

# Study Overview and Methods

## ABOUT THIS BRIEF

In 2016–2017 FANTA conducted qualitative formative research with the USAID Office of Food for Peace (FFP)-funded Njira development food security activity implemented by Project Concern International and Emmanuel International in Balaka and Machinga districts in Malawi.

This brief, one in a series of four, provides an overview of the study and the methods used. The briefs describing the findings from the three study objectives are available at [www.fantaproject.org/FPintegration](http://www.fantaproject.org/FPintegration).

## Introduction

Growing recognition of the critical importance of voluntary family planning (FP) efforts to achieving the Sustainable Development Goals, including improving nutrition, food security, and resilience outcomes, has spurred interest in integrating FP within food security and nutrition programs (Bremner, Patterson, & Yavinsky, 2015; Naik & Smith, 2015; Smith & Smith, 2015; Starbird, Norton, & Marcus, 2016; USAID, 2015). A desk review by the Food and Nutrition Technical Assistance III Project (FANTA) published in 2015 highlighted the considerable variety of approaches for integrating FP into food security and nutrition programming (Borwankar & Amieva, 2015). Clearly, there is no one-size-fits-all solution; rather, integration needs to be tailored to the local context, accounting for the needs of the clients, existing FP infrastructure and services, and available resources.

USAID Office of Food for Peace (FFP)-funded multisectoral development food security activities (DFSAs) are an example of programs seeking to determine how best to operationalize

FP integration. These programs typically work across two or three technical areas, specifically agriculture and livelihoods, maternal and child health and nutrition, and disaster risk reduction. In accordance with U.S. Government FP legislative and policy requirements, including the Tiahrt Amendment, DFSAs are not permitted to procure FP commodities and must ensure that there is no perception that receipt of benefits such as food rations is linked to FP in any way. However, DFSAs can work on demand creation by increasing knowledge and improving the normative environment for the use of FP; strengthening health service delivery systems by building the capacity of FP providers at the facility or community level; and improving FP access by strengthening referrals to FP services provided by the government or other existing organizations working in service delivery. Since FP is not their primary focus, questions remain on how best to operationalize FP activities within DFSAs.

In an effort to better understand how to systematically integrate FP across health and non-health sector programming into DFSAs, Food for Peace asked FANTA to conduct a formative research study with one of its implementing partners in Malawi, the Njira activity (2015–2020, hereinafter referred to as Njira), which is implemented in Balaka and Machinga districts by Project Concern International and Emmanuel International.

## Study Goals and Objectives

The goal of the formative research study was to inform the strategic design of FP activities in Njira, taking into account the overarching activity design, local context, existing FP services within the health system, client and provider perspectives on FP, and service delivery. More broadly, the study was intended to serve as a proof of concept to generate learning on a process to help identify how to best integrate FP into DFSAs.



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The objectives of the study were to:

1. Investigate demand and supply side barriers to accessing FP services among priority target groups, namely mothers with young children and adolescent girls and young women (AGYW)
2. Assess the acceptability and feasibility of two interventions for improving access to FP services among priority target groups:
  - i. Referrals from activity Care Groups and youth groups to FP providers in the government health system, including health surveillance assistants (HSAs), community-based distribution agents (CBDAs), and facility providers
  - ii. Provision of FP services by government FP providers at a community resource center (Ubwino Center) leveraged by Njira
3. Explore community perspectives on connections between population growth, FP, health, and food security

Objective 1 provides information on factors affecting FP access and use. Objective 2 is intended to explore opportunities for improving access to FP services among two priority target groups through linkages between the activity's platforms and the public health system. For the purposes of the study, acceptability is primarily examined from the perspectives of Njira beneficiaries. Feasibility is primarily assessed in terms of implications for the actors in the public health system and the activity staff that would be engaged in implementing the interventions. The third objective is geared toward supporting the development of integrated FP messages that go beyond health in an effort to effectively leverage the activity's health and non-health platforms in promoting broader normative change and enhanced social acceptability of FP.

## Methods

This was a cross-sectional descriptive study using qualitative methods including 20 focus group discussions (FGDs) and 46 semi-structured interviews (SSIs) with a range of respondents (see Table 1).

**Location and site selection.** Study participants were recruited from four communities or Group Village Heads (GVHs)<sup>1</sup> in Balaka district and five GVHs in Machinga district. The sites in the two districts were selected to represent a mix of livelihood and FP service delivery contexts (e.g., access to public clinics and/or privately run clinics operated by Christian Health Association of Malawi [CHAM]<sup>2</sup>). Other selection criteria included having active CBDAs and HSAs trained to provide injectable contraceptives. Priority was given to GVHs where the roll-out of relevant Njira program platforms was more advanced to facilitate the recruitment of participants and to ensure participants would be able to relate to feasibility and acceptability questions. Logistical considerations related to the implementation of fieldwork were also factored into site selection.

**Sample.** A total of 229 people (141 females and 88 males) participated in the study, including:

- Activity beneficiaries or community members:
  - 160 cluster group members or those engaged in Njira's health activities, including; 52 mothers (4 FGDs, 12 SSIs) and 33 fathers (4 FGDs) of young children belonging to Care Groups, Father Groups, or spouses/partners of Care Group members
  - 40 adolescent girls and young women (4 FGDs, 6 SSIs) and 35 adolescent boys and young men (ABYM, 4 FGDs) participating in youth groups Njira planned to collaborate with
  - 41 men and women who were members of other health and non-health sector activity platforms, such as producer groups, women's empowerment (WE) groups, water point committees (4 FGDs), and village civil protection committees (VCPC, 4 SSIs)
- Activity informants (10 SSIs) engaged with Care Groups and youth groups (youth leaders, lead mothers, and health promoters)
- Government health service providers including facility-based, HSAs, and CBDAs (14 SSIs)

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1 Districts are divided into traditional authorities and sub-traditional authorities. The Group Village Heads is the smallest administrative unit.

2 As the largest non-governmental healthcare provider, CHAM provides at least a third of health care services in Malawi.

The numbers of FGDs and SSIs per respondent category (e.g., mothers, ABYM, activity informants) shown in Table 1 were based on the minimum considered acceptable to capture the most prevalent themes among relatively homogenous individuals within the sub-population (Greg, Namey, & McKenna, 2016; Guest, Bunce, & Johnson, 2006). The overall sample size was also based on financial and time considerations.

**Demographic characteristics of sample.** About 60 percent of the community members and providers participating in the study were female. The average age of AGYW and ABYM from youth groups was 20.3 years (range 18–24 years) and the average age of the rest of the community members interviewed was 29.8 years (range 19–59 years).

Although efforts were made to recruit adolescents 18–19 years and emancipated minors (15–17 years and married), the most common age range of the youth group members who met the eligibility criteria was 20–24 years. About 80 percent of the providers and activity informants were under 35 years.

Almost two-thirds of the community members in the study sample were married, including close to a third of the AGYW and ABYM. Eighty percent of the community members and 40 percent of the providers and activity informants were Muslim. Having no children was an inclusion criterion for AGYW and ABYM; the average number of children for other community members was 3.4 (range from 1 to 10); and about 20 percent reported having 5 or more children.

**Table 1. Data collection components by district and respondent categories**

Data Collection Methods and Respondent Categories	DISTRICT		TOTAL
	Balaka	Machinga	
FGDs with cluster group members	8	8	16
Adolescent girls and young women	2	2	4
Adolescent boys and young men	2	2	4
Mothers	2	2	4
Fathers	2	2	4
FGDs with members of other health and non-health platforms	2	2	4
Women's Empowerment group	1	1	2
Water point committee and producer group	1	1	2
SSIs with cluster group members	12	6	18
Adolescent girls and young women (youth group)	4	2	6
Mothers – FP users	4	2	6
Mothers – FP non-users	4	2	6
SSIs with activity informants	5	5	10
Youth leaders	2	2	4
Lead mothers	2	2	4
Health promoters	1	1	2
SSIs with providers	9	5	14
HSAs	2	2	4
Adult CBDAs	4	-	4
Youth CBDAs	2	2	4
Facility-based FP providers	1	1	2
SSIs with VCPC members	2	2	4
VCPC members	2	2	4
<b>Total</b>	<b>38</b>	<b>28</b>	<b>66</b>

About two-thirds of community members said they were using an FP method, including close to 40 percent of AGYW and ABYM. Almost all community members had some education, but more than half had not completed primary school. ABYM were the most likely to have completed secondary school. While youth leaders and lead mothers had somewhat lower levels of education (only one youth leader had completed secondary school), nearly all health promoters and providers had completed secondary school or higher education.

**Data collection.** Data were collected between October and November 2016 by a team of seven trained research assistants. A set of 10 data collection guides (five FGD and five SSI) were developed for the study. Table 2 provides a summary of how the broad domains explored in the various data collection guides align with the three study objectives and the respondent groups. The English guides were translated into Chichewa and Yao and pre-tested during the research assistant training. All FGDs and SSIs were digitally recorded with participants' permission.

The FGDs with AGYW and mothers utilized a vignette or form of directed storytelling with fictitious characters to explore the acceptability of the two possible FP integration design options that were assessed in the study. The stories were used to assess interest and/or concerns about each design option, elicit recommendations related to operationalizing referrals and/or service provision at the community resource center, probe and pursue issues related to accessing FP services in the context of the stories, and invite any other ideas or suggestions participants had on the design options. Similarly, the FGDs with group members of other activity platforms utilized a vignette to explore community member perceptions of the benefits of healthy timing and spacing of pregnancies and implications of family size on resilience and livelihoods.

**Data analysis.** The research assistants transcribed and translated the digital recordings verbatim from Chichewa or Yao into English in password-protected word-processing files. NVivo 11, a qualitative data analysis software, was used to

**Table 2. Data collection guides and topics, by study objective**

Research Objective and Domain	Data Source	
	FGDs	SSIs
<b>Objective 1: Demand and supply side barriers to FP use among adult women with young children and AGYW</b>		
Attitudes toward fertility, ideal family size, child spacing, and FP	Mothers, fathers, AGYW, ABYM	Mothers, AGYW, VCPC members
Perspectives on partner and social support for FP; FP decision making	Mothers, fathers, AGYW, ABYM	Mothers, AGYW, activity informants, VCPC members
Perspectives on current FP services	Mothers, fathers, AGYW	Mothers, AGYW, providers, activity informants, VCPC members
<b>Objective 2: Acceptability and feasibility of two FP integration interventions</b>		
Perspectives on the two FP integration design options	Mothers, AGYW, fathers	Activity informants, providers
<b>Objective 3: Perspectives on connections between population growth, FP, health, and food security</b>		
Perspectives on changes in the community, population, and environment and perceived impacts of these changes on livelihoods, food, health, and resilience of families	Other project platforms (members of WE and producer groups, water point committees)	VCPC members
Perspectives on ideal family size and implications of family size for resilience		
Perspectives on benefits of healthy timing and spacing of pregnancy on other aspects of lives and livelihoods		

organize the data for analysis. Both thematic and structural codebooks were developed. A separate structural codebook was developed for each interview type, while a single thematic codebook that captured overarching themes was used across all interviews.

Two coders were assigned to code each interview type. Approximately 15 percent of transcripts for each interview type were independently coded by both coders, then compared and reconciled to reach 100 percent agreement; intercoder agreement was established early in the coding process then intermittently checked during the coding to ensure consistency throughout the process. Coding summaries and analysis memos extracting key findings from families of related thematic and/or structural codes were generated based on an analysis framework that was developed to align with the three research objectives. The preliminary findings were shared with the Njira project at a two-day workshop in September 2017 in Zomba, Malawi, to ground-truth the findings and discuss programmatic recommendations.

**Ethical considerations.** The study was reviewed and approved by the ethical review boards at FHI 360 and College of Medicine Research Ethics Committee (COMREC). Written informed consent was obtained from all participants before conducting the interviews. The study team used unique identification numbers during interviews and for transcription to protect participants' privacy and confidentiality.

## Findings

To facilitate broad uptake of research findings beyond Njira, key findings from the three research objectives are reported on in three research briefs available at: [www.fantaproject.org/FPintegration](http://www.fantaproject.org/FPintegration).

**Research Brief 2** discusses the demand side factors affecting FP use.

**Research Brief 3** describes community perceptions of current FP services, including supply side factors affecting FP use, and the feedback obtained on the two design options for FP integration that the study assessed.

**Research Brief 4** describes community perspectives on connections between population growth, FP, health, and food security.

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