Youth perceptions (18-24) on the role of youth clubs in delivering family planning information and services in Blantyre district, Malawi.

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DEDICATION

This thesis is dedicated to Charles, my husband and best friend, for his unconditional support, and my children, Dumisani and Thabisa for their understanding and support.

ABSTRACT

Background: Unmet need for family planning is a significant health problem for the youth in Malawi. In order to promote family planning uptake, youth clubs were established to provide a safe and friendly environment for the youth to access sexual and reproductive health information and services. Although these tailored youth clubs exist, evidence on family planning utilisation in this population has been collected in clinics and hospitals rather than youth clubs. This study explored the perspectives of the youth on the role of youth clubs in delivering family planning information and services including condom distribution.

Methods: An exploratory qualitative study design was used for this study. Four focus group discussions and ten semi-structured interviews were used to collect information from young boys and girls aged between 18 – 24. Participants were purposively sampled and were asked to give a written consent before the commencement of the interviews. The discussions and semi-structured interviews were tape-recorded and transcribed verbatim. Transcripts were coded manually and analysed using thematic analysis.

Results: Youth clubs played a role in creating awareness about family planning methods and promoting positive sexual and reproductive health wellbeing of young people. The youth identified effective facilitation skills, trained peer educators and dynamic collaborations with health service providers as the facilitators of smooth delivery of family planning information. The perceived barriers to the smooth delivery of family planning information in the clubs included limited availability of resources and religious/cultural biases.

Conclusions: Youth clubs are crucial in empowering the youth with knowledge and understanding about family planning hence enabling them to make informed decisions about their sexual and reproductive health and wellbeing. Effective delivery of family planning information and services in youth clubs require strong partnerships with relevant stakeholders such as local health service providers and non-governmental organisations through leveraging their expertise, resources and networks hence strengthening the impact of family planning initiatives.

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ACRONYMS AND ABBREVIATIONS

APHRC: African Population and Health Research Centre

FGD: Focus Group Discussion

FP: Family Planning

HREC: Human Research Ethics Committee

IDU: Intrauterine Device

LARC: Long Acting Reversible Contraceptives

MoH: Ministry of Health

NGO: Non-Governmental Organisation

SADC: Southern Africa Development Community

SARC: Short Acting Reversible Contraceptives

SRH: Sexual and Reproductive Health

SRHR: Sexual and Reproductive Health and Rights

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PART A: PROTOCOL

YOUTH PERCEPTIONS (18-24) ON THE ROLE OF YOUTH CLUBS IN DELIVERING FAMILY PLANNING INFORMATION AND SERVICES IN BLANTYRE DISTRICT, MALAWI.

1. INTRODUCTION

Globally, unmet need for family planning among women of reproductive age is a public health concern. Sedgh et al. (2016) define unmet need as a term that is used to describe sexually active women of reproductive age who are not using any contraception methods and yet they do not want to become pregnant. Women with unmet need, therefore, are likely to have unintended pregnancies which are a major contributing factor of maternal depression, abortion and obstetric complications among others (Bahk et al., 2015; Yaya & Ghose, 2018).

In 2019, global statistics for unintended pregnancies among women aged between 15 and 49 were estimated at 121 million with sub-Saharan Africa having the highest prevalence rate of 91% (Bearak et al., 2022). It is worth mentioning that sub-Saharan Africa registers high rates of unintended pregnancies especially among the youth population. For example, 44% of unintended pregnancies reported each year between 2010 and 2014 were recorded amongst the youth aged between 15 to 24 years in sub-Saharan Africa (Ameyaw et al., 2019; Lusinje et al., 2015; Obiezu-Umeh et al., 2021). This represents a very a significant proportion of sexually active youths with unmet needs for contraception. It is argued that most unintended pregnancies are due to non-use of contraceptives and also contraceptive failure (Böttcher et al., 2019). So many questions can be explored from this information. For instance, why do youths have unmet need for contraception even if family planning information and services are made available to them? How do youths access contraception services? The issue of contraceptives information and use amongst the youth is very complex and needs to be examined carefully as it is crucial to youth's sexual and reproductive health and rights (SRHR) outcomes.

1.1 BACKGROUND AND CONTEXT

1.1.1. Contraceptive use amongst the youth

Worldwide, literature on contraceptive use amongst the youth exposes a low trend of contraceptive uptake in low and medium income countries (Ahinkorah, 2020b; Crédo et al., 2022; Li et al., 2020; Makola et al., 2019; Olika et al., 2021). There are varying factors that contribute to low contraceptive use especially among the youth. Some of the reasoning behind the low uptake include lack of appropriate information on family planning methods, contraceptive accessibility, cultural and religious beliefs, contraceptive uptake decision making and youths' socio-economic status among others.

In a study to examine individual and contextual factors that lead to unintended pregnancies in sub-Saharan Africa, Ahinkorah (2020) argues that most adolescent girls and young women have poor knowledge in contraceptive use. In the first place, lack of contraceptive knowledge may arise due to the fact that the youth are not exposed to platforms which enhance the sharing of such information. Contraception information can be easily sourced from peers, family, health experts, education, and other advocacy channels (Israel et al., 2016). Although this is the case, contraception information gained may sometimes be limited or untrue. For example, limited access to contraception information was reported amongst adolescents during an assessment of adolescents' contraceptive knowledge and practices in Zimbabwe and this was attributed to fear of parents who believed that the promotion of contraceptives could encourage promiscuity (Moyo & Rusinga, 2017). Limited access to contraception information, therefore, puts the youth at a disadvantage as they do not have knowledge on a wide range of contraceptive methods available to them. In situations where contraceptive methods are available and there is a will to use them, youths may end up not using those contraception methods effectively due to limited knowledge hence contributing to high rates of contraceptive failure.

Secondly, most studies have argued that peers sometimes share contraception information which is not true hence limiting the use of various contraceptive methods (Israel et al., 2016; Mbachu et al., 2021; Mwaisaka et al., 2020). Contraceptive misinformation has a negative influence on contraceptive use. For instance, Li, et al. (2020) claims that contraceptive knowledge gap perpetuates myths surrounding future ability to conceive healthy babies because of previous contraceptive use. Similarly, Dioubaté, et al. (2021) agrees that people have made false rumors that contraceptives make women sterile and also that implants can just disappear from the body of their users. The contraception knowledge gap that exists due to misinformation, therefore, limits contraceptive use amongst the youth.

Accessibility, availability, and affordability of contraceptives determine contraceptive uptake amongst the youth. Contraceptives can be accessed by the youth in public health facilities, private health institutions, one stop shops, pharmacies, and other youth friendly centres. However, there are various factors at play when it comes to accessing contraceptives. In terms of contraception affordability, Dioubaté et al. (2021)'s study noted that most young people in Guinea were financially constrained since they were more dependent on their families and as such, they opted to access low cost contraceptive services at public health facilities. Although public health institutions provide cheaper contraceptive alternatives, their capacity to meet contraceptive needs is heavily challenged. In low and medium income countries, for example, access to contraception services by the youth is limited due to inadequate contraceptive supplies, geographical proximity of services and lastly, health care provider judgmental attitudes towards the youth (Ahinkorah, 2020b; L. Davids, 2019; Dioubaté et al., 2021; Li et al., 2020). Challenges in contraceptive access, therefore, need to be carefully addressed in order to promote contraceptive use.

Cultural and religious beliefs have an influence on the usage of contraceptives among the youth. There is a misconception that if young people use contraception services, then it means they are engaging themselves in sexual activities (Moyo & Rusinga, 2017). Again, some societies believe in the culture of preserving virginity until marriage (Crédo et al., 2022). A similar belief is also promoted in some religious institutions where sex before marriage is viewed as a sin before God. Having said this, unmarried young women who use contraception services in such societies are often viewed as loose women who do not value the preservation of their culture and religious beliefs (Tchokossa, 2018). On the other hand, contraceptive uptake studies conducted in sub-Saharan Africa indicated that high rates of non-use of contraception among Muslim young women compared to Christians were due to the religious belief that children are a gift from God (Ahinkorah, 2020a; Davids, 2019).

Decision making in contraceptive choice and use is crucial in promoting SRHR amongst the youth. SRHR affords everyone the right to control their own sexuality and also make free choices on reproductive health matters including contraception without coercion, discrimination and violence(Ministry of Health, 2020). There are diverse factors that contribute to contraceptive use amongst the youth. Dioubaté et al. (2021)'s study in Guinea uncovered that young people's decision to choose and also use contraceptive methods depend on the approval of their sexual partners and this helps to avoid possible conflicts. This reveals that negotiations about contraceptive use are discussed between sexual partners. However, the scenario may be different in some other cases especially where gender dynamics in sexual relationships are visible. For example, a research study by Kinaro (2013) established that adolescents' decision to use condoms during sex rested in the hands of boys compared to girls who are always afraid to make contraceptive use suggestions due to the fear of being accused that they are practicing infidelity.

Further to this, the decision of condom use is mostly constrained in scenarios where intimate partner or sexual violence is taking place (Davids et al., 2021). The decision to use contraceptives is also influenced by personal or peer experiences of contraceptive use. Most research studies have highlighted that young women's preference of contraceptive methods depends on the perceived contraceptive side effects (Hayer et al., 2017; Nishtar et al., 2013) . It is envisaged that contraceptive use trigger side effects such as fatigue, nausea, and menstrual irregularities among others. These side effects reduce the chance of contraceptive uptake amongst the youths.

Young people's socio- economic status is also a determinant of contraceptive uptake. In a study to determine the trends and determinants of contraceptive use amongst young people in Ethiopia, the youth who were more educated were more likely to use contraceptives compared to their counterparts who were less educated (Olika et al., 2021). Likewise, adolescent girls and young women from communities with low literacy levels in South Africa were associated with low use of contraceptives compared to those who had higher literacy levels (Makola et al., 2019). The education level disparity amongst the youth, therefore, depicts a need for education and advocacy strategies aiming at the promotion of contraceptive uptake hence reducing the unmet need for family planning.

Over the years, youth friendly health programmes in Africa have highly contributed to improved sexual and reproductive health (SRH) outcomes such as increased knowledge of contraception services, reduced cases of unsafe abortion, met need for contraception among others (Aarø et al., 2014; Bankole et al., 2020; Denno et al., 2015; UNFPA, 2019; Zuma et al., 2020). Although this has been the case, statistics from 2020 demonstrated that the Southern African Development Community (SADC) region compared to other regions in Africa registered increased numbers of unmet need for family planning amongst adolescent girls and young women (Yah et al., 2020).

1.1.2. Youths' unmet needs for family planning in Malawi

Malawi as a member state of the SADC region is featured amongst the top 5 countries with high rates of unintended pregnancies amongst the youth. The youth unlike other age groups in Malawi have the highest level of unmet need for family planning and they contribute to almost 30% of unintended pregnancies amongst all women (UNPF, 2020; Yah et al., 2020). It is worth noting that efforts to improve SRH care for the youth aged between 15 to 24 years in Malawi have yielded commendable results in reducing the unmet need for family planning from 26.2 % in 2010 to 19.4 % in 2016 (MacQuarrie, 2014; MDHS, 2017). However, a further review of the youth population in Malawi uncovers a huge gap in the unmet need for family planning between those women who are married and those who are not married with the former having less prevalent cases compared to the latter.

The most recent Malawi demographic health survey that was conducted between 2015 and 2016 identified 45.8% of the unmarried youths aged between 15 to 24 years as having the unmet need for family planning compared to 13.4 % of the married youths within the same age population (Bhushan et al., 2021; MDHS, 2017; Nkoka et al., 2020; Odland et al., 2021; Self et al., 2018). Additionally, available eastern Africa demographic health statistics for 2016 ranked Malawian unmarried youths as the number one age population with unmet need for family planning compared to their counterparts in Burundi, Ethiopia, Mozambique, Tanzania, Uganda, and Zimbabwe (ICF International, 2020). This demonstrates the need to support SRH initiatives for all the youth in Malawi in order to achieve positive health outcomes related to contraception use. It is argued that unintended pregnancies would drop by almost 59% in developing countries if 23 million young women were to receive improved contraception services hence saving the costs associated with unintended pregnancies (Darroch, et al., 2016). Meeting the contraceptive needs for both married and unmarried youths, therefore, will help to reduce cases of unsafe abortions and pregnancy related complications.

1.1.3. Ways of mitigating unmet needs for the youth in Malawi

The Malawi national SRHR policy document advocates for increased coverage of family planning services among the youth at both the health facility and community level (Ministry of Health, 2020). The youth are at liberty to choose whether they would want to access either short acting reversible contraceptives (SARCs) such as pills, condoms and injectable Depo-Provera or long active reversible contraceptives (LARCs) such us hormonal contraceptive implants and intrauterine devices (IDUs) among others (Ministry of Health, 2020). Moreover, contraceptive services are offered for free in all government health facilities in Malawi.

Despite the wide range availability of family planning services in health facilities, contraceptive use amongst the youth in Malawi is low hence contributing to high unmet need for family planning (USAID, 2017). Palamuleni (2017) advises that perhaps the low uptake of contraceptives among adolescent girls and young women may be due to the fact that these young people do encounter problems with accessing FP services at the clinics and hospitals. It is further argued that unmarried youths are more likely to shun away from accessing family planning services at health facilities in order to save themselves from the embarrassment of being judged by health workers and everyone around them (Ministry of Health, 2016). Davids (2019) echoes the same sentiments that health professionals tend to stigmatize those youth seeking for contraception services to the extent of either scolding or emotionally abusing them. This is a limiting factor for contraception uptake. The best solution to tackle this problem would be training health professionals in providing effective youth friendly health services. Again, the youth should be afforded spaces where they can freely explore issues to do with family planning without experiencing any form of discrimination. Literature from around the world have referred these youth friendly spaces as youth corners, youth friendly centres, and youth clubs (Castle et al., 2016; Lambert et al., 2013; Makwinja et al., 2021).

1.1.4. Youth Clubs in Malawi

It is important to recognize the right to good health for everyone and as such, SRHR of unmarried youths ought to be respected. It is for this reason that youth clubs in Malawi were established with an aim of providing SRHR to the youth in safe and friendly spaces (USAID, 2017). Youth clubs are classified as community delivery points for youth friendly health services such as contraceptive services, HIV counselling and testing, and referral services (Lusinje et al., 2015). It must be pointed out that the youth in clubs meet either indoors or outdoors depending on the space available in the community. Most youth clubs do not have proper building structures and as such, most meetings occur in open outdoor spaces that have a good shade (Lusinje et al., 2015). On the promotion of sexual and reproductive health services, youth clubs are limited in the sense that they can only offer one contraceptive method which is the use of condoms. All other contraceptive services are accessed at the health centres through referrals provided by the health care workers linked to the youth club. Other than this, the youth also share information on SARC and LARC methods amongst themselves in the clubs (Self et al., 2018). It must be pointed out that these clubs are patronized by both in and out of school unmarried adolescents and young people aged between 10 to 24 years. Youth clubs, therefore, create an environment where young people can explore SRH issues freely and privately. Makwinja et al. (2021) agrees that youth clubs may be a good community-based outlet where youths' confidentiality and privacy is guaranteed when accessing family planning information and services. Most research on access and utilisation of family planning services for the youths in Malawi have recommended the enhancement of youth clubs in the communities (Chimatiro et al., 2022; Makwinja et al., 2021; Ministry of Health, 2020). However, some studies questioned the capacity and nature of influence that youth clubs have in promoting family planning services. For example, an exploration of youth and adult perspectives on barriers to accessing family planning methods in Malawi recommended a review of these youth clubs as their impact on the ground is not clear (Self et al., 2018). Similarly, Lusinje et al. (2015)

reported on the existence of youth clubs in different communities in Malawi but further claimed that there was no clear-cut on the clubs' contribution towards access to family planning information and services. Currently, it is very difficult to know the role that youth clubs play in facilitating the delivery of family planning information and services to the youth. Do clubs promote the sexual and reproductive health well-being of the youth? There is a need for more in depth research on how youth clubs are perceived by the users. An understanding of family planning service delivery in clubs will help to improve youth's SRH outcomes including the met need for family planning.

2. RATIONALE FOR THE STUDY

Most studies on family planning in Malawi have focused on access, quality and utilization of services offered in health centres and hospitals other than youth clubs (Chilinda et al., 2020; Hazel et al., 2021; Kapira, 2021; Skiles et al., 2015). Youth clubs are located in the communities and usually one or more health care providers from the nearest health centre support the activities that happen in the clubs (USAID, 2017). As stated earlier on, the youth especially those who are not married do not turn up in large numbers at public health facilities to access family planning services in fear of being judged. Many of the youth do not have free and fair access to SRH care and services because of the idea that sex should only happen in the context of marriage and yet in reality, there are increased numbers of unmarried youths who are sexually active. For example, 2016 demographic health statistics for Malawi disclosed that 42% of unmarried youths are sexually active (MDHS, 2017). This implies that family planning preferences and expectations of these unmarried youths are often unheard since most research studies in Malawi generalize youths. Bhushan et al., (2021) also points out that many SRH interventions treat adolescent girls and young women as a homogenous group and mostly the needs of the unmarried are overlooked and yet this group has the highest risk for unintended pregnancy.

This study will particularly focus on the perceptions of the older group of young people who are aged between 18 to 24 years in order to get a deeper understanding of the youth club's role in delivering family planning information and services. This age group is envisaged to be going towards maturity and their understanding of things is better compared to the lower group of youths. Besides, Patton et al. (2016) highlights the importance of examining SRH issues of adolescents who are transitioning from childhood to adulthood as this helps to understand their sexual behaviours and decisions which contribute to their future social, health and economic prospects.

This research project seeks to answer the research question: What are the youths' experiences in terms of family planning information, condom uptake and referral services offered to them in youth clubs? This study, therefore, will help to bring effective and appropriate interventions which are necessary for reducing the unmet need for family planning amongst the youth.

Research studies on young people in Malawi have shown a substantial regional variation when it comes to SRH outcomes. For example, Digitale et al. (2017) argued that young women in the southern region had lower first births and highest prevalence of unwanted pregnancies compared to their colleagues in the north and central region. Precisely, Blantyre which is amongst the 13 districts located in the southern region of Malawi recently registered high rates of unwanted pregnancies. A study by African Population and Health Research Center (APHRC) & Centre for Social Research (2022) recorded an increased number of pregnant and parenting adolescents from only 8 in 2019 to 309 in 2020 in Blantyre district. Another study on factors associated with unmet need for family planning in Southern region identified the youth aged between 20 and 24 in Blantyre district as having the highest unmet need at 20.1% compared to youths in Chiradzulu and Chikwawa district who had 15.1 % and 7.3% respectively (Odland et al., 2021). Due to increased

cases of unwanted pregnancies, Blantyre has been chosen for this study because it gives a good rapport to investigate youth perspectives as this will yield rich data which may help to improve and support youth clubs better.

Overall, the study will help policy makers to come up with powerful and feasible recommendations on how community youth clubs should be organized in order to effectively deliver family planning information and referral services to the youth.

3. RESEARCH AIM AND OBJECTIVES

3.1 Research Aim

The aim of this research study is to explore the perspectives of the youth aged between 18 to 24 on the role of youth clubs in delivering family planning information and services in Blantyre district, Malawi.

3.2 Research Objectives

The study objectives for this research include the following:

- To gain insight of youth experiences on family planning information and referral services offered to them in the youth clubs.
- To investigate condoms uptake amongst the youth in the youth clubs.
- To understand the perceived facilitators associated with the delivery of information on all family planning methods and referral services in the youth clubs.
- To understand the perceived barriers associated with the delivery of information on all family planning methods and referral services in the youth clubs.

4. RESEARCH METHODOLOGY

4.1 Research design and Approach

An exploratory qualitative study design will be adopted as this will enable the youth to describe their thoughts, feelings, and experiences of how youth clubs should function in order to ensure smooth delivery of FP information and services. In the context of Malawi, there is little information about how youth clubs are perceived by their users and as such, qualitative exploratory studies will help to yield a lot of information since they aim at investigating issues that have previously not been studied in depth (Creswell, 2003). In this case, the study will generate more information on how clubs are organized, and this will bridge the information gap that exists when it comes to supporting youths' uptake of condoms and also utilizing FP information and SRH referral services offered in the clubs. Again, studies that have explored youth clubs in Malawi have provided very limited information about FP services. For example, a review of the youth clubs' contributions towards the promotion of SRH services was conducted in Machinga district using a mixed methods research approach and the study lacked an in depth understanding of specific SRH issues such as contraception services as the focus was also on other SRH services including HIV care, sexually transmitted infection and life skills education (Lusinje et al., 2015). Using qualitative exploratory study design in this study, therefore, will also help to establish the nature of the problem being explored rather than coming up with conclusive evidence (De Vos et al., 2011).

4.2 Research study site

The research study will be conducted in Malawi particularly in Blantyre district. There are 28 districts in Malawi out of which 13, 9 and 6 are located in the southern, central, and northern regions respectively. In 2018, the population of Malawi was estimated at 18 million with two-thirds of the population under the age of 25 (Self et al., 2018).

Blantyre is located in the southern region of Malawi, and it is surrounded by 8 government health centres. All these health centres have youth clubs which provide youth friendly health services and as such, two sites namely Bangwe and Ndirande will be selected for the study. Blantyre district has been chosen for the study because of high prevalent cases of unwanted pregnancies (UNFPA, 2020).

4.3 Population and Sampling

Youth clubs are attended by all the youth aged between 15 to 24 years in Malawi. The population for this study will include male and female youth who attend youth clubs in Bangwe and Ndirande. The study will employ purposive sampling and the inclusion criteria will include those members of the youth club aged between 18 to 24 who either have had children before or not. The exclusion criteria will include male and female youths who are less than 18 years old and also all those youths with cognitive impairment. The total sample size for this study is 34. A total of 10 participants will be sampled for the semi structured interviews and 24 participants will take part in the focus group discussions (FGDs). There will be 4 FGDs comprising of 6 members in each group.

4.4. Recruitment

Firstly, permission to undertake a research study in the youth clubs will be sought from Blantyre district department of health office and also the nearest health facilities linked to the clubs. The recruitment of study participants will take place at the youth clubs and participation will be on voluntary basis. On the first visit to the clubs, study objectives will be unpacked and any questions arising from the information presented will be clearly answered. The potential participants will be asked to give a written consent to participate in the study. It must be pointed out that I, as the researcher, already established a good rapport with the communities where these youth clubs are

located. Initially, I was working for a PEPFAR funded project on the promotion of SRH services to the youth and as such, I developed a strong connection with not only members from Blantyre district health office but also youths in the youth clubs linked to government health facilities. In this case, I will not take advantage of coercing people to participate in the study against their will because of the connections that exist. At this stage, the recruited participants will also be assured of anonymity and confidentiality during the data management process.

4.5 Data Collection Methods

Data will be collected through semi structured interviews with the youth. The interview questions will specifically explore the family planning knowledge that young people gain in the clubs and how that knowledge is utilized in order for their family planning needs to be met. FDGs will also be conducted at the youth clubs in order to understand diverse perspectives of the youths' experiences at the youth clubs. These will complement the information gained during the semi-structured interviews since FGDs allow participants to bounce ideas off one another. FDGS also yield rich information since participants are always comfortable to share their thoughts because they have similar experiences about the phenomenon under discussion (Creswell, 2013). This study will conduct a total of 4 focus group discussions (2 in each youth club). Each focus group discussion will comprise of about 6 people and there will be 2 FDGs for the female youth and 2 FDGs for the male youth. I believe that separating male and female young people in the FGDs will allow the participants to give an account of their full perspectives since the issue under discussion may be experienced differently by each gender. Data for this research will be collected in the native language, Chichewa and later translated to English by the researcher. The data collected will be audio-recorded for easy reference during data transcription. Permission to record will be sought from the participants. The data will be collected within a period of 2 months. Semi-structured

interviews for each session will take about 40 minutes while FGDs will take between 1:30 to 2 hours. All interviews will be conducted in spaces agreed with the participants as this will enable them to express themselves freely without worrying about privacy.

4.6 Data Analysis

The process of data analysis will begin alongside data collection and this exercise will be managed by myself as the researcher for the study. I am well equipped with skills and knowledge on qualitative research data collection and analysis. Field notes will be taken for easy understanding of information collected through audio. Initial interpretations explored will be validated by the respondents through member checking. The data collected through semi structured interviews and FGDs will be analysed manually using thematic analysis. This approach to data analysis is preferred for this study because it is an appropriate method that is used when one wants to seek an understanding of subjective experiences and behaviors across the data set (Braun & Clarke, 2012). Moreover, Boyatzis (1998) argues that thematic analysis is not only aligned to one particular epistemological position, but researchers rather analyse a huge amount of data from multiple participants. This in turn, synthesizes the data into a meaningful account. Besides, the researcher is new to qualitative research, therefore, manual data analysis provides the basis to be totally submerged in the data compared to data analysis that relies on a software.

Braun & Clarke's (2006) six-phase guide of thematic analysis will be used in this study. The first phase of data familiarization will follow soon after data transcription. This is where I will be immersed in the data through repeated active reading and thorough checking of the transcribed data in order to ensure accuracy. I will particularly create thick descriptions from unintelligible texts and any sounds uttered as these may have meanings attached to them (McLellan, et.al. 2003).

During this process of data familiarisation, notes and comments will also be taken in a notebook with an aim of identifying potential areas of interests that are related to the research aim. The notes will be based on individual transcripts as well as the entire data set. In the second phase of thematic analysis, I shall inductively generate initial codes through line-by-line review of the transcribed interview data. The codes identified from the data extracts will be written down in a code book. I shall then highlight the manageable chunk of texts that are associated with the codes in order to make the code review process easier (Kuckartz, 2019). From the initial coding process, emergent themes will be identified. At this stage, I shall sort and group together all the data with similar codes and link this to a potential theme. The fourth phase will focus on reviewing the identified themes in order to check if the coded data matches well with the suggested potential theme. At this point, some themes will be revised, combined and others will be totally discarded. In the fifth stage, I shall clearly define and name the themes. Where there will be overarching patterns within the data, sub themes will be developed (Braun & Clarke, 2012). The idea here is to define themes until theme saturation is reached. In the final phase, I shall present the write up of the final analysis which describes the key findings of this research study.

4.7 Data Trustworthiness

Trustworthiness of this research study will be achieved by ensuring high levels of credibility and dependability. Lincoln and Guba (2011) argue that credibility can be achieved through triangulation and member checking. In this research study, triangulation will be achieved through using two data collection instruments namely semi-interview guide and FDG guide. I will also ensure that member checking is attained during the data collection period through sharing the interpreted data with the study participants in order for them to clarify if the intended meaning from their perspective has been captured.

Dependability will be achieved by ensuring that all the research methodological processes for the study are clearly defined. After seeking for participant informed consent to participate in the study, I will clearly explain the objectives of the research and also outline what the research study wants to achieve. The methods for collecting information from participants will also be thoroughly discussed with the participants. The study report will be made available to the participants and other stakeholders, and this will also enhance the study's dependability. The researcher will not only present the key finding to the youths in the clubs under study but also district health facility directors who are in charge of the youth clubs in the communities of Malawi. A copy of the key findings will also be emailed to the top officials in charge of youth clubs at the Malawi ministry of health.

4.8 Data safety and management

This research study will ensure that the data collected from the semi structured interviews and FGDs is well secured and protected. Audio data collected from recorded interviews will be stored on a computer that is protected with a password. Signed consent forms, field notes and hard copies of interview transcripts will be safely stored in a lockable cabinet which will only be accessible to me and the supervisors for this study. In this way, participants' confidentiality will be maintained. When the research study is completed, the collected research data will be stored for a period of 5 years after which it will then be destroyed. The research data will only be used for research purposes and at the end of the study, the findings will be presented at a dissemination meeting with youth club members, health care providers and heads of clinics who manage the youth clubs.

4.9 Ethical Principles

Ethical considerations are important in research as they ensure the protection and preservation of study participants' dignity. Ethical principles in research studies afford participants the right to autonomy and also the right to make informed decisions with regards to participating in the research (World Medical Association, 2001). It is further argued that researchers must not prioritise social sciences interests at the expense of human beings (Strydom, 2011). For the purpose of this study, the following steps will be taken in order to maintain the rights and integrity of study participants.

4.9.1 Ethics Approval

The study will seek for ethical review and approval from University of Cape Town's Human Research Ethics Committee (HREC) at the School of Public health and family medicine. Another approval will be sought from Blantyre district health Office. Once the approval has been granted, permission to conduct the research study will be obtained from the health facility directors and health care providers who are in charge of activities that happen at Bangwe and Ndirande youth clubs.

4.9.2 Informed consent process

The study participants will be provided with verbal and written information about the aim and objectives of the research study. All study procedures including the approximated duration of interviews, confidentiality and privacy issues will be discussed. Potential participants will have the chance to ask questions about any issues that are not clear to them. Once clarity has been made and there are no more issues to be addressed, informed written consent will be obtained from all the recruited participants. The participants will be informed that their involvement in the research

study will be on voluntary basis. They will be given the freedom to withdraw at any point in time if they no longer want to participate in the study and I will also point out that this would cause no repercussions on their participation in the club.

4.9.3 Privacy and Confidentiality

This research study will ensure that participants' privacy is maintained by conducting interviews in private spaces that are free from disturbances and also agreeable with individual participants. The participants will be assured of confidentiality and anonymity throughout the study. I will inform participants that all the transcribed data will be coded, and pseudonyms will be used in the final write up so that information from the interviews should not be linked to the study participants. In respect to FGDs where data is collected from a number of participants at the same time, confidentiality will be ensured by asking participants not to disclose any information discussed at the FDGs with anyone and they will also be required to sign a confidentiality agreement which will be part of the consent form. This will give participants information about what it means for them to take part in the study and also take confidentiality issues seriously.

4.9.4 Reimbursement

The participants will be informed that there will be no reimbursements for their participation in the study but during interviews, a light refreshment will be shared as an act of kindness.

5. RISKS

This research study is anticipated to be of minimal risk. Sharing of information and experiences on condoms uptake, for example, can trigger emotions that could cause some discomfort as it is considered as a sensitive topic in some contexts. If participants experience any discomfort, they

will be given the freedom to skip the questions and also withdraw from the interview at any given time if need be. Should participants experience any psychological distress due to participation in the study, they will be referred to psychosocial counsellors at the health facilities linked to the clubs so that counselling services can be provided to them.

6. BENEFITS

This research study will be of direct benefit to the participants in the sense that the research findings will help to bring out the youths' perspectives of how youth clubs should be organised when it comes to the delivery of FP information and services hence promoting the utilisation of condoms and FP referral services. Health care providers who are in charge of the youth clubs will be informed on how best to run youth club activities since the facilitators and barriers associated with the delivery of FP information and services will be identified. The research study, therefore, will afford participants a chance to contribute to the knowledge that is needed to improve operations of the youth clubs hence improving SRH health outcomes.

7. STUDY TIME FRAME

Activity	**Estimated time frame**
1. Protocol submission to HERC	November 2022
2. Data collection	Mid-January to March 2023
3. Data Analysis	February 2023 to April 2023
4. Thesis Write up	May 2023
5. Draft submission and final write-up	June 2023
6. Thesis Submission date	End of July 2023

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PART B: JOURNAL "READY" MANUSCRIPT

BMC Public Health

RESEARCH ARTICLE

"You are empowered to make informed decisions": exploring young peoples' experiences of family planning promotion in youth clubs in Blantyre, Malawi.

Nancy Makamo, Alison Swartz & Lucia Knight

Abstract

Background: Unmet need for family planning is a significant health problem for the youth in Malawi. In order to promote family planning uptake, youth clubs were established to provide a safe and friendly environment for the youth to access sexual and reproductive health information and services. Although these tailored youth clubs exist, evidence on family planning utilisation in this population has been collected in clinics and hospitals rather than youth clubs. This study explored the perspectives of the youth on the role of youth clubs in delivering family planning information and services including condom distribution.

Methods: Four focus group discussions and ten semi-structured interviews were used to collect information from young boys and girls aged between 18 – 24. Participants were purposively sampled and were asked to give a written consent before the commencement of the interviews. The discussions and semi-structured interviews were tape-recorded and transcribed verbatim. Transcripts were coded manually and analysed using thematic analysis.

Results: Youth clubs played a role in creating awareness about family planning methods and promoting positive sexual and reproductive health wellbeing of young people. The youth identified effective facilitation skills, trained peer educators and dynamic collaborations with health service providers as the facilitators of smooth delivery of family planning information. The perceived barriers to the smooth delivery of family planning information in the clubs included limited availability of resources and religious/cultural biases.

Conclusions: Youth clubs are crucial in empowering youth with knowledge and understanding about family planning hence enabling them to make informed decisions about their sexual and reproductive health and wellbeing. Effective delivery of family planning information and services in youth clubs requires strong partnerships with relevant stakeholders such as local health service providers and non-governmental organisations through leveraging their expertise, resources and networks hence strengthening the impact of family planning initiatives.

Keywords: Family planning, Contraceptives, Youth, Unmet need, Condoms, youth clubs, Malawi

Background

Worldwide, literature on contraceptive use amongst the youth exposes a low trend of contraceptive uptake in low and medium income countries [1–5]. There are various factors that contribute to low contraceptive use especially among youth people. Some point to low uptake as a consequence of lack of appropriate information on Family Planning (FP) methods, contraceptive accessibility, cultural and religious beliefs, contraceptive uptake decision making and youths' socio-economic status among others[1,2,4,6–9].

Over the years, youth friendly health programmes in Africa have contributed significantly to improved Sexual and Reproductive Health (SRH) outcomes, such as increased knowledge of contraception services, reduced cases of unsafe abortion, met need for contraception among others [6,10–13]. Despite this, statistics from 2020 demonstrated that the Southern African Development Community (SADC) region compared to other regions in Africa registered increased numbers of unmet need for family planning amongst adolescent girls and young women [14].

Malawi as a member state of the SADC region is featured amongst the top 5 countries with high rates of unintended pregnancies amongst the youth. The youth unlike other age groups in Malawi have the highest level of unmet need for family planning and they contribute to almost 30% of unintended pregnancies amongst all women [14,15]. This demonstrates the need to support SRH initiatives for all the youth in Malawi in order to achieve positive health outcomes related to contraception use.

The Malawi national Sexual Reproductive Health and Rights (SRHR) policy document advocates for increased coverage of FP services among the youth at both the health facility and community level [16].These services are offered for free. The youth are at liberty to choose whether they would want to access either Short Acting Reversible Contraceptives (SARCs) such as pills, condoms and injectable Depo-Provera or Long Active Reversible Contraceptives (LARCs) such as hormonal contraceptive implants and intrauterine devices (IDUs) among others [16].

Although a range of contraceptive options are available to young people, contraceptive use among the youth in Malawi is low hence contributing to high unmet need for FP [17]. The low uptake of contraceptives among adolescent girls and young women may be due to the fact that these young people encounter problems with accessing FP services especially in the rural clinics compared to urban clinics which are well served with medical and health care [18]. It is further argued that unmarried youths are more likely to shy away from accessing FP services at health facilities in order to save themselves from the embarrassment of being judged by health workers and everyone around them[19]. The youth, therefore, need be afforded spaces where they can freely explore issues to do with FP without experiencing any form of discrimination. Literature from around the world have referred these youth friendly spaces as youth corners, youth friendly centres, and youth clubs [7,20,21].

In Malawi, youth clubs are classified as delivery points for young people who seek to obtain health services that are equitable, accessible, acceptable, appropriate and effective.

These health services include; FP services, HIV counselling and testing, and referral services [22]. It is worth noting that most of these youth clubs do not have proper building structures and as such, most meetings occur in open outdoor spaces that have a good shade [22]. Youth clubs are patronized by both in and out of school adolescents and young people aged between 10 to 24 years.

Most research on access and utilisation of FP services for the youth in Malawi have recommended the enhancement of youth clubs in the communities since confidentiality and privacy is guaranteed when accessing FP information and services. [7,16,23]. However, some studies questioned the capacity and nature of influence that youth clubs have in promoting FP services. For example, an exploration of youth and adult perspectives on barriers to accessing FP methods in Malawi recommended a review of these youth clubs as their impact on the ground is not clear [9]. Another study reported on the existence of youth clubs in different Malawian communities but further claimed that there was no clear-cut on the clubs' contribution towards access to FP information and services [22].

Currently, it is very difficult to know the role that youth clubs play in facilitating the delivery of FP information and services to the youth. Using primary qualitative data collected from two youth clubs in Blantyre district, this study explored young peoples' perspectives of how they thought youth clubs could best be run to facilitate the smooth delivery of FP information and services. The findings of this study are expected to contribute to insights on how community youth clubs should be designed in order to effectively deliver FP information and referral services to the youth.

Methods

Study setting and design

The research study was conducted in Malawi particularly in Blantyre district. In 2018, the population of Malawi was estimated at 18 million with two-thirds of the population under the age of 25 [9]. Blantyre is located in the southern region of Malawi, and it is surrounded by 8 government health centres. All these health centres have youth clubs that provide youth friendly health services and as such, two sites namely Bangwe and Ndirande were selected for the study. Blantyre district was chosen as the ideal study site because of high prevalent cases of unwanted pregnancies among the youth compared to other districts in the region [15].

This study adopted an exploratory qualitative study design in order to have an in-depth understanding of the problem being explored hence contributing to the development of new knowledge in that area [24]. Focus group discussions (FGDs) and semi-structured interviews were used to understand young peoples' feelings, experiences and thoughts of how youth clubs should function in order to ensure smooth delivery of FP information and services.

Study Procedure and Recruitment of Participants

The population for this study included male and female youth who attended youth clubs in Bangwe and Ndirande. The study employed purposive sampling so as to yield rich information on the subject matter and the inclusion criteria included those members of the youth club aged between 18 to 24 who had more than 2 years of experience in the youth clubs. The exclusion criteria included male and female youth who were less than 18 years old and also all those young people with cognitive impairment.

Before the recruitment process, I attended 2 club sessions where study objectives were unpacked and questions arising from the information presented were clearly answered. The potential participants in both clubs were encouraged to attend the next club session where voluntary basis recruitment was exercised. Those willing to participate in the FGDs raised up their hands and 30 participants were randomly sampled. The club leaders helped in sampling 10 participants for the semi-structured interviews as they believed they could help in providing detailed information about the clubs. It must be pointed out that I, as the researcher, already established a good rapport with the communities where these youth clubs are located since I was initially working for a PEPFAR funded project on the promotion of SRH services to the youth. In this case, I did not take advantage of coercing people to participate in the study against their will because of the connections that existed. The participants were asked to give a written consent and they were also informed about their ability to withdraw at any point in time if they no longer wanted to participate in the study. This research study involved a total of 40 participants.

Data collection methods

Data collection was conducted between January and March 2023.There were 4 FGDs, 2 in each site and 10 semi-structured interviews, 5 in each site, with male and female youth from Bangwe and Ndirande youth clubs (see Table 1).

The FGD and interview guide covered issues such as participants' club session experiences and perceptions as regards to the delivery of FP information and services, condom uptake, barriers and facilitators associated with the delivery of family planning information and services. I conducted FGDs and semi-structured interviews alongside a male research assistant. Due to the sensitivity of the topic under study, the following measures were put in place in order to ensure that both female and male respondents participate freely in an environment where there was both a male and female interviewer. 1) respectful tone and professional language that was clear, non-judgmental and free from any bias or stigmitisation were maintained throughout the interviews; 2) Non-sensitive issues were discussed early in the interviews in order to build rapport and establish a comfortable environment; 3) participants were asked to skip questions if they felt uncomfortable and they were also checked periodically to gauge their level of comfort by asking them if there wanted anything to be clarified before proceeding to the next question.

Data was collected in Malawi's national language, Chichewa and I translated this data into English. The data collected was audio-recorded for easy reference during data transcription.

Focus Group Discussions

In each setting, one FGD was for the male youth and also one was for the female youth. The rationale for separating males from the females was to allow participants to speak as openly as possible, and to discuss experiences that could be different by gender. Each FGD comprised of about 6 - 9 people and each session lasted between 55 and 90 minutes. All the discussions were held within the youth club premises.

Table 1: Participants for FGDs and Semi-Structured Interviews

Youth Club	Semi-structured interview Participants	FGD Participants
Ndirande		
Males	2	7
Females	3	9
Bangwe		
Males	3	6
Females	2	8
Total	**10**	**30**

Semi-structured Interviews

10 semi-structured interviews with the youth who did not participate in the FGDs were conducted in order to supplement the information generated from the FGDs. This data collection method also helped the interviewers to fully address the research questions through prompting and probing study participants for more information where necessary. All interviews were conducted within the youth club surrounding area in spaces agreed with the participants. This enabled them to express themselves freely without concerns for their privacy. Each interview session lasted between 30 – 45 minutes.

Data management and analysis

The process of data analysis took place alongside data collection. Field notes were taken to supplement the audio recordings. To ensure anonymity of the respondents, all the audio recordings were assigned numbers. Data from FGDs and semi structured interviews was transcribed verbatim. Transcripts were read and checked against the audio recordings to ensure quality of the data. Initial interpretations were validated by the respondents through member checking where transcripts were sent to the respondents for comments and correction. The data collected through semi structured interviews and FGDs was analysed manually using thematic analysis. The analysis was carried out following Braun and Clarke's six phase guide[25].

The first phase of data familiarization followed soon after data transcription. The transcribed data was reviewed multiple times through repeated active reading and all initial impressions and interesting observations were jotted down. Based on the study objectives, a code book was developed where similar codes were sorted, grouped together and linked to a potential theme The codes identified from the data extracts were written down in a code book. Through constant review of the emergent potential themes, some themes were completely taken out because they lacked data to support them while other themes were merged to make one theme because they were backed with the same kind of data and had the same interpretation. A final review and refinement was conducted to ensure a coherent pattern and the themes were clearly named and defined until saturation was reached. The final themes are discussed in the research findings section.

Ethical Consideration

The ethical clearance approvals required for this study were obtained from University of Cape Town's Human Research Ethics Committee (HREC) at the School of Public health and family medicine under reference HREC REF: 756/2022. Permission to conduct the study was also sought from Blantyre district Youth Office authorities and the youth club's leaders prior to the recruitment of study participants. To ensure confidentiality of the participants, pseudonyms were used in the final write-up and no identifying information was linked to the study participants. In FGDs where data was collected from a number of participants at the same time, confidentiality was encouraged through reinforcing the commitment to confidentiality throughout the discussion. Respondents were discouraged to use identifiable details or any information that could link responses to a particular participant. Lastly, all the respondents signed a confidentiality agreement which was part of the consent form.

Findings

Characteristics of Participants

This study involved 40 youths out of which 22 were females and 18 were males. As shown in table 1, a total of 5 males and 5 females participated in the semi-structured interviews whilst 13 males and 17 females took part in FGDs. The sample size had a majority of the older age group with 70% youths aged between

21-24 years whilst 30 % were aged between 18-20 years. The mean age was 22. At least 45 % of the study participants had completed secondary school education level with 25% still pursuing secondary school education and 30% were secondary school drop outs. There were no participants that were still in primary school in this study. With respect to the duration of time they joined the youth clubs, 10 participants had been attending club sessions for less than 3 years. The rest of them have been members of the youth clubs for more than 4 years with 10 years as the highest number for the longest serving member. All the respondents reported to have been having youth club sessions for an average of 4 times in a month.

Four overarching themes encompassing the youth experiences and perceptions on the youth club's role in delivering FP information and services emerged from the study. These included: 1) Knowledge about FP methods; 2) promotion of positive SRH wellbeing; 3) perceived facilitators of smooth delivery of FP information and services; and 4) perceived barriers that affect the delivery of FP information and services. Subthemes within these themes also emerged from the data set and these are also fully presented. The themes and subthemes are summarized in table 2.

Table 2: Research Study Themes and Subthemes

Themes	Subthemes
Knowledge about Family Planning Methods	Family Planning methods commonly discussed Myths around condom use
Promotion of positive SRH wellbeing	Peer to peer support/education Easy access to SRH information Awareness and Stereotype breaking Condom distribution Referral and linkages
Perceived facilitators of smooth delivery of FP information and services	Effective facilitation techniques Trained peer educators Collaborative partnerships
Perceived barriers that affect the delivery of FP information and services	Cultural and religious biases Limited availability of resources

Knowledge about Family Planning Methods

Family planning methods commonly discussed

The study responses indicated that youth clubs help in sharing knowledge and awareness about FP methods. A majority of the respondents admitted to have had a discussion mostly on FP methods such as condoms, Jadelle Implant, emergency pills and Intrauterine device in the youth clubs. There was a strong consensus amongst all the study participants that male and female condoms are widely discussed and promoted in youth clubs. However, knowledge about female condoms was limited:

"*Although we discuss about female condoms, we are only supplied with male condoms in the clubs so most of the discussions that we have, centre around male condoms. We do not have a lot of information about female condoms."* (Bangwe female youth, 22 years old, IDI 7).

Another male youth from Ndirande youth club gave similar sentiments:

"For girls, it is always a long process to follow for them to wear condoms. Girls lack more information on how to wear them. Most sensitisations overlook a demonstration on how to wear female condoms." (Ndirande male youth, 19 years old, FGD 1).

Myths around condom use

The use of condoms was generally associated with the reduction of sexual pleasure. Most male young people felt that condoms reduce the intimacy associated with skin to skin contact during sex. One male youth had this to say:

"Yes condoms are good but if you trust your partner then you can't use a condom, I mean, mmmh, can you eat a sweet whilst it's in a packet?" (Bangwe male youth, 23 years old, FGD 3).

Another female youth agreed that most male youths do not want to use condoms during sex.

"we may have condoms available but you see our partners always refuse to use them because they say sex with a condom does not feel as good as sex without a condom." (Bangwe female youth, 20 years old, FGD 4).

Another common thing that came out of the study was that condom use affects females in the sense that they experience stomach ache after sex. This has been a common discussion amongst the youth including those who have never used a condom. In the FGDs with male youths at Ndirande youth club, two participants shared that condom uptake may be low because most girls do not like condoms.

"*Sometimes for us boys, we may want to use condoms but our girlfriends refuse because they say they have heard that condoms cause stomach pain after sex.* (Ndirande male youth,21 years old, FGD 1).

"We blame our female partners indeed because even for me, my girlfriend has always preferred pills because she is always afraid of a having stomach ache after sex." (Ndirande male youth, 24 years old, FGD 1).

Most of the youth commented that condom use promotes positive sexual health lifestyle, but some shared that the more you ask for condoms at the youth club, the more you are labelled as someone who loves sex too much.

"I can't be taking condoms from the box at the club now and again, otherwise, people think I am a sex addict or I have multiple partners. Although we promote the use of condoms, some of these friends laugh at us." (Bangwe male youth, 22years old, IDI 9).

Promotion of Positive Sexual and Reproductive Health Wellbeing

Peer to peer support

Most of the study participants held the view that youth clubs provide a safe and supportive environment where young people feel comfortable to discuss sensitive topics related to sexual health in a relatable and non-judgmental manner. It was mentioned that club settings helped the youths to share personal experiences, concerns and seek advice from those facing similar challenges. These sentiments were shared by both male and female youths.

"As a youth network, we are there to help each other clear out misconceptions. We normally have discussions that tackle advantages and challenges that we face when using FP especially condoms." (Bangwe male youth, 21 years old, IDI 8).

"I like discussions a lot because we learn how others handle situations that affect their sex lives. Where advise is needed, we always brainstorm on how best to deal with specific situations. (Bangwe female youth, 19 years old, IDI 6).

Despite the support that peers give one another, the study found that youth clubs lacked trained peer educators. In the FGDs with Bangwe youth club, only one female youth mentioned that she had received SRH training from one non-governmental organisation (NGO) and she uses that knowledge to share with friends during club sessions.

"Like for me, I am very knowledgeable about FP methods because I have been trained. We do share this information amongst ourselves but I know other clubs struggle because they don't have peer educators." (Bangwe female youth,22 years old, FGD 4).

Another participant narrated that a lack of comprehensive information limited the way youth could support each other in the clubs:

> *"We conduct FP sessions let's say for 1 hour but mostly we lack information because sometimes we go in circles talking about the same issue. But then, the little information we know, we discuss."* (Ndirande male youth,20 years old, IDI 2).

Easy access to SRH information

Although clubs lacked comprehensive information, it was commonly agreed across all groups that youth clubs need to exist in order to provide a platform for accessing reliable information about FP as clubs may sometimes have resources such as brochures, posters and other relevant information, educational and communication (IEC) materials. Most of these resources either come from the clinics or NGOs that support SRH initiatives.

> *"Our club meeting place is just next to the clinic so we call the youth friendly health services health personnel to come and help us understand some of these issues and sometimes we get this information from pamphlets shared to us by this clinic or other NGO's who give us other IEC materials."* (Ndirande female youth, 24 years old, IDI 1).

> *"We use girl guide books to understand FP methods such as pills, norplant and we discuss this amongst ourselves."* (Bangwe female youth, 19 years old, IDI 6).

Further to this, most youths were happy with the mode of delivery for FP information as activities such as drama, debate and songs are mostly used in the clubs. One participant narrated that clubs become so fun and the activities helped them to get FP information that sticks in their heads.

> *"What I love the most is that drama educates us quite a lot. There are some scenes that depict situations that we can easily relate to when it comes to FP issues. We enjoy these activities and we are always empowered to make informed decisions about our sexual and reproductive health them."* (Bangwe female youth, 20 years old, FGD 4).

Awareness and Stereotype breaking

Some study participants were of the view that club activities such as community awareness campaigns encouraged open dialogue and helped to combat stigma associated with the use of FP in some cultural contexts. One female participant pointed out that some communities would not want FP information to be shared to young people and yet the very same young people are engaging in sexual activities.

"Youths these days become sexually active at a tender age so for us, sometimes, we target girls who are in primary schools. We talk to them about family planning issues which is a taboo in our community because FP issues are mostly considered as issues to be discussed by those who are married. In most cases, we invite them to join our clubs."
(Ndirande female youth, 23years old, FGD 2).

Despite all the awareness efforts, some participants felt that youth club members lacked resources such as SRH education materials and trained facilitators in order to address misconceptions and provide accurate information during campaigns. Most youths shared that trained health personnel are mostly engaged and do not have time to go with them to conduct campaigns.

"The clinic health personnel come to give us information in the clubs when they are free but most of the times when we make plans to reach out to other youths in the communities, they rarely come with us, and sometimes the health personnel need incentives such as meal allowances."
(Ndirande male youth, 24 years old, IDI 4).

Condom distribution

Study findings showed that youth clubs were the main hubs in which condoms are distributed. Almost all study participants mentioned that health personnel from nearby clinics always encouraged them to go and get boxes of condoms for distribution at the clubs.

"We put a box of condoms right at that corner and everyone is free to get them. When condoms have run out of stock, our club chairperson gets in touch with the clinic health personnel to get some more."
(Bangwe male youth, 20 years old, IDI 10).

Although condoms are distributed in the clubs, study findings also revealed that condom use is low due to relationship dynamics and negotiation skills. These views were shared by both male and female youths in the clubs.

"Mostly it's the boys who take condoms from the boxes. Most ladies don't take them because they are either shy or they are afraid of their partners because men usually think that girls who keep condoms in their handbags have multiple partners."
(Bangwe female youth, 21 years old, IDI 6).

"Our female partners fail to make decisions on their own. We ask them whether they need us to use a condom or not during sex but they tell us to do whatever we want. They are submissive to us and sometimes we choose not to use a condom."
(Ndirande male youth, 22years old, FGD 1).

Referral and linkages

The predominant perspective amongst study participants was that youth clubs gave them a platform to work with health care providers that specialize in SRH services and this ensured that

youths had access to comprehensive care beyond the club's scope. In some clubs, for example, young people were provided with referral slips to access contraceptive services that can only be accessed at the clinics. A majority of the participants also reported that health providers visited them in the clubs when needed to explain some FP concepts that were not clear and also encouraged them to visit clinics to access FP services. However, some participants noted that most youth clubs did not offer referral services and further suggested a need to intensify referral services at the clubs so that youths should have a variety of FP choices.

> *"There was only one time when a certain NGO project supported our clinic with FP referral slips which we could get here At the club and use at the clinic. By the time we were going to the clinic, the health providers could know what we were there for. This made things better for us because it's not easy just to start talking with health providers about accessing FP. We are always shy you know…"* (Bangwe female youth, 23 years old, IDI 7).

Perceived facilitators of smooth delivery of family planning information and services

The study established that effective facilitation techniques, trained peer educators and collaborative partnerships were the perceived facilitators of smooth delivery of FP information and services in the clubs.

Effective facilitation techniques

Some study participants stated that FP information could be smoothly delivered in clubs if the session facilitators from the clinics could have facilitation skills that allow interactive activities as these also helped to answer some questions that need further clarification.

> *"In most cases, the health personnel come to give us talks on different topics related to sexual health. If only they could have enough time to do some activities for us to understand these issues clearly. For example, group exercises or discussions could help us to know if we really understand these issues."* (Ndirande male youth, 24 years, IDI 2).

In addition to this, participants were of the view that facilitation that allows active listening helped to establish trust and respect for individuals' perspectives hence providing a safe space for open dialogue which is free from judgements.

> *"You see it's also important for the facilitators to listen to our views and in the end help us to understand properly rather than cutting us off. In this way, we feel respected and want to keep the conversation going."* (Bangwe male youth, 19 years old, IDI 8).

Trained peer educators

Study participants recommended that peer educators needed to be equipped with skills and knowledge on FP as this helped them to provide accurate information and offer support and guidance to their peers in a relatable manner.

> *"We don't have trained peer educators in our club, we just have basic knowledge but we are always happy to discuss these sensitive topics amongst ourselves because we have same experiences and we always learn from each other."* (Ndirande female youth, 21 years old, FGD 2)

Collaborative partnerships

Most study respondents strongly believed that engaging relevant stakeholders such as NGOs and health providers could ensure a comprehensive approach to FP information delivery. One participant in the FGDs narrated that clubs on their own did not have adequate resources and expertise to effectively promote the delivery of FP information.

> *"Clubs are limited because they do not get any funding but good partnerships with stakeholders in the health sector would help us to gain more knowledge on SRH issues."* (Bangwe male youth, 20 years old, FGD 3).

Perceived barriers that affect the delivery of FP information and services

Amongst the study participants, cultural and religious biases, and limited availability of resources were the major perceived barriers to the effective delivery of FP information and services.

Cultural and religious biases

This study unveiled that some youths held conservative views that discouraged discussions about sex and contraception due to cultural and religious beliefs. It was mentioned that some cultures in the region considered open sex discussions as a taboo hence making it challenging to deliver SRH accurate information and services to the youth. The same sentiments were echoed by some Christian youths who considered sex before marriage as a sin. In the FGDs with Ndirande male youths, one participant argued that clubs promoted the use of FP methods rather than encouraging abstinence.

> *"We benefit a lot from the clubs since we also do other activities such as craft work. What I do not like is the fact that abstinence is not promoted during our discussions. Sex before marriage is a sin and you will see that the more we promote condom use, the more the youth indulge in premarital sex."* (Ndirande male youth, 19 years old, FGD 1).

Limited availability of resources

Limited availability of resources was perceived as a hindrance to the effective delivery of FP information and services to the youth. Most participants narrated that clubs were supposed to conduct outreach activities to reach a wider audience of young people in the community but this rarely happened due to limited financial and logistical resources.

> *"All we need to achieve is mindset change amongst the youth. Community sensitization campaigns can help us to share accurate FP knowledge to all youths but we lack resources such as the public address system to make the campaigns lively and audible."* (Bangwe Female youth, 23 years old, IDI 6).

Discussion

This study explored the perspectives of the youth on the role that youth clubs play in delivering FP information and services to the youth. Four main themes emerged from the study: Knowledge about FP methods, promotion of positive SRH wellbeing, perceived facilitators of delivering FP information and perceived barriers of delivering FP information and services to the youth.

Study findings showed that youth clubs created awareness on different types of FP methods particularly male condoms other than female condoms. Similar to other studies [22,23], condoms were widely discussed and they were the most advocated mode of FP in the youth clubs. Contrary to other studies which suggest that condom utilisation is high when young people have adequate knowledge on condoms [23,26], this study revealed that condom uptake was low in youth clubs although youths were very knowledgeable about the benefits of using condoms. This could be explained by the fact that myths and misconceptions about condoms were highly perpetuated amongst the youth. Notably, most female youths complained about stomach pains after sex when a condom is used. These findings are in agreement with those reported in a study conducted in Machinga, Malawi where most female youths listed stomach ache as a side effect of condom use [9]. There is a need to dispel these misconceptions through comprehensive sexual education which is lacking in the clubs at the moment. If male condoms seem to be causing problems in females, then promotion of female condoms would also help female youths to make informed decisions about their sexual health since they will also have increased options of contraceptive methods.

The findings of this study echo others that suggest that youth clubs promote positive SRH wellbeing [8,28,29]. While many youths commended clubs for providing them with easy access to FP information, a majority of the study participants felt that clubs lacked trained peer educators. This implies that youth club members may rely on unreliable sources hence gaining limited accurate information which can

be detrimental to their SRH wellbeing [30]. Further to this, the study established that community awareness campaigns helped to bring awareness and also break stereotyping when it came to FP issues. However, it was noted that clubs lacked facilitation support from the health personnel who were not motivated enough to support club initiatives because of unavailability of incentives. True to these findings, availability of incentives was associated with community health workers' positive attitude and motivation towards work in Malawi [31]. In light of the above scenarios, it is evident that the Ministry of Health (MoH) firstly needs to create SRH training opportunities for more young people to become peer educators. Usually, peer educators are often close in age to club members and as such, they share personalized guidance based on the own experiences and understanding of the challenges faced by their peers. Secondly, the MoH needs to formulate measures that will ensure that community clinic health providers support youth clubs' outreach initiatives. There is a need to have a youth advocate in the clinic committee as this ensures that the unique perspectives and needs of young people are considered in decision making processes within the clinic hence improving SRH care for all the youth.

Available findings revealed strong links between clinics and youth clubs when it came to supplying condoms for distribution in the youth clubs. However, the study unveiled a gap in the delivery of referral services that linked the youths to the clinic health service providers for comprehensive support tailored to specific FP needs. This study, just like other publications, highlights the significance of promoting referral services in the youth clubs as this allows youths to have access to specialized youth friendly health care providers who are trained to address their concerns in a non-judgmental and supportive manner [32–35].

Irrespective of perceived barriers associated with the delivery of FP information and services, the study exposed that cultural or religious biases which do not condone sex before marriage, in some way, contributed to stigmitisation and shame associated with discussions around FP and this led to feelings of guilt and embarrassment amongst youths seeking information and support. Although clubs encouraged the youth to openly discuss sex and FP issues, some conservative young people in the same clubs could later on label the open minded youth as promiscuous and immoral. Having these biases unaddressed could limit the scope of FP discussion and prevent young people from making fully informed decisions about their sexual health [23]. Perhaps, lessons could be drawn from Novib's study [37] on overcoming barriers to family planning in Pakistan where it was recommended that cultural or religious leaders who already take a positive stance on FP need to be engaged in awareness campaigns to help change people's attitudes which are deeply rooted in social foundations built on religious or cultural norms.

Participants in the study advocated for the need to engage with relevant stakeholders such as local health service providers and NGOs to leverage their expertise, resources and networks hence strengthening the impact of FP initiatives. For example, local health service providers can offer their expertise by providing accurate and up to date information on SRH issues including FP. Similarly, NGO's can choose to offer funding opportunities to youth clubs to plan, organize and implement their SRH outreach initiatives effectively. It is, therefore, important to consider the suggestions made by the youth in this study. If these recommendations are not given special attention, efforts to effectively deliver FP information and services to the youth could be curtailed thereby limiting the dissemination of FP information to vulnerable youths.

Limitations

This study only focused on the experiences of the youth attending youth clubs. There was no exploration of views of the youth who never attended or had stopped attending club sessions. As such, these findings may be limited in terms of determining the actual role that youth clubs play in delivering FP information and services to the youth. Another limitation is that perspectives of other stakeholders such as local health service providers were not investigated. Future studies need to explore health providers' perspectives as well since they mostly work hand in hand with youth clubs.

This study only focused on two youth clubs out of eight youth clubs in Blantyre district hence the results cannot be generalized for the entire district or country. However, the insights given by the youth may be a reflection of what happens in other similar settings.

Conclusion

This study has highlighted the role of youth clubs in delivering family planning information and services to the youth. Through attending club sessions, the youth gained knowledge on various family planning methods especially condoms. Engagement with health service providers through the referral service, peer-to-peer education and availability of education materials all contributed to the youths' positive SRH wellbeing. However, limited support from local health providers affected the smooth delivery of family planning information and services. For example, youth clubs' outreach activities lacked support from local health professionals who were not only knowledgeable about FP issues but also had effective facilitation skills. Again, lack of trained peer educators and religious biases contributed to limited provision of FP comprehensive education. All in all, this study demonstrates that youth clubs can effectively deliver FP information and services if there are strong partnerships with local health service providers and other stakeholders such as, NGOs who may support clubs through the provision of comprehensive education, training peer educators and provision of contraceptives including female condoms.

List of abbreviations

SRH: Sexual and reproductive health; SADC: Southern Africa Development Community; SRHR: Sexual and reproductive health and rights; FP: Family planning; LARC: long active reversible contraceptives; SARC: Short active reversible contraceptives; IUD: Intrauterine devices; FGD: Focus group discussion; HREC: Human Research Ethics Committee; MoH: Ministry of Health; NGO: Non-governmental organisation; IEC: Information, education and communication.

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Data availability

The data used during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

This study was conducted in accordance with the ethical principles laid down in the Declaration of Helsinki and all participants gave verbal and written informed consent to participate in the study. Ethical approval for the study was obtained from the Human Research Ethics Committee at the University of Cape town (HREC Ref: 756/2022).

Competing interests

The authors have no competing interests to declare that are relevant to the content of this article.

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PART C: APPENDICES

Appendix A: Information sheet and Interviews Consent form

Title: Perceptions of the youths (18-24) on the role of youth clubs in delivering family planning information and services in Blantyre district, Malawi.

Lead Researcher: Alison Swartz

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Co-lead Researcher: Lucia Knight

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Student Researcher: Nancy Makamo

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Contact Information: Human Research Ethics Committee (HREC), Faculty of Health Sciences, University of Cape town.

Email: marc.blockman@uct.ac.za **Phone:** +27 214066338

The purpose of the study: We are inviting you to participate in this research study which aims at understanding the role that youth clubs play in delivering family planning information and referral services. You will be asked questions about what happens in the youth clubs in relation to the activities that facilitate the delivery of information on family planning and referral services. Your thoughts and experience will help to generate information on how best the clubs should be organised in order to promote the utilisation of family planning services.

What are the study Procedures? What will happen if you decide to be part of the study?

Participation in this study is voluntary. If you choose to participate in this study, we will discuss how the study will be conducted and also the role that you are going to play in this study. You are invited to participate in an individual interview, which will be conducted by the student researcher at a place that is safe and very convenient with you. The interview will be conducted in either English or Chichewa depending on your preference. Each interview will take approximately 40 minutes. During the interview, you will be asked to share your opinions and experiences with regards to the youth clubs' role in delivering family planning information and services. However, you are not obliged to answer the questions that you are not comfortable with. You will be allowed

to skip those questions, and should you need to withdraw from the interviews, your decision will be respected, and this will not cause any repercussions as regards to your participation in the youth clubs. If you need any psychosocial support, the researcher will refer you to a counsellor at the health facility affiliated to this youth club. At the end of the interview, the researcher will give you an opportunity to ask any question that you might have. The interview will be recorded, with your consent and if you don't want to be recorded then we will not do so. You can be assured that you will remain anonymous as you will be assigned a false name in the final write up. All the information collected will be kept on a computer protected with a password so that the data should remain private, safe and secure. The researchers for this study will be the only ones who will have access to the data collected.

Are there any reimbursements?

No, the study will not make any reimbursements. However, at the end of the interview, you will be provided with a light refreshment.

What will happen at the end of the study?

The finding for this study will be presented back to you in one of your weekly meetings. The health facility director and health care provider linked to this club will also be invited to this dissemination meeting so that they should take the recommendations to the health department office. This study will also be submitted to University of Cape town in partial fulfilment of my master's degree in public health. Please be assured that no information will be linked directly to you as an individual since all the real names will be removed.

Are there any questions or do you need any clarification?

Do you consent to the interview?

☐ YES ☐ NO

Do you allow the researcher to collect data using an audio recorder? ☐ YES ☐ NO

_____	_____	_____
Signature of research participant	Name of Participant	Date

Appendix B: Information sheet and Focus Group Discussions Consent form

Title: Perceptions of the youths (18-24) on the role of youth clubs in delivering family planning information and services in Blantyre district, Malawi.

Lead Researcher: Alison Swartz

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Student Researcher: Nancy Makamo

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Contact Information: Human Research Ethics Committee (HREC), Faculty of Health Sciences, University of Cape town.

Email: marc.blockman@uct.ac.za **Phone:** +27 214066338

The purpose of the study: We are inviting you to participate in this research study which aims at understanding the role that youth clubs play in delivering family planning information and referral services. You will be asked questions about what happens in the youth clubs in relation to the activities that facilitate the delivery of information on family planning and referral services. Your thoughts and experience will help to generate information on how best the clubs should be organised in order to promote the utilisation of family planning services.

What are the study Procedures? What will happen if you decide to be part of the study?

Participation in this study is voluntary. If you choose to participate in this study, we will discuss how the study will be conducted and also the role that you are going to play in this study. You are invited to participate in the focus group discussions, which will be conducted by the student researcher at a place where all the group members will be comfortable with. You will be asked to sign an agreement that you will not share with anyone the information discussed in the group. The discussions will be conducted in either English or Chichewa depending on the group's preference. The discussions will take approximately between 1:30 to 2 hrs. During the discussion, you will be asked to share your opinions and experiences with regards to the youth clubs' role in delivering

family planning information and services. However, you are not obliged to answer the questions that you are not comfortable with. You will be allowed to skip those questions, and should you need to withdraw from the interviews, your decision will be respected, and this will not cause any repercussions as regards to your participation in the youth clubs. If you need any psychosocial support, the researcher will refer you to a counsellor at the health facility affiliated to this youth club. All group participants will be asked not to interrupt other participants when they are speaking. At the end of the discussion, the researcher will give you an opportunity to ask any question that you might have. The discussions will be recorded, with your consent and if you don't want to be recorded then we will not do so. You can be assured that you will remain anonymous as false names will be used in the final write up. All the information collected will be kept on a computer protected with a password so that the data should remain private, safe and secure. The researchers for this study will be the only ones who will have access to the data collected.

Are there any reimbursements?

No, the study will not make any reimbursements. However, at the end of the discussion, you will be provided with a light refreshment.

What will happen at the end of the study?

The finding for this study will be presented back to you in one of your weekly meetings. The health facility director and health care provider linked to this club will also be invited to this dissemination meeting so that they should take the recommendations to the health department office. This study will also be submitted to University of Cape town in partial fulfilment of my master's degree in public health. Please be assured that no information will be linked directly to you as an individual since all the real names will be removed.

Are there any questions or do you need any clarification?

Do you give your consent to be part of the focus group discussions? ☐ YES ☐ NO

Do you allow the researcher to collect data using an audio recorder? ☐ YES ☐ NO

Do you agree not to share the information discussed with anyone else? ☐ YES ☐ NO

_____	_____	_____
Signature of research participant	Name of Participant	Date

Appendix C: Socio-demographic form

1. Name: _____
2. Age: _____
3. Gender **(please tick):** ☐ Male ☐ Female ☐ Other
4. Name of youth club: _____
5. For how long have you been attending youth clubs? _____
6. How many times do you meet as a club in a month? _____

Appendix D: Semi- Structured Interview guide

1. **What has been your experience in the clubs as regards to activities related to family planning (FP)?**

- Please tell me anything you know about FP information that is shared with you in the youth clubs.
- Who gives you this FP information?
- How often do you get this information?
- How long are the sessions for delivering FP information?
- Are you allowed to ask questions when you do not understand?
- What do you do with the FP knowledge gained?
- Does the club offer any FP referral services? If yes, what are these FP referral services?
- Who offers these referral services?
- What is the referral process like?
- Have you ever used these referral services? If yes, please tell me your experiences.

2. **Let us talk about condoms uptake in the club. According to you,**

- What do you know about condoms?
- Are the condoms made available for youths to access them in the club?
- If yes, who provides the condoms? How do you describe the availability of these condoms in the club? Do youths take the condoms to use for FP?
- What do you think can be done to promote the utilisation of condoms in the club?

3. **In your opinion, what are facilitators associated with the delivery of information on all FP methods and referral services in the youth clubs.**

    - What are the activities that help to promote the delivery of FP information and services?
    - How are the FP activities conducted?
    - How do those activities enhance your understanding on FP information and services that are delivered to you?
    - Is there anything else that can be done in order to promote the quality delivery of FP information and services in the clubs?

4. **In your opinion, what are the barriers associated with the delivery of information on all family planning methods and referral services in the youth clubs.**

- What are the activities that hinder the quality delivery of FP information and services?
- How are these FP activities conducted?
- How do these activities inhibit the smooth delivery of FP information and services?
- What can be done differently as regards to these activities you have mentioned?

Neutral prompts to get more information

1. Could you please say a bit more on ……
2. I did not understand when you said……. Could you please explain further?
3. I will come back to this question in a short while…….
4. What did you mean by ……

Concluding Remarks

1. Do you have any questions that you would like to ask me?

2. Is there anything that I failed to mention, and you feel is important to discuss regarding The youth clubs and family planning services?

Thank you for your time and participation in this study!
[Stop the recording]

Appendix E: Focus Group Discussions guide

1. **Now I would like to understand your experiences in the club as regards to activities related to family planning (FP).**

- Please tell me anything you know about FP information that is shared with you in the youth clubs.
- Who gives you this FP information?
- How often do you get this information?
- How long are the sessions for delivering FP information?
- Are you allowed to ask questions when you do not understand?
- What do you do with the FP knowledge gained?
- Does the club offer any FP referral services? If yes, what are these FP referral services?
- Who offers these referral services?
- What is the referral process like?
- Have you ever used these referral services? If yes, please tell me your experiences.

2. **Let us talk about condoms uptake in the club. According to you,**

- What do you know about condoms?
- Are the condoms made available for youths to access them in the club?
- If yes, who provides the condoms? How do you describe the availability of these condoms in the club? Do youths take the condoms to use for FP?
- What do you think can be done to promote the utilisation of condoms in the club?

3. **In your opinion, what are facilitators associated with the delivery of information on all FP methods and referral services in the youth clubs.**

    - What are the activities that help to promote the delivery of FP information and services?
    - How are the FP activities conducted?
    - How do those activities enhance your understanding on FP information and services that are delivered to you?
    - Is there anything else that can be done in order to promote the quality delivery of FP information and services in the clubs?

4. **In your opinion, what are the barriers associated with the delivery of information on all family planning methods and referral services in the youth clubs.**

- What are the activities that hinder the quality delivery of FP information and services?
- How are these FP activities conducted?
- How do these activities inhibit the smooth delivery of FP information and services?
- What can be done differently as regards to these activities you have mentioned?

Neutral prompts to get more information

1. Could we discuss a bit more on ……
2. I did not understand when you said……. Could you please explain further?
3. What do others say on this…….
4. What did you mean by ……

Concluding Remarks

1. What are your thoughts about today's discussion?

2. What stood out for you in today's discussion?

3. Is there anything else regarding youth clubs and FP services that we did not discuss and you feel it is important to be discussed?

4. Do you have any questions that you would like to ask me?

Thank you for your time and participation in this study!
[Stop the recording]

Appendix F: HREC Ethics Approval Letter

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room 45 E-52-E-Floor- Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: hrec-submissions@uct.ac.za
Website: www.health.uct.ac.za/home/human-research-ethics

17 January 2023

HREC REF: 756/2022

Dr A Swart
Division of Public Health
FHS
Email: Alison.swartz@uct.ac.za
Student: mkmnan003@myuct.ac.za

Dear Dr Swartz

PROJECT TITLE: YOUTH PERCEPTIONS (18-24) ON THE ROLE OF YOUTH CLUBS IN DELIVERING FAMILY PLANNING INFORMATION AND SERVICES IN BLANTYRE DISTRICT, MALAWI-MASTERS CANDIDATE-MS NANCY MAKAMO

Thank you for your response letter, addressing the issues raised by the Faculty of Health Sciences Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 January 2024.

Please submit a progress form, using the standardised Annual Report Form (FHS016) if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

The HREC acknowledge that the student: Ms Nancy Makamo will also be involved in this study.

Please quote the HREC REF 756/2022 in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FACULTY OF HEALTH SCIENCES HUMAN RESEARCH ETHICS COMMITTEE

Appendix G: Manuscript Submission Guidelines – BMC Public Health

Preparing your manuscript

The information below details the section headings that you should include in your manuscript and what information should be within each section. Please note that your manuscript must include a 'Declarations' section including all of the subheadings (please see below for more information).

Title page

The title page should:

- present a title that includes, if appropriate, the study design e.g.:
    - "A versus B in the treatment of C: a randomized controlled trial", "X is a risk factor for Y: a case control study", "What is the impact of factor X on subject Y: A systematic review"
    - or for non-clinical or non-research studies a description of what the article reports

- list the full names and institutional addresses for all authors
    - if a collaboration group should be listed as an author, please list the Group name as an author. If you would like the names of the individual members of the Group to be searchable through their individual PubMed records, please include this information in the "Acknowledgements" section in accordance with the instructions below

- indicate the corresponding author

Abstract

The Abstract should not exceed 350 words. Please minimize the use of abbreviations and do not cite references in the abstract. The abstract must include the following separate sections:

- **Background:** the context and purpose of the study
- **Methods:** how the study was performed and statistical tests used
- **Results:** the main findings
- **Conclusions:** brief summary and potential implications

Keywords

Three to ten keywords representing the main content of the article.

Background

The Background section should explain the background to the study, its aims, a summary of the existing literature and why this study was necessary or its contribution to the field.

Methods

The methods section should include:

- the aim, design and setting of the study
- the characteristics of participants or description of materials
- a clear description of all processes, interventions and comparisons. Generic drug names should generally be used. When proprietary brands are used in research, include the brand names in parentheses
- the type of statistical analysis used, including a power calculation if appropriate

Results

This should include the findings of the study including, if appropriate, results of statistical analysis which must be included either in the text or as tables and figures.

Discussion

This section should discuss the implications of the findings in context of existing research and highlight limitations of the study.

Conclusions

This should state clearly the main conclusions and provide an explanation of the importance and relevance of the study reported.

List of abbreviations

If abbreviations are used in the text they should be defined in the text at first use, and a list of abbreviations should be provided.

Declarations

All manuscripts must contain the following sections under the heading 'Declarations':

- Ethics approval and consent to participate
- Consent for publication
- Availability of data and materials
- Competing interests
- Funding
- Authors' contributions
- Acknowledgements
- Authors' information (optional)
- Please see below for details on the information to be included in these sections.

If any of the sections are not relevant to your manuscript, please include the heading and write 'Not applicable' for that section.

Ethics approval and consent to participate

Manuscripts reporting studies involving human participants, human data or human tissue must:

- include a statement on ethics approval and consent (even where the need for approval was waived)
- include the name of the ethics committee that approved the study and the committee's reference number if appropriate

Studies involving animals must include a statement on ethics approval and for experimental studies involving client-owned animals, authors must also include a statement on informed consent from the client or owner.

See our editorial policies for more information.

If your manuscript does not report on or involve the use of any animal or human data or tissue, please state "Not applicable" in this section.

Consent for publication

If your manuscript contains any individual person's data in any form (including any individual details, images or videos), consent for publication must be obtained from that person, or in the case of children, their parent or legal guardian. All presentations of case reports must have consent for publication.

You can use your institutional consent form or our consent form if you prefer. You should not send the form to us on submission, but we may request to see a copy at any stage (including after publication).

See our editorial policies for more information on consent for publication.

If your manuscript does not contain data from any individual person, please state "Not applicable" in this section.

Availability of data and materials

All manuscripts must include an 'Availability of data and materials' statement. Data availability statements should include information on where data supporting the results reported in the article can be found including, where applicable, hyperlinks to publicly archived datasets analysed or generated during the study. By data we mean the minimal dataset that would be necessary to interpret, replicate and build upon the findings reported in the article. We recognise it is not always possible to share research data publicly, for instance when individual privacy could be compromised, and in such instances data availability should still be stated in the manuscript along with any conditions for access.

Data availability statements can take one of the following forms (or a combination of more than one if required for multiple datasets):

- The datasets generated and/or analysed during the current study are available in the [NAME] repository, [PERSISTENT WEB LINK TO DATASETS]
- The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

- All data generated or analysed during this study are included in this published article [and its supplementary information files].
- The datasets generated and/or analysed during the current study are not publicly available due [REASON WHY DATA ARE NOT PUBLIC] but are available from the corresponding author on reasonable request.
- Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.
- The data that support the findings of this study are available from [third party name] but restrictions apply to the availability of these data, which were used under license for the current study, and so are not publicly available. Data are however available from the authors upon reasonable request and with permission of [third party name].
- Not applicable. If your manuscript does not contain any data, please state 'Not applicable' in this section.

Competing interests

All financial and non-financial competing interests must be declared in this section. Please use the authors initials to refer to each authors' competing interests in this section. If you do not have any competing interests, please state "The authors declare that they have no competing interests" in this section.

Funding

All sources of funding for the research reported should be declared. If the funder has a specific role in the conceptualization, design, data collection, analysis, decision to publish, or preparation of the manuscript, this should be declared.

Authors' contributions

The individual contributions of authors to the manuscript should be specified in this section.
Please use initials to refer to each author's contribution in this section, for example: "FC analyzed and interpreted the patient data regarding the hematological disease and the transplant. RH performed the histological examination of the kidney, and was a major contributor in writing the manuscript. All authors read and approved the final manuscript."

Acknowledgements

Please acknowledge anyone who contributed towards the article who does not meet the criteria for authorship including anyone who provided professional writing services or materials. Authors should obtain permission to acknowledge from all those mentioned in the Acknowledgements section. If you do not have anyone to acknowledge, please write "Not applicable" in this section.

Group authorship (for manuscripts involving a collaboration group): if you would like the names of the individual members of a collaboration Group to be searchable through their individual PubMed records, please ensure that the title of the collaboration Group is included on the title page and in the submission system and also include collaborating author names as the last paragraph of the "Acknowledgements" section. Please add authors in the format First Name, Middle initial(s) (optional), Last Name. You can add institution or country information for each author if you wish, but this should be consistent across all authors.

Please note that individual names may not be present in the PubMed record at the time a published article is initially included in PubMed as it takes PubMed additional time to code this information.

Authors' information

This section is optional.

You may choose to use this section to include any relevant information about the author(s) that may aid the reader's interpretation of the article, and understand the standpoint of the author(s). This may include details about the authors' qualifications, current positions they hold at institutions or societies, or any other relevant background information. Please refer to authors using their initials. Note this section should not be used to describe any competing interests.

Footnotes

Footnotes can be used to give additional information, which may include the citation of a reference included in the reference list. They should not consist solely of a reference citation, and they should never include the bibliographic details of a reference. They should also not contain any figures or tables.

Footnotes to the text are numbered consecutively; those to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data). Footnotes to the title or the authors of the article are not given reference symbols.

Always use footnotes instead of endnotes.

References

Vancouver reference style