Assessing Efforts to Mainstream

Youth-Friendly Health Services in Madagascar, Malawi, and Mali

August 2019

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ABSTRACT

High fertility rates and low modern contraceptive use put African youth and adolescents at high risk for health complications, including maternal mortality. Mainstreaming youth-friendly health services (YFHS) into existing services is one approach to improve access to reproductive health services for youth and adolescents. The objective of the evaluation was to assess the effects of three PSI-sponsored YFHS training packages on voluntary uptake of family planning (FP) among youth and perceptions of service quality by youth and trained healthcare providers. In 2018, a retrospective review and analysis of relevant monitoring and evaluation documents and service statistics from PSI Madagascar, PSI Malawi, and PSI Mali was conducted. Qualitative data on perceptions of service quality from Malawian youth and healthcare providers were also collected and assessed through thematic analysis. Results show that the number of FP clients ages 15–24 increased after implementation of the YFHS training packages. Data from PSI Madagascar and PSI Malawi show that positive trends were not sustained after other YFHS components ended. Focus group discussions with youth in Malawi indicated that clinics were perceived as providing high-quality services to youth. The main barriers to accessing the services were cost and embarrassment. Malawi's healthcare providers made many efforts to improve clinic accessibility and understood the barrier of cost and importance of outreach to youth and the broader community. The results provide evidence that provider training alone will not sustain initial increases in youth FP clients. Across the three countries, the greatest benefits of the YFHS training packages were seen when combined with demand-generation activities and increased access to peer education.

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August 2019

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ABBREVIATIONS

FP	family planning
HIP	high-impact practice
ISM	Integrated Social Marketing program
IUD	intrauterine device
LARC	long-acting reversible contraception
OCP	oral contraceptive pills
PSI	Population Services International
SAM	short-acting method
SIFPO2	Support for International Family Planning Organizations 2
RH	reproductive health
USAID	United States Agency for International Development
WHO	World Health Organization
YFHS	youth-friendly health services

EXECUTIVE SUMMARY

Background

High fertility rates and low prevalence of modern contraceptive use put African youth and adolescents at high risk for health complications, negative economic and social consequences, and maternal mortality. Stand-alone youth-centered health clinics have proven effective at improving youth access to reproductive health services and have shown positive effects in reducing negative health outcomes, but these stand-alone clinics are costly and difficult to scale up, especially in resource-constrained settings. Mainstreaming youth-friendly health services (YFHS) into existing services is a way to minimize costs and create more sustainable voluntary family planning (FP) services. Limited evidence exists related to efforts to mainstream youth and adolescent-friendly elements into existing FP services. However, available evidence indicates that YFHS training for healthcare staff has positive effects when combined with changes to make facilities more youth friendly and broad information dissemination campaigns.

Objectives

The objective of the evaluation was to provide evidence on the effects of mainstreaming adolescent- and youth-friendly health service elements into existing FP service delivery. More precisely, the evaluation assessed the changes in youths' voluntary uptake of FP methods and perceptions of service quality in three country network members after implementation of a YFHS training package, which was sponsored by Population Services International (PSI). The evaluation also sought to assess the motivations of healthcare staff and their attitudes and behaviors towards youth as a result of the interventions.

Country network members selected for the evaluation were PSI Madagascar, PSI Malawi, and PSI Mali. Each of these countries has high rates of early marriage, early childbearing, and maternal mortality. Each of these countries implemented YFHS programs that included training on a YFHS curriculum (updated by PSI in 2015) in addition to other components, such as peer mobilizers, outreach events, and voucher programs. The countries implemented YFHS activities and provided the update training in a variety of ways. PSI Madagascar provided the training in 2016 as a refresher for their franchise providers; PSI Malawi provided YFHS trainings in 2013, 2014, and (with the updated curriculum) 2016 and 2017; and PSI Mali trained providers in a short pilot intervention in 2017.

Methods

The evaluation used a retrospective review and analysis of relevant monitoring and evaluation and service statistics data. Three types of analysis were conducted. The first was a document review of country network program reports, technical briefs, case studies, strategic documents, and previous evaluation protocols and results. The availability of documents varied by country member. The second type of analysis was an assessment of service statistics captured by the routine health information system of the network members. Availability of data also varied by country member. Third, an assessment of qualitative data collected in Malawi for the evaluation was used to investigate perceptions of YFHS and service quality among youth, to explore healthcare provider and staff attitudes towards YFHS mainstreaming efforts, and to investigate sustainability around the mainstreaming effort.

The evaluation was approved by the University of North Carolina Institutional Review Board in August 2018 and by the Malawi National Committee on Research in the Social Sciences and Humanities in November 2018.

Results: Number of Clients

The number of FP clients ages 15–24 served in Madagascar peaked in April and May 2017. The twelve months after the trainings saw increases, though the trends were not sustained after other YFHS training components ended. Likewise in Malawi, although noticeable increases in the number of FP clients ages 15–24 occurred in the months after the YFHS training, the initial increases were not sustained. The pilot training intervention in Mali recorded large initial increases in number of clients ages 15–24. For example, their number increased to 431 from 138 between the pilot intervention period and the same period from the previous year, a 212-percent increase. Service data from Mali also show large increases in voluntary uptake of long-acting methods, including implants and copper intrauterine devices (IUDs), and a reduction in the share of FP counseling-only visits.

Results: Perceptions of Service Quality by Malawian Youth

Focus group discussions with youth in Malawi indicated that, overall, certified Tunza[1] clinics in which at least one provider had undergone YFHS training were perceived as providing high-quality services to youth. The youth participants used positive words, such as "respectful" and "friendly" to describe services. There were no known barriers to service provision based on demographic barriers. Importantly, most youth thought privacy and confidentiality were protected at the clinics. However, the issue was more problematic for youth living in small communities in which the provider(s) may know them, their family, or their friends. These youth would be hesitant to go to the clinics despite the overall positive assessment of services. The main barriers to accessing services at Tunza clinics were reported to be the cost of services and the potential embarrassment of being seen or known to be accessing FP services, particularly for youth who have not had a child. Regarding cost, the youth seemed aware of places to receive free FP methods and to know that free services are not always consistently available, depending on the provider.

Results: Attitudes and Behaviors by Trained Healthcare Providers and Staff

Malawi's Tunza providers made many efforts to improve clinic accessibility. This was especially the case for the provision of confidential services. The providers understood the barrier of cost, though some reported that, without financial support from PSI, they are not able to provide free services for youth. The importance of outreach to youth and to the broader community was also highlighted. Finally, Tunza providers reported that interest in IUDs and implants is low among youth, and as a result, these methods are not always offered as options. Such practices could reinforce negative attitudes of youth toward long-acting methods and undermine uptake of these methods.

PSI internal evaluations in Madagascar found that, although important positive changes to clinic practice were noted, more than one-third of the clinics did not meet the YFHS standards, specifically standards related to counseling practices. The findings suggest a need for improvements in FP counseling for all clients, including

[1] Tunza is the name of the PSI Malawi franchise.

the youth population. In contrast, an internal evaluation of the Mali pilot found that clinics had improved counseling for youth, and conveying verbal confidentiality was the area of greatest improvement.

Discussion

Previous evidence suggests that YFHS training is most effective as a package of interventions addressing core components of YFHS, not as an isolated intervention. The three PSI network members included in the evaluation packaged the delivery of the YFHS training curriculum with multiple components. The results from the three network member countries suggest that provider training alone will not sustain initial positive increases in youth client numbers. This finding underscores the importance of delivering YFHS training to providers within the larger framework of YFHS core components. Across the three countries, the greatest benefits of the training were seen when combined with demand-generation activities and increased access to peer education.

A main limitation of the evaluation was the variability of programmatic and service data available by country. There were different periods for implementation of the YFHS training, different lengths of implementation of the YFHS intervention packages, and differences in the ways in which the data were collected. Supplemental data from youth and healthcare providers were only collected in Malawi. The evaluation design used a nonexperimental "before/after" design, in which numbers and trends from before and after the implementation of the YFHS training packages were compared, thus secular increases in the trend of FP use or other nonprogrammatic factors could influence the interpretation of results.

Conclusions

The results of the evaluation provide a stronger basis for evidence-based decision making about youth programming. The findings support research showing positive effects of YFHS training for healthcare staff combined with changes to make facilities more youth friendly, when implemented with demand-generation activities and free or reduced-cost services. The results suggest that without sustainable demand-generation activities, initial increases in the number of youth clients will not be sustained. Based on this evidence, the provision of YFHS should include effective training of providers and staff while also considering the structural, financial, and community contexts in which youth FP and RH services are provided.

INTRODUCTION

There are 344.4 million youth ages 10–24 living in Africa, and by 2050 this number is projected to rise to 605 million (Clifton & Hervish, 2013). Although there is wide variability between countries, adolescent fertility is higher in Africa than in any other part of the world, at 108 births per 1,000 women ages 15–19 (Population Reference Bureau [PRB], 2017). High fertility rates and low prevalence of modern contraceptive use contribute to increased maternal and infant mortality (Donovan & Wulf, 2002; World Health Organization [WHO], 2018a). Compared to adults, adolescents who give birth are at higher risk for death, health complications, and long-term economic and social consequences (WHO, 2018b; Guttmacher Institute, 2015).

Young people (ages 15–24) and adolescents (ages 15–19) face unique individual, interpersonal, institutional, and community-level barriers to exercising their rights to make and act on decisions about their reproductive health and to access voluntary modern contraception (Huaynoca, Svanemyr, Chandra-Mouli, Moreno, & Lopez, 2015; Hainsworth Engel, Simon, Rahimtoola, & Ghiron, 2014; Radovich, Dennis, & Wong, 2017; Tylee, Haller, Graham, Churchill, & Sanci, 2007). Efforts to improve access for female and male youth and adolescents have frequently focused on providing stand-alone youth and adolescent health clinics, which have shown positive effects in reducing adolescent pregnancies and improving access to modern contraception (Huaynoca et al., 2015; Denno, Hoopes, & Chandra-Mouli, 2015; Perry & Thurston, 2008; Blank Baxter, Payne, Guillaume, & Squires, 2012; Kempers, Ketting, & Lesco, 2014; United States Agency for International Development [USAID] 2015).

However, these stand-alone clinics are often costly and difficult to scale up, because they require additional infrastructure and staffing (Hainsworth et al., 2014; Huaynoca et al., 2015; Kempers, 2015; Goicolea et al., 2016). The costs of providing parallel services for youth and adults is particularly challenging in resource-constrained settings (Huaynoca et al., 2015; Kempers, Ketting, & Lesco, 2014; Tylee et al., 2007; Chandra-Mouli, McCarraher, Phillips, Williamson, & Hainsworth, 2014; Deogan, Ferguson, & Stenberg, 2012; Kempers et al., 2015). An alternative solution to increase access to voluntary family planning (FP) and modern contraception is mainstreaming YFHS into already existing services, thereby minimizing costs and creating more sustainable voluntary FP services (Baraitser, Fettiplace, Dolan, Massil, & Cowley, 2002; Kempers, Ketting, & Lesco, 2014). The evidence for mainstreaming adolescent-friendly elements into existing FP services is limited, but promising (Denno, Hoopes, & Chandra-Mouli, 2015; USAID, 2015; Baraitser, Dolan, Feldman, & Cowley 2002; Baraitser, Fettiplace, Dolan, Massil, & Cowley, 2002; French et al., 2006). The WHO Quality of Care Framework criterion for YFHS are services that are equitable, accessible, acceptable, appropriate, effective and gender equitable (WHO, 2012). Provision of services to youth that have these attributes have been shown to have positive effects on uptake of modern contraception and reduced pregnancy and abortion among youth and adolescents (Brittain et al., 2015).

Lack of youth-friendly training and youth-friendliness among providers is a substantial barrier to adolescents' and young people's use of contraceptive and FP services (Geary, Gomez-Olive, Kahn, Tollman, & Norris, 2014; Geary, Webb, Clarke, & Norris, 2015; Bankole & Malarcher, 2010; Pathfinder International, 2017). In a review of strategies to provide youth reproductive health (RH) services and increase demand, Denno, Hoopes, and Chandra-Mouli (2015) found limited evidence that provision of YFHS training to healthcare staff alone is effective in improving health service uptake or reducing incidence of STIs and HIV among youth. However, they found evidence YFHS training had positive effects for healthcare staff, combined with changes to make

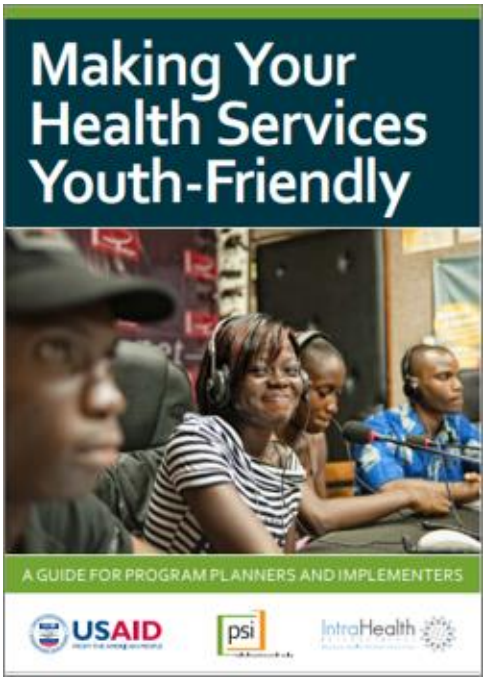
facilities more youth friendly and broad information dissemination campaigns. Different campaigns targeted parents, schools, and communities, or used broad mass media approaches to increase community acceptance of YFHS and RH for youth and to generate market demand for services. Positive effects noted in the reviewed studies included increased clinic attendance, contraceptive uptake, and reported contraception and condom use among youth and adolescents.

Program Description

Since 2010, USAID, the United Kingdom's Department for International Development, the Netherlands Development Cooperation, and private foundations such as the Bill & Melinda Gates Foundation and the Children's Investment Fund Foundation, among others, have partnered with PSI through the Support for International Family Planning Organizations (SIFPO) and SIFPO2 projects. The projects have worked to strengthen local FP programs in most priority countries of the USAID Office of Population and Reproductive Health and Ouagadougou Partnership The projects have particularly focused on improving the quality of healthcare in private sector and NGO delivery channels. Capacity building for implementation of YFHS is an integral part of the work to expand access to voluntary FP and contraceptive choice.

PSI provided its country network members with a youth programming guide for healthcare providers, service administrators, program implementers, researchers, and planners (Girard, 2011). The guide presented an evidence-based overview of the need for YFHS and key recommendations for developing, implementing, and evaluating YFHS. The guide included tools and checklists for clinics to evaluate YFHS delivery at their site, interactions between patients and providers, and overall patient satisfaction (Figure 1). Finally, PSI also created a YFHS certification tool that helped to ensure that these practices were put into place and followed within each individual clinic. The PSI network member in each country chose whether to use these tools, adapt them, or adopt other tools.

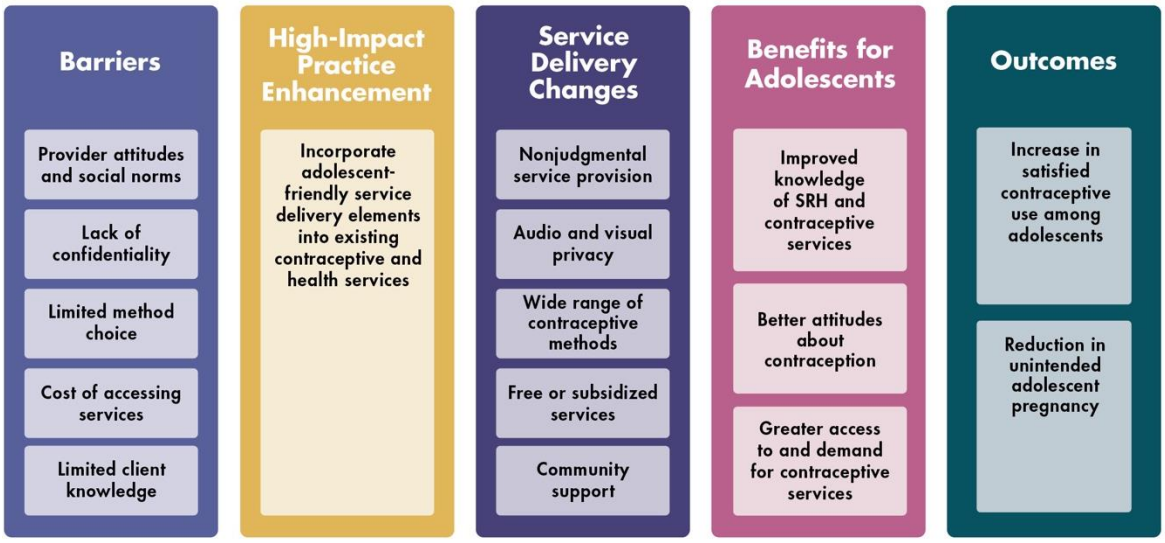
Figure 1. PSI youth programming guide



To further support the implementation of YFHS in private and public sector partner clinics, PSI provided YFHS training directly to franchise providers and staff,[2] health officials, referral agents, and local youth, with the aim of expanding youth access to healthcare in facilities, i.e., by "mainstreaming" YFHS. An adaptable 3–5-day curriculum was used to educate participants on the unique RH and FP service needs of young people (10–24), youth (15–24), and adolescents (10–19). Curriculum topics included an overview of core YFHS components, discussion of adolescent development, and updates on contraceptive technology. Activities included examining the impact of provider and clinic staff's personal values on youth access to and use of health resources and developing practical skills for communicating with and counseling youth in RH and reproductive rights (Population Services International [PSI], 2016). Each training was tailored to fit the local country context and needs of providers and staff. To help ensure that training was put into practice, PSI network member staff provided support such as on-site visits to assist providers and staff in implementing YFHS into their clinic. At the global level, PSI also added a quality assurance standard related to the inclusion of young people, youth, and adolescents for all voluntary FP service delivery programs, regardless of funding source. With SIFPO2 support, PSI made an updated YFHS training curriculum available in 2015.

The PSI program to mainstream YFHS implements key elements of the High Impact Practices Framework for Providing Adolescent Friendly Contraceptive Services (High-Impact Practices in Family Planning [HIP], 2015). The framework is shown in Figure 2. Key service delivery elements to overcome barriers are training and supporting providers to offer nonjudgmental services to adolescents, enforcing confidentiality and ensuring audio and visual privacy, offering a wide range of contraceptive methods, and providing free or subsidized services. Ensuring legal rights, policies, and guidelines to protect adolescent's rights and fostering support among communities are key to building an enabling environment.

Figure 2. Improving adolescent access to and use of contraception through adolescent-friendly services: Theory of change framework



Source: HIP, 2015

[2] PSI does not operate clinics but, instead, engages independent private and public-sector health clinics in social franchise relationships as part of a broad franchise of healthcare networks

Evaluation Purpose and Objectives

The objective of the evaluation was to contribute to evidence on the effects of mainstreaming elements of adolescent- and youth-friendly health services into existing FP service delivery. More precisely, the evaluation assessed the changes in youth's voluntary uptake of FP methods and perceptions of service quality. We hypothesized that YFHS training, activities, and support would improve the quality of mainstreamed services for youth, which in turn, would increase the number of youth accessing services and choosing voluntary FP methods. The evaluation also sought to assess the motivations of healthcare staff and their attitudes and behaviors towards youth as a result of the intervention. We hypothesized that the intervention would lead to provider and staff uptake of youth-friendly behavior, which in turn, would contribute to a perception of high service quality among youth. The results of the evaluation provide a stronger basis for evidence-based decision making about youth programming.

Evaluation Questions

The main outcomes of interest in the evaluation were related to (1) use of FP services and contraceptive methods by youth, (2) youth's perceptions of FP service quality, and (3) provider and staff attitudes. To evaluate the effects of mainstreaming adolescent and YFHS elements into existing FP service delivery, the evaluation sought to answer the following questions:

1. To what extent was the PSI YFHS intervention package associated with an increase in the number of FP clients ages 15–24?
2. To what extent did voluntary FP (by method) uptake increase among clients ages 15–24 after the implementation of the YFHS intervention package?
3. How, and in what ways, did the PSI YFHS intervention package influence perceptions of service quality?
4. What are provider and clinic staff attitudes and behaviors regarding the provision of YFHS? How, and in what ways, did PSI's YFHS intervention package influence the attitudes and behaviors of providers and staff within clinics?

Selection of Country Network Members

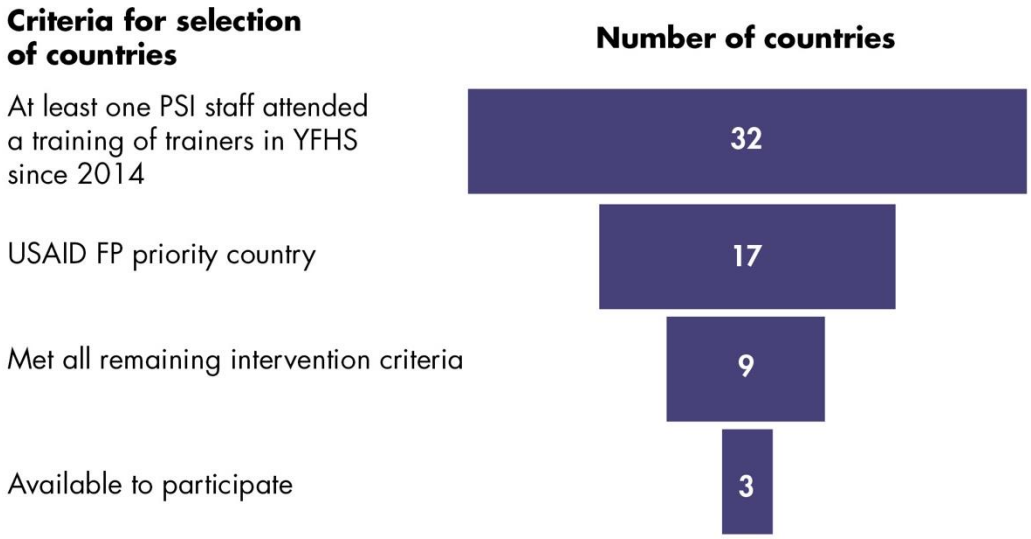
The evaluation focused on three PSI network member countries that implemented a 2015 updated YFHS training curriculum as part of a comprehensive strategy to improve youth access to quality FP services: Madagascar, Malawi, and Mali. These countries were selected based on the following criteria established by PSI, USAID, and MEASURE Evaluation:

- At least one PSI network member staff attended a SIFPO and PSI training-of-trainers in YFHS since 2014.
- The country network member was in a USAID FP priority or assisted country.
- Following the training-of-trainers, the network member staff led at least one training of FP providers and staff in YFHS.
- The network member conducted at least one follow-up support visit or YFHS-focused meeting with the majority of providers and staff who received training.
- The trained providers and staff offered a wide range of FP methods, including long-acting, reversible contraception (LARC), including implants and copper intrauterine devices (IUDs).

- The trained providers and staff received FP quality assurance support from the network member and/or PSI Washington, including supervision standards for privacy & confidentiality.
- The trained providers and staff offered free or subsidized FP products and services to youth with a financial need.
- The network member agreed to participate in the evaluation and share data.
- The network member collected data on the number of FP clients by age before and after initiating YFHS.

Figure 3 shows the selection of country network members through the application of these criteria. Of the 32 countries in which at least one PSI staff attended a training in YFHS since 2014, 17 were in USAID PRH priority countries. Of these, nine country network members met the remaining YFHS intervention criteria. Six were unable to participate, owing to time and logistical constraints, which introduced the possibility of selection bias among network members willing to participate in the study. The three network members meeting all selection criteria and able to participate were PSI Madagascar, PSI Malawi, and PSI Mali.

Figure 3. Selection of country network members to participate in the evaluation



Context and Country Program

Madagascar

Madagascar is one of the poorest countries in the world and has a maternal mortality ratio of 478 per 100,000 live births (Institut National de la Statistique Ministère de l'Économie et de l'Industrie Antananarivo, Madagascar & ICF Macro, 2010). Maternal mortality fell 54.6 percent between 1990 and 2015; however, it remains well above the Millennium Development Goal target of 180/100,000 (Alkema et al., 2016). Approximately two-thirds of Madagascar's population is under age 25. Among 20–24-year-old women, 12 percent were married by age 15 and 41 percent by age 18; 36 percent have given birth by age 18 (Institut National de la Statistique Ministère de l'Économie et de l'Industrie Antananarivo, Madagascar & ICF Macro,

2010; WHO, 2018c). Recent data suggest that approximately 33 percent of married women ages 15–49 use modern contraception (WHO, 2018c).

In 2000, PSI Madagascar, in cooperation with a number of other partners, launched the Top Réseau[3] social franchising network. The network expanded to include nine regions, and approximately 200 affiliated clinics in 2012. Between January 2001 and June 2011, the network saw over 730,000 youth patients. Since 2008, the network has expanded method availability to include LARCs. In 2013, PSI Madagascar began training outreach workers and providers in youth-friendly outreach and health provision and began including assessment of youth-friendly quality standards in PSI quality assurance visits. In 2017, Top Réseau clinics served more than 50,232 family planning clients under the age of 25; 1,519 of whom were adolescent girls (ages 15–19) who chose voluntary LARC methods. All Top Réseau franchise clinics receive YFHS training and must have a youth-friendly clinic environment as part of the minimum criteria for network membership.

In 2016, the updated YFHS training curriculum and tools were given as a refresher course to Top Réseau providers. The refresher training was provided within the context of additional and ongoing programs for youth outreach and demand generation, including a voucher distribution program for youth that was already in place.

Malawi

Malawi has a maternal mortality ratio of 634 per 100,000, which decreased by 33.6 percent between 1990 and 2015 (Alkema et al., 2016). Like Madagascar, the population in Malawi is young, with two-thirds of the population under 25. Among 20–24 year-old women, 9 percent were married by age 15 and 42 percent by age 18, 35 percent had given birth by age 18, and 38 percent use a method of modern contraception (WHO, 2018c; National Statistical Office/Malawi and ICF, 2017). Among women ages 15–49, modern contraception is used by 58.1 percent of married women and 43.2 percent of sexually active unmarried women (National Statistical Office/Malawi and ICF, 2017).

In 2012, PSI Malawi launched a social franchise network for health services, the Tunza Family Heath Network, to increase access to quality health services in Malawi. The Tunza Family Health Network currently has 59 franchises; PSI Malawi provides franchisees with training and mentorship in business management, quality assurance of clinical services and YFHS. PSI Malawi has trained 46 providers in YFHS, of which 40 providers remain active in the network. In 2017, 34 percent of Tunza Family Health Network FP clients were youth; 9,893 youth (under 25 years of age) out of 29,248 clients total.

YFHS training was conducted in 2013, 2014, 2016 and 2017. Trainings in 2016 and 2017 used the updated YFHS training curriculum, and were given as a refresher for some providers and a first training for newer franchise members. The curriculum was implemented within a context of additional and ongoing programs for youth outreach and demand generation. "Youth Friendly" clinic branding certification was available. However, there was no funding for youth peer educators, and RH outreach programs concluded at the end of 2016.

Mali

Mali has a maternal mortality ratio of 587 per 100,000, which represents a decrease of 41.9 percent since 1990 (Alkema et al., 2016). Mali has a young population, with nearly two-thirds under the age of 25. Early marriage

[3] Top Réseau is the name of the PSI Madagascar franchise.

is more common in Mali than in Madagascar and Malawi, with 17 percent of women ages 20–24 married by age 15 and 52 percent by age 18; 46 percent of women in this age group have given birth by age 18, and only 10 percent use a modern method of contraception (WHO, 2018c; UNFPA, 2017). Mali has one of the lowest modern contraceptive prevalence rates in the world, and recent estimates place modern contraceptive prevalence at 15 percent of married women 15–49 (PRB, 2017).

PSI Mali has partnered with the government of Mali to increase voluntary access to FP, including LARCs, through a package of services including the ProFam social franchise health network, and *Le Grin,* an initiative that integrates YFHS into the ProFam health network. PSI Mali also piloted a program to increase women's access to voluntary IUDs, by providing training and support to providers, leading to considerable uptake of IUDs within the context of informed choice. In 2017, PSI Mali provided 30,253 young women under age 25 with voluntary LARCs within the context of informed choice and a broad range of method options.

In Mali, the YFHS training intervention consisted of a pilot study of 14 clinics with no prior YFHS training. The clinics were provided with training, using the 2015 YFHS curriculum, in March and April 2017 and supportive supervision, in conjunction with Le Grin social and radio drama listening clubs that took place outside of the participating clinics. Peer mobilizers also distributed referral cards to enable youth to access FP services in the ProFam network at reduced prices.

METHODS

Evaluation Design

The evaluation used a retrospective review and analysis of relevant monitoring and evaluation data and service statistics collected by the network members in Madagascar, Malawi, and Mali. Three types of analyses were conducted for the evaluation. The first was a document review of country network program reports, technical briefs, case studies, strategic documents, and previous evaluation protocols and results. The availability of documents varied by country member. The second was an assessment of service statistics captured by the routine health information system of the network members. Availability of data also varied by country member. Third, an assessment of qualitative data collected in Malawi was used to investigate perceptions of YFHS and service quality among youth and to explore healthcare provider and staff attitudes towards the YFHS and efforts to mainstream YFHS, and to investigate sustainability around the mainstreaming effort. The types of data available for each network member are listed in Table 1.

Table 1. Type of data available for evaluation, by country network member, 2018

	Service data	Mystery clients	Program reports and documents	Focus groups	Provider/staff interviews
Madagascar	X	X*	X		
Malawi	X	X*	X	X	X
Mali	X	X*	X		X*

*Summary from internal evaluation

A triangulation of the data was used to address the evaluation questions.

Service Statistics

Service data from partner countries were provided to MEASURE Evaluation by PSI from June–October 2018. Dates of statistics ranged from 2013 through mid-2018, differing by country and when the YFHS trainings were implemented. The service statistics and programmatic data available for the evaluation varied between countries in the following ways:

Madagascar: Total monthly FP services provided January 2013–July 2018 in which at least one clinic provider received YFHS training in March, April, May, or October of 2016. Data disaggregated by the 15–19 and 20–24 age groups and method type were unavailable, per an in-country funding agreement for PSI Madagascar.

Malawi: Monthly service data from January 2013–July 2018 in which at least one clinic provider received YFHS training in 2013, 2014, 2016, or 2017. Data include number of services by age group (15–19 and 20–24), FP method related to service (IUD, implant, oral contraceptive pill [OCP], injectable, condoms, counseling-only) and type of service (method adoption, continuation or discontinuation). Data on method continuation and discontinuation were incomplete and were not included in the evaluation.

Mali: Monthly service data from May 2016–June 2017 for 14 clinics included in a pilot YFHS program. Data include number of services by age group (15–19 and 20–24) and include monthly counts of counseling-only

FP visits (in which methods were offered but none adopted that day) and adoption of the IUD, implant, injectable, and OCP. The updated YFHS training was delivered in March and April of 2017.

The indicators for the analysis of service statistics follow:

Madagascar: Number of monthly FP clients ages 15–24

Malawi and Mali: Number of monthly FP clients 15–24, 15–19, and 20–24

Number of monthly FP services disaggregated by age group, LARC (copper IUD and implant), short-acting method (SAM) (OCP, injectable, condoms[4]), or counseling-only

Program Documents

Materials related to PSI activities to support the mainstreaming of YFHS in each of the three countries were collected and reviewed June–October 2018. The documents included quarterly program reports and briefs, previous evaluations, and mystery client evaluations conducted by PSI. Information requests were sent to in-country PSI offices (typically to the Youth Services Program Coordinator, when available), or PSI Washington to clarify emergent questions. The list of documents reviewed is included in Appendix A. Findings of previous research are included in this assessment; when possible, MEASURE Evaluation further examined the primary data.

Supplementary Data

Service statistics and program documents are rarely sufficient to assess service quality, particularly the perception of service quality by clients and potential clients. Therefore, supplementary qualitative data were collected to gain a better understanding of youth and healthcare staff perceptions of YFHS in one of the three selected PSI network programs. Malawi was chosen for supplementary data collection because it had a long period of YFHS trainings and PSI Malawi agreed to assist with the logistics of the data collection. Focus group discussions (FGD) were conducted with male and female youth ages 15–24 living in communities served by PSI franchise clinics that had worked to mainstream YFHS. In-depth interviews were conducted with 10 healthcare providers and staff that received the YFHS training since 2014. The qualitative data were collected November 25, 2018–December 5, 2018, by two in-country consultants (one female and one male) for MEASURE Evaluation. Interviews were recorded, transcribed, and translated into English. Transcripts were analyzed by respondent sex and age to identify relevant themes and patterns of responses to help contextualize quantitative findings.

Focus Group Discussions (FGD)

Six focus groups were conducted with females (two for ages 15–19 and four for ages 20–24) and three with males (ages 18–25) living in the area of the health facility. Groups ranged in size from 4–13 youths—the group of four was a result of heavy rains that kept some recruited individuals from attending the discussion session. Local organizations were contacted to assist with recruiting and finding space for the FGDs. Recruitment and discussions took place near the health facility or in program space in the selected community. Participants in FGDs (1) were ages 15–24, regardless of parity or marital status, and (2) had knowledge of the PSI network

[4] Although it was noted that condoms were distributed during the time frame, data from Mali did not include information on condoms distributed or number of services in which condoms were selected as FP method.

member healthcare facility, regardless of whether they had personally been a client. There were no exclusions based on gender, race, or ethnicity. The FGDs took place in Dowa, Kasungu, Mzuzu, Ekwendeni, Lilongwe, Nkhata Bay, and Nkhotakota.

Focus group participants were asked about their attitudes toward services offered to youth, perceptions of service quality at the facility, and whether the healthcare facility was seen as meeting the needs of youth in their communities.

Provider and Staff Interviews

Key informant interviews were conducted with ten healthcare providers who work at health facilities in which YFHS are provided and that received the YFHS training. The sample allowed for about one-quarter of the overall number of trained health staff to provide input to the study. (As of June 2017, Malawi had trained 39 providers and staff.) The ten facilities were selectively sampled among PSI network member facilities that have worked to mainstream YFHS to include different locations and facility sizes. Staff eligible for interview were those who (1) received the training and materials for mainstreaming YFHS, (2) were currently working in PSI YFHS clinics, and (3) were available for the interview on the day of data collection. Staff eligible for the interviews were identified through collaboration with the PSI Malawi headquarters staff. An attempt was made to include a mix of service provider types (in-charges, physicians, counselors, and nurses). Service providers were not excluded by whether they currently serve adolescents and youth. The communities in which the health staff interviews took place included Dowa, Kasungu, Mzuzu, Lilongwe, Nkhata Bay, and Nkhotakota.

Healthcare providers were asked about their attitudes on mainstreaming YFHS; their perceptions of successes and challenges to these efforts; attitudes on YFHS training; and perceptions on sustainability of the YFHS efforts. Providers were also asked their opinions for improving YFHS efforts and areas for future work.

Analysis

Evaluation of PSI's YFHS training and intervention package started with a document review and identification and contextualization of information contained within program reports, evaluations, and strategy documents from the three partner countries. Service statistics were provided in Excel. Spreadsheets were then used to assess trends in FP service counts according to the indicators presented previously and by training cohort. Graphs were developed to display trends. Numbers were compared by calendar year, quarter, month, and "implementation period," as available, in an effort to smooth out data issues, such as the effects of non-reporting for any single month. Finally, content analysis of qualitative data according to themes used in the interview and focus group guides (Appendix C) was undertaken to assess youth's perception of service quality and healthcare staff's perceptions of the YFHS training and implementation in Malawi. Information from documents, program reports, PSI management inquiries, in-depth interviews, and FGDs was used to contextualize the available service data and to identify and assess the strengths of implementation of context-specific, multipronged interventions that pair YFHS provider and staff training with community outreach and demand-generation strategies. The analysis also identified barriers to effectiveness of YFHS provider and staff training, long-term perceptions of the YFHS training, and youth perceptions of barriers to accessing FP within the Malawian context and assessed whether the training was successful in increasing use of FP services among youth in the three countries evaluated.

Ethical Considerations

In preparation for the activity, a memorandum of understanding for the sharing of data between PSI and MEASURE Evaluation was signed on November 10, 2017. The University of North Carolina Institutional Review Board approved the evaluation protocol and data collection tools, including consent forms, on August 24, 2018, through expedited review #18-1303. The Malawi National Committee on Research in the Social Sciences and Humanities approved the collection of qualitative data on November 12, 2018, through permit #P.09/18/318. Informed written consent and assent was obtained from all key informants and FGD participants. Providers and staff approached for participation in the study were informed that the interview was not required and would not influence their relationship or affiliation with PSI. A waiver of parental permission was received for participants aged 15–17. The waiver was received on the grounds that (1) the study presented minimal risk to participants, (2) obtaining permission from parents or guardians could increase the risks of study participation, rather than decrease them, owing to social norms and negative perceptions of discussing contraception with adolescents, and (3) section 4.1.2 of the Malawian National Commission for Science and Technology research framework stated that parental permission may be waived for research involving adolescents about their contraceptive access (National Commission for Science and Technology, 2011).

The anticipated risks of participating in FGDs included possible disclosure of personal information and the potential for feeling uncomfortable discussing RH topics. To reduce these risks, researchers emphasized that participants should not disclose personal information about their sexual behaviors, that what was discussed in the group should be kept confidential, and that participation in the discussion was voluntary and participants were free to refuse to answer any question or to leave at any time.

RESULTS

Given the varied context of the YFHS training curriculum implementation in Madagascar, Malawi, and Mali, results are presented first within the framework of individual country program narratives, followed by a cross-country comparison of how each partner country addressed the different components of YFHS.

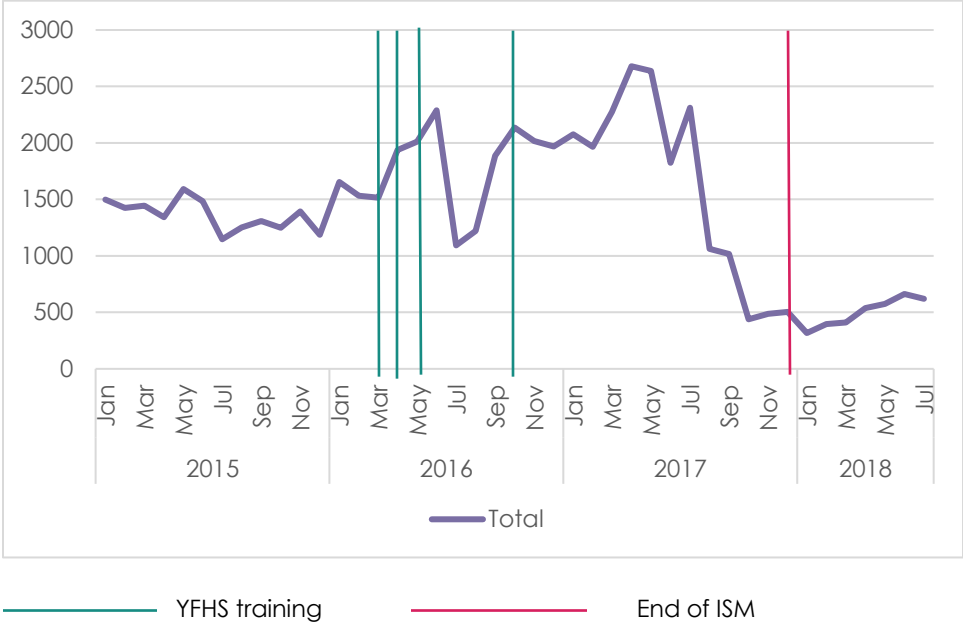
Madagascar

PSI Madagascar's Integrated Social Marketing (ISM) program ran from 2013–2017 and sought to increase use of health products and services, particularly targeting FP and reproductive health, maternal and child health, and malaria. The goal of the program was to improve the health of the Malagasy population, particularly youth 15–24, women of reproductive age, children under five, and those living in rural and underserved areas. In support of this goal, PSI's updated YFHS curriculum was delivered to healthcare staff as a refresher of YFHS.

PSI Madagascar's ISM package included elements that addressed all four components of effective YFHS programs. PSI's updated YFHS curriculum was delivered to healthcare staff in four training cohorts from March through October 2016 (March, April, May, and October), followed by supportive supervision of clinics to refresh the understanding of staff attitudes and clinic characteristics that promote youth-access to FP services. At least one provider from 73 network member clinics, representing nearly 30 percent of the Top Réseau member clinics, attended one of four updated YFHS training sessions. The *Tanora 100 percent* campaign, in which PSI-trained peer educators and providers jointly engaged youth in sensitization activities ranging from small group discussions to large events, such as weekend festivals, to increase youth demand for FP services. Increasing youth demand for voluntary FP services was also an aim of the "Fan Club Tanora," a loyalty scheme in which club members served as youth ambassadors to their peers and received rewards for referring other youth to Top Réseau clinics for counseling. Vouchers for subsidized services were distributed by peer educators. FP counselors aimed to increase demand for services and make them more accessible to youth. Finally, the ISM package targeted community awareness and approval of youth use of FP services via broadcasts of their "Healthy Family" radio drama and radio and TV spots about youth and FP.

A graph of the monthly trend in the number of FP clients ages 15–24, from January 2015 through July 2018, for clinics with at least one provider trained in 2016 is shown in Figure 4. The graph shows that the total number of FP clients ages 15–24 peaks in April and May 2017 and declines thereafter. In the twelve months after staff received the updated training refresher (i.e., pre- and post-training intervention, rather than calendar year), the total number of youth FP clients increased 94 percent, 65 percent and 72 percent for the March, April, and May 2016 training cohorts compared to the 12 months prior to the training, though the trends were not sustained. Furthermore, the clinics with staff trained in October had an 80-percent decline in the number of FP clients ages 15–24 in the twelve months after the training, compared to the twelve months prior to the training. The decline in client numbers for this final cohort may have been affected by the end of ISM, which funded youth vouchers and peer-led mobilization. ISM ended in Dec 2017, which meant youth program activities took place for only part of the year before the closeout process began.

Figure 4. Total number of FP clients ages 15–24 in clinics with staff receiving the updated YFHS training curriculum in 2016, Madagascar



To explore the possible effects of non-reporting or very low youth client volume at FP clinics, we repeated the analysis excluding clinics that reported fewer than 15 FP visits for young people in 2016 and 2017. (There were 10 in the October cohort and two in the April cohort.) The trends were not affected (results not shown).

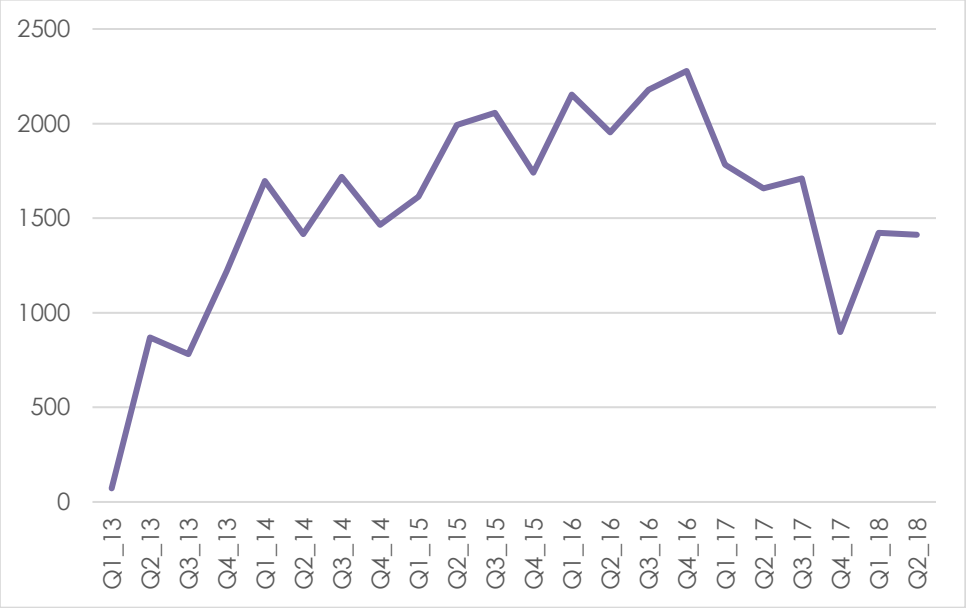
Positive changes in youth experiences were observed at clinics in which at least one provider had attended one of the YFHS trainings. A mystery client study conducted by PSI in 2016 found that 61.5 percent of providers and clinics included in the study met the standards for YFHS provision. The greatest strengths among clinics and providers were found to be the explanation of multiple contraceptive methods, respectful provider interactions with clients, and youth-friendly clinic structures and settings. Identified weaknesses included the omission by providers of verbal assurance of confidentiality and limited counseling on effectiveness of condoms relative to other methods for protecting against pregnancy and HIV and other STIs (PSI Madagascar, 2016).

Malawi

PSI Malawi addressed all four of the YFHS effective program components. Provider and staff training in YFHS was offered in 2013, 2014, 2016, and 2017. Beginning in 2016, PSI Malawi provided the updated PSI YFHS curriculum. The updated curriculum was delivered to 23 providers and staff from 2016–2017. Supportive supervision by PSI reinforced the youth-friendly adaptations to facilities, as did requirements for clinics to receive a "Youth-Friendly Clinic" certification (and branding), which almost all clinics completed within a year following YFHS training. PSI-trained interpersonal communication agents also engaged in one-to-one sessions with youth and referred them to Tunza health clinics. Partners also conducted activities to increase community awareness and approval of youth use of FP services by engaging local community and religious leaders, radio and television broadcasts, and a broad range of communication and sensitization events.

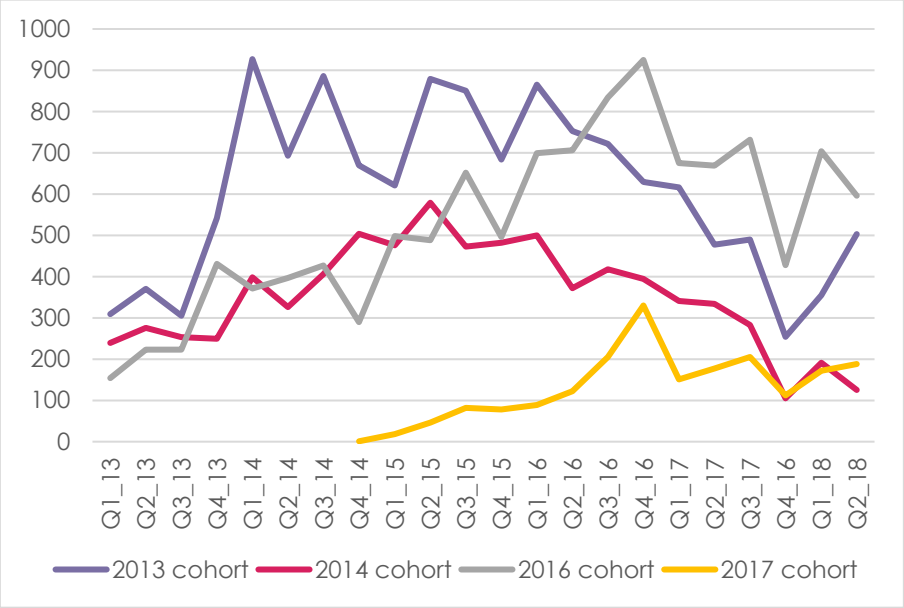
The five-year trend in the number of FP clients ages 15–24 seen at clinics in which staff received training is shown in Figure 5. There is an increasing trend in numbers through most of the period with a peak of 2,278 youth clients during the fourth quarter of 2016, after which the numbers begin to decline.

Figure 5. Total number of FP clients ages 15–24 in clinics included in the YFHS training intervention, Malawi



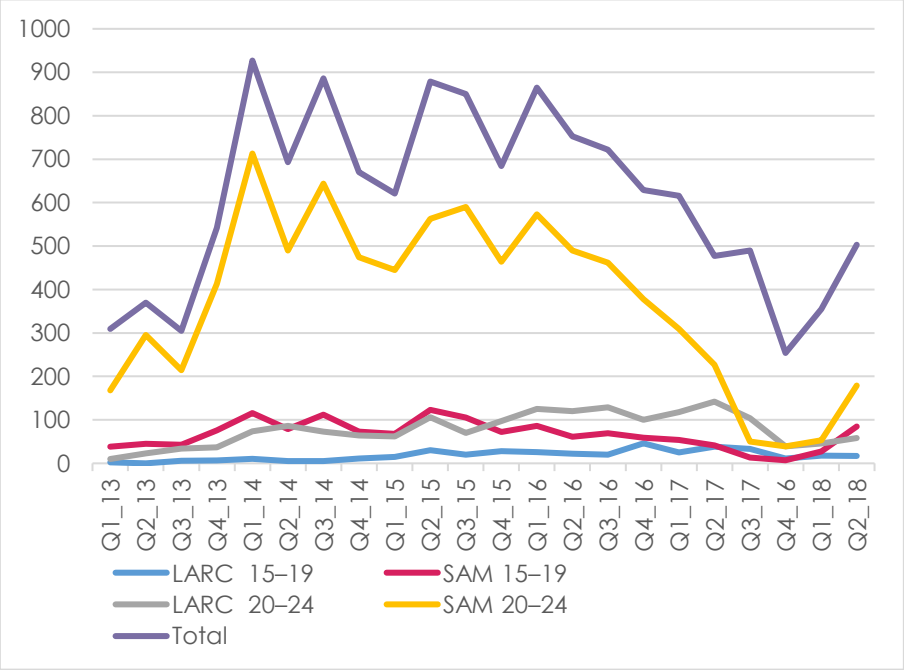
Disaggregation of the clinic data by training cohort shows noticeable increases in the total number of FP clients in the months after the training. The initial increases, however, were not sustained. Notably, the 2013 and 2014 training cohorts were already showing declines in numbers by the time the 2016 and 2017 cohorts were reaching their peaks (Figure 6).

Figure 6. Number of FP clients ages 15–24 in clinics included in the YFHS training intervention, by training cohort, Malawi



The general pattern is replicated when looking at method choice (long acting and short acting) and age group (15–19 and 20–24), as shown for the 2013 training cohort in Figure 7. The initial increase and subsequent decrease in numbers was driven mainly by clients ages 20–24 who chose SAMs (specifically, the injectable). This pattern holds true for the other training cohorts as well, with only one exception: the clinics involved in the 2017 cohort show higher initial use of LARCs among the 20–24 age group (see figures in Appendix B).

Figure 7. Number of FP clients ages 15–24 in clinics included in the 2013 YFHS training cohort, by age group and method type, Malawi



Mali

In 2017, PSI Mali piloted a packaged intervention to improve youth experience with and use of FP services. The comprehensive package consisted of the following components:

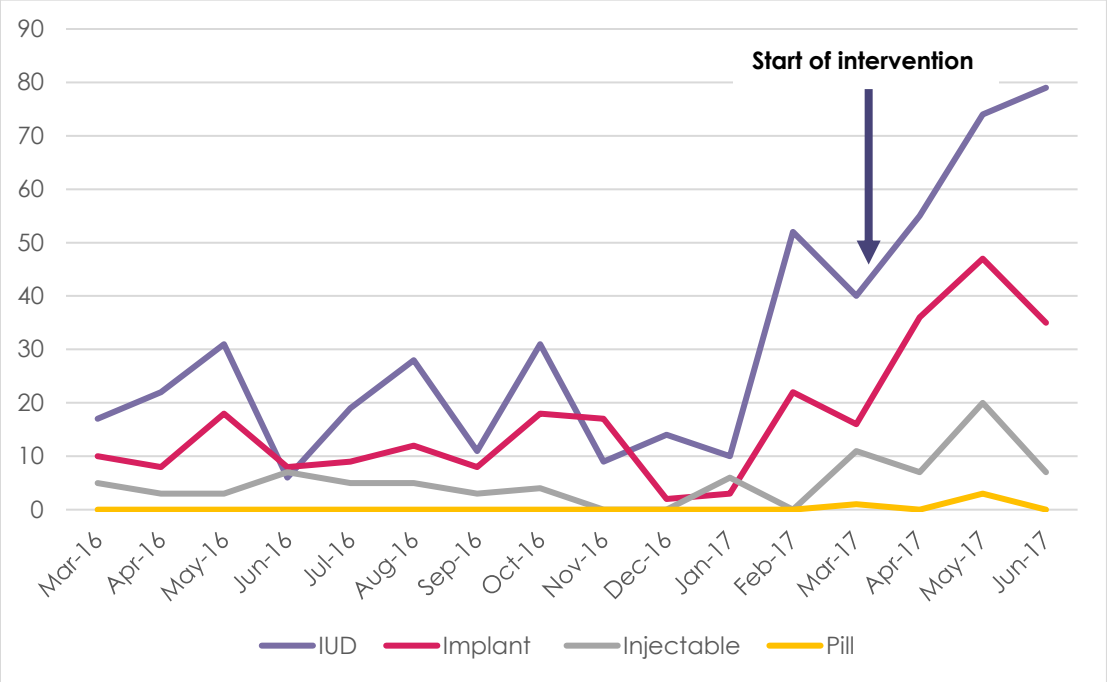
1. Delivery of PSI's YFHS training curriculum to providers and staff of 14 PROFAM clinics that had not previously received YFHS training or support (March and April 2017)
2. Supportive supervision of clinics after the training to support implementation of YFHS at each clinic
3. Establishment of monthly youth discussion groups *(Grins*) near clinics and led by peer educators trained by PSI to promote youth awareness of RH, facilitate comfortable supportive discussion of RH issues, and link youth to desired FP services at PROFAM clinics
4. Conducting outreach activities at schools, public gathering places, and festivals and other large events to raise community, and youth awareness about clinics and the Grins
5. Distribution of referral cards by Grins members to youth for free FP counseling, STI testing and condoms, and a 50-percent discount on contraceptive methods at pilot clinics

Additionally, although not explicitly included in their intervention package, PSI Mali sought to improve community awareness and acceptability of FP, particularly for youth, through broad information dissemination campaigns in the form of segments on popular radio and television shows.

Based on document review and analysis of services statistics from the pilot (monthly services statistics were available March 2016–June 2017 for the 14 clinics in the pilot study), the Mali pilot clinics showed significant gains in the number of FP clients seen and in the uptake of LARC in the months following the intervention.

The number of FP services per month for FP clients ages 15–24 in the 14 clinics is shown in Figure 8 (PSI, 2018). To control for seasonal differences in contraceptive service use, we compared the number of FP services for the four months during and after the intervention (March–June 2017) to the same period in 2016. This comparison shows that the number of adolescent and youth FP clients served increased from 138 to 431, a 212-percent increase between the two periods. By method, the largest increases were seen in services for the IUD (increasing to 248 from 76), followed by the implant (increasing to 134 from 44) and the injectable (increasing to 45 from 18) between these two periods.

Figure 8. Number of FP services per month for FP clients ages 15–24 in clinics included in the 2017 YFHS pilot intervention, by method, Mali

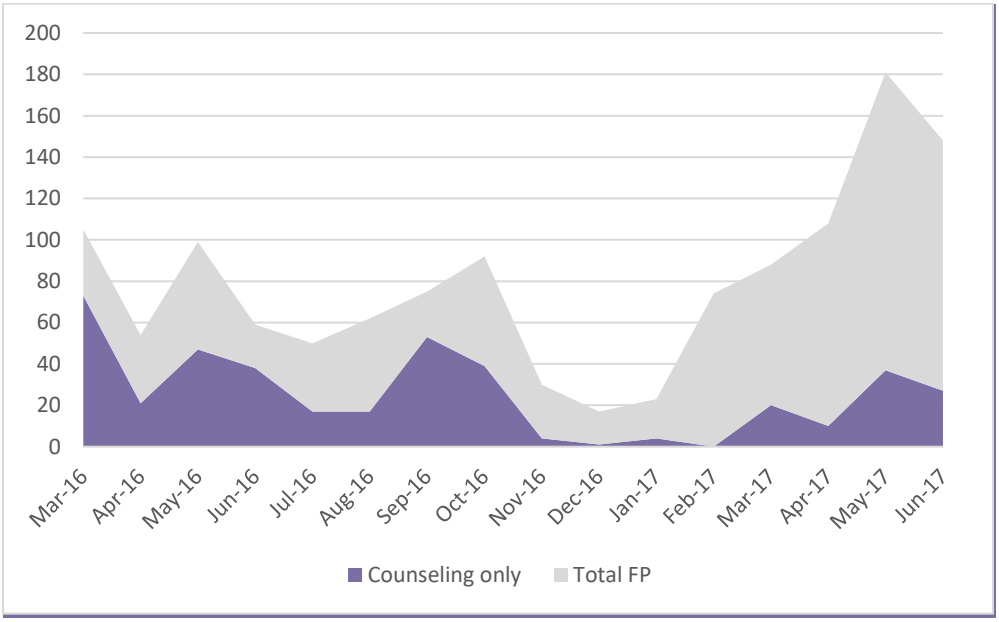


Source: PSI, 2018

The increase in services after the intervention occurred for both age groups: for the same periods, the number of FP clients ages 15–19 increased to 147 from 69, an increase of 113 percent. The number of FP clients aged 20–24 increased to 273 from 68, an increase of 301 percent.

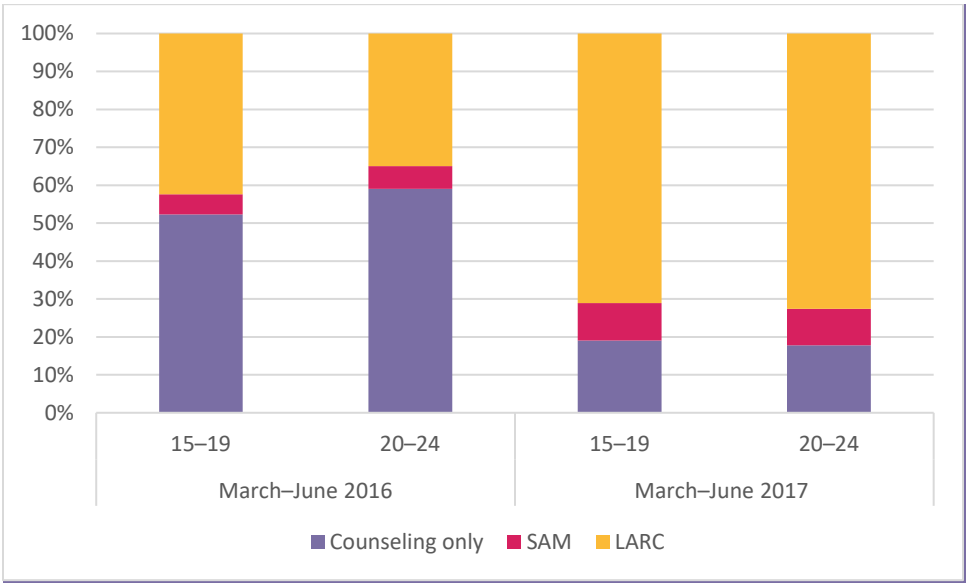
A substantial change in the distribution of FP visit types was found in the comparison of these two periods as well. Counseling-only FP visits comprised 18.0 percent of all FP visits in the four months during and after the YFHS training, compared to 56.2 percent of all visits during the same period in 2016. The trend in total numbers of counseling-only visits compared to method-visits is shown for the entire March 2016–June 2017 period in Figure 9.

Figure 9. Number of FP services per month for FP clients ages 15–24 in clinics included in the 2017 YFHS pilot intervention, by counseling-only vs method visits, Mali



The reduction in counseling-only visits was seen for both the 15–19 and 20–24-year-old age groups. Although there was a slight increase in the number of visits for SAMs, the main increase was for LARCs (Figure 10).

Figure 10. Percentage of counseling-only SAM and LARC services to clients ages 15–24 in clinics included in the 2017 YFHS pilot intervention pre- and post-intervention, by age group, Mali



Regarding quality of services, mystery client interviews, conducted by PSI as part of their evaluation, found some areas of improvement, for example, a 175-percent increase in providers verbally guaranteeing confidentiality to youth patients and improved counseling on all FP methods. Other areas were unchanged or needed improvement, such as use of visual aids during counseling. (PSI, 2018).

Youth Perceptions of Service Quality: Malawi

Nine focus group discussions were held with youth—two with groups of 15–19-year-old females and seven with groups of 20–24-year-olds (four female-only and three male-only). In total, 51 females and 21 males participated in discussions. Recruitment of the youngest respondents proved to be a challenge, because the data collection occurred during end-of-semester testing, and youth that were still in school were either busy with test preparation or too tired to participate after the school day. As a result, few youth ages 15–17 were recruited, and only two FGDs were held for this younger age group.

The youth discussed issues related to the accessibility and acceptability of FP services at Tunza clinics. Some youth reported on their direct experiences, and others reported on what they had heard from their peers. Youth also provided suggestions for improving youth-friendly FP services. In general, there was little variation in responses provided by males and females, or by age group.

Youth were first asked what they would do if they wanted to prevent a pregnancy. In response, both female and male youth reported that they could abstain from sex, obtain FP methods (condoms, pills, injectables, implants, and IUDs were mentioned), practice withdrawal, or practice the rhythm method. The youth listed a wide range of sources where they could access FP services, including at private clinics, such as Tunza clinics, public health facilities, pharmacies, Banja la Mtsogolo nonprofit health centers, youth clubs (mainly for condoms), and the Family Planning Association of Malawi, a nongovernmental organization.

Youth were then asked about the treatment provided by their local Tunza Family Health Network private clinic. A main reason youth said that they or their peers did not access FP services at the Tunza clinic was because they had to pay a fee and could access free FP services elsewhere (specifically, at a Banja la Mtsogolo health center or from the Family Planning Association of Malawi). In the case of one Tunza clinic, male youth indicated that they did not access FP services there because the in-charge (senior clinic staff) was older or busy and the wait time was long. Regarding another clinic, male youth reported they or their peers did not access services because the clinic staff were community members, and this made the youth uncomfortable:

> *The workers in this clinic live with us in the neighborhood and some of them are our relations.* —Male youth, 20–24

> *At a Tunza clinic you have access to any birth control method you would like. However, this clinic offers family planning on same days as older women come, so it is not as private.* —Female youth, 20–24

Among youth who did obtain FP services from a Tunza clinic, most reported that staff were "friendly," "warm," "approachable," "respectful of privacy and confidentiality," and "understanding" when people have money problems and that the staff provided information about different FP methods. One youth also appreciated the location of the clinic and the speed of service compared to public health facilities.

> *The doctor here always urges us to be approaching him for service, even if it means calling him. . . . He is always ready to assist us. He is always there for us.* —Male youth, 20–24

> *People are warm. They teach us not to be shy around them.* —Female youth, 15–19

A participant in one of the female focus groups in the 20–24 age range added that the Tunza staff treat people well, better than at the government health facilities, "and faster too," but it is because they are paying clients.

The youth did not perceive any barriers to FP services at Tunza clinics based on demographic characteristics. However, one of the male groups discussed that youth were lower in priority rankings relative to other age groups, perhaps because of their inability to pay. Overall, the youth reported that unmarried youth are able to access FP at Tunza clinics and that parental consent has never been required to their knowledge. Most of the youth groups also felt that even very young clients would be served by Tunza clinics. However, a member of one of the male discussion groups thought that the in-charge at the local Tunza clinic may want parental approval for a girl, because he might worry what would happen if she has complications. The group then clarified that parental consent has never actually been "required." This discussion group also thought the clinic in-charge would refuse services to someone he considered to be too young to be sexually active. (The in-charge was described as being "old.") Belonging to a different ethnic group was not seen as a barrier to obtaining services at any of the Tunza clinics.

In contrast to demographic characteristics, embarrassment was seen as a common barrier to accessing FP services by both female and male youth. For example, some youth (both female and male) stated that they or their peers would be embarrassed if they were seen entering a Tunza clinic by a friend, because the friend might conclude they are there for FP, which is one of Tunza's highly promoted services:

> *Their friends might see them and start asking questions like, "what is she doing there? If she is there then she has to be going there for the condoms, or is she pregnant.* —Female youth, 20–24

> *You may come to get condoms here, but before entering the gate, one starts asking themselves questions, "what will I say if people ask me what I was doing here?" . . . Unlike other facilities, this one does not have bawo* [a board game] *or chess.* [that could be used as an explanation for being in the clinic] —Male youth, 20–24

The female groups discussed the issue of clinics with multiple services, saying a person could pretend to go for treatment of malaria or because of illness, to avoid anyone finding out the person wanted FP services. However, this tactic was reported as being difficult if the clinic was too small or if the visit was during specific FP hours. Another female group added that women who have had children do not experience the same level of embarrassment.

Another common barrier was cost. Youth reported that the main barrier to obtaining services at a Tunza clinic is that most methods are not free and that some methods, such as implants and IUDs, are expensive.

> *We heard PSI subsidized family planning services at this clinic, but we wonder why services are still on the higher side.* —Male youth, 20–24

Female youth also noted that their peers do not access FP services at Tunza clinics (or anywhere) owing to misconceptions about different FP methods—believing they cause sterility or cancer:

> *Some say that family planning methods have some side effects . . . , that you might never be able to conceive. As a result, youth who have not given birth avoid them.* —Female youth, 20–24

Youth were asked to comment on whether they think FP services at the Tunza clinics would be private (not seen or overheard by others) and confidential (the clinic staff would not talk about their concerns with other clinic staff, clients, or parents). In most cases, both female and male youth reported that privacy and confidentiality at Tunza clinics was good:

> *We feel there is confidentiality because the service providers are trained and they know their ethics.* —Male youth, 20–24

One of the female groups (ages 20–24) added that even though there is confidentiality at the clinic, they are "just embarrassed to come." However, in two of the male and one of the female groups near the seven clinic locations, youth were skeptical of confidentiality because the clinic staff were community members. Members of these groups stated they would prefer to obtain FP services from clinicians who were not from their community.

Finally, the youth were asked if they had any suggestions for improving FP service for young people at the Tunza clinic. The youth offered a variety of suggestions. A common response was the importance of FP service and methods being free of charge or offered at reduced prices to youth. Another common response was that youth would like to see youth clubs restored at clinics, with someone appointed to support or supervise the club and organize health talks. Other youth reported they would like the clinic to have a dedicated room for youth with games such as *bawo* and booklets about FP, or specific days set aside for youth to obtain FP services. One male group suggested more interaction between the in-charge and youth, stating that "youth and service providers can only be free with each other if they interact frequently."

Healthcare Provider Attitudes and Behaviors: Malawi

Ten healthcare staff (nine male and one female) from Tunza Family Health Network clinics participated in key informant interviews. Five of the staff were clinic in-charges, three were clinic directors, one was a nurse, and one was an HIV testing assistant. Three had received their most recent training from PSI in 2013, three in 2014, two in 2016, and one in 2017. One provider reported being trained in 2015. Respondents had been in their current positions an average of 11 years, with a range of 1–27 years. Six of the clinics were located in more rural areas, and four were in urban areas.

Providers discussed accessibility of FP services for youth, acceptability of FP methods for youth, and the importance of confidentiality in providing services to youth. They also expressed their views on mainstreamed versus stand-alone youth friendly clinics and provided suggestions for improving the Tunza Family Health Network initiative.

Accessibility

The interviewed healthcare staff were first asked to describe what it means to make FP services accessible to youth. The staff reported a variety of ways that FP services can be made accessible. These included providing services for free or at reduced cost, being friendly to youth and treating them with respect, educating youth about FP methods, and ensuring confidentiality. One of the providers summed the issues up in this way:

> [To be accessible] *there should be provision of free services for youth, and also, there should be confidentiality in the environment in which these services are provided. In addition, the people providing these*

> *services, are they youth-friendly? Some are afraid of meeting old personnel who they feel might judge them for their actions.* —Tunza service provider

Another provided the following description of accessibility:

> *Spending time with youth and discussing health related issues with them to prevent them from making bad decisions.* —Tunza service provider

One provider mentioned easy access to FP services, regardless of age, "assuming they are over 12."

The healthcare staff emphasized that provision of free or reduced price FP services is key to making the services accessible to youth:

> *The most important thing is the services must be free.* —Tunza service provider

However, several healthcare staff reported that their clinic was only able to offer free or reduced services when supported by PSI:

> *They* [the youth] *pay the whole amount, and only when it is offered by PSI can we allow them to receive the services free of charge.* —Tunza service provider

To improve accessibility, build rapport with youth, and create an avenue for educating youth about FP and other health issues, some clinics have games available, such as bawo or chess, or have youth clubs for football or netball, with games and balls provided by PSI. To promote community awareness of FP services at their clinic, some healthcare staff reported that they gave health talks to youth clubs, have community outreach personnel that educate families about FP services and other health issues, and mobilize youth when they are offering free FP services on a particular day. In contrast, a few providers did not conduct outreach and felt that community awareness of services was low.

Overall, most providers thought the steps they had taken to make FP services accessible to youth were successful, citing increased numbers of youth clients as evidence; however, none had formally assessed youth satisfaction.

Acceptability

Most providers and staff reported that youth in their clinics were allowed to choose the FP method each found most acceptable after counseling was provided on all methods:

> *Providing family planning methods that are acceptable by the youth entails providing information about all the methods and helping the youth make an informed decision on their preferred choice.* —Tunza service provider

However, a couple of providers stated they did not counsel youth on LARC, specifically implants and IUDs, stating that youth do not like those methods because they fear they will never have a child if they use them. Nearly all providers reported that condoms, oral contraceptive pills, injectables, and emergency contraceptive pills were the methods most acceptable to youth, noting that condoms are primarily accessed by males and that

females generally access the other methods. Providers stated that these short-term methods are safe and appropriate for youth and reiterated that it is rare for youth to request LARCs.

Confidentiality

Providers unanimously stressed the importance of confidentiality in providing services to youth:

> *Confidentiality is a primary thing. You have to make a person understand that whatever they are going to volunteer to you is going to be confidential and it is emphasized to her if a person wants a third party to be involved that would be up to them.* —Tunza service provider

> *I tell the youth, "whatever we discuss here will be between you and me. No one apart from us will know."* —Tunza service provider

A few providers reported that they allowed youth to enter their clinic through a special door or provided a special room for youth consultations to help ensure privacy and confidentiality. Others employed young people at reception whom the youth could chat with while waiting for services—in this way, if youth were seen at the clinic, they could say they were just visiting a friend (the receptionist). A few reported that youth were not made to wait in a queue but were brought to see a provider immediately.

Equity

None of the providers stated that they would require parental consent to provide FP services to youth under age 17. However, a few reported that they were "uncomfortable" or "reluctant" to provide services to youth under age 15; in one of the cases the provider stated he would be hesitant to provide services to a youth under age 13. With regard to providing FP services to married females under 17, only one of the providers reported that he would require the husband's involvement. Other providers stated that involving the husband would be the choice of the woman:

> *She is the one who has the choice. It is not for the husband. . . . If she wants the husband to be there, she is free to do so. The choice is hers.* —Tunza service provider

> *Informing the husband is the responsibility of the woman.* —Tunza service provider

With regard to other groups that providers do not feel comfortable serving, a few providers mentioned "drunk youth" and one mentioned "Jehovah's Witnesses" (because "they do not like FP").

Effectiveness: Mainstreamed Compared to Stand-Alone Youth-Friendly Clinics

The healthcare providers and staff had mixed views of whether mainstreamed youth-friendly clinics or stand-alone youth-friendly clinics were more accessible for youth. Their views were based on the issue of which type of clinic could potentially offer the most confidentiality. Some healthcare staff felt that youth could access mainstreamed clinics with greater confidentiality because they could be visiting such clinics for a variety of reasons: FP, malaria treatment, or others. On the other hand, some staff felt that stand-alone clinics offered more confidentiality because youth would not have to worry about seeing older family or community members there.

Experience with PSI and Suggestions for Improvement

The interviewed providers gave positive feedback regarding the training they received from PSI, noting they learned how to approach youth and understand their needs, challenges, and fears with regards to FP. After the training, providers reported receiving items for youth such as footballs, netballs, bawo, and booklets. However, many providers reported that follow-up by PSI after the training was infrequent, with a few reporting that promised materials (such as condoms) were not delivered or that promised activities (such as youth club trips) never materialized. These providers felt this was discouraging to youth:

> *They* [PSI] *should be fulfilling the promises they make to the youth, otherwise they are demotivated and stop participating in youth activities.* —Tunza service provider

This also made it difficult to continue with some of the activities seen as helpful in improving accessibility. The healthcare staff offered suggestions for strengthening the Tunza Family Health Network youth-friendly initiative, which included adding a hands-on practical component to the initial training, adding refresher trainings, convening meetings of providers so they can share experiences and learn from each other, and training youth as peer educators or youth coordinators to manage and organize youth clubs and activities.

Cross-Country Comparison

Each of the three PSI network members packaged multiple YFHS components concurrently with the delivery of the training curriculum to providers and staff at franchise clinics, with the goal of having the greatest positive effect on voluntary youth uptake of FP services. The following are core components of YFHS: (1) YFHS training for providers and staff, (2) adaptation of facilities to be more youth-friendly, (3) generation of youth demand for RH/FP services, and (4) broad information dissemination campaigns to increase community acceptance and support of youth use of RH/FP services. Table 2 provides a brief summary of how each partner country addressed these core components of effective YFHS programs with similar component activities. Narratives of activities, interventions, and program evaluations provided by each partner country highlighted the similarities and differences in the implementation, monitoring, and evaluation of the intervention packages.

Table 2. Summary of YFHS components included in intervention activities by PSI network members in Madagascar, Malawi, and Mali

Component	Example activities	Madagascar	Malawi	Mali	PSI Evaluation & indicators
YFHS training for Providers and staff	Pre-2015 curriculum training	x	x		# staff trained, # youth FP clients, uptake of methods vs. counseling only, method choice, mystery client surveys
	2015 curriculum training	x	x	x	
	new to YFHS training		x	x	
	as a YFHS refresher	x	x		
	Quarterly supportive supervision & assessment by PSI program officers	x	x	x	YFHS assessment tools Client exit interviews

Adaptation of facilities to be youth friendly	Required for network membership	x			# maintaining YFHS certification after franchise entry
	Required for YFHS certification/branding		x		# clinics with YFHS certification within 1 year of training
	Quarterly supportive supervision & assessment by PSI program officers	x	x	x	YFHS Assessment tools Client exit interviews
Generate demand for youth services	Youth groups—social, radio listening, RH focused gatherings (at clinic or elsewhere)	x	x	x	# Youth clubs/ambassadors
	Youth outreach campaigns	x			# of contacts reached # vouchers redeemed
	Youth club ambassadors	x	x	x	# contacts reached
	Referral incentives	x			# Vouchers distributed # vouchers redeemed
	Peer mobilizers	x	x	x	# youth contacts reached # vouchers distributed
	Voucher distribution/youth discount programs	x		x	# vouchers distributed vs. # vouchers redeemed
Promote community approval and acceptance	Outreach events attended by peer mobilizers and RH counselors		x	x	# events attended # contacts reached
	Clinic open days		x		# of open days
	Radio & TV advertisements	x		x	# of broadcasts
	Radio/TV drama series	x	x	x	# of broadcasts
	Engagement with local community & religious leaders		x	x	# of contacts reached

Regarding demand generation for youth services, all PSI partner countries used radio broadcasts and television spots to raise awareness of RH issues and advertise franchise network clinics. All three programs coincided with demand-generation events, such as clinic open days, and, in some cases, representatives or peer educators attended events such as concerts or festivals to engage with local youth and community members. Mali's pilot study explicitly linked the YFHS provider trainings with implementation of Le Grin youth peer social clubs, often held in front of the clinics. Madagascar's clubs were specifically focused on generating demand for Top

Réseau services. In Malawi, youth outreach and demand generation has been largely conducted by other partners, and PSI Malawi and the Tunza network are less directly involved; these clubs were very broadly focused and did not have direct links to Tunza clinics, so the clinics may not have directly benefitted from this demand generation. Malawi began to pilot a voucher program in late 2017, but results from the program were not yet available during the study period.

In addition to outreach and demand-generation events, such as concerts and clinic open days, each partner country sought to further generate community support in a number of ways. Mali's program actively sought to engage local community and religious leaders. In Malawi, PSI and other N'Zatonse partners also engaged local leaders to engender community support. Madagascar's radio drama program "Healthy Families" concluded in 2015, but peer-education and outreach events continued to use episodes as a starting point for interaction and discussion with youth about FP. [Owing to changes in the 2017 work plan, outreach efforts to engage local and traditional leaders were put on hold.]

DISCUSSION

Evidence suggests that the most effective programs to improve youth access to and uptake of RH services do not provide YFHS training for clinic staff and providers as an isolated intervention; rather they package interventions addressing core components of providing successful YFHS. Denno, Hoopes, and Chandra-Mouli (2015) found that intervention programs are more successful when programs combine YFHS training and adaptation of facilities with at least one other core component (demand generation for services and/or broad information dissemination campaigns). In alignment with this evidence, the three PSI network members included in the evaluation packaged the delivery of the YFHS training curriculum with multiple components. Unlike the other two country network members included in this evaluation, PSI Mali implemented a pilot program that intentionally combined all four components to effectively increase YFHS access and quality. The program package benefitted by capitalizing on Le Grin*,* an already common widespread social structure in Mali, for gathering youth and community members. The intentionality of the pilot program may account for their highly successful initial results, and further evaluation will be needed to explore the long-term impact of the training in combination with the Le Grin model. However, as the pilot program is integrated into the larger clinic franchise network, it may become more sensitive to funding and resource shortages. For example, stock-outs of LARCs and STI testing supplies did occur in some of the pilot clinics, and these issues may be more common after the conclusion of the study period.

Results from Madagascar show declines in client numbers after funding and other elements of the intervention package ended. (The ISM package ended in 2017.) In fact, 2018 presents the lowest numbers of youth receiving FP services of the study period. The results suggest that provider training alone will not sustain initial positive increases in youth client numbers. This finding underscores the importance of delivering YFHS training to providers within the larger framework of YFHS core components. Across the three countries, the greatest benefits of the training were seen when combined with demand-generation activities and increased access to peer education.

It is worth noting that at the organizational level, PSI has achieved significant success in meeting a commitment to reach 10 million users under the age of 25 with modern contraceptive methods by the year 2020. As of December 2018, they report reaching 14 million young people with a contraceptive method, two years ahead of schedule. They credit their achievement to a commitment to YFHS, specifically by hiring more young people than ever before, designing programs alongside young people as equal decision makers, increasing intentional youth programming at the global, regional, and national levels, and generating and disseminating new learnings (Pope, 2019).

Quality of YFHS Services

Findings from the FGDs in Malawi indicate that, overall, certified Tunza clinics in which at least one provider had undergone YFHS training were perceived as providing high-quality services to youth. Youth FGD participants used positive words, such as "respectful" and "friendly" to describe services. There were no known barriers to service provision based on demographic barriers. Importantly, most youth thought privacy and confidentiality were protected at the clinics. However, the issue was more problematic for youth living in small communities in which the provider(s) may know the youth, their family, or their friends. These youth would be hesitant to go to the clinics despite the overall positive assessment of services. The main barriers to accessing services at Tunza clinics were reported to be the cost of services and the potential embarrassment of

being seen and known to be accessing FP services, particularly for youth who have not had a child. Regarding cost, the youth seemed aware of places to receive free FP methods and to know that free services are not always consistently available, depending on the provider. For their part, Malawi's Tunza providers made many efforts to improve clinic accessibility. This was especially the case for the provision of confidential services. Providers understood the barrier of cost, though some reported that without financial support from PSI they are not able to provide free services for youth. Inconsistent access to services or contraceptive methods could lead to disruptions in care and use, with potentially negative health outcomes. The importance of outreach to youth and to the broader community was also highlighted. Finally, some providers felt that interest in LARC is low among youth and, as a result, do not always offer these methods as options. Such practices could reinforce negative attitudes of youth toward LARC and undermine uptake of these methods.

PSI evaluations in Madagascar and Mali used mystery clients to assess the quality of YFHS. In Madagascar, while important positive changes to clinic practice were noted, over one-third of the clinics were found to not meet the YFHS standards, specifically those related to counseling practices. The findings suggest improvements were likely needed to FP counseling for clients in general (i.e., assuring confidentiality, explaining use of condoms for protection, and using visual aids), in addition for the youth population. In contrast, Mali pilot clinics were found to have improved counseling to youth, especially in conveying verbal confidentiality.

Limitations

As expected, a main limitation to the evaluation is the variability of programmatic and service data available by country. There were different periods for implementation of the YFHS training, different lengths of implementation of the YFHS intervention packages, and differences in the ways in which the data were collected. A direct comparison of findings, particularly from the analysis of service statistics, across the three countries was therefore limited. Furthermore, the retrospective design meant that the evaluation was constrained by the information available. The exception to this was the supplemental data collected in Malawi to add information on youths' perceptions of quality of care and providers' understanding and experiences implementing YFHS. Unfortunately, similar data were not available for the programs in Madagascar or Mali.

The evaluation design used a nonexperimental "before/after" design, in which numbers and trends were compared from before and after the implementation of the YFHS training packages. Secular increases in the trend of FP use or other nonprogrammatic factors could influence the interpretation of results. Additionally, with the exception of Mali, YFHS training was conducted in a context of ongoing programmatic changes to improve services for youth, making the determination of "before intervention" problematic. The evaluation compared client numbers and trends to various periods in the effort to construct clean "before" periods, unaffected by previous efforts to improve RH services for youth; however, we acknowledge that the constructed baselines may have been affected by previous interventions.

The positive outcomes of PSI Mali's pilot of YFHS is limited by the fact that only two months of data were collected and available post-intervention. Longer-term outcomes are therefore not known. Given the findings from Madagascar and Malawi, in which client numbers decline without continuous program support and funding, assumptions about the sustainability of results should be made with caution.

The recruitment of FGD participants ages 15–17 for supplemental data collection was difficult, because it occurred during end-of-semester testing, and youth that were still in school were either busy with test

preparation or too tired to participate after the school day. As a result, we were not able to make comparisons between the youngest and oldest youth. The evaluation planned to have ten FGDs; the sample was based on the assumption that saturation of themes would be reached, in accordance with research by Guest, Namey, and McKenna (2016). This assumption was based on the fact that the groups were to be structured (using a structured tool and the same discussion leaders), the topic was not too technical, the groups were not too large or too small, and the groups would have low to moderate levels of heterogeneity. It is not known whether having one additional FGD would change the findings, though a saturation of themes was evident across the nine FGDs included in the analysis.

RECOMMENDATIONS

Programmatic and research recommendations from the evaluation results are as follows:

- Ensure that YFHS intervention packages contain at least three of the four programmatic components outlined by Denno, Hoopes and Chandra-Mouli (2015): (1) YFHS training for providers and staff, (2) adaptation of facilities to be more youth-friendly, (3) generation of youth demand for RH/FP services, and (4) broad information dissemination campaigns to increase community acceptance and support of youth use of RH/FP services. YFHS training works best when conducted in coordination with other YFHS programmatic components; the more integrated the components, the better (e.g., targeted demand generation at clinics in Mali vs broad demand generation of youth radio clubs in Malawi).

- Cost remains a significant barrier to FP/RH services for youth. This issue is recognized by program staff and service providers, though it appears private franchise clinics do not have a clear path to providing free or subsidized services to youth without financial support from PSI. Cost-recovery models or other potential solutions for long-term provision of FP/RH services for youth should be part of YFHS training and intervention activities.

- Organizational support is important for monitoring adherence to franchise YFHS practices and to provide refresher training as needed. The certification process of PSI Malawi ensured that Tunza clinics met certain standards; although some clinics had difficulty being certified, clinics tended to maintain the standards once certified. Support provided from the franchise also indicates the level of importance the organization places on the provision of YFHS.

- Owing to the popularity of short-acting methods—injectables in particular (especially in Malawi)—ensure that counseling on these methods includes messages on dual method use for preventing STIs including HIV.

- In accordance with the global consensus statement on expanding youth access to contraceptives to include LARCs, reinforce that LARCs are appropriate for young people through pre-service and in-service mentoring and coaching with providers and demand-generation efforts with young people (FP2020, n.d.).

- Additional research is needed to assess the sustainability of short-term outcomes. This evaluation provides evidence that short-term improvements in the number of youth clients are not sustained when essential elements of YFHS interventions are discontinued; however, more information is needed.

CONCLUSIONS

The findings support research showing positive effects of YFHS training for healthcare staff, combined with changes to make facilities more youth friendly, when implemented with demand-generation activities, such as the formation of youth groups and clubs; increased presence at community events; and radio, TV, or other mass media approaches. However, the sustainability of YFHS intervention packages is an issue that needs attention. The results from PSI Madagascar and PSI Malawi show that without sustainable demand-generation activities, including the provision of free or reduced-cost RH services, initial increases in youth clients will not be sustained. Based on this evidence, to improve young peoples' health and access to FP resources, provision of YFHS should include effective training of providers and staff while also considering the structural, financial, and community contexts in which youth FP and RH services are provided.

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APPENDIX A. LIST OF REVIEWED DOCUMENTS

Document	Type	Country	Published
YFHS Training Curriculum	Training	All	2016/2017
SIFPO2 Project Results Summary	Project summary	All	2016/2017
From Innovation to Scale: Advancing the SRHR of Young People	Project summary	All	2016
FY 18 Plague Funding Report	County program report	Madagascar	March 2018
ISM FY 2015 Annual Report (October 2014–September 2015)	Country program report	Madagascar	Nov 2015
ISM FY 2016 Annual Report (October 2015–September 2016)	Country program report	Madagascar	Nov 2016
ISM FY 2017 Annual Report (October 2016–Sep 2017)	Country program report	Madagascar	Nov 2017
Madagascar Social Franchise Case Study	Project summary	Madagascar	2011
2015 TRaC FP Report	Countrywide survey	Madagascar	2016
2017 TRaC FP Report (French)	Countrywide survey	Madagascar	2018
Malawi Social Franchise Technical Brief	Project summary	Malawi	2015
PPP in SRHR N'Zatonse Jan–Jun 2015 (Report #3)	Country program report	Malawi	2015
PPP in SRHR N'Zatonse Jul–Dec 2015 (Report #4)	Country program report	Malawi	2016
PPP in SRHR N'Zatonse Jan–Jun 2016 (Report #5)	Country program report	Malawi	2016
PPP in SRHR N'Zatonse Jul–Dec 2016 (Report #6)	Country program report	Malawi	2017
Malawi Youth FP Data over Time	Data (Service)	Malawi	2017
SIFPO2 Mali YFHS Research Brief	Project summary	Mali	May 2018 Draft
Mali Le Grin Project Results (poster)	Project summary	Mali	Not dated
Mali Mystery Client Data	Data (Mystery Client)	Mali	2017
Mali Mystery Client Protocol	Project summary	Mali	2016

Document	Type	Country	Published
Mali Grin Table Data (from SIFOPO 2 Mali brief)	Data (service)	Mali	2017
Mali Le Grin Strategy & 2015 Summary of Contacts Made	Project summary	Mali	2016
Mali Postpartum IUD Brief	Project summary	Mali	2017

APPENDIX B. MALAWI RESULTS BY TRAINING COHORT

Figure C1. Number of FP clients ages 15–24 in clinics included in the 2014 YFHS training cohort, by age group and method type, Malawi

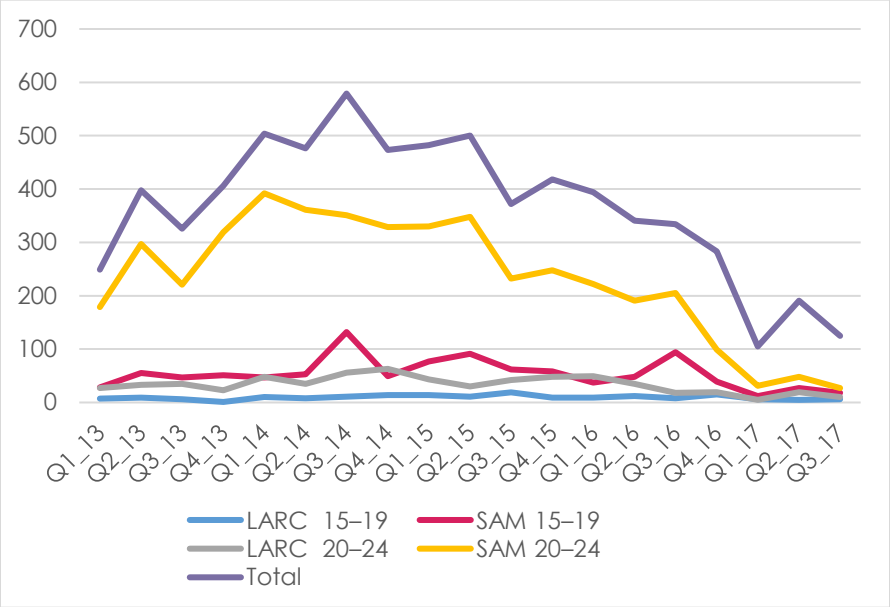


Figure C2. Number of FP clients ages 15–24 in clinics included in the 2016 YFHS training cohort, by age group and method type, Malawi

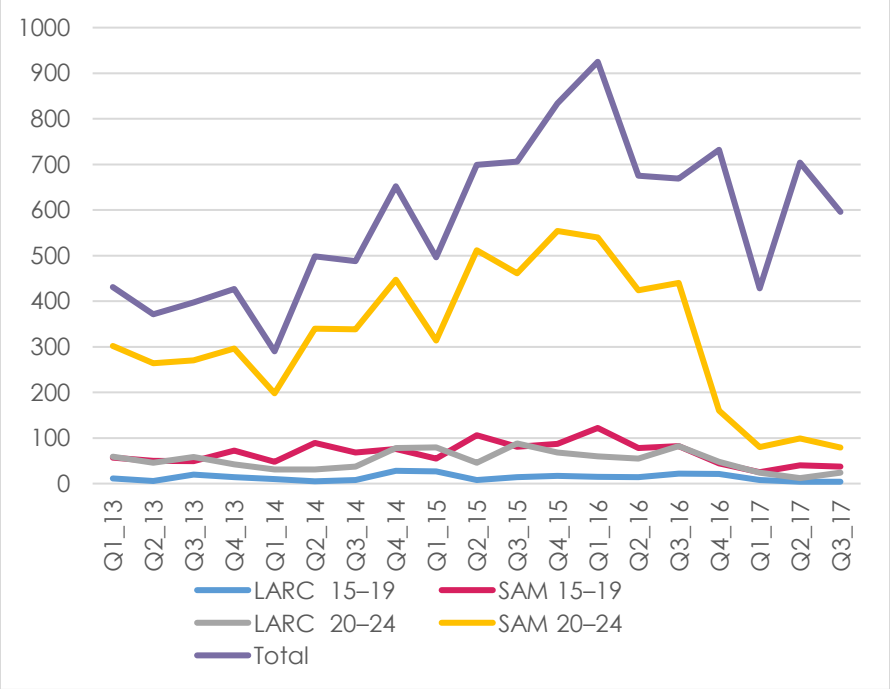
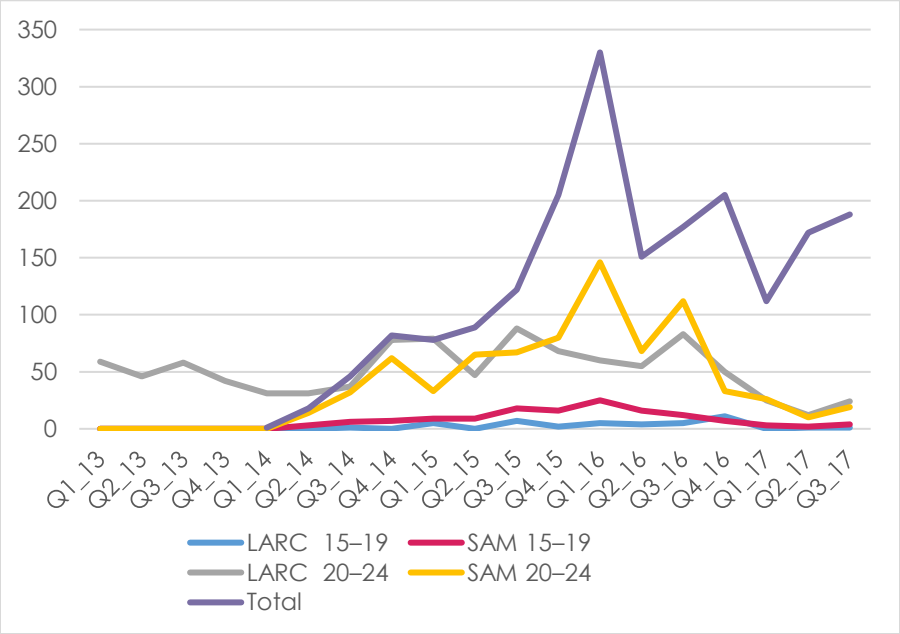


Figure C3. Number of FP clients ages 15–24 in clinics included in the 2017 YFHS training cohort, by age group and method type, Malawi



APPENDIX C. DATA COLLECTION TOOLS

Impact of PSI's YFHS Training on Mainstream Youth SRH Services

PROVIDER INTERVIEW GUIDE

Interviewer _____

Date _____

To be filled before the provider interview.	
Provider Interview Number	
CLINIC IDENTIFICATION	
Name of clinic	_____
Clinic Number	___ ___
District	Lilongwe 1 Mzuzu 2 Nkhata Bay 3 Kasungu 4 Nkhotakota 5 Dowa 6
Urban/Rural	URBAN 1 RURAL 2

INTRODUCTION AND CONSENT

Hello. My name is_____. I am working with Tunza Family Health Network. We are conducting a study about Youth Friendly Family Planning Services in [Tunza Family Health Network clinics]. We hope this study will help improve youth access to high quality family planning services that meet their needs.

We would like to ask you some questions about your experience with providing family planning care to youth, and recent training you may have received in this. First, I will go over an informed consent form with you, and tell you a little bit more about the study.

[Obtain Informed Consent and signatures before proceeding]

Thank you for agreeing to participate. As a reminder, your personal information and answers that you provide are confidential and will not be shared with anyone outside of the study team. Your participation is completely voluntary and will not affect your position at this clinic. You may refuse to answer any question or stop the interview at any time.

Do you have any questions?

No.	Questions	Coding Categories		
READ: First, I would like to get some background information about your work and training experiences.				
P1	RECORD THE SEX OF THE PROVIDER	1	FEMALE	
		2	MALE	
P2	What is your current title or position?	1	FACILITY IN CHARGE	
		2	MEDICAL DOCTOR	
		3	MEDICAL OFFICER	
		4	NURSE	
		5	OTHER, SPECIFY:_____	
P3	How long have you been working as a [CURRENT POSITION]?	1	LESS THAN 6 MONTHS	
		2	6 – 11 MONTHS	
		3	1-2 YEARS	
		4	3-4 YEARS	
		5	5 OR MORE YEARS	
P4	How long have you been working at this clinic?	1	LESS THAN 6 MONTHS	
		2	6 – 11 MONTHS	

		3	1-2 YEARS	
		4	3-4 YEARS	
		5	5 OR MORE YEARS	
P5	When did you attend your most recent PSI YFHS training?	1	2018	
		2	2017	
		3	2016	
		4	2015	
		5	2014 or earlier	

I would like your permission to start audio recording. Your name will not be recorded in the audio. May I begin the interview now?

[START RECORDING]
ONCE RECORDING HAS STARTED, STATE THE PROVIDER INTERVIEW NUMBER FROM PAGE 1.

Accessibility	
READ: Now I would like to ask you some open-ended questions about providing youth friendly family planning services	
P6	In your own words can you describe what it means to provide family planning services that are <u>accessible</u> to youth? *Probe 1: In general, what makes family planning services more accessible for youth?*
P7	How well do you think this clinic does in terms of making services accessible to youth? *Probe 1: Are extended, or 'youth only' clinic hours available?* *Probe 2: How easy is the clinic for youth to get to?*

	Probe 3: Are youth required to pay for particular methods? (Are there other costs associated with getting services?) *Probe 4: Do you think you have had enough training on providing services to youth?*
P8	Do you think youth in the community are generally aware about your services and how to get them? *Follow up: Why or why not?*

Acceptability	
P9	In your own words can you describe what it means to provide family planning services that are <u>acceptable</u> to youth? *Probe 1: What features of services might make youth more willing to access services at a specific clinic?*
P10	How well do you think this clinic does in terms of making FP services acceptable to youth? *Probe 1: What does the clinic do to help youth feel that they are treated respectfully and are not judged for using family planning services?* *Probe 2: What, if anything, has the clinic done about the layout, or waiting areas, to make youth more comfortable?*

P11	Are there policies or procedures in place that guarantee the confidentiality of youth clients at this health clinic? If so, can you explain what they are?
P12	How satisfied do you think youth are generally with the services they get at the clinic? *Follow up: Why do you think this?*

Appropriate	
READ: The next few topics will have both open and closed ended questions, but are still about providing family planning for youth	
P13	What, if any, changes do you make for youth clinic visits as compared to adults?
P14	Are the following services available to youth ages 15-19 at this clinic Please answer "yes", "no", "not appropriate" or "unsure/don't know" for each service.
a	Information and counselling on reproductive health, sexuality and safe sex?
b	Testing and counselling services for HIV?
c	STI/RTI testing?
d	STI/RTI treatment?
e	Pregnancy testing?
f	Counseling on contraceptive pills?

g	Information and counseling on condom use or dual method use?
h	Information and counseling on emergency contraception?
I	Information and counselling on injectable contraception?
J	Information and counselling on implants?
k	Information and counselling on IUDs?
P15	If you answered "No " or "Not appropriate" to any of the above could you explain why for each item that you answered that? *PROBE EACH ITEM ANSWERED "NO " OR "NOT APPROPRIATE" PROBE FOR DIFFERENCES BASED ON AGE, SEX, OR MARITAL STATUS.*

Equity	
P16	Are there some groups of youth that you do not feel comfortable dealing with? If so, why? *Probe 1: What about clients who are less than a certain age?* *Probe 2: What about youth clients that are not married?* *Probe 3: What about youth clients from certain ethnic/religious groups?* *Probe 4: What about males?*
P17	What contraceptive methods would you provide to sexually active unmarried youth? *Probe 1: How does this differ for males vs. females?*

P18	What contraceptive methods would you NOT provide to sexually active unmarried youth?
P19	Would you require parental consent before providing any contraceptive methods to youth younger than 17 years old? If so, what methods would require consent? What ages would require parental consent?
P19A	Would you require a husband's permission before providing any contraceptive methods to married females younger than 17 years old? If so, what methods would require permission?

Effectiveness	
P20	How do you think that coming to a mainstreamed youth friendly clinic instead of a stand-alone youth-only clinic affects youth's access to and quality of care? [If at all]

Training	
READ: The last part of the interview will ask you about your training in YFHS.	
P21	Thinking back to your most recent PSI YFHS training, how would you summarize your experience with the PSI YFHS Training? *Follow up: What was helpful about it?*
P22	What kind of follow-up engagement for providing YFHS did you (your clinic) get from PSI after the training? *Probe: Did you have site visits? Audits? Was this clinic "certified" youth friendly by PSI?*

P23	After the training, were any changes made at the clinic based on what you learned? If so, what were they? *Probe:* - *Clinic hours* - *Clinic policies towards youth* - *Treatment of youth clients* - *Privacy and confidentiality* - *Reduced prices for youth* - *Discussions with parents and other community members* - *Formation of youth club / youth radio listening group*
P24	Were there any changes that you made initially that you did not continue? If so what were they and why were they not continued?
P25	Do you have any suggestions for how training might better help integrate YFHS in this clinic, or health clinics in general?
P26	Are there any other comments or suggestions you would like to add?

END OF INTERVIEW:

This concludes the interview, thank you for your participation and taking the time to speak with us today.

Tool: Youth Focus Group Discussions

Note to Discussion Leader: The conversation should flow naturally. Use this guide to ensure that all topics are covered, and that necessary information is obtained. You may read or summarize the introduction. Privately obtain written consent for participation in the FGD from all participants before beginning the introduction and welcome.

In your notes, please record:

Name of District

Date of FGD

Number of Participants

Group Type: Males OR Females

Age Group: 15-19 OR 20-24

Introduction & Welcome

Welcome and thank you for volunteering to take part in this discussion. You have been asked to participate because your point of view is important. I realize you are busy and I appreciate your time.

The purpose of this discussion is to learn about where youth go for family planning and contraceptive services in your community and how they feel about their experiences.

The discussion will take no more than 1 hour.

Please know that your participation in this discussion is voluntary. I asked you to sign a consent to participate but will not attach your name to your comments or to our report. Please do not discuss the comments of the other individuals outside of the group. If there are any questions that you do not wish to answer or participate in, you do not have to do so; however please try to participate and be as involved as possible.

Please also know that it is important that only one person speak at a time, however, you do not have to speak in any particular order. If you have something to say, please do so. You do not have to agree with the views of other women in the group.

As mentioned in the consent, I will record the discussion so that no information is lost.

Are there any questions before we begin?

1. Thank you for coming. As an "ice-breaker", I'd like to go around and have everyone tell us their age, where you would go if you could travel to anyplace in Malawi, and how you first heard about the clinic, if you can remember.

2. If youth like you wanted to prevent a pregnancy, what would they do? (When contraception is mentioned, ask: how would they get the contraception? Would they come to get it at [CLINIC NAME]? Why or why not?
   - *Probe: where else might youth go, if not here?*
   - *Probe/Follow up: what about where they would go for:*
     - *Questions or fears about pregnancy*
     - *Questions about family planning in general*

3. How do youth like you feel about the treatment provided by the [CLINIC] staff members?
   - *What words would people your age use to describe the clinic staff?*
     - *Probe: Would you describe them as…*
       - *Friendly?*
       - *Respectful?*
       - *Non-judgmental?*
     - *Probe for each term mentioned: Can you give an example of this? (Especially if negative terms are used)*
     - *Probe: Does this vary by the type of provider?*

4. What methods do you think/do you know that youth can get at the clinic??
     - Follow up: Are some methods harder to get than others?

5. Do you think youth feel their visit will be private? (meaning that it will not be seen or overheard by anyone other than them and the provider)

6. Do you think youth feel their visit will be kept confidential? (meaning that the clinic staff will not talk about your problem to other clinic staff, patients, or even parents)

7. Is there any embarrassment [or shame] for people your age to seek family planning services at this clinic?
    - *Probe: are they are afraid that their parents could find out or they could disapprove of it?*
    - *Probe: are they afraid of being seen at the clinic and embarrassed or shamed?*

8. Sometimes people your age are not able to get the family planning services they want. Do you think people your age have problems getting family planning services at this clinic? Why or why not?
    - *Probe: What problems have you heard about? Do you think these are common problems?*
    - *Probe: Financial: Are some methods too expensive? Is this clinic more or less affordable for youth compared to other clinics?*

9. Do think that young people can get family planning services at this clinic: (ask each separately)
    - if they are unmarried?
    - If they don't have permission from a parent?
    - If they are considered too young to be sexually active?
    - If they belong to a different ethnic group?
    - Is there any other reason you think people your age might not get the family planning services they want at this clinic?

10. What suggestions do you have for this clinic to improve its services to young people?

Thank you for participating. This has been a very successful discussion. We hope you have found the discussion interesting.

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