HEALTH COMMUNICATION CAPACITY COLLABORATIVE

Findings from a Qualitative Study About Influences on Adolescent Sexual and Reproductive Health in Rural Areas of Madagascar

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USAID FROM THE AMERICAN PEOPLE

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Cover Photo: Young mother with baby, Madagascar © 2017, Tilly Gurman.

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ACRONYMS

AC	Agent Communautaire (Community Health Worker)
CIA	Central Intelligence Agency
CPR	Contraceptive Prevalence Rate
CSB	Centre de Santé de Base (Community Health Center)
DHS	Demographic and Health Survey
FGD	Focus Group Discussions
FP	Family Planning
HC3	Health Communication Capacity Collaborative
HIV	Human Immunodeficiency Virus
IDI	In-depth Interview
IRB	Internal Review Board
IUD	Intrauterine Device
LARC	Long-Acting Reversible Contraceptives
mCPR	Modern Contraceptive Prevalence Rate
MDGs	United Nations Millennium Development Goals
MSI	Marie Stopes International
PSI	Population Services International
RH	Reproductive Health
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	Women of Reproductive Age

EXECUTIVE SUMMARY

In Madagascar, between 1992 and 2008, the contraceptive prevalence rate (CPR) increased from 17 percent to 40 percent while the total fertility rate (TFR) decreased from 6.1 children per woman of reproductive age (WRA) to 4.8 children per woman. Despite these strides, however, recent rates of teenagers (ages 15 to 19) who are pregnant or have had a child vary between urban (17 percent) and rural areas (35 percent) (Demographic and Health Survey [DHS], 2008). In a country like Madagascar, where more than 60 percent of the population is under 24 years old and living in rural areas (Central Intelligence Agency, 2016; the World Bank, 2016), bridging this disparity is required in order to continue increasing the CPR and reducing the TFR.

With these realities in mind, the United States Agency for International Development (USAID) Mission in Madagascar commissioned the Health Communication Capacity Collaborative (HC3) project to conduct a sexual and reproductive health (SRH)/family planning (FP) study of young adolescents (ages 10 to 19) in the rural areas of four diverse regions (Anamalanga, Atsinanana, Menabe and Sofia) in terms of ethnicity, access to services, demographics and SRH indicators. During December 2016, the study team conducted in-depth interviews (IDIs) with very young (ages 10 to 14) adolescent females, and focus group discussions (FGDs) with slightly older (ages 15 to 19) adolescent females. To gain additional perspectives about other factors that may influence adolescent SRH, the study team also conducted FGDs with males (ages 15 to 19) and IDIs with health care providers (both facility- and non-facility-based).

A total of 169 adolescents ages 15 to 19 (37 males and 132 females) participated in the FGDs. A total of 31 adolescent females, ages 10 to 14, and 26 health care providers (e.g., “agents comunautaires” [ACs], midwives and doctors) participated in IDIs. Results from the IDIs and FGDs with adolescents uncovered that injectables were the most popular method of FP among youth, followed by the calendar method or fertility beads. Adolescent participants also discussed beliefs regarding FP methods, including advantages and disadvantages.

A deeper analysis of the 78 transcripts uncovered four overarching themes reflecting the ways in which rural Malagasy adolescents view SRH. First, adolescents described the role of fear and shame in the decision-making process regarding various SRH behaviors. For example, the fear and shame associated with getting pregnant drove decision-making regarding sexual initiation and use of FP. Second, both adolescents and providers described female adolescents’ SRH beliefs and behaviors as being heavily influenced by interpersonal relationships, and largely by parents and friends. Third, across all groups of participants, there was a notion that there is an appropriate FP method for every individual. Finding the right fit was inextricably linked to both the age and parity of a young woman seeking FP. Finally, female respondents and providers described the process of seeking and obtaining FP as a set of written and unwritten rules, which weighed standard medical eligibility and sociocultural tradition and practice. Standardized and expected etiquette and protocol during a visit with a provider included consideration of individual choice, but ultimately resulted in providers making prescriptive decisions based on socio-cultural ideology and justified by a set of predetermined screening criteria.

Findings from the current study shed light on perceived facilitators and barriers to SRH for rural adolescents from the perspective of adolescents as well as health care providers. This study fills a gap in available literature about adolescents in Madagascar by looking specifically at adolescents living in rural areas. In addition, by having spoken with younger adolescents, this study highlights a group of adolescents often overlooked by research.

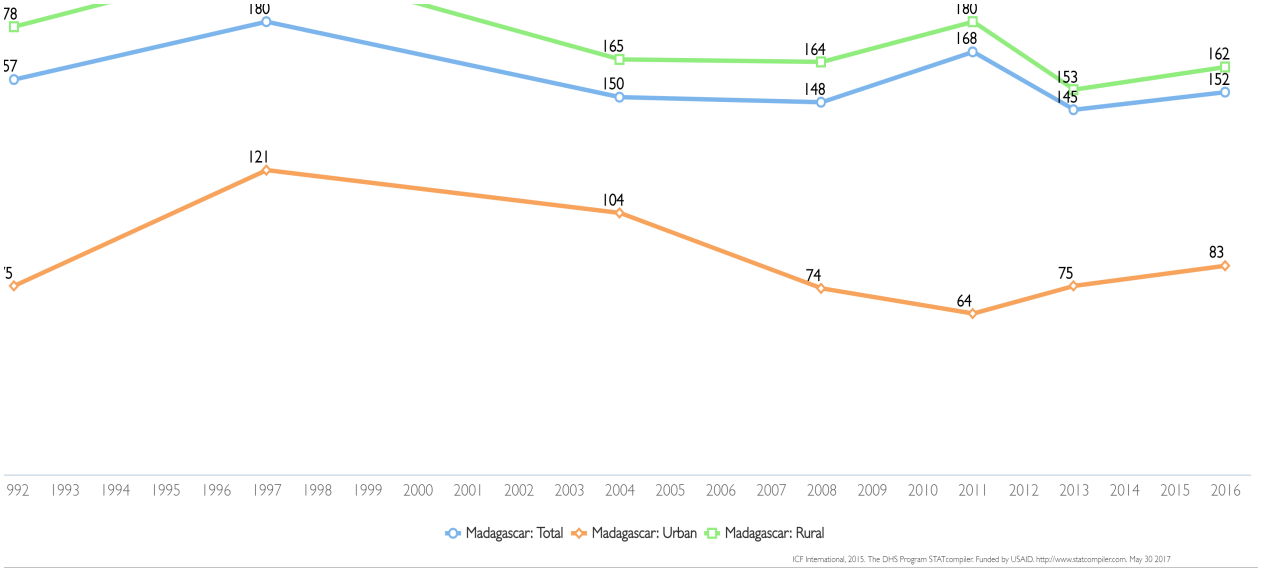
INTRODUCTION

BACKGROUND

Goals set through the United Nations (UN) Millennium Development Goals (MDGs), the London Summit on Family Planning and the UN Sustainable Development Goals highlight the importance of sexual and reproductive health (SRH) in low- and middle-income countries (United Nations Population Fund [UNFPA], 2014; FP2020, 2016; UN, 2016; UN, 2017). These goals are particularly relevant and important to the health of the population of Madagascar, as they address access to family planning services, information and supplies (UNFPA, 2014; FP2020, 2016; UN, 2016; UN, 2017). Madagascar has made great strides towards improving SRH and maternal health. Between 1992 and 2008, the contraceptive prevalence rate (CPR) in Madagascar increased dramatically, from 17 percent to 40 percent (DHS, 2008). During the same time period, the total fertility rate (TFR) of Madagascar fell from 6.1 children per woman of reproductive age (WRA) to 4.8 children per woman (DHS, 2008). Despite this encouraging progress, 19 percent of Malagasy women continue to have unmet need for contraception, with vast disparities in access between rural and urban Madagascar (DHS, 2008).

Bridging the gaps in the unmet need for contraception is especially important for those living in rural areas, where women still give birth to an average of 5.2 children (DHS, 2008). The median age at first sexual intercourse among rural women (17.1 years) was younger than that of urban women (18.3 years) (DHS, 2008). Over the last two decades, the CPR among rural women who are married (37.2 percent) has remained consistently lower than that of married women in urban areas (54.3 percent) (DHS, 2008). In addition, teenage birth rates and fertility rates are all higher in rural areas of Madagascar compared

Figure 1. Age-specific Fertility Rate (per 1,000 15 to 19 Year-old Females), Madagascar, 1992-2016



to urban areas (DHS, 2008). Figure 1 below compares urban versus rural adolescent fertility rates in Madagascar over time.

Not only does data indicate SRH disparities between urban and rural Madagascar, but they also show disparities between Malagasy adolescents and older women. Among WRA in Madagascar, the rate of modern contraceptive use was lowest among adolescents ages 15 to 19 years (18 percent) (National Statistics Institute, 2013). In 2008, 32 percent of Malagasy teenage girls (ages 15 to 19) were pregnant or had a child, with dramatic variation between urban (17 percent) and rural areas (35 percent) (DHS, 2008).

PURPOSE

Adolescence is a critical life stage marked by transitions between childhood and young adulthood, including experimentation with independence, sexuality and relationships. The World Health Organization (WHO) defines young people as individuals between the ages 10 and 24, with adolescents representing a subset comprising of individuals 10 and 19 years of age (WHO, 2014). Family planning (FP) and reproductive health (RH) research about young people most often focuses on individuals between the ages 15 and 24. Rarely are there studies that focus on the full age range of adolescents or are findings about adolescents teased out from studies that encompass the larger age classification of young people. As a result, little is known about adolescents' unique FP/RH needs and perspectives. Insight about very young adolescents (ages 10 to 14) is even scarcer. FP/RH programs, therefore, may not have the data needed to effectively reach very young adolescents with information, services and assistance to help prevent potentially harmful circumstances such as early marriage, unintended pregnancy and early childbirth (Igras et al., 2014).

In Madagascar, where more than 60 percent of the population is under 24 years old, circumstances are no different (Central Intelligence Agency [CIA], 2016). A 2012 Madagascar portfolio review by United States Agency for International Development (USAID)/Washington's Youth and Health Advisors found the country's youth programs focused heavily on unmarried youth between 15 and 24 years of age, but did not necessarily address the FP/RH needs of young people outside of this age range, nor of young married women or youth living in rural areas (Lane & Andriamiadana, 2012). The 2013 United Nations (UN) Millennium Development Goals (MDGs) Survey found that approximately 20 percent of maternal deaths were among women between 15 and 19 years old (INSTAT, 2013). In 2008, the Government of Madagascar included FP in one of its eight 2007-2012 Madagascar Action Plan commitments (Government of Madagascar, 2007). More recently, as a part of the "Campaign on the Accelerated Reduction of Maternal Mortality," the Government of Madagascar committed to reducing maternal mortality, a problem that significantly affects adolescents ages 15 to 19, by 2019 (Minister of Health, 2014). However, adolescent RH programs currently focus more on urban populations and tend to promote condoms over comprehensive FP methods (Lane & Andriamiadana, 2012). Few programs focus on rural youth, which is an issue of concern since they tend to experience marriage at a younger age, as well as higher fertility and maternal mortality rates.

With these priorities and the SRH of adolescents in Madagascar in mind, in October 2015 the USAID Mission in Madagascar asked the Health Communication Capacity Collaborative (HC3) to conduct a comprehensive SRH/FP study of adolescents. In December 2016, HC3 conducted a qualitative study of adolescents (ages 10 to 19) in rural Madagascar. This report details study findings and includes recommendations for potential future research and programs focused on SRH for adolescents in rural areas of Madagascar.

OBJECTIVES

The qualitative study of adolescents (ages 10 to 19) and health providers in rural Madagascar sought to answer the following research questions:

- What are the social, cultural and economic factors that influence adolescents' RH choices in Madagascar?
- What factors promote or facilitate early pregnancy and/or childbearing?
- What are the factors that facilitate or hinder adolescents from seeking and accessing RH/FP services?

The study investigated how the following factors affect SRH and FP behaviors:

- Attitudes, perceived social norms, gender norms and practices related to SRH (e.g., FP, sexual behaviors and pregnancy)
- Partner communication and SRH/FP decision-making among young couples
- Youth access to and utilization of SRH/FP services
- Health care providers' attitudes towards youth accessing SRH services (e.g., sexually transmitted infections [STIs], FP and pre-natal services)

METHODOLOGY

HC3 in collaboration with Tandem, a Madagascar research firm, conducted the qualitative research at the end of 2016. Training of data collectors occurred in November 2016. Data collection and transcription took place December 2016-January 2017, and data analysis occurred January-March 2017.

Location

HC3 identified a potential set of regions with the intent of establishing a diverse representation of the population in Madagascar, including ethnicity, access to health services, literacy rate and a range of RH indicators. The selected indicators, although not solely about adolescents, portrayed a general landscape of the status of women's RH, from sexual debut to adolescent pregnancy to unmet need for contraception. This study employed the following RH indicators:

- Percent of modern contraceptive use among currently married or sexually active women of reproductive age (15 to 49 years old)
- Median age at first marriage (women 25 to 49 years old)
- Median age at first sexual intercourse (women 25 to 49 years old)
- Median age at first birth (women 25 to 49 years old)
- Percent of unmet need for FP services among currently married or sexually active WRA (15 to 49 years old)
- Percent of adolescents (15 to 19 years old) who are pregnant with their first child or who have children

HC3 conducted regional selection in consultation with USAID/Madagascar and USAID/Washington, as well as the selected local research firm, Tandem. Insecure regions were not eligible for selection. After this process, HC3 finalized the four regions (Sofia, Atsinanana, Analamanga and Menabe) to include in the study. The selected regions represented four of the 15 of USAID priority regions for community-based FP service outreach. Two of the regions—Anamalanga and Atsinanana—represented regions with relatively favorable adolescent SRH outcomes whereas the other two regions—Menabe and Sofia—represented regions with relatively poor SRH outcomes.

Among the selected regions, Menabe and Sofia lag behind the national average in terms of the modern CPR (mCPR) among married women, median age of first marriage, timing of sexual debut and median age at first birth. These two regions also have roughly double the unmet need for FP services among married women compared to Anamalanga and Antsinanana (see Table 1). Compared to the other three regions as well as the national average, Analamanga has a higher literacy rate and CPR, and a lower percentage of adolescents that either are pregnant or have a child.

Participants

The study focused primarily on females between the ages of 10 and 19, and investigated two age groups of young women in particular: very young (ages 10 to 14) and slightly older (ages 15 to 19). For the older adolescent females, HC3 wanted to explore the experiences of adolescents who currently had children as well as adolescents who were not mothers. In order to keep the sample more clearly distinct, adolescent females who had carried a pregnancy but currently had no living children were excluded.

To gain additional perspective about other factors that may influence young women's ability to engage in healthy SRH behaviors, the study also engaged young males (ages 15 to 19) and health care providers (facility- and non-facility based). Health providers included community health workers (known in

Madagascar as “agents communautaires” [ACs]) with varied amounts of vocational training, or clinical personnel such as nurses, midwives or doctors.

Table 1. Relevant Indicators for Regional Selection for Madagascar Adolescent Study

	REGION				NATIONAL AVERAGE
	Analamanga	Atsinanana	Menabe	Sofia	
Literacy rate among women (15 to 49 years old)	95.8	78.4	52.5	84.9	74.7
Use of modern contraception among currently married or sexually active women (15 to 49 years)	39.2	37.0	26.9	17.9	29.2
Median age at first marriage (25 to 49 years old)	20.1	19.8	17.6	17.4	18.9
Median age at first sexual intercourse (25 to 49 years old)	18.8	17.2	16.5	16.7	17.3
Median age at first birth (25 to 49 years old)	21.6	19.0	18.0	16.9	20.1
Unmet need for FP among currently married or sexually active women (15 to 49 years)	18.5	11.1	19.7	17.1	19.0
Percent of adolescents who are pregnant with their first child or who have children (15 to 19 years)	17.9	30.5	60.4	56.3	31.7

Data sources: (Institut National de la Statistique, 2010)

In order to be eligible for the study, all adolescents had to have lived in the geographic location of data collection for at least the previous 12 months. Adolescents in foster care, with cognitive disabilities or in prison were ineligible to participate in the study. Eligible health providers had to have worked in the particular location for at least the previous 12 months.

Recruitment process

Tandem’s data collection team recruited individuals using purposive sampling at the community level. The most common type of rural health facility is a “centre de santé de base” (CSB). CSB Managers at both public and private CSBs were asked to suggest health providers that provide SRH/FP advice or services to adolescents in the data collection area that were interested in participating in the study. Both ACs and clinical personnel are supervised by CSB Managers.

The study’s data collection team managed recruitment of research participants, and community participation and support was critical to our recruitment process. Data collectors presented to each CSB Manager the written proof of study approval from the Ministry of Public Health’s National Ethics Committee as well as the written approval from the regional (“Direction Régionale de la Santé Publique”) and district health authorities (“Service de District de Santé Publique”). Data collectors contacted parents and adolescents with the help of an AC or the Fokontany Chief. ACs, Fokontany Chiefs or data collection staff listed potential research participants (e.g., names, telephone numbers and addresses) for the purpose of discussing their eligibility or organizing recruitment based on where they live.

When recruiting male and female adolescents ages 10 to 19, the data collection team visited the Fokontany Chief and the CSB Manager in each study location. The CSB Manager then identified an AC affiliated with that CSB who suggested potential research participants to the data collection team and who also served as their guide to the community. Likewise, the Fokontany Chiefs suggested adolescents that might participate. The data collection team verbally described the study to the Fokontany Chief.

Data collectors read aloud the appropriate recruitment script in the potential research participant's house or in an otherwise private and comfortable setting. Data collectors approached potential participants in a quiet location and in a discrete manner to maximize their privacy and comfort. If a parent's eligible minor was not present or at home when the data collection team member approached them, the data collector arranged to meet the adolescents when and where the parents suggested the adolescent(s) were available.

When recruiting health care providers, the CSB Manager suggested eligible staff. The data collector then selected staff to recruit for the study. Only health professionals identified by the CSB Manager were eligible to participate.

Human Subjects Considerations

Data collectors obtained consent/assent from potential participants in a discrete manner to maximize privacy. They read the appropriate assent/consent form aloud to participants which described the purpose of the study, what is expected of participation and the risks and benefits of the study, as well as the voluntary and confidential nature of the study. Data collectors obtained oral, as opposed to written, consent and assent for participation, due to low literacy concerns. Adolescents age 18 and over, health providers and parents and legal guardians of adolescents under the age of 18 gave oral consent. Adolescents under the age of 18 gave oral assent. The study received IRB approval from the Johns Hopkins University Institutional Review Board (IRB) as well as from the National Ethics Committee in Madagascar.

Data Collection

Tandem trained data collectors for three days at the end of November 2016 about the research and the specific data collection instruments. In addition, in order to optimize the formatting and wording of data collection instruments, Tandem, via their data collectors, piloted each instrument for several days at the beginning of December 2016. Tandem selected a community in the Anamalanga region for piloting, which was similar to, but not one of, the regions they would visit later for actual data collection.

Data collectors obtained qualitative data through a combination of in-depth interviews (IDIs) and focus group discussions (FGDs)—all conducted in Malagasy (see Appendices 1-3 for the data collection instruments in English). Tandem conducted a total of 20 FGDs with adolescents ages 15 to 19 (16 with females and 4 with males). In addition, Tandem stratified FGDs for young women based on parity (having no children versus having one or more child). Due to limited study resources as well as the consideration that parity is less likely of a critical factor in influencing young men's opinions about SRH/FP, no stratification for males occurred. For the younger cohort of adolescent women (10 to 14 years) Tandem conducted IDIs and not FGDs because young adolescent females would likely feel more at ease discussing SRH topics in a more-private, one-on-one setting. The use of several retrospective questions gained insight into the male experience during early adolescence (10 to 14 years). In addition to collecting data from female and male adolescents, Tandem conducted IDIs with health care providers in each study region. The IDIs represented a mix of public and private health providers. (See Table 2 for distribution of research activities across regions.)

Table 2. Qualitative Research Activity Totals, by Region and Type of Participant

Activity (# per region)	Number of individuals per region				Total # activity	Total # participants
	Anamalanga	Atsinanana	Sofia	Menabe		
FGDs						
Males 15 to 19 years old (1)	9	12	8	8	4	37
Females 15 to 19 years old, without children (2)	16	17	16	16	8	65
Females 15 to 19 years old, with children (2)	16	19	16	16	8	67
Subtotal	**41**	**48**	**40**	**40**	**20**	**169**
IDIs						
Females 10 to 14 years old	8	8	8	7	31	31
Health care providers	7	5	8	6	26	26
Subtotal	**15**	**13**	**16**	**13**	**58**	**57**
Total adolescents						**200**
Total health care providers						**26**
Total all participants						**226**

FGDs and IDIs with Adolescents

In order to engage adolescents, the study employed a variety of interactive activities. These activities asked individuals to share their opinions and attitudes, while not asking them directly about their personal behavior. HC3 decided to take this approach, not only because we felt it would engage adolescents more, but it would also allow individuals to "save face" and not have to share any more than they felt comfortable. The latter point was especially relevant for the context of Madagascar, where saving face is an important cultural value. The activities used included the following:

- **Timeline (for IDIs with 10 to 14 year old young women only):** Interviewers asked young women to create a timeline of events that mark the transition between being a girl and becoming a woman. The interviewer asked the young woman to describe each event in terms of its significance in marking the transition to adulthood.
- **Vignettes (all adolescents):** Facilitators/interviewers read aloud vignettes, displayed a poster of the characters in the vignettes and asked questions about them. The vignettes focused on situations regarding sexual debut/initiation, unintended pregnancy and transactional sex. Facilitators/interviewers asked participants to give their opinion on the characters and events in the vignettes and what they or their friends might do in similar situations.
- **Drawings (all adolescents):** Facilitators/interviewers asked participants to draw a picture of a health provider that s/he might go to for SRH/FP services and then asked to discuss characteristics of each of these health providers to determine what factors influence their care-seeking behaviors.

For FGDs, a gender concordant facilitator and a note-taker conducted FGDs in a private setting with minimal distractions using a semi-structured FGD guide centered on the vignettes and drawings described above. For IDIs with young women, a female interviewer conducted IDIs using a semi-structured interview guide which incorporated the three activities described above. Data collectors recorded FGDs and IDIs using digital recording devices.

IDIs with Health Care Providers

At each location, an interviewer conducted IDIs using a semi-structured interview guide. IDIs asked providers to describe their daily routine as well as the factors that facilitate and prevent adolescents from using contraception. Interviewers also asked health providers about what types of FP methods adolescents ask for, if at all, and how they ask for them. Data collectors recorded IDIs using digital recording devices.

Data Analysis

Tandem transcribed the Malagasy digital recordings from the IDIs and FGDs and then translated the transcripts into French. Tandem and HC3 used Atlas.ti 7/Atlas.ti Mac to organize and manage all transcripts, timelines and drawings.

Data analysis encompassed two stages. The first stage included deductive coding, whereby Tandem applied a set of pre-determined general codes to the French transcripts (see Appendix 4 for the list of deductive codes). These pre-determined codes originated from the content areas within the research instruments as well as from an initial scan of the available published research literature relevant to rural adolescent youth in Madagascar. Deductive codes included a range of topics such as attitudes, social norms, and gender norms for various SRH behaviors (e.g., sexual initiation, use of FP). Early on in the deductive coding process, Tandem engaged in double coding for 16 transcripts (20.5 percent). These transcripts represented all four regions as well as all types of study participants. Pairs of coders independently coded transcripts and then compared results from their application of deductive codes. They agreed upon the final coding and discussed their decisions with the larger team. This process of double-coding served as a practical training opportunity for the Tandem research team while also helped to ensure greater reliability in the final dataset of coded transcripts. Upon completion of this double-coding process, Tandem then individually assigned the rest of the transcripts across coders.

The second stage of data analysis employed inductive coding based on a grounded theory approach (Corbin & Strauss, 2008). For this stage, Baltimore HC3 staff travelled to Madagascar to work intensively onsite with Tandem. During a three-week time-period, the combined HC3/Tandem team conducted manual coding to identify themes that captured the way in which study participants spoke about the deductive code topics. The larger research team applied this analysis to the deductively coded qualitative data. The larger team then categorized and organized the newly generated themes in order to establish larger overarching themes that explain the factors that influence rural adolescent SRH in Madagascar.

RESULTS

Participant Characteristics

A total of 226 individuals (200 adolescents and 26 providers) participated in the study (see Table 3 for participant characteristics, separated by adolescents and health care providers). Among adolescents, 18.5 percent were male and 81.5 percent were female. Among providers, 30.8 percent were male and 69.2 percent were female. ACs represented the majority of providers, followed by midwives (69.2 percent and 15.4 percent, respectively).

Table 3. Participant Characteristics (N=226)

		n	%
Adolescents (N=200)			
Gender	M	37	18.5%
	F	163	81.5%
Age	10 to 14	31	15.5%
	15 to 19	169	84.5%
Region	Anamalanga	49	24.5%
	Atsinanana	56	28.0%
	Menabe	47	23.5%
	Sofia	48	24.0%
Parity	Parity = 0	65	49.2%
(Adolescent females ages 15 to 19 only)	Parity ≥1	67	50.8%
Health Care Providers (N=26)			
Gender	M	8	30.8%
	F	18	69.2%
Age	20 to 29	2	7.7%
	30 to 39	6	23.1%
	40 to 49	7	26.9%
	≥50	7	26.9%
	Missing	4	15.4%
Region	Anamalanga	7	26.9%
	Atsinanana	5	19.2%
	Menabe	6	23.1%
	Sofia	8	30.8%
Type	Doctor	3	11.5%
	Midwife	4	15.4%
	AC (Community Health Worker)	18	69.2%
	Dispensatrice	1	3.8%

Adolescent Beliefs about FP Methods

When discussing what methods of FP were most popular among young people, adolescents overwhelmingly stated that the injectable was the most popular, followed by calendar method or fertility beads and oral contraceptive pills. Adolescents discussed beliefs regarding FP methods in general as well as towards specific methods. The beliefs encompassed advantages and disadvantages as well as beliefs about for whom the particular method was appropriate and its side effects (see Table 4). No distinction in beliefs existed by gender, age group, or parity of adolescents.

Table 4. Beliefs Expressed by Adolescents About Specific FP Methods

FP METHOD	BELIEFS			
	Advantages	**Disadvantages**	**Appropriate for…**	**Side effects**
Injectable	➢ No period ➢ Less risk of forgetting ➢ Possible to have a child after stopping ➢ Easy to hide use from others	➢ No period ➢ Can cause a miscarriage ➢ Hormones accumulate in the body	➢ Not appropriate for Antandroy people (Menabe) ➢ Good for women without children ➢ Good for students Good for minors ➢ Good for adult women	➢ Fatigue ➢ Headache ➢ Weight gain ➢ Sterility ➢ Destroys uterus
Implant	➢ Lasts a long time ➢ Presence of period ➢ Possible to have a child after stopping ➢ More effective compared to other methods	➢ Hormones spread throughout the body and make the body sick over time ➢ Painful insertion	➢ Good for adult women ➢ Good for women with children ➢ Not good for minors	➢ Skin reaction ➢ Destroys your bones ➢ Destroys uterus
IUD	➢ Does not bother user during sexual activity ➢ Does not hurt the body ➢ Lasts a long time	➢ Provoke sickness	➢ Good for adult women	➢ Sterility ➢ Destroys uterus
Oral contraceptive	➢ Presence of period ➢ Easy to access	➢ Risk of forgetting to take everyday ➢ Risk of parents/partners finding out ➢ Hormones accumulate in body ➢ Can cause a miscarriage	➢ Good for students and minors ➢ Not good for students ➢ Not good for minors	➢ Stomach ache ➢ Weight gain ➢ Weight loss ➢ Destroys uterus ➢ Risk of getting cancer
Condom	➢ Prevent pregnancy and sickness at the same time ➢ Easy access ➢ No side effects	➢ No pleasure	➢ Good for minors	

Fertility beads/ calendar	➢ Learned at school ➢ Better for the body ➢ No side effects ➢ Natural ➢ Easy to use	➢ Not effective ➢ Risk of messing up ➢ Complicated	➢ Good for minors ➢ Good for students ➢ Good for women without children	
Abstinence		➢ Not effective	➢ Good for unmarried	

Where to Access to SRH Counseling and Services

Adolescents also discussed the various places where young people go for SRH counseling and/or services (see Table 5). Across all four regions, adolescent respondents consistently named the CSB as a place where young people go for both counseling and services. Across all four regions adolescent respondents named the AC as a resource for counseling whereby they named the pharmacy and "matrone" (i.e, midwife/birth attendant) as where to go for services.

Table 5. Where Adolescent Participants Mentioned that Adolescents Go for Sexual and Reproductive Health Counseling (C) or Services (S)

	Anamalanga	Menabe	Sofia	Atsinanana
Centre de santé de base (community health center)	C/S	C/S	C /S	C/S
Pharmacy	S	S	S	S
Dispensary	C/S			
Agent Communautaire (community health worker)	C	C/S	C	C
Seecaline	S	S		S
Marie Stopes		C/S		C/S
Top réseau (Population Services International)	C/S			
Matrone	S	S	S	S
Guérisseur	S			
Sorcier			S	

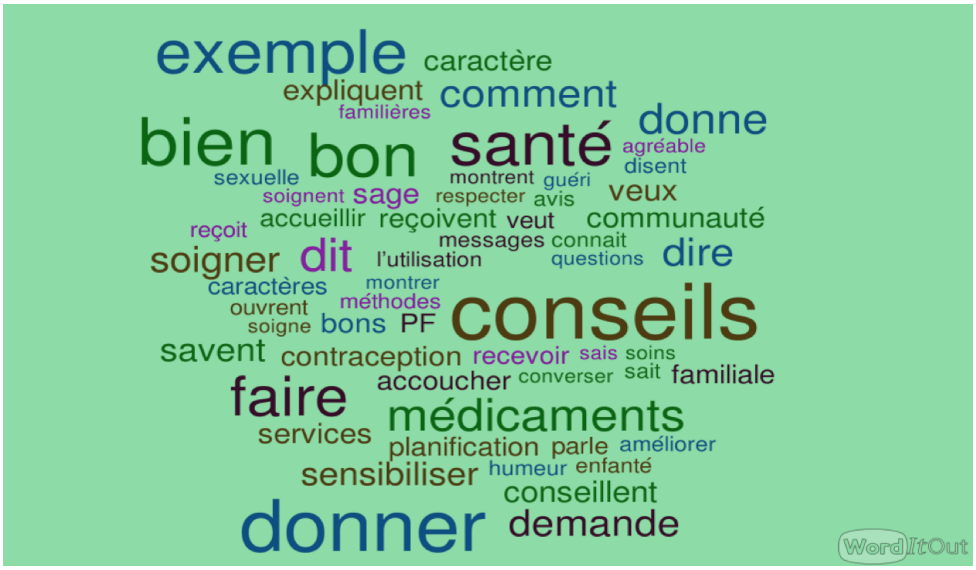
Legend:

Publicly- or privately-funded location	
Non-governmental organization	
Publicly-funded location	
Alternative/traditional provider	

Perceived Treatment of Adolescents by Providers

In general, adolescent respondents expressed positive attitudes about the way in which adolescents are treated when seeking SRH care services. Facilitators asked adolescents what they felt providers did well and in what way they could improve. Figure 2 illustrates the type of words commonly used by adolescents to describe the way in which providers treat adolescents. Words around counseling (i.e., "conseils," and "conseillent"), medications ("medicaments"), cure (e.g., "soigner," "soigne," and "soins"), and health ("santé"), as well as verbs like give ("donner"), do ("faire"), explain ("expliquent") were especially prominent.

Figure 2. Words Used by Adolescents to Describe the Way in Which Providers Treat Adolescents



Several providers reiterated similar perspectives when describing how they treated adolescents. For example, a 50-year-old male AC from Sofia described the type of FP education ("sensibilisation") he would provide to young people saying, "our strategy for educating and raising awareness, for example, is about students—those that are in school… They arrive and I go over to the young people, and I ask questions." Similarly, a 30-year old female AC from Menabe described the care she provided as:

> *"I train the young people and educate them. Me, I'm always educating. I educate young people. During HIV activities, I educate them about faithful relationships with men, staying with one woman, staying with one man, and using condoms."*

When asked to describe what sources of information adolescents use regarding FP, the same AC stated:

> *"Some are informed by their friends. Depending on how you receive people, people assess your quality of welcome by the smile, your gentleness towards people. Thus [friends say], 'Go there.' Moreover, with us, we give credit, we give credit, and that's what draws the students to us more than anything... A girl comes and complains to me that, 'I don't have money to practice that thing [FP]. Give it to me and I'll bring you the money on Saturday.'"*

Although adolescents expressed general satisfaction when asked about how providers treat adolescents, they, nevertheless, commented that there was room for improvement. Specifically, they mentioned the need for providers to improve their communication skills with adolescents. Figure 3 illustrates the type of words commonly used by adolescents to describe the way in which providers could improve. Adolescents offered suggestions such as to be less strict and severe ("séverè"), to scold adolescents less often, to create a calmer environment that is more private and confidential and to educate/raise awareness ("sensibiliser") adolescents more often. They also mentioned that they think providers should give adolescents what they ask for during an FP visit more often as opposed to having a fixed idea of what they will or will not provide adolescents.

Figure 3. Words Used by Adolescents to Describe the Way in Which Providers Could Improve Their Treatment of Adolescents

Influences on Adolescent SRH

After further review of all the data extracted from the deductive coding stage of qualitative analysis, four primary themes that described the various influences on adolescent SRH emerged (see Appendix 5 for additional quotations organized by the themes below). These themes applied to all types of adolescent respondents, regardless of age or gender, as well as all types of providers. The four themes included the following:

1. **Internalizing perceived judgment:** Fear and shame in decision-making
2. **Influence of others:** The decision is not just the young female's
3. **Finding the right fit:** What one can tolerate versus what fits one's lifestyle
4. **Rules of engagement:** Written and unwritten rules

Theme 1: Internalizing Perceived Judgment: Fear and Shame in Decision-making

Adolescents as well as providers across all four regions used words such as "peur" (fear) and "honte" (shame) to describe feelings that adolescents might hold about various SRH behaviors. For transactional

sex, fear rarely came up in discussion among adolescents, although shame from the community occasionally was mentioned as a negative consequence. For sexual initiation, FP and unintended pregnancy, fear and shame was frequently highlighted. Interestingly, the fear and shame associated with sexual initiation and use of FP seemed to be more about a fear of getting pregnant rather than a fear of the behavior itself. For example, many adolescents mentioned fear of getting pregnant as a motivating factor for FP as well as for delaying sexual initiation. Moreover, the fear around pregnancy revolved around either a fear of disappointing parents or a fear of being stigmatized in the community as opposed to a fear about the physical consequences or risks associated with carrying a pregnancy.

In addition, although fear of pregnancy could motivate an individual to initiate FP, adolescents also talked about the fact that adolescents feared both parents and community members finding out about their FP use, especially if they were either too young, unmarried or without children. As a result, adolescents and providers both mentioned that an adolescents' preferred FP method was often based on the ability to hide its use. For example, a 42-year-old AC stated, "for example, for young people, sometimes they hide it [using FP] from their parents, and it is here that they use the injectable. If they take the pill and take it home, their parents can find out, so they use the injectable."

Another associated fear which adolescent respondents often described was a perceived severity of FP side effects. In particular, adolescents talked about severe perceived consequences of long-term use of FP methods, such as sterility, irreversible damage to the uterus, fetal damage or even death. When talking about these consequences, adolescents did not use the word fear, although they did express concern for the long-term damage they perceived FP methods such as the IUD, implant and injectable could inflict.

For example, a 10-to-14-year-old female from Menabe described the use of IUDs, stating that if an umarried girl uses an IUD, then has it removed in order to get pregnant after marriage, the resulting child may be "damaged" or disabled in some way. Later, when asked about the consequences of using another hormonal method such as the birth control pill or injection, she similarly explained, "the consequence is first of all wanting to have children, and this child will inevitably be destroyed or somewhat mentally handicapped or even sterile, that is to say, that she will not be able to have children."

Once an individual has decided she wants to use FP, adolescents also expressed fear and potential shame of talking to a provider and asking for FP. For example, a young mother (age 15 to 19) from Sofia was asked if she felt that there were things the doctor does that might keep an adolescent from speaking openly. She answered:

> *"She is ashamed to say 'Doctor, I am here to ask for advice to have sex'. She is, therefore, ashamed to reveal that since the doctor scolds. She is still a student, therefore she is ashamed."*

Similarly, a 15-to-19-year-old female without children from Anamalanga summarized, "when the doctor asks the reason for her visit, she is afraid to say it."

At the same time, while some adolescents alluded to fear and shame caused by projecting what the provider may or may not say, other adolescents described situations where adolescents might feel shame due to feeling scolded or treated in a severe manner by providers. When explaining the communication that occurs between adolescents with a doctor, for example, an adolescent (age 15 to 19) from Anamalanga said:

"When the doctor asks something, for example, and scolds her a lot, and that's where she feels uncomfortable. She is a little hesitant even to talk to the doctor... For example, the doctor is a man, she is ashamed to talk to the doctor and she is not comfortable in this instance... She is still a minor, the doctor is obliged to speak him harshly to her, 'What's your hurry?'"

Theme 2: Influence of Others: The Decision Is Not Just the Female's

Both adolescents and providers described female adolescents' RH beliefs and behaviors as being heavily influenced by interpersonal relationships, and largely by parents and friends. For example, for sexual initiation, many adolescent respondents commented that parents generally discouraged adolescents from initiating sex before marriage. Parents were described as having specific expectations including that a minor should not engage in sex and that a student must be dedicated to his or her studies without the interference of a love life or sexual relationships. For example, a young adolescent female from Sofia responded to a question about what a parent would tell his/her son about initiating sexual activity. She stated, "his mother will tell him not to do stupid things given that he is still a minor, and that he is still too young to have a girlfriend!"

When asked what type of advice they would give to a friend who is contemplating initiating sex, many adolescent respondents provided advice about waiting until marriage. However some respondents did mention that friends could often be a source of bad advice, leading to early sexual initiation.

Providers seemed to play a more secondary role, if at all, in influencing sexual initiation, as they were often advising in response to an adolescent seeking FP. While providers continually mentioned how they counsel and encourage young girls to wait to have sex, adolescents mentioned that providers serve the least influential role in this behavior. A 59-year-old AC from Menabe stated, "but one should always encourage her, encourage her to behave in a healthy way, you are still a student, it is better to first pay attention to behavior and avoid having sex. However, if she is already in it, you must always advise her to use FP."

Although respondents did not explicitly mention partner influence on sexual initiation, adolescent females did discuss scenarios where sexual relations were influenced by pressure from their partners. This pressure could often lead to seeking FP to stay in a relationship or to ensure monogamy.

For example, a 15-to-19 year-old mother from Menabe remarked in response to a question about how she would respond if her boyfriend wanted to initiate sex but she was not sure what she wanted:

"If it was me, if he loves me, he will wait until I am ready to do it [sex]. But if he forces me to do it, because people these days force you to do what you don't want to do, then you are obliged to use a condom… I have no choice, since if I refuse, then he will go look for someone else. Then we use condoms to protect ourselves!"

When discussing transactional sex, FP and unintended pregnancy, however, adolescent participants described parents and friends as able to both encourage and inhibit those behaviors. When discussing interpersonal influences on whether or not an adolescent female engages in transactional sex, many male and female adolescent respondents stated that a young woman's friends play a major role. Specifically, the desire to compete to be fashionable or to collect luxury goods is a facilitator for some adolescent girls to engage in this type of behavior. For example, a young mother from Menabe stated, "because she sees her girlfriends follow fashion and she also wants to do the same." To a lesser degree,

adolescents commented that male friends may also encourage one another to engage in transactional sex.

The role of parents in transactional sex was largely discussed as both a strong facilitating and prohibiting influence on young women. Adolescents mentioned that parents were a primary influence for stopping a young woman from engaging in transactional sex. At the same time, some adolescent respondents described the opposite scenario, where parents encouraged transactional sex among their daughters in order to alleviate the burdens of poverty, including the need for money and food.

For example, a young mother from Anamalanga described the role of parents in transactional sex, stating "maybe she sees all the difficulty her family is going through, and her parents do not have the means, so her body has become a source of income, that is, she has become like a prostitute." Another young woman without children from Atsinanana described a more indirect influence of parents, stating, "her family is poor and she wants to get out of her parents' poverty."

For FP, adolescents mentioned that parents and friends could facilitate use of a contraceptive method. Providers also gave examples of parents accompanying their daughter to a visit. For example, a 50-year-old male AC from Sofia stated, "for the children who are still young enough, it is the parents themselves who accompany them here."

There was a positive association between an adolescent using FP and the notion of "protection" from actions that may "destroy" one's future. Adolescents repeatedly discussed influences and advice from parents as a concern for the direction of their life, especially with regard to focusing on school and having success.

A 48-year-old female doctor from Menabe highlighted:

> *"Have they come by themselves or with someone when you're talking about young girls around 15 years old? Are there other people who have come with them or do they come by themselves? … Their girlfriends, their school friends? Sometimes her mother comes with her, because their mothers know. The custom, or rather the mentality here, is not to forbid the girls to do anything, no matter what they do. Once they have grown up, so as not to have children, the parents prefer to say, 'use a family planning method.' … But eventually, for those who are older, who are 20 years old and up, they come by themselves. But for the youngest ones, they are accompanied by the boy, by a girlfriend or by their mother. It's really the mother who brings her: 'here she is, she wants to use FP because she already has a boyfriend.'"*

Providers also saw themselves as more than just as a point of access for obtaining a method. In particular, providers self-described as playing a role in FP counseling and helping a young woman decide what is appropriate for her. Adolescents similarly mentioned that they seek information and counseling on FP methods from providers, especially from ACs.

Theme 3: Finding the Right Fit: What One Can Tolerate Versus What Fits One's Lifestyle

Across all groups of participants, a common belief was that there is an appropriate FP method for every individual. Determining the right fit was based on two reinforcing but different concepts. The first concept was the notion of "supporter"*,* or the body's physical ability to tolerate a particular type of method. Some methods were believed to be harmful or too powerful for a particular type of adolescent. The second concept was the idea of finding a method that suits someone ("ce qui convient"*),* or fits the daily lifestyle of a particular young person. For the latter concept, appropriateness of a method was

dependent on a variety of lifestyle factors and current realities around how to access and use a method. Although these two concepts were based in different justifications for a particular method choice, they were both inextricably linked to both the age and parity of a young woman seeking FP. For example, a young mother (age 15 to 19) from Menabe described when she was 18 years old and went to a midwife for the first time,

> *"The midwife needs to ask 'what's convenient for you' and she needs to analyze ... Like me, the first time I did it, she [the midwife] asked me what is right for you and I told her that I did not know and 'I came to you.' And she asked me how old I was, and I told her I was 18 years old!"*
>
> She continued,
>
> *"The midwife told me about it. And she examines the health status of the people who come. And she asks for their age, and there she knows what [FP method] is suitable. For example, if she already has a child, she says, 'Here's what suits you'."*

The process of establishing the appropriateness of a method could include consideration of what the body can tolerate. Responses from both providers and adolescents suggested that perspectives around parity and age were part and parcel to the norms dictating when it is appropriate for an adolescent female to use FP. The belief that there were distinct differences between very young females without any children and older adolescent females with children (and likely also married) influenced whether or not hormonal methods or any methods outside of abstinence were appropriate. For example, some respondents believed certain methods were only for adults and not minors. When discussing an appropriate method for young women, a young mother (age 15 to 19) from Sofia remarked, "you see they are still children—they are not yet 18. And if she is still a child, she could not tolerate the powerful injectable."

Another young mother from Anamalanga specified that a non-hormonal method like cycle beads was best for a young adolescent, saying:

> *"The necklace [fertility beads] are best suited for Voahirana because she is too young, very small and still a minor. In order not to destroy her body, so that she does not introduce hormones into her body, but just counts the days!... She should use the necklace [fertility beads] because she wants to have children later on. So she should not take the pill or injection, because pills and injections destroy if you have not yet given birth."*

An overall belief existed that the body of young woman without children is unable to tolerate hormonal contraception in general. In addition, there were also concerns around a young woman's ability to tolerate specific side effects, including weight gain/loss, headaches, stomachaches, bone deterioration, acne or allergic reactions and fatigue. Some of these concerns were based on accurate knowledge of potential side effects. For example, a young adolescent (age 10 to 14) from Anamalanga summarized the idea of tolerating certain methods when she declared:

> *"Everything is effective as I said earlier. But the side effect manifests itself differently in everyone. There are those who gain weight after using it. There are those who lose weight. If she has become too thin, if she has dizziness, if she often has headaches, it means she cannot handle it, so it's better that she stops."*

At the same time, many respondents also mentioned fear or concern around side effects that were based on misconceptions and beliefs about certain methods. For example, many adolescents espoused the belief that FP can cause sickness, lead to sterility and destroy the uterus. A young mother (age 15 to 19) from Sofia illustrated this point when she commented, “it dirties the uterus. There are people who have fibroids, cysts—be careful with that. There are some that are sterile, and it gets serious. That is the reality. It does not suit me.”

Providers also mentioned the need to address rumors and misconceptions around FP methods. A male doctor from Anamalanga described a conversation with a young female patient:

> *“The most common thing is that if you use it, you become sterile. This is what is most widespread, as 'it causes cancer, it seems.' These are all rumors. So the education given is that these rumors are false. Those who have received an education have been informed that this is not true. By educating, we explain that even if problems arise, even if breast cancer cases exist, we explain to teen girls that it has no connection.”*
>
> He continued:
>
> *“That's how it happens. She talks. I ask her what she wants me to do for her. 'No, I do not know, it's you, doctor, who knows'. That's what she says. And while discussing, she says: 'I am apprehensive about the ingestion of pills because of the risks of cancer, it seems. I am afraid of injectables because it seems that it can make you sterile.' It is more or less like that. I ask her what method she finds reassuring. After reflection, it is the condom that solves her problems.”*

Often, misconceptions were encompassed by a more general concern of taking “medicine” or putting any foreign or unnatural products in the body. Adolescent females expressed an aversion to staying on any FP method for very long since a young girl’s general health and RH could be affected. Sometimes this idea was justified by the notion that a method that infiltrates the body a certain way will have quicker or longer-lasting effects on an adolescent’s health. When discussing the long-term effects of FP on the body, a young adolescent female (age 10 to 14) from Atsinanana commented, "the consequence of FP? It is possible, how to say, it can lead to, when we practice the FP for too long, it can cause injury to the uterus."

She continued to explain the effects of an implant stating, "this can hurt the uterus in the end, if it lasts, and this can also spread... It spreads to the arms, the whole body. It spreads everywhere."

In addition, when describing the type of advice she would offer an adolescent female wanting to choose an FP method, a female adolescent (age 15 to 19) from Menabe rationalized:

> *“For me, the advice I will give to Soa is to use something. They should use condoms, because, I say why, there are some who cannot tolerate injectables, the Pilplan. And it may ruin your body. That’s it. She can tolerate anything. So condoms it is!”*

Through many of the transcripts, the duration of a method was found to influence preference based not only on how long it is perceived to last in the body but also how often it needs to be replaced or how often one might need to return to the provider for a refill. Implants and injectables were often considered to last a long time and to allow a user to quickly or easily get pregnant if she should decide to at any time. Pills were also often thought of as a choice that was appropriate for ensuring fertility thereafter, as long as a user did not use the method for “too long.” In fact, some respondents—both

adolescents and providers—mentioned the importance of preparing for pregnancy and even “preparing the body” in order to rid the body of medicines that may have affected fertility. A young adolescent (age 10 to 14) from Atsinanana discussed negative effects of hormonal FP (i.e., injectables and pills) on the body, stating “maybe we may become sterile.” And she continued, explaining how one might prepare herself for pregnancy "and before they first give birth, they 'cleanse the womb' at the health center."

In addition to knowledge and beliefs about who is able to tolerate FP in general or specific FP methods, adolescents and providers also discussed the appropriateness of a method based on various lifestyle factors and current realities affecting convenience. Responses revealed an internal conflict between the belief that one’s body might not be able to tolerate a method and that it may be dangerous (e.g., cause sterility) versus having a method that is more convenient, easier to access/use or to hide, etc. The preference to choose what was most convenient employed notions around what adolescents heard or saw among their friends, beliefs around what was easier to use (based on the method, itself, or a young woman’s ability to understand how to use it effectively), and what aligned most with their plan for future pregnancies. For example, adolescents and providers often mentioned that continuation of certain methods could be easy to forget, including replacing an implant after three years or taking a pill every day. A young mother (age 15 to 19) from Menabe explained why one might choose an injectable over the pill when she declared, "use the injection because if you take Pilplan, you risk forgetting, then you can get pregnant if you forget once!"

Several providers similarly agreed that method choice was often dictated by a young adolescent’s concern or fear of forgetting to take a daily method. For example, a 50-year-old female AC from Anamalanga discussed what her patients often preferred, saying:

> *“Often, it is the injectable they prefer because it is every three months that one does it. And they prefer when there is no risk of forgetting. They have only to count "it's been three months,’ and they just look at the appointment in the notebook. And often, it [injectable] is the most appreciated and the most used.”*

Both adolescents and providers overwhelmingly referred to injectables and condoms when mentioning ease of use. In addition, injectables were described as easy to hide or keep private from parents, partners and the larger community. Despite responses that indicated that the calendar method was not easy, young adolescents (and in particular, those with children) agreed that it was a more appropriate method for minors. Justification partly came from the belief that because young girls were taught how to use the calendar method in school that, therefore, the method was easily accessible to students. A young adolescent from Atsinanana explained how students understood the calendar method saying, "for me it's a bit like that too, because she can know how to use the 14th day since she is a student and since grade five she has already learned this. So she already knows."

Furthermore, adolescents mentioned that providers were likely to prescribe methods that required awareness of the menstrual cycle to students. A young mother (age 15 to 19) from Menabe explained, “they will give her the necklace [fertility beads] because she's still a student! Because she knows how to count the days!"

Similarly, providers explained that after injectables, many adolescents, especially students, preferred cycle beads. A 50-year-old male AC from Sofia said “it's the injectable they [adolescents] ask for the most, then fertility beads ... It is the necklace [fertility beads] that the students ask for the most."

A 30-year-old female AC from Sofia also specified students' preference for fertility beads or the calendar method said:

> *"There are young people who just come to talk. But there are also those who are determined to use family planning and that is the reason for their coming. And I give them the choice, saying 'Family planning is not just the injectable, but there are others. For example, you young single people and students, you can use the necklace [fertility beads] or follow your cycle [calendar method]. You can use this because you are able to master it yourself.' Some learn right away to use this. It is for this reason that they like to come to see me, asking me to teach them to use the cycle [calendar method] and necklace [fertility beads].*

Theme 4: Rules of Engagement: Written and Unwritten Rules

Female respondents and providers described the process of actually seeking and obtaining an FP method as a dichotomous set of written and unwritten rules that balance standard medical eligibility and cultural traditions and practice. These written and unwritten rules dictated the process during a visit to an AC, midwife, or doctor and simultaneously reinforced the construct of finding the right fit (based on beliefs regarding both physical tolerance and lifestyle factors). Standardized and expected etiquette and protocol during a visit with a provider included consideration of individual choice, but ultimately resulted in prescriptive decisions based on socio-cultural ideology and justified by a "critère du criblage" (screening criteria). For example, one 46-year-old male AC from Sofia explained, "it depends on the screening criteria. I ask the questions [and if I determine] it is not suitable for her body, then she cannot do that option."

Providers and adolescents similarly discussed the process of a typical visit for FP services. The expectation that an adolescent must first discuss their problems and request counseling before requesting FP was mentioned by many adolescents as well as providers. An adolescent female (age 15 to 19) from Atsinanana described what happens during a typical visit, stating: "she should not, for example, ask for contraception immediately, but she first asks for advice. She asks for advice from the AC."

Although providers did not mention that communication between provider and patient for an FP visit follows a specific protocol, providers' perspectives about an unwritten protocol of communication was similar to adolescents' perspectives. For example, when describing a typical visit, a 50-year-old female AC from Anamalanga explained:

> *"I give her advice immediately. First, if you cannot pay attention to yourself [follow the calendar method], you must use contraception, since there is not yet a man ready to take you in marriage. In addition, it will cause a problem for your parents and for you to be pregnant without being married. Second, I tell her that it is when you start your period, that is when one should start to use contraception."*

Providers mentioned that they used a standard form to guide any FP visit. The form seemed to play a critical role in deciding whether or not an adolescent would receive an FP method and providers and adolescents often referred to the importance of being eligible for FP. Often, providers would mention the process of completing the screening criteria form to assess which method is the best fit. Two ACs from Sofia described a typical FP visit and the role of the screening criteria on client eligibility of a method:

"For example, she comes. I talk to her about the injectable and I look at the criteria for screening. If she does not tolerate it, I tell her about the necklace [fertility beads]. If she is not open for that, I refer her to the CSB II." – 50-year-old male AC

"Because it depends on the screening criteria. I ask the questions, her choice does not suit her. I ask questions, it does not suit her body... she can not do that thing then." – 46-year-old male AC

Providers described using the form to collect demographic information like age, marital status, occupation/student, parity, date of first menstruation, etc., as well as health vitals or assessments, including blood pressure, weight, height and history of headaches, for example. The information guided discussion on potential side effects of particular methods, including weight gain/loss, irregular periods, fatigue, headaches, stomachaches and abdominal pain. It also provided an opportunity for discussion around misconceptions, and some providers mentioned how they attempted to educate youth during each visit. When describing the impact of misconceptions on FP use and how she addresses misconceptions, a 48-year-old female doctor from Menabe said:

"There are also rumors because it is not necessarily us. It is not only when they arrive here, but during education activities with ACs. When we educate people, because before, we had quotas to reach, we did a lot of awareness raising and education about family planning. And it is these rumors that hinder people. [Some believe] 'this [FP] leads to the birth of handicapped children to use this.'"

Another provider (a female midwife) from Atsinanana discussed specific misconceptions around implants explaining:

"First, she must know what she wants to use. And also, she must know the effects of what she wants to use before doing so. But if she does not know what she is doing—she does not know the effects—and she still does it, that's why they become, because before they did not talk about it. For example, Implanon, we did not show them the effects, and they come to say that there is a lot of bleeding or things like that. People talk and [say] 'I'm going to remove that because it is not good for me.' But what you have to show them is that this medication is like that, and these are its effects."

The notion of what the body could tolerate given potential side effects, was taken into account through the process of assessing what method is most appropriate for a patient. The screening criteria form was intended to encourage a conversation and allow a patient to choose with informed consent. And while providers mentioned the importance of considering the patient's desire for a certain method, the process was also influenced by providers' misconceptions and biases about what was deemed most appropriate based on age and parity of a woman. For example, if a woman is very young, unmarried and without any children, a provider may hesitate to prescribe her a hormonal method. An FP method's ease of use also influenced some providers' decisions about whether a certain method was more appropriate for a student or very young female. Although part of the standard questionnaire collected basic demographic information that should not necessarily dictate eligibility for a certain method, certain questions including whether or not she was a student, married or in a relationship were considered when assessing eligibility. Some providers also mentioned hesitation to prescribe any FP method to students without any children and only considered a non-hormonal method like fertility beads or the calendar method or even condoms. For example, a 43-year-old female midwife from Sofia mentioned prescribing a non-hormonal method to a young patient who had not yet been pregnant:

"When she comes, we place our emphasis on her. When we welcome her, we always ask her why she came, 'do you have a lot of children?' Or if it is not that, if, for example, it is a student, for example a student, 'I am a student', she says, 'I can not wait for the thing. I have someone with me. I am going to possibly use FP.' But to use FP, how is the person with whom she is with. Is that a schoolmate? Or, he is not from her family. It is not a loved one. The girl is hard to hold back. So we note everything that concerns them, we examine all their needs. Sometimes I remain cautious because I do not know what they want. I'm a little afraid of seeing them take thirty thousand Ariary. She says 'I'm in a hurry'. But I hesitate because she does not have a child yet, so I hesitate. And then, one looks at her health. In FP, one examines everything, tension, weight, pulse, fatigue, if she has never been seriously ill, if she does not have frequent headaches. We ask all this. And when asked, if the result is not good, she cannot use [FP]."

A 39-year-old female AC from Sofia further discussed the process she goes through during a visit with a minor:

"When she comes, it is to ask to use FP. I must first know how old she is. Then I have to inquire about her. Is she from my fokontany? How is her mother? Why does she not come with her mother? [If] she is under 15 years old, I am more demanding. I am less strict when it comes to girls over 16 years old because life is really tough these days. So I'm not too strict with those. But when she's only 15 years old—she's about 15 years old—that's different. So I have to thoroughly check. Then I have to ask her questions about how is it going, why she has decided to use that method. And mostly it's because I have children. They often reply that it is their mother who advises them to take the plunge, or that they have money problems and that they have to go out with someone to have some [money]. But as a parent, I have to ask questions and, above all, that they do not end up getting pregnant... And that's why I have to ask questions before making a decision about her condition."

There was also a connection between the liberal use of the critères du criblage with regard to determining a patient's eligibility for a particular method and adolescents' perspectives with regard to whether or not they are able to obtain an FP method during a visit. Often, adolescents discussed that they may not be given an FP method or sent to a hospital or CSB if they were not eligible for a method of their choosing. For example, an adolescent (age 15 to 19) from Menabe stated that "each time that she has her period, she goes to the doctor to seek advice to obtain FP but she does not get it."

Adolescents also believed that eligibility was required for any FP method, including requiring parental consent. When describing a typical FP visit with a provider, a young mother (age 15 to 19) from Sofia described a situation where a very young parent was not offered contraception, even though she already had a child. She described,

"What I saw, there was a minor who was not yet 15 years old. Even if she was not yet 15 years old, she already had a child… Even if they are 15 years old, they do not bring up their child if they do not take their parents. But they did not do that... She should come with her parents, to do, to go to the doctor for contraception. That's when they will give it to her."

Providers also discussed when and if there was a need for parental consent during an FP visit. One male doctor from Anamalanga specifically mentioned how parental consent led to a specific method choice, stating, "in fact, the use of condoms does not require parental consent. On the other hand, for taking pills, one needs the opinion of parents."

DISCUSSION

Findings from the qualitative study shed light on perceived facilitators and barriers to SRH for rural adolescents from the perspective of adolescents as well as health care providers. Interestingly, regardless of gender and age, adolescents similarly discussed influences on and attitudes about SRH behaviors. Overall study findings fill a gap in available literature about adolescents in Madagascar by looking specifically at adolescents living in rural areas. In addition, by having included younger adolescents, the study reflects insight from a group of adolescents often overlooked by research.

Adolescents across all four regions consistently named injectables and fertility beads as the most popular methods for adolescents, with fertility beads named as most appropriate for young women without children. Beliefs around long-acting reversible contraception (LARCs), specifically implants, centered around the belief that they are only appropriate for women with children and that they were not only not ideal for nulliparous adolescents but that LARCs could even be harmful for these adolescents.

Apart from general discussion about the popularity and appropriateness of certain FP methods, our findings can be summarized into four general themes. First, fear and shame served as emotional drivers of various SRH behaviors. In particular, study respondents highlighted the role of fear and shame for sexual initiation, FP and unintended pregnancy. Interestingly, the fear and shame associated with these three behaviors seemed to be more about a fear of getting pregnant rather than a fear of the behavior itself. For example, many adolescents mentioned fear of getting pregnant as a motivating factor for FP as well as for delaying sexual initiation.

Second, both adolescents and providers described female adolescents' RH beliefs and behaviors as being heavily influenced by interpersonal relationships—especially those with parents and friends. According to study participants, parents and friends encouraged and discouraged participation in transactional sex, use of FP, and decision-making related to unintended pregnancy.

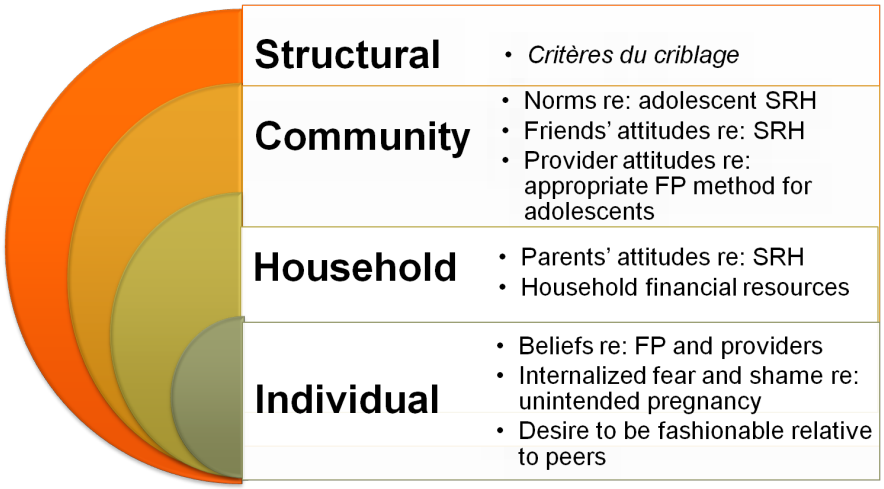
Third, all groups of participants expressed the idea that there is an appropriate FP method for everyone, determined by the body's physical ability to tolerate a particular type of method ("supporter") and what fits the lifestyle of a particular young person ("ce que convient"). These two different yet reinforcing constructs resulted in supporting beliefs around the inappropriateness of young people (especially those without children) to use LARCs, such as injections and implants.

Fourth, female respondents and providers described the process of navigating a set of written and unwritten rules which balanced criteria around medical eligibility with sociocultural beliefs. These written and unwritten rules dictated the process during a visit to an AC, midwife or doctor and simultaneously reinforced the construct of finding the right fit. Standardized and expected etiquette and protocol during a visit with a provider included consideration of individual choice, yet ultimately led to prescriptive decisions justified by the existing screening criteria form. Although this criteria was originally developed to encourage dialogue between providers and patients regarding FP method selection, it served to reinforce existing provider biases and misconceptions. Morover, the strict interpretation of the screening criteria by providers about a limited range of FP options the providers

deemed appropriate for adolescents. The screening criteria reinforced previously existing beliefs that choosing the most appropriate method was largely based on the age and parity of a woman.

The idea that individuals are nested within their household, the household within the community and the community within national policies and structures is commonly referred to as an ecological framework. Study findings supported the idea that adolescents in rural areas are influenced from a variety of factors outside their individual control. These influences occur at the individual, household, community, and structural levels. The four overarching themes about the influences on adolescent SRH, therefore, find connection via a conceptual model grounded in an ecological perspective (see Figure 4). A conceptual model framed from an ecological perspective helps explain the influences within and outside an individual's control as well as helps identify a diverse range of recommendations for programs aimed at improving SRH for youth in rural areas of Madagascar.

Figure 4. Conceptual Model: Influences on Adolescent SRH in Rural Madagascar



At the individual level, adolescents were influenced by their own perceptions and beliefs. For example, beliefs that fed into fear and shame could drive as well as impede the uptake of a particular FP method. An individual's beliefs about a young woman's lifestyle and whether her body was physically capable of tolerating certain FP methods dictated self-assessments regarding the appropriateness of certain FP methods. For example, many adolescents expressed the belief that LARCs were not appropriate for adolescents who were unmarried or had yet to give birth. Attitudes of parents at the household level and norms at the community level also influenced FP decisions as well as decisions about other SRH behaviors, including transactional sex. Additionally at the community level, provider's attitudes and biases about the appropriateness of certain FP methods for adolescents would affect whether adolescents could access methods such as LARCs. At the structural level, the application of standardized screening criteria reinforced misconceptions about what methods were appropriate for youth based on age and parity.

Limitations

Although this study identified novel findings regarding adolescent SRH in rural parts of Madagascar, these findings should be understood in light of four limitations.

First, the study methodology did not include specific questions about individuals' SRH behaviors but rather framed discussions around hypothetical scenarios and assessed general opinions. This decision was based on the determination that it was not appropriate to ask about individual behavior among the very young, nor in a FGD format, nor in Malagasy culture where there is a strong emphasis on saving face and not asking very personal questions. Moreover, the original mixed methods study design included the qualitative study as the first component, with a subsequent quantitative survey that would measure actual behavior among young women in rural areas. Unfortunately, we did not conduct the quantitative study, thereby eliminating the opportunity to measure actual SRH behavior. Nevertheless, although the qualitative study did not explicitly assess individuals' actual SRH behaviors, we did obtain a rich set of opinions and attitudes about these behaviors across the four regions.

Second, due to financial and time constraints, we did not specifically talk with parents. Given that adolescents across regions stressed the strong influence of parents on children, parents would be important secondary audiences to reach with messages about SRH for adolescents. Therefore, it would valuable for future studies to consider including a sample of parents in order to obtain their perspective on adolescent SRH as well. Similarly, financial and time constraints limited the study sample to four regions in Madagascar. Due to sampling from only four regions of the country and the fact that we employed qualitative methods, the current study is not generalizable to all rural areas of Madagascar. At the same time, qualitative research is not intended to serve as representative of a population but rather to provide a rich in-depth exploration of topics. Furthermore, we selected the four regions using a strategic set of criteria to establish a diverse set of areas in terms of ethnicity, access to services, demographics and SRH indicators. As a result, our findings, nevertheless, paint a detailed picture of the various influences on SRH among adolescents in rural areas across a diverse set of regions in Madagascar.

Third, the qualitative study design, in particular the FGDs, may have yielded certain findings based on what was deemed appropriate to share with others. For example, adolescents more often discussed the fact that adolescents engaged in transactional sex due to wanting to be in fashion ("a la mode") as opposed to due to financial need. It is possible that adolescent participants did not talk about transactional sex for economic needs because they wanted to save face in front of others, especially their peers. But because adolescents shared similar stories in the IDIs (a more private encounter without peer influence) as well as FGDs across all four regions, this finding was likely less due to social desirability and saving face. Instead, this interesting finding speaks to a primary factor that drives transactional sex in rural areas of Madagascar among adolescents.

Long-Acting Reversible Contraception

Among adolescents and providers across all four regions, a commonly held belief was that LARCs, specifically implants, were only appropriate for women with children. Moreover, LARCs were perceived as a poor fit, and even harmful for nulliparous adolescents. Not surprisingly, implants were not popular among youth. Moreover, the findings indicated that injectables and fertility beads—both of which are less effective than LARCs—were more popular among adolescents. The findings suggest a potential opportunity for the promotion of LARCs as a viable and effective FP method for adolescents, and stress the need to address the misconceptions held by providers and adolescents, alike, about LARCs as a key component of a comprehensive FP program for rural adolescents.

A recent study, commissioned by USAID and implemented by Marie Stopes International (MSI) found that the use of vouchers (both paper and electronic) to promote SRH counseling and services to youth

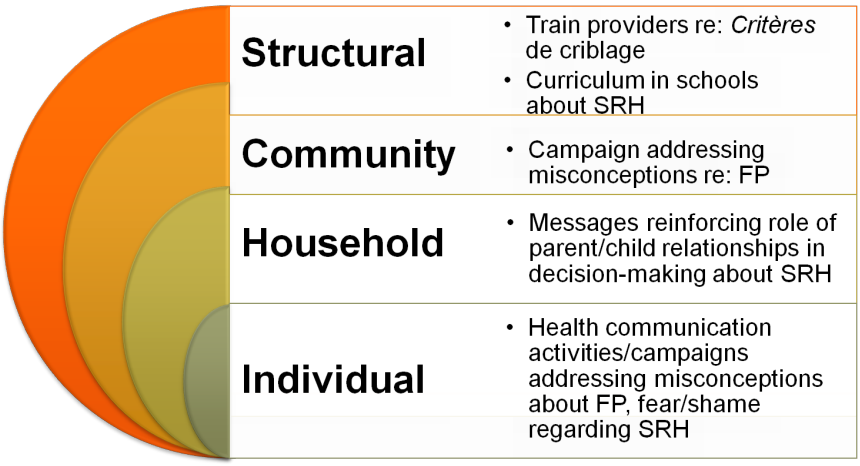
was successful in various parts of Madagascar, in both rural and urban areas (Burke et al., 2017). Over a period of about 18 months, youth accessed a total of 66,027 services through the use of vouchers. Implant insertion represented 39 percent of services redeemed, followed by STI counseling (33 percent) and IUD insertion (13 percent). The vast majority of voucher distribution (80 percent) and redemption (78 percent) occurred in the Anamalanga region, which is home to the country's capital, Antananarivo. Nevertheless, study authors suggest the strong potential of vouchers to increase uptake of LARCs among youth across Madagascar. Since data collection, the MSI voucher program has expanded to 11 of Madagascar's 22 regions where MSI works (Burke et al., 2017).

MSI's work with vouchers and their success in LARC uptake suggests that increasing access and removing financial barriers were key to the uptake of LARCs among the youth in their study. The combination of increasing access to LARCs with interpersonal counseling at the clinic may have also facilitated the especially high LARC uptake among youth (Burke et al. 2017). Although the findings from Burke et al. (2017) are promising, especially for a more urban region, our study findings suggest that current misinformation and concerns—held among young women, within the communities in which they live, and by the providers who serve them—need to be addressed before any further scale up. As previously mentioned, our findings indicated that both adolescents and providers held strong misconceptions and concerns about LARCs. These concerns included misconceptions about LARCs not being appropriate for adolescents, as well as concerns about negative implications of long-term use of hormonal FP methods (e.g., sterility). These concerns may be able to be addressed with thorough and client-centered counseling. Providers who are client-centered, aware of their own biases, educated about the methods and trained on insertion and removal of LARCs are a key component to increasing use of these FP methods.

RECOMMENDATIONS

In light of the above-mentioned limitations, our findings, nevertheless, provide valuable insight for activities aimed at improving SRH for rural adolescents in Madagascar. Here we offer a set of recommendations for both programs and research regarding rural adolescent SRH. Program recommendations, organized according to the four ecological levels of our conceptual model (see Figure 5), suggest the need to go beyond activities that solely focus on adolescents as the primary audience. Instead, our findings suggest the importance of addressing the influences on adolescent SRH that come from the household, community, and structural levels in order to achieve the greatest level of impact.

Figure 5. Conceptual Model: Recommendations for Adolescent SRH Programming in Rural Madagascar



Program Recommendations

Individual level

At the individual level, communication activities or campaigns should incorporate messages that address misconceptions about all FP methods. Given the high level of effectiveness of LARCs along with recent global interest to promote LARCs among young people in order to achieve higher levels of mCPR (FP2020, 2017), one approach might promote LARCs. Given our findings which indicate strongly held negative attitudes towards implants, it is imperative that LARC promotion messages accurately address potential side effects as well as the appropriateness for adolescents. Messages around SRH should also address and work to reduce the potential internalized fear and shame that adolescents may experience. In addition, given that adolescents discussed parents and friends as important influences on SRH behaviors, messages should incorporate these groups of individuals in fictionalized depictions of decision-making. For example, mass-media spots promoting LARCs for adolescents could incorporate dialogue between a fictional parent and child talking about LARCs as an appropriate FP method for adolescents regardless of parity.

Household Level

At the household level, communication activities or campaigns should incorporate messages aimed at parents that complement and accompany the primary messages aimed at adolescents. These messages should work to address misconceptions regarding adolescent SRH among parents as well as encourage parents to talk to their adolescent children about SRH before their sexual debut. Similarly, messages aimed at parents should include accurate information about FP methods, especially LARCs.

Community Level

At the community level, campaign messages should address misconceptions about FP methods and incorporate specific messages about the appropriateness of specific FP methods for adolescents. In particular, these messages should counter the misconception that FP methods, including LARCs, are only appropriate for young women with children. In addition, program activities aimed at providing services for adolescents should strategically incorporate the local CSB along with the pharmacy as well as midwives/birth attendants. Similarly, program activities focused on counseling activities should consider the AC a key type of health care provider to engage.

Structural Level

At the structural level, health care providers should receive training about the intended use and correct application of the screening criteria. This professional development training should address providers' knowledge as well as attitudes/beliefs about the appropriateness of FP methods, especially LARCs, for adolescents. Providers should also receive training about effective strategies for communicating with adolescents as well as client-centered communication strategies.. Beyond training providers, additional program activities should consider the potential of addressing misconceptions about SRH, including inaccurate beliefs about FP, within the national educational curriculum. During our encounters with youth and providers, participants shared that students learn about counting one's fertility by tracking the calendar. Since these discussions about adolescent development are already occurring within schools, this setting may also provide a rich opportunity to discuss accurate information about SRH prior to sexual debut. This curriculum could address misconceptions about FP, incorporate accurate information about the full range of FP methods as well as address the potential fear and shame that adolescents may experience as they begin to engage in SRH behaviors. Addressing structural factors aimed at providers as well as the educational curriculum for adolescents could help foster adolescents' ability to make informed choices about their SRH, including sexual debut and use of FP (FP2020, 2017).

Research Recommendations

In addition to suggestions for future programs, our findings yield recommendations for additional research with adolescents as well as with health care providers and parents.

1: Adolescent Female SRH Behavior and Willingness to Uptake LARCs

Before developing, implementing or scaling up any programmatic strategies around adolescent SRH, including promotion of LARCs, we strongly suggest considering conducting a representative survey about SRH among adolescent females in rural areas of Madagascar. Such a survey could explore issues such as willingness to uptake LARCs as well as measure actual SRH behaviors. Such quantitative findings would complement our findings and provide additional valuable insight for programs. In addition, we suggest conducting qualitative research to explicitly explore the receptivity of rural adolescents to using LARCs, including whether financial access to FP methods is, indeed, a critical barrier to the use of FP methods such as LARCs. Such research would also be useful in order to assess the potential for scaling up the use of vouchers to promote LARC uptake across the country and also to explore the various reasons why or why not these initiatives could work in various regions.

2: Health Care Provider Application of Screening Criteria and Communication with Adolescents

With providers, we suggest additional quantitative research around providers' actual application of the screening criteria form. Quantitative methods could assess which types of providers are overly rigid in the application of the criteria and thereby identify segments of providers to reach out to and train about the appropriate application of the criteria. In addition, from the feedback of youth about areas where providers could improve, it would be helpful to assess communication skills of providers, including skills related to communicating with adolescents in a client-centered manner. Such information could be especially useful when tailoring professional development trainings for health care providers about adolescent SRH as well as about promotion of LARCs for youth.

3: Parents' Role in Adolescent SRH

Given the importance that youth placed on parents, we recommend conducting qualitative research with parents of rural adolescents would help to further understand their role in adolescent SRH. Such research would also help to identify potential strategies for reaching this key secondary audience. If conducting IDIs with parents, we suggest employing questions that ask parents specifically about their attitudes, actual experience with their adolescent children, as well as about their perceptions about other parents. If conducting FGDs with parents, we strongly suggest using scenarios to generate discussion, similar to what was used with adolescents. Using scenarios would allow parents to save face in front of other parents of adolescents in their community.

In conclusion, the study explored the influences on SRH among adolescents in rural areas of Madagascar. The findings help to fill a gap in previous research about adolescents in Madagascar, specifically adolescents living in rural areas. Moreover, our study provides valuable recommendations for both future research and programs in Madagascar.

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APPENDIX 1: IN-DEPTH INTERVIEW GUIDE – FEMALES AGES 10 to 14

Welcome (5 min):

Thank you for agreeing to talk with me today. Remember that everything shared here today is confidential. I will be recording our interview so I do not forget anything you say. If you are not comfortable being recorded at any point, let me know and I will pause the recording. You can also leave at any time if you feel uncomfortable or if you don't want to talk about something.

I am interested in what you how girls in your society grow up and become adult women. There are no wrong or right answers to the questions I will ask you. Are there any questions for me before we begin?

[*Start audio digital recording*]

Discussion:

1 Timeline Creation

You have seen other people grow up and you are also growing up. As a boy or girl grows up, they might begin relationships with new people and there relationships may change over time. I want you to make map out the changes in a girl's life as she grows into an adult woman. On your timeline, you should think about things that happen to most adolescents your age in this community. You might put in things like going to school, marrying a husband and having a child.

This is how such a timeline might look like. *[Describe or draw sample timeline on piece of paper with and use tick-marks to represent events on the line. You should not mention sexual or reproductive events but probe about them if the participant mentions them. If the participant cannot write, the interviewer will draw what the participant verbally describes to them.]*

Now that we have a timeline, let's talk about each of the events you drew and what they mean.

Box 1: Key sexual and reproductive events

- *a girl begins her sexual relationship with a boy,*
- *a girl seeks advice from her friends,*
- *a girl visits the clinic to get contraception,*
- *a girl becomes pregnant,*
- *a girl becomes a mother,*
- *a girl gets married*

1.1 What happens during this event? What kind of people does this happen to?

1.2 Why is this event important in terms of becoming a woman?

2 Scenario Brainstorming

Now that we have a timeline of some of the key events on a timeline I'd like you to create a story of a girl like you that goes through some of these events.

[If the timeline includes one of the events in the box above or similar events, discuss the following questions for each.]

2.1 How did the event take place? Describe the characters in terms of family relationships, poverty/wealth, friendships with peers, age, education, employment, physical appearance, etc.?
2.2 If applicable, describe the girl's boyfriend or husband in terms of poverty/wealth, age, education, employment, physical appearance, etc.
2.3 Who and what played a role in the event happening?
2.4 When and how did people in her life react and how might it effect her other relationships (e.g., with sexual partner, peer, family, community, health provider)
2.5 Where and to whom might she turn for advice, help or support (e.g., with sexual partner, peer, family, community, health provider)

[Male perspective: Discuss the following for relevant events that were discussed above (e.g., sexual initiation, seeking advice from friends, becoming a father):]

2.6 Could some of these transformation events also happen to a boy/man? If so, how would he react to these events? How would he feel?
2.7 When and how would people in his life react?
2.8 How might the event effect his relationships *(e.g., with sexual partner, peer, family, community, health provider)*

[Several scenarios of each transformational event may emerge which is fine. The important thing is to find common scenarios in that community and how the participant feels about these scenarios and different characters.]

3 Transactional Sex

Sometimes a girl may spend time in private with boy or man and in exchange, he gives her gifts or does favors for her or her family and friends. If the girl stops spending that private time with him, she will no longer receive gifts or favors.

3.1 How might it happen that girl and a boy/man in your community come to be in such a relationship? Who or what might stop them from beginning this relationship? Who or what might help them to begin such a relationship?
3.2 What kinds of girls usually have this type of relationship with a boy/man? What are they like in terms of age, education, family or appearance?
3.3 What kinds of boys/men usually have this type of relationship with a young female? What are they like in terms of age, education, family or appearance?
3.4 What do girls have to gain from having such a relationship with a boy/man? What bad things might happen if she sees the boy/man?
3.5 If you had a friend that spent time with a boy/man, what would you advise her to do? What or who would convince her to avoid or leave such a relationship?

4 Contraception

If a girl spends time with a boy or man in private she may go to a health center or take medication to avoid having a baby.

4.1 In your community, what do most girls do if they are seeing a boy/man in private and do not want to get pregnant right away?

4.2 If you had a friend your age that spent time with a boy/man in private, what would you advise her to do in order to not get pregnant?

4.3 Tell me more about the things a girl or woman can do to avoid becoming pregnant.

4.4 *[If they mention any contraceptives or family planning methods*:]

- 4.4.1 What is good or what are the advantages of this type of family planning method/ contraceptive?
- 4.4.2 Tell me about family planning methods that are less effective than others, if any?
- 4.4.3 Tell me about family planning methods that are more likely to cause you side effects or harm than others, if any?
- 4.4.4 Tell me about family planning method that are better than others, if any? *Probe to solicit their knowledge of various modern family planning methods: pill, injectable, IUD, condom, implant, sterilization.*
- 4.4.5 What kinds of girls use family planning methods/ contraceptives? What kinds of girls do not? What kinds of boys use family planning methods/ contraceptives?
- 4.4.6 How do girls talk with their partners about family planning methods/ contraceptives?

4.5 What else might a friend your age do to avoid having a child?

5 Health Provider

We have talked about some of the events in the events that might take place as a girl becomes a women. One such event that might be when a female decides to seek health care services related to her reproductive health, such as family planning. Before she seeks any service, where do you think she goes for information about reproductive health in general? With whom does she talk? When she does decide to seek services, where do you think she goes? *[Here we want to explore whether she goes to a health care facility, pharmacy, or elsewhere.]*

Now I want you to think about an adolescent female who decides to go to a health care facility for sexual and reproductive health services, such as family planning. *[Pass out a sheet of paper and drawing utensils.]* I want you to draw what you think a typical health care provider in this setting looks like. Think about how to depict the providers' gender, age, appearance, dress, personality, etc. Also, think about ways to draw the types of things this provider might do or say to make his/her adolescent patient feel comfortable during the health care visit. I will give you about 10 minutes to draw what this health care provider looks like. Then we will discuss your drawing in greater detail. There are no right or wrong ways to draw the health care provider and it does not matter whether or not you have ever been to a health care provider for these types of services. You can think about what you have heard or what family members or friends have told you.

[Give the participant 10 minutes to draw. Ask the participant to share her drawing and describe in detail. Make sure to collect the drawing at the end of the activity.]

I want to start to finish our time together by getting a sense of how well you think health care facilities in your community meet the health care needs of adolescents. What do they do well? What could they do better? What about health care providers in those facilities? What do they do well? What could they do better?

Closing: (5 min)

To close I'd like to review some of the main points you mentioned. [*Describe main themes or ask for clarification on others]* You said this …, you also said this… Do you have anything to add or correct?

Thank you so much for participating today and sharing your views with me. Please let me know after the session if you have any questions for me.

[End audio digital recording]

APPENDIX 2: IN-DEPTH INTERVIEW GUIDE – HEALTH PROVIDERS

Welcome (3 min):

Thank you for agreeing to talk with me today.

I want to talk to you about what how adolescents in this community make decisions about how to access health services for family planning, pre-natal and maternal health services. When I say adolescents, I am talking about females and males 10-19 years old. Remember that you do not have to talk about your own experiences at your health facility during this interview, but can instead describe the experiences of health providers like you in your community.

Remember that everything shared here today is confidential. I will be recording our interview so I do not forget anything you say. If you are not comfortable being recorded at any point, let me know and I will pause the recording. You can also leave at any time if you feel uncomfortable or if you don't want to talk about something.

To make sure we can be heard on the recorder please put your phone on silent if you have one. There are no wrong or right answers.

Are there any questions for me before we begin?

[Start audio digital recording]

Discussion

6 Introduction

6.1 First I would like to start by getting to know a little about you as well as your work. *[Please note gender in your notes. Probe on the following:]*

- *Age*
- *Profession*
- *Number of years in profession*
- *Number of years working in current health provider role*

6.2 Please tell me about your job/profession as well as your role here at the hospital/health center/community. *[Probe on the following:]*

- *Role at hospital/health center/community*
- *What type of services he/she provides*
- *Type/range of clients interact with most often [ie all community members, women]*
- *How long have been employed at this particular facility*
- *Get a sense of other interactions, responsibilities, etc.*

6.3 Now I want you to think about what a typical day at your job looks like, from when you first arrive until you leave. *[Discuss the participant's typical day with him/her. Use the following probes.]*

- When does your work day start?
- What do you do? When does your day end?

- What are the different kinds of patients/community members that you see?
- How often do you see adolescents (10-19 years old)? Can you give me some examples of what they usually come in to see you for? What types of services do most adolescents request?

7 Family planning services

7.1 You said that most adolescents request _____ services. I would like to hear about a typical health care consult for_____ service that you might have with an adolescent female client/patient. *[Use the following probes.]*

- What is the process from when you first go to meet an adolescent female client/patient to when the visit is finished?
- When a client leaves, how do you know if he/she is pleased with the care received?

B. Now I want to explore a bit more about the type of female adolescent patients that you see specifically for family planning services. I want you to think about a typical female adolescent patient who requests family planning services. *[Possible probes.]*

- How old is she? Is she in school?
- What kind of family does she come from?
- Who does she come with? (e.g., family, friends, boyfriend, alone)
- How does she ask for a family planning method?
- What kind of family planning method does she ask for? What is the most common type of family planning method others like her might ask for?
- How similar is she compared to female adolescent patients that you see for other types of services?

C. I would now like to talk a bit about the type of discussions that occur when you are with a female adolescent patient during a family planning service visit. *[Use the following probes.]*

- What type of advice do you give her?
- What do you think she should consider before deciding to begin a family planning method?
- How do you think your advice would compare to advice from other health care providers?

D. Now I want you to think more broadly about adolescents in your community. *[Use the following probes.]*

- Where do adolescents <u>hear</u> about family planning?
- What do adolescents <u>know</u> about family planning?
- What factors do you think influence whether or not an adolescent female <u>requests</u> a family planning method?
- What factors do you think influence <u>whether or not</u> an adolescent girl decides to use a family planning method?

- What factors influence whether a health provider suggests an adolescent female begin to use a family planning method?
- How well do you think your health care facility serves female adolescent patients? What do you think your facility does well?

Closing: (5 min)

To close I'd like to review some of the main points surrounding the factors that influence adolescent decisions about family planning that came up today. I understood this … and this… Do you have anything to add or correct?

Thank you so much for participating today and sharing your views with me. Please let me know after the session if you have any questions for me.

[End audio digital recording]

APPENDIX 3: EXAMPLE FOCUS GROUP DISCUSSION GUIDE FOR ADOLESCENTS

Welcome (3 min):

> Welcome everyone and thank you for agreeing to talk with us today. We're here today to talk about what how adolescents in this community create attitudes about becoming sexually active, pregnancy, using family planning and using reproductive health services. Remember that you do not have to talk about your own experiences during this discussion. Instead, we will ask you to describe the experiences of other female youth like you in your community.

Remember that everything shared here today is confidential. I'll be leading the discussion today and [*name of recorder]* will be helping me. *[Name of recorder] will be recording our discussion so we do not forget anything you say.* If you are not comfortable being recorded, you can ask me to pause the recorder at any time. You can also leave at any time if you feel uncomfortable or if you don't want to talk about something.

> To make sure everyone can be heard on please put your phones on silent if you have one. Try to let other people finish speaking before you begin speaking. There are no wrong or right answers. We are eager to hear about your opinions and thoughts on these topics.
>
> Are there any questions for me before we begin?

Introductions & Ice-breaker (10 min):

First let's go around and choose our names for today. Please give us the name you would like to be called— please use a nickname or another name other than your real name just for today. Use only these nicknames when you speak to each other during conversations today.

[Start audio digital recording]

> *Have the partners break into pairs. Have each person share with their partner one thing they like about being an adolescent and one thing they like about their community. After a few minutes, have each person introduce their partner to the rest of the group.*

Discussion

8 Vignette #1 : Sexual Initiation & Family Planning

Now we're going to describe a few scenarios and we will discuss what you think about the people in these stories. The stories are about adolescent girls your age meeting boys of the opposite sex, about pregnancy and about family planning.

Read the vignette aloud section by section. For Vignette #1, begin by displaying a poster representing a young couple A and P that are both 17 years old and look typically Malagasy. The names A and P maybe replaced with other common names so as to make the story easier to understand. After each section ask the participants to reflect upon the story and probe using the questions below that section.

8.1 P is 17 years old and she has started to spend time with A who is the same age. P thinks that A wants to have sex with her, but she is not sure what she wants.

8.1.1 What do you think she is most likely to do?

8.1.2 What do you think you would do in that situation?

8.2 P meets up with A and they begin to kiss. When she stops him he gets angry and accuses P of not trusting him. P explains that she is worried about pregnancies and STIs.

8.2.1 What do you think P is most likely to do?

8.2.2 What do you think A expects P to do?

8.2.3 What would you do in P's situation?

8.2.4 Where is the best place to go for advice or information about pregnancy? What about for STIs?

8.2.5 Where do most girls go for advice or information about preventing pregnancy? What about for STIs?

8.3 P tells A she will go to the health center to ask about contraception. On her way, she meets her friend in the road and confides in her. Her friend gives P some advice about her situation.

8.3.1 What advice is her friend most likely to give to P?

8.3.2 What advice would you give P about her relationship with A?

8.3.3 What advice would you give P about contraception, if any?

8.3.4 If P takes a contraceptive, which would you advise her to take? Explain why that contraceptive is a better choice for P? Would P easily be able to get this contraceptive?

8.4 P decides to continue on to the health center to get more information. She begins to talk to the health provider who asks her questions.

8.4.1 What kind of questions would the health provider ask her?

8.4.2 In what situation would P feel comfortable talking to the health provider?

8.4.3 In what kind of situation would P feel uncomfortable talking to the health provider?

8.4.4 How likely is it that P will ask the health provider directly for a contraceptive?

8.4.5 What kind of contraceptive is the health provider most likely to offer P, if any? Explain.

8.4.6 How likely is it that P will leave the center with a contraceptive? Explain.

8.5 The health provider explains that P should abstain from sex until marriage. P leaves the clinic without a contraceptive.

8.5.1 How often might girls like P meet a health provider who says this?

8.5.2 What is P most likely to do next?

8.5.3 What other resources besides the health provider does P have to avoid pregnancy and STIs? Which is she most likely to use, if any? Explain.

8.5.4 She texts A about the visit. What do you think she's most likely to tell him?

8.5.5 How do you think P's mother would react if she found out that her daughter had gone asked about contraceptives?

8.5.6 What would P's mother do?

8.5.7 How do you think P's father would react if he found out that his daughter had gone and asked about contraceptives?

8.5.8 What would the father do?

9 Vignette # 2 : Pregnancy

Read the vignette aloud section by section. After each section ask the participants to reflect upon the story and probe using the questions below that section. . For Vignette #2, begin by displaying a poster representing a young couple A and P that are both 17 years old and look typically Malagasy. In the background of this poster will be the couples friends and parents.

9.1 P is 17 years old and in school. Her boyfriend, A, is also 17 years old. Lately P has been feeling sick. She has missed periods and now realizes that she is pregnant, and that A is the father. A doesn't know. Her best friend notices that P is not herself and asks her what the problem is.

9.1.1 How do you think Pi is most likely to react when she realizes that she is pregnant?

9.1.2 How do you think you would react if you were ever in P's situation?

9.2 P tells her friend that she is pregnant and that A has caused the pregnancy.

9.2.1 What is her friend most likely to advise P to do?

9.2.2 What would you advise P to do?

9.3 P tells A that she is pregnant. A is surprised.

9.3.1 How do you think P should tell A that she is pregnant?

9.3.2 What is A most likely to advise P to do?

9.4 P is scared and decides to run away from home. She tells her friend of her plan, who in turn tells P's younger sister. Her younger sister then tells their parents that P is pregnant and A is the father.

9.4.1 What will P's parents think when they find out their daughter is pregnant?

9.4.2 What will P's parents do?

9.5 P's parents insist that their daughter is not responsible for the pregnancy. They say that P is too young to be having sex, and accuse A of tricking their daughter into having sex with him.

9.5.1 What do you think P should do in this kind of situation?

9.5.2 What do you think your friends would do if they were ever in this kind of situation?

10 Family Health Provider

We have talked about some of the events that might take place as a girl becomes a women. One such event that might be when a female decides to seek health care services related to her reproductive health, such as family planning. Before she seeks any service, where do you think she goes for information about reproductive health in general? With whom does she talk? When she does decide to seek services, where do you think she goes? *[Here we want to explore places such as a health care facility, pharmacy, or elsewhere.]*

Now I want you to think about an adolescent female who decides to go to a health care facility for sexual and reproductive health services, such as family planning. *[Pass out sheets of paper and drawing utensils.]* I want you to draw what you think a typical health care provider in this setting looks like. Think about how to depict the providers' gender, age, appearance, dress, personality, etc. Also, think about ways to draw the types of things this provider might do or say to make his/her adolescent patient feel comfortable during the health care visit. I will give you about 10 minutes to draw what this health care provider looks like. Then we will discuss your drawing in greater detail. There are no right or wrong ways to draw the health care provider and it does not matter whether or not you have ever been to a health care provider for these types of services. You can think about what you have heard or what family members or friends have told you.

[Give participants 10 minutes to draw. Ask the participants to share their drawings to the larger group and describe in detail. If you do not have time to have everyone share or if some people choose not to share, that is fine. Make sure to collect the drawing at the end of the activity. Also, if you can identify which drawings were the ones shared with the group, and in what order, it will help to connect the drawing to the audio.]

I want to start to finish our time together by getting a sense of how well you think health care facilities in your community meet the health care needs of young people like you. What do they do well? What could they do better? What about health care providers in those facilities? What do they do well? What could they do better?

11 Transactional Sex

Sometimes a girl may spend time in private with boy or man and in exchange he gives her gifts or does her or her family and friends favors. If the girl stops spending that private time with him, she will no longer receive gifts or favors.

11.1 How might it happen that girl and a boy/man in your community come to be in such a relationship? Who or what might stop them from beginning this relationship? Who or what might help them to begin such a relationship?

11.2 What kinds of girls usually have this type of relationship with a boy/man? What are they like in terms of age, education, family or appearance?

11.3 What kinds of boys/men usually have this type of relationship with a young female? What are they like in terms of age, education, family or appearance?

11.4 What do girls have to gain from having such a relationship with a boy/man? What bad things might happen if she sees the boy/man?

11.5 If you had a friend that spent time with a boy/man, what would you advise her to do? What or who would convince her to avoid or leave such a relationship?

Closing: (5 min)

To close I'd like to review some of the main points you mentioned. *[Describe main themes or ask for clarification on others]* Some people said this …, others said this… Does anyone have anything to add or correct?

Thank you so much for participating today and sharing your views with us. Please let me know after the session if you have any questions for us.

[End audio digital recording]

APPENDIX 4: LIST OF DEDUCTIVE CODES

Category	Code #	Code name	Code definition
FAMILY PLANNING	1	Family planning: Knowledge	Use when participants discuss what they know about family planning/contraception, whether accurate or not.
	2	Family planning: Self-efficacy	Use whenever participants reference confidence in their ability to accessing/using family planning.
	3	Family planning: Attitudes	Use when participants discuss attitudes pertaining to the use of family planning/contraception. These attitudes could be ones that they hold as well as ones that their family, boyfriend, or friends hold. Attitudes could include perceived advantages or disadvantages to using (or not using) family planning in general or to using (or not using) specific methods
	4	Family planning: Gender norms	Use when participant discuss gender norms around family planning. For example, when participants discuss what type of female/male use family planning methods, use this code.
	5	Family planning: Social norms	Use when participants talk about what is customary in their community - perceptions about what other adolescents do or would do or perceptions about whether others approve or disapprove of specific behaviors) regarding family planning.
	6	Family planning: Other	Use when participants discuss family planning but does not fit one of the other family planning codes.
GENDER	7	Gender: Male	Use when participants discuss what it means to be a man, including the process of transitioning from being a boy to becoming a man.
	8	Gender: Female	Use when participants discuss what it means to be a woman, including the process of transitioning from being a girl to becoming a woman.
	9	Gender: Other	Use when participants discuss gender but does not fit one of the other gender codes.
RH INFORMATION SOURCE	10	Information source: Interpersonal	Use whenever participants mention discussing sexual/reproductive health (including family planning, contraception, unintended pregnancy, etc.) with another individual - family member, friend, community member, health care service provider, etc. This code can be the opinion of the participant as well as the opinion that the participant thinks that other teenagers have.
	11	Information source: Mass media	Use whenever participants mention hearing anything about sexual/reproductive health (including family planning, contraception, unintended pregnancy, etc.) via mass media (radio, television, newspaper). This code can be the opinion of the participant as well as the opinion that the participant thinks that other teenagers have.
	12	Information source: Internet	Use whenever participants mention hearing anything about sexual/reproductive health (including family planning, contraception, unintended pregnancy, etc.) on the internet. This code can be the opinion of the participant as well as the opinion that the participant thinks that other teenagers have.

	13	Information source: Social media	Use whenever participants mention reading/seeing anything about sexual/reproductive health (including family planning, contraception, unintended pregnancy, etc.) via social medi (Facebook, Twitter, etc.).
	14	Information source: Other	Use whenever the participant mentions an information source for RH that is not captured by one of the other codes. This code can be the opinion of the participant as well as the opinion that the participant thinks that other teenagers have.
RELATIONSHIPS	15	Relationships: Sexual partner/boyfriend	Use whenever participants mention relationship between an adolescent and their actual/hypothetical sexual partner/boyfriend
	16	Relationships: Friends	Use whenever participants mention relationship between an adolescent and friends (actual or hypothetical)
	17	Relationships: Parents	Use whenever participants mention relationship between an adolescent and his/her parents (mother/father/both)
	18	Relationships: Other	Use whenever participants mention relationship that does not fall into one of the other relationship codes.
REPRODUCTIVE HEALTH (RH) CARE	19	RH care: Provider-patient communication	Use whenever participants (either adolescents or health care provider) discuss communication and/or interactions between patients and health care providers
	20	RH care: Care-seeking behavior	Use whenever participants discuss behaviors (either actual or hypothetical) related to seeking RH care services
	21	RH care: Attitudes about health care providers	Use whenever participants discuss attitudes/opinions about health care providers. Use when participants discuss what is a typical provider
	22	RH care: Ideal provider	Use whenever participants discuss/draw what an ideal health care provider would be like.
	23	RH care: Service location	Use whenever participants discuss where they would/do go to access health care services
	24	RH care: Treatment of adolescents	Use whenever participants discuss either how adolescents are treated when accessing reproductive health care services or how they would like to be treated.
	25	RH care: Provider do well	Use whenever participants discuss what providers do well in regards to treating adolescent patients accessing reproductive health care services
	26	RH care: Provider improve	Use whenever participants discuss what providers could do better in regards to treating adolescent patients accessing reproductive health care services
	27	RH care: Facility	Use when participants discuss health care facilities where RH services are accessed. This code could also be used when participant is discussing either what health care facilities do well and what they could do better to serve the needs of adolescents or other patients.
	28	RH care: Other	Use when participants discuss RH care but does not fit one of the other RH care codes.
PREGNANCY	29	Pregnancy: Prevention	Use whenever participants talk about things they or others do or would do to prevent pregnancy. Could include family planning, abstinence, not having a boyfriend/girlfriend, unintended pregnancy, etc. It could also include discussion

			about preventing pregnancy in general or adolescent pregnancy in particular.
	30	Pregnancy: Knowledge beliefs	Use when participants discuss what they know about adolescent pregnancy or pregnancy in general, whether accurate or not.
	31	Pregnancy: Attitudes	Use when participants discuss attitudes pertaining to pregnancy, in general, or adolescent pregnancy, in particular. These attitudes could be ones that they hold as well as ones that their family, boyfriend, or friends hold. Attitudes could include perceived advantages or disadvantages to an adolescent getting pregnant.
	32	Pregnancy: Gender norms	Use when participant discuss norms around pregnancy, in general, or adolescent pregnancy, in particular. Example: when participants discuss the responsibility of females or males to prevent an unintended pregnancy.
	33	Pregnancy: Social norms	Use when participants talk about what is customary in their community - perceptions about what other adolescents do or would do or perceptions about whether others approve or disapprove of specific behaviors) regarding pregnancy, in general, or adolescent pregnancy, in particular
	34	Pregnancy: Other	Use when participants discuss pregnancy or adolescent pregnancy but does not fit one of the other pregnancy codes.
SEXUAL INITIATION	35	Sexual initiation: Attitudes	Use when participants discuss attitudes pertaining to delaying the onset (or not) of sexual initiation. These attitudes could be ones that they hold as well as ones that their family, boyfriend, or friends hold. Attitudes could include perceived advantages or disadvantages to delaying the onset of sexual initiation.
	36	Sexual initiation: Gender norms	Use when participant discuss norms regardomg the onset of sexual activity Example: when participants discuss that it is expected that females delay sexual onset or that males should start sexual activity earlier than females.
	37	Sexual initiation: Social norms	Use when participants talk about what is customary in their community - perceptions about what other adolescents do or would do or perceptions about whether others approve or disapprove of specific behaviors) regarding the onset of sexual activity.
	38	Sexual initiation: Peer pressure	Use when participants discuss peer pressure regarding initiating sexual activity
	39	Sexual initiation: Other	Use when participants discuss the onset of sexual activity but does not fit one of the other sexual initiation codes.
TRANSACTIONAL SEX	40	Transactional sex: Attitudes	Use when participants discuss attitudes pertaining to transactional sex (the exchange of sexual behaviors/favors for money, gifts, or other goods). These attitudes could be ones that they hold as well as ones that their family, boyfriend, or friends hold. Attitudes could include perceived advantages or disadvantages to transactional sex.
	41	Transactional sex: Gender norms	Use when participant discuss norms regarding transactional sex (the exchange of sexual behaviors/favors for money, gifts, or other goods).

	42	Transactional sex: Social norms	Use when participants talk about what is customary in their community - perceptions about what other adolescents do or would do or perceptions about whether others approve or disapprove of specific behaviors) regarding transactional sex (the exchange of sexual behaviors/favors for money, gifts, or other goods).
	43	Transactional sex: Peer pressure	Use when participants discuss peer pressure regarding transactional sex (the exchange of sexual behaviors/favors for money, gifts, or other goods).
	44	Transactional sex: Advice	Use when participants discuss what type of advice they would give to someone else about whether or not to engage in transactional sex (the exchange of sexual behaviors/favors for money, gifts, or other goods).
	45	Transactional sex: Other	Use when participants discuss the transactional sex (the exchange of sexual behaviors/favors for money, gifts, or other goods) but does not fit one of the other transactional sex codes.

APPENDIX 5: ADDITIONAL QUOTATIONS BY THEME

Theme 1: Internalizing perceived judgment: Fear and shame in decision-making

Adolescents

Selon moi, ses parents seront peut-être fâchés contre Zefa, car il est encore mineur, il a 17 ans. Et ses parents auront sûrement honte de ce que les autres vont dire, et ils vont lui demander 'pourquoi tu es allé chez le docteur'?

– Male, 15 to 19 years old, Analamanga

Pour moi, il vaut mieux qu'il aille seul le médecin pour demander des renseignements concernant la planification familiale. Car peut-être que leurs parents sont des gens importants dans la société et il aura honte, il ne veut pas déshonorer ses parents.

– Male, 15 to 19 years old, Analamanga

La communauté te discriminera, qui n'est pas encore sorti avec, elle a des maladies, plus personne ne la mariera, dans la communauté où tu te trouves. Mais il se peut qu'une autre personne ne se trouvant pas dans ta communauté, peut-être que celle-là te mariera. A ce moment là, tu seras le sujet de discussion de tout le monde, ils se moqueront de toi. Cela pourra générer des conflits dans la maison lorsqu'on utilise des contraceptifs si on n'est pas encore mariée.

– Female, 15 to 19 years old, without children, Analamanga

Il se peut qu'elle soit égarée dans ses pensées lorsqu'elle a eu les contraceptions, là elle commencerait à penser: je ne suis pas encore mariée et j'utilise déjà des méthodes contraceptives. C'est déjà comme si elle se détruit elle-même dans ce cas. Elle ne s'inquiètera plus de grand-chose. Il se peut qu'elle soit égarée dans ses pensées genre comment elle va finir si elle utilise ces méthodes contraceptives. Elle pourrait peut-être avoir honte genre si quelqu'un sait ce que j'ai fait, ce serait de l'humiliation pour moi

– Female, 15 to 19 years old, without children, Analamanga

Et sa mère pourra discuter avec elle, sa mère pourra lui forcer: vas te marier si tu ne sais pas te maîtriser au lieu de m'humilier au niveau de la communauté, à un si jeune âge tu fais utilises des contraceptifs, la communauté pourra penser que c'est moi qui t'influence.

– Female, 15 to 19 years old, without children, Analamanga

Il y a des répercussions, parce que, si par exemple quelqu'un tombe enceinte et que pour un village donné, une fille mineure tombe enceinte dans ce village, puis ensuite elle accouche. Et il y a un autre village, il y a déshonneur car chez vous les filles tombent enceinte sans se marier. Et il y a aussi ceux qui enfoncent le clou en disant que la plupart des filles chez vous tombent enceinte sans se marier, comme ça. Et la personne est déshonorée.

– Female, 10 to 14 years old, Analamanga

Ce qui ne la rend pas à l'aise dans la discussion avec le prestataire de santé est, par exemple, il y a beaucoup de monde avec elle dans le centre de santé et elle ne sait pas raconter beaucoup de choses ou son mari également, par exemple, vient avec elle là-bas.

– Female, 15 to 19 years old, without children, Atsinanana

… Mais elle, elle avait peur…avait peur…. car elle était encore très jeune, et elle utilisait de la PF. Elle avait honte et peur en même temps.

– Female, 10 to 14 years old, Atsinanana

Participant 5: Au moment où Mora n'est pas là donc, au moment où Mora n'est pas là, elle est à l'aise. Elle aurait honte ou peur de Mora donc si Mora la voit parler là.

Participant 2: Elle est à l'aise quand il n'y a pas d'autres personnes mais peut-être elle et le médecin seulement sont là et elle peut bien parler.

– Females, 15 to 19 years old, without children, Atsinanana

Ce que la maman de Mira dit, elle demande d'abord à Mira: 'qu'est-ce que tu es allée faire au centre de santé'? Elle raconterait qu'elle est allée demander de la contraception. Et cela pourrait être: 'tu as déjà un amoureux puisque tu fais cela'? Et Mira dit: 'oui, j'ai déjà un amoureux'. 'Et pourquoi tu ne parles pas'? 'J'ai peur que vous me chassiez d'ici'. C'est cela donc.

– Female, 15 to 19 years old, without children, Atsinanana

Elle n'est pas à l'aise parce que, après avoir couché avec son mari, elle a du souci, car peut-être, elle est déjà enceinte. Pourtant elle ne veut pas encore enfanter, et ainsi, elle a peur de parler au docteur!

– Young mother, 15 to 19 years old, Atsinanana

La chose qui a pu se passer avec Robin quand il a reçu le matériel qu'on peut utiliser c'est qu'il peut avoir peur de l'utiliser car il ne l'a jamais fait. Mais c'est le docteur donc qui l'a incité à l'utiliser alors lui il a peur. Et il craint, c'est-à-dire qu'il a laissé tomber ou bien il s'est dit 's'ils font ça, ils peuvent ne pas avoir d'enfants et il a laissé tomber'!

– Male, 15 to 19 years old, Atsinanana

Et parce qu'elle a peur d'être enceinte, il faut que Koto vienne avec elle, parce qu'elle a peur donc que sa Maman la gronde, elle préfère qu'elle dise cela tout de suite!

– Female, 15 to 19 years old, without children, Menabe

C'est mieux d'accoucher car si elle avorte, elle va mourir.

– Young mother, 15 to 19 years old, Menabe

Il est obligé de penser que c'est mieux de s'enfuir. Car il a peur d'aller se rendre chez leurs parents, car il a peur d'aller chez ses parents.

– Female, 15 to 19 years old, without children, Sofia

Les gens semblent attaquer si on parle beaucoup, on lui parle beaucoup, elle a donc honte d'en parler au médecin puisqu'elle a compris avoir dit: 'Je sors avec Rakoto demander des suggestions au médecin'. Elle a donc honte de le dire au médecin.

– Young mother, 15 to 19 years old, Sofia

Pour moi aussi, soit on utilise l'injectable de temps en temps car il y en a celles qui se cachent de leur mari pour faire cela, et avec celui-ci donc, c'est seulement une fois tous les trois mois et…

– Female, 15 to 19 years old, without children, Sofia

Comme ça, ses parents ne sauront pas qu'elle voit un médecin pour faire cela, pour faire de la contraception, pour que le bruit ne couvre pas. Et qu'elle prend déjà cette pilule, comme ça personne ne saura, à part son amie qui l'a donné, qui saura garder le silence, que c'est leur secret, elle prend déjà la pilule.

– Female, 15 to 19 years old, without children, Sofia

Comme elle n'a que quatorze ans, elle a peur de demander en ce qui concerne la relation sexuelle, elle est encore mineure.

– Female, 15 to 19 years old, without children, Sofia

Health Care Providers

Un constat: une adolescente qui souhaite utiliser la contraception n'ose pas en parler du premier d'abord.

– Agent communautaire, age unspecified, Anamalanga

Maintenant, j'ai vraiment remarqué que…je vous remercie d'avoir posé cette question, car j'ai vu que c'est vraiment un problème à la campagne. Ce qu'elle devrait faire d'abord, c'est de s'affranchir des rumeurs et des doutes….Qu'utiliser ce planning familial rend stérile comme çi, comme ça. Et j'ai dit à J. savez-vous bien ce qu'est la PF ? Vous pouvez avoir un enfant. Quand vous ne voulez pas avoir d'enfant, vous n'en avez pas »Voilà une chose. Il y a aussi ceux qui disent qu'avec cela, vous pouvez avoir une mort subite. Si vous êtes trop grosse, vous pouvez mourir subitement.

– Agent communautaire, 46 years old, Analamanga

En fait, elles ont honte. Au foyer, il n'y a encore aucun partage, à la campagne. C'est rare à la campagne que parents et enfants vont discuter.

– Agent communautaire, 46 years old, Analamanga

Il n'y en a pas qui viennent avec leur mère, elles viennent seules et se renseignent. Et dès qu'elles arrivent ici, elles ont peur que leurs parents leur donnent des ordres. Par exemple, si elles tombent enceintes, cela gêne leurs parents, au sujet de ce qu'on lui ferait. Mais pour les jeunes adolescentes qui n'ont pas encore eu d'enfants, les gens de la champagne ont peur qu'elles en utilisent.

– Agent communautaire, 59 years old, Atsinanana

S'il s'agit des jeunes adolescentes, elles ont peur de tomber enceinte.

– Agent communautaire, 59 years old, Atsinanana

Theme 2: Influence of others: The decision is not just the young female's

Adolescents

Les parents diraient aussi qu'il ne faut pas encore faire cela puisqu'elle est encore mineure.

– Female, 15 to 19 years old, without children, Analamanga

Elle est à la fois heureuse et inquiète parce que ses parents le sauront et ses parents vont lui demander pourquoi faire ces choses-là, la planification familiale, alors que tu voudras donner naissance plus tard !

– Young mother, 15 to 19 years old, Analamanga

Qu'il y ait des amies qui la convaincraient toujours que si cette relation a une contrepartie, elle ne dure pas et ce n'est pas du vrai amour. L'amour devient ainsi sans saveur puisque même si cet homme n'a pas d'argent mais t'aime, c'est ce qui est agréable et elle serait convaincue.

– Female, 15 to 19 years old, without children, Analamanga

Elle est poussée par ses amies, car elles veulent que le corps de la fille soit affecté. Donc ces amies l'incitent: 'vas-y, fais-le, ça ne fait rien. Au moins, tu recevras ceci ou cela. Donc fais-le, ça ne fait rien!

– Young mother, 15 to 19 years old, Analamanga

Ce que fait la mère de Noro, c'est de conseiller Noro comme: 'tu es encore mineure entretenant une relation sexuelle avec une personne'. 'Un enfant mineur ne peut pas utiliser de la Planification Familiale, tu ne peux pas encore être avec une personne mais attends la majorité'.

– Female, 15 to 19 years old, without children, Atsinanana

Ce sont ses parents donc qui lui montrent les conséquences néfastes. Ce sont les parents et ses amis qui lui montrent les conséquences néfastes: 'faites bien attention car il y a des hommes qui font de telles choses'.

– Male, 15 to 19 years old, Atsinanana

Il faut leur dire les conséquences néfastes de leurs actes. Les conséquences néfastes pour les organes sexuels des femmes, le décès possible de l'enfant, le décès possible de la mère! Il faut qu'elle y aille, demander un implant ou réfléchir si elle doit se marier.

– Male, 15 to 19 years old, Atsinanana

Elle peut aussi prendre des solutions avec ses amies, que 'moi, je suis enceinte, et qu'est-ce que j'ai de mieux à faire'? Et son amie va alors dire, cherche du « ravinala », dans une petite forêt. Il y a beaucoup de secrets qu'elles dévoilent comme ceci, comme cela. Elles lui montrent et elle va en chercher, le fait bouillir, et le consomme!

– Young mother, 15 to 19 years old, Atsinanana

Les conseils que je vais donner par exemple, s'il y a une amie qui me demande des conseils car un garçon veut la pousser à avoir des relations sexuelles, mais elle ne veut pas, car elle pense aux conséquences de sa grossesse. Donc, elle peut demander conseil pour toute chose. Donc, 'ne fais pas ça d'abord, parce que si tu accouches, toi qui es enceinte, tes parents vont être déshonorés. Et si tu avortes, tes parents veulent élever un enfant, donc ils vont se fâcher. Et ce garçon devra être emprisonné parce qu'il a détourné une mineure'.

– Female, 10 to 14 years old, Menabe

En fait, c'est comme les sermons à l'église, vous semez la parole de sensibilisation. Mais il y a des parents qui les incitent à se marier dès leur jeune âge afin de se décharger des lourdes charges de les élever. Donc 'il est temps que tu te maries'. Ou bien il arrive aussi que ce sont les parents eux-mêmes qui encouragent: 'untel te convient bien ou bien untel est bien pour toi'. C'est vraiment un problème pour certains enfants.

– Female, 15 to 19 years old, without children, Menabe

Remontrances par exemple, des remontrances que lui donne le médecin, 'ne sois pas pressé de faire cela'. Ou il se peut que le médecin soit fâché: 'qu'est-ce qui vous presse à entrer dans les relations sexuelles', et il se peut que le médecin dise: 'laisse-la tranquille ou sors avec elle platoniquement'.

– Male, 15 to 19 years old, Menabe

Parler avec des amies, il y a des mauvaises amies qui sont prêtes à te pourrir la vie, qui te disent de ne pas aller à l'hôpital que comme-ci que comme çà. Et il y a celles qui te donnent de bons conseils, va à l'hôpital et ne fais pas le rapport sexuel avec lui si tu ne fais pas encore de la PF. Et ce sont les bonnes amies qui font ça mais si c'était une mauvaise amie elle va lui conseiller de faire le rapport sexuel, que ça ne fait rien car tu sais compter les jours, compter les jours! Si j'ai bien compris!

– Young mother, 15 to 19 years old, Menabe

Pour moi, la raison de l'adolescente est premièrement les moyens, les moyens sont manquants et les parents l'envoient pour pouvoir s'acheter une blouse, un cartable car nous n'avons pas d'argent, nous souffrons maintenant, voilà pour moi!

– Male, 15 to 19 years old, Menabe

Ce sont ses parents qui la poussent à avoir ce genre de relation sexuelle avec un homme pour gagner de l'argent avant de rentrer chez elle!

– Young mother, 15 to 19 years old, Menabe

Peut-être une amie qui la pousserait, peut-être qu'elle lui raconte qu'elle reçoit ceci ou cela, et elle décide de faire la même chose que son amie car elle veut aussi avoir les mêmes choses!

– Young mother, 15 to 19 years old, Menabe

Il y a certaines mauvaises amies qui disent à Fara: 'avorte', ce sont par exemple celles qui critiquent.

– Female, 15 to 19 years old, without children, Menabe

C'est ça donc son conseil, pour qu'elle n'y aille pas. Je ne vais peut-être pas voir le Médecin mais l'avis de son amie qui lui a déjà dit d'utiliser la pilule ou le DIU.

– Female, 15 to 19 years old, without children, Sofia

Parce qu'elle est allée chez le médecin, il ne lui a rien prescrit. Après elle a des doutes, donc son dernier espoir c'est d'aller chez le sorcier (mpimasy). Le sorcier va lui donner ce qu'elle cherche et elle lui donne de l'argent.

– Female, 15 to 19 years old, without children, Sofia

Ce qu'elle ferait, une fois qu'elle n'en a pas eu quand elle est allée en acheter au centre de santé. Ce n'est pas là seulement qu'on en trouve. Elle peut aller à un autre endroit car ici, il y en a beaucoup. Les médecins ne veulent pas s'y impliquer. Par exemple je vais chez vous, j'en obtiendrai toujours mais quand j'étais chez le médecin, je n'ai pas pu obtenir.

– Young mother, 15 to 19 years old, Sofia

Health Care Providers

C'est un peu difficile pour les jeunes qui sont encore mineures, de venir ici, à cause de la communauté. Il y a aussi les parents qui disent, mon enfant ne fréquente pas encore un garçon pourquoi utiliser de la contraception? Un autre cas, l'enfant est déjà enceinte, alors qu'elle dit qu'elle n'a jamais fait de rapport sexuel. Pour des parents qui ont peur, ils emmènent ici leurs enfants et disent que mon enfant va utiliser de la contraception.

– Agent Communautaire, 42 years old, Analamanga

On dirait que d'autres sont d'abord intéressés, et après, ils demandent à leurs parents. Et ensuite: « C'est ce qu'AC vous a dit ? » Et ses parents arrivent et j'explique bien que ces choses, qu'il vaut mieux que les enfants les sachent, pour éviter la panique en cas d'accident… Cela est… déjà fréquent.

– Agent Communautaire, 42 years old, Analamanga

Et quand la fille a un problème, c'est moi qui explique à sa mère et espère que ce cas ne se reproduise plus. Mais le cas échéant, elle doit prendre une décision, d'utiliser la contraception si elle est consciente qu'elle doit avoir des relations sexuelles. Mais en tant que responsable de santé et de la contraception, je dis à l'enfant que la contraception n'est pas faite pour pousser à faire n'importe quoi.

– Agent Communautaire, 42 years old, Analamanga

Quand le moment commence à venir naturellement, cela se met en place dans le corps, c'est naturel. Les garçons commencent à regarder des filles. Mais cette progression naturelle est renforcée par les amis. Par exemple, la fille commence à avoir ses règles, et un ami à elle, même un peu plus âgé qu'elle, soit un garçon, soit une fille, et c'est son ami qui la pousse, « pourquoi ne pas faire comme ceci ». C'est l'ami qui pousse d'abord et c'est à cause de la persuasion d'un ami donc.

– Doctor, age unspecified, Atsinanana

Parfois, elles sont aussi accompagnées par leurs parents. Les adolescents quand ils veulent la FISA. Et en général, ce sont eux qui voudraient le faire. Et parfois, si par exemple, ils sont accompagnés par leur parents, c'est la mère elle-même qui dit: « faites-le à mon enfant », ou « donnez de l'injectable à mon enfant ». Je veux parler du comportement à propos de la planification familiale, le comportement des parents donc, et la communauté qui prend en main. C'est surtout la femme qui introduit la première. C'est l'adolescente qui dit: « je vais faire ça ». Là, parfois, elle le cache à ses parents, elle le cache à son mari. Parce que les hommes donc, surtout, surtout quand ils n'écoutent jamais ce que disent les femmes, ils n'approuvent pas les femmes qui font de la PF.

– Doctor, age unspecified, Atsinanana

Des fois, il y a les cousines mais ce n'est pas fréquent, c'est surtout elles seules. Et au moment où la mère accompagne, par exemple, on dit que Marie Stopes va venir, et c'est là qu'elles se soucient que, des fois nous n'en avons pas, alors que Marie Stopes va venir. Alors, la mère ramène la fille par exemple de 13 ou 14 ans, « elle va utiliser Implanon car je crains qu'elle ne tombe enceinte ».

– Midwife, 42 years old, Atsinanana

Ses amies, amies d'école. Parfois, sa mère qui vient avec elle parce que leurs mères savent. La coutume, ou plutôt la mentalité d'ici est ne rien interdire aux filles, quoi qu'elles fassent. Une fois qu'elles ont grandi, pour ne pas avoir d'enfant, les parents préfèrent dire « utilise une méthode de PF ».

– Doctor, 48 years old, Menabe

Et elles viennent ensemble. Je leur demande comment elles vont ; elles répondent: « nous avons entendu de notre amie présente ; nous aimerions aussi le faire aussi docteur ».

– Agent Communautaire, 62 years old, Menabe

En ce qui me concerne, cela fait longtemps que je suis AC et cela concerne toutes les rubriques: la distribution des moustiquaires ou autres Les gens du village me connaissent parce que je suis d'ici. De plus, je suis amie avec eux, je leur parle souvent. Et ils me posent des questions, car moi aussi je vais auprès d'eux pour les sensibiliser, ils savent que je fournis l'injectable, la pilule. Ils savent que je suis AC, c'est pour cela qu'elles viennent chez moi.

– Agent Communautaire, 30 years old, Menabe

« Oui, voilà ce que j'aime » dit-elle. Vous êtes pressée de la persuader qu'elle utilise Implanon, mais elle répond 'c'est ceci que je préfère'. Bon, puisque c'est ce qu'elle préfère, et si elle supporte la chose, je lui explique que ceci est comme cela… Je dis: 'voilà pourquoi je préfère ceci', tels sont les avantages, et là vous expliquez les avantages. Et vous lui expliquez aussi les effets indésirables, qu'elle ne soit pas étonnée, c'est comme cela, après avoir fait la chose chez nous, par exemple ce

– Midwife, 43 years old, Sofia

Il y a des adolescents qui le font déjà alors les parents les autorisent. Et il y a les parents qui viennent me voir en me disant de faire en sorte que leur fille ne tombe pas enceinte. Et ils se sentent soulagés car je leur dit que leur fille est déjà venue chez moi.

– Agent Communautaire, 46 years old, Sofia

Theme 3: Finding the right fit: "Supporter" and "ce qui convient"

Adolescents

Parce que si c'est l'implanon, peut-être qu'elle ne pas le supporter, son âge pourrait ne pas le supporter. Si c'est le DIU par exemple, et peut-être que les parents ne sont pas au courant de leur relation, et les parents n'aiment pas qu'elle utilise le DIU. Et si c'est la pilule, par contre, s'il y a oubli la personne tombe enceinte. Donc on utilise l'injectable.

– Female, 10 to 14 years old, Analamanga

Par exemple, si elle prend tout le temps la pilule, ses organes internes vont être abîmés, l'intérieur de l'adolescente.

– Female, 10 to 14 years old, Analamanga

Pour moi personnellement, rien de tel que de compter les jours. Car ici à la campagne, il y a beaucoup de travail à faire et il y a des femmes qui ne supportent pas la planification familiale. Donc, il vaut mieux compter les jours.

– Male, 15 to 19 years old, Analamanga

Je ne me souviens pas du nom de la contraception avec ces petites pilules. Avec elles, si on en prend tous les jours, et qu'on oublie un jour, alors que pendant cela, il y avait un rapport sexuel, la personne tombe enceinte.

– Female, 10 to 14 years old, Analamanga

… parce qu'il sait que la planification familiale endommage l'utérus et ne protège pas contre les IST.

– Young mother, 15 to 19 years old, Analamanga

Ca pourrait être des pilules donc que le docteur donnera car ainsi c'est possible pour toi de suivre sa prise. Il est possible car on peut lire les instructions avec, et lui aussi c'est quelqu'un qui a étudié alors il arrive à très bien suivre sa prise. Et après aussi, pour eux si c'est épuisé, ils peuvent en prendre chez le docteur.

– Male, 15 to 19 years old, Atsinanana

Ce qui est meilleur, c'est celui de douze ans, car celui-ci n'affecte pas le corps, et ne gêne pas les relations sexuelles.

– Young mother, 15 to 19 years old, Atsinanana

Elle peut aussi utiliser celui de tous les trois mois. Mais cela dépend de ce corps peut supporter! Il se peut qu'elle ne supporte pas celui de tous les trois ans, elle peut ainsi changer en celui de tous les trois mois.

– Young mother, 15 to 19 years old, Atsinanana

Puisque Noro est donc encore une étudiante, elle devrait faire une injection tous les 3 mois, une fois tous les 3 mois. Mais si, par exemple, elle utilise un implant et que c'est une chose qui ne lui convient pas, ça lui fait mal alors que l'injectable lui est supportable. C'est une fois tous les 3 mois qu'elle consulte un médecin pour l'injectable.

– Female, 15 to 19 years old, without children, Atsinanana

Ah ! Oui ! Ce que le médecin leur demande donc c'est la raison de leur venue. Et ils disent: nous allons vraiment faire quelque chose, faire, faire de la PF pour soigner, pour soigner, faire de la PF donc, pour entretenir le corps. Et le médecin demande toujours: vous deux, quel âge avez-vous? Et ils disent que… Est-ce que vous étudiez encore? Et qu'est-ce que vous devez faire? Ils disent que leur venue est pour faire de la PF. Et à ce moment-là, le médecin fait la comparaison: quelle PF voulez-vous faire? Et ils disent: l'implant. Et le médecin dit que son âge ne le supporte pas encore car elle encore étudiante et encore jeune, mais plutôt l'injectable. Et on te fait l'injectable donc.

– Female, 15 to 19 years old, without children, Atsinanana

Par exemple, l'injectable est pour les étudiantes mais ces implants sur les bras sont pour les femmes mariées.

– Female, 10 to 14 years old, Atsinanana

Cela ne donne pas des maux d'estomac, parce que la pilule, il faut la prendre tous les jours et si tu ne la supportes pas, tu peux tomber malade, par exemple, tu peux avoir mal à l'estomac. Mais la piqûre, je ne sais pas, tu peux y aller tous les mois et le moment venu, il faut revenir et la faire encore une foi sI

– Female, 10 to 14 years old, Atsinanana

Si la personne ne la supporte pas, elle peut tomber malade !

– Female, 10 to 14 years old, Atsinanana

L'injectable, par le fait qu'elle est donc mineure. Et ce n'est pas bon pour elle de faire de la Planification Familiale, mis à part à son 14ème jour. Et elle devrait en faire au 14ème jour puisqu'elle est étudiante. Et si par exemple tu es mineure mais utilise la pilule ou l'implant, ceci peut t'affecter. Affecter son appareil génital et c'est au 14ème qu'on s'en occupe ainsi.

– Female, 15 to 19 years old, without children, Atsinanana

Parce qu'elle est encore mineure, alors il donne du "Pilplan". Le "Pilplan" convient à son âge alors, la rend jeune. Parce qu'elle est étudiante alors elle sait suivre cela si le docteur l'instruit.

– Young mother, 15 to 19 years old, Menabe

Ou on compte « les jours » comme je disais là. Parce que, l'« implanon » et le DIU sont réservés aux gens qui sont déjà, vraiment, qui sont très fertiles, par exemple, les gens qui sont forts en accouchement, qui en ont déjà beaucoup (enfants).

– Young mother, 15 to 19 years old, Menabe

Ce qui les rende mauvaises, si par exemple, il y a une personne qui l'utilise, cela pourrait provoquer une maladie, celle qui pourrait être fatale. Puis si par exemple tu es déjà malade, son utilisation pourrait rajouter encore plus de maladie. Si tu es sensible, tu pourrais avoir des démangeaisons et des fibromes par exemple. Ça entraîne des effets secondaires

– Female, 10 to 14 years old, Menabe

Et il y a aussi celles qui envoient des signes comme quoi, on devient ronde, ça fait comme ça (rire). Il y a celles qui deviennent très maigres. Et il y a même des couples qui le font tous les jours parce que ça reste toujours raide, ça ne se ramollit pas encore, on peut suivre le cycle dans ce cas…Ces contraceptions, il y en a qui n'est pas compatible avec l'organisme de la personne.

– Female, 15 to 19 years old, without children, Menabe

Peut-être que l'injectable, par exemple si je le fais, le médecin dit qu'on ne revient qu'après une longue période tandis que pour le médicament, on doit revenir assez souvent car on le prend tous les jours.

– Female, 10 to 14 years old, Sofia

Si elle se fait injecter or qu'elle n'a pas encore accouché, elle pourrait ne pas en avoir d'enfants, l'injection pourra la rendre stérile, mais les pilules lui permettraient d'avoir d'enfants.

– Female, 10 to 14 years old, Sofia

'Je demande de la PF au centre de santé, car je vais aller avec Rakoto' selon elle. 'Etes-vous donc ensemble', dit-elle ? 'Pas encore ensemble mais je viens demander des conseils'. 'Es-tu majeure ou mineure'? 'Mineure', selon elle. Il donne d'autres suggestions. Si, par exemple, elle était majeure, il lui prescrirait un injectable. Elle est mineure, donc immédiatement, il lui dira de mettre un préservatif.

– Young mother, 15 to 19 years old, Sofia

Ce qui est très bien avec les préservatifs, c'est que ça protège vraiment, contre la grossesse non désirée, les IST. Donc, quand on a des relations sexuelles, on est protégé par le préservatif.

– Male, 15 to 19 years old, Sofia

Quatre filles venant de notre région l'utilisent là. On ne voit pas immédiatement, mais une fois qu'on l'enlève, cela provoque des réactions cutanées. Ce qui veut dire qu'on devient maigre et très sensible aux maladies. C'est ainsi que le médecin le voit. Elle mange tout, elle mange même des os. Et c'est la méthode de trois mois que le médecin donne habituellement pour les personnes qui viennent d'accoucher ou celles qui n'ont pas encore enfanté. Quand tu viens faire de la contraception, c'est ce que le médecin fait assez souvent. Mais si tu demandes celle qui dure trois ans.

– Young mother, 15 to 19 years old, Sofia

Oui, Confiance, utiliser l'injectable! Mais personnellement, je trouve que ceci n'est pas convenable d'avoir une copine qui utilise Confiance. Ce n'est pas bon selon moi, car la chose doit sortir et cela reste dans son corps. Ceci entraine d'autres maladies que celles qu'elle a déjà.

– Male, 15 to 19 years old, Sofia

Health Care Providers

Souvent, il y en a qui choisissent la pilule. Mais beaucoup disent: 'Nous préférons l'injectable, en plus c'est… ça ne se voit pas, et en plus, c'est seulement après trois mois qu'on revient'. Mais quoi qu'il en soit, le PSI nous a montrés, nous a donnés une formation comme quoi 'il n'y a pas de problème si on lui donne tout de suite l'injectable'. Mais c'est mieux, nous avons pensé que 'c'est mieux si elle prend d'abord la pilule, et après l'injectable'. Mais, selon la formation du MSI, on peut tout de suite lui donner l'injectable.

– Agent Communautaire, 50 years old, Analamanga

Mais pour celles qui sont déjà mariées, elles préfèrent utiliser la méthode, ce que l'on met sur le bras. C'est surtout destiné à celles qui veulent encore avoir des enfants, puisque cette méthode est une prévention. Si on l'enlève aujourd'hui ou bien la date est terminée pour aujourd'hui, donc la femme peut avoir des enfants demain. Donc cette méthode est utilisée par la plupart de celles qui sont déjà mariées. Mais l'injectable est préféré par les gens qui ne veulent pas encore avoir d'enfant.

– Agent Communautaire, 42 years old, Analamanga

Si elle n'a pas encore d'enfant, on lui apprend d'abord l'abstinence. Mais si elle ne peut vraiment pas se maîtriser, elle utilise le préservatif. Si elle n'arrive pas non plus à maîtriser le préservatif, là seulement, la fille est initiée à la contraception. Mais elles sont rares, c'est le préservatif qui est le plus utilisé. Et il y a très peu de femmes mariées qui utilisent les injectables.

– Doctor, age unspecified, Analamanga

Pour les jeunes adolescents, il y en a parmi celles qui en utilisent, qui trouvent des avantages. Mais pour celles qui utilisent le Pilplan, beaucoup ne le supportent pas. Ainsi je n'ose leur en donner, et quand le poids change, vaut mieux parler à sa sage-femme, c'est-à-dire changer en injectable. Si c'est une injection, on abandonne le Pilplan, c'est-à-dire, on ne fait que que de l'injection.

– Agent Communautaire, 59 years old, Atsinanana

Ainsi je n'ose leur en donner, et quand le poids change, vaut mieux parler à la sage-femme, c'est-à-dire changer en injectable. Si c'est une injection, on abandonne le Pilplan, c'est-à-dire, on ne fait que de l'injection. Mais pour cela, il y a des cas où l'estomac ne supporte pas, d'autres tombent malade et maigrissent. On ne peut pas laisser comme çà mais il faut changer encore. Il y a même des femmes déjà enceintes qui utilisent des implants, c'est contradictoire, et les rendent malades. Et il ne faut pas laisser comme cela, il faut toujours changer pour éviter cela

– Agent Communautaire, 59 years old, Atsinanana

Oui, des rumeurs aussi ! « Cela rend malade », disent-elles, nombreuses disent « cela rend malade, j'ai utilisé cela et je suis tombée malade ». Mais il y en a qui viennent vraiment « j'ai vraiment envie d'utiliser, ou comme ceci et cela, puisqu'une telle a dit qu'elle a déjà utilisé ». Cela arrive aussi.

– Midwife, 50 years old, Menabe

Quand les jeunes veulent utiliser la PF, tu dois leur dire, « puisqu'il en est ainsi, quel est ton véritable avis ? ». C'est-à-dire la raison de sa décision: elle sort avec quelqu'un, elle ne veut pas encore avoir

d'enfant et elle va encore à l'école, telles sont d'abord les raisons. Et on peut lui donner le choix. Car en tant que médecin, je sais qu'en utilisant le Depoprovera, par exemple, cela prend assez longtemps avant de tomber enceinte. On doit l'informer sur tous les effets et lui demander si elle prête à assumer ce choix. Idem si la personne est déjà plus âgée et qu'elle souhaite encore avoir des enfants. Cela prend un certain temps après avoir arrêté la méthode, avant de tomber enceinte. Mais chacune a son organisme et parfois, il suffit d'un retard à un rendez-vous pour qu'une femme tombe enceinte. Mais ce qui se produit le plus souvent est que cela prend un certain temps avant qu'elle ne tombe enceinte. Alors à elle de prendre une décision, je ne sais pas si c'est ce que vous voulez demander ?

– Doctor, 48 years old, Menabe

Et certaines demandent les injectables, mais moi je ne donne pas d'injectables car elles n'ont pas encore eu d'enfant. Donc, je ne leur donne pas d'injectable. Par contre, je leur donne souvent le Pilplan.

– Agent Communautaire, 34 years old, Menabe

Mais le DIU, ce sont les femmes un peu plus âgées qui l'utilisent.

– Doctor, 48 years old, Menabe

Beaucoup demandent l'injectable parce que quand elles prennent la pilule, peut-être qu'elles oublient. Mais celles qui utilisent l'injectable, il n'y a rien à part la date du prochain rendez-vous. En plus, beaucoup font cela en se cachant des parents. Certains parents ne sont vraiment pas d'accord pour leurs enfants utilisent cela. Pourtant, il y a des enfants qui osent. Parfois, c'est la mère en personne qui l'amène pour utiliser de la PF. Quand elle se cache de ses parents, elle préfère, en allant à l'école, c'est là qu'elle rejoint le centre et c'est fait.

– Agent Communautaire, 40 years old, Sofia

La raison pour laquelle elles ne sont pas enthousiastes à l'idée des pilules, selon ce que j'ai dit au commencement, chez nous, elles évitent de prendre des médicaments parce qu'elles disent qu'elles ont mal à l'estomac. Elles ne l'aiment pas contrairement aux injections, on n'est pas… J'ai oublié la raison pour laquelle elles ne l'aiment pas. Le fait qu'il faut la prendre tous les jours, tous les jours il faut toujours en prendre. Chaque jour qui vient, on ne peut jamais interrompre les pilules, voilà pourquoi elles… ainsi elles…l'injection est efficiente pour une durée assez longue, elles ne reviennent qu'après 3 mois.

– Agent Communautaire, 52 years old, Sofia

Theme 4: Rules of engagement: Written and unwritten rules

Adolescents

A chaque fois que Benja et Voahirana ont un rendez-vous, ils doivent consulter le médecin pour demander des conseils, quels sont les différents moyens pour éviter la grossesse précoce

– Young mother, 15 to 19 years old, Analamanga

Participant 1: Les parents de Raozy lui demanderont pourquoi elle a fait n'importe quoi, tu devrais nous en informer avant d'être allée au centre de santé.

Participant 8: Ses parents seront obligés de la gronder parce qu'elle n'est pas encore mariée alors qu'elle veut utiliser un contraceptif qui peut la rendre stérile.

– Young mothers, 15 to 19 years old, Analamanga

Participant 3: Selon moi il s'agit de… peut-être des questions si la personne est déjà majeure ou s'il étudie encore, son âge, son nom, s'il est déjà sorti avec quelqu'un, a-t-il consulté d'autre médecin, il se peut que ceux soient les questions posées à Dolin.

Participant 8: J'ajouterais un peu sur les dires de mon ami, peut-être qu'il demandera s'ils ont déjà été ensemble, et consulter un médecin pour faire des analyses.

Participant 6: Le mien est la même, il devient bénéficiaire des conseils qui pourraient améliorer leur relation alors sa morale remonte.

– Males, 15 to 19 years old, Menabe

Facilitator: Quelles sont les différentes questions que ce prestataire lui pose? Quelles questions devraient être posées par le prestataire de santé quand elle viendra voir les agents de santé? P2!

Participant 2: Il demande son âge, et il demande la date des prochaines règles avant de faire l'injection!

Participant 3: La façon de discuter du docteur quand on arrive chez lui est de lui dire 'tu utiliseras la méthode que tu tolères parmi ces méthodes'.

– Young mothers, 15 to 19 years old, Menabe

<u>Health Care Providers</u>

En général, chacun a ses propres motifs de consultation. Il y a ceux qui se disent 'je vais aller utiliser la PF'. A ce sujet en particulier, des agents de sensibilisation en termes de PF sont déjà déployés dans les Fokontany. Et les AC décèlent que tel adolescent semble 'délinquant', mieux vaut l'envoyer au CSB. Et avant, on discute avec eux, on demande vraiment leur consentement. Après seulement, on peut lui proposer la PF. Si l'adolescente a moins de 18 ans, on a encore besoin des parents, mais non pas tout de suite… A moins qu'elle ne soit déjà mariée. Car ici, certaines sont assez jeunes, certaines ont 15 ans, et elles sont déjà mariées. Ce sont les cas qui requièrent la légalisation de leur état-civil auprès du Tribunal.

– Doctor, age unspecified, Analamanga

Ils ont environ 13 ans et ont déjà des rapports sexuels. Donc, je les sensibilise ainsi « utilise quand même de la contraception parce que tu es encore mineure, tu n'es pas assez âgée, donc si tu as un enfant, l'accouchement sera très compliqué parce que tu beaucoup trop jeune, car tous tes organes ne sont pas assez matures ».

– Dispensatrice, 29 years old, Atsinanana

C'est à partir de ces critères de criblage que je décide de ce qui la concerne. Je lui pose donc des questions à partir de cela. Les questions pourraient être répondues par oui ou non. Et lorsque je les pose et qu'elle réponde à une seule 'je ne suis pas enceinte' ou bien 'j'ai mes règles', je ne pose plus d'autres questions mais je décide tout de suite qu'elle peut en utiliser. Et je lui présente les choix possibles à

l'aide d'un van, parce qu'il y a un van sur lequel ces choses sont présentées. Et je le lui montre et l'interroge, 'lequel sera ton choix, vas-y choisis' ! 'L'injectable sera mon choix, cela me convient'. Et là, je lui explique l'injectable. 'Si tu utilises cet injectable, cela se fera tous les trois mois' Cependant, je lui explique, 'cet injectable, ma chère, si tu n'as pas encore enfanté, cela ne te convient pas de l'utiliser. La raison est qu'il serait difficile pour ton utérus de reprendre son fonctionnement normal lorsque tu arrêtes de l'utiliser, ça prend assez longtemps'. Et là elle te dit: 'lorsqu'on utilise le Pilplan, c'est ce qu'elle dit, lorsqu'on utilise le pilplan ?' 'Alors, il est plus facile de tomber enceinte avec le Pilplan, si tu t'arrêtes, la muqueuse dans ton utérus ne se vide pas de son sang mais s'accroît de jour en jour, donc il y a toujours du sang, et forcément dès que tu t'arrêtes, tu tombes très vite enceinte. C'est un peu plus difficile de tomber enceinte avec l'injectable, tu peux le choisir, mais je ne te force pas hein. Ah.

– Agent Communautaire, 38 years old, Menabe

Ce sont là les critères. Il y a d'abord une consultation médicale à faire, par exemple pour l'injectable. Si on regarde la tension, si quelque chose ne lui convient pas, on ne lui donne pas. On lui dit franchement: « cela ne convient pas ta santé ! Cela peut vous rendre malade, cela peut vraiment vous rendre malade, c'est interdit ». Voilà, mais si c'est autorisé, on aurait pu. Et on lui donne d'autres choix ! Il y a d'autres choix pour elle, des choix de PF qu'elle peut utiliser, mis à part celui qui ne convient pas à sa santé… Mais c'est un libre choix, il a le libre choix pour la PF, c'est à elle de choisir, cela dépend de cela…

– Midwife, 50 years old, Menabe

Parfois, je les conseille, puisque de nos jours, les enfants sont difficiles à éduquer car ils font n'importe quoi, et ils font des bêtises. Ils vont à l'école et ils font des bêtises là-bas. Donc, je les conseille: 'ici, la PF est confidentielle. Tu peux venir me voir, je ne dirai rien à tes parents. Ils n'en sauront rien, c'est entre nous deux !' Et maintenant, il y en a qui utilisent des contraceptifs injectables, et c'est moi-même qui leur fais les injections. Et leur carnet n'est pas avec eux, mais c'est moi qui les garde. Certaines utilisent la pilule, et 'cache tes pilules et ne les montre pas'. Voilà les conseils que je leur donne pour les protéger des grossesses précoces.

– Agent Communautaire, 34 years old, Menabe

Pour les filles, elles vont au centre pour faire de la PF. Nous leur administrons les critères de criblage. Nous leur posons plusieurs questions. Elles deviennent très apeurées. Beaucoup ne sont pas éligibles quand on utilise les critères de criblage, dès qu'il y a un 'non', l'adolescente ne peut pas utiliser. Ensuite, nous n'avons pas de matériel pour consulter la tension des adolescentes qui veulent utiliser de la PF.

– Agent Communautaire, 40 years old, Sofia

Oui, critères de criblage. Et il y a un questionnaire qu'on lui pose, et si ça va, on lui fait l'injection. Sinon, « tu vas chez le docteur pour te plaindre et tu reviendras ici quand tu sera guérie pour faire la contraception ». Si par exemple, ce n'est pas le genre de maladie qui pourrait se compliquer si, par exemple, elle en fait, et il y a aussi une autre enquête rapide : « est-ce que tes règles sont arrivées ou est-ce que tu viens d'avoir un rapport avec quelqu'un ». Et on lui donne tout de suite le médicament, si elle dit que ce n'est pas le moment de mes règles mais je le ferai quand même. Et là nous lui disons d'attendre l'arrivée de ses règles, « après tu reviendras ici », nous lui disons aussi ça.

– Agent Communautaire, 54 years old, Sofia

Ce qu'on fait, nous n'avons pas encore beaucoup de matériel, mais nous avons des critères de criblage à utiliser, lors des sélections convenant à l'utilisation de cela, on peut faire la PF. Mais si la situation de vie de la cliente va à l'encontre des critères de sélection, on ne peut le faire, on doit l'envoyer au CSB.

– Agent Communautaire, 52 years old, Sofia