End of project evaluation of the "Community Outreach Family Planning project".

Final Report

Submitted to:
Adventist Health Services in Malawi
PO Box 951,
Blantyre,
Malawi.

Submitted by:

CENTRE FOR
HEALTH, AGRICULTURE,
DEVELOPMENT RESEARCH
AND CONSULTING

P. O. Box 399
Blantyre

Mobile : 265 (0) 999 554 003/265 999 218 808
E-mail: info@centreforhealthmw.com
bagreyngwira@gmail.com

Disclaimer

This report is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of Adventist Health Services (AHS) and do not necessarily reflect the views of USAID or the United States Government.

Acknowledgements

CHAD is grateful to various stakeholders who provided comments that formed the basis of the "End of Project Evaluation". The key informants included those at central level in the Ministry of Health's Reproductive Health Directorate, district, health facility and community levels.

CHAD also would like to express gratitude to all the study participants for providing useful insights into how the project was implemented which informed this evaluation. Without their selfless participation, this assessment would not have been possible.

The team at Adventist Health Services (AHS) deserve special mention. They provided timely feedback and direction of the evaluation. The exceptional coordination process, led by Mr. Denis Munthali (Project Coordinator), allowed for smooth and timely progress of the end of project evaluation. Further, financial support and timely disbursement of funds by AHS eased the logistical arrangements related to this evaluation.

Table of Contents

EXECUTIVE SUMMARY

Background:
Adventist Health Services (AHS) in Malawi has been implementing a 3-year "Community Outreach Family Planning" project with funding from USAID. This report presents findings of an "End of Project Evaluation for this project. The original aim of the project was to reduce the unmet need for family planning among 272,271 women and 163,909 men of reproductive age in and around 5, 17, 20 and 23 health facilities in Blantyre, Dedza, Rumphi and Mzimba South Districts, respectively.

Objectives:
The overall aim of this evaluation was to assess the effectiveness, relevance, efficiency, sustainability, and impact of the "**Community Outreach Family Planning Project**". There were six specific objectives, 1) to establish progress made towards the achievement of the desired outcomes, 2) to highlight factors that contributed to the achievement of the desired outcomes, 3) to assess project impact on knowledge, attitude and practice (KAP) of family planning, 4) to identify best practices and lessons learnt, and make necessary recommendations for future program improvement, 5) to validate data on the key indicators of project deliverables and 6) to assess the potential sustainability of project interventions after the end of the project.

Methods:
A cross-sectional survey was carried out over a period of 30 days. Quantitative and qualitative data collection methods were employed which included, desk reviews, individual questionnaires administered with the aid of electronic data capture devices, key informant interviews and focus group discussions.

Main findings:
The project was successful as evidenced by the achievement of almost all of the seven core indicators (71%) except two. Failure to achieve the 2 indicators was due to either staff turn-over or death over which AHS had no direct control.

There was a high increase in dissemination of awareness messages and counselling regarding family planning (FP) an achievement that can be attributed to the effectiveness of community based approaches (including engagement of CAGS and CAYOGS) to FP service delivery.

The program captured an increase in number of new users of modern FP methods (94.2% increase) across the life span of the project. This finding is likely due to effective communication and engagement at community level as observed above.

It is encouraging to report that there was universal awareness of modern FP methods among the study participants and possibly the communities in general. This awareness could also be attributed to project activities that were community based and that reached even the youth through the CaYoGs structures.

The survey has found a relatively high (61.6%) modern contraceptive prevalence rate (mPCR). The calculated mPCR is comparable to the contraceptive prevalence rate (CPR) which nationally stands at 59% as reported in the MDHS 2015-2016. The AHS project areas being largely rural, this finding is likely to be a result of the intensity of community based interventions especially the use of CBDAs and CAGs/CAYoGs.

There was a distinct preference for injectables (61/137; 47.3%) and implants (34/137; 26.0%) across all the four study districts. This corresponds with findings in other national surveys including the MDHs. This observation requires deliberate efforts targeting promotion of other FP methods that may meet contextual requirements of some clients.

The unmet need at 44.7% is higher than that reported in the MDHS (19%). As noted above, this could be due to the fact that this survey targeted rural areas as well as a small number of participants on whom this indicator is calculated. However, this observation is a concern and calls for efforts to comprehensively promote modern FP methods that offer long protection against unwanted pregnancy as well as emergency contraception.

Stock-outs of at least one method on the day of the survey ranged from 30.0 to 66.7%. Thus there is need to establish robust supply chain systems. This requires both human and physical infrastructure investment by government and partners working in this sector.

The qualitative component of this survey identified a number of key issues including the finding that there was limited male involvement regarding initiation and use of modern FP methods. Thus there is need for concerted efforts in future programs that incorporate male involvement. It is noteworthy that the study found that some women indicated that their partners were not aware of their being on an FP method. This suggests a certain level of women empowerment as regard independence in decision making to initiate FP use. This could be a result of this project's efforts in promoting women empowerment.

Further, there are negative attitudes and perceptions such as the belief that children were from God and that family planning is meant for those in union. Future programming should incorporate comprehensive behaviour change approaches that dispel such negative perceptions.

Exit interviews showed that the method mix was dominated by short term contraceptives. Most of the study participants were using injectable and implants. These findings are consistent with the findings in the MDHS2015-16 as noted above. This might be due to the availability or acceptability of this method by the community. This could also be attributed to lack of information on other available methods. It is therefore important that healthcare professionals deliberately inform their clients or users about the benefits and side effects of all available contraceptives. This may prompt women to reconsider their

original choice, potentially selecting a method which best suits their medical and lifestyle needs. In addition, in future programs there should be deliberate efforts and strategies to incorporate male involvement in family planning through provision of methods that are acceptable to males.

The innovation of setting up CAGs and CAYoGs seems to be acceptable and feasible in the project areas. This seems to have led to measurable positive results. The survey has however identified a number of key issues that need to be addressed in future programming. These are 1) the criterion related to literacy and social standing should be revised to be all encompassing 2) CAYoGs should include youths that are not in union or they should have a separate group of their own 3) there is need for an alternative approach to rolling out the orientation of CAGS/CAYoGs members other than relying on senior HSAs who have a lot of competing activities. This could involve engagement of Community Based Organisations (CBOs) with established capacity to lead facilitation efforts.

This evaluation has demonstrated a number of positive outcomes of this project. The assessment has established that the project is felt to have addressed a relevant area which aligns with the Malawi Growth Strategy II. Furthermore, the study has demonstrated effectiveness as most indicators were either met or surpassed. In addition, there were a number of activities that are judged to be sustainable including capacity building activities for CBDAs, HSAs and other facility based staff. These cadres are integrated in the normal service delivery system. Furthermore, a number of best practices were noted. These included close collaboration with district health management teams, customised data collection tools (including stock tracking registers) which are now recommended to other stakeholders and a focus on capacity building for community based providers which enhanced access to FP services.

Recommendations:
Based on evidence gathered from this evaluation the following recommendations are made:

1. **Stakeholder collaboration.** Intensify stakeholder involvement at all levels from the onset of the project to implementation stage. This would ensure sustainability and effectiveness of the project

2. **Funding.** Government, implementing partners and donors should make sure there is predictable and regular funding in order not to disrupt service delivery.

3. **Strengthening local level advocacy.** The project should make deliberate effort to make sure that there is active male involvement during decision making and implementation of the project. This could be achieved by active community mobilization focused on males. Further, the project should raise awareness about family planning amongst males to remove misconceptions that most men have on family planning.

4. **Mobility for community based service providers.** CBDAs and HSAs should be provided with bicycles to ease mobility challenges in order for them to effectively reach out to the communities as well as source supplies from their respective facilities.

5. **Standardizing data collection tools.** Data collection tools should incorporate ability to capture individual level data (including repeat visits) to allow computation of continuation rates.

6. **Counselling**. A comprehensive counselling package should be developed that contains information on side effects of some modern family planning methods. Providers would need to be trained on this and encouraged to provide this information to clients at each visit.

7. **Involvement of non-traditional stakeholders**. A deliberate effort should be made to involve religious and other civil leaders during advocacy and implementation of similar project. This is so as such stakeholders tend to hold beliefs that run counter to the efforts of FP related projects.

8. **Composition of CAGS and CAYoGs.** There is need to review the composition of CAGS and CAYoGs so that they are all encompassing to include unmarried youths, all social classes and even illiterate community members.

9. **Rollout of CAGS and CAYoGs model**. Rolling out of this model should incorporate local CBOs that can cascade facilitation of capacity building efforts throughout the prescribed cycle as opposed to relying on HSAs who usually have concurrent competing activities

List of Acronyms

AHS	Adventist Health Services
CAG	Community Action Group
CAYoG	Community Action Youth Group
CBDA	Community Based Distribution Agents
CHAD	Centre for Health, Agriculture, Development Research and Consulting
DHOs	District Health Offices
FGD	Focus Group Discussions
FP	Family Planning
KAP	Knowledge Attitudes & Practices
KII	Key Informant Interviews
MDHS	Malawi Demographic Health Survey
MGDS	Malawi Growth Development Strategy
MoH	Ministry of Health
NGOs	Non-Governmental Organizations
NSO	National Statistical Office
ODK	Open Data Kit
SRH	Sexual and Reproductive Health
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WCF	Women and Children First
WHO	World Health Organization

List of Tables

List of Figures

1 INTRODUCTION

1.1 Background

Adventist Health Services (AHS) in Malawi has been implementing a 3-year "Community outreach Family Planning" project with funding from USAID. The project aimed at contributing to the reduction of unmet need for family planning among women and men of reproductive age. The project targeted to reach 272,271 and 163,909 women and men respectively. As a way of improving the quality of programming and increasing access to services and demand for family planning, AHS has been working with two key partners including Women and Children First (WCF) and Ministry of Health (MoH) through respective District Health Management Teams (DHMTs).

1.2 Family Planning Situation in Malawi

Modern contraceptive use by currently married women has increased steadily during the last 25 years, increasing from 7% in 1992 to 58% in 2015-16. Injectables are the most popular contraceptive method used by 30% of currently married women. In the 5 years before the 2015-16 MDHs, 37% of the women who began using a contraceptive method discontinued the method in less than 12 months. The leading reasons for discontinuation are method-related health concerns and side effects (26%) and a desire to become pregnant (26%). The same survey reported that 76% of the demand for family planning among currently married women is satisfied whereas 53% of the demand for family planning among unmarried sexually active women is satisfied.

The unmet need for family planning has been declining over the years, from 37% in 1992 to 19% in 2015-16. Sixty-nine percent of currently married women who are not currently using contraception intend to use family planning at some future time (MDHS, 2016). Malawi's total fertility rate (TFR) still remains high. [1]. According to MDHS (2015-2016), TFR for women in urban areas was registered at 3.0 while for rural women is at 5. This can be attributed to the low uptake of FP methods by rural women (UNFPA, 2013) due to limited access to FP methods as compared to women in urban settings. Women in urban areas are more likely to use modern FP methods than women in rural areas, which use less effective traditional FP methods. [2]The total TFR is estimated at 4.4 children per woman. This shows a downward trend when compared to the rates in the DHS (2004) and DHS (2010) and where the total TFR was at 6.0 (36.4%) and 5.7 (29.5%) respectively (see figure 1). The DHS 2015-16 also reported that women in rural areas had higher fertility (4.7 children per woman) compared to their counterparts in urban areas (3.0 children per woman).

It is worth noting that Malawi has been registering an increasing trend in CPR from 7% in 1992 to 58.6% in 2016 amongst married women.(Figure 1) (NationalStatistical Office (NSO), 2014) . Furthermore, the most preferred modern contraceptives are injectables (30%) followed by implants (12%) (National Statistical Office (NSO) [Malawi] & ICF International, 2016). Further review of the key findings shows some regional differences

[1] National statistical office (2013) Malawi national fertility rate. Retrieved from www.nsomalawi.mw. Retrieved on 3rd March, 2017

[2] UNFPA (2013) Family planning report

in Contraceptive Prevalence Rate (CPR) with the central region having a higher rate(63.9%) and the southern region having the highest percentage for injectables usage (31%) (National Statistical Office (NSO) [Malawi] & ICF International, 2016). There are no district level data for family planning. Another important and more recent indicator to be considered is the modern Contraceptive Prevalence Rate (mCPR).It is defined as the percentage of women who are currently using, or whose sexual partner is currently using, at least one method of modern contraception, regardless of the method used (World Health Organization, n.d.). However, there are not published data available on this indicator locally.

1.3 Purpose of the Evaluation

The purpose of the evaluation was to assess the effectiveness, relevance, efficiency, sustainability, and impact of the "**Community Outreach Family Planning Project**".

1.4 Scope of the Evaluation

The evaluation covered the entire project duration, from June 2014 to October 2017. The evaluation assessed project results at all levels within the targeted Communities, health centers, District Health Management Teams, and at national level at the Reproductive Health Directorate. The evaluation covered all areas of implementation, including activities delivered by AHS (as a grant holder) as well as partners.

1.5 Specific Objectives of the Evaluation

The overall objectives of the evaluation were to:

1. Establish progress made towards the achievement of the desired outcomes
2. Highlight factors that contributed to the achievement of the desired outcomes.
3. Assess project impact on Knowledge, Attitude and Practice of family planning.
4. Identify best practices and lessons learnt, and make necessary recommendations for future program improvement.
5. Validate data on the key indicators of project deliverables.
6. Assess the potential sustainability of project interventions after the project ends.

1.6 Project strategies

In order to effectively implement the project, AHS had two strategies. The strategies were informed by two corresponding hypotheses. Firstly, the realization that if women and men are empowered and build their confidence to own their challenges related to family planning and take action to address these challenges, then this will lead to communities encouraging and supporting its members to use modern family planning methods. Secondly, was the understanding that if appropriate family planning services are taken to the community, then services will be more readily available and uptake of the services will increase. The strategies include:

1. In addressing hypothesis one AHS employed the strategy of engaging with the community in family planning through Community Action Groups (CAGs) and Community Action Youth Groups (CAYoGs) using Participatory Learning Action Cycle (PLAC) model.
2. In addressing hypothesis two AHS deployed a strategy of Community Based Distribution (CBD) of family planning using community based structure.

1.7 Expected results of the project

The expected results for this project were;

1. Empowered women and men with increased confidence, seeking access to, and encouraging and supporting fellow community members to use modern family planning methods.
2. Increased supply of quality family planning services and method mix at community and facility.
3. Improved linkages and partnership between communities and facilities to increase accessibility and uptake of family planning services
4. Improved management systems to ensure commodity security and service delivery.

2 METHODOLOGY

2.1 Study Areas

AHS implemented this project in the districts of Blantyre, Dedza, Rumphi and Mzimba South. The project was implemented in 5 health centres in Blantyre, 17 health centres in Rumphi, 20 health centres in Dedza and 23 health centres in Mzimba South.

2.2 Study Methodology

The survey used cross sectional design. Qualitative and quantitative approaches were used. The quantitative component collected primary and secondary data while the qualitative data captured prevalent normative views and perceptions regarding Family Planning in general as well as those related to the project.

2.3 Data collection tools

These included:

- Desk Review
- Household/community Survey
- Facility Survey
- Focus Group Discussions (FGDs)
- Key Informant Interviews
- Exit Interviews
- CAG/CAYoG Checklist

2.3.1. Desk Review

The study team initially engaged into reviewing existing ***secondary sources*** of information related and relevant to the AHS project.

The Pertinent documents reviewed included the following:

- Project Appraisal Document (PAD) which, inter alia, includes the log-frame and the M&E framework, and all inception material for Adventist Health Services– to understand the project design;
- Baseline report;
- Other Adventist Health Services reports and documentation;
- Relevant policy and strategy documents – to assess the extent the project contributes/contradicts relevant policies and strategies, including the
    - Malawi Demographic Health Survey (MDHS 2016)
    - Sexual Reproductive Health Policy
    - Family planning policy
    - Guidelines for Family Planning Communication (2011)
    - Reproductive Health Strategic Plan;

.

2.3.2 Household/community Survey

A household survey was conducted at community level, using a pre-tested semi-structured questionnaire (**see Appendix 1**) mainly to generate quantitative data.

2.3.2.1 Sampling Design

A multi-stage (three stage) sampling approach was used;

1st stage – The Terms of reference prescribed a random selection of the Health facilities under the project including 5 health centres in Blantyre, 17 health centres in Rumphi, 20health centres in Dedza and 23health centres in Mzimba south. Thus a total of 65health centres were included in the sampling frame. The sampled villages are shown in Table1.

Table 1: Health facility, sampled villages and population size in each project district

District	Sampled health facility	Sampled villages	Population Size	TA
Blantyre	Mpemba	Mbande	194	Somba
		Linolo	358	Somba
Dedza	Kaphuka	Chisangwi	778	Kaphuka
		Chilimata	431	Tambala
	Kasina	Mjelema	122	Kaphuka
		Makwinja	882	Kaphuka
	Golomoti	Nkholokombwa	201	Kachindamoto
		Jumbe	219	Kachindamoto
	Kanyezi	Kachiramadzi	675	Chilikumwendo
		Chamangwane	103	Chilikumwendo
	Kaundu	Sitolo 1	630	Kachindamoto
		Chikoleza	1110	Kachindamoto
Mzimba	Bulala	Zokozoko	109	Chindi
		Chimodzimodzi	289	Chindi
	Kabuwa	Isaac Lukhanda A	627	Khosolo
		Mwazama	410	Khosolo
	Edingeni	Chibo Phulira	585	M'mbelwa
		Wiliam Ngwenya	936	M'mbelwa
	Mzambazi	Johnasi	188	Chindi
		Mzale	114	Chindi
	Emfeni	Kambaju Sibande	209	Mabulabo
		Nkhani za mowa	132	Mabulabo
	Jenda	Jenda 1 B	1609	Mzikubola
		Simwenje	209	Mzikubola
	Mzalangwe	Chikosera Nyirenda	142	Chindi
		Ndezu	430	Chindi

Rumphi	Ng'onga	Mwang'onga	157	Chikulamayembe
		Chibanibani	171	Chikulamayembe
	Bolero	Lupalare	242	Chikulamayembe
		Chimbizgani	328	Chikulamayembe
	Lura	Kabonda	1932	
		Khungulume	1301	
	Tcharo	Old Salawe	1134	Chapinduka
		Tcharo proper	1269	Chapinduka

Up to 25% of the health facilities were sampled for the evaluation as shown in Table 1. Thus,1 health centre in Blantyre, 4 in Rumphi, 5 in Dedza, 7 in Mzimba South.

2nd stage - Simple random sampling of smaller administrative units (Village clusters) in the catchment areas of the sampled health facilities was done. A list of the villages within the catchment areas of the selected health facilities was obtained from the AHS from which selection of survey participants was conducted.

3rd stage – Random Selection of survey participants (male and female in reproductive age range 15-49) was done**.** To accomplish this, a list of eligible participants was established through a household census which captured the number of household members and their ages. This was facilitated with the assistance of community leaders and Health Surveillance Assistants (HSAs) in the selected health facility. Participants included in the survey were randomly selected from the sampling frame. The final sample was stratified according to the main target age groups (20% men and 80% women).

2.3.2.2 Sample Size Calculation

In order to evaluate the set indicators, the sample size formula below was used. As this was a cluster based survey, the design effect and inter-cluster correlation were taken into account.

$$n = \frac{1.96^2\, p(1-p)(DEFF)}{d^2}$$

Where:

(p) = Estimate of the expected proportion

(d) = Desired level of absolute precision
($DEFF$) =Estimated design effect

In order to generate the largest sample size, the value of (p) was set at 0.5 (or 50%). In addition, the *DEFF* was set at 1.5. The desired level of absolute precision was set at ± 5.0%. Thus, based on these parameters the sample size for each district was calculated. For the four districts 569 participants were targeted, this was inflated by 10% for non-response and total number of participants to be included in the study was 633, rounded off to 650 for logistical purposes.

2.3.3 Facility Survey

A pre-tested questionnaire was used to conduct a facility survey including Community Based Distribution Agents (CBDAs) and HSAs servicing the sampled facilities in all the four project districts. Facility level questionnaire **(see Appendix 2)** was used to capture the following information:

- FP services offered
- Training and competencies of FP services providers as well as SRH services
- FP 'Stock out' status on the day of survey and over the past 3 months
- Number of cases referred from CBDAs and HSAs.

2.3.4 Focus Group Discussions

Focus Group Discussions (FGDs) were conducted in all the selected health facilities using a pre-tested FGD guides (**see appendix 3**). FGDs were used to capture normative views and perceptions of beneficiaries (the youth, men and women) in the target communities (used at the baseline stage). Up to 6 FGDs segregated by age and sex were conducted in each district (except Blantyre) spread across the catchment areas of the selected health facilities. FGDs were stratified in the following age brackets: 15-24, 25-34, 35-49.

2.2.5 Key Informant Interviews

In order to gain a deeper understanding as regards issues surrounding Family Planning, sexual and reproductive health, current challenges and potential solutions, key informant interviews were conducted using a pre-tested checklist **(see Appendix 4)** with the following:

- District Health Officers
- Peer Educators e.g. CAG/CAYoG leaders
- Staff from NGOs providing FP and SRH services
- National Family Planning Coordinators
- Community Leaders (civil and religious)
- Health Surveillance Assistants
- Community Based Distribution Agents(CBDAs)
- Health facility in-charges/ Family Planning Focal Persons.

2.2.6 Exit interviews

In the sampled health facilities, exit interviews were conducted with people who had just attended FP services. Ten clients per health centre were interviewed. Where a surveyed facility did not provide family planning on the day of the survey, help was sought from the CBDAs or HSAs to help identify clients who had recently accessed FP (1 to 2 weeks prior to the day of the survey). Furthermore, CBDAs or HSAs registers were used to identify clients who had recently accessed family planning commodities. The aim of exit interviews was to capture satisfaction related to services offered, opening times, waiting times; provider care/ attitude, confidentiality, privacy and price **(see Appendix 5)**.

3 RESULTS

3.1 Geographical Coverage

As described above the survey included the four project districts of Blantyre, Dedza, Mzimba and Rumphi (Figure 1). A total of seventeen health facilities were surveyed across the four project districts.

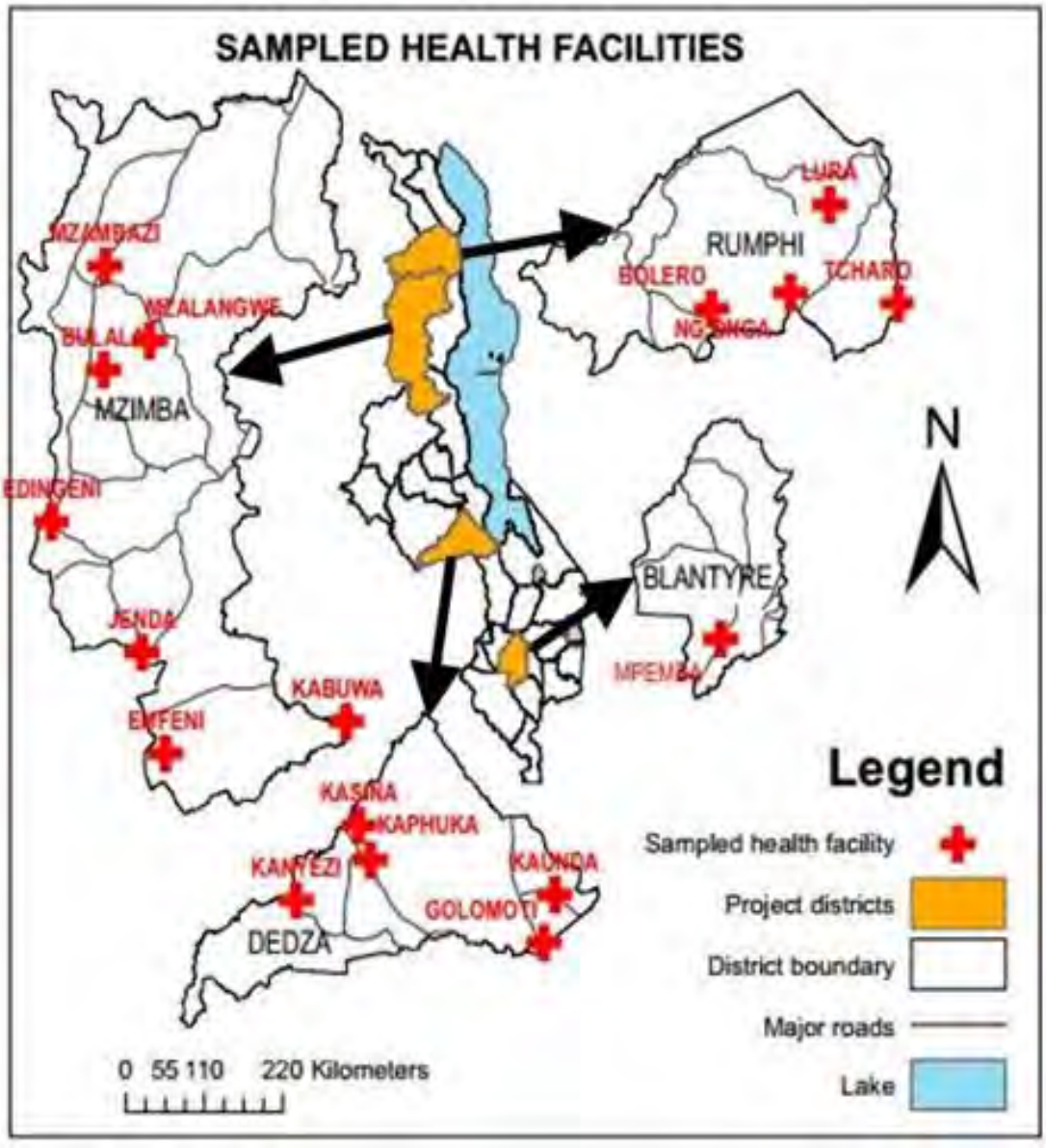

Figure 1: Map of Malawi showing four project districts and the sampled health facilities

3.2 Demographic Characteristics of study participants

3.2.1 Individual questionnaires

Table 2 shows the number of participants interviewed by district. A total of 645 individuals were interviewed across the four districts. Of these 79.5% (513) were females.

Table 2: Number of female and male study participants in the four study districts

District	Female n (%)	Male n (%)	Total n (%)
Blantyre	32 (80.0)	8 (20.0)	40 (100)
Dedza	148 (80.0)	37 (20.0)	185 (100)
Mzimba	209 (79.2)	55 (20.8)	264 (100)
Rumphi	124 (79.5)	32 (20.5)	156 (100)
Total	**513 (79.5)**	**132 (20.5)**	**645 (100)**

Age and sex distribution of the study participants are shown in Figure 2. The majority of the respondents were in the 15– 24 age bracket (44.8% for women and 41.7% for men) followed by the 24 – 29 (35.5% for women and 37.9% for men) age bracket.

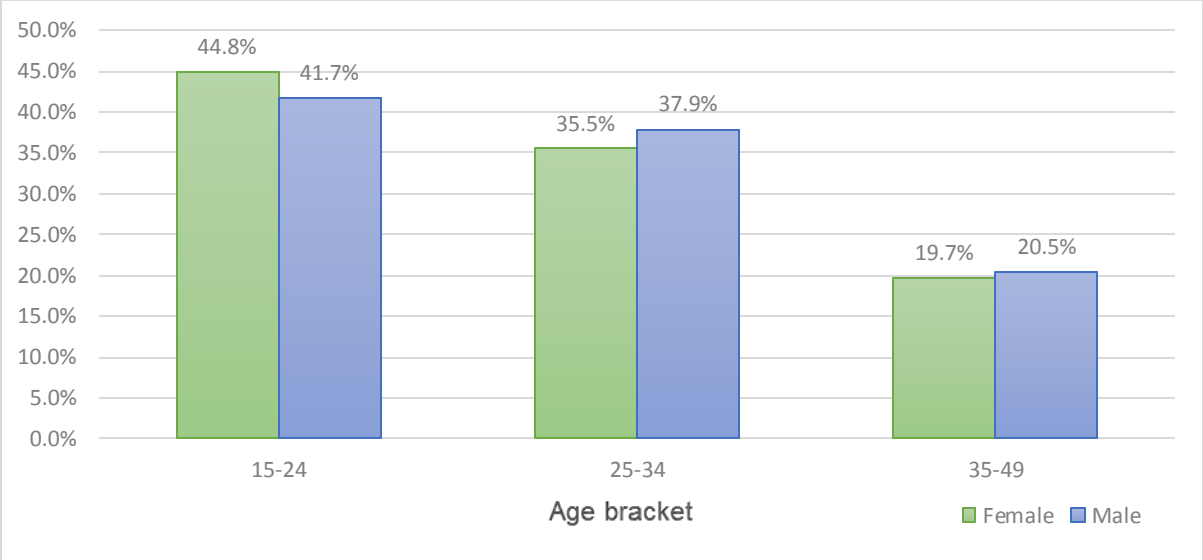

Figure 2: Age and sex distribution of study participants across the study sites

3.2.2 Exit interviews

Figure 3 shows results of exit interviews with family planning clients. A total of 137 exit interviews were conducted. Of these 88.3% (121) were with female clients and the remainder 11.7% (16) were with males. The low male involvement found in the study area probably reflects national observations.

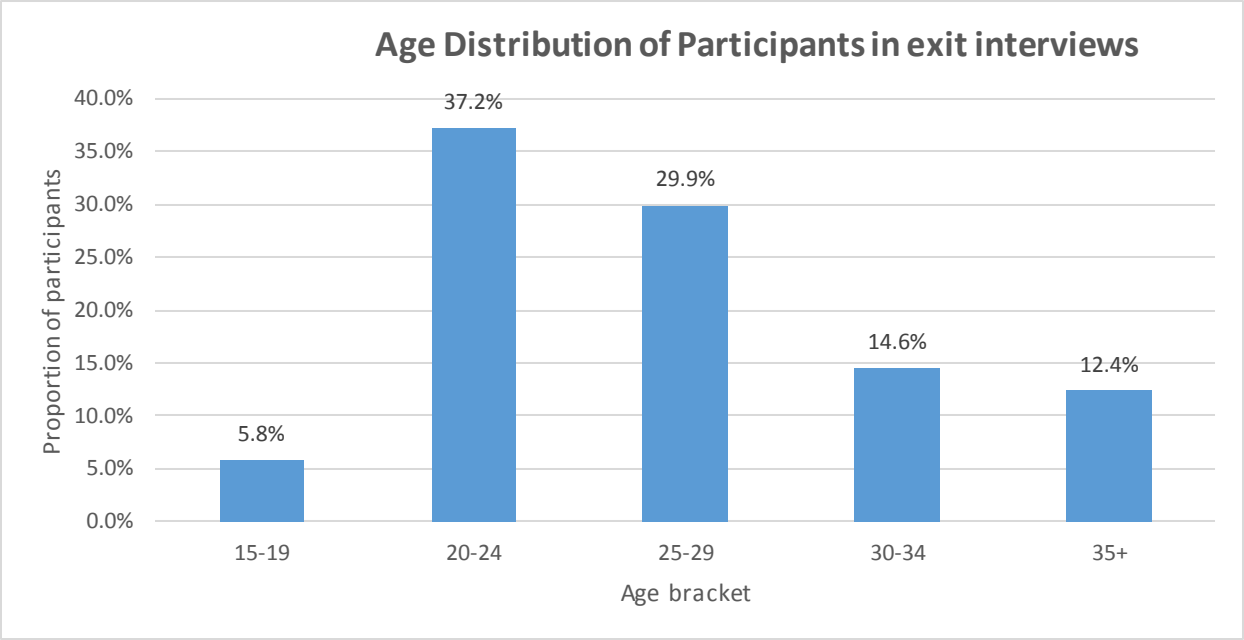

Figure 3: Age distribution of study participants who took part in exit interviews

3.2.3 Key informant interviews

Key informants that were interviewed in this survey with their designation and organization are listed in Appendix 1. A total of 25 key informants were interviewed as presented in Table 3.

Table 3: Summary of the key informants

Designation	Number	Affiliation
CAG members	1	Community level volunteers
CBDA members	12	Community level volunteers
HSAs	4	MOH community health workers
Family planning coordinators	3	MOH health centre level
Family planning coordinators	1	MOH district level
Service providers	1	Partners district level
Family planning desk officers	2	MOH reproductive health directorate
M&E and project coordinator	1	AHS

3.2.4 Focus group discussion (FGDs)

A total of 18 FGDs were done in this evaluation. These are summarized in Table 4.

Table 4: Summary of FDGs

Age ranges	Male	Female
15-24	4	2
25-34	2	4
35-49	2	4
Total	8	10

3.3 Endline Evaluation Findings by objective

3.3.1 Verification of Key indicator results

This component relied on abstraction of data from the Monitoring and Evaluation reports. Facility level data were verified in the sampled facilities. Table 5 presents a summary of the key indicators tracked in this project. An assessment against the set targets (where available) was made against each indicator. Overall, 5 out of 7 key indicators were either achieved or surpassed.

Table 5: summary of the key indicators

Performance Indicators	Project Target **(Yr 1-3)**	Project Result **(Yr 1-3)**	Variance	Overall assessment
Couple Years Protection in USG programs	94,500	95,910	1410	Surpassed
USG-assisted service delivery sites providing family planning counselling and/or services (%)	100%	100%	0	Reached
Number of USG-assisted service delivery sites providing family planning counseling and/or services	57	57	0	Reached
Number of USG service delivery sites	57	57	0	Reached
Number of additional USG Community Health Care Workers providing family planning information and/or services	900	902	2	Not achieved
Number of USG -assisted Community Health Care Workers providing family planning information and/or services	900	837	(63)	63 Community Health Care Workers either died or were transferred to non-targeted health facility
Number of USG assisted service delivery points	957	894	(63)	63 service delivery points are the Community Health Care Workers who died or got transferred
Number of community healthcare workers trained in provision of family planning information and/or services	900	902	2	Reached
Number of people trained in provision of long term and reversible contraceptives	160	92	(94)	Not achieved
Number of Women of Reproductive Age (WRA) who report being a new user of modern methods of FP	No target	37,024	N/A	Cannot be assessed
Number of counselling visits for FP/RH as a result of USG assistance	No target	349,934	N/A	Cannot be assessed

Number of individuals provided with contraceptives as a result of USG assistance		-	-	No data
Number of people reached with specific FP/RH messages as result of USG assistance	No target	665,514	N/A	Cannot be assessed
Number of Community Action Groups Established	320	319	(1)	One HSAin Mzimba did not turn up for training and consequently was unable to establish agroup.

Further, detailed review of the indicators shows that the project made tremendous achievement in recruitment of women of reproductive age that report being new users of modern family planning. The project achieved more than 35% increase on year one figures in the third year as shown in Figure 4.

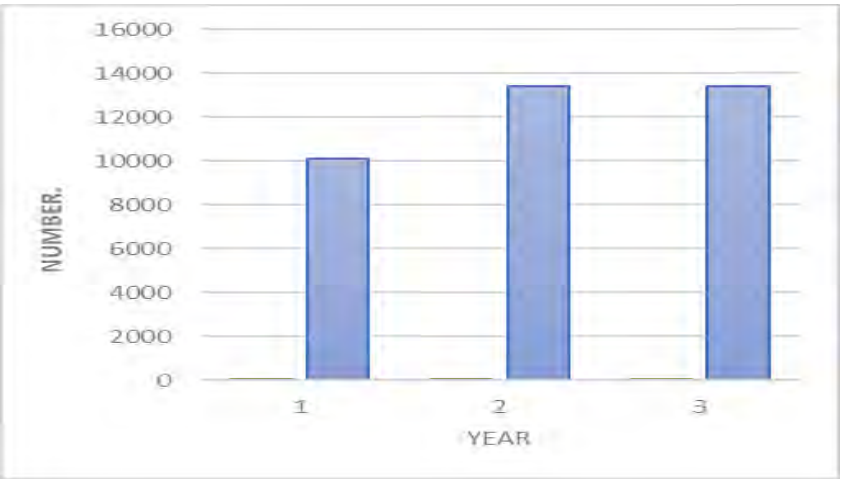

Figure 4: Number of Women of Reproductive Age who reported being a new user of modern methods of FP by project year

Figure 5 shows progress made in counseling visits and dissemination of FP messages. An increased number of counselling visits (129,576; 85.9%) were registered in year 2 and less so (150,647; 16.3%) in year 3 of the project. Similarly, between year 1 and 2 the project disseminated approximately 324,955 FP messages (141.2% increase on year 1 figure). And fewer (205,855 messages representing -36.7%) between year 2 and 3.

Figure 5: Number of people reached with counselling and FP/SRH messages as a result of USG assistance

3.4 Knowledge Attitude and Practice

3.4.1 Knowledge about family planning

In order to assess general awareness of family planning methods, the survey adopted an approach used in the MDHS. Respondents in the survey were asked to spontaneously indicate if they are aware of any modern FP methods. If the respondent failed to mention a particular family planning method spontaneously, the interviewer described the method and asked whether the respondent had heard of it. The results are shown in Table 6.

The survey found universal awareness of at least one modern FP method in all the four project districts. These findings are similar to those reported in the 2015-16 MDHS. Overall, the most commonly mentioned methods included male condoms (98.6%), injectables (96.3%), female condoms (94.0%) pills (93.8%) and implants (91.5%). The pattern was consistent in Mzimba and Rumphi whereas Blantyre and Dedza registered slight differences. In addition, females were more aware of FP methods than male participants. The study observed that male condoms and injectables were among the most commonly known contraceptives. This observation aligns to the findings of the MDHS 2015-16 and indicate a reasonably high level of awareness of modern FP methods in the project districts.There is a general lack of awareness (28.7%) of the emergency contraception across the study areas.

Table 6: Universal Awareness of Family Planning

Contraceptive Method	Blantyre n (%)	Dedza n (%)	Mzimba n (%)	Rumphi n (%)	Total n (%)
Female Sterilization	37 (92.5)	167 (90.3)	211 (79.9)	144 (92.3)	559 (86.7)
Male sterilization	34 (85.0)	141 (76.2)	183 (69.3)	130 (83.3)	488 (75.7)
IUCD	33 (82.5)	153 (82.7)	191 (72.4)	123 (78.9)	500 (77.5)
Implants	39 (97.5)	175 (94.6)	229 (86.7)	147 (94.2)	590 (91.5)
Injectables	40 (100)	183 (98.9)	249 (94.3)	149 (95.5)	621 (96.3)
Pills	39 (97.5)	182 (98.4)	240 (90.9)	144 (92.3)	605 (93.8)
Male condoms	40 (100)	181 (97.8)	259 (98.1)	156 (100)	636 (98.6)
Female Condoms	38 (95.0)	172 (93.0)	244 (92.4)	152 (97.4)	606 (94.0)
Emergency Contraception	17 (42.5)	55 (29.7)	64 (24.2)	49 (31.4)	185 (28.7)
Withdraw	30 (75.0)	143 (77.3)	175 (66.3)	125 (80.1)	473 (73.3)
Rhythm	25 (62.5)	106 (57.3)	141 (53.4)	109 (69.9)	381 (59.1)
Any other method	10 (25.0)	42 (22.7)	35 (13.3)	1 (0.6)	88 (13.6)

3.4.2 Awareness of at least three modern family planning methods

Survey data were analysed to determine the proportion of participants that were aware of at least three modern FP methods. The results are shown in Table 7. Overall, 100% (40), 99.5% (184), 94.7% (250) and 98.1% (153) of respondents in Blantyre, Dedza, Mzimba and Rumphi, respectively were aware of at least three family planning methods. Analysis by age indicated that the respondents aged 25-34 were more knowledgeable of at least

three modern FP methods as indicated by 100%, 100% and 97.5%, in Blantyre, Dedza, Mzimba and Rumphi, respectively. Furthermore, the findings suggest differences by gender especially for females older than 24 years being more aware of at least three modern FP methods as compared to their male counterparts. However, these differences were not statistically different.

Table 7: Awareness of at least three modern family planning methods analysed by district, marital status, education level and age.

Percentage of respondents who know at least three modern and traditional method						
	Any Method n (%)		**Any Modern method n (%)**		**Any tradition method n (%)**	
	Female	Male	Female	Male	Female	Male
Blantyre	32 (100)	8 (100)	32 (100%)	8 (100)	28 (87.5)	6 (75.0)
Dedza	147 (99.3)	37 (100)	142 (99.3%)	37 (100)	123 (83.1)	34 (91.9)
Mzimba	201 (96.2)	49 (89.1)	200 (95.7%)	49 (89.1)	163 (78.0)	39 (70.9)
Rumphi	122 (98.4)	31 (96.9)	122 (98.4%)	31 (96.9)	114 (91.9)	26 (81.3)
Marital status						
Single/Never Married	79 (91.9)	40 (93.0)	79 (91.9)	40 (93.0)	67 (77.9)	35 (81.4)
Married Monogamous	341 (98.8)	76 (95.0)	341 (98.8)	75 (93.8)	288 (83.5)	65 (81.3)
Married Polygamous	30 (100)	1 (100)	30 (100)	1 (100)	26 (86.7)	1 (100)
Other	52 (100)	8 (100)	51 (98.1)	8 (100)	47 (90.4)	4 (50.0)
Education						
None	19 (86.4)	2 (100)	18 (81.8)	2 (100)	14 (63.6)	1 (50.0)
Primary	345 (98.6)	68 (93.2)	345 (98.6)	68 (93.2)	289 (82.6)	55 (75.3)
Secondary	136 (97.8)	52 (96.3)	136 (97.8)	51 (94.4)	123 (88.5)	46 (85.2)
Tertiary/Vocational Training	2 (100)	3 (100)	2 (100)	3 (100)	2 (100)	3 (100)
Age						
15-24	222 (96.5)	51 (92.7)	222 (96.5)	51 (92.7)	188 (81.7)	43 (78.2)

25-34	181 (99.5)	49 (98.0)	181 (99.5)	48 (96.0)	152 (83.5)	41 (82.0)
35-49	99 (98.0)	25 (92.6)	98 (98.0)	25 (92.6)	88 (87.1)	21 (77.8)

The high levels of awareness of family planning were further corroborated by the findings from the qualitative component of this evaluation. This awareness was demonstrated by the quotations below from study participants.

"Family planning is a choice that one makes especially on the number of children they want to have and the spacing that they desire."
KII CBDA MPEMBA BLANTYRE

> *"It is giving proper spacing between one child and the unborn one. It is one way of avoiding pregnancies in a family where there are more children".*
> – FGD WITH WOMEN_15-24 DEDZA

3.4.3 Utilization of family planning

The survey aimed at capturing modern Contraceptive Prevalence Rate (mCPR) and the results are shown in Figure 6 and mCPR for individual methods are shown in Table 8. Overall, a total of 316 (61.6%) of female participants aged 15-49 years reported to be on a modern contraceptive method. Of these, 50.3% (n=152) were on injectables followed by 21.5% (n=65) on implants. A similar pattern is observed in all districts except Blantyre where injectables and pills were widely reported being used. Further analyses show that the mCPR was 53.1% (17), 60.8% (90), 60.8% (127) and 75.0% (48) for Blantyre, Dedza, Mzimba and Rumphi respectively. Further, an overall CPR was estimated at 66.9% (252).

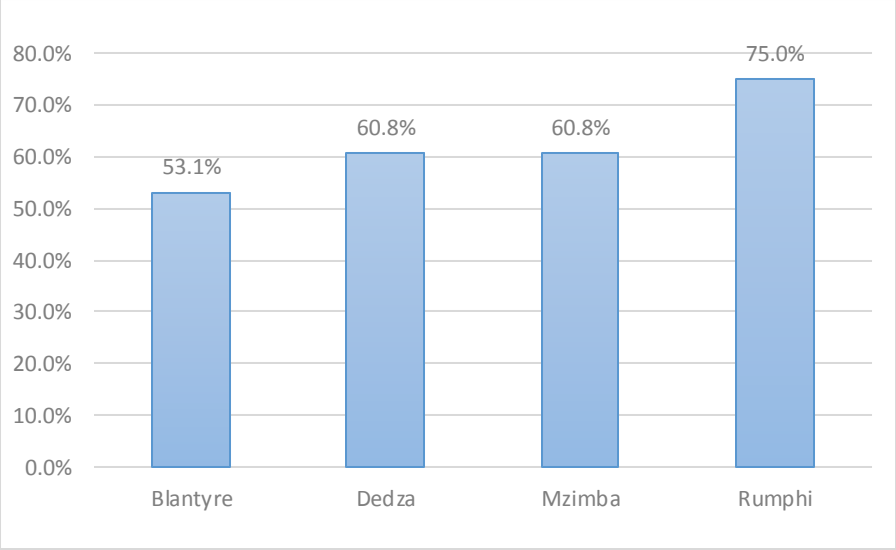

Figure 6: Modern Contraceptive Prevalence Rate (mCPR) by study districts

Noteworthy, the mCPR calculated is higher than the reported CPR of 59% in the MDH 2015-16. This could be attributed to differences in both calculation as well as definition of the two. mCPR is based on all women in the reproductive age where as CPR is restricted to women in union. Survey data were further analyzed to show the distribution of use by method for survey participants aged above 15 years. Table 8 provides the specific mCPR results. Injectables were clearly the most preferred used contraceptive method in the targeted districts. Use of female condom is hugely lacking across the study sites.

Table 8: Results of mCPR based on all women in the reproductive age and each FP method

Contraceptive Method	Blantyre	Dedza	Mzimba	Rumphi	Total
Female Sterilization	2 (9.1)	18 (18.8)	8 (5.6)	6 (5.6)	**34 (9.3)**
Male Sterilization	0 (0)	0 (0)	1 (0.7)	1 (9.3)	**2 (0.5)**
Pills	6 (27.3)	6 (6.3)	6 (4.2)	6 (5.6)	**24 (6.5)**
Injectables	11 (50.0)	48 (50.0)	72 (50.7)	40 (37.4)	**171 (46.6)**
Implants	0 (0)	17 (17.7)	28 (19.7)	27 (25.2)	**72 (19.6)**
Male Condom	3 (13.6)	7 (7.3)	27 (19.0)	26 (24.3)	**63 (17.2)**
Female Condom	0 (0)	0 (0)	0 (0)	1 (0.9)	**1 (0.3)**
Total	**22 (100)**	**96 (100)**	**142 (100)**	**107 (100)**	**367 (100)**

3.4.4 Unmet need for family planning

Women are defined to have unmet need if they 1) are not pregnant and not postpartum amenorrhoeic, are considered fecund, and want to postpone their next birth for 2 or more years or stop childbearing altogether but are not using a contraceptive method, or (2) have a mistimed or unwanted current pregnancy, or (3) are postpartum amenorrhoeic and their last birth in the last 2 years was mistimed or unwanted. In this survey a total of 38 women were pregnant at the time of the survey. Of these, 17 wanted to wait or did not want to be pregnant as shown in Table 9.

Table 9: Unmet need for family planning

At the time you became pregnant, did you want to become pregnant then, did you want to wait until later, or did you not want to have anymore at all?	n	%
Wanted to be pregnant	21	55.3%
Wanted to wait	13	34.2%
Did not want to be pregnant	4	10.5%
Total	**38**	

3.4.5 Knowledge of a place to obtain Family Planning services

Survey participants were asked if they were aware of a place where they could obtain family planning services from and the various sources of FP services are listed in Table 10. Up to 575 (89.2%) of respondents were knowledgeable of a place to obtain FP services. Furthermore, those that indicated to be aware of a place where they can obtain FP services were asked to mention such places. The majority of respondents indicated a government health centre (82.3%), a government hospital (45.7%) and Health surveillance assistance (39.0%) as main places where they could obtain family planning services. Notably, CBDAs and HSAs were mentioned by 33.6% and 39.0% of the participants respectively. This supports the increasing role played by these two cadres in the provision of family planning services

Table 10: The various sources of FP services accessed by females in the study area

Place where Can Obtain FP Services	n	%
Government Hospital	263	45.7%
Government Health Centre	473	82.3%
Government Health Post/ Clinic/ Station	167	29.0%
CBDA/Door-to-Door/CBD/CBRHA	193	33.6%
Other Public Sector Health Facility	15	2.6%
Health Surveillance Assistant (HSAs)	224	39.0%
Mobile Clinic	36	6.3%
Banja La Mtsogolo Clinic	129	22.4%
Blue Star Clinic	11	1.9%
Other NGO Clinics	8	1.4%
Other Pvt Medical	9	1.6%
Private Hospital/Doctor/Clinic	33	5.7%
Pharmacy/Drug Store	4	0.7%
Other Private Health Sector	3	0.5%
Facility/Shop	49	8.5%
CHAM	25	4.3%
Church	4	0.7%
Friend/Relative	6	1.0%
Youth Drop-In Centre	6	1.0%
Other	7	1.2%
Total	**575**	**100.0%**

3.4.6 Attitudes of participants about family planning

In order to assess attitudes towards FP, respondents were asked to agree or disagree to pre-tested sentences aimed at assessing attitudes and the responses are summarised in Table11. Overall there was no major difference in attitudes between male and female respondents in all the assessed areas. Of concern was the finding that over 55.0% of

respondents think there is nothing that they can do as pregnancy is a god's gift. Furthermore, there were some religions that did not allow the use of modern Family Planning methods among their followers.

Table 11: A summary of women study participants' attitudes towards family planning

		Each additional child makes it more difficult for the family to educate all their children properly *	Each additional child makes the man work harder to meet the family expenses.	If a woman gives birth to another child too soon after the previous, both her health and the child's health suffer.*	Wives are told not to worry about having too many children because they will be provided for by husbands *	With each child birth, a woman becomes weaker making her less able to do housework *	Couples who have only girl children keep trying for more children until they have a son*	My spouse/partner does not see the need to avoid or delay pregnancy *	My spouse/partner does not see the need to use family planning methods.*	In our society, women cannot discuss family planning openly *	If destiny brings another child, we cannot help, as pregnancy is god's gift. *	My religion does not support use of family planning methods*
Women	AGREE	487 (94.9%)	483 (94.2%)	491 (95.7%)	196 (38.2%)	453 (88.3%)	402 (78.4%)	94 (18.3%)	78 (15.2%)	218 (42.5%)	288 (56.1%)	175 (34.1%)
	DISAGREE	18 (3.5%)	24 (4.7%)	13 (2.5%)	300 (58.5%)	42 (8.2%)	87 (17.0%)	371 (72.3%)	383 (74.7%)	262 (51.1%)	195 (38.0%)	298 (58.1%)
	NEITHER AGREE NOR DISAGREE	5 (1.0%)	3 (0.6%)	6 (1.2%)	7 (1.4%)	8 (1.6%)	16 (3.1%)	16 (3.1%)	15 (2.9%)	13 (2.5%)	9 (1.8%)	15 (2.9)%
	DON'T KNOW	3 (0.6%)	3 (0.6%)	3 (0.6%)	10 (2.0%)	10 (2.0%)	8 (1.6%)	32 (6.2%)	37 (7.2%)	20 (3.9%)	21 (4.1%)	25 (4.9%)
Men	AGREE	125 (94.7%)	120 (90.9%)	128 (97.0%)	86 (65.2%)	188 (89.4%)	100 (75.8%)	46 (34.9%)	36 (27.3%)	50 (37.9)%	67 (50.8%)	50 (37.9%)

	DISAGREE	3 (2.3%)	8 (6.1%)	1 (0.8%)	40 (30.3%)	7 (5.3%)	25 (18.9%)	67 (50.8%)	75 (56.8%)	59 (44.7)%	51 (38.6%)	71 (53.8%)
	NEITHER AGREE NOR DISAGREE	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (1.5%)	3 (2.3%)	5 (3.8%)	7 (5.3%)	4 (3.0%)	6 (4.6%)	4 (3.0%)
	DON'T KNOW	4 (3.0%)	4 (3.0%)	3 (2.3%)	6 (4.6%)	5 (3.8%)	4 (3.0%)	14 (10.6%)	14 (10.6%)	19 (14.4%)	8 (6.1%)	7 (5.3%)
	Total	**612 (94.9%)**	**603 (93.5%)**	619 (96.0%)	282 (43.7%)	571 (88.5%)	502 (77.8%)	140 (21.7%)	**114 (17.7%)**	**268 (41.6%)**	**355 (55.0%)**	**225 (34.9%)**

3.4.7 Contraceptive Decision Making

Most of the study respondents agreed that both the husband and the wife play a key role in the decision about whether to use contraception. However, the study revealed that the idea to practice FP was normally initiated by the wife. One respondent during a FGD said that

> *"Women are usually at the forefront when it comes to issues to do with family planning since they are the ones who give birth. They are the ones who know the pains of child bearing, so if they don't make the decision to start family planning, the men may never initiate it".*

– KII SENIOR HSA NG'ONGA

3.4.8 Perceptions about family planning

Results from the FGDs and KII interviews showed that some people still believe that FP methods were only for those in union. One key informant said:

> *"People in this community believe that family planning is only for married couples, when they see someone who is single taking family planning methods they always associate that person with promiscuity. You know a lot of people here go to RSA to seek greener pastures and they leave behind their wives. As such, it is not right for a woman whose husband has gone to RSA to get a family planning method".*

- KII Edingeni Health Centre, Mzimba

3.4.9 Beliefs on family sizes

Most people during discussions were of the view that people have resorted to having less children than in the past when people used to have more than eight children. This was due to different socio-economic challenges that people are faced with when they have more children. One respondent said:

> *"As of now most people in this generation prefer a small family size and is evidenced in child spacing. If you interview some of the families, you will find out that the maximum number of children in a family is five and the minimum is two".*

- KII Senior HSA Ng'onga Rumphi

However, some respondents were still of the view that having small number of children in a family was a risk. They said:

> *"it is safe to have 4 children than 2. If you have 2 children, what if they all die? Who will take care of you when you are old?"*

- FGD with men 15-24

Another respondent said that:

"when one has more kids, they help during farming. You don't spend much time on the field because there are many of you sharing it hence it is good to have more children. But this means more mouths to feed.

- FGD with men 15-24

3.4.10 Challenges/ Barrierstouse of Family Planning methods

Respondents were asked to mention some of the challenges that they meet when using family planning methods. The majority of the respondents explained the following notable challenges:

"sometimes it happens that a woman who is taking family planning method experiences non-stop monthly period and this irritates most men therefore they instruct their women not to get the methods just because they will not have time for sex if a woman is on family planning method"

- FDG with women 15-24, Dedza

"Some marriages are ending due to FP methods. Some women tend to start using injectables without the knowledge of their spouses and when they find out that the women are going to hospitals/HSAs to get injected, it causes troubles in the families and in some instances divorces".

- CBDA Bolero Rumphi

"When I had just started using family planning method, I had prolonged monthly menses and had severe stomachache. I could also have backache problems until I stopped using them. Right now, we have resorted to using condoms but it is risky".

- FGD with females 25-35, Tcharo Rumphi

Respondents were also asked about barriers that prevent them from using FP methods. The following were the commonly cited barriers:

- Religious beliefs
- Gender norms
- Negative effects of FP methods
- Lack of sexual pleasure

3.4.11 Religious beliefs

It was noted that some religions prevent their members from using modern FP methods as they consider it a sin. As a result, the members resolved to not using FP methods for fear of sinning.

"indeedthere are churches that bar their members from using family planning methods instead they advise them to use natural methods but we are lucky that those religions are not available in our communities"

- FGD with men 25-34 Dedza

"Other religious leaders preach the script from the bible that says we should multiply like sand and fill the earth. They say that children are a gift from God and that no one can go against God's will and plan."

- FGD with women 25-34, Mzimba

3.4.12 Gender norms

It was also reported that some men were barriers in their own families. Some respondents reported that men tended to stop their wives from getting any family planning methods since they were the heads of their families and therefore had the final say on all decisions being made. One respondent said:

"Some men in this village say that they paid lobola so that they can have children with their wives. As such they stop them from taking family planning methods. This means that women do not have a voice even though they are the ones who give birth".

- FDG 35-49, Mzimba

3.4.13 Negative effects of FP methods

Most of the respondents reported that they experienced some negative effects after using some FP methods and as such, when other women hear about this, they were discouraged from using the same methods. For instance, on the use of pills, most of the respondents said that it was associated with abdominal tumors and pains when used as a family planning method. The other effect that was prominent was prolonged menstrual bleeding being mentioned by most of the respondents interviewed.

"sometimes it happens that a woman who is on a family planning method experiences non-stop monthly period and this irritates most men therefore they instruct their women not to get the methods just because they will not have time for sex if a woman is on family planning method",

- *FDG with women 15-24, Dedza*

When I had just started using family planning method, I had prolonged monthly menses and had severe stomachache. I could also have backache problems until I stopped using them. Right now, we have resorted to using condoms but it is risky",

- *FGD with females 25-35, Tcharo Rumphi*

Furthermore, in some communities' members believed those FP methods were meant to stop the users from having any more children. It was believed that even reversible FP methods made users infertile even after they stopped using the methods.

3.4.14 Lack of sexual pleasure

Men reported that they did enjoy sex with their wives (azibambo samamva kukoma akamagonana ndiakazi awo). Similar sentiments were raised by women. There was a perception that use of FP reduced libido and sweetness in women hence when having

sex women were mostly not in it but just do it as an obligation which in turn affected the pleasure of sex for most men.

> *"most men believe that they don't perform (thus sex) good with a woman who has acquired family planning method just because they don't taste good during sex".*

- *FGD Women 15-24, Dedza*

3.5 Facility Assessment Survey

As indicated above a facility assessment survey was conducted using a pre-tested questionnaire to capture information related to FP services offered, competencies of FP service providers and 'stock out' status. A total of 14 health facilities offering FP were surveyed (see Figure 7).

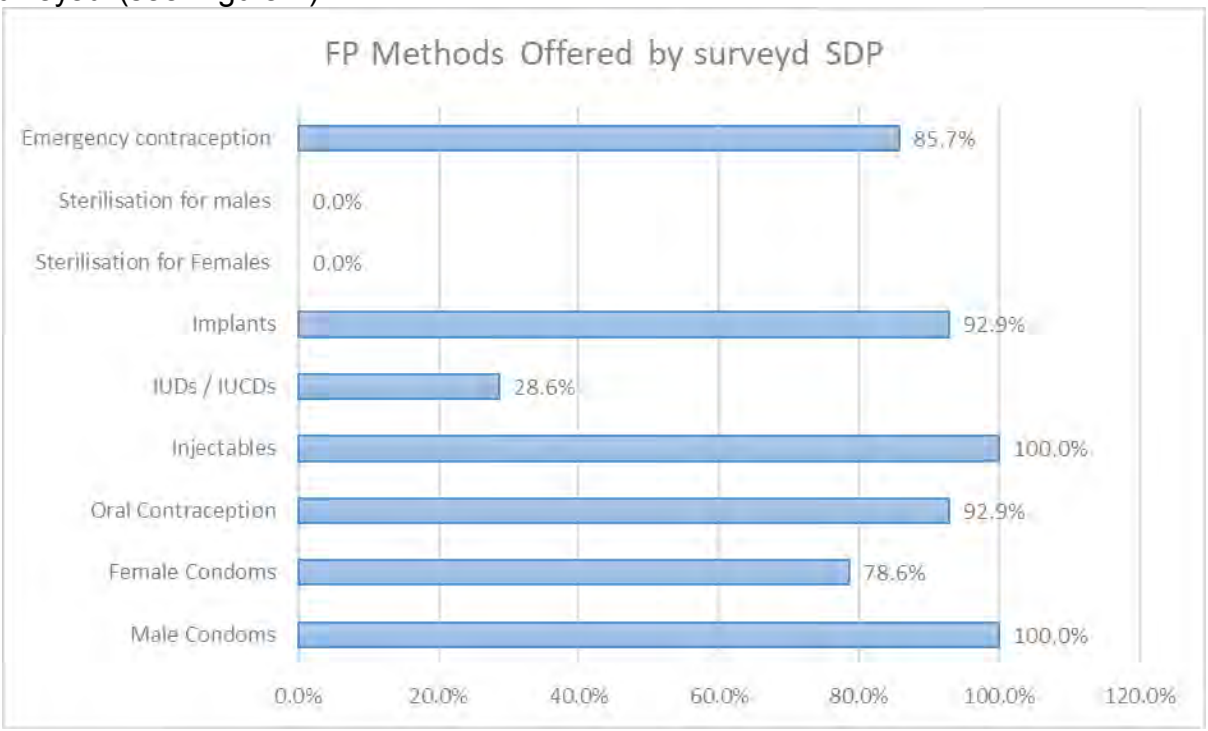

Figure 7: The various family planning methods offered by surveyed health facilities

3.5.1 Contraceptive Methods offered by surveyed health facilities

Health facility in-charges or family planning service providers at the surveyed health facilities were asked to mention family planning services that were offered at their respective facilities Overall, all surveyed facilities offer short term family planning methods. However, none of the surveyed facilities offer sterilization. Of note 13 out of 14 facilities offered implants whereas only 4 offer IUCDs. Figure 8 presents these findings.

3.5.2 Stock status Of family planning commodities

At each of the surveyed facilities, in charges/family planning service providers were asked stock status of FP commodities on the day of the survey. Overall all facilities were stocked out of at least one FP method. Notably, female condoms and implants were 'stocked out' in majority of surveyed facilities at 66.7% and 38.5% respectively. Table 12 below shows the results.

Table 12: Stock status of the various FP products and services

Method	Modern contraceptive method not in stock [stock out] on the day of the survey	Modern contraceptive method in stock [in stock] on the day of the survey
Male Condoms	4 (40.0%)	6 (60.0%)
Female Condoms	6 (66.7%)	3 (33.3)
Oral Contraception	4 (44.4)	5 (55.6%)
Injectables	3 (30.0%)	7 (70.0%)
IUDs / IUCDs	4 (44.4%)	5 (55.6%)
Implants	5 (38.5%)	8 (61.5%)
Emergency contraception	4 (44.4%)	5 (55.6%)

3.6 Staff Training

Data were obtained on the number of personnel trained in family planning including insertion and removal of implants (see Table 13). All facilities surveyed reported having staff trained in provision of family planning. Facility staff were further asked the sponsors of the training. Up to 11 facilities reported that their staff had underwent training organised by AHS.

Table 13: Training of personnel in family planning

	n	%
Pre-service	1	7.1%
In- service	4	28.6%
Both	9	64.3%
Did the staff attend any training organised/facilitated by AHS (Adventist Health Services)		
Yes	11	78.6%
No	3	21.4%
Of the staff trained by AHS, did any of them leave (transfer out) this facility		
Yes	5	45.5%
No	6	54.6%
Is any staff member trained for the insertion and removal of implants		
Yes	13	92.9%
No	1	7.1%

3.7 EXIT Interviews

Data from exit interviews were analyzed for the fallowing aspects:

3.7.1 Current Method

Table 14 presents findings of FP methods that were used by FP clients that participated in exit interviews. Of the 137 FP clients interviewed 129 (94.2) were on a modern FP method. The majority of respondents were on injectables [61 (47.3%)] and implants [34 (26%)].

Table 14: Family planning methods that were being used by women that participated in the exit interviews

Method	n	%
Oral Contraceptive Pill	11	8.5%
Injectables	61	47.3%
Implants	34	26.4%
Male Condom	22	17.1%
Other specify	1	0.8%
Total	129	

3.7.2 Provider adherence to technical aspects

The following seven parameters of technical aspects were assessed: (i) if the user received the preferred method of choice; (ii) if the provider took into consideration the

preferences of the user at the time of the decision on the method; (iii) if the provider gave clear instruction on how to use the chosen method; (iv) if the provider explained the side effects associated with the chosen method; (v) if the provider informed the client about remedial procedures; (vi) if the provider informed the user about serious complications that may occur; and (vii) if any date has been given for subsequent visit. Table 15 shows these parameters. Overall FP clients reported high levels of adherence to technical aspects by service providers. Of concern is the finding that 25% of clients reported not being informed of side effects of the method provided.

Table 15: Technical parameter assessed

Parameter	Yes	No
Provided with method of their choice	125 (96.9)	4 (3.1%)
Provider took clients preference and wishes into consideration	127 (98.4%)	2 (1.6%)
Client taught how to use the method	117 (90.7%)	12 (9.3%)
Client told about the common side effects of the method	99 (76.7%)	30 (23.3%)
Provider informed client about what can be done regarding the side effects of the method	96 (74.4%)	33 (25.6%)
Provider informed client about what to do in case any serious complications occur	94 (72.9%)	35 (27.1%)
Client given date to return to SDP for check-up and /or additional supplies	97 (75.2%)	32 (24.8%)

3.7.3 Partner Involvement in FP

Participants were asked if their partners were aware of the method that they were using. Up to 113 (87.6%) of respondents indicated that their partners were aware that they were on a method. Of interest is the finding that 9.3% (n=12) indicated that their sexual partner did not know that they were on contraception. Those that indicated that their partners were aware of the method were further asked if they approved the method. All respondents reported having approval from their partners.

3.7.4 Information about Family Planning Services Offered

Clients exiting a family planning clinic or those that had access to FP services two weeks preceding the survey were asked where they heard about FP services they were offered and the results are shown in Table 16. HSAs and peers were reportedly the main source of information at 51.8% and 40.9% respectively.

Table 16: Sources of information regarding family planning

Source of Information	n	%
Through local media	16	11.7%
Pamphlets/posters	4	2.9%
Friends/peers	56	40.9%
CAGs or CAYoGs /A community member/ Social groups	44	32.1%
Parents	15	10.9%
Schools	2	1.5%
Health Care Delivery System	23	16.8%
HSAs	71	51.8%
Other	6	4.4%
Total	137	100.0%

3.7.5 Waiting Time to Access Family planning Services

Figure 8 below present's perceived waiting time among clients that access family planning. Up to 30% family planning clients indicated waiting less than 15minutes before receiving the services. Cumulatively over 45% of clients received family planning services within 30minutes and 1 hour.

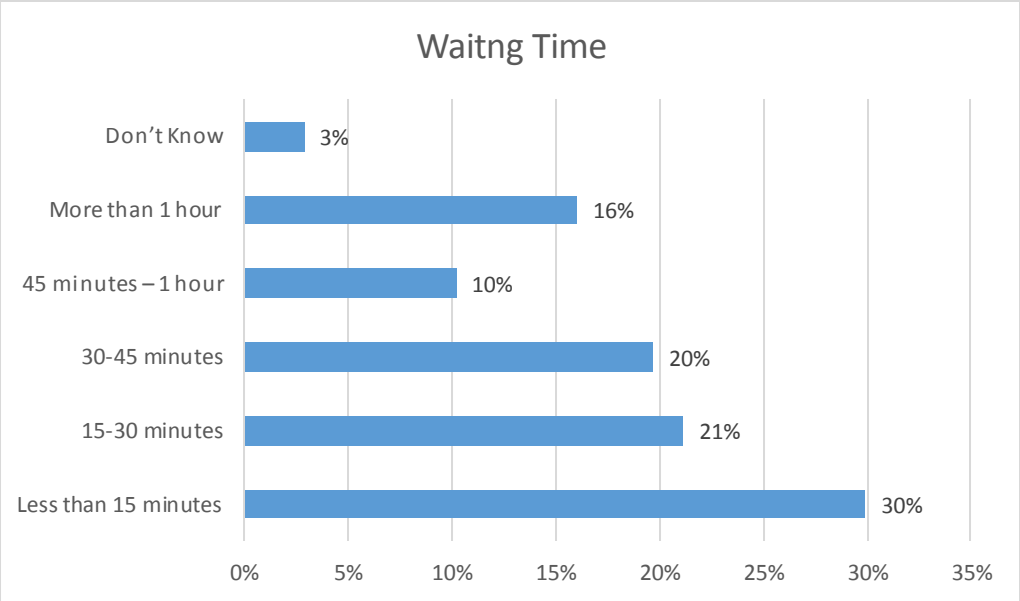

Figure 8: Waiting times study participants indicated to access family planning services

3.5.8 The CAGS/CAYoGs model

The innovation of setting up CAGs and CAYoGs seems to be acceptable and feasible in the project areas. This seems to have led to measurable positive results reported above. The survey has however identified a number of key issues that need to be included in future programming. These are 1) the criterion related to literacy and social standing should be revised to be all encompassing 2) CAYoGs should include youths that are not in union or these should have a separate group of their own 3) there is need for an alternative approach to rolling out the orientation of CAGS/CAYoGs members through the 15 cycles other than relying on senior HSAs who have a lot of competing activities. This could involve engagement of Community Based Organisations (CBOs) with capacity to provide this facilitation.

3.8 Overall impact of the project

3.8.1 Knowledge and awareness of the community outreach project

Most of the respondents in the visited project areas when asked about the community outreach FP project showed awareness of the project and how it has helped them in accessing FP services. One key informant said:

> *"Yes, I am aware and thanks to them (AHS), people can now access family planning methods in their communities, they don't have to come to the facility just for family planning methods unless if they are looking for long term family planning methods. We were trained by the AHS so that we can also be giving family planning methods to the people in the community in our catchment areas."*
> ***HSA Edingeni Mzimba***

3.8.2 Effectiveness of the project

This evaluation also focused on finding out about the effectiveness of the project. Data from the key informants indicated that the project has been effective in carrying out its objectives. Of note, there was universal appreciation of capacity building initiatives of HSAs, CBDAs as well as CAGs. During the project implementation, health workers were also trained on family planning.

Furthermore, the indicators tracked have shown tremendous achievements especially regarding recruitment of new users to family planning, dissemination of FP messages and delivery of FP counselling sessions as discussed below.

However, in some areas where the project started late, the project was reported not being effective due to duration of the project. One key informant said:

> *"AHS introduced CAGs last year, trained people on family planning especially on men involvement in family planning. Now, Adventist has just dropped the issue abruptly and phasing out. Those groups are supposed to go into four cycles and we are very far from that. As a result, we can't see the effectiveness of this project since the project has been cut short."*

KII family planning coordinator Rumphi

3.8.3 Relevance

Interviews that were conducted have established that the project focus was relevant as it aligns to government priorities as outlined in the Malawi Development Strategy III especially that it decentralised FP services (bringing FP services closer to the community).

"As a family planning coordinator here in Rumphi, I am aware and have seen the importance and relevance of this project where HSAs were trained on how to provide family planning methods in outreach clinics. There are 129 outreach clinics providing family planning methods. This has increased number of people getting modern family planning methods since they are easily accessed in their own communities. In the past people used to walk long distances just to get family planning services. Those who did not want to walk long distances could just stay at home and as a result get unwanted pregnancies."

- ***KII Rumphi family planning coordinator***

3.8.4 Efficiency

On efficiency, the notable problem was late disbursement of funding for activities. This was noted in Rumphi where the formation of CAGs was delayed. As a result, the project has phased out before the desired cycles were completed. On training of the CBDAs the project did not manage to train members from other centres like Tcharo which is one of the hard to reach areas along the lakeshore.

3.8.5 Sustainability

This assessment has determined that the implementation of this project has had inherent sustainability elements including:

Project design:

- Incorporation of District Health Management Teams (DHMTs): The involvement of DHMTs entails potential continued implementation of activities initiated during the project cycle.
- Capacity building initiatives: The evaluation has established that the project implemented comprehensive capacity building activities. These included CBDAs, CAGS/CAYOGs, HSAs and facility level health workers. The skills built are likely to last beyond the life-span of the project.
- Commodity supply: the fact that family planning commodities used at community level were supplied through the normal government supply chain system is a sustainable arrangement. Thus the project did not create dependency hence ensuring sustainability
- Alignment with government policy: Promotion of family planning services through decentralization of services to community level is in line with government policies as outlined in the Malawi Growth Development Strategy III.

- MOH training curriculum: CBDA program followed the Reproductive Health Directorate (3 weeks) and the trainers were from the Ministry of Health.
- Introduction of customized data collection tools: The introduction of registers in booklet format has been identified as a positive achievement for the project. It has further been noted that the customized tally sheets for the project are recommended to other stakeholders. Figures 9 a-c shows some of the data collection tools.

a) *stock tracking*

b) *contraceptive tally sheet*

c) *stock tracking*

Figure 9 (a-c): Pictures showing FP registers (a=stock tracking, b=contraceptive tally sheet and c=stock tracking) and stock tracking tool

- Use of CBDAs: The fact that the project activities centered on engagement of CBDAs who volunteer their services ensures community participation and ownership of the project. Thus enhancing likelihood of sustainability

However, there are potential threats to sustainability. These include:

- Lack of regular and predictable financial resources beyond the life-span of the project: This will likely affect provision of tools including registers and tally sheets as well facilitation of supervisory visits. In addition, though CBDAs were not paid a salary, allowances paid during training and review meeting are seen as incentives for this cadre and thus the unavailability of this will likely affect their morale and retention rates.

  "AHS trained CBDAs, CAGs as well as HSAs. Almost 75 CBDAs were trained and also used to provide refresher courses. I don't know Government can still maintain these trainings and supervisions since it is already handicapped in finances as well as human resources. The problem is that people even at district level view this as an Adventist project and as a result, once it is gone, no one will be following it up. I am really afraid of the sustainability of this project".

  Family Planning coordinator Rumphi

  "since family planning is part of our job and we are already in the system that means it will be sustainable though we wouldn't be sure about availability of resources like registers, tally sheets and availability of family planning methods. The AHS are trying their best making sure that we always have the materials available as well as stationery".

  HSA Edingeni Health Centre

- Limited time of engagement with some key partners: Though the evaluation has found evidence of extensive engagement at district level, there seems to have been limited engagement with some stakeholders. The central level at Reproductive Health Department was engaged at the initiation of the project but not during the implementation phase. Further, at district level (for instance Rumphi), BLM indicated that they had not been fully engaged with the activities of the project.

  "I have heard about that project, that they provide trainings on family planning but I have never met them one to one. I just know that they train health service providers so that they offer FP services in outreach clinics but I have not met or seen them. As such, I can't say much on their roles in this district".

  BLM Clinician Rumphi

3.9 Project outcomes

3.9.1 Women and men empowerment

It was observed that since the introduction of the project, women are able to seek and access FP methods with confidence. Some women are able to make a decision on their own to get FP services even if it means sneaking on their partners. Most women are also able to discuss family planning openly in the community and encourage their fellow women to seek family planning services. One respondent said

"I am able to get family planning without the knowledge of my husband, injectables provide the opportunity of being on FP without your partner knowing. What we do is we live the health passport with a friend or health worker and you visit the service delivery point as if am to access other health services and I get the method. What is key is having a friend or health worker who will keep it confidential"

FGD with women 24-35 Tchalo Rumphi

With the introduction of CAGs, men are now being more empowered and involved in seeking FP services. However, it was also observed that men would easily allow their wives to get family planning services but not them getting the family planning services or accompany their wives to get the methods.

"AHS also helped in forming CAGs. With these village groups, they have helped in involving men in family planning issues since male involvement is a very big issue in family planning, so as you can see, this project is really relevant. However, the problem is that we just started training those men last year and now the project is phasing out."

KII Family Planning coordinator Rumphi

3.9.2 Increased supply of quality family planning services

The project decentralised provision of the FP methods down to community level which enabled people to access family planning services right in their communities this ensure increased supply of the FP services at all levels.

> *"The project has empowered community health workers to provide services right in their communities and this has helped the facility to meet the increased demand and reduce work load at the facility as other methods are available right in the communities"*
>
> ***KII Iura Health centreFamily planning focal person***

3.10 Best practices

Alignment of the project to government policies was among other best practices that the project had. These included:

- Alignment allowed promotion of integration of project related services in the routine family planning service provision at health centre level,
- Use of CBDAs who are integrated in the routine family planning service delivery system.
- Close collaboration between AHS and District Health Management teams from planning, supervision and training of service providers. In fact, AHS district level coordinators were accommodated by the respective DHOs.
- Introduction of stock out registers helped in early identification of stock outs allowing timely re-supply of stocked out commodities.
- Introduction of bound registers which made allowed for easy reporting and since they are in triplicate the service provider, the local facility and district supervisors kept a copy for future reference.
- Community action groups (CAGs)/CAYoGs and outreach clinics improved access to FP services by removing distance as a barrier to these services.

4.0 Discussion

The study has established that 71% (5 out of 7) of core indicators were either achieved or surpassed. It has further been observed that the two indicators that were not achieved were as result of transfer or death of staff. This therefore calls for deliberate effort in future programming to monitor staff movement and build a plan for replacement.

The observation that there is a tremendous increase in dissemination of messages and FP counselling attests to the effective of community based approaches to FP service delivery. However, there was a notable decrease especially for FP messages in year 3. It is important to maintain these activities as they are critical for demand creation and behavior change. Thus there needs to be strategies for maintaining these activities beyond the life span of the project.

Further it has been observed that the program captured an increase in number of new users of modern FP methods across the life span of the project. This likely to be a consequence of community activities (including FP message dissemination and counseling services as discussed above). However, in future programming it is important to incorporate tracking systems that capture individual level data in order to allow monitoring of continuation rates on FP methods.

This survey found that there was universal awareness of modern FP methods. This is similar to findings in the MDHS 2015-16. However, as opposed to findings in the MDHS, the survey has found that age does not influence awareness in the end-line survey. This could also be attributed to project activities that were community based and that reached even the youth through the CaYoGs structures.

The overall mCPR from this survey was estimated at 61.6%. However, to compare to the national figure we computed the CPR. The overall CPR was at 66.9%. This is higher than the national average as reported in the MDHS at 59% whereas for the rural setting is at 57.5%. This could be a function of the intensity of community based interventions especially the use of CBDAs and CAGs/CAYoGs by this project. This could also be supported by the fact that over 60% of respondents mentioned HSA and CBDAs as source of FP methods (addressing transport related barrier).

Preference of injectables and implants across all districts calls for efforts to promote other FP choices including IUCDs, male sterilization and female condoms. Furthermore, it is recommended that future programs should incorporate other preparations of delivering FP methods such as self-injection for injectables.

The unmet need at 44.7% is higher than that reported in the MDHS (19%). As noted above, this could be due to the fact that this survey targeted rural areas as well as small number of participants on which this indicator is calculated on. However, this observation is a concern and calls for efforts to comprehensively promote modern FP methods that offer long protection as well as emergency contraception.

The finding that the surveyed facility had a stock-out of at least one method on the day of the survey calls for a robust supply chain system that tracks stock levels. This will require future programs to invest in infrastructure resources (human and physical) in order to ensure commodity security.

The qualitative component of this survey identified a number of key issues including the finding that there was limited male involvement regarding initiation of FP methods. Thus there is need for concerted efforts in future program designs that incorporate male involvement. It is noteworthy that the study found that some women indicated that their partners were not aware of their being on an FP method. This calls for programs that empower women to make independent decisions regarding FP.

Further, there are negative attitudes and perceptions such as the belief that children were from God and that family planning is meant for those in union. Future programming

should incorporate compressive behaviour change approaches that dispel the negative perceptions.

Exit interviews showed that the method mix was dominated by short term contraceptives. Most of the study participants were using injectable and implants. These findings are consistent with the findings in the MDHS2015-16. This might be due to the availability or acceptability of this method by the community. This could also be attributed to lack of information on other available methods. It is therefore important that healthcare professionals deliberately inform their patients or users about the benefits and risks of all available contraceptives. This may prompt women to reconsider their original choice, potentially selecting a method which best suits their medical and lifestyle needs. In addition, in the future there should be deliberate efforts and strategies to expand male involvement in family planning through provision of methods that are acceptable to males.

The innovation of setting up CAGs and CAYoGs seems to be acceptable and feasible in the project areas. This seems to have led to measurable positive results. The survey has however identified a number of key issues that need to be included in future programming. These are 1) the criterion related to literacy and social standing should be revised to be all encompassing 2) CAYoGs should include youths that are not in union or they should have a separate group of their own 3) there is need for an alternative approach to rolling out the orientation of CAGS/CAYoGs members other than relying on senior HSAs who have a lot of competing activities. This should engagement of Community Based Organisations (CBOs).

This evaluation has demonstrated a number of positive outcomes of this project. This assessment has established that the project is felt to have addressed a relevant area which aligns with the Malawi Development Growth Strategy II. Furthermore, the study has demonstrated effectiveness as most indicators were either met or surpassed. In addition, there were a number of activities that are judged to sustainable including capacity building activities for CBDAs, HSAs and other facility based staff. These cadres are integrated in the normal service delivery system. Furthermore, a number of best practices were noted. These included close collaboration with district health management teams, customised data collection tools (including stock tracking registers) which are now recommended to other stakeholders and a focus on capacity building for community based providers which enhanced access to FP services.

5 Recommendations

Based on evidence gathered from this evaluation the following recommendations are made:

1. **Stakeholder collaboration.** Intensify stakeholder involvement at all levels from the onset of the project to implementation stage. This would ensure sustainability and effectiveness of the project

2. **Funding.** Government, implementing partners and donors should make sure there is predictable and regular funding in order not to disrupt service delivery.

3. **Strengthening local level advocacy.** The project should make deliberate effort to make sure that there is active male involvement during decision making and implementation of the project. This could be achieved by active community mobilization focused on males. Further, the project should raise awareness about family planning amongst males to remove misconceptions that most men have on family planning.

4. **Mobility for community based service providers.** CBDAs and HSAs should be provided with bicycles to ease mobility challenges in order for them to effectively reach out to the communities as well as source supplies from their respective facilities.

5. **Standardizing data collection tools.** Data collection tools should incorporate ability to capture individual level data (including repeat visits) to allow computation of continuation rates.

6. **Counselling**. A comprehensive counselling package should be developed that contains information on side effects of some modern family planning methods. Providers would need to be trained on this and encouraged to provide this information to clients at each visit.

7. **Involvement of non-traditional stakeholders**. A deliberate effort should be made to involve religious and other civil leaders during advocacy and implementation of similar project. This is so as such stakeholders tend to hold beliefs that run counter to the efforts of FP related projects.

8. **Composition of CAGS and CAYoGs.** There is need to review the composition of CAGS and CAYoGs so that they are all encompassing to include unmarried youths, all social classes and even illiterate community members.

9. **Rollout of CAGS and CAYoGs model**. Rolling out of this model should incorporate local CBOs that can cascade facilitation of capacity building efforts throughout the prescribed cycle as opposed to relying on HSAs who usually have concurrent competing activities

6 Appendices

Appendix 1: **Household/community Survey (Males & Females)**

Target age group: females 15-49.

INFORMATION ABOUT THE INTERVIEW
Name of Interviewer …….....……
Date of Interview……
Time Interview Started……
Questionnaire checked and attested to be properly completed
Name of Supervisor…… Signature …… Date) ……..……

Please read the following consent form:
Hello. My name is.....and I am working with Centre for Health, Agriculture, Development Research and Consulting (CHAD). On behalf of Adventist Health Services on a project called **"Community Outreach Family Planning Project**". We are carrying out an endline study to assess the impact of the project on targeted beneficiaries, including primary beneficiaries (women of reproductive age) and secondary beneficiaries (men).

The results of this evaluation will be used to generate information on best practices and learning that can inform recommendations in order to improve uptake of family planning use and inform future AHS program development

006 INTERVIEWER: Code [____|____] Name_____

007 DATE OF INTERVIEW: ___\ ____ \ 2013

008 CHECKED BY SUPERVISOR: Signature_____ CODE |___|___| Date _____

SECTION 1: RESPONDENT'S BACKGROUND **First I would like to ask you questions about you.**			
101.	Could you please tell me your age in completed years?	**CODE IN 2 DIGITS IN [ ][ ] BOXES**	
102.	Marital status	SINGLE/NEVER MARRIED……1 MARRIED MONOGAMOUS……2 MARRIED POLYGAMOUS……..3 LIVING TOGETHER WITH PARTNER..4 DIVORCED……5 SEPARATED……..6 WIDOW OR WIDOWER……...7	
103.	Have you ever attended school?	YES……1 NO……..2	→Q107
104.	Could you please tell me the highest level of education that you have completed?	LESS THAN PRIMARY)……..2 PRIMARY COMPLETED……3 SECONDARY COMPLETED……..4 HIGHER COMPLETED……5 DON'T KNOW……9	→Q106 →Q106

105.	AS YOU KNOW, SOME PEOPLE TAKE UP JOBS FOR WHICH THEY ARE PAID IN CASH OR KIND. OTHERS SELL THINGS AT THE MARKET OR HAVE A SMALL BUSINESS. OTHERS MIGHT DO GANYU WORK OR WORK FOR OTHERS. What is your **MAIN** Occupation? (READ RESPONSES)	FARMING……. 1 SALARIED WORK…….. 2 BUSINESS/TRADER/VENDOR….. 3 HOUSEWIFE…….. 4 HOUSEWORKER…….. 5 SCHOOLING…….. 6 GANYU…….. 7 NONE…….. 8 OTHER (SPECIFY)…….. 99	
SECTION 2: REPRODUCTION			

201.	Now, I would like to ask about all the births you have had during your life. Have you ever given birth?	YES ..... 1 NO..... 2	→Q210
202.	Do you have any sons or daughters to whom you have given birth who are now living with you?	YES ..... 1 NO..... 2	→Q204
203.	How many sons live with you? And how many daughters live with you? **IF NONE, RECORD '00'.**	SONS AT HOME..... ☐☐ DAUGHTERS AT HOME..... ☐☐	

204.	Do you have any sons or daughters you have given birth who are alive but do not live with you?	YES..... 1 NO..... 2	→Q206
205.	How many sons are alive but do not live with you? And how many daughters are alive but do not live with you? **IF NONE, RECORD '00'.**	SONS ELSEWHERE..... ☐☐ DAUGHTERS ELSEWHERE ☐☐	
206.	Have you ever given birth to a boy or a girl who was born alive but later died? **IF NO, PROBE:** Any baby who cried or showed signs of life but did not survive?	YES..... 1 NO..... 2	→Q208
207.	How many boys have died? And how many girls have died? **IF NONE, RECORD '00'**.	BOYS DEAD..... ☐☐ GIRLS DEAD..... ☐☐	
208.	**SUM ANSWERS TO Q203, Q205 AND Q207 AND ENTER TOTAL. IF NONE, RECORD '00'.**	TOTAL . . . ☐☐	
209.	**CHECK Q208:** Just to make sure that I have this right: you have had in TOTAL_____ births during your life. Is that correct? Yes : → **CONTINUE** No : → **PROBE AND CORRECT Q201 TO Q207 AS NECESSARY**		
210.	Have you ever had a pregnancy that miscarried, was aborted, or ended in a still birth?	YES……..……..1 NO..... 2	→Q212
211.	On this occasion, how was the pregnancy terminated? Did you take some pills, take an injection, have an operation or did you do something else?	Pills……..……..1 Injection…….……2 Operation.……3 Other(Specify)..……4	
212.	Are you currently pregnant?	YES 1 NO 2 UNSURE 8	→Q213 →Q213

<table>
<tr><td>213.</td><td>How many months pregnant are you?</td><td>MONTHS ☐☐</td><td></td></tr>
<tr><td>214.</td><td>At the time you became pregnant, did you want to become pregnant then, did you want to wait until later, or did you not want to have any more children at all?</td><td>THEN..... 1
LATER..... 2
NOT AT ALL..... 3</td><td></td></tr>
<tr><td>215.</td><td>Have you ever had a pregnancy that miscarried, was aborted, or ended in a stillbirth?</td><td>YES.....1
NO..... 2</td><td>→Q301</td></tr>
<tr><td>216.</td><td>When did the last such pregnancy end?</td><td>MONTH.....
YEAR..... ☐☐☐☐</td><td></td></tr>
<tr><td>217.</td><td>How many months pregnant were you when the last such pregnancy ended?

RECORD NUMBER OF COMPLETED MONTHS.</td><td>MONTH..... ☐☐</td><td></td></tr>
<tr><td>218.</td><td>Have you had any other pregnancies that did not result in a live birth?</td><td>YES.....1
NO..... 2</td><td>→Q301</td></tr>
<tr><td>219.</td><td>ASK THE DATE , MONTH, AND THE DURATION OF PREGNANCY FOR EACH EARLIER NON-LIVE BIRTH PREGNANCY</td><td>
<table>
<tr><th>217A. MONTH</th><th>217B. YEAR</th><th>217C. DURATION</th></tr>
<tr><td>DEC</td><td></td><td></td></tr>
<tr><td>NOV</td><td></td><td></td></tr>
<tr><td>OCT</td><td></td><td></td></tr>
<tr><td>SEP</td><td></td><td></td></tr>
<tr><td>AUG</td><td></td><td></td></tr>
<tr><td>JUL</td><td></td><td></td></tr>
<tr><td>JUN</td><td></td><td></td></tr>
<tr><td>MAY</td><td></td><td></td></tr>
<tr><td>APR</td><td></td><td></td></tr>
<tr><td>MAR</td><td></td><td></td></tr>
<tr><td>FEB</td><td></td><td></td></tr>
<tr><td>JAN</td><td></td><td></td></tr>
</table>
</td><td></td></tr>
</table>

SECTION 3: CONTRACEPTION

301. Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy.
a) Which ways or methods have you heard of? **DO NOT READ THE OPTIONS, CIRCLE METHODS SPONTANEOUSLY MENTIONED**
b) **NOW, ASK ABOUT METHODS WHICH ARE NOT MENTIONED:** Have you ever heard of _____(**READ NAME AND DESCRIPTION OF METHOD**)? **CIRCLE THE RESPONSE GIVEN IN AIDED COLUMN (301b)**.
c) **FOR EVERY METHOD MENTIONED (SPONT. OR AIDED)**
ASK: Have you or your spouse/partner ever used this method?
ONLY READ DESCRIPTION OF EACH METHOD. **ASK 302 IF 301a and 301b HAS CODE 1 CIRCLED**

	METHOD:	**HAVE YOU EVER HEARD (METHOD)?**		**(302) Ever Used**
		301a) SPONT.	**301b) AIDED**	
1.	FEMALE STERILIZATION Women can have tubal ligation to avoid having any more children.	YES... 1 NO..... 2	YES... 1 NO..... 2	Have you ever had a tubal ligation to avoid having any more children? YES.....1 NO.....2
2.	MALE STERILIZATION Men can have an operation to avoid having any more children.	YES... 1 NO…..2	YES... 1 NO…..2	Have you ever had a partner who had an operation to avoid having any more children? YES.....1 NO.....2
3.	PILL Women can take a pill every day or every week to avoid becoming pregnant.	YES... 1 NO..... 2	YES... 1 NO..... 2	YES.....1 NO.....2
4.	IUCD: Women can have a loop or coil placed inside them by a doctor or a nurse.	YES... 1 NO..... 2	YES... 1 NO..... 2	YES.....1 NO.....2

5.	INJECTABLES Women can have an injection by a health provider that stops them from becoming pregnant for one or more months.	YES... 1 NO..... 2	YES... 1 NO.... 2	YES.....1 NO.....2
6.	IMPLANTS (OR NORPLANTS): Women can have several small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for five or more years	YES... 1 NO..... 2	YES... 1 NO..... 2	YES.....1 NO.....2
7.	CONDOM: Men can put a rubber sheath on their penis before sexual intercourse.	YES... 1 NO…..2	YES... 1 NO…..2	YES.....1 NO.....2
8.	FEMALE CONDOM: Women can place a sheath in their vigina before sexual intercourse.	YES….1 NO.....2	YES... 1 NO.... 2	YES.....1 NO.....2
9.	RHYTHM METHOD Every month that a woman is sexually active, she can avoid pregnancy by not having sexual intercourse on the days of the month she is most likely to get pregnant.	YES.....1 NO……2	YES... 1 NO…..2	YES.....1 NO.....2
10.	WITHDRAWAL Men can be careful and pull out before climax.	YES... 1 NO…..2	YES... 1 NO…..2	YES.....1 NO.....2
11.	EMERGENCY CONTRACEPTION Women can take pills up to three days after sexual intercourse to avoid becoming pregnant.	YES... 1 NO…..2	YES... 1 NO.....2	YES.....1 NO.....2
12.	Have you heard of any other ways or methods that women or men can use to avoid pregnancy? Which ones? SPECIFY	YES... 1 NO…..2	YES... 1 NO.....2	SPECIFY
13.	**NONE IF NONE, RECORD 00**	00	00	

302.	**CHECK:** **NOT A SINGLE YES (NEVER USED ANY METHOD) (Q301 m=NONE) →Q316** **CURRENTLY PREGNANT (Q210=1) →Q310**		
303.	Are you or your spouse/partner **currently using** any method to delay or avoid pregnancy?	Yes.....1 No.....2 DK.....3	Continue →Q316 →Q316

CHECK 302 (01): WOMAN NOT STERILIZED **WOMAN STERILIZED**

CHECK 210 (01): WOMAN NOT PREGNANT **WOMAN PREGNANT (SKIP 406)**

(A) Which method are you / your spouse/partner using? **CODE IN GRID BELOW. MULTIPLE CODES POSSIBLE. PROBE:** Any others?
(B) For how long have you been using this? **RECORD IN MONTHS IN 2 DIGITS**

	METHOD	**CURRENT USE (A)**	**DURATION (MONTHS) (B)**	
1	FEMALE STERILIZATION	1	☐☐	
2	MALE STERILIZATION	2	☐☐	
3	PILL	3	☐☐	
4	COPPER-T /IUCD	4	☐☐	
5	INJECTABLES	5	☐☐	
6	IMPLANTS	6	☐☐	
7	MALE CONDOM	7	☐☐	
8	FEMALE CONDOM	8	☐☐	
9	WITHDRAWAL BEFORE EJACULATION	9	☐☐	
10	RHYTHM METHOD/ SAFE PERIOD	10	☐☐	
11	OTHERS (SPECIFY)_____	11	☐☐	

304.	Are you using the method for spacing or limiting the number of children	SPACING……..... .1 LIMITING…….....2 DON'T KNOW..... 3	
305.	Does your partner / spouse know that you are using a method of family planning?	YES….....1 NO….. .....2 DON'T KNOW.....3	

306.	Who initiated to use the family planning method?	RESPONDENT.....1 SPOUSE…….. ...2 DOCTOR.....……..3 OTHER (SPECIFY)...4	
307.	How often did you discuss with your partner on the family planning method?	MORE OFTEN...……...1 ONCE OR TWICE..…..2 NEVER....…….....3	
308.	Did you approve of the family planning method?	APPROVES....……..1 DISAPPROVES…….....2 DON'T KNOW...……...3	
309.	Did your partner approve of the family method?	APPROVES..…… 1 DISAPPROVES..…….. 2 DON'T KNOW..……. 3	
310.	Now I would like to ask you about the first time that you did something or used a method to avoid getting pregnant. How many living children did you have at that time, if any? **IF NONE, RECORD '00'.**	NUMBER OF CHILDREN ☐☐	

311.	Where did you obtain (CURRENT METHOD) when you started using it? IF UNABLE TO DETERMINE IF HOSPITAL, HEALTH CENTER, OR PRIVATE HOSPITAL/CLINIC/ CLINIC IS PUBLIC OR PRIVATE MEDICAL, WRITE THE PLACE.	**PUBLIC SECTOR** GOVT. HOSPITAL..…..... 11 GOVT. HEALTH CENTRE.....12 GOVT HEALTH POST/CLINIC/STATION.. 13 CBDA/DOOR TO DOOR..... 14 OTHER PUBLIC SECTOR HEALTH FACILITY……... 15 HSA..…….. 16 MOBILE CLINIC..... 17	

	(**NAME OF PLACE(S)**)	**NGO OR TRUST HOSPITAL /CLINIC** BANJA LA MTSOGOLO CLINIC..... 21 BLUE STAR CLINIC..... 22 OTHER NGO CLINIC..... 23 CBD/CBRHA.....24 BLM COCI..... 25 BLM TOCI.....26 OTHER PRIVATE MEDICAL..... 27	
		PRIVATE MEDICAL SECTOR PVT. HOSPITAL/DOCTOR/CLINIC.....31 PHARMACY/DRUGSTORE.....32 OTHER PRIVATE SECTOR HEALTH.33 FACILITY/SHOP.....34	
		OTHER SOURCE SHOP..... 41 CHURCH.....42 FRIEND/RELATIVE.....43 YOUTH DROP IN CENTRE..... 45	
		OTHER (SPECIFY).....96	
312.	Did your spouse accompany you to get family planning method?	YES.....1 NO.....2	
313.	Were you ever advised that this contraceptive method does not protect against AIDS or other sexually-transmitted diseases?	YES.....1 NO.....2	
314.	At that time, were you told about side effects or problems you might have with the method?	YES.....1 NO.....2	
315.	Were you told what to do if you experienced side effects or problems?	YES.....1 NO.....2	

316.	Do you know of a place where you can obtain a method of family planning?	YES.....1 NO.....2	→ 401
317.	Where is that? Any other place? PROBE TO IDENTIFY EACH TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE(S). IF UNABLE TO DETERMINE IF HOSPITAL, HEALTH CENTER OR CLINIC IS PUBLIC OR PRIVATE MEDICAL, WRITE THE NAME OF THE PLACE. (NAME OF PLACE(S))	**PUBLIC SECTOR** GOVT. HOSPITAL..... A GOVT. HEALTH CENTRE..... B GOVT HEALTH POST/CLINIC/STATION.....C CBDA/DOOR TO DOOR..... D OTHER PUBLIC SECTOR HEALTH FACILITY...E HSA..... F OUTREACH..... G BLM (OUTREACH POINT).....H MOBILE CLINIC..... I	
		NGO OR TRUST HOSPITAL /CLINIC BANJA LA MTSOGOLO CLINIC..... J BLUE STAR CLINIC..... K OTHER NGO CLINIC..... L CBD/CBRHA..... M BLM COCI.....N BLM TOCI.....N OTHER PRIVATE CLINIC..... ....O	
		PRIVATE MEDICAL SECTOR PVT. HOSPITAL/DOCTOR/CLINIC.....P PHARMACY/DRUGSTORE.....O OTHER PRIVATE SECTOR HEALTH.....Q FACILITY/SHOP.....R	
		OTHER SOURCE SHOP.....S CHURCH.....T FRIEND/RELATIVE.....U YOUTH DROP IN CENTRE.....V OTHER (SPECIFY).....X	

SECTION 4: MARRIAGE AND SEXUAL ACTIVITY

401.	Are you currently married, or living together with a man as if married? **PROBE IF '2' WHETHER FORMALISED**	YES, CURRENTLY MARRIED.....1 YES, LIVING WITH A MAN.....2 NO, NOT IN UNION.....9	→Q404 →Q404
402.	Have you ever been married or lived together with a man as if married?	YES, FORMERLY MARRIED..... 1 YES, LIVED WITH A MAN.....2 NO..... 3	→Q406
403.	What is your marital status now: are you widowed, divorced or separated?	WIDOWED..... 1 DIVORCED..... 2 SEPARATED..... 3	
404.	Is your husband/partner living with you now, or is he staying elsewhere?	LIVING TOGETHER.....1 STAYING ELSEWHERE..... 2	
405.	**CHECK FOR PRESENCE OF OTHERS. BEFORE CONTINUING MAKE EVERY EFFORT TO ENSURE PRIVACY**		
406.	Now I need to ask you some questions about sexual activity in order to gain a better understanding of family life issues. How old were you when you had sexual intercourse for the very first time (if ever)?	NEVER HAD SEX.....0 AGE IN YEARS ☐☐	→Q501
407.	The first time you had sexual intercourse, was a any family planning mtehod used?	YES.....1 NO.....2 DON'T KNOW/DON'T REMEMBER.....3	

408.	When is the last time you had sexual intercourse?	DAYS AGO ☐☐ WEEKS AGO ☐☐ MONTHS AGO ☐☐ YEARS AGO	→Q701
409.	The last time you had sexual intercourse, what was the relationship of your partner with whom you had sexual intercourse?	MARITAL PARTNER.....1 BOY FIREND.....2 SOME ONE ELSE JUST MET.....3 CASUAL AQUITANCE.....4	
410.	The last time you had sexual intercourse, was any condom used?	YES.....1 NO.....2 DON'T KNOW/DON'T REMEMBER..3	→Q701 →Q701
411.	Was the condom used to avoid to getting pregnant or avoid HIV/STIs?	TO AVOID A PREGNANCY.....1 TO PREVENT A DISEASE (HIV/STI).....2 TO PREVENT PREGNANCY & DISEASE3 DON'T KNOW/NOT SURE.....9	
412.	CHECK 410, ASK CONDOM USED WAS FEMALE OR MALE CONDOM	USED A MALE CONDOM.....1 USED A FEMALE CONDOM.....2	

SECTION 5: FERTILITY PREFERENCES

501.	**CHECK: STERILIZED (Q301a=1 or 2): → Q507** **PREGNANT (Q210=1):** **→ CONTINUE** **NOT PREGNANT OR UNSURE (Q210=2 OR 8): → Q601**		
502.	Now I have some questions about the future. After the child you are expecting now, would you like to have another child, or would you prefer not to have any more children?	HAVE ANOTHER CHILD 1 NO MORE / NONE 2 SAYS SHE CANNOT GET PREGNANT 8 UNDECIDED / DON'T KNOW 9	
503.	After the birth of the child you are expecting now, how long would you like to wait before the birth of another child?	MONTHS [ ][ ] 1 YEARS [ ][ ] 2 SOON / NOW 3 SAYS SHE CANNOT GET PREGNANT 4 OTHER (SPECIFY) 5 DON'T KNOW 9	
504.	Now I have some questions about the future. Would you like to have (a/another) child, or would you prefer not to have any (more) children?	HAVE ANOTHER CHILD 1 NO MORE / NONE 2 SAYS SHE CANNOT GET PREGNANT 8 UNDECIDED / DON'T KNOW 9	→Q507 →Q507 →Q507
505.	How long would you like to wait from now before the birth of (a/another) child?	MONTHS [ ][ ] 1 YEARS [ ][ ] 2 SOON / NOW 3 SAYS SHE CANNOT GET PREGNANT 4 OTHER (SPECIFY) DON'T KNOW 9	
506.	Do think your spouse/partner wants the same number of children that you want, more number than what you want, or fewer than you want	SPOUSE/PARTNER WANTS SAME 1 SPOUSE/PARTNER WANTS MORE 2 SPOUSE/PARTNER WANTS FEWER 3 Don't Know 4	

507.	**CHECK Q : 202** **HAS LIVING CHILDREN** If you could go back to the time you did not have any children and choose exactly the number of children to have in your whole life, how many would that be? **NO LIVING CHILDREN** If you could choose exactly the number of children to have in your whole life, how many would that be? **PROBE FOR A NUMERIC RESPONSE**	NONE..... 00 NUMBER..... ☐☐☐ OTHER (SPECIFY)..... 99	
508.	How many of these children would you like to be boys, how many would you like to be girls and for how many would the sex not matter?	NUMBER: Boys ☐☐ Girls ☐☐ Either ☐☐ OTHER (SPECIFY).....99	

509.	**CHECK:** **USING MODERN METHOD (Q303a=1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 or 8) → Q601** **ELSE→CONTINUE**		
510.	You have said that you are currently using family planning method, do you intend to use a method to delay or avoid pregnancy in the future?	YES..... 1 NO..... 2 DON'T KNOW..... 3	→Q601 →Q601
511.	Do you think that you or your spouse/partner will use some contraceptive method within the **next 12 months?**	YES..... 1 NO..... 2 DON'T KNOW..... 3	→Q701 →Q701
512.	(If at all you and your spouse/partner were to use a method) Which method would you prefer to use? **ONLY SINGLE RESPONSE IS POSSIBLE**	PILLS..... 1 CONDOMS..... 2 INJECTABLES..... 3 IUD..... 4 FEMALE STERILIZATION..... 5 MALE STERILIZATION..... 6	

513.	If you were to get family planning methods for yourself, who would you want to give you the methods? **ONLY SINGLE RESPONSE IS POSSIBLE**	MALE PROVIDER..... 1 FEMALE PROVIDER..... 2 DOES NOT MATTER..... 3	

SECTION 6: AWARENESS AND PERCEPTION OF FAMILY PLANNING SERVICE PROVIDERS

601 Now, I would like to ask you about places where a person can get advice or services for family planning.

(a) When you think of hospitals, clinics and organizations providing advice or services for family planning, what comes to your mind? Any others? **DO NOT READ OUT OPTIONS.**

(b) **ASK FOR ORGANIZATIONS NOT CODED IN (a)** I will read out the names of some organizations providing family planning. Please tell me if you have heard of these organizations or not?

Organization	**Q601(a) FP: SPONTANIOUS**	**Q601(b) FP: AIDED**	
Public Medical Sector	10	10	
Govt. hospital	11	11	
Govt. health centre	12	12	
Govt health post/clinic/station	13	13	
Other public sector health facility	14	14	
NGO or Trust Hospital /Clinic	20	20	
Banja La Mtsogolo Clinic	21	21	
Banja La Mtsogolo COCI	22	22	
Banja La Mtsogolo TOCI	23	23	
Blue Star Clinic	24	22	
Other NGO Clinic	25	23	
Private Medical Sector	30	30	
Other	40	40	

602.	**CHECK IF Q511=2 or 9, SKIPQ701** (a) Which of these places have you ever visited for advice or services related to family planning? (b) Thinking about the most recent occasion when you sought advice or services for		(a)	(b)
		Public Medical Sector	10	10
		Govt. hospital	11	11
		Govt. health centre	12	12
		Govt. health post/clinic/station	13	13
		Other public sector health facility	14	14
		NGO or Trust Hospital /Clinic	20	20
		Banja La Mtsogolo Clinic	21	21
		Banja La Mtsogolo COCI	22	22
		Banja La Mtsogolo TOCI	23	23

	family planning, where did you go?	Blue Star Clinic	24	24
		Other NGO Clinic	25	25
		Private Medical Sector	30	30
		Other	40	40

SECTION 7: AVAILABILITY AND ACCESSIBILITY OF FAMILY PLANNING SERVICES			
701.	What is the name of the nearest facility that provides family planning services to (village/place)?	[NAME]……...…….	
702.	Who provides the services?	GOVERNMENT ..... 1 MISSION/CHURCH ..... 2 PRIVATE ..... 3 BLM ..... 4 OTHER (Specify) 5	
703.	How far is the facility from here (in Kms or miles)?	KILOMETERS ..... 1 [_____] MILES ..... 2 [_____]	
704.	How do most people in your community get from here to (FACILITY NAME)?	CAR.....A MOTORCYCLE.....B PUBLIC TRANSPORT.....C BICYCLE .....D WALKING.....E OXCART .....F OTHER (Specify).....Z	
705.	How long does it take to get from here to (FACILITY NAME MENTIONED ABOVE) USING (MEANS MENTIONED IN…..)? **RECORD IN MINUTES IF LESS THAN 2 HOURS AND IN HOURS IF 2 HOURS OR MORE**	HOURS ..... 1 [_____] MINUTES ..... 2 [_____]	
706.	Is (NAME OF VILLAGE /PLACE) served by mobile outreach, that is, by a health unit that arrives regularly nearby to provide family planning services to persons in this community IF YES: What is the name of the outreach point? [_____]	[_ /__/__] NO MOBILE OUTREACH....00	

	(NAME) IF NO: RECORD ‘00’		

90	NOW I WILL READ YOU A NUMBER OF STATEMENTS THAT REFLECT DIFFERENT OPINIONS ABOUT FAMILY PLANNING AND PEOPLE WHO USE THEM. KEEP IN MIND THAT THESE OPINIONS ARE NOT RIGHT OR WRONG, BUT ARE JUST OPINIONS. PLEASE TELL ME IF YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS. **1** = AGREE, **2**=DISAGREE, **3**=NEITHER AGREE NOR DISAGREE, **4** = DON'T KNOW

CONDOMS: NOW I AM GOING TO READ STATEMENTS ABOUT CONDOMS, PLEASE STATE YOUR OPINION.

		MALE CONDOMS	FEMALE CONDOMS
a.	Condoms are available in many stores in this area.		
b.	I could easily get a condom if I wanted it		
c.	I do not have to go out of village to buy condoms.		
d.	Only free condoms are available in this village		
e.	Condoms priced higher are of better quality		
f.	Condoms priced higher are available only in saloons or in towns		
g.	Condoms priced higher are available only in medical stores or in towns		
h.	There is no difference between free condoms and condoms we purchase.		
i.	In your area, some women use female condoms for bungles		
j.	I do not like the look or feel of condoms		
k.	Condoms do not have any side effects		
l.	Condoms are for those who do wrong deeds.		
m.	Condoms sometimes remain inside the woman		
n.	Condoms cause eruptions on our body		
o.	The lubricant in condoms can cause infection		
p.	Condoms with dots, perfumes or extra lubrication are not available in our village.		
q.	Condoms are an effective method for maintaining a gap between births		
r.	Only free condoms are available in this village		
s.	Sometime condoms fail		
t.	Condoms sometimes remain inside the woman		
u.	Most people have not seen a condom closely		
v.	Most people do not know how to use a condom		
w.	I find condoms very easy to use		

x.	I find condoms very easy to dispose *after use*		
y.	I can persuade my spouse/partner to use condoms if I wanted to.		
z.	We have to depend on men to get condoms		

SECTION 9: ATTITUDES AND PERCEPTIONS REGARDING FAMILY PLANNING		
902	**INTERVIEWER TO SAY:** In the next few questions, I am interested in hearing your opinion on certain issues related to family planning methods and spacing between children. I will read out various things that people have said on these topics one by one. As I read out each one, please tell me whether you agree or disagree with the statement. **INTERVIEWER TO PROBE** if they **1 = AGREE 2=DISAGREE 3=NEITHER AGREE NOR DISAGREE 4= DON'T KNOW**	
(a)	Each additional child makes it more difficult for the family to educate all their children properly	
(b)	Each additional child makes the man work harder to meet the family expenses.	
(c)	If a woman gives birth to another child too soon after the previous, both her health and the child's health suffer.	
(d)	Wives are told not to worry about having too many children because they will be provided for by husbands	
(e)	With each child birth, a woman becomes weaker making her less able to do housework	
(f)	There is more quarrel and worries in families with many children.	
(g)	Couples who have only girl children keep trying for more children until they have a son	
(h)	When a woman gives birth to boys the family line is continued but when a woman gives birth to girls, the family line ends	
(i)	My spouse/partner does not see the need to avoid or delay pregnancy	
(j)	My spouse/partner does not see the need to use family planning methods.	
(k)	I am unable to discuss the need for family planning with my spouse/partner	
(l)	In our society, women cannot discuss family planning openly	
(m)	Other people mock women who have small families	
(n)	My mother-in-law believes that when a couple has self-control, there is no need to use family planning methods	
(o)	If destiny brings another child, we cannot help, as pregnancy is god's gift.	
(p)	My religion does not support use of family planning methods	
(q)	When a couple has self-control, there is no need to use any contraceptive method.	
(r)	Contraceptive methods harm a woman's body in some way or the other	
(s)	Natural methods are safer than using family planning methods	
(t)	Natural methods are more convenient to use than family planning methods	

903.	**ORAL PILLS: NOW I AM GOING TO READ STATEMENTS ABOUT ORAL PILLS, PLEASE STATE YOUR OPINION.** **1** = AGREE, **2**=DISAGREE, **3**=NEITHER AGREE NOR DISAGREE, **4** = DON'T KNOW				
a.	Pills are available in government hospitals and health centers.	1	2	3	4
b.	Pills are available in medical stores	1	2	3	4
c.	Pills are available in many stores in this area	1	2	3	4
d.	I could easily get pills if I wanted to use them	1	2	3	4
e.	I do not have to go outside the village to get pills	1	2	3	4
f.	It is very inconvenient to take a pill daily	1	2	3	4
g.	I am likely to forget to take pills regularly	1	2	3	4
h.	Pills which we have to take twice a week are more convenient	1	2	3	4
i.	Pills cause giddiness, headaches or weakness in most women.	1	2	3	4
j.	Pills cause menstrual irregularity.	1	2	3	4
k.	Pills cause problem in urination	1	2	3	4
l.	Pills cause swelling in the body	1	2	3	4
m.	Pills are likely to make me infertile	1	2	3	4
n.	Pills cause heat in the body.	1	2	3	4
o.	Pills are likely to suit me	1	2	3	4
p.	The treatment for side effects of pills is very expensive	1	2	3	4
q.	Even if I were to take pills regularly, I could become pregnant	1	2	3	4
r.	My spouse/partner does not allow me to take any pills	1	2	3	4
904.	**INJECTABLES: NOW I AM GOING TO READ STATEMENTS ABOUT INJECTABLES, PLEASE STATE YOUR OPINION.** **1** = AGREE, **2**=DISAGREE, **3**=NEITHER AGREE NOR DISAGREE, **4** = DON'T KNOW				
a.	I could easily get injectables if I wanted it	1	2	3	4
b.	There are hospitals or health centers near my village where I can get a injectables	1	2	3	4
c.	I can reach a hospital where injectables are available within 30 minutes by walk from my house	1	2	3	4
d.	Women should have 1–2 children before taking oral contraceptives	1	2	3	4
e.	Women who want to hide their contraceptive use are given injectables	1	2	3	4

f.	Women must be 35 years or older to receive an injectables	1	2	3	4
g.	Injectables are available in government hospitals and health centers.	1	2	3	4
h.	Injectables cause swelling in the body	1	2	3	4
i.	Injectables are likely to make me infertile	1	2	3	4
j.	Injectables cause heat in the body.	1	2	3	4
k.	Injectables causes weakness	1	2	3	4
l.	Women experience white discharge after using injectables	1	2	3	4
m.	Injectables make women gain weight	1	2	3	4
905.	**IUD: NOW I AM GOING TO READ STATEMENTS ABOUT IUD, PLEASE STATE YOUR OPINION.** **1** = AGREE, **2**=DISAGREE, **3**=NEITHER AGREE NOR DISAGREE, **4** = DON'T KNOW				
a.	I could easily get Copper-T if I wanted it	1	2	3	4
b.	There are hospitals or health centers near my village where I can get a Copper-T	1	2	3	4
c.	Doctors with expertise in Copper-T are not available near my village	1	2	3	4
d.	I can reach a hospital where Copper-T is available within 30 minutes by walk from my house	1	2	3	4
e.	Private doctors are better than government doctors for Copper-T	1	2	3	4
f.	General physicians do not know how to treat problems that may arise from Copper-T, only specialists can	1	2	3	4
g.	I would trust most doctors to insert a Copper-T properly	1	2	3	4
h.	Women using Copper-T suffer from backaches	1	2	3	4
i.	Women using Copper-T suffer from gastric problems	1	2	3	4
j.	Copper-T causes heavy or prolonged bleeding	1	2	3	4
k.	Copper-T causes weakness	1	2	3	4
l.	Women experience white discharge after using Copper-T.	1	2	3	4
m.	Copper-T causes wounds inside the body	1	2	3	4
n.	Copper-T climbs up the body of the woman	1	2	3	4
o.	Weak women do not take risk of using copper-T.	1	2	3	4
p.	If a woman does not take precaution then Copper-T hurts.	1	2	3	4
q.	During insertion of Copper-T, it hurts a lot	1	2	3	4
r.	Copper-T is not suitable for women who are weak	1	2	3	4
s.	Copper-T does not suit most women	1	2	3	4
t.	Copper T offers protection for a long time.	1	2	3	4

u.	Copper-T is very convenient since you do not have to use anything daily	1	2	3	4
v.	Copper- T does not burst the way condom does.	1	2	3	4
906.	**IMPLANTS: NOW I AM GOING TO READ STATEMENTS ABOUT IMPLANTS, PLEASE STATE YOUR OPINION.** **1** = AGREE, **2**=DISAGREE, **3**=NEITHER AGREE NOR DISAGREE, **4** = DON'T KNOW				
a.	I could easily get implants I wanted them	1	2	3	4
b.	There are hospitals or health centers near my village where I can get implants	1	2	3	4
c.	Doctors with expertise in insertion of implants are not available near my village	1	2	3	4
d.	Women who use implants as a family planning method are likely to have breast cancer, uterine cancer, and ovarian cancer.	1	2	3	4
e.	Using implants can cause birth defects in their babies	1	2	3	4
f.	Implants can cause hair loss, asthma, and headaches	1	2	3	4
g.	Implants will not affect the pregnancy or harm the fetus	1	2	3	4
h.	Implants can cause complications in the arm	1	2	3	4
i.	The insertion of implants requires surgery or that insertion is painful and causes infection	1	2	3	4
j.	Implants will reduce a woman's libido or affect a couple's sexual life in some way	1	2	3	4
k.	Using implants will cause infertility, delay the return of fertility after the implants are removed	1	2	3	4
l.	Implants should not be used by women who are young or who have not had children.	1	2	3	4
907.	**FEMALE STERILIZATION: NOW I AM GOING TO READ STATEMENTS ABOUT FEMALE STERILIZATION, PLEASE STATE YOUR OPINION.** **1** = AGREE, **2**=DISAGREE, **3**=NEITHER AGREE NOR DISAGREE, **4** = DON'T KNOW				
a.	Female sterilization is the best method for someone who does not want anymore children.	1	2	3	4
b.	After undergoing female sterilization, the couple does not need to worry about pregnancy at all.	1	2	3	4
c.	Female sterilization is very convenient – there are no hassles with this method.	1	2	3	4
d.	With female sterilization, there are no side-effects.	1	2	3	4
e.	Some people have become pregnant even after undergoing female sterilization	1	2	3	4
f.	Sterilization, like any other surgery can harm our body.	1	2	3	4
g.	I fear sterilization because of the pain during surgery.	1	2	3	4

h.	After sterilization people often experience a lot of back pain and gastric problems.	1	2	3	4
i.	The stitches do not heal and women keep bleeding for some time.	1	2	3	4
j.	Many women put on weight after sterilization.	1	2	3	4
k.	Women who are weak should not consider sterilazation	1	2	3	4
l.	After sterilization people will not be able to do heavy work - they cannot carry heavy things for at least 6 months.	1	2	3	4
m.	Because a woman will be unable to work after sterilization, she will become dependent on others.	1	2	3	4
n.	I can easily get a sterilization if I wanted to	1	2	3	4
o.	Sterilization services are available in private hospitals too.	1	2	3	4
p.	I can reach a hospital where female sterilization services are available within 30 minutes by walk from my house	1	2	3	4
q.	Most couples in my community use female sterilization to avoid pregnancies	1	2	3	4
r.	In terms of family planning, youth may be reluctant to seek services due to concerns about confidentiality,	1	2	3	4
s.	In terms of family planning, youth may be reluctant to seek services due to fears regarding side effects from certain methods.	1	2	3	4
t.	Adolescents, if they have parental consent can access family planning but that leads to promiscuity.	1	2	3	4

908. In your community, family members (husbands, in-laws, parents) and community leaders (religious leaders) exert considerable influence on women's decision to use a Family Planning methods
Husbands
In-laws
Parents
Community leaders
Religious leaders

	YES	NO	DK
a) Husbands…	1	2	3
b) In-laws	1	2	3
c) Parents	1	2	3
d) Community leaders	1	2	3
e) Religious leaders	1	2	3

909. In your opinion, is it acceptable or unacceptable for family planning methods to be discussed?
A) On the radio?
B) On the TV
C) In the Newspapers
D) Public place like markets
E) In Church/Mosques
F) In schools

	ACCEPT.	**NOT-ACCEP.**
RADIO	1	2
TV.....	1	2
NEWSPAPERS	1	2
PUBLIC PLACE	1	2
CHURCH/MOSQUE	1	2
SCHOOLS	1	2

910.	In the last few months have you heard/ seen anything about family planning: On the radio? On the television? In a newspaper or magazine? On a poster? On clothing (i.e., cap, chitenji, t-shirt)? In a drama? Somewhere else?	YES NO RADIO 1 2 TELEVISION 1 2 NEWSPAPER OR MAGAZINE.... 1 2 POSTER . . .. 1 2 CLOTHING. ..... 1 2 DRAMA . . . . 1 2 LEAFLETS..... 1 2 OTHER..... 1 2	
911.	In the last few months, have you listened to any of the following program series about family planning on the radio?	YES NO TIKAMBE ZA EDZI 1 2 TILERE…..... 1 2 BLM TALK SHOW 1 2 UBALE WATHU ..... 1 2 UFULU WA ANA 1 2	
912.	In the last few months, have you seen the following posters about the following Modern Family Planning Methods? CHECK 105: (ABLE TO READ)	YES NO Tubal Ligation 1 2 Injectables 1 2 Pills 1 2 Implants 1 2 Vasectomy 1 2 Condoms 1 2 IUCD 1 2 Emergency Contraception 1 2	
913.	In the last few months, have you seen the following posters about AIDS? CHECK 105: (ABLE TO READ)	YES NO Yezetsani Magazi lelo kuti muziwe za tsogolo lanu.....1 2 Ine ndinakayezetsa magazi anga ndipo ndikuziwa momwe ndilili…nanga inu?.....1 2 Pewani kugonana ndi anthu ambilimbili, edzi ndi matenda oopysa..1 2	

914.	Now I would like to ask you about a certain product BLM is providing for family planning. Have you ever heard of a family planning method called ZARIN?	**910A.** EVER HEARD?	**910B**. KNOW ZARIN?	**910C**. EVER USED?	
		YES.....1 NO.....2 **(END)**	YES.....1 NO.....2. . **(END)**	YES.....1 NO.....2..	

RECORD TIME AND END OF INTERVIEW TIME:

THANK AND END INTERVIEW

Appendix 2: **FACILITY QUESTIONNAIRE (Interview in-charge of family planning services)**

INFORMATION ABOUT THE INTERVIEW
Name of Interviewer …….....……. Date of Interview…… Time Interview Started……
Questionnaire checked and attested to be properly completed Name of Supervisor……Signature …… Date)……..……

Please read the following consent form:

Hello. My name is.....and I am working with Centre for Health, Agriculture, Development Research and Consulting (CHAD). On behalf of Adventist Health Services on a project called **"Community Outreach Family Planning Project**". We are carrying out an endlinestudyto assess the impact of the project on targeted beneficiaries, including primary beneficiaries (women of reproductive age) and secondary beneficiaries (men).

The results of this evaluation will be used to generate information on best practices and learning that

SECTION 1: FACILITY CHARACTERISTICS			
NO.	**QUESTION**	**CODING**	
6.1.1.1.1.1	Section 1A is to be completed by the interviewer (without asking questions of the client)		
Q101	Facility name	_____ ___	
Q102	Level of facility where interview took place.	**PUBLIC SECTOR**: Govt. Hospital Govt. Health Center Gov't Health Post/Outreach Mobile Clinic. HSA CBDA/Door To Door Other Public (specify)_____ **CHAM/MISSION** Hospital Health Center Mobile Clinic Door To Door **PRIVATE SECTOR**: Private Hosp/Clinic/ Doctor Pharmacy Mobile Clinic CBDA/Door To Door Other Private/Medical BLM MACRO Youth Drop In Centre	 1 2 3 4 5 6 98 8 9 10 11 12 13 14 15 16 17 18 19
Q103	Locality of facility	URBAN RURAL	1 2

SECTION 2: FACILITY INFORMATION						
NO.	QUESTION		CODING		SKIP TO	COMMENTS (regarding verifications) IS THIS FOR EVERY VERIFICATION
201	How long have you been working at this health facility?		YEARS |___|___| MONTHS |___|___|			
202	How long have you been working in this position?		YEARS |___|___| MONTHS |___|___|			
203	How many service providers are in this health facility? (IF NONE PUT 00)	1 2 3 4 5 6 7 8 98	MEDICAL ASSISTNAT CLINICAL OFFICER NURSE-MIDWIFE……. REGISTERED NURSE… AUXILIARY NURSE……. HSA SOCIAL WORKER…….. YOUTH FRIENDLY HEALTH SERVICEPROVIDER……. OTHER(SPECIFY)_____:	|__|__|__| |__|__|__| |__|__|__| |__|__|__| |__|__|__| |__|__|__| |__|__|__| |__|__|__| |__|__|__|		
204	How many support staff are in this health facility?		Number of support staff_____			

205	Is the facility providing family planning services?	YES NO		1 2

SECTION 3: MODERN CONTRACEPTIVE METHODS OFFERED AT SDP									
No.	**(1) Male condoms**	**(2) Female Condoms**	**(3) Oral Contraception**	**(4) Injectables**	**(5) IUDs**	**(6) Implants**	**(7) Sterilisation for Females**	**(8) Sterilisation for Male**	**(9) Emergency contraception**
301 Is this facility offering these FP services	**1 Yes**☐ **2 No**☐ **3 Not Applicable** (because "No" to item 011) ☐ *(Tick only one option)*	**1 Yes**☐ **2 No**☐ **3 Not Applicable** (because "No" to item 011) ☐ *(Tick only one option)*	**1 Yes**☐ **2 No**☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes**☐ **2 No**☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes**☐ **2 No**☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes**☐ **2 No**☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes**☐ **2 No**☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes**☐ **2 No**☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes**☐ **2 No**☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*

SECTION 4: NUMBER OF STOCK OUT OF MODERN CONTRACEPTIVE METHODS AT SDP									
Item	**(1) Male condoms**	**(2) Female Condoms**	**(3) Oral Contraception**	**(4) Injectables**	**(5) Emergency contraception**	**(6) IUDs**	**(7) Implants**	**(8) Sterilisation for Females**	**(9) Sterilisation for Male**
(i): NO STOCK-OUT IN THE LAST 7DAYSBEFORE THE SURVEY									
302	**1 Yes;** s☐ **2 No;** ☐ *(Tick only one option)*	**1 Yes;** ☐ **2 No;** ☐ *(Tick only one option)*	**1 Yes;** ☐ **2 No**☐ *(Tick only one option)*	**1 Yes;** ☐ **2 No;** ☐ *(Tick only one option)*	**1 Yes;** ☐ **2 No;** ☐ *(Tick only one option)*	**1 Yes;** ☐ **2 No**☐ *(Tick only one option)*	**1 Yes;** s☐ **2 No;** ☐ *(Tick only one option)*	**1 Yes;** ☐ **2 No**☐ *(Tick only one option)*	**1 Yes** ☐ **2 No;** ☐ *(Tick only one option)*
	(1) Male condoms	**(2) Female Condoms**	**(3) Oral Contraception**	**(4) Injectables**	**(5) Emergency contraception**	**(6) IUDs**	**(7) Implants**	**(8) Sterilisation for Females**	**(9) Sterilisation for Male**
303 If "Yes" (that this method has been out of stock **(STOCK OUT)** at this SDP on any given day within **the last seven days including today** please **indicate the main reason**	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐

	2 Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐	**2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐	**2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐	**2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐	**2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐	**2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ **5** Notrain staff to provide this contraceptive at the SDP ☐	**2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ **5** Notrain staff to provide this contraceptive at the SDP ☐	**2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ **5** Notrain staff to provide this contraceptive at the SDP ☐	**2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ **5** Notrain staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of

	7. Any other Reason (please specify)……. …… …… …	7. Any other Reason (please specify)……. …… …… …	7. Any other Reason (please specify)……. …… …… …	7. Any other Reason (please specify)……. …… …… …	7. Any other Reason (please specify)……. …… …… …	**6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify)……. …… …… …	**6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify)……. …… …… …	**6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify)……. …… …… …	this contraceptive ☐ 7. Any other Reason (please specify)……. …… ……

SECTION 5: STAFF TRAINING FAMILY PLANNING ***[To be responded to by all SDPs]***		
501 Are there staff working at this SDP who are trained to provide family planning services? *(Tick only one option)*	Yes 1☐ No 2☐	
Where was the training done	Pre-service In-service	1 2
502If yes; please indicate how many staff members are trained in provision of family planning services	[…….]	

503 Is any staff member trained for the insertion and removal of implant contraceptive, specifically? *(Tick only one option)*	Yes 1☐ No 2☐
504 If yes; please indicate how many staff members are trained for the insertion and removal of implant contraceptive	[……]
505 Are the trained staff actually providing FP services *(Tick only one option)*	Yes 1☐ No 2☐
506 If no to item 041 please indicate the reason why the staff is NOT actually providing FP services	_____ _____ _____ _____ _____open response
507 When last did any staff at this SDP receive training in provision of family planning services *(Tick only one option)*	In the last two months 1☐ Between two and six months ago 2☐ Between six month and one year ago 3☐ More than one year ago 4☐
508 Did the training exercise include the insertion and removal of implant contraceptive *(Tick only one option)*	Yes 1☐ No 2☐

Appendix 3: Focus Group Discussion Guide

CHECKLIST FOR FGD 15 -49 MEN_WOMEN

Focus Group Discussion Guide (MEN_WOMEN_15-49)

1. What do you understand by Family planning
2. Which ways or methods have you heard of? **DO NOT READ THE OPTIONS,**
3. Why do you think people use the mentioned contraceptive methods?
4. Who usually initiates theuse of family planning method in a family in this community?
5. What are the beliefs on family size from people in this village?
6. Do you think FP is only for women
7. What are the current beliefs around Modern FP methods in this village
8. What challenges do people face in using the method in this village
9. How do you resolve the challenges?
10. What are some of the barriers that have prevented people from using FP methods or other FP methods in this area?**PROBE**
11. What measures should be put in place to ensure your future use for people in this village?
12. What role do modern religious beliefs play in influencing access to and use of modern family planning methods in this village
13. Where do people obtain the family planning methods in this community?
14. Are you aware of community action groups (CAGs) on family planning?
15. What role have these groups played in promoting access to family planning?
16. What could be done to ensure that CAGs effective and sustainable

Appendix 4: Provides key informants that were interviewed in this survey with their designation and organization. A total of 25 key informants were interviewed.

Name	Designation	Position	Organization
Frank Makhilika	Service Provider	Senior HSA	Golomoti HC
Ballen Kampeza	Service Provider	HSA	Golomoti HC
James Phiri	Service Provider	Senior HAS	Edingeni HC
Memory	CBDA	CBDA	Mpemba HC
Iness Zenengeya	CBDA	CBDA	Mpemba HC
Rose Chathyoka	CBDA	CBDA	Mpemba HC
Paul Bekeseni	CBDA	CBDA	Mpemba HC
Edwin Mungondida	CBDA	CBDA	Mpemba HC
Jenipher Kwilashe	CBDA	CBDA	Kasina HC
Fanny George	CBDA	CBDA	Kasina HC
Lita James	CBDA	CBDA	Kasina HC
Alex Chiwoko	CBDA	CBDA	Kasina HC
Benjamin Wilson	CBDA	CBDA	Kasina HC
Etoman Jephter	CBDA	CBDA	Kasina HC
Enala Mwanyongo	Service provider	Senior HSA	Ng'onga HC
Watson Haluni	Service provider	Nurse	Lula HC
Astrida moyo	FP Coordinator	Nurse/midwife	Rumphi DHO
Glory Gondwe	Service provider	Nurse	Emfeni HC
Patrick Kaligambe	CAG Chair	CAG Chair	Kaundu HC
Austine Moyo	Service provider	Clinical officer	Rumphi BLM
Sam Mkandawire	Service provider	CBDA	Rumphi
Mrs Mary Mlombe Phiri	FP desk officer	FP desk officer	Reproductive Health Directorate (MoH)
Mrs Modesta Kasawala	FP desk officer	FP desk officer	Reproductive Health Directorate (MoH)
Denis Munthali	M & E and Project Coordinator	M & E and Project coordinator	AHS

Appendix 5: Exit Interview guide

Target group: Women and Men of reproductive age exiting Family Planning clinic

INFORMATION ABOUT THE INTERVIEW
Name of Interviewer …….....……   Date of Interview……   Time Interview Started……
Questionnaire checked and attested to be properly completed   Name of Supervisor……Signature …… Date) ……..……

Please read the following consent form:

Hello. My name is.....and I am working with Centre for Health, Agriculture, Development Research and Consulting (CHAD). On behalf of Adventist Health Services on a project called **"Community Outreach Family Planning Project**". We are carrying out an endlinestudy to assess the impact of the project on targeted beneficiaries, including primary beneficiaries (women of reproductive age) and secondary beneficiaries (men).

The results of this evaluation will be used to generate information on best practices and learning that can inform recommendations in order to improve uptake of family planning use and inform future AHS program development

SECTION 2: CLIENT BACKGROUND CHARACTERISTICS				
NO.	**QUESTION**	**CODING**		**SKIP TO**
6.1.1.1.1.2	Thank you for agreeing to participate in this interview. As I mentioned in asking for your consent, I would like to know about your feelings about the services that you just received. To begin, I am going to ask you some background questions about yourself.			
Q201	Sex of client (do not ask)	FEMALE MALE	1 2	
Q202	In what month and year were you born?	MONTH [__|__] DON'T KNOW MONTH 97 YEAR [__|__][__|__] DON'T KNOW YEAR9997		
Q203	Have you ever attended school?	YES (OUT OF SCHOOL NOW) YES (IN SCHOOL NOW) NO NO RESPONSE	1 2 3 95	 ➔ **Q206** ➔ **Q206**
Q204	What is the highest level of school you attended (or are attending): primary, secondary or higher? CIRCLE ONE	PRIMARY SECONDARY HIGHER	1 2 3	
Q205	Have you *ever* been married/lived with a sexual partner?	YES NO NO RESPONSE	1 2 95	 ➔ **Q208** ➔ **Q208**
Q207	How old were you when you first got married/started living with a sexual partner?	Age in years [__|__] NO RESPONSE 95 DON'T KNOW 97		
Q208	Are you *currently*……	MARRIED/ LIVING WITH SEXUAL PARTNER SINGLE SEPARATED/DIVORCED WIDOWED	1 2 3 4	
Q209	Do you/your partner have any living children? (PLEASE USE 'YOU' FOR FEMALE RESPONDENT AND 'YOUR PARTNER' FOR MALE RESPONDENT IN Q209-211	YES NO	1 2	 **Q213**
Q210	How many living children do you/your partner have?	Number |___|___|	

Q211	Do you want more children?	YES NO DON'T KNOW	1 2 97	
Q212	How long would you like to wait before the birth of another child?	MONTHS |__|__| YEARS |__|__| DON'T KNOW 97		**ALL ➔Q301**
Q213	Do you want children?	YES NO DON'T KNOW NO RESPONSE	1 2 3 95	
Q214	If you have more than one child, how long would you want to wait between having the first and second child?	MONTHS |__|__| YEARS |__|__| DON'T KNOW 97		
	SECTION: FAMILY PLANNING			
Q215	Are you currently using any FP method	YES NO	1 2	**➔Q**
Q216	What method are you currently using?	Oral Contraceptive Pill.....1 IUD (Intrauterine Device).....2 Injectables.....3 Implants.....4 Male Condom.....5 Female Condom.....6 LAM (Lactational Amenorrhea Method) .....7 Emergency Contraception.....8 Withdrawal.....9 SDM.....10 Don't know.....97 Other (specify).....98		
Q217	Were you provided with the family planning method of your choice at this SDP? *(Tick only one option)*	YES NO	1 2	
Q218	Did the family service provider take your preference and wishes into consideration in deciding on the family planning method you received? *(Tick only one option)*	YES NO	1 2	
Q219	Did the health worker teach you how to use the family planning method? *(Tick only one option)*	YES NO	1 2	
Q220	Were you told about the common side effects of the family planning method? *(Tick only one option)*	YES NO	1 2	

Q221	Did the health worker inform you about what you can do regarding the side effects of the family planning method should they occur? *(Tick only one option)*	YES NO	1 2	
Q222	Did the health worker inform you about any serious complications that can occur, as a result of using the family planning method, for which you should come back to the SDP should such occur? *(Tick only one option)*	YES NO	1 2	
Q223	Were you given any date when you should come back for check-up and/or additional supplies? *(Tick only one option)*	YES NO	1 2	
Q224	Have ever used any FP method apart from the one mentioned above?	YES NO	1 2	➔Q2
Q225	Why did you switch (Verbatim)			
Q226	Why are you not on any FP method?	Not married ……..……1 Do not engage in sexual activities …… 2		
SECTION 3: INFORMATION ABOUT SERVICES				
Q301	Is this your first visit to this health facility?	YES (First visit) …… 1 NO (Subsequent visit)…....2		**➔Q303**
Q302	Why did you return to this facility for services?			
Q303	Why did you come to this health facility today (for what service(s))? (CIRCLE ALL THAT APPLY)	Contraceptive counselling.....1 Contraceptive purchasing.....2 Prenatal care.....3 Postpartum care.....4 Counselling about nutrition.....5 Pregnancy test.....6 STI screening.....7 STI treatment.....8 HIV test.....9 Gynecological exam.....10 Peer counselling.....11 Abortion-related services.....12 Infertility consultation.....13 Maternal/neonatal healthcare....14 Other……..98		
Q304	Did you know that YFHS are provided to young people at this facility?	Yes.....1 No.....2 Don't know.....97		

Q305	How did you come to know that YFHS services are provided to young people at this facility? [Multiple Responses Allowed]	Through local media.....1 Pamphlets/posters.....2 Friends/peers.....3 A community member.....4 Parents.....5 Schools.....6 Social groups.....7 Health Care Delivery System.....8 Didn't know there were YFHS.....9 Other (specify).....98			
I would now like to ask you questions about your familiarity with YFHS services offered at this health facility.					
Q306	Is counseling provided to youth in this facility?	Yes.....1 No.....2 Don't know.....97			**➔Q308** **➔Q308**
Q307	What type of counseling is provided to youth at this facility? (CIRCLE ALL THAT APPLY)	Sexuality Safer Sex Pregnancy Prevention STI Prevention HIV Prevention	YES 1 1 1 1	NO 2 2 2 2	
Q308	What contraceptive methods are offered in this facility? (CIRCLE ALL THAT APPLY)	Oral Contraceptive Pill.....1 IUD (Intrauterine Device) .....2 Injectables.....3 Implants.....4 Male Condom.....5 Female Condom.....6 LAM (Lactational Amenorrhea Method).....7 Emergency Contraception.....8 Withdrawal.....9 SDM.....10 Don't know.....97 Other (specify).....98			
Q309	Are condoms provided to both males and females?	Yes.....1 No.....2 Don't know.....97			
Q310	Have you ever been asked to return to this health facility because the health facility was not able to supply you with what had been prescribed by your health provider?	Yes.....1 No.....2 Don't know.....97			**➔Q312** **➔Q312**

Q311	What did you have to return for? (CIRCLE ALL THAT APPLY)	Contraceptive method.....1 Medicine.....2 Testing.....3 Other.....98	
Q312	Is pregnancy testing offered at this facility?	Yes.....1 No.....2 Don't know.....97	
Q313	Is STI management offered at this facility?	Yes.....1 No.....2 Don't know.....97	
Q314	Have you received any STI management service at this facility?	Yes.....1 No.....2 No response.....95	**➔Q316** **➔Q316**
Q315	For what STI have you received this service?	HIV.....1 Syphilis.....2 Other (specify)_____98	
Q316	Is HIV testing offered at this facility?	Yes.....1 No.....2 Don't know.....97	
Q317	Have you been tested for HIV at this facility?	Yes.....1 No.....2 No response.....95	
Q318	Did you need services that were not provided at this facility?	Yes.....1 No.....2 Don't know.....97	**➔Q401** **➔Q401**
Q319	What services did you need that were not provided? (CIRCLE ALL THAT APPLY)	Contraceptive counselling.....1 Contraceptive purchasing.....2 Prenatal care.....3 Postpartum care.....4 Counselling about nutrition.....5 Pregnancy test.....6 STI screening.....7 STI treatment.....8 HIV test.....9 Gynecological exam.....10 Peer counselling.....11 Abortion-related services.....12 Infertility consultation.....13 Emergency contraception.....14 Other.....98	

Q320	Were you referred to a different facility for these services?	Yes.....1 No.....2 Don't know.....98	 **➔Q401** **➔Q401**
Q321	Where were you referred? (RECORD VERBATIM)		
SECTION 4: ACCESSIBILITY AND AFFORDABILITY OF THE HEALTH FACILITY			
Q401	How long did it take to reach the health facility from your home, workplace, or school?	Less than 15 minutes.....1 15-30 minutes.....2 30-45 minutes.....3 45 minutes – 1 hour.....4 More than 1 hour.....5 Can't Remember..... 96 Don't Know.....97	
Q402	What was your mode of transport to reach this health facility?	Walking.....1 Public transportation.....2 Own transportation.....3 Other (specify).....98	
Q403	How long did you wait before seeing a service provider?	Less than 15 minutes.....1 15-30 minutes.....2 30-45 minutes.....3 45 minutes – 1 hour.....4 More than 1 hour.....5 Don't Know.....97	
Q404	Did you see information material or display boards providing health information relevant to the health concerns of youth at this health facility?	Yes.....1 No.....2 Don't know.....97	
Q405	Was the time that you came to the facility convenient for you?	Yes.....1 No.....2 Don't know.....97	**➔Q407** **➔Q407**
Q406	Why was this time not convenient for you?	Open response	
Q407	Is there a different time that would have been more convenient for you?	Yes.....1 No.....2 Don't know.....97	**➔Q409** **➔Q409**
Q408	What time(s) would that be?	Open response	

Q409	Was the day that you came to the facility convenient for you?	Yes.....1 No.....2 Don't know.....97	**➔Q411** **➔Q411**
Q410	Why was this day not convenient for you?	Open response	
Q411	Is there a different day that would have been more convenient for you?	Yes.....1 No.....2 Don't know.....97	**➔Q413** **➔Q413**
Q412	What day(s) would that be?	Open response	
Q413	What was your fee for visiting the facility? (ENTER 0 IF SERVICES WERE FREE)	MK |__|___|___|___|___|___|.|__|___|	
Q414	Was this fee affordable for you?	Yes.....1 No.....2 Don't know.....97	
Q415	Did you purchase a contraceptive method today?	Yes.....1 No.....2 Method was free.....3	**➔Q418**
Q416	What was the fee for the contraceptive method?	MK |__|___|___|___|___|___|.|__|___|	
Q417	Was this fee affordable for you?	Yes.....1 No.....2 Don't know.....97	
Q418	Did you purchase medicine today?	Yes.....1 No.....2 Medicine was free.....3	**➔Q501**
Q419	What was the fee for this medicine?	MK |__|___|___|___|___|___|.|__|___|	
Q420	Was this fee affordable for you?	Yes.....1 No.....2 Don't know.....97	
SECTION 5: SATISFACTION WITH SERVICES PROVIDED			
Q501	What aspects were you satisfied with during your visit today?	Open response	

Q502	What aspects were you dissatisfied with during your visit today?	Open response	
Q503	Do you feel that you received the information and services that you wanted today?	Yes.....1 No.....2 Partially.....3 Don't know.....97	
Q504	Do you feel that your consultation with the health provider was too short, too long, or about the right amount of time?	Too short.....1 Too long.....2 About right.....3 Don't know.....97	
Q505	During this visit, did you have any concerns about health issues that you wanted to discuss with the provider?	Yes.....1 No.....2	**➔Q507**
Q506	Did the provider listen to your concerns to your satisfaction?	Yes.....1 No.....2	
Q507	During this visit, did you have any concerns about contraception that you wanted to discuss with the provider?	Yes.....1 No.....2	**➔Q509**
Q508	Did the provider listen to your concerns to your satisfaction?	Yes.....1 No.....2	
Q509	During this visit, did you have any other questions you wanted to ask?	Yes.....1 No.....2	**➔Q511**
Q510	Did the provider respond to your questions to your satisfaction?	Yes.....1 No.....2	
Q511	Did the provider encourage you to ask any other questions?	Yes.....1 No.....2	
Q512	During your visit, how were you treated by the provider that you met with?	Very well.....1 Well.....2 Not very well/poorly.....3	
Q513	During your visit, how were you treated by the other providers?	Very well.....1 Well.....2 Not very well/poorly.....3	
Q514	During your visit, how were you treated by the registration staff?	Very well.....1 Well.....2 Not very well/poorly.....3	
Q515	During your visit, how were you treated by the other support staff?	Very well.....1 Well.....2 Not very well/poorly.....3	

Q516	During your visit, did you feel that the provider's explanations were easy to understand, or did you feel that the provider was difficult to understand?	Easy to understand.....1 Difficult to understand.....2 Don't know.....97	
Q517	Did the provider do or say anything that made you uncomfortable?	Yes.....1 No.....2 Don't know.....97	**➔Q519** **➔Q519**
Q518	What did the provider do or say that made you uncomfortable?	Open response	
Q519	Did the provider do or say anything during your visit that led you to believe he/she did not approve of you?	Yes.....1 No.....2 Don't know.....97	**➔Q601** **➔Q601**
Q520	What did the provider do or say to make you feel this way?	Open response	
SECTION 6: COMFORT AND PRIVACY AT THE FACILITY			
Q601	Could anyone overhear the conversation you had with the provider?	Yes.....1 No.....2 Don't know.....97	
Q602	Did you meet with the provider in a separate room?	Yes.....1 No.....2	
Q603	Did you feel that when you were seeing the provider, it was very private?	Yes.....1 No.....2 Don't know.....97	
Q604	Do you believe that the information you shared with the provider will be kept confidential?	Yes.....1 No.....2 Don't know.....97	
Q605	Did the provider ask you to return for another visit?	Yes.....1 No.....2	
Q606	Did you set a date for your next appointment?	Yes.....1 No.....2	
Q607	Do you feel that this facility equally serves both young men and young women?	Yes.....1 No.....2 Don't know.....97	
Q608	Why do you feel this way?	Open response	
Q609	How would you rate the physical environment of the facility (cleanliness, toilet, waiting area)	Very good.....1 Good.....2 Fair.....3 Bad.....4	

		Very bad.....5	
Q610	Were educational materials available in the waiting room?	Yes.....1 No.....2 Don't know.....97	**➔Q612** **➔Q612**
Q611	Were the educational materials un the waiting room relevant to you?	Yes.....1 No.....2 Don't know.....97	
Q612	Were there signs or posters in the waiting room that were relevant to or appealing to youth?	Yes.....1 No.....2 Don't know.....97	
Q613	What could be done to attract more youth to use this facility?	Open response	
END: The interview is now complete. Thank you for answering these questions. Do you have any questions for me?			

Appendix 6: Facility Checklist

CHECKLIST FORKII

a. Are people in this village aware of Modern FP methods? What methods?

b. Do people in this village use modern FP methods?

c. What are the beliefs on family size from people in this village?

d. Do you think FP is only for women? Are partners involved in the use of FP methods?

e. What are the current beliefs around Modern FP methods in this village?

f. Are you aware of any side effects of mentioned on use FP?

g. What challenges do people face in using the method in this village?

h. How do you resolve the challenges?

i. What are some of the barriers that have prevented people from using FP methods or other FP methods in this area?

j. What measures should be put in place to ensure future use of FP methods in this village?

k. What role do modern religious beliefs playing influencing access to and use of modern family planning methods in this village.

l. Are you aware of community action groups (CAGs) on family planning?

m. What role have these groups played in promoting access to family planning?

n. What could be done to ensure that CAGs effective and sustainable?