported having heard about YFHS were able to identify a health service delivery point located in or closest to the community in which they live. Consequently, the interviewers asked the youth whether they knew the health service delivery point closest to them, mentioning the service delivery points by name; 72 percent of youth reported knowing the service delivery points mentioned by the interviewers (panel 6 of Table 6.3.2), and of these, 76.7 percent reported knowing that the closest service delivery point offers YFHS (panel 7).

Table 6.3.2: What Community Survey Respondents Know About YFHS

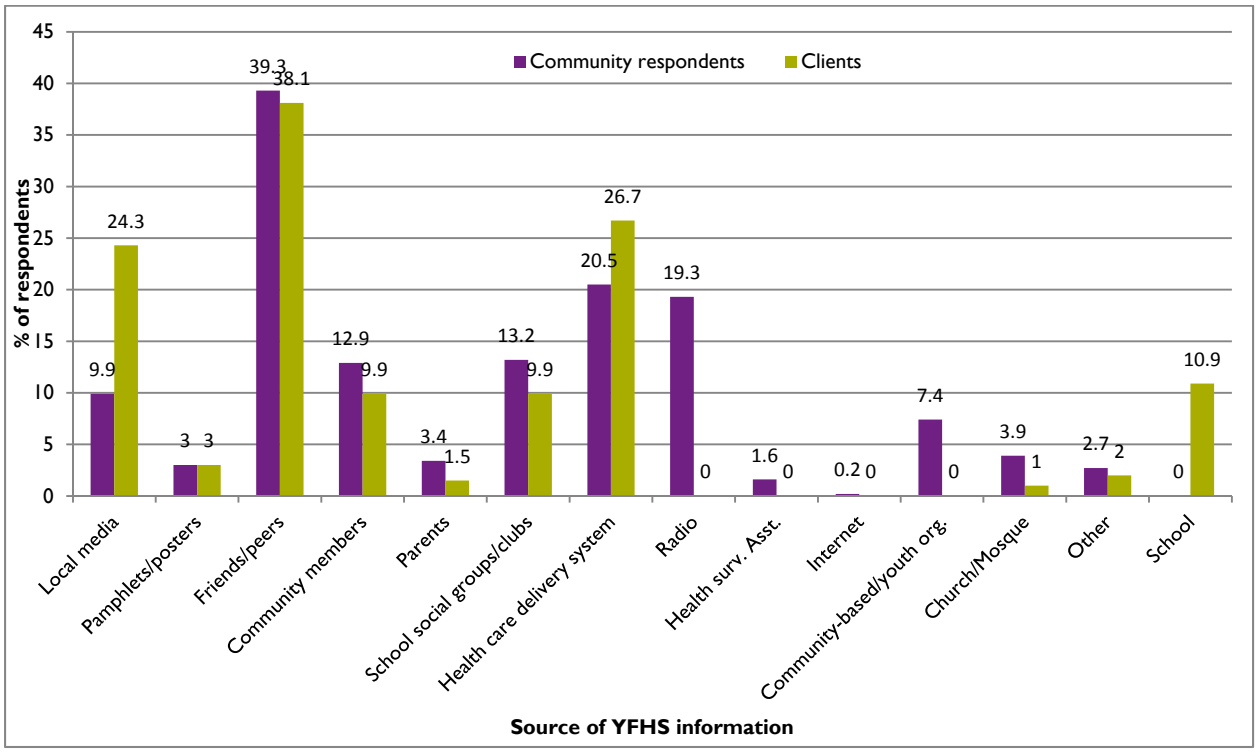
		North	Central East	Central West	South East	South West	All
	Of surveyed youth who have ever heard of YFHS:						
1	**Percentage who stated that the beneficiaries of YFHS are:**						
	Married and unmarried males and females 10-24	30.1	49.6	44.6	57.7	64.0	49.1
	Only unmarried males and females 10-24	11.8	26.0	28.9	18.6	2.9	16.2
	Only unmarried females 10-24	-	0.4	-	1.0	-	0.7
	Only unmarried males 10-24	0.7	1.6	-	3.1	0.7	1.2
	Only married females 10-24	-	0.8	-	-	-	0.2
	Only married males 10-24	-	0.8	-	-	-	0.2
	Other	58.1	21.1	26.5	20.6	32.4	33.2
	Number of cases	**136**	**123**	**83**	**97**	**139**	**578**
2	**Percentage who reported to know services offered at YFHS delivery points:**	64.1 **(145)**	74.1 **(135)**	71.1 **(90)**	69.0 **(112)**	79.2 **(159)**	71.9 **(641)**
3	**Of those who reported to know YFHS offered, percent who identified the following as youth friendly health services**:						
	General counseling	43.0	41.0	43.8	64.1	60.2	46.0
	Contraceptive counseling	25.8	44.0	45.3	53.8	57.9	46.0
	Provision/distribution of contraceptive methods	54.8	53.0	50.0	55.1	65.1	56.6
	HIV testing and Counseling	43.0	55.0	54.7	47.4	62.7	53.4
	Referral to other health facility/other service delivery points	4.3	4.9	1.6	1.3	4.0	3.3
	Prevention, diagnosis and management of STIs	16.1	17.6	20.3	24.4	29.4	21.9
	Antenatal, delivery and postnatal care services	2.2	3.0	1.6	3.8	0.8	2.2
	PMTCT	3.2	3.0	4.7	3.8	2.4	3.3
	Treatment of sexual abuse (including PEP)	3.2	2.0	3.1	10.3	4.8	4.6
	Post abortion care	2.2	-	1.6	3.8	-	1.3
	Provision of ARVs	3.2	2.0	6.3	7.7	9.5	5.9
	Other	6.5	1.0	3.1	7.7	4.8	4.6
	Number of cases	**93**	**100**	**64**	**78**	**126**	**461**
4	**Percent who reported to**						

		North	Central East	Central West	South East	South West	All
	know the types of contraceptive methods offered at YFHS delivery points:	66.9 **(145)**	68.4 **(136)**	73.3 **(90)**	66.1 **(112)**	83.0 **(159)**	72.0 **(642)**
5	**Of those who reported to know the contraceptive methods offered, percent who mentioned the following contraceptive methods:**						
	Oral contraceptive/pill	36.1	33.3	39.4	73.0	40.9	43.3
	IUD	11.2	15.1	9.1	13.5	8.3	11.3
	Injectables	55.7	54.8	42.4	67.6	60.6	56.9
	Implants	17.5	38.1	21.2	41.9	27.3	27.3
	Male condom	89.7	87.1	81.8	77.0	86.4	85.1
	Female condom	68.0	46.2	42.4	54.1	32.6	47.5
	Lactational Amenorrhea Method	=	-	-	-	-	
	Emergency Contraception	-	2.2	-	1.4	2.3	1.3
	Withdrawal	-	1.1	3.0	2.7	1.5	1.5
	Don't know	-	2.2	1.5	-	1.5	1.1
	Other	3.1	1.1	-	6.8	-	1.9
	Number of cases	**97**	**93**	**66**	**74**	**132**	**462**
6	**Percent who reported to have heard of the YFHS facility closest to their community:**	92.4 **(145)**	97.0 **(144)**	86.5 **(89)**	84.5 **(110)**	93.7 **(159)**	**91.5 (647)**
7	**Of those who reported to know the closest YFHS facility, percentage who reported to know that the facility provides YFHS:**	69.4 **(134)**	82.6 **(132)**	65.8 **(76)**	74.5 **(98)**	85.2 **(149)**	76.7 **(589)**

6.3.3. Exit Interview Respondents

Exit interview respondents who reported to have heard about YFHS were also asked about sources of information, what they knew about YFHS, and how they knew that the health facilities where they were interviewed offer YFHS. As observed among community youth survey respondents, panel 1 of Table 6.3.3 shows the dominant role of friends/peers as a source of information about the YFHS program (38.1 percent of all health facility clients; 40.7 percent of clients of health facilities implementing YHFS; 24.1 percent of clients of facilities not implementing YFHS; 45.9 percent of hospital clients, and 35 percent of health center clients). As with the community survey respondents, other major sources of information among the client exit interview respondents are the health care delivery system (26.7 percent all clients; 27.3 percent of clients of facilities implementing YFHS, 24.1 percent of clients of facilities not implementing YFHS, 23 percent of hospital clients, and 28.6 percent of health center clients) and the local media (24.3 percent all clients; 44.8 percent of clients of health facilities not implementing YFHS, 31.1 percent of hospital clients, 20.7 percent of health center clients, and 20.3 percent of clients of health facilities implementing YFHS). Graph 6.3, below, compares the sources of information, as reported by community youth survey respondents and clients.

Graph 6.3: Sources of Information Reported by Community Survey Respondents and Exit Interview Clients



We also examined what the exit interview respondents knew about the YFHS package by asking them to state what they understood from their different sources of information to be the services offered under the YFHS package. Panel 2 of Table 6.3.3 shows that not all clients who reported to have heard of YFHS were able to mention one or more services offered under the YFHS package. Among clients of health facilities offering YFHS, 69.4 percent reported to know one or more services that are offered under the YFHS package. Among clients of health facilities not offering YFHS, only 53.8 percent reported to know one or more services offered under the YFHS package. Ability to mention one or more services is generally higher among hospital clients (75.8 percent) than among health center clients (63.7 percent).

The YFHS mentioned cut across services that are expected to be provided at the community, health center, and hospital levels. Prominent among the services listed in panel 3 of Table 6.3.3 are:

HIV and AIDS counseling (66.1 percent of clients from facilities implementing YFHS; 57.1 percent of clients from facilities not implementing YFHS; 70.2 percent of hospital clients and 61.6 percent of health center clients);

- Contraceptive counseling (53.2 percent of clients from facilities implementing YFHS; 50 percent of clients from facilities not implementing YFHS; 48.9 percent of hospital clients; and 54.7% of health center clients);
- HIV testing (52.3 percent of clients from facilities implementing YFHS; 64.3 percent of clients from facilities not implementing YFHS; 46.8 percent of hospital clients; and 57 percent of health center clients);
- Distribution of contraceptives (50.8 percent of clients from facilities implementing YFHS; 57.1 percent of clients from facilities not implementing YFHS; 51.1 percent of hospital clients and 51.2 percent of health center clients);
- General counseling (38.1 percent of clients from facilities implementing YFHS; 42.9 percent of clients from facilities not implementing YFHS; 44.7 percent of hospital clients and 36 percent of health center clients);
- STI services (18.6 percent of clients from facilities implementing YFHS; 14.3 percent of clients from facilities not implementing YFHS; 21.3 percent of hospital clients and 16.3 percent of health center clients).

The exit interview respondents were also asked to state why they thought that the health facilities they had visited offered YFHS. Panel 4 of Table 6.3.3 shows that:

- About 39 percent of clients said they thought that the health facilities they had visited offered YFHS because service providers usually gave youth special attention in the provision of services.
- Thirty-five percent said they thought that the health facility they visited offered YFHS because they (the youth) and peer educators usually met on specific days of the week to discuss health issues and provide/obtain required services.
- About 15 percent said they thought the health facilities they visited offered YFHS because health services are usually provided to youth by peer educators and other health providers in a separate room allocated to youth activities.
- About 6 percent stated that they believed that only YFHS are provided in the facility they visited.

Table 6.3.3: Clients' Sources of Information about YFHS and What They Know

	YFHS Implementing Status		**Total**	**Facility Type**		**Total**
	YFHS Facility	**Non-YFHS Facility**		**Hospital**	**Health Center**	
1. Of those who have heard of YFHS, percent who heard from:						
Local media	20.3	44.8	23.9	32.3	20.7	24.3
Pamphlets/posters	2.9	3.4	3.0	1.6	3.6	3.0
Friends/peers	40.7	24.1	38.3	45.2	35.0	38.1
Community members	11.6	0.0	10.0	8.1	10.7	9.9
Parents	1.2	3.4	1.5	1.6	1.4	1.5
School	12.8	0.0	10.9	9.7	11.4	10.9
Social group/clubs	9.9	10.3	10.0	11.3	9.3	9.9
Health care delivery system	27.3	24.1	26.9	22.6	28.6	26.7
Church/Mosque	1.2	0.0	1.0	0.0	1.4	1.0
Other	2.3	0.0	2.0	0.0	2.9	2.0
Number of cases	**172**	**29**	**201**	**62**	**140**	**202**

	YFHS Implementing Status		Total	Facility Type		Total
	YFHS Facility	Non-YFHS Facility		Hospital	Health Center	
2. **Of those who have heard of YFHS, percent reporting to know services offered under the YFHS package:**	69.4 (170)	53.8 (26)	67.3 (196)	75.8 (62)	63.7 (115)	67.5 (197)
3. **Of those who know services provided under the YFHS package, percent stating:**						
General counseling	38.1	42.9	38.6	44.7	36.0	39.1
Contraceptive counseling	53.4	50.0	53.0	48.9	54.7	52.6
Distribution of contraceptives	50.8	57.1	51.5	51.1	51.2	51.1
Antenatal care	13.6	14.3	13.6	8.5	16.3	13.5
Delivery	3.4	7.1	3.8	0.0	5.8	3.8
Postnatal care	5.1	7.1	5.3	2.1	7.0	5.3
Treatment of abortion complications	5.1	7.1	5.3	0.0	8.1	5.3
HIV and AIDS counseling	66.1	57.1	65.2	70.2	61.6	64.7
HIV testing	52.5	64.3	53.8	46.8	57.0	53.4
Treatment and care for adolescents living with HIV	7.6	7.1	7.6	10.6	5.8	7.5
Prevention of mother-to-child transmission of HIV	3.4	7.1	3.8	2.1	4.7	3.8
STI services	18.6	14.3	18.2	21.3	16.3	18.0
Child/adolescent immunization	1.7	0.0	1.5	0.0	2.3	1.5
Child/adolescent growth & development monitoring	1.7	0.0	1.5	2.1	1.2	1.5
Curative services for women	1.7	0.0	1.5	0.0	2.3	1.5
Curative services for children	0.8	7.1	1.5	0.0	2.3	1.5
Nutrition	5.1	7.1	5.3	4.3	5.8	5.3
Monitoring & support for sexual abuse	5.1	0.0	4.5	4.3	4.7	4.5
Psychosocial support	5.1	0.0	4.5	6.4	3.5	4.5
Emergency contraception	3.4	7.1	3.8	2.1	4.7	3.8
Referral to health facility/other service delivery point	0.8	7.1	1.5	0.0	2.3	1.5
Referral for social services/psychosocial services	0.0	0.0	0.0	0.0	0.0	0.0
Other	2.5	0.0	2.3	2.1	2.3	2.3
Total	**118**	**14**	**132**	**47**	**86**	**133**
4. **Of those reporting that YFHS are provided in the facility of interview, percent who thought so because:**						
Only YFHS are provided in this facility	5.2	14.3	5.8	8.6	4.4	5.8
Health services are provided to youth by peer educators and other health providers in a separate room allocated to youth activities	15.6	0.0	14.6	20.0	11.8	14.6
Peer educators meet with youth on	37.5	0.0	35.0	28.6	38.2	35.0

	YFHS Implementing Status		Total	Facility Type		Total
	YFHS Facility	Non-YFHS Facility		Hospital	Health Center	
specific days of the week to discuss their health issues and provide required service						
Youth are given special attention when receiving services (youth providers give youth special attention the moment they know they are youth)	37.5	57.1	38.8	34.3	41.2	38.8
Other	11.5	28.6	12.6	11.4	13.2	12.6
Total (n)	**96**	**7**	**103**	**35**	**68**	**103**

As part of the evaluation, we assessed clients' knowledge of the youth health services being offered at the health facilities where they had just received services. . To do this, we identified some key health services[75] and asked them to state which ones were offered. The key health services identified by clients include counseling, distribution of contraceptives, HIV testing, STI management, and pregnancy testing. The results, presented in panels 1 to 6 of Table 6.3.4 below, show that except for counseling, which was reported by less than 50 percent of clients from facilities not implementing YFHS, high percentages of clients reported that the health facilities where they had just received services offer the key services. More clients reported availability of HIV testing (92 percent) than any other service. Following HIV testing are STI management (80.8 percent), pregnancy testing (80.5 percent), provision of contraceptives (70.6 percent), and counseling (60.8 percent). About 86 percent of clients who reported distribution of contraceptives reported that condoms are distributed to male and female clients. The percentages of clients reporting the availability of these services do not vary significantly by whether or not the health facility implements the YFHS package, or between health centers and hospitals.

In response to the question about whether clients received desired health services on the day of the interview, panel 7 shows that majority of the clients (87.2 percent) responded in the affirmative.

[75] Under the YFHS package, these are some of the services that should be provided at both the health center and hospital levels.

Table 6.3.4: Key Services Offered at Facilities Where Youth Were Interviewed

	YFHS Implementing Status			Facility Type		
	YFHS Facility	Non-YFHS Facility	All	Hospital	Health Center	All
1. Percentage reporting that health facility (HF) provides counseling	64.7	43.8	60.8	63.4	58.5	60.1
Number of cases[76]	**456**	**130**	**586**	**186**	**405**	**591**
2. Percentage reporting that the HF provides contraceptives	73.7	60.0	70.6	70.1	71.0	70.7
Number of cases	**456**	**130**	**586**	**187**	**404**	**591**
3. Of those reporting contraceptives, percent reporting that condoms are distributed to both male and female	87.5	77.5	85.6	85.8	85.7	85.5
Number of cases	**337**	**80**	**417**	**134**	**286**	**420**
4. Percentage reporting that the HF provides pregnancy testing	81.1	78.3	80.5	77.0	81.8	80.3
Number of cases	**455**	**129**	**584**	**187**	**402**	**589**
5. Percentage reporting that the HF provides STI management	83.1	72.9	80.8	85.5	78.7	80.8
Number of cases	**455**	**129**	**584**	**186**	**403**	**589**
6. Percentage reporting that the HF provides HIV testing	92.7	89.2	91.9	92.9	91.5	92.0
Number of cases	**451**	**130**	**581**	**184**	**402**	**586**
7. Percentage who received desired services on the day of interview	87.7	85.4	87.2	90.3	85.6	87.1
Number of cases	**455**	**130**	**585**	**186**	**404**	**590**

[76] Number of cases may vary due to missing information on some variables.

6.3.3. Knowledge of YFHS: FGD participants

Some youth FGD participants reported that they knew about facilities offering YFHS through the youth NGOs and community-based organizations (CBOs) with which they were associated. For example, participants in an FGD with female youth 20-24 in Nsanje said that Goal Malawi was working with the CBOs with which they were associated, and they knew about the services offered at Mbenje Health Centre through Goal Malawi. They also mentioned drama performances during which the health center staff informed members of the community about the services being offered. In the Mbenje Health Centre catchment area, the secretary of the youth CBO went from door to door to tell people about youth services available at the health facility. In Kasungu, some youth FGD participants reported knowing about the services offered by the Family Planning Association of Malawi (FPAM) because they are members of a youth group connected to FPAM. Some other young people said they knew about services offered by FPAM because FPAM staff visited their communities. Others said that BLM visited their schools and told them about the services they offer.
Other sources of information are captured in the following excerpts:

> "The health personnel explained [the services] to me when I went [to the clinic] for medical attention [to receive treatment]. I also heard about the services from other people and friends" (P2, FGD with young males, Lilongwe).

> "They [health facilities] even use posters to sensitize people on the services they offer" (P1, FGD with young males, Kasungu).

> "I saw posters that talked about YFHS when I came for HIV testing. Through that I learnt that there are YFHS" (P5, FGD with young males, Lilongwe).

Some health facilities have posters or signposts with a list of YFH services they provide. In an FGD with female youth aged 15-19 in Phalombe, participants said that the Holy Family Mission Hospital has a signpost with a list of YFHS it offers. In many FGDs, participants mentioned the radio and health workers as sources of information.

6.4. Utilization of YFHS

6.4.1. Community Survey Respondents

In Table 6.1.1, we show that ever use of YFHS does not vary by whether or not the youth live in a community with a YFHS-implementing health facility. We also show the percentage of youth who have used YFHS by zone. Table 6.1.2 shows significant variation in the use of YFHS by background characteristics. In this section, we examine in more detail use of YFHS by zone and background characteristics. The results are presented in Table 6.4.1.

As indicated above, ever use of YFHS was defined by a positive response to the question, "Have you ever been to a youth friendly health service delivery point?" with the word 'been' interpreted as 'sought services.' Table 6.4.1 and Graph 6.4 show that ever use of YFHS is highest in the South West (17.6 percent) and lowest in the South East (8.1 percent). In between the two zones are the North (15.1 percent), the Central East (14.8 percent), and the Central West (8.3 percent). The table also shows that in each zone, ever use of YFHS increases with age and is higher among sexually experienced youth (who as we noted above might be seeking services to prevent pregnancy and contraction of STIs). Variations in ever use of YFHS among subpopulation groups, defined by other background characteristics, differ across zones. For instance:

- Ever use of YFHS differs between in- and out-of-school youth only in the North and Central West, where out-of-school youth are more likely to have accessed YFHS. In other zones, ever use of YFHS does not differ significantly by current school attendance status.

- Youth with secondary or higher education reported higher use of YFHS in the North, Central East, and Central West. In the South East and South West, ever use of YFHS does not differ by levels of education.
- Youth who work for money are more likely to have accessed YFHS in the North and Central East; in other zones, ever use of YFHS does not differ by employment status.
- Ever use of YFHS does not vary between youth who listen to the radio at least once a week and their counterparts who do not listen to the radio. Among those who listen to the radio, ever use of YFHS does not vary by frequency of listening. Although the radio ranks high among sources of information on YFHS, it appears the information received through the radio has not influenced the use of YFHS. Ever use of YFHS does not differ significantly between youth who watch television at least once a week and their counterparts who do not watch television.

The results in Table 6.4.1 highlight the need to develop appropriate strategies to reach young persons at different lifecycle stages—defined by age, sexual experience, and in- or out-of-school status.

Graph 6.4: Ever Use of YFHS by Zone as Reported by Community Survey Respondents

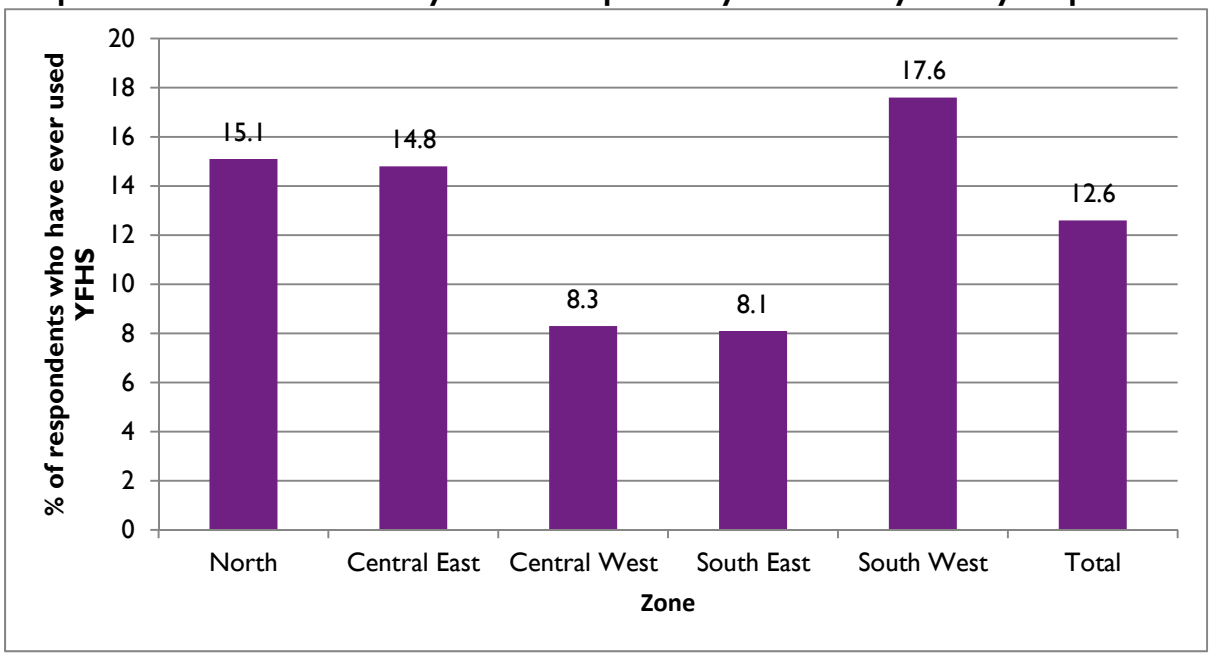


Table 6.4.1: Percentage of Community Survey Respondents (Youth) Who Had Been to a Youth-Friendly Health Services Delivery Point by Selected Characteristics and Zone

Characteristic	Percentage of respondents who have ever been to a YFHS delivery point					
	North	Central East	Central West	South East	South West	All
Age:						
10-14	3.4 (119)	6.6 (122)	1.6 (123)	0.8 (130)	11.8 (110)	4.6
15-19	14.5 (159)	19.3* (176)	10.6 (160)	8.8 (159)	18.5 (157)	14.4
20-24	27.3* (126)	16.8 (113)	12.2* (115)	13.5* (156)	22.2 (108)	18.1
Sex:						
Male	15.9 (207)	15.5 (238)	9.4 (203)	6.7 (179)	26.1 (184)	14.7
Female	14.3 (196)	13.9 (173)	7.3 (192)	9.0 (255)	9.5 (190)	10.6
Sexual experience:						
Ever had sex	27.1* (170)	25.5* (196)	13.9* (209)	12.4* (249)	21.9* (192)	19.5
Never had sex	6.4 (234)	5.1 (215	2.1 (189)	2.6 (196)	13.1 (183)	5.8
Marital Status:						
Never married	11.7 (342)	14.3 (343)	6.1 (311)	5.6 (305)	18.7 (294)	11.3
Currently married	31.1 (45)	15.3 (59)	17.9* (78)	12.6 (111)	13.2 (68)	16.6
Previously married	41.2* (17)	33.3 (9)	0 (9)	17.2* (29)	15.4 (13)	22.1
Current School Attendance Status:						
Out of school	26.7* (135)	16.6 (145)	12.6* (174)	10.4 (183)	15.4 (149)	15.8
In school	9.1 (265)	14.1 (263)	5.0 (221)	6.3 (238)	18.9 (212)	10.6
Never attended school	- (4)	- (3)	- (3)	8.7 (23)	21.4 (14)	12.8
Education:						
None	- (4)	- (3)	- (3)	8.7 (23)	21.4 (14)	12.8
Primary	10.7 (234)	12.4 (290)	6.0 (266)	4.1 (296)	14.3 (230)	9.3
Secondary & above	21.1* (166)	21.2* (118)	13.0* (129)	17.5 (126)	22.9 (130)	19.3
Type of Residence:						
Rural	12.9 (280)	12.0 (299)	9.3 (194)	9.9 (242)	18.7 (182)	12.4
Urban	20.2 (124)	22.3 (112)	7.4 (204)	5.9 (203)	16.6 (193)	13.0
Work to earn money:						
Yes	42.6* (40)	24.0* (75)	13.0 (92)	12.2 (82)	16.7 (60)	19.2
No	12.1 (364)	12.8 (336)	6.9 (306)	7.2 (362)	17.6 (315)	11.3
Length of stay (at place of interview):						
Less than 1 year	20.0 (30)	0.0 (25)	5.1 (39)	5.6 (18)	0 (20)	6.8
1-4 years	16.7 (90)	13.8 (80)	9.8 (92)	10.0 (80)	18.0 (50)	13.3
5-9 years	20.0 (55)	17.9 (30)	11.6 (43)	7.5 (40)	31.8 (22)	16.6
10-14 years	6.8 (103)	6.1 (99)	2.5 (80)	3.5 (115)	17.1 (105)	7.4
15-19	15.8 (76)	22.8* (114)	6.5 (81)	10.9 (101)	18.2 (110)	15.4
20 and above	22.7 (44)	22.0 (50)	19.2* (52)	10.8 (83)	19.7 (61)	17.9
Don't know	0 (6)	0 (4)	0 (11)	0 (8)	0 (7)	0
Frequency of listening to the radio:						
Almost everyday	18.0 (161)	21.3 (141)	11.9 (126)	10.6 (123)	14.5 (131)	15.5
At least once a week	16.4 (122)	12.0 (158)	9.0 (134)	9.7 (113)	22.5 (120)	13.8

Characteristic	Percentage of respondents who have ever been to a YFHS delivery point					
	North	**Central East**	**Central West**	**South East**	**South West**	**All**
Less than once a week	12.1 (33)	9.7 (31)	7.2 (69)	4.5 (66)	18.9 (37)	9.3
Never	9.1 (88)	11.1 (91)	1.4 (69)	6.3 (143)	14.9 (87)	8.5
Frequency of watching the TV:						
Almost everyday	23.1 (91)	13.3 (30)	12.5 (64)	16.1 (31)	15.6 (45)	17.2
At least once a week	11.1 (108)	26.4* (91)	10.3 (68)	1.7 (59)	23.6 (84)	15.4
Less than once a week	17.9 (56)	20.0 (50)	7.1 (84)	8.1 (74)	14.6 (48)	12.5
Never	12.1 (149)	9.8 (240)	6.1 (182)	8.5 (281)	16.7 (198)	10.5
Frequency of using Internet:						
Almost everyday	17.4 (23)	20.0 (5)	50.0 (10)	33.3 (9)	- (4)	27.5
At least once a week	25.0 (32)	9.1 (11)	13.3 (15)	16.7 (6)	- (4)	22.1
Less than once a week	18.2 (22)	0 (5)	20.0 (10)	25.0 (4)	40,0 (5)	10.6
Never	13.8 (327)	15.1 (390)	6.6 (363)	7.3 (426)	16.6 (362)	11.7
Religion:						
Catholic	21.0 (119)	12.4 (113)	8.5 (82)	16.7 (60)	12.0 (83)	14.4
Protestant	13.3 (248)	16.2 (278)	7.4 (285)	6.5 (154)	19.6 (260)	13.1
African church	- (2)	- (2)	- (2)	-- (3)	-	-
Muslim	10.0 (10)	- (2)	14.3 (21)	8.2 (158)	23.8 (21)	10.4
Other	8.0 (25)	6.7 (15)	14.3 (7)	4.5 (66)	0 (10)	5.7
All	**15.1 (404)**	**14.8 (411)**	**8.3 (398)**	**8.1 (445)**	**17.6 (375)**	**12.6**

(*) Indicates that at least one of the groups is different from the others with respect to the variable under discussion (p=0.05)

6.4.2. How Comfortable are Youth with Youth-Friendly Health Services? Information from FGDs

Since the likelihood of using YFHS depends to some extent on youth being comfortable with available services, we asked the young people, during the FGDs, to state how comfortable they are with accessing YFHS. Some participants, particularly the unmarried females, stated that they would not be comfortable accessing RH services at designated YFHS facilities. The reluctance to access RH services results from the general belief that a girl who starts using RH services before being pregnant or having her first child would destroy her womb. Some also stated that use of FP methods can cause cervical cancer. They noted that use of FP methods by a girl who has never had a child can also lead to a delay in her becoming pregnant in the future. Such delays in pregnancy can lead to divorce if the woman cannot have children. In an FGD with femal aged 20-24 in Nsanje, participants mentioned that although unmarried girls do access FP methods, they do so covertly to avoid attacks from witches. According to them, an unmarried girl who tries to access FP methods stands the risk of being bewitched, which would prevent her from having children, a situation that the community would later attribute to her use of FP methods (FGD reports from Nsanje). Some young people wondered why an unmarried girl would use FP:

> "I cannot go because I feel most of the services are for those that are married; for example, contraceptives" (P1, FGD with girls 15-19, Lilongwe).

> "I would not access the services because I am still in school. I just learn about HIV and AIDS and reproductive health at school, but I wouldn't go to the facility for reproductive health services" (P3, FGD with girls 15-19, Lilongwe).

Some male youth also said that they would not access RH services because they were not yet married:

> "I will not feel comfortable receiving reproductive health services because I have not married yet; I may just go there for HIV testing and counseling" (P3, FGD male youth, Kasungu).

These statements point to the misperception that RH services are for married people alone. Besides not being married, some youth FGD participants said that a lack of privacy prevents them from accessing RH services; many health workers know the young people in their area.

> "No I can't. I need new medical personnel. These ones are not appropriate. They know us as well as our parents and they end up telling them what we have sought from the hospital and our parents will be angry with us" (P4, FGD with male youth, Lilongwe).

A number of young people, particularly the married ones and those above 18, reported that they feel comfortable accessing RH services. They do not have problems accessing RH services because of personal benefits they could derive from the services: For instance:

> "I had a child but I wanted to go back to school so I decided to protect myself", (P2, FGD with female youth, Nsanje).

> "I am free to get FP methods but as of now I can't because my husband is away. When he comes back I will go and get them. If I take them now people might think that I have other sexual relationships," (P, FGD with female youth, Nsanje).

These responses show that while many older youth and those who have had children were willing to access RH services, only a few younger youth with no children reported willingness to access such services.

6.4.3. Experience of Community Youth Survey Respondents During First Visit to a YFHS Delivery Point

The community youth survey respondents who reported to have visited a YFHS delivery point were asked to provide more information on their first and last visits: how long before the survey the visits were made, where they received services, the services received, whether they received desired services, and for those who did not receive desired services, the reasons for not receiving them. The data on first visit to a YFHS delivery point are presented in Table 6.4.2. The table shows that:

- The majority of youth who reported to have visited a YFHS delivery point visited for the first time in the 12 months preceding the survey—62.5 percent overall; 68.9 percent in the North, 57.4 percent in the Central East, 50 percent in Central West, 61.1 percent in South East, and 67.3 percent in South West. The majority of first visits in the "one or more years" category actually took place in the one to two years before the survey. This finding suggests that utilization of YFHS has gained track only in the last year or two across the country.
- Although there are slight variations among zones in the percentages of first visits that took place in different service delivery points listed in panel 2 of Table 6.4.2, the most common ones are: government health center (39 percent overall), government hospital (18.9 percent overall), private hospital/clinic/doctor (5 percent), and BLM (4.7 percent). The predominance of public health facilities as the first place of visit might be due to the fact that most, if not all, the services are free.
- The young people obtained services that cut across the spectrum of YFHS packages at the health center and hospital levels of care—contraceptive methods (40.3 percent), HIV testing and counseling (36 percent), general counseling (30.2 percent), contraceptive counseling (17.8 percent), and prevention, diagnosis, and management of STIs (5.4 percent). There are variations among the zones in the percentage of youth who received these services during their first visit to the YFHS delivery points.
- Almost all the young people reported to have received the desired services the first time they visited the YFHS delivery points (95.2 percent in the North, 96.7 percent in the Central East, 97 percent in the Central West, 91.7 percent in the South East, and 92.2 percent in the South West).

Table 6.4.2: Experience During First Visit to the YFHS Delivery Point: Community Survey Respondents

		North	Central East	Central West	South East	South West	All
1	**Percentage who made the first visit:**	**(61)**	**(61)**	**(32)**	**(36)**	**(61)**	**(251)**
	Within the past one year	68.9	57.4	50.0	61.1	67.3	62.5
	1 or more years ago	31.1	36.1	42.8	38.9	32.6	35.5
	Don't know	-	6.6	6.3	-	-	2.4
2	**Percentage who received YFHS from the following SDPs during the first visit:**						
	Public Health Facilities:						
	Government Hospital	14.5	17.5	21.3	13.9	26.2	18.9
	Government Health Center	30.6	23.8	39.4	44.4	58.5	39.0
	Govt. Health Post/Outreach	4.8	6.3	6.1	-	-	3.5
	HSA	1.1	11.1	-	2.8	1.6	3.9
	CBDA/Door to Door	3.2	0	6.1	5.6	-	2.3
	Other	-	1.6	-	-	1.6	0.8
	CHAM/MISSION:						
	Hospital	1.6	3.2	-	8.3	3.1	3.1
	Health Center	1.6	4.8	3.0	5.6	-	2.7
	PRIVATE SECTOR:						
	Hospital/Clinic/Doctor	3.2	7.9	9.1	2.8	3.1	5.0
	CBDA/Door to Door	3.2	3.2	-	2.8	1.6	2.3
	Other	-	3.2	6.1	-	1.6	1.9
	Banja La Mtsogolo	8.1	4.8	3.0	8.3	-	4.7
	MCRO	12.9	1.6	3.0	-	-	3.9
	Youth Drop in Center	1.6	3.2	3.0	2.8	-	1.9
	OTHER SOURCES:						
	Market/Shop	1.6	-	-	-	1.6	0.8
	Church	1.6	-	-	-	-	0.4
	Other	8.1	11.1	6.1	5.6	4.7	7.4
3	**Percentage who received the following services during the first visit:**	**(62)**	**(61)**	**(33)**	**(36)**	**(66)**	**(258)**
	General counseling	27.4	19.7	24.2	30.6	45.5	30.2
	Contraceptive counseling	16.1	23.0	6.1	16.7	21.2	17.9
	Obtain contraceptive methods	48.4	34.4	33.2	47.2	37.9	40.3
	HIV testing and Counseling	33.9	34.4	30.3	36.1	42.4	36.0
	Referral to other health facility/service delivery point	-	3.3	-	-	1.5	1.2
	Prevention, diagnosis and management of STIs	1.6	4.4	6.1	-	12.1	5.4
	Antenatal, delivery, and postnatal care services	1.6	1.6	3.0	2.8	1.5	1.9
	Other	17.7	11.5	18,2	8.3	6.1	12.0
4	**Percentage who reported to have received the services they wanted during the first visit:**	95.2 **(62)**	96.7 **(61)**	97.0 **(33)**	91.7 **(36)**	92.2 **(64)**	94.6 **(256)**

		North	Central East	Central West	South East	South West	All
5	**Of those who reported to have not received the desired services, number who stated the following as reason(s):**	**(3)**	**(1)**	**(1)**	**(3)**	**(4)**	**(12)**
	Service not available	1			2	1	4
	Service provider not available	1	1		1		3
	Shy/afraid to ask				1	1	2

6.4.4. Experience of Community Youth Survey Respondents During Last Visit to a YFHS Delivery Point

In this section, we examine the experience of clients during their most recent visit to a YFHS delivery point to assess any changes in services desired and where they sought them between the first and last visits. Some indicators of quality of service were examined: privacy of discussion, disclosure of health conditions to other people by providers, respect for clients, and satisfaction with services. Significant findings from the data, presented in Table 6.4.3., include:

- The overwhelming majority of last visits to YFHS were in public health facilities. Although there are slight variations among zones in the percentage of last visits that took place in each of the service delivery points, the most commonly cited are: government health center (40.7 percent); government hospital (16.3 percent); private hospital/clinic/doctor (5.1 percent); MACRO (3.5 percent); CHAM health center (3.5 percent); and BLM (3.4 percent). Table 6.4.4 shows the predominance of public health facilities among youth living in communities with YFHS-implementing health facilities or in communities without YFHS-implementing facilities.
- About 78 percent (79.9 percent of those in communities with YFHS-implementing health facilities and 77.7 percent of those in communities without YFHS-implementing facilities) reported that the service delivery point they last visited is located in their community—68.5 percent in the North, 78.2 percent in the Central East, 80.6 percent in the Central West, 68.6 percent in the South East, and 89.1 percent in the South West (panel 2). Not all of them visited a health facility located in their community. While several factors could influence young people's decision to seek services outside of their communities, FGD participants reported that they sometimes do so to avoid being seen by other community members who might report them to their parents.
- As was the case during their first visits to YFHS delivery points, the youth obtained services that cut across the spectrum of YFHS packages at the health center and hospital levels during their last visits to the YFHS delivery points (panel 3). These services include uptake of contraceptive methods (44.7 percent), HIV testing and counseling (32.9 percent), general counseling (29.8 percent), contraceptive counseling (18.9 percent), and prevention, diagnosis, and management of STIs (8.3 percent).
- About nine in ten (92.5 percent) YFHS users reported to have received the desired services the last time they visited the YFHS delivery points (95.2 percent in the North, 86.7 percent in the Central East, 97 percent in the Central West, 94.4 percent in the South East, and 92.2 percent in the South West) (panel 4). As highlighted earlier, satisfying customer needs is a facilitator of service utilization. The percentage of YFHS users who felt that service providers could share their discussions and test results with others is generally low (panels 6, 7, 8, and 9).
- About nine in ten (92.6 percent) YFHS users expressed satisfaction with the service they received during their last visit: 94.9 percent in the North, 96.4 percent in the Central East, 93.9 percent in the Central West, 88.2 percent in the South East, and 88.7 percent in the South West (panel 10).

- Over 90 percent of YFHS users felt that the YFHS program offers youth some benefits which include: (i) services that are focused on the needs of youth; (ii) a program that enables the youth to receive health care on time; (iii) a program that protects the privacy of youth (panels 11 and 12).

Table 6.4.3: Experience During Last Visit to the YFHS Delivery Point: Community Survey Respondents

	North	Central East	Central West	South East	South West	All
1. Percentage who received YFHS from the following places during the last visit:						
Public health facilities:						
• Govt. hospital	16.1	8.1	15.2	20.0	23.1	16.3
• Govt. health center	27.4	31.7	39.4	42.9	61.5	40.7
• Govt. health post/outreach	14.8	6.3	6.1	-	-	3.5
• Mobile clinic	1.6	-	-	5.7	-	1.2
• HSA	-	3.2	-	-	-	0.8
• CBDA/door to door	8.1	7.9	6.1	8.6	1.6	6.2
• Other	-	3.2	-	2.9	1.6	1.6
CHAM/MISSION:						
• Hospital	1.6	1.6	-	5.7	3.1	2.3
• Health center	3.2 -	4.8	6.1	5.7	=	3.5
PRIVATE SECTOR:						
• Hospital/clinic/doctor	1.6	11.1	9.1	-	3.1	5.1
• CBDA/door to door	4.9	1.6	3.0	-	3.1	2.7
• Other	-	3.2	6.1	-	3.1	
BLM	8.1	1.6	3.0	5.7	-	3.5
MACRO	9.7	3.2	3.0	-	-	3.5
Youth drop-in center	3.2	-	3.0	2.9	-	1.6
OTHER SOURCES:						
• Friend/relative	-	-	3.0	-	-	
• Other	6.5	11.1	=	2.9	1.6	5.1
2. Percentage who reported to have obtained services from a facility located in their community:	69.5 **(59)**	78.2 **(60)**	80.6 **(31)**	68.6 **(35)**	89.1 **(64)**	77.9 **(249)**
3. **Percentage who reported to have received the following services during the last visit:**	**(54)**	**(54)**	**(30)**	**(35)**	**(55)**	**(228)**
• General counseling	16.7	25.9	20.0	40.0	45.5	29.8
• Contraceptive counseling	20.4	20.4	13.3	20.0	18.2	18.9
• Obtain/purchase contraceptive methods	51.9	38.9	50.0	45.7	40.0	44.7
• HIV testing and Counseling	31.5	40.7	36.7	28.6	27.3	32.9
• Referral to other health	-	3.7	3.3	-	1.8	1.8

	North	Central East	Central West	South East	South West	All
facility/other service delivery points						
• Prevention, diagnosis and management of STIs	1.9	11.1	3.3	2.9	18.2	8.3
• Antenatal, delivery and postnatal care services	1.9	1.9	3.3	5.7	1.8	2.6
• PMTCT	-	-	-	2.9	-	0.4
• Treatment of sexual abuse (including PEP)	-	1.9	-	2.0	=	0.9
• Other	1.9	3.7	-	2.9	-	1.8
4. Percentage who reported to have received the services they wanted during the last visit:	95.2 **(59)**	86.7 **(52)**	97.0 **(32)**	94.4 **(34)**	92.2 **(59)**	92.5 **(236)**
5. Of those who reported to have not received the desired services, number who stated the following as reason(s):	**(4)**	**(7)**	**(1)**	**(2)**	**(3)**	**(17)**
• Service not available	3	5	1	2	2	13
• Service too expensive	1	1				2
• Service provider not available		2		1		3
• Shy/afraid to ask	1			1		2
• Other					1	
6. Percentage who reported that someone entered the room while consultation was going on:	10.2 **(59)**	24.1 **(54)**	6.1 **(33)**	14.7 **(34)**	9.5 **(63)**	13.2 **(243)**
7. Percentage who felt that health service provider might discuss results of consultation with other people without their knowledge	6.9 **(58)**	12.7 **(55)**	15.2 **(33)**	14.7 **(34)**	9.7 **(62)**	11.2 **(242)**
8. Percentage who felt that health service provider might discuss test results with other people without their knowledge:	5.1 **(59)**	16.4 **(55)**	9.1 **(33)**	6.1 **(33)**	**1.8** **(57)**	7.8 **(237)**
9. Percentage who felt that health service treated them with disrespect:	1.7 **(59)**	9.1 **(55)**	6.1 **(33)**	11.8 **(34)**	4.8 **(62)**	6.2 **(243)**
10. Percentage who felt satisfied with services received:	94.9 **(59)**	96.4 **(55)**	93.9 **(33)**	88.2 **(34)**	88.7 **(62)**	92.6 **(225)**

	North	Central East	Central West	South East	South West	All
11. Percent who felt there are benefits in using health services:	91.0 **(145)**	91.9 **(136)**	95.6 **(90)**	89.3 **(112)**	86.1 **(158)**	90.3 **(641)**
12. Of those who felt there were benefits, percentage who stated the following as benefits:	**(132)**	**(125)**	**(86)**	**(100)**	**(136)**	**(579)**
• Focused on health needs of youth	72.7	64.8	59.3	55.0	82.4	68.2
• Enables youth to receive timely health care	41.9	38.4	47.7	56.0	55.1	47.5
• Protects privacy of youth	10.6	16.8	14.0	3.0	24.3	14.5
• Good relationship with health provider	6.1	6.4	8.1	9.0	10.3	7.9
• Other	13.6	16.0	14.0	8.0	2.0	10.7

Table 6.4.4: Last Service Delivery Point by Zone and Type of Community

	North		Central East		Central West		South east		South West	
	YFHS IMP[a] (YI)	**YFHS NIMP (YN)**	**YI**	**YN**	**YI**	**YN**	**YI**	**YN**	**YI**	**YN**
Public Health Facilities:										
• Govt. hospital	17.0	13.3	8.2	7.7	19.2*	0	14.8	37.5	31.1	5.0
• Govt. health center	23.4	40.0	32.0	30.8	26.9	85.7*	48.1	25.0	51.1*	85.0
• Govt. health post/outreach	6.4	0	8.0	0	7.7	0	0	0	0	0
• Mobile clinic	2.1	0	0	0	0	0	3.7	12.5	0	0
• HSA	0	0	4.0	0	0	0	0	0	0	0
• CBDA/door to door	6.4	13.3	8.0	7.7	7.7	0	11.	0	0	0
• Other	0	0	2.0	7.7	0	0	3.7	0	2.3	0
CHAM/MISSION:										
• Hospital	0	6.7	0	7.7	0	0	7.4	0	4.5	0
• Health center	0	13.3	4.0	7.7	3.8	14.3	0	25.0	0	0
PRIVATE SECTOR:										
• Hospital/clinic/doctor	2.1	0	12.0	7.7	11.5	0	0	0	4.5	0
• CBDA/door to door	6.4	0	2.0	0	3.8	0	0	0	4.5	0
• Other	0	0	0	15.4	7.7	0	0	0	0	0
BLM	10.6	0	2.0	0	3.8	0	7.4	0	0	0
MACRO	12.8	0	2.0	7.7	3.8	0	7.4	0	0	0
Youth drop-in center	4.3	0	0	0	3.8	0	0	0	0	0

OTHER SOURCES:										
• Friend/Relative	0	0	0	0	3.8	0	0	0	0	0
• Other	4.3	13.3	14.0	0	0	0	3.7	0	2.3	0
Number of cases	**47**	**15**	**49**	**13**	**26**	**7**	**27**	**8**	**45**	**23**

6.4.5. Quality of Service from Clients' Perspectives

Exit interview respondents were asked how they felt about the services they had just received during their last visit, prior to being interviewed. The questions covered quality of care issues such as: waiting time, provider attitude, privacy of discussion, level of interaction between client and provider, and respect for the client. Responses to these questions provide insight into the timeliness and adequacy of services and help to identify service elements that require strengthening/improvement. Each of the questions has a response category that is indicative of a good quality service and the percentages of respondents that gave those responses are presented in Tables 6.4.5 - 6.4.7. For Tables 6.4.5 and 6.4.6, the percentages were calculated separately for clients who received services from health facilities implementing the YFHS package and those who received services from facilities not implementing the YFHS package. Table 6.4.5 shows that in only 1 of the 20 service elements—*client was encouraged by service provider to ask questions*—was there a significant difference between facilities implementing the YFHS package and those not implementing the package. The percentage of clients who reported to have been encouraged by the provider to ask questions was significantly higher among clients who received services from health facilities not implementing YFHS. Table 6.4.5 shows that there is room for improvement in the way YFHS are delivered. For instance, in 7 of the 20 service elements, less than half of clients gave responses that are indicative of good-quality services. These results confirm the low implementation of standards observed in the preceding chapter.

The percentage of clients who gave responses that are indicative of good-quality services are examined by zones (Table 6.4.7). The table shows that at the zonal level, there are more quality of service elements in which significant differences exist between facilities that are implementing YFHS and those that are not. For instance:

- In the North, clients from facilities implementing YFHS were more likely to report that they waited for less than 15 minutes before receiving services and that the health facility equally serves both young men and women; however, higher percentages of clients from facilities not implementing YFHS reported that they believed the information they shared with the provider would be kept confidential.
- In the Central East, a higher percentage of clients from facilities implementing YFHS reported that they were asked by the provider to return for another visit; on the other hand, a higher percentage of clients from facilities not implementing YFHS reported that they were treated very well by other providers during visit.
- In the South East, a significantly higher percentage of clients from facilities not implementing YFHS reported that: they were encouraged by the provider to ask any other question; they were treated very well by the provider during the visit; they were asked by the provider to return for another visit; and they felt that the physical environment of the facility was very good. In this zone, clients from facilities not implementing YFHS appear more positive about the services being provided.
- In the South West, a higher percentage of clients from facilities not implementing YFHS reported that they were asked to return for another visit.

Besides showing variations in the percentage of clients who gave responses that are indicative of good-quality services by zone, the results show that across zones there is work to be done to improve quality of services.

Table 6.4.5: Clients' Perceptions of the Quality of Services Obtained on the Day of Interview

Service elements (quality of service indicators)	Type of facility		Total	
	YFHS facility	Non-YFHS facility	%	n
	457	**130**		
1. Waited for less than 15 minutes	35.9	30.0	34.5	579
2. Felt that he/she received the information he/she wanted	77.0	78.5	77.3	577
3. Was encouraged by the provider to ask any other questions*	39.0	48.8	41.2	573
4. Was treated very well by the provider during the visit	51.6	58.6	53.1	578
5. Was treated very well by other providers during the visit	42.4	53.5	44.9	575
6. Was treated very well by the registration staff during the visit	45.9	48.4	46.4	573
7. Was treated very well by the other support staff during the visit	42.3	50.4	44.1	567
8. Felt that that the provider's explanations during the visit were easy to understand	93.8	93.7	93.8	576
9. The provider did not do or say anything that made him/her uncomfortable	96.0	96.9	96.2	578
10. The provider did not do or say anything during the visit that led him/her to believe that the provider did not approve of him/her	96.9	100.0	97.6	578
11. Said that no one could hear the conversation he/she had with the provider	80.4	76.7	79.6	578
12. Met with the provider in a separate room	84.9	88.4	85.6	578
13. Felt meeting with the provider was private	74.6	81.2	76.1	577
14. Believed that the information he/she shared with the provider will be kept confidential	83.5	90.7	85.1	578
15. Was asked by the provider to return for another visit	44.5	51.9	46.2	578
16. Felt that the facility equally serves both young men and young women	79.5	72.1	77.8	577
17. Felt that the physical environment of the facility (cleanliness, toilet, waiting area) was very good	40.1	41.9	40.5	575
18. Said that educational materials were available in the waiting room	64.6	68.9	65.6	549
19. Said that the educational materials in the waiting room were relevant to him/her	88.6	90.4	89.0	373
20. Said that the signs or posters in the waiting room were relevant or appealing to the youth	62.6	61.7	62.4	574

*p<0.050

Table 6.4.6: Clients' Perceptions of the Quality of Services Obtained on the Day of Interview by Zone

Indicator Client:	North Zone		Central East Zone		Central West Zone		South East Zone		South West Zone	
	YFHS facility	Non-YFHS facility	YFHS facility	Non-YFHS facility	YFHS facility	Non-YFHS facility	YFHS facility	Non-YFHS facility	YFHS facility	Non-YFHS facility
	89	**29**	**80**	**28**	**87**	**25**	**113**	**20**	**88**	**28**
Waited for less than 15 minutes	48.3*	13.8*	40.5	64.3	34.1	20.0	30.4	35.0	27.6	17.9
Felt that he/she received the information he/she wanted	83.1	82.8	78.5	89.3	70.8	80.0	72.7	60.0	81.0	75.0
Was encouraged by the provider to ask any other questions	49.4	50.0	27.8	34.6	26.2	36.0	44.1*	75.0*	44.7	53.6
Was treated very well by the provider during the visit	56.2	44.8	45.6	69.2	50.0	44.0	55.0*	90.0*	49.4	53.6
Was treated very well by other providers during the visit	48.3	51.3	36.7**	73.1**	39.3	36.0	45.9	70.0	40.0	40.7
Was treated very well by the registration staff during the visit	48.3	44.8	41.0	57.7	41.7	28.0	50.5	78.9	45.9	40.7
Was treated very well by the other support staff during the visit	47.2	51.7	35.4	61.5	35.7	28.0	52.7	73.7	36.2	42.3
Felt that that the provider's explanations during the visit were easy to understand	93.3	93.1	93.6	100.0	88.1	92.0	95.5	89.5	97.7	92.9
The provider did not do or say something that made him/her uncomfortable	96.6	96.6	96.2	96.2	97.6	100.0	93.4	90.0	96.6	100.0
The provider did not do or say something during the visit that led him/her to believe that the provider did not approve of him/her	96.6	100.0	93.7	100.0	97.6	100.0	97.3	100.0	98.9	100.0
No one could hear the conversation they had with the provider	80.9	75.9	81.0	85.2	74.7	80.0	87.4	75.0	75.9	67.9
Met with the provider in a separate room	84.3	93.1	88.6	96.3	73.5	80.0	86.5	80.0	90.8	89.3

Felt that his/her meeting with the provider was private	77.5+	96.9+	81.0	84.6	61.4	72.0	80.2	75.0	71.3	75.0
Believed that the information he/she shared with the provider will be kept confidential	74.2*	100.0*	82.3	88.9	89.2	76.0	87.4	90.0	83.9	96.4
Was asked by the provider to return for another visit	62.9	58.6	41.8*	14.8*	47.0	60.0	36.0**	70.0**	36.8*	60.7*
Felt that the facility equally serves both young men and young women	84.1*	69.0*	83.5	63.0	73.5	80.0	75.7	80.0	81.6	71.4
Felt that the physical environment of the facility (cleanliness, toilet, waiting area) was very good	34.1	27.6	38.5	51.9	47.1	32.0	43.1*	80.0*	37.2	28.6
Said that educational materials were available in the waiting room	57.0	73.1	61.0	53.8	74.1	70.8	63.2	70.0	68.8	76.9
Said that the educational materials in the waiting room were relevant to him/her	92.3	94.4	95.9	100.0	83.6	94.1	85.9	100.0	87.7	70.0
Said that the signs or posters in the waiting room were relevant or appealing to the youth	61.4	53.6	65.4	74.1	66.7	68.0	55.0	65.0	66.7	50.0

*p<0.050; **p<0.01.

Table 6.4.7 shows the percentage of clients who gave responses that are indicative of good-quality services by type of YFHS delivery approach. Of the 20 quality-of-service elements examined, there are only 7 on which the clients' perceptions differed by service delivery approach. The seven elements measure adequacy of information received, respect from service providers, privacy and confidentiality of discussion with service providers, and the physical environment of the facility. A clear relationship does not emerge between the service delivery approach and clients' perceptions of the quality of services they receive from the health facilities. However, in five of the seven quality-of-service elements on which clients' perceptions differed significantly, higher percentages of clients from health facilities implementing the integrated approach gave responses that are indicative of good quality. Specifically, Table 6.4.7 shows that clients who received services from a health facility that implements the integrated approach were most likely to state/feel that:

- They were treated very well by the provider during the visit.
- They were treated very well by the registration staff during the visit.
- They were treated very well by other support staff during the visit.
- No one could hear the conversation they had with the provider.
- The physical environment of the facility (e.g., cleanliness, toilet, waiting area) was very good.

Clients who received services from health facilities that offer services through health facility-based peer educators and CBDAs in a separate space reserved for youth activities were most likely to state that:

- They received the information they desired.
- Their meeting with the service provider was private.

Table 6.4.7: Client's Perceptions of the Quality of Services Obtained on the Day of Interview by YFHS Delivery Approach

Indicator	Approach to service delivery					All
	Separate space within health facility (HF) using HF-based peer educators	Separate space in the HF (using HF-based peer educators) combined with community activities (using CBDA)	YFHS only on specific days of the week using the CBDAs (Specific youth days/activities + CBDA youth activities	Integrated services provided to all clients at the same place but clients 10-24 are offered YFHS package on identification	Other	
Number of respondents	**29**	**47**	**128**	**243**	**9**	**456**
Waited for less than 15 minutes	44.8	47.8	39.4	31.6	33.3	36.3
Felt that he/she received the information he/she wanted *	73.3	87.2	65.1	81.7	77.8	77.0
Was encouraged by the provider to ask any other questions	44.8	38.3	29.7	44.8	33.3	39.6
Was treated very well by the provider during the visit*	31.0	48.9	45.3	59.7	22.2	52.0
Was treated very well by other providers during the visit	24.1	44.7	36.5	48.1	33.3	42.7
Was treated very well by the registration staff during the visit***	20.7	43.5	38.1	55.1	0.0	45.9
Was treated very well by the other support staff during the visit*	24.1	42.6	36.1	49.2	0.0	42.4
Felt that that the provider's explanations during the visit were easy to understand	96.6	97.9	93.7	92.2	88.9	93.4
The provider did not do or say something that made him/her uncomfortable	96.6	95.7	94.5	95.9	100.0	95.6
The provider did not do or say something during the visit that led him/her to believe that the provider did not approve of him/her	96.6	97.9	94.5	96.7	100.0	96.3
No one could hear the conversation they had with the provider **	79.3	80.9	74.0	84.4	66.7	80.4
Met with the provider in	79.3	85.1	81.9	87.2	77.8	84.8

a separate room						
Felt that his/her meeting with the provider was private*	58.6	80.9	71.7	76.5	66.7	74.3
Believed that the information he/she shared with the provider will be kept confidential	82.8	74.5	85.0	85.2	77.8	83.7
Was asked by the provider to return for another visit	48.3	48.9	38.6	47.7	22.2	44.8
Felt that the facility equally serves both young men and young women	69.0	78.7	79.5	81.0	66.7	79.3
Felt that the physical environment of the facility (cleanliness, toilet, waiting area) was very good*	23.3	34.0	40.2	44.4	22.2	40.3
Said that educational materials were available in the waiting room	64.3	69.6	59.7	67.4	42.9	64.9
Said that the educational materials in the waiting room were relevant to him/her	94.4	93.9	80.5	91.7	100.0	89.2
Said that the signs or posters in the waiting room were relevant or appealing to the youth	62.1	57.4	57.5	68.3	44.4	63.3

*p<0.050; **p<0.01; ***p<0.001

6.5. Uptake of YFHS

For this analysis, uptake of services was measured by the number of youth that health facility-based service providers[77] reported as having received services. YFHS providers in YFHS-implementing facilities and youth-focused service providers in non-implementing facilities were asked to provide data on the number of youth served in the two years preceding the survey. The data were used to examine recent changes in the volume of youth served in the surveyed facilities. The data are presented in Table 6.5.1 and organized by YFHS-implementing and YFHS non-implementing facilities. Only facilities that reported data for two periods—October 2011-September 2013 and October 2012-September 2013—were included in the analysis.[78]

Table 6.5.1 shows that the number of youth served between October 2012 and September 2013 was slightly higher than the number served between October 2011 and September 2012[79] in both YFHS-implementing and non-implementing facilities,[80] with the exception of the North and Central West. In those two zones, the number of youth served in YFHS-implementing health centers from October 2012 to September 2013 was slightly lower than the number served from October 2011 to September 2012. Although the data suggest modest or little improvements in service utilization during the two-year period, they nevertheless indicate a trend in the right direction.

[77] We attempted to collect service statistics from district coordinators with a view to having a district-level picture of service utilization. However, the data are of poor quality and are incomplete in many respects. They cannot be used for this evaluation. This evaluation highlights the weak state of data collection, management, and use at the district level.

[78] Some facilities did not report data for either of the two periods, while some reported data for one of them. Of the 46 YFHS-implementing health facilities surveyed, 27 provided data for the two periods, and of the 14 YFHS non-implementing facilities, only 9 reported data for the two periods.

[79] We would like to note that not all the figures were verified by the interviewers. Some service providers did not show their registers or reporting forms to the interviewers.

[80] There was no attempt to compare the volume of clients between zones or between YFHS-implementing and non-implementing health facilities as the facilities are of different sizes. Our interest is in examining the trend in client volume over time.

of Youth Reported by Service Providers to Have Accessed YFHS in the Two Years Preceding the Survey
ember 2013)

	North		Central East		Central West		South East		South West		All	
	Oct 2011 – Sep 2012	**Oct 2012 – Sep 2013**	**Oct 2011 – Sep 2012**	**Oct 2012 – Sep 2013**	**Oct 2011 – Sep 2012**	**Oct 2012 – Sep 2013**	**Oct 2011 – Sep 2012**	**Oct 2012 – Sep 2013**	**Oct 2011 – Sep 2012**	**Oct 2012 – Sep 2013**	**Oct 2011 – Sep 2012**	**Oct 2012 – Sep 2013**
	4	4	7	7	4	4	10	10	2	2	27	27
	19,170	16,195	50,792	58,577	48,020	56,022	17,343	28,901	4,950	6,152	14,0275	165,847
	35 (1)	60 (1)	14,089 (3)	15,936 (3)	23,537 (2)	27,658 (2)	1,320 (2)	6,160 (2)	-	-	11,502 (8)	14,438 (8)
	6,378 (3)	5,378 (3)	2,132 (4)	2,692 (4)	474 (2)	353 (2)	1,837 (8)	2,072 (8)	2,475 (2)	3,076 (2)	2,440 (19)	2,649 (19)
	Oct 2011 – Sep 2012	Oct 2012 – Sep 2013	Oct 2011 – Sep 2012	Oct 2012 – Sep 2013	Oct 2011 – Sep 2012	Oct 2012 – Sep 2013	Oct 2011 – Sep 2012	Oct 2012 – Sep 2013	Oct 2011 – Sep 2012	Oct 2012 – Sep 2013	Oct 2011 – Sep 2012	Oct 2012 – Sep 2013
	2	2	2	2	1	1	1	1	3	3	9	9
	864	900	810	1,088	6,356	9,388	1,000	1,200	7,127	7,310	16,157	19,786
	-	-	405 (2)	544 (2)	-	-	-	-	6,000 (1)	6,000 (1)	2,270 (3)	2,362 (3)
	432 (2)	450 (2)	=	=	6,356 (1)	9,388 (1)	1,000 (1)	1,200 (1)	564 (2)	605 (2)	1,557 (6)	2,116 (6)

Chapter 7: Factors Influencing Utilization of Youth-Friendly Health Services

7.1. Introduction

One of the major objectives of this study was to examine factors that influence uptake of YFHS. Consequently, attempts were made to examine the following aspects: (i) parents' and community leaders' knowledge of and support for their wards' use of YFHS and (ii) youth perceptions of their health needs, acceptability, and accessibility of YFHS, and the extent to which YFHS meet their health needs. Because youth, particularly those below the age of 18, require parental consent to participate in several health and social programs, parents' level of knowledge of the program, including their perceptions of the need for the program, their appreciation of the program benefits, their perceptions of the cultural appropriateness of the program and consequent acceptability or unacceptability of the program play a major role in determining whether youth will utilize the program or not. As custodians of community norms and values, community leaders can work against programs that they do not perceive to enhance moral values or benefit the community at large. Consequently, a major strategy of any program for youth should be to raise awareness of the parents and community leaders on the benefits of the program for youth and society at large. Information for this chapter was collected mainly from FGDs among parents and youth, and in-depth interviews with community leaders.

7.2. Most Important Health Problems/Issues of Youth: Youth and Parent FGD Participants and Community Leader In-depth Interview Respondents

Health programs are likely to be more effective and acceptable when they meet the perceived health needs of youth. A means of assessing the likelihood that health services will be used is to determine whether the perceived health needs of the target populations align with the health needs that the health services are expected to meet. As a part of this evaluation, FGD participants (both youth and parents) were asked to identify the major health problems/issues, and by implication the major health needs, of youth in the community. In most cases, responses from parents aligned with those of the young people themselves. Besides mentioning health problems/issues that are similar to those mentioned by youth, several parents were able to state perceived causes of some health problems. A few parents stated that the reluctance of the youth to discuss or disclose their problems to their parents makes it difficult for them to mention specific health problems/issues affecting youth. However, across all districts and zones, the majority of parents mentioned one or more youth health problems.

7.2.1. HIV and AIDS and STIs

HIV and AIDS and STIs were the health problems most commonly mentioned by youth and parents as major health problems affecting youth, with female parents pointing to HIV as becoming more significant problem than other STIs in recent years. Community leaders also mentioned HIV and STIs as the most common health problems affecting youth. FGD participants had extensive discussions about the causes of HIV and STIs, with many of them attributing them to unprotected (multiple) sexual relationships among youth. Regarding the role of unprotected sex in STI contraction, a male youth FGD participant in Nsanje said:

> "Contracting sexually transmitted infections is another problem faced by the youth. They contract these diseases because the health personnel deny them of condoms and other medicines" (P4, FGD with male youth 15-19, Nsanje).

Some parents highlighted the role excessive alcohol consumption plays in HIV infection, particularly through unprotected sex with commercial sex workers. Once the youth are drunk, said some parents, they find it difficult to control their desires for sex. By having unprotected sex with commercial sex workers who frequent bars, they become exposed to HIV infection. Some female youth, particularly those aged 20-24, blamed husbands' infidelity for HIV infection within the household. After contracting HIV through extramarital affairs, these men in turn infect their wives. While some youth blamed husbands for infecting their wives, in a number of male parent FGDs, participants blamed female youth who seduced men sexually with their provocative clothing:

> "[Sexual] problems arise from girls who put on miniskirts with the aim of seducing boys to have sex with them with this resulting in transmission of HIV/STIs. Government should introduce punishments for these girls and they should be jailed for one week" (P5, FGD with male parents, Kasungu).

While youth can be infected with HIV when they become sexually active, in a number of FGDs, participants also talked about youth who become infected through mother to child transmission of HIV:

> "HIV/AIDS is really affecting the youth because some of them are born with the infection from their parents and they start to show signs of AIDS before they get married or when they are very young" (P2, FGD with female youth 15-19, Nsanje).

7.2.2. Early Unwanted Pregnancies

Another common health issue mentioned by both parents and youth themselves is early and unwanted pregnancy. Besides being infected with HIV, several young people and parents said that the other consequence of unprotected sex is unwanted pregnancy. Table 3.5.2 confirms unwanted pregnancy as a major health issue among youth. Asked if the last pregnancy was desired at the time it occurred, only 43.4 percent[81] of ever-pregnant female youth wanted their last pregnancy. Many FGD participants remarked that female youth engage in unprotected sex with much older men for monetary returns:

> "The youth of today are not scared of having relationships with old people—they sleep around with older men with the result that you have 13- or 14-year-olds having unwanted pregnancies" (P1, FGD with female parents, Lilongwe).

Again, the tendency for female youth to have a relationship with much older men was confirmed by the community youth survey respondents. Table 3.4.3 reveals that about 28 percent of sexually experienced female youth had sexual partners who were five or more years older than them.

While discussing the causes of unwanted pregnancy, a female youth FGD participant in Karonga added that girls *sell their bodies* because they are poor, and in the process of selling their bodies, they become pregnant. The participants remarked that premarital sex has become the order of the day with unwanted pregnancies becoming very common. Besides the pregnancy being unwanted, another major concern relates to the fact that many girls are not able to support themselves and are often abandoned by their sexual partners once they become pregnant. A female parent FGD participant in Kasungu noted that:

[81] The percentage wanting the last pregnancy declines with age. Among the 20-24 year-olds who had been pregnant, the percentage wanting the last pregnancy is 46.1; among the 15-19 year-olds, the percentage is 38.9, and among the 10-14 year-olds, the percentage is 0.

"Today, girls go on their own to their boyfriends' houses. There are some old men who have sexual relationships with them and when they become pregnant the men abandon them. This is seen as a big problem because children's rights are being abused" (P1, FGD with female parents, Kasungu).

Parents also expressed concerns about early pregnancies for other reasons. First, the parents are often called upon to assume the responsibility of taking care of the pregnancy (once the girls are abandoned by their boyfriends) and subsequently the baby, since the young girl does not have the resources to take care of herself or her child. This deprives families of resources to take care of other children. Secondly, parents are aware that girls who get pregnant early will experience difficulties during labor and may even die in the process. Thirdly, parents are concerned that young women who did not want a pregnancy might resort to unsafe abortion and die in the process:

"Female youth get pregnant early and they try to abort by taking medicines and they may die in the process" (P2, FGD with female youth 20-24, Kasungu).

Finally, girls who get pregnant too early stand at risk of not being married later in life. This is because men do not want to get married to women who already have children from other men.

7.2.3. Early Marriage

Besides HIV and AIDS/STIs and early pregnancies, parents and youth FGD participants also mentioned early marriage as an issue affecting young people. According to data from the community survey, 40 percent of ever-married female youth had married by the time they were 17 years old (Table 3.1). Unfortunately, as stated by many FGD participants, many female youth have no control over when and who they marry as they are forced into early marriages by their parents or guardians. Early marriage becomes more of an issue when it is associated with gender-based violence. The FGD participants remarked that young wives stand the risk of being abused by their much older husbands and that when this happens, the young wives often find it difficult to leave their abusive husbands and return to their parents/guardians who forced them into early marriage in the first place.

"Young ladies are forced into marriages by their parents. Female youth, even if they are physically abused, cannot return to their parents' home since it is their parents who forced them to get married" (P4, FGD with female youth 20-24, Nsanje).

7.2.4. Challenges in Accessing Health Services

In addition to HIV and AIDS and STIs, early unwanted pregnancies, and early marriage, parent and youth FGD participants and community leaders mentioned the following service delivery-related barriers to young people accessing health services: shortage of medicines, overcrowding in health facilities, non-availability of certain services, and nurses reporting late for duties:

"Overcrowding in hospitals is another problem. The youth stand in a queue for a long time to access the services they need and in the process many of them become discouraged" (P7, FGD with male parents, Lilongwe).

"…… When we want to get condoms they [nurses] ask us about our age and where we are coming from. They also ask us if we have ever been tested for HIV. After being asked all these questions, we are told that there are no condoms. This discourages us from going to health facilities" (P8, FGD with male youth 20-24, Kasungu).

"There are not enough condoms in health centers. We go to the health centers to access condoms but we are told to come back another day as they are finished" (P6, FGD with male youth 15-19, Lilongwe).

According to the FGD participants, youth get discouraged when desired services are not available or when they are being asked a lot of questions they do not see as relevant to obtaining desired services. Some youth who do not have access to free health services in public health facilities mentioned the inability to pay for some health services as a major constraint to seeking services. Some youth FGD participants also accused health workers of 'favoritism,' alleging that they (health workers) give condoms only to individuals they know or who give them money. The youth also stated that they find it difficult to access services provided by adults:

"Many youth are not comfortable accessing youth-friendly health services because many providers are adults; therefore, they don't understand us" (P2, FGD with male youth, Lilongwe).

The preceding discussion shows that what parents and youth identified as health problems/issues faced by youth are the ones the YFHS program is supposed to address. The YFHS program was established to reduce the incidence and prevalence of HIV and AIDS and STIs, prevent early unwanted pregnancy, and promote late marriage, and provide services that are accessible, acceptable, and affordable to all. The next section examines how the health needs of youth are traditionally addressed to determine the degree of complementarity or contradiction between traditional methods and the YFHS program.

7.3. Addressing Health Problems of Youth: The Traditional Way

Attempts were made in the FGDs to examine how parents have addressed youth health problems in order to determine the extent to which the YFHS program complements or contradicts traditional health-seeking practices. Reports from various FGDs show that parents help youth address their health problems/concerns through:

- Counseling/general advice on how to lead a productive and healthy life
- Offering problem-specific solutions, like marrying off girls who become pregnant early or helping them readjust to life by sending them back to school after delivery
- Being directly involved in seeking help for their children at the health facilities

7.3.1. Counseling/Advice on Leading Productive and Healthy Life

In almost all parent FGDs, parents said that they usually counsel or advise their children on how to lead a productive and healthy life. Such advice is sometimes disease-specific and sometimes not. For instance, perceiving education as a means to achieving a better life, physically and economically, parents reported that they have always encouraged their children to get an education. Their disease-specific advice focuses on the need for children *to protect themselves against contracting diseases.* The parents expressed discontent with children not following their advice. Female parent FGD participants in Nsanje reported that children who refuse to follow their advice are usually reported to their fathers or other adults in the community who advise them on their behalf. One major issue that came out of the discussions was the uneasiness of parents with discussing SRH issues with their children; hence they usually invite others to do it for them:[82]

"There are times when I cannot advise my children because of cultural values; as a result I invite other people to counsel them" (P1, FGD with female parents, Lilongwe).

[82] This approach is similar to referral to a professional counselor in the YFHS program.

Parents reported that they have usually advised their children against premarital sex, excessive alcohol drinking, and smoking *chamba*. This advice is intended to help youth prevent early pregnancies and HIV/STIs infection. Female youth are usually reminded of the negative consequences of early pregnancy, particularly the potential difficulties they face during child birth.

7.3.2. Offering Problem-Specific Solutions: The Example of Early Pregnancy

Parents also offer solutions when problems arise. For example, in the case of early pregnancy, the parent FGD participants reported that girls who become pregnant are sometimes married off according to prevailing customs. A female parent FGD participant in Karonga had this to say:

> "They [parents] ask their daughter if she is pregnant and if she answers in the affirmative, they send her to an aunt who enquires about the person responsible for the pregnancy and then arrangements are made to marry the girl off" (FGD, female parents, Karonga).

Not all girls are married off when they become pregnant. In situations where pregnancies are disowned by the alleged boyfriends, parents usually assume the responsibility of taking care of the daughters and their babies. The parents assume this responsibility because the girls do not have the resources to adequately take care of themselves and their babies. In some households, the girls are sent back to school after delivery. A female parent FGD participant in Nsanje gave an example of how her daughter who became pregnant when she was in Standard 8 was sent back to school after delivery. According to her, the daughter was in Form 3[83] at the time of data collection in November 2013. She said the daughter would not be married until she finishes school.

7.3.3. Direct Involvement of Parents in Seeking Care

One other way in which parents have addressed the health problems/concerns of youth is by direct involvement in where, how, and when they seek health services. Many parents did not express any objection to youth seeking health services from health facilities, but stated that they should be the ones seeking help for their wards at these facilities. Where required, they should be the ones paying for the services. Some parents said that in order to avoid paying or to minimize costs, the youth should go to public health facilities that offer free services.

Recognizing their inability to act alone in all cases, some parent FGD participants identified teachers as potential advisers on health and recognized the role of organizations in the provision of necessary assistance to youth. According to the parents, CBOs and NGOs can play a role in counseling services for youth:

> "Youth clubs like community-based organization, for example Chusuwe CBO, do counsel youth on HIV/AIDS and nutrition issues and sporting activities" (P6, FGD with female parents, Kasungu).

7.3.4. Are the YFHS Program and Traditional Ways of Helping Youth to Address Health Concerns Complementary or Contradictory? Analysis of Reports from Parent FGD Participants

In this section, we present a brief analysis of reports from parent FGD participants about how they perceive the relationship between the YFHS program and traditional values and practices related to sex, and parental role in the provision of SRH information and services to youth. While the preceding

[83] Malawi operates an 8-4-4 system in which a person spends 8 years in primary school (Standards 1-8), then 4 years in secondary school (Form 1-4), and then 4 years at university.

section suggests that parents do not object to their wards[84] seeking health services as long as they are involved, analysis of reports on the YFHS program tend to suggest that parents who reported knowledge of the YFHS program felt that the program erodes traditional values on sex and reduces parental control over health-seeking practices. Many parents did not see how the YFHS program provides information that other community members were observed to have provided on behalf of parents who were unable to do so. A number of studies confirm the role of other community members in the dissemination of information on sex. Studies show that while most societies teach young people SRH issues, the role of parents as sex educators is limited. Instead of parents, traditional counselors, such as *angaliba* and *anankungwi,* counsel young people about sex.[85] Traditionally, extended family members (aunts, uncles, and grandparents) are also the main providers of SRH information to young people, and in recent times, a significant percentage of youth have obtained SRH information from friends.[86] The major concern with these traditional sources of information is the high probability of providing inaccurate information because of lack of knowledge or misperceptions about SRH issues.

With parents unable to disseminate some SRH information and the possibility that information from other traditional sources could be inaccurate, it might be expected that parents would see the YFHS program as complementing their role and guaranteeing more accurate SRH information than is provided by traditional sources of information. Counter to this expectation, parents in the FGDs emphasized how YFHS erode traditional values through the provision of SRH information, why they perceive as encouraging sex rather than promoting abstinence. For instance, male parent FGD participants in Lilongwe expressed disapproval of YFHS promoting condom use since doing so contradicts their traditional value of promoting abstinence before marriage. Male parents in Nsanje had this to say:

> "Youth nowadays like sexual intercourse and as a result they differ from the traditional ways of our community which emphasizes abstinence. This was not the case in the past" (P11, FGD with male parents, Nsanje).

While parents appeared to blame the YFHS program for promoting sex, they did not mention traditional practices that tend to promote sex rather than abstinence. For instance, a Malawi Human Rights Commission report noted that in some parts of Malawi, boys are circumcised and are advised to have sex soon after circumcision in a rite called *kutaya mafuta* (which means spilling the oil). The belief is that if boys do not have sex immediately after circumcision, their penis will shrink and become too small for sex.[87] This practice is now being counteracted by Christian religious denominations which have introduced counseling services that discourage premarital sex.[88]

One other traditional value that the parents felt has been eroded by the YFHS program is parental control. Parents expressed that the introduction of YFHS has reduced their control over what services youth can obtain and where to obtain them since young people can obtain desired information and services without their permission. According to the parent FGD participants in Karonga, in the absence

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[84] In Malawi, children under the care of parents are sometimes referred to as wards.

[85] Jimmy-Gama, D.B., An assessment of the capacity of facility-based youth friendly reproductive health among unmarried adolescents: evidence from rural Malawi. PhD Thesis (Queen Margaret University, 2009).

[86] Also see Maleta, T. *Parent and child communication on sexual and reproductive health matters in Malawi* (Blantyre: College of Medicine, 2006).

[87] Malawi Human Rights Commission, *Cultural practices and their impact on the enjoyment of human rights, particularly the rights of women and children* (Human Rights Commission, Lilongwe, Malawi, 2006)

[88] Munthali, A.C. and E. Zulu, "The timing and role of initiation rites in preparing young people for adolescence and responsible sexual and reproductive behavior in Malawi," *African Journal of Reproductive Health* (2006) II (3):150-167.

of parental control, youth are now exposed to SRH information and services that give them the impression they know everything, can have sex when they want, and obtain information and services where and when they desire. In the process of doing things their own way, youth ignore traditional advice:

> "In the past, parents used to monitor whether we had sex with a man or not. If one married as a virgin people would celebrate. This helped us to abstain from having sexual intercourse. However, this tradition no longer exists" (FGD with female parents, Karonga).

> "The provision of these services to youth has caused more harm than good. Our children do not listen to us anymore. Instead of abstaining they go for contraceptives. Even a Standard 6 girl is found with STIs/ HIV or is found pregnant. They look healthy on the outside, but they are rotten inside" (FGD with female parents, Karonga.)

Section 7.3.4 shows that there appears to be a disconnect between the perceptions of YFHS program implementers and parents regarding how culturally appropriate the services provided by the YFHS program are, particularly those related to the provision of SRH information and services. While program implementers and evaluators might perceive the YFHS program as complementing traditional practices and parental roles, the parents feel otherwise. This finding has implications for how much the program is accepted and supported by parents.

7.4. Parents' Perceptions About Youth

In FGDs with parents and interviews with community leaders, participants were asked about their perceptions of youth. Negative perceptions can result in diminished support for youth-centered programs, even when such programs are not perceived to erode traditional values, whereas positive perceptions of youth can lead to increased support. Parents' perceptions of youth are varied. In a few FGDs, parents perceived youth as a great resource to them, the community, and the nation. In the home, youth help with household chores, and most parents would like their children to go to school so that in future they can get good jobs and lead independent lives. By working, they would be in a better position to assist their parents financially.

In most cases, however, parents' and community leaders' perceptions about youth were quite negative. Youth were perceived as stubborn and disobedient, as illustrated by this male parent in Lilongwe:

> "We do advise our children, but usually they don't obey us because they are very stubborn. In our presence they pretend to be innocent and obedient, but when they meet in their groups they end up doing immoral things" (P4, FGD with male parents, Lilongwe).

While some parents continue to advise their children, others have given up because they are afraid of the reactions from youth; some young people were reported to be intimidating. In addition the way young people concerned some parents. Female parents in Lilongwe had this to say:

> "I do not do anything because I fear my child. My child almost strangled me when I tried to advise her; she left me with scars" (P5, FGD with female parents, Lilongwe).

> "As much as they [youth] are helpers at home, there are areas of concern, particularly the way they dress these days. Young girls are not dressing well—you see them in miniskirts, surging cloths, and when you try to talk to them they answer back that it is their right" (P7, FGD with female parents, Lilongwe).

Parents and community leaders were concerned about what the future holds for youth:

> "The future of most youth is uncertain because of the things they are involved in, for example bad dressing, drinking, smoking, and prostitution; when they contract infection, they don't go to the hospital for fear of being ridiculed and/or stigmatized" (P3, FGD with male parents, Lilongwe).

> "The youth do a lot of bad things, such as engaging in premarital sex, but they never go to the hospital to get tested; their behavior is worse when compared to that of the youth of our time" (P8, FGD with male parents, Lilongwe).

> "These days girls and boys go early into marriages. You find 12-year-old girls already pregnant, and this is a huge problem", (P3, FGD with female parents, Kasungu).

Despite being perceived as sometimes rude and disrespectful, the parents still felt that the young people should be guided on SRH issues. The parents noted that one of the challenges to helping them with SRH issues is the lack of transparency between them and their children, especially concerning SRH issues:

> **"**Openness with our children is a major challenge. Many of us feel it is unethical or morally wrong to discuss sexual and reproductive health issues with our children. Consequently, most of our children learn sexual issues from their friends and usually they are misled" (P5, FGD with male parents, Lilongwe).

7.5. Community Expectation of Youth

What does the community expect from youth and how do the expectations inform the way they feel about the behaviors of youth? To answer these questions, community leaders were asked to state what the community expects from youth aged 10-24 regarding sex, marriage, and childbearing. The findings are presented in sections 7.5.1-7.5.3. It is important to note that, like parents, community leaders expect youth to complete their education and be employed in order to help their parents in the future. They are also expected to help implement development projects in their respective communities. The community leaders, however, added that while the community expects youth to go to school, many of them drop out because of lack of funds for school fees.

7.5.1. Community Expectation of Youth 10-24: Marriage

Most community leaders said that the community considers youth aged 20-24 as mature and that they can get married, especially if they are not attending school:

> "We know that at that age they are fully grown and they can go into marriage" (male community leader, Karonga).

A few community leaders, however, said that the community still thinks of youth aged 20-24 as young people who should postpone marriage until they finish their education. Youth aged 15-19 were perceived by community leaders as too young to marry; they expressed the view that this age group should focus on their education. A community leader in Karonga said that they speak out publicly against marriage among youth aged below 20:

> "This age (15-19) is too early for marriage and we speak on this during funerals and community meetings" (male community leader, Karonga).

The community leaders acknowledged that youth aged 15-19 still get married no matter what they say or do. Regarding marriage among youth aged 10-14, the community leaders stated that this age cohort is too young to get married; rather than thinking of marriage, the 10-14 year-olds should focus on getting an education.

7.5.2. Community Expectations of Youth 10-24: Sex

Most community leaders stated that youth aged 20-24 can have sex and that they are aware that they already are. They remarked that this is the right age to start having sex. One community leader even added that any young man or woman in this age group who does not show interest in having a sexual partner should be encouraged to do so. For youth aged 15-19, most community leaders stated that they are too young to engage in sex, as most of them are still in school. However, the community leaders acknowledged the difficulty of getting youth in this age group to practice abstinence; hence they usually advise them to use a method of protection when engaging in sexual activities. For the 10-14 year-olds, all the community leaders were against them having sex because they are too young:

> "No. No. They (youth 10-14) should never have sex. In fact, they cannot enjoy the fruits of sex because they are too young" (male community leader, Karonga).

> "I know they are involved [in sex], but through schools we encourage them to concentrate on school and that their time to have sex will come" (female community leader, Nsanje).

7.5.3. Community Expectation of Youth 10-24: Childbearing

Most community leaders said that the community expects youth aged 20-24 to start childbearing because they are physiologically mature. Some community leaders added a condition that childbearing should occur only among those who are married. A few perceived those aged 20-24 as not mature enough and stated that childbearing should start at a later age. The community leaders acknowledged that there are a lot of cases of teenage pregnancies and childbearing which the community does not encourage because the youth are not physiologically mature. They also said there have been many complications during pregnancy among women in this group. No community leader supported childbearing among youth aged 10-14.

The discussion in sections 7.5.1-7.5.3 shows that the attitudes of parents about sex, marriage, and childbearing among young people are informed by community expectations/values. The community does not expect youth, particularly those below 20 and unmarried, to engage in sex, marriage, and childbearing. However, as stated above, some traditional practices promote sex among youth and hence run counter to expectations expressed here.

7.6. Attitudes Toward Youth Accessing RH Services

7.6.1. Parents and Community Attitudes to Youth Accessing RH Services

The reactions of parents to their children or wards accessing RH services varied. In most parent FGDs, participants were against their children using contraceptive methods. Use of contraceptive methods was perceived as culturally inappropriate, particularly for youth aged below 15 years. The parents could also not understand why unmarried girls should use contraceptive methods. Some parents even stated that they would beat or stop paying the school fees of the young people under their care found to be using contraceptive methods. In Nsanje and Lilongwe, parents had this to say about the use of contraceptive methods by young people:

"I cannot allow a 10-year-old child to go to the hospital and get condoms, but for a 15-year-old I can allow him or her to go get condoms" (P7, FGD with female parents, Nsanje).

"I found my 11-year-old son with a condom. I reprimanded him about this and told him he was too young to be found with condoms. I also told him that was a spirit of prostitution and that it would bring him diseases" (P9, FGD with male parents, Lilongwe).

"For the male child I would not worry because he is protecting himself from diseases. For the girl I would not be happy because if she is getting injectables at an early stage she can end up being barren because injections destroy the uterus" (P5, FGD with female parents, Nsanje).

The latter statement shows that while some parents tolerate their sons having sex and using condoms to prevent STIs, they do not tolerate their daughters' use of contraceptive methods. Also, many parents expressed disapproval of their children seeking RH services. A few of them stated that they would be happy to see their children access RH services if that would help them protect themselves against diseases and prevent unwanted/early pregnancies:

"I like the idea of young people accessing RH services. This could help our children find help for their health problems. As a parent, I can also advise my child on the things that health personnel have shared with him or her. For example, if my child wants to use injections as a family panning method, as a parent I would enlighten the child on how the injection would prevent pregnancy, but there would be room for contracting STIs" (P4, FGD with female parents, Karonga).

7.6.2. Community Support for Youth to Use RH Services

Community support for youth to access RH services varies across communities. While some communities provide support for youth to access RH services, in others support is limited or non-existent. In general, while communities give some support to youth to access non-contraceptive health services, like HIV testing and counselling, there is little support for use of contraceptive methods, except under special circumstances:

"Parents cannot be happy with youth accessing RH services and the whole community cannot accept the idea that youth should access such services" (participant, FGD with male parents, Phalombe).

"If a 10-year-old child is found HIV positive, I can help her access the medicines and ensure that she follows the dosage", (Participant, FGD with female parents, Karonga)

"If the child is pregnant, we escort her to the hospital for pregnancy test and antenatal care services" (participant, FGD with female parents, Karonga).

7.6.3. Youth Perceptions About How Their Parents Would React if They Accessed RH Services

Youth FGD participants stated that the way parents would react to their children accessing RH services depends on the parents' level of education and understanding of RH issues. While some parents with little education might not understand why their children are accessing RH services and hence accuse them of immoral behavior, more educated parents might have better understanding of RH issues and consequently be more open to youth seeking RH services. Most of the youth, particularly the unmarried, in-school youth, said their parents would not be happy to know that they were accessing RH services.

Some youth reported that seeking or using contraceptive methods often gives parents the impression that a girl is ready for marriage since she is already having sex; consequently parents tend to encourage girls who are seeking or using contraceptives to get married. Some youth also reported that girls who are found to be using contraceptives are often punished by parents:

> "My parents would beat me up if they knew that I went to the hospital to get contraceptives" (P3, FGD with female youth 10-15, Lilongwe).

Some youth tend to align with parents' disapproval of youth accessing RH services by stating that they could not understand why female youth, especially those who have never been pregnant nor had a child would use FP methods. According to them, RH services should be for those who are married. Many single, in-school youth, expressed discomfort accessing RH services:

> "I cannot go because I feel most of the services, for example contraceptives, are for those who are married" (P1, FGD with girls 15-19, Lilongwe).

> "I would not access the services, because I have not yet started using them. I am still in school. I just learned about HIV/AIDS and reproductive health at school, but I wouldn't go to the facility for reproductive health services" (P3, FGD with girls 15-19, Lilongwe).

> "I may not feel comfortable to receive reproductive health services because I am not yet married. I may just go there for HIV testing and counseling" (P3, FGD male youth Kasungu)

Youth were also of the view that girls who have never been pregnant or have never had a child can get their wombs destroyed if they use FP methods

While in most cases youth reported that their parents and community members disapprove of their accessing RH services, in a few cases, they reported that some parents would be happy to know that their children are using something to prevent HIV and pregnancy. The youth reported that some parents actually encourage their daughters to use contraceptive methods:

> "My parents encouraged me to go and access contraceptives because they were of the view that I may have another child (since I already have one). They advised me to get injectables when I least expected to hear that from my parents. Some parents do sit down with their children and explain things to them for the children to understand" (P3, FGD with female youth 20-24).

For married female youth or single mothers, parents and community members tend to be more favorable to their using contraceptives, as is the case with P3 above. For these categories of youth, some parents even assist the young people to access contraceptive methods.

Because of the perceptions that their parents are likely to disapprove of their accessing RH services, many youth do not inform their parents of their intentions to use contraceptives. Rather than talk to their parents, they discuss their intentions with friends who share condoms they receive from the health services.

7.6.4. Who Makes Decisions On Youth Accessing YFHS?

In most parent FGDs, participants stated that the youth, and not them (parents), make decisions about what YFHS to access and where to access them:

"The youth are found in bushes having sex when they are supposed to be in school. When you ask them what they were doing to prevent pregnancy or avoid contracting STIs they say there are condoms around. So should we say I am the one who has made a decision for them here?" (FGD with female parents, Karonga).

"They (youth) do not even open up to tell us if they have a boyfriend/girlfriend. We know after things have gone wrong but we can never tell them to go and get these services" (P7, FGD with female parents, Lilongwe).

However, in a few instances, parents reported that they still have some influence on the types of YFHS accessed by their wards and where to access those services:

"All powers to determine whether youth should receive YFHS are in the hands of the parents." (P12, FGD with male parents, Lilongwe).

"Sometimes parents encourage their children to access family planning methods to avoid getting pregnant. They even tell their children that considering the way they are behaving it is important that they use family planning methods" (P2, FGD with female parents, Kasungu).

Some parents argued that since they brought up these children, they should be the ones to make decisions related to the children accessing YFHS; what services to obtain and where to obtain them.

Most community leaders also said that youth make decisions on their own regarding accessing YFHS. Youth are often assisted in their decisions by peers who have used the services and, consequently, are in a position to advise them about what contraceptive methods to get and where to get them. Young people do not usually tell parents of their intentions to use RH services because they believe that their parents would not approve of their accessing these services.

7.6.5. Should Parents be Notified of Their Children Seeking RH Services?

Parents were divided as to whether service providers should notify them of their children seeking RH services. While some parents did not see the need for service providers to notify them, others felt that parents should be notified because, as parents, they deserve to know what is going on in the lives of their children. Parents who did not think service providers should notify them argued that their children, and not the service providers, should be the ones to tell them if they wanted them to know. Since the children did not tell them, they should not expect the service providers to tell them about the services their children were seeking:

"It is not right (to expect service providers to notify parents of services the children are seeking) since most parents do not allow their children to access reproductive health services in the first place; therefore, if the child has decided to access these services it is his or her right" (P2, FGD with male parents, Kasungu).

"It is not right because it is confidential. This is why the child did not tell the parent when he or she was going for the services. It is wrong for the health personnel to disclose to us as parents what they discussed with our wards. It is better for the health workers to just treat the child and keep us out of it" (P8, FGD with male parents, Kasungu).

Besides the issue of confidentiality, some parents did not want to be notified of the services being sought by their children because they felt they might react badly if they knew. Participants in a female parent FGD stated that they would be so disappointed knowing that their children accessed RH services

that they could resort to beating them. Others argued that asking service providers to notify them of their children's RH-seeking behavior places too much burden on the service providers; it would be too much to expect service providers to notify every parent. Most community leaders also stated that parents should not be notified of their children seeking RH services because this should be confidential.

As indicated above, opinions differ among parents as to whether they should be notified of their children seeking RH services. Parents who stated that they should know argued that they have the right to know what their children are doing and that such knowledge would help them to better assist their children:

> "If the medical personnel notifies parents about the services their children have accessed or are accessing, the children will feel more comfortable or freer to use the services since they know that their parents are aware" (FGD with female parents, Karonga).

Some of these parents stated that the youth should be denied RH or any services unless they come with parents, or if there is evidence that parents have consented. They argued that they have seen cases of married women who have been denied services at health facilities because they went alone without their husbands; hence this can be applied to the children as well.

7.7. Barriers to Accessing YFHS

The barriers to use of YFHS were examined from different respondents—youth in the community, health facility clients, service providers, youth coordinators, parents, community leaders, and NGO managers. A number of these barriers have already been touched upon in earlier chapters and in the preceding sections of this chapter. Besides the negative attitudes of parents, it has been shown that knowledge of YFHS is low across the country, not only among youth, but also among their parents. As stated earlier, youth can only access YFHS if they are well informed of their availability and benefits. Parents can only encourage their wards to access YFHS if they are also aware of these services and their benefits. Chapter 6 shows that only about one-third of the community youth survey respondents aged 10-24 had heard about YFHS and that the majority of the parents did not know about YFHS. Community leaders also reported that lack of knowledge on YFHS makes it difficult for youth to access these services. In this chapter, it has also been shown that among both parents and youth, there are misconceptions about RH services. For example, there is the perception that the use of injectables will destroy the womb or cause cancer; some people also believe that FP methods are for adults and youth who are married. Such misconceptions make it difficult for youth to access FP methods. In the subsequent paragraphs, we present a summary of other barriers mentioned by different respondents.

7.7.1. Long Distance to the Nearest Health Facility

Almost 14 percent of community youth survey respondents mentioned the distance to YFHS as a challenge to accessing them. For youth in some local communities, the only way they can access YFHS is to travel to the district headquarters when the district hospitals and the FPAM clinics are located. Parent and youth FGD participants as well as community leaders reported that having to travel long distances to access YFHS is a disincentive. They noted that even for those who do not live too far from a YFHS delivery point, inadequate transport make a visit to the YFHS challenging and consequently unappealing. The CBDA system was introduced to mitigate the effects of long distances to health facilities by making certain services available at the community level. Unfortunately, in many places, the CBDA system has not been highly effective due to inadequate transport that make it challenging for CBDAs to cover their large catchment areas, particularly for those who provide services across many villages. Some CBDAs reported that they serve large catchment areas, and because they do not have adequate transportation, are not able to provide services in all the communities they are expected to

cover. Consequently, youth in such communities who are not able to travel to the nearest health facility are not able to access YFHS.

7.7.2. Cost of Services

In the community youth survey, about 4 percent of respondents said that services are not free (Table 7.1). This is especially true for youth in the catchment areas of CHAM facilities that charge user fee. Although user fees may not yet constitute a major barrier, since they affect a small percentage of youth, user fees and some other costs that youth reported to be covering out of pocket could become a major barrier in the future, particularly among unemployed youth with no resources. Some youth reported that they currently pay for some items like health passport books in public health facilities, where services are supposed to be free.

7.7.3. Unfriendly Services and Low Self-Confidence

Almost one-fifth (19.7 percent) of community survey respondents who reported not accessing YFHS cited 'shyness' as a reason. Some youth FGD participants also reported that many young people do not access RH services because they are shy. Although being shy is considered a personal characteristic, it is a barrier to accessing YFHS as it reflects low self-confidence that is linked to social barriers—judgmental attitude of service providers and/other clients or lack of privacy. Some female FGD participants stated that girls are generally uncomfortable asking for certain services because of what other people might think of them. They noted, for instance, that many girls who would have requested condoms failed to do so for the fear of being labeled sex workers:

> "Sometimes we fail to access reproductive health services because of shyness. Youth fail to go and collect condoms because we are concerned about what other people will say" (P1, FGD with male youth 15-19, Kasungu).

> "Most of the youth are shy to go and get contraception at the hospital' (P5, FGD with female youth 10-15, Lilongwe).

7.7.4. Long Waiting Times and Inconvenient Opening Times

Over half of the client exit interview respondents reported to have waited for more than 15 minutes before obtaining services on the day of the interview. In a few youth FGDs, participants reported that long waiting times at health facilities are a barrier to accessing YFHS:

> "There are usually a lot of people at the hospital in a day which makes it difficult to be attended to" (P1, FGD with female youth 10-15, Lilongwe).

Participants in a male youth FGD in Phalombe reported that congestion at health facilities, which could result in some youth spending a whole day at the health facility, discourages youth from accessing YFHS. The long queue, they reported, sometimes results from late openings. Youth who arrive early have to stay on the queue until the facility opens. Unfortunately, some of the facilities close early leaving only a short interval for people to obtain services. In Nsanje, the female youth FGD participants reported that the facility opens at 9 or 10 a.m. and closes at 12 noon for lunch, even when there are people on the queue; sometimes, the facility may not reopen till 2 or 3 .pm. In Kasungu, female FGD participants aged 20-24 complained about not having any facility that offers YFHS at night.

7.7.5. Non-availability/Denial of Services

Non-availability of services could discourage youth from seeking services. Youth go to health facilities to obtain desired/needed services and in some cases have found out that the health facility is closed, the health worker is not available, or the services are not available on that day:

> "Sometimes we go there for certain services but they are not offered; for example we may want condoms and contraceptive methods, but these may not be available" (P4, FGD with male youth 15-19, Nsanje).

> "When you visit the hospital and you want to get condoms you will find that the condoms are out of stock and you come back without them. If you go there again and you do not find the condoms, you will be discouraged and not go again" (P3, FGD with male youth, Lilongwe).

> "There was a time I visited the hospital and was sent back because it had run out of medicines. This makes it impossible for one to access the required service" (P3, FGD with male youth 10-14, Nsanje).

Some youth FGD participants reported that they are sometimes sent back home and asked to come back the following day simply because the nurse is off duty. Others reported that very young adolescents are sometimes denied services. They reported that in some cases service providers refuse to provide services to youth below the age of 18. In Phalombe, youth FGD participants stated that health workers do not provide contraceptive methods to young people below 18 because they (health worker) believe provision of contraceptive methods to youth below 18 promotes promiscuity/immoral behavior. The issue of youth being denied services was also reported in some FGDs with parents.

7.7.6. Lack of Privacy and Confidentiality

Youths' doubts about their privacy and confidentiality related to test results, discussions with health workers, and services obtained constrain access to YFHS. Although a high percentage (85.1 percent) of community youth survey respondents who have accessed YFHS expressed confidence that the SRH services obtained will be kept confidential by service providers, this feeling was not shared by the general population of youth. The youth FGD participants expressed concerns about the confidentiality of test results and remarked that since the health workers know them and their parents, there is a chance that they could divulge their discussions and information about the SRH services they obtained to their parents. A male youth FGD participant remarked that:

> "When one is found HIV positive, hardly does a month pass by after that before other people know that one is HIV positive" (FGD with male youth 15-19, Nsanje).

Some youth FGD participants remarked that rather than seek health services at the health facility nearest to them, they would rather seek services when organizations outside their communities of residence visit their communities to provide services. Some youth also expressed concerns about being identified at the YFHS delivery points by other members of their communities who could then report the visit to their parents:

> "Youth are also afraid of meeting community members such as friends, parents, and relatives" (P7, FGD with female youth 15-19, Lilongwe)

> "The maternity wing is very close to where youth-friendly health services are offered. I have friends who have told me they have STIs and when I tell them to go to the hospital they ask to know how I expect them to go through the maternity ward where the pregnant women are waiting. This is

problematic. It would be good if government should take into consideration the need for youth friendly health services to be provided in separate locations that will make more youth to feel comfortable" (P2, FGD with males 20-24, Kasungu).

Community leaders also expressed concerns about confidentiality. They said that youth are not sure if their health problems are going to be kept confidential and reported that there have been instances where providers inform parents of youth accessing FP methods in their facilities.

7.7.7. Making HIV Testing and Counseling as a Condition for Other Services

HIV testing and counseling services are offered at health facilities as part of YFHS. In fact over one-third of community youth survey respondents who have ever accessed YFHS have accessed HIV counseling and testing services. However, requiring youth to undergo HIV counseling and testing before being offered other health services they request, for example condoms, be a disincentive to accessing YFHS, particularly those who are scared of being diagnosed as HIV positive. Some FGD participants reported that there had been instances where health workers have demanded that they be tested for HIV before being provided desired services. Nearly one-tenth (8.2 percent) of the community youth survey respondents (Table 7.1) and some youth FGD participants reported that one of the reasons for not accessing YFHS is the requirement that they should be tested for HIV first before they get the services they want. Because of the fear of being found HIV positive, some youth did not take the HIV test and consequently did not access their desired services.

"In most cases when we go to collect condoms, we are told to get tested for HIV and most youth do not want to" (P1, FGD with female youth, Lilongwe).

"The youth fear that if they get tested and found to be HIV positive they may kill themselves" (P12, FGD with female youth 15-19, Kasungu).

Youth reported that although stigma and discrimination against persons living with HIV has declined, youth and parents are still concerned about disclosing HIV status to others:

"Stigma is declining in our area; people are now disclosing their HIV status. But sometimes parents do not allow their children to disclose their status to their friends in the community. They think that they will be a cause of embarrassment to the community" (P2, FGD with male youth 20-24, Kasungu).

7.7.8. Religious and Other Beliefs

Religious beliefs constrain access to YFHS. While some churches teach their members, including youth, to believe in supernatural healing and hence avoid seeking modern health services, others have doctrines that discourage the use of contraceptive methods. These issues were extensively discussed in many FGDs.

7.7.9. Lack of Financial Resources/infrastructure

The district YFHS coordinators, district health officers, NGO managers, and hospital and health center managers reported that one of the major challenges to the implementation of YFHS is lack of financial resources. Because some health facilities lack adequate recreational, IEC, and sensitization materials, many youth are not motivated to seek services there. Inadequate financial resources among district health offices slow down the scale-up of the YFHS program to health facilities, thus limiting the reach of the program. The district YFHS coordinators and district health officers attributed their failure to conduct supportive supervision of YFHS providers to lack of financial resources. Some NGOs also reported that they had no vehicles and gas to reach out to youth in hard-to-reach communities.

7.7.10. Shortage of Trained Human Resource

District health officers and district YFHS coordinators reported a shortage of YFHS providers at the health facility and community levels. Some facilities in the selected districts did not have youth CBDAs, peer educators, or youth HIV testing and counseling counselors. The shortage of these categories of providers limits the reach of the YFHS program. It was also reported that some of the YFHS providers were not trained. The shortage of young health providers to whom youth can relate was also a concern of district health officers, district YFHS coordinators, and health center managers. Most hospital managers reported staff turnover as a big challenge and that some service providers trained in YFHS provision left their work stations shortly after training, resulting in few trained providers being retained. Several CBDAs and peer educators reported not receiving training in YFHS, thus making it difficult for them to mobilize and educate youth on the YFHS program.

7.7.11. Poor Attitudes of Health Workers

About 3 percent of youth who reported challenges in accessing YFHS (N=693) stated poor attitudes/unfriendliness of the health worker as a challenge. The district health officers and health facility managers also acknowledged the poor attitude of service providers as a challenge they are facing in the implementation of the YFHS program.

7.7.12. Inadequate Health Worker Encouragement for Youth to Access YFHS

Although there were reports that service providers have conducted some community meetings and organized mobilization activities, such as drama and comedies, youth FGD participants reported that not much has been done to motivate youth to access YFHS. They stated that some health facilities do not have sign posts and have not distributed materials to inform youth of services available in their facilities. Consequently, they are not aware of the YFHS available.

7.7.13. Lack of Youth Participation in Activities to Improve Services Provided to Them

It is important that youth participate in the design and implementation of activities or interventions seeking to improve the services provided to them. Most youth FGD participants, however, reported that they have never participated in such activities. Only a few young people said they had taken part in sports or drama aimed at creating awareness about HIV and AIDS.

Even though most of young people had never participated in YFHS-promotional activities, they expressed interest in participating in the future, particularly in teaching their peers about health and related issues including HIV and AIDS through drama and songs, establishing and managing youth clubs, conducting one-on-one discussions with fellow youth, participating in sporting activities, and distributing condoms.

Table 7.1: Challenges in Accessing YFHS: Community Youth Survey Respondents

Challenges stated	Percentage of youth who reported to have challenges (N=693)
Lack of drugs and other medical supplies	6.7
Youth are shy	19.7
Long distances	13.9
Lack/inadequate services	3.1
Long queues at health facilities	0.9
Afraid of being tested for HIV	8.2
Young people are lazy/reluctant to go to health facilities	4.1
Lack of time	3.2
Lack of knowledge about services/place where services are delivered	7.8
Health workers not helpful/unfriendly	3.4
Services are not free	3.8
Lack of transport	5.5
Denied access to services by parents/church	5.6
Lack of privacy and confidentiality	3.3
Denied services by health workers	1.9
Lack of space where youth can meet	1.3
Shortage of staff	2.5
Lack of resources (e.g., posters)	1.4

7.8. Some Suggestions by Parents, Youth, and Community Leaders on Delivery of and Access to YFHS

This study has shown that there are challenges in the delivery of YFHS in Malawi and that youth also face a number of challenges in accessing these services. Efforts to address these challenges should consider suggestions from youth, service providers, parents, and community leaders.[89] This section provides a summary of these suggestions as well as others that emanate from our findings.

7.8.1 Parents' Suggestions on Activities or Programs Needed to Address Youth Health Problems

Parents said that to address the needs of youth, health facility- and community-based YFHS providers should:

- Educate not only young people, but parents and community leaders as well on the benefits of the YFHS program. The education program should highlight what services will be provided, why they will be provided, who will provide them, and when they will be provided. The parents noted that this would help them better understand and support the program.
- Involve village chiefs in their activities, particularly with respect to mobilizing community members. The parents suggested that village chiefs should be given the responsibility of

[89] These are suggestions from the respondents and do not necessarily reflect recommendations from the evaluation team.

organizing community meetings to sensitize both parents and youth about the need for YFHS, including RH services.

- Assist youth in establishing youth clubs where they can advise one another on RH issues, including sex, pregnancy, and HIV. Club activities should also include recreational activities to reduce boredom.
- Align YFHS messages with traditional values through consultations between service providers and community leaders, including parents.
- Train some parents as promoters of YFHS.
- Provide more guidance on the use of contraceptives, like injectables, by young people, to prevent them from using these as a motivation to engage in indiscriminate sex.
- Involve teachers in YFHS-promotional activities to reach in-school youth.

7.8.2. Youth's Suggestion on Building Greater Community Acceptance and Support for Youth Accessing RH Services.

Young people offered the following suggestions about ways to improve the delivery of YFHS:

- Sensitize both youth and parents on YFHS through NGOs, health workers, chiefs, church leaders, and community-based health workers and other organizations. For in-school youth, teachers should be involved in sensitization activities.
- Have health facility service providers go into the communities to educate people about the benefits of YFHS. This would complement reports from CBDAs and peer educators.
- Involve village chiefs in mobilization activities as they have authority to organize meetings where health workers can provide more information on YFHS.
- Assist youth to take on the responsibility of creating awareness among their peers about available YFHS, including RH services. Some youth can therefore be trained as peer educators.
- Ensure youth are counseled by counselors of the same sex.

Chapter 8: Summary, Conclusion, and Recommendations

8.1. Key Findings

Key findings related to implementation of YFHS standards at different levels of care, coverage of the YFHS program, and the attitudes of parents to young people's SRH behavior and utilization of YFHS are summarized in this section. These findings can be used to inform YFHS programming and policies moving forward.

8.1.1. Implementation of the YFHS Program/Standards

Training and supervision of service providers

In Chapter 4, we noted that the extent to which youth service providers are able to perform their expected roles depends on how well they are prepared, or equipped with the skills to do so, as well as the amount of supervision they receive from higher level officers. Regarding training and supervision of service providers, the evaluation shows that:

- About half (52.3 percent)[90] of interviewed CBDAs reported to have received training in YFHS and the percentage trained ranges from 40 percent in Central West to 61.1 percent in the South East. Areas in which the CBDAs have received training include: contraceptive counseling (84 percent); counseling in HIV and AIDS (60 percent); counseling in STIs (57.8 percent); information about condoms (51.1 percent); and, condom distribution (40 percent).
- About 64 percent[91] of peer educators reported to have received training in YFHS and the percentage ranges from 33.3 percent in Central East to 72.7 percent in Central West. Areas in which the peer educators have been trained include: counseling in HIV and AIDS (72.1 percent); SRH (48.8 percent); counseling on other health issues (44.2 percent); counseling on STIs (39.5 percent); condom use and benefits (39.5 percent); general counseling (34.9 percent); and contraceptive counseling (27.9 percent).
- About 68 percent of health center-based and 73.3 percent of hospital-based youth service providers reported to have been trained in YFHS. The percentage of health center-based youth service providers trained in YFHS ranges from 40 percent in the North to 80 percent in Central East. For the hospital-based youth service providers, the percentage trained ranges from 57.1 percent in Central West to 100 percent in South West (see Table 4.2.2).
- Areas in which the health center youth service provides have been trained include: general counseling (77.5 percent); HIV and AIDS counseling (70.7 percent); contraceptive counseling (62.5 percent); distribution of contraceptives (60 percent); STI services (58 percent); HIV and AIDS testing (48.7 percent); antenatal care (37.5 percent); treatment of abortion complications (37.5 percent); PMTCT (36.6 percent), and treatment and care for adolescents living with HIV (34.4 percent).
- For hospital-based youth service providers, major areas in which they have been trained include: general counseling (54.5 percent); HIV and AIDS counseling (54.5 percent); contraceptive counseling (54.5 percent); HIV and AIDS testing (50 percent); PMTCT (50 percent); STI services (50 percent); and treatment and care for adolescents living with HIV (36.4 percent).

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[90] The percentage of CBDAs who reported to have received training in YFHS did not vary significantly by location of facility (urban or rural): 53.1% of CBDAs in the urban areas and 51.9% of CBDAs in the rural areas reported to have received training in YFHS.

[91] The percentage of peer educator reporting to have not been trained in YFHS did not vary significantly by location of facility (urban or rural); 33.3% of peer educators in the urban areas and 38.1% of peer educators in the rural areas reported to have not been trained in YFHS.

- Although high percentages of CBDAs and peer educators reported to have ever been supervised, supervision by key designated officers is low. For example, 41.5, 92.3, and 96.3 percent of CBDAs reported to have never been supervised by a CBDA supervisor, sponsoring NGO officer and YFHS coordinator, respectively. Among the peer educators, 77.6, 65.5, and 82.8 percent reported to have never been supervised by peer educator supervisor, sponsoring NGO officer, and health facility YFHS provider, respectively.

NGO support

- The majority of partner NGOs support the YFHS program at both the community and health facility levels (55 percent); while 20 percent support only community-based programs, 25 percent support only health facility-based programs.
- The five identified service-delivery approaches were supported by NGOs with the most widely supported approach being the integrated approach (39 percent). Additionally, 20 percent support the "stand-alone" YFHS center approach; 20 percent support provision of facility-based services on specific days of the week by engaging CBDAs; 15 percent support provision of facility-based services in designated space for YFHS, engaging facility-based peer educators and CBDAs; and 10 percent support provision of facility-based services in designated space for YFHS, engaging facility-based peer educators.
- High percentages of NGOs provide support to community- and health facility-based service providers; health facility-based service providers (75 percent), peer educators (75 percent), and CBDAs (65 percent).
- At the health facility level, NGOs support several activities to ensure adequate implementation of the YFHS program: training of YFHS providers (55 percent); supply of IEC materials (50 percent); supply of commodities/medicines (40 percent); supply of equipment (35 percent); and provision of recreational materials (35 percent).
- At the community level, NGO support for the YFHS program included: support to YFHS providers (60 percent); supply of contraception (60 percent); provision of space for youth to meet for YFHS (40 percent); and supply of IEC materials (40 percent).

Implementation of YFHS Standards

As indicated in Chapter 5, a major objective of this evaluation is to assess the extent to which the YFHS program has been implemented according to the YFHS Standards. Levels of implementation according to the Standards were not determined for each health facility, neither was a composite index developed for the standards elements. Rather, we examined the percentages of health facilities that reported to be implementing the elements of each standard. As outlined in Chapter 5, we focused more on the description of the extent to which health facilities that reported to be implementing the YFHS program at the time of the survey have implemented the Standards elements.

In the absence of baseline or target levels of implementation with which to compare observed levels, we developed a scale to classify observed levels of implementation as high, medium, and low. For this evaluation, the implementation of a standard element was considered:

- Low, if less than 50 percent of health facilities reported to be implementing it at the time of the survey.
- Medium, if between 50 and 75 percent of health facilities reported to be implementing it at the time of the survey.
- High, if more than 75 percent of health facilities reported to be implementing it at the time of the survey.

An assessment of the extent to which the YFHS Standards have been implemented reveals that overall the implementation of the Standards can be rated as medium, with elements of the Standards unevenly implemented within and across zones.[92] Implementation of the elements also differs, sometimes significantly and sometimes slightly, between health facilities reporting to implement and not implement YFHS. Overall:

- Of the 8 Standard 1 elements, implementation was rated as low for two (25 percent), medium for three (37.5 percent), and high for three (37.5 percent).
- Of the five Standard 2 elements, implementation was rated as low for three (60 percent) and high for two (40 percent).
- Of the seven Standard 3 elements, implementation was rated as low for four (57.1 percent) and medium for three (42.9 percent).
- Of the eighteen Standard 4 elements, implementation was rated low for 12 (66.6 percent), medium for three (16.7 percent) and high for three (16.7 percent).
- Of the nine Standard 5 elements, implementation was rated as low for five (55.6 percent), medium for one (11.1 percent), and high for three (33.4 percent).

Highlights related to implementation of the critical elements include:

- About three-fifths (60.5 percent) of health facilities reported to have copies of the YFHS standards, and this percentage varies from 33.3 percent in South east to 80 percent in Central East and Central West.
- Less than one-third (30 percent) of health facilities reported to have a clearly displayed sign that shows available YFHS, location, and hours of operation. The percentage ranges from 20 percent in Central West to 40 percent in Central East.
- Less than one-third (32.6 percent) of health facilities provide outreach services specific to youth and less than half of these facilities (14 percent) reported to provide the services on schedule.
- About one-fifth (20.9 percent) of health facilities surveyed reported not to have youth service providers who have been trained in YFHS standards. This percentage varies from 10 percent in the South West to 44.4 percent in the North. The percentage not trained in the YFHS standards is much higher among support staff, where almost nine in ten (88.4 percent) facilities reported not to have support staff[93] trained in YFHS standards
- Only 23.2 percent of health facilities have youth-specific and appropriate IEC materials on display for young people to take away.
- Only about half (51.2%[94]) of health facilities have organized community meetings to provide information about YFHS. This percentage ranges from 27.3 percent in the North to 63.6 percent in the South East.
- Only about two-fifths (41.9 percent) of health facilities analyze and utilize data on feedback to improve services for young people. This percentage ranges from 11.1 percent in the North to 60 percent in Central West and South West.
- About two-fifths (37.2 percent) of health facilities reported to have disaggregated data for young people's profiles in the catchment area (age, sex, school status, and marital status), and the percentage ranges from 11.1 percent in the South East to 77.8 percent in the North.

[92] Variations across zones are more pronounced than variations by location of facilities. In most cases, the variation in implementation between urban and rural facilities is statistically insignificant.
[93] The support staff include pharmacy attendants, laboratory attendants and hospital attendants)
[94] This consists of 61.98% of health facilities in the rural areas and 45.4% of health facilities in the urban areas.

- Only about one-third (32.6 percent) of all health facilities reported to have a register to record the age of the adolescents/youth separately and compile the data into age categories (10-14, 15-19, 20-24). The percentage varies from 0 in the South East to 66.7 percent in the North.

8.1.2. Coverage and Utilization of YFHS

As conveyed in Chapter 6, a major objective of this evaluation is an assessment of YFHS program coverage. Evaluation results reveal that:

- Awareness of the YFHS program is generally low. Less than one-third (31.7 percent) of community youth survey respondents (34.5 percent of youth living in communities with YFHS-implementing health facilities and 24.5 percent of those living in communities without YFHS-implementing facilities) reported to have heard about YFHS. Low knowledge of YFHS was also confirmed by FGD participants, many of whom reported to have not heard about YFHS. Several parent FGD participants who reported to have heard about the YFHS program perceived the program mainly in terms of the provision of contraceptive methods, particularly the distribution of condoms. Ever use of YFHS is low, much lower than was assumed at the planning phase of the evaluation.[95] Only 12.6 percent (13.3 percent of youth living in communities with YFHS-implementing health facilities and 11 percent of those living in communities without YFHS-implementing health facilities) reported to have ever used YFHS. While awareness of YFHS differs by whether or not youth reside in communities with YFHS implementing health facilities, ever use of YFHS does not differ significantly by type of community. Knowledge and use of YFHS vary significantly by district and zone. The percentage reporting to have heard about YFHS varies from 22.6 percent in Central West to 42.1 percent in South West, and the percentage reporting to have used a YFH service varies from 8.1 percent in the South East to 17.6 percent in the South West.
- Besides zonal variations, knowledge and use of YFHS vary by demographic and social characteristics of youth: age, sexual experience, and school attendance status (in or out of school). For instance, the percentage of youth who reported to have accessed YFHS varies from 4.6 percent among 10-14 year-olds to 18.1 percent among the 20-24 year-olds. Sexually experienced youth are about three times more likely than the sexually inexperienced to have accessed YFHS (19.5 percent of sexually active vs. 5.8 percent of sexually inactive). While about 16 percent of out-of-school youth reported to have accessed YFHS, 11 percent of in-school youth reported same. These observations suggest that the likelihood of knowing and using YFHS depends on a young person's lifecycle stage, as defined by the aforementioned characteristics.
- Young people reported to receive information from several sources, most frequently including: friends/peers (39.9 percent of community survey respondents and 38.1 percent of exit interview respondents); the health care service delivery system, through facility sign posts, posters, and other materials (20.5 percent of community survey respondents and 26.7 percent of exit interview respondents); the radio, through special programs (19.3 percent of community survey respondents); and community members (13 percent of community survey respondents and 9.9 percent of exit interview respondents). The sources of information vary significantly across zones and slightly by whether or not the young people live in communities with YFHS-implementing health facilities or not.
- The majority (62.5 percent) of community survey respondents who reported to have ever visited a YFHS delivery point did so for the first time in the 12 months preceding the survey.

[95] At the Stakeholder TWG meeting of June 28, 2013, it was assumed that the baseline coverage value would be about 17-20% and that the coverage at the time of the survey would be about 35%. These assumptions were used to estimate the sample size for the community survey component of the evaluation.

This suggests that utilization of YFHS gained traction only in the last year or two of the seven-year program.

- The majority (61.4 percent) of YFHS clients obtain their services from government health facilities—hospitals, health centers, and health post. Less than one-third of community youth survey respondents who have accessed YFHS reported to have obtained their last services from NGO- and private sector-supported health facilities.
- There is some misconception about who the beneficiaries of the YFHS are. Among the community youth survey respondents, only about half (49.1 percent) were able to accurately identify the intended beneficiaries as all youth aged 10-24, whether married or not. Many FGD participants thought the beneficiaries were only married youth.
- About 93 percent of community youth survey respondents who have accessed YFHS expressed satisfaction with the services they received. Only a few respondents felt that service providers could share their discussions and test[96] results with others. Unfortunately, this feeling was not shared by several youth FGD participants.
- Perceptions of quality of care do not differ much by whether or not youths receive services in a health facility implementing YFHS or by service delivery approach. In only one of 20 service elements was there a significant difference. Of the 20 quality-of-service elements examined, clients perceptions of quality, there are only 7 on which the clients' perceptions differed by service delivery approach. The 7 elements measure adequacy of information received, respect from service providers, privacy and confidentiality of discussion with service providers, and the physical environment of the facility. In 5 of the 7 quality-of-service elements on which clients' perceptions differed significantly, higher percentages of clients from health facilities implementing the integrated approach gave responses that are indicative of good quality.
- Among community survey respondents who have accessed YFHS, over 90 percent felt that the YFHS program offers youth some benefits, including: (i) the services are focused on the needs of youth; (ii) the program enables the youth to receive health care on time; (iii) the program protects the privacy of youth.

8.1.3. Barriers to Uptake of YFHS[97]

Several factors were identified in Chapters 6 and 7 that impede the uptake of YFHS, including:

- Low knowledge of the YFHS program among youth, their parents, and community leaders. Among community youth survey respondents, only 31.7 percent reported to have heard about YFHS and a lower percentage (24.1 percent) reported to know a place where a YFHS could be obtained. FGD participants reported perceiving the program mainly in terms of the provision of contraceptive methods.
- Young people's doubts about their privacy and confidentiality of test results, discussions with health workers, and services obtained constrain access of YFHS. Although a high percentage (85.1 percent) of community youth survey respondents who have accessed YFHS expressed confidence that the SRH services they obtained will be kept confidential by service providers, this feeling was not shared by the general population of youth. The youth FGD participants expressed concerns about the confidentiality of test results and remarked that since the health workers know them and their parents, there is a chance that they (the health workers) could divulge their discussions and the SRH services they obtained to their parents. Some youth FGD participants remarked that rather than seek health services at the health facility nearest to them, they would seek services when organizations outside their communities visit their communities

[96] Covers all types of laboratory tests – HIV, STI, or pregnancy tests.

[97] Data on the barriers come mainly from community youth survey respondents, FGDs among parents and youth, and in-depth interviews among community leaders.

to provide services. Some youth also expressed concerns about being identified at the YFHS delivery points by other members of their communities who would then report the visit to their parents.

- Reports that some health service providers require youth to undergo HIV testing and counseling before being offered other health services they request, for example condoms, serve as a barrier to youth accessing YFHS, particularly for those who are scared of being diagnosed as HIV positive. Some FGD participants reported that there had been instances where health workers demanded that they be tested for HIV before being provided desired services. This requirement has discouraged them from going to health facilities to seek services.
- Inadequate encouragement from health workers. Although there were reports that service providers have conducted community meetings and organized mobilization activities such as drama and comedies, some youth FGD participants reported that not much has been done to motivate youth to access YFHS. They stated that some health facilities do not have sign posts and have not distributed materials to inform youth of services available in their facilities. Consequently, they are unaware of the YFHS available in these facilities.
- Low self-confidence, particularly among girls, constitutes a barrier to accessing YFHS. Almost one-fifth of community survey respondents who reported to have not accessed YFHS cited 'shyness' as a reason. Although being shy is considered a personal characteristic, it is a barrier to accessing YFHS as it reflects low self-confidence that is linked to social barriers—judgmental attitude of service providers and/other clients or lack of privacy. Some female FGD participants stated that girls are generally uncomfortable asking for certain services because of what other people might think of them. They noted, for instance, that many girls who would have requested condoms failed to do so for the fear of being labeled commercial sex workers.
- Parental and community support for youth seeking SRH services is low, partly because these services are perceived only in terms of the provision of contraceptive information and methods. The majority of parents believe that the provision of SRH services to youth encourages sexual promiscuity and hence is culturally inappropriate. They expressed the view that while the society encourages abstinence among youth, the YFHS program encourages sex through the provision of comprehensive SRH information and services to youth. Aware of the low parental and community support for SRH services, many youth, especially the younger ones, are not encouraged to seek these services. The majority of those who seek SRH services do so without the knowledge of their parents and many of them risk being sanctioned if and when parents found out. The situation is compounded by the youth's inability to accurately understand parents who support their children accessing certain services like HIV testing and counseling and disapprove of other services like provision of contraceptive methods. The level of parental and community disapproval of SRH services, however, varies by where the youth are in the lifecycle stage. Parents and community members are more favorably disposed to use of contraceptive methods by married women and single mothers.
- Misconceptions about who should access SRH services and the effects of these services constitute a barrier to accessing YFHS. For instance, many youth FGD participants expressed the view that SRH services should be for only married female youth who have ever been pregnant or have had a child. Many of them expressed concerns about unmarried youth or those who have never been pregnant seeking contraceptive methods. According to some of the youth FGD participants, girls who have never been pregnant or have never had a child can destroy their wombs if they use contraceptive methods.
- Concerns about the negative side effects of contraceptive methods affect parental support for their children using them and discourage several youth from accessing these services.
- For several young people, long distances between their communities of residence and the nearest YFHS delivery points constitute a barrier to accessing YFHS. The FGD participants noted that even for those who do not live too far from a YFHS delivery point, inadequate

transport facilities make a visit to the YFHS delivery points challenging and consequently unappealing. The CBDA system was introduced to mitigate the effects of long distances to the nearest health facilities by making certain services available at the community level. Unfortunately, in many places, the CBDA system has not been highly effective due to inadequate transport that make it challenging for CBDAs to cover their large catchment areas, particularly those who provide services across many villages. Some CBDAs reported that they have large catchment areas and because they do not have adequate transportation, they are not able to provide services in all the communities they are expected to cover. Consequently, youth in such communities who are not able to travel to the nearest health facility are not able to access YFHS.

- Religious beliefs constrain access to YFHS. While some churches teach their members, including youth, to believe in supernatural healings and hence avoid seeking any modern health services, others have doctrines that discourage only the use of contraceptive methods.

8.1.4. Other Findings: Sexual and Reproductive Behavior of Youth

In order to highlight the SRH needs of youth, and consequently the relevance of the YFHS program, information was collected on the sexual and reproductive behaviors of youth: sexual experience of youth (awareness of sex among young adolescents aged 10-14, whether youth have ever had sex, age at first sex, and age of sexual partner at first sex); contraceptive use (at first and last sex, methods used, and sources of contraceptive methods); and pregnancy and childbearing. The information collected reveals that youth are distributed across several lifecycle stages defined by age, sexual experience, pregnancy, and childbearing. The findings from the study show that:

- Awareness about sex is high among young adolescents aged 10-14 with about 72 percent of them (76.5 percent of males and 66.3 percent of females) reporting to have heard or talked about sex. Awareness about sex varies only slightly by location of residence (rural or urban). In the rural areas, 73.6 percent of youth 10-14 (76.9 percent of males and 70.7 percent of females) reported to have heard about sex and in the urban areas 67.9 percent (75.8 percent of males and 60.3 percent of females) reported to have heard about sex. The percentage of male adolescents aged 10-14 who have heard or talked about sex ranges from 58 percent in the South East to 91 percent in Central East and for their female counterparts, the percentage ranges from 47.4 percent in the South West to 96.3 percent in Central East.
- Half of youth aged 10-24 reported to have had sex at the time of the survey and the likelihood of reporting to have had sex increases with age (12.6 percent of those aged 10-14, 51.9 percent of those aged 15-19, and 84.0 percent of those aged 20-24)[98]. Among males 10-24, 54.5 percent reported to have had sex at the time of the survey, with the percentage reporting to have ever had sex increasing with age (20.3 percent of those 10-14[99]; 58.7 percent of those 15-19, and 81.9 percent of those 20-24). Males in the North were least likely to report ever having sex (47.3 percent) and those in the Central West were most likely to report ever having sex (59.1 percent). In addition, males in rural areas were more likely to report ever having sex (57.2 percent for rural vs. 50.4 percent for urban). Among females, 45.9 percent (5.3 percent of those aged 10-14, 44.9 percent of those aged 15-19, and 86.4 percent of those aged 20-24) reported to have ever had sex. There are also variations by zone with females in the North least likely to report ever having sex (36.2%) and those in the South East most likely to report ever having sex (54.5%).

[98] The sexually experienced youth consist of all ever-married youth and some never-married youth; 36.2% of never-married youth (48.7% of never married males and 20.4% of never married female) reported to be sexually experienced at the time of the survey.

[99] For the age group 10-14, the denominator for the percentage of adolescents reporting to have ever had sex is the number who reported to have heard or talked about sex. Those who reported to have not heard about sex were not asked whether they have ever had sex.

- High percentages of sexually experienced youth expressed intention to use contraception during future sex (85.2 percent of males, and 74.7 percent of females). While the percentages of male youth intending to use contraception in the future vary widely across zones (from 79.8 percent in Central West to 93.9 percent in the South West), there are little zonal variations for females (from 71.8 percent in Central East to 77.3 percent in Central West). There is a high preference for condoms among sexually active male and female youth who intend to use a contraceptive method during future sex. Among male youth, 85.7 percent expressed preference for condom and 8.7 percent for injectable contraceptives. Among females, 40.4 percent expressed preference for injectable contraceptives and 36.6 percent for condoms; another 4.7 percent would like oral pills.
- Public facilities were the major source of contraceptive methods and the majority of youth (55 percent of males and 72 percent of females) who expressed the desire to use a contraceptive method in the future expressed the desire to obtain their methods from these public health facilities (government hospitals and health centers). The other major source of contraceptive commodities is the market/shop (25.7 percent of males and 13.5 percent of females). CHAM and other private sources have not been significant sources of contraceptive methods for youth.
- Among sexually experienced female respondents, 72.4 percent reported to have ever been pregnant. The percentage reporting to have ever been pregnant also increases with age (20 percent, 60.3 percent, 83.4 percent among the 10-14, 15-19 and 20-24 year-olds, respectively) and varies across zones (from 62.9 percent in Central East to 81.3 percent in South West)
- As to whether the last pregnancy was wanted or not, 43.4 percent of female respondents (none of those aged 10-14, 39.3 percent of those aged 15-19, and 45.6 percent of those aged 20-24) reported to want the last pregnancy; 31 percent (100 percent of those aged 10-14, 38 percent of those aged 15-19, and 29.9 percent of those aged 20-24) did not want the pregnancy at all, while 9 percent (none of those aged 10-14, 7.9 percent of those aged 15-19, and 10.2 percent of those aged 20-24) wanted to wait until a later time.

8.2. Recommendations

8.2.1. Implementation of YFHS Program/Standards

Quality of and emphasis on specific topics in youth training should be prioritized.
By MOH standards, all youth service providers should be trained in YFHS. That almost 48 percent of CBDAs and 36 percent of peer educators have not received training in YFHS shows significant training gaps that must be redressed. Without adequate training, the ability of service providers to disseminate appropriate information about the program and provide quality services might be limited. The following should be particularly reinforced in trainings: information about use, benefits, and distribution of condoms; contraceptive counseling; and treatment and care for adolescents living with HIV.

Supervision should be conducted by all cadres of supervisors responsible for overseeing the work of CBDAs. Associated with training is the need to ensure that designated officers monitor the quality of services provided through integrated supportive supervision. Although high percentages of CBDAs and peer educators reported to have been supervised, significant proportions have not been supervised by designated key (or high-ranking) officers who can provide meaningful feedback related to their performance.

The MOH should work with stakeholders to develop strategies to implement and monitor implementation of the standards. With respect to the YFHS standards, this evaluation reveals significant implementation gaps. Adequate resources will have to be put in place for monitoring, and district YFHS coordinators have key supervisory role to play. To ensure all key implementation issues

are covered, the MOH might consider developing and costing a five-year strategic plan to guide the implementation and monitoring of the standards.

Monitoring quality and use of data to improve services for young people and to inform programming should be strengthened. Data should be disaggregated to inform strategies based on lifecycle, sex, marital status, and parity.

8.2.2. Coverage of YFHS and Barriers to Utilization of Services

Strategies should be developed to generate awareness about the YFHS program and support among parents. The low levels of knowledge and use of the YFHS suggest the need to go back to the drawing board to develop appropriate strategies to create awareness about the program—the package of services, the program benefits, and the intended beneficiaries. Both the youth and their parents should be provided with adequate information on the program. If parents do not buy into the program, the reach of the program might be limited, as considerable proportions of youth need parental consent to obtain services.

Strategies should reach youth at their different lifecycle stages. The evaluation shows that the probability youth would use YFHS is a function of their lifecycle stage, which is defined by age, sexual experience, parity, and school attendance. Consequently, appropriate strategies should be developed to reach young persons at different lifecycle stages with information, education, and services that meet their needs. Prevention of unwanted pregnancies and STIs/HIV, awareness about contraception, knowledge about SRH, and the healthy timing and spacing of pregnancy are topics that should be consistently addressed. Special attention should be paid to the integration of in- and out-of-school programs with YFHS. Youth would benefit from a multisectoral approach.

Youth programs should develop strategies to address personal, social, and structural barriers that hamper access to and use of services by youth.

Clear mechanisms to improve dialogue with the community in the catchment areas surrounding YFHS should be implemented. The dialogue should focus on increasing awareness and knowledge about the services provided, barriers to accessing services, outreach services; services data against community health needs; increase access and use of services by youth.

Efforts should be made to address the negative attitudes of parents and the wider community about youth behaviors. These negative attitudes hinder their support for the YFHS program, which many parents perceive as condoning the 'bad' sexual behavior of the youth. Health facilities and community-based providers of YFHS should do more to educate parents and community leaders about the benefits of the YFHS program. Service providers should seek ways to align YFHS messages with traditional values through consultations with community leaders, including parents. The YFHS program might consider training parents as YFHS promoters, as suggested by some parents. The parent promoters might be better placed to educate other parents on the benefits of the YFHS program.

The YFHS program should seek ways to involve village chiefs (community leaders) in its activities, particularly with respect to mobilizing community members. As suggested by parents, village chiefs could be given the responsibility of organizing community meetings where parents and youth could be sensitized about the need for YFHS, including RH services.

Strategies should be developed to address health providers' attitudes to facilitate access to services. Privacy and confidentiality should be guaranteed and a friendly, non-judgmental attitude should

guide health providers' attitudes. Youth reported concerns about confidentiality of test results and/or provision of SRH services, as well as being "pushed" to be tested for HIV before getting condoms.

Strategies addressing youth misconceptions about SRH services and the effects of these services should be developed and implemented by peer educators, CBDA, and health providers. Young people, particularly girls, fear the effects of contraceptive methods and many interviewed said that YFHS are only for married females.

The YFHS program should coordinate with NGOs to streamline the different approaches to YFHS. The approaches should be streamlined with regard to implementation of the YFHS standards, quality of service provision, training and supervision, consistency of data, and response to the specific health needs of the different youth subpopulation groups.

8.2.3. Sexual and Reproductive Health

Young people must be reached with accurate information about SRH. With awareness of sex relatively high among the 10-14 year-olds (72 percent) and knowledge and use of YFHS low (4.6 percent), it is important to review the content of sex education to ascertain that it provides sufficient information for them to understand issues of sex, particularly those related to misconceptions about sex, contraception, and pregnancy.

The YFHS program should identify the unique needs of subpopulation groups of youth. Findings from this evaluation suggest that the likelihood of knowing and using YFHS depends on a young person's lifecycle stage. Information on each subpopulation can be used to inform interventions that meet the unique needs of young people at their different lifecycle stages.

More should be done to engage friends and peers as distributors of information on YFHS. Although considerable proportions of community youth survey respondents identified the health care delivery system and local media as sources of information on YFHS, the most commonly cited source of information is friends/peers. This observation raises the issue of how to harness this channel for effective dissemination of accurate information.

Efforts should be made to increase access to contraceptive methods by making them more affordable and attractive to youth, particularly in private and NGO-supported facilities. Although the YFHS package includes provision of contraceptive information and methods, some findings from this evaluation draw attention to the need to strengthen the contraception component of the package; for example, half of youth aged 10-24 reported to have had sex at the time of the interview, implying that significant percentage of the youth population, particularly the never-married and the previously married (separated, divorced, or widowed) ones, want to prevent pregnancy and/or contraction of STIs; about 72 percent of sexually experienced female youth have been pregnant, and among them, 40 percent did not want the last pregnancy or wanted it at a later time; and high percentages of sexually experienced young people expressed the intention to use a contraceptive method during future sex. Special attention should be given to the 10-14 years old girls a significant percentage of who are becoming pregnant with unwanted children. Although the data collected by evaluators did not specifically show the absence of a comprehensive contraceptive package in services offered the Malawian youth, it should be ensured that the YFHS package offers a range of contraceptives, with particular focus on long-acting reversible contraceptives and dual protection. Female youth expressed preference for injectable contraceptives, condoms, and very few of them, for oral pills. This suggests the need for more sensitization and information about the benefits of long-acting methods, and the importance of reinforcing health providers' training to be able to offer them.

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