

**USE OF MODERN FAMILY PLANNING METHODS: UNDERSTANDING THE
CONTEXT OF UNMET FAMILY PLANNING NEEDS IN RURAL MZIMBA,
NORTHERN MALAWI.**

PHD (SOCIOLOGY) THESIS

by

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the requirements for the degree of Doctor of Philosophy (Sociology)

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DECLARATION

I, the undersigned, hereby declare that this thesis is my own original work which has not been submitted to any other institution for similar purposes. Acknowledgements have been made where other people's work has been used.

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CERTIFICATE OF APPROVAL

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DEDICATION

To my mother Vera, I never realized you would return to the Lord before I finalized this thesis. Every day you woke up and found me writing you asked: *mulemba?(are you writing?)*. Your words inspired me to keep writing. You should have lived mum to see and read what I was writing. RIP mum till meet again!

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ABSTRACT

In Malawi, total fertility rate (TFR) has remained high at 6.0 children per woman. Use of modern contraceptive methods is lower at 42 percent than the current demand at 72 percent. This has resulted in high unmet contraception need, currently at 26 percent (NSO and ICF Macro 2011). The available evidence suggests that there are barriers to contraceptive use at both community and health service delivery level. This study was done in Mzimba District in the rural communities of Traditional Authority (TA) Mzukuzuku, and Mzimba District headquarters. The aim of the study was to understand the context of unmet family planning (FP) need among currently married women within the age group 15-49 years. Specifically the study sought to: establish the level of unmet FP need in Mzimba, identify socio-cultural factors that influence unmet FP need, examine health system factors influencing unmet FP need and explore community perceptions regarding use of modern contraceptive methods. This cross-sectional study employed both qualitative and quantitative methods which included a survey of currently married women; focus group discussions with users and non-users of modern contraceptive methods; and married men separately. In-depth interviews with key informants and clients exiting FP facilities were done. The findings of this study suggest that a combination of factors mitigate against use of modern contraceptive methods. Prominent among these are gender based power imbalances, social influences and health system barriers.

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LIST OF ABBREVIATIONS AND ACRONYMS

AEHO	Assistant Environmental Health Officer
AFIDEP	African Institute for Development Policy
AIDS	Acquired Immunodeficiency Virus
APHRC	African Population Health Research Centre
ART	Anti- Retroviral Therapy
BLM	Banja la Mtsogolo
BTL	Bilateral Tubal Ligation
CBDA	Community-based Distributing Agents
CBD	Community Based Distribution
c-Change	Communication Change
c-EHP).	Community Essential Health Package
CFPHS	Community-Based Family Planning and HIV/AIDS Services
CHAM	Christian Health Association of Malawi
CI	Confidence Interval
COCI	Community Outreach Clinic Initiative
COMREC	College of Medicine Research and Ethics Committee
CPR	Contraceptive Prevalence Rate
CSA	Central Statistical Authority
DFID	Department for International Development
DHO	District Health Office
DHS	Demographic Health Surveys
DMPA	Depot Medroxy-Progesterone Acetate
DHMT	District Health Management Team
DVD	Digital Versatile Disc

EAs	Enumeration Areas
EHP	Essential Health Package
ESD	Essential Service Delivery
FGDs	Focus Group Discussions
FHI	Family Health International
FP	Family Planning
FPAM	Family Planning Association of Malawi
GOM	Government of Malawi
HC	Health Centre
HCT	HIV Testing and Counseling
HIV	Human Immunodeficiency Virus
HSSP	Health Service Strategic Plan
HSA	Health Surveillance Assistants
IEC	Information, Education and Counseling
ICPD	International Conference on Population and Development
IDI	In-depth Interviews
IPPF	International Planned Parenthood Federation
IUCD	Intra Uterine Contraceptive Device
KAP	Knowledge Attitudes Practices
LGA	Local Government Area
MCP	Malawi Congress Party
MoLGRD	Ministry of Local Government and Rural Development
MDHS	Malawi Demographic Health Survey
MDGS	Malawi Growth and Development Strategy
MDGs	Millenium Development Goals

MHRC	Malawi Human Rights Commission
MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MRHS	Malawi Reproductive Health Strategy
MSH	Management Sciences for Health
NCSP	National Child Spacing Programme
NSO	National statistical Office
NGO	Non-Governmental Organization
PoA	Programme of Action
PAI	Population Action International
PHC	Primary Health Care
PoW	Programme of Work
PopFP	Population and Family planning
PMTCT	Prevention of mother to child transmission
PRB	Population Reference Bureau
RH	Reproductive Health
RHU	Reproductive Health Unit
SLA	Service Level Agreements
SWAp	Sector Wide Approach
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
TA	Traditional Authority
TOCI	Tent Outreach Clinic Initiative
TFR	Total Fertility Rate

VDC	Village Development Committee
VHC	Village Health Committees
WCBA	Women of Child Bearing Age
WHO	World Health Organization
YFS	Youth Friendly services
US	United States
USAID	United States Aid for International Development
UNICEF	United Nations Children’s Fund
UNFPA	United Nation Fund for Population Activities
ZHSOs	Zonal Health Support Offices

CHAPTER ONE

INTRODUCTION

1.1 Fertility and population growth rates for Malawi

Malawi is one of the countries with high fertility and rapid population growth in Sub Saharan Africa (AFIDEP 2012; UNFPA 2012). The population of Malawi has grown from 4,039,583 million people in 1966 to 13,102,076 people in 2008 representing an increase of 32 percent, or an intercensal population growth rate of 2.8 percent per year (Figure 1). Population projections for 2015 put the country's population at 16,310,431 million, representing a population growth rate of 3.21 percent (NSO 2008; NSO 2010).

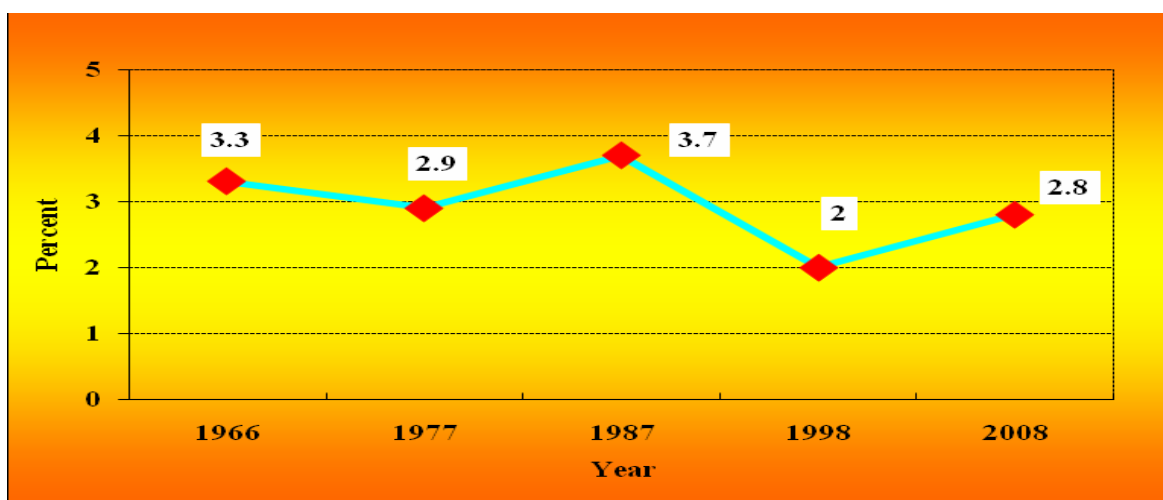


Figure 1 Malawi's annual intercensal growth rate 1966-2008

Source: Malawi Population and Housing Census, 2008

By 2050 the population is projected to increase to 45,180,255 million which is three times the current population (NSO 2010). The steady increase in population is due to

continued high fertility rates. According to the 2010 Malawi Demographic and Health Survey (MDHS) the total fertility rate (TFR) stood at 5.7 births per woman. This represents a decline from 6.7 recorded in 1992, 6.3 in 2000 and 6.0 in 2004. Although the fertility trends show a substantial decline in the period between 1992 and 2010, the number of children ever born to a woman of reproductive age remains high, and the rate of decrease has not been as fast as expected. The TFR has remained high in the rural areas at 6.1 compared to urban areas at 4.0 births per woman (NSO and ICF Macro 2011).

1.1.1 Implications of high fertility and population growth rates for Malawi

The high TFR for Malawi have contributed significantly to high maternal mortality rates. Malawi's maternal mortality ratio (MMR) is one of the highest in the Sub-Saharan Africa region currently estimated at 675 maternal deaths per 100,000 live births (NSO and ICF Macro 2011). These poor indicators have adverse effects on the population particularly on the quality of life and longevity which impact negatively on the socio-economic development of Malawi. Furthermore, the rapid rate of population growth can hinder current and future progress in national economic growth, development, and health (AFIDEP 2012). It is known, for example, that rapid population growth on a limited land base leads to land fragmentation and resultant farm holdings which may be too small for household subsistence and livelihood requirements. Land poverty is a major determinant of rural poverty in Malawi (Kishindo 2009; Republic of Malawi and World Bank 2007). Given its small resource envelope the country is struggling to provide adequate social services such as health care, education and portable water to its citizens. Inadequate social service provision is reflected in poor social indicators (NSO and ICF Macro 2011).

1.2 Malawi's family planning (FP) policy: objectives and operationalization

The Malawi National Reproductive Health Programme is the framework through which MoH manages sexual and reproductive health and rights (SRHR) services. Malawi adopted the National Population Policy, which among other outcomes also aimed to improve FP and health care programmes. In line with the recommendations of the Programme of Action (PoA) of the 1994 International Conference on Population and Development (ICPD) held in Cairo, Egypt, the Malawi government committed itself to implementing the comprehensive and integrated approaches to SRHR to improve not only the health of childbearing women, but also address the needs of youth and men in all aspects of SRHR (MoH 2009a). The ICPD PoA called on governments to provide universal access to FP and sexual and reproductive health (SRH) services and reproductive rights; deliver gender equality, empowerment of women and equal access to education for girls; address the individual, social and economic impact of urbanization and migration and support sustainable development and also address environmental issues associated with population changes. These recommendations were essential for eradicating poverty and stabilizing population growth which is crucial to sustainable development. In response to this, MoH through the Reproductive Health Directorate (RHD) has since 1997 intensified efforts in the implementation of the FP programme at all levels as well as the development of the SRH policy. The SRHR policy was developed and launched in 2002 and it provides the framework for implementation of the SRHR programme in the country supporting both the National Health Plan 1999-2004 and Malawi Government vision for the health sector 2020 (MoH 2009a).

Apart from the SRHR policy, several documents provide policy direction on SRH issues including FP, viz:

- a) The Malawi Growth and Development Strategy (MDGS): This is an overall development plan for Malawi and aims at creating wealth through sustainable economic growth and infrastructure development as a means of achieving poverty reduction.
- b) The National SRHR Strategy (SRHRS) 2011-2016: The SRHR Policy and Strategy underpins Malawi's commitment to the achievement of MDG 3, 4, and 5 and identifies priority actions to reach the MDG's targets and improve SRH outcomes of Malawians. This national SRHR strategy aims at giving direction and guidance to the implementation of SRH services countrywide so as to achieve the highest possible level of quality integrated SRH for all Malawians.
- c) The Road Map for accelerating the reduction of maternal and neonatal mortality and morbidity in Malawi (2007): This was developed in response to the maternal mortality situation and also to the global and regional call for each country to develop a country specific Road Map to accelerate the attainment of the MDGs related to maternal and neonatal health.
- d) African Union Maputo Plan of Action (2006). It takes into account the human cycle approach in the provision of integrated reproductive health services and one of its nine (9) components directly related to FP is the repositioning of FP as a key development strategy.
- e) Ouagadougou Declaration. African countries reaffirmed their commitment to Primary Health Care (PHC) as a strategy for delivering health services, and as an approach to accelerate the achievement of the MDGs.
- f) Abuja Declaration (2001) called on African Governments to increase allocation of resources to the health sector to at least 15% of the national

budget. However, for Malawi this is still a long term goal and is expected to be achieved within the context of the overall budgetary balance.

- g) The Millennium Development Goals (MDGs): The Malawi Growth and Development Goals were derived from the MDGs. Out of the eight MDGs, Goal 5b which aims to achieve universal access to reproductive health is directly related to FP. MDG Goal 5b's major focus is to increase contraceptive prevalence rate, reduce adolescent pregnancies, improve antenatal care coverage and reduce the unmet need for FP. Fulfilling these commitments is critical to improving women's reproductive health (United Nations 2013).

Malawi's SRHR policy reflects international concerns and is not entirely home-grown. The policy also incorporates emerging issues in various components of SRHR and these are in line with both national and international recommendations on SRHR services.

1.2.1 Family planning service delivery in Malawi

In order to increase FP coverage and meet demand for FP services, MoH and other stakeholders embarked on scaling up FP services at community level through use of innovative approaches such as engagement of community health workers namely, Community based distribution agents (CBDAs) and Health surveillance assistants (HSAs). The CBDAs are selected by their communities and recruited as volunteers. CBDAs are responsible for provision of information and counselling of FP and distribution of condoms and oral contraceptives using a door to door approach. Currently, selected CBDAs also provide HIV counseling and door to door testing. In cases where the client has chosen a method that they cannot provide, they refer the

client to the next level of care (in this case it is the health centre). For hormonal injectables they refer to HSAs and for long term and permanent contraception methods they refer to the outreach clinics or health facility (MoH 2013). The MoH guidelines stipulate that there should be about 20 CBDAs in every health centre catchment area and each CBDA should serve at least five villages (estimated population of 1,000).

HSAs are primary health care workers who serve as a link between the health facility and the community. They reside and work in the community and are known to be community members. HSAs work through village health committees and are supported by Assistant Environmental Health Officers (AEHOs). They constitute 30 percent of staff working in the health sector. The MoH's plan is to have one HSA serve a Village Health Clinic, which serves a population of 1,000 (MoH 2009b; MoH 2010). HSAs spearhead provision of community essential health package (c-EHP). These include disease surveillance, environmental health promotion, demographic surveillance, vaccination and growth monitoring, which is done at the community in their catchment areas. In addition, they provide other health services based on community needs. The HSAs also work at Village Health Clinics where they treat under- five children for minor ailments and they also provide FP methods (condoms and oral contraceptive pills) and Depot Medroxy-Progesterone Acetate (DMPA) at community level (MoH 2009b; MoH 2013). The provision of DMPA was initiated in 2008 by MoH in order to increase the contraceptive method mix at community level. Available evidence show increased access to DMPA in the rural underserved communities (Figure 2 below) (USAID-Malawi 2011).

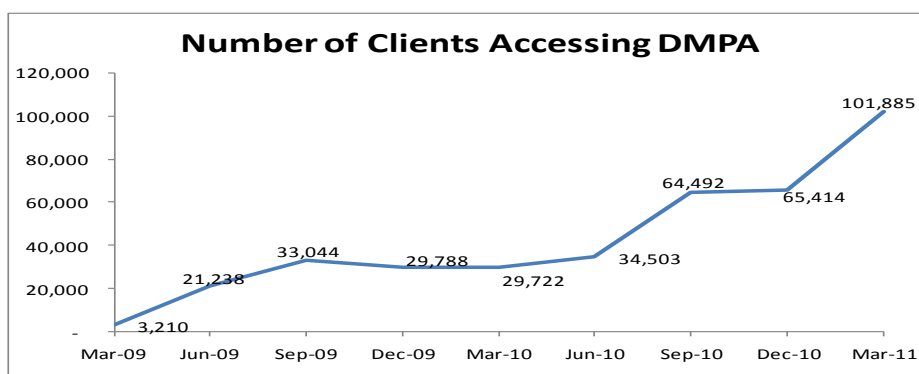


Figure 2 Uptake of DMPA, 2009-2011

Source: USAID-Malawi (2011)

These two community based distribution (CBD) models, using CBDAs and HSAs, have shown evidence of success in areas where they are implemented resulting in increased access to FP services in the communities they serve (MoH 2003; Barnes et al. 2010). There is evidence to show that there is a reduction in TFR in countries where HSAs have provided injectable contraception at community level (PATH 2005).

FP services like other maternal and child health services have largely been facility-based. The facility based FP services are provided through the network of public, NGO and private sector facilities. FP services are delivered as an integral part of comprehensive and integrated SRH services. At the health facility level, SRH services are integrated with other health programmes such as nutrition, HIV and AIDS, tuberculosis and malaria (MoH 2008). A number of CHAM facilities provide FP services except those that belong to the Catholic Church (which promotes use of natural methods). To ensure that services in the EHP are available with universal coverage for all Malawians, MoH has signed Service Level Agreements (SLAs) with CHAM facilities for the delivery of Maternal and Neonatal Health (MNH) services including FP. This has resulted in the removal of user fees as one way of ensuring that

the services are accessed by everyone regardless of their socioeconomic status (MoH 2011a). Under this arrangement, DHOs enter into agreement with CHAM institutions at their level at which health services are provided free of charge by CHAM institutions and the cost of which are subsidized by the DHO from their budgetary allocation to ensure coverage. There are currently 72 SLAs in operation. This arrangement has contributed to the improved access to health care services, especially for the poor and vulnerable in the rural communities (MoH 2011a).

Other NGOs actively providing FP services are Banja la M'tsogolo (BLM) and Family Planning Association of Malawi (FPAM). BLM is a Malawian health care NGO established in 1987. The organization has national coverage and provides quality SRH services, with a focus on FP, to un-served or under-served communities, free at the point of delivery. BLM also extends its reach through social franchising of private health care providers in the southern and central regions of the country under the BlueStar Healthcare Network. All these initiatives have played a significant role in expanding access to reproductive health services (BLM 2012).

FPAM is a non-profit making NGO dealing with SRH. It is a full member of International Planned Parenthood Federation (IPPF) and was established in 1999. FPAM largely focuses on providing a wide range of integrated SRH services including FP, targeting mainly young people and rural communities. These are provided through its service delivery points at the Youth Life Centres and schools. FPAM also distributes contraceptives through their community-based distributors and advocates for gender-sensitive SRH rights in the country (FPAM 2012).

1.3 Statement of the problem

Malawi has experienced a steady increase in use of modern contraceptive methods among currently married women from 28 percent in 2004 to 42 percent in 2010. However, despite this, the TFR has remained high (NSO and ICF Macro 2011). Available evidence further highlights discrepancies between current demand for contraception (72 percent) and current use (42 percent- for modern contraceptive methods) resulting in high unmet FP need (NSO and ICF Macro 2011) (Figure 3 below).

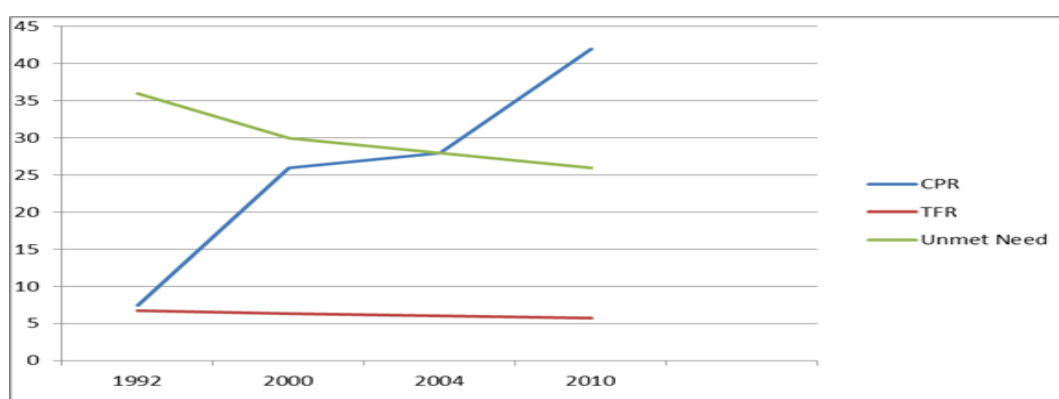


Figure 3 Contraceptive prevalence rate, TFR and Unmet need in Malawi, 1992-2010

Source: MDHS 1992, 2000, 2004, 2010

Unmet FP need, which is described as number of currently married women who want to avoid pregnancy but are not using any method of contraception, is highest in the younger age group (15-19), with 23 percent of women having an unmet need for spacing their births. More women in rural areas (27 percent) have an unmet need for FP compared with urban women (24 percent) (NSO and ICF Macro 2011). The high FP unmet need is attributed to several factors that hinder contraceptive access in Malawi which include social, cultural, religious factors and health system barriers (c-Change 2012; MoH 2009a). Stephenson et al. (2007) found that cultural beliefs and

values as well as social practices were major barriers to FP use in Malawi (Stephenson et al. 2007; Yeatman 2009). Studies done by Zulu (1996); Solo et al. (2005) and Yeatman (2009) identified social and cultural factors that encourage high fertility in traditional Malawian society. These sociocultural factors included the desire for large families, opposition by males and family members and strong son preference norms especially in patriarchal societies. In most Malawian societies, the desire for more children especially in rural areas resulted from the perceived value of children as a source of social, economic and political security (Hoffman et al. 2008). Sarlio and Kulmala (2007) observed that in rural Malawi, men had a central role in decision making, including on matters of family size, use of health services and contraception. Since it is men who decided when and where a woman should seek health care, women failed to recognize and voice their concerns about health needs. Furthermore, men controlled all resources and usually a woman alone could not make the decision to spend money on health care (Shaikh and Hatcher 2004).

Apart from sociocultural factors, the rural areas of Malawi are least served by health care facilities (Chintsanya and ICF Macro 2013). This has resulted in poor access to FP services (MoH 2008; Solo et al. 2005). Furthermore, ensuring contraceptive security has been a challenge for the FP programme in Malawi resulting in persistent stock-outs of contraceptive commodities (MoH 2013; c- Change 2012).

Many studies have sought to provide explanations on the barriers to access of modern contraceptive methods in general terms. Unmet FP need in the context of specific cultural groups has not been adequately studied in Malawi. This study sought to capture the contextual factors that influence unmet FP need in a rural patrilineal-

virilocal society in Mzimba, northern Malawi. It was envisioned that the study would identify culture-specific and localized health system factors and how these impact on use or non- use of modern contraceptive methods.

1.4 Aim of the study

The aim of this study was to understand the context of unmet FP needs among currently married women within the age group 15-49 years in the patrilineal-virilocal society of TA Mzukuzuku in Mzimba, northern Malawi.

1.4.1 Specific objectives

To achieve this aim the following specific objectives were formulated:

1. To establish the level of unmet FP need.
2. To identify sociocultural factors that influence unmet FP need.
3. To identify health system factors that influence unmet FP need.
4. To explore the influence of community perceptions on use of modern contraceptive methods.

1.5 Conceptual framework

The decision to adopt modern contraceptive methods is complex. It involves interplay of many factors which are personal, socio-cultural and institutional. The complexity of underlying factors renders single theory explanations inadequate. The conceptual framework used in this study is derived from theories of gender and power, social cognitive theory, diffusion of innovation theory (theory of perceived attributes) and health care utilization theory. It was envisaged that integration of elements of these theories into a conceptual framework would produce a more robust explanatory

framework than the individual theories. The individual theories from which the framework is derived are discussed below:

1.5.1 Gender and power

The theory of gender and power as used in this study explains the sexual division of power and the sexual division of labour between men and women (Connell 1987). These two structures have been identified as fundamental structures in explaining gender relations (Wingood and DiClemente 2000) and are embedded at the societal level. These structures remain largely intact over a long period of time despite changes at the societal level (Wingood and DiClemente 2000). The sexual division of power results in power imbalances between men and women leading to inequalities which have resulted in men having greater freedom and rights than women enjoy (Mason 1995; Riley 1997). According to de Beauvoirs (1974) males are perceived as 'real' and everything else, including women, are perceived as 'other' (de Beauvoir 1974). This leads to gendered stereotypes which often foster a negative self- image among women and is reflected in the woman's inferior personal and family status (Haj-Yahia 2005), and lack of autonomy in reproductive choices such as limiting or spacing births. An important consequence of 'otherizing' women is that they become defined in terms of their functional significance to men rather than in terms of their own significance. A woman is therefore perceived of value depending on the number of children she can produce for the man and his clan. This forces women to bear more children in order to fulfill society's expectations.

On the other hand, the sexual division of labour often results in differential roles between men and women. At the societal level, the sexual division of labour refers to

the allocation of women and men to certain roles and responsibilities. Often, women are assigned different and unequal positions relative to men. 'Women's work' is often perceived as inferior to 'men's' work (Wingood and DiClemente 2000; Haj-Yahia 2005). The gendered assignment of roles and responsibilities constrains women because the nature and organization of women's work subject them to economic constraints and discrimination imposed on them within and outside the family. This limits their economic potential resulting in economic dependency on men. This dependence compromises women's ability to make independent decisions on fertility regulation including seeking contraceptive supplies (Bogale et al. 2011; Gage 1995). Creanga et al. (2011) and Diniz et al. (2012) observe that possibility of spousal economic support deprives women of their ability to discuss their FP needs freely with their own spouses, other members of the household and the community.

1.5.2 Social - cognitive theory

The social cognitive theory is based on the idea that people acquire and maintain certain behavioral patterns through learning (Bandura 1986). People learn by watching what others do and will not do and these processes are central to understanding personality. Furthermore, the influence of the environment in which one grows up and the individual person (therefore cognition) are important determinants of moral behaviour. Environment refers to the factors that can affect a person's behaviour (such as the situation, roles and relationships). Of particular importance in this study are social and physical environments. In this study, the social environment includes family members, friends and colleagues while the physical environment refers to the place where the person lives with its norms and values (household or community). Environment and situation provide the framework for

understanding behaviour. Applied to fertility regulation, it is known that the behaviour outcome of use or non-use of contraception depends heavily on social influences (Ali and Okud 2013; Behrman et al. 2002; Montgomery and Casterline 1996). Family members and peers (as part of social networks) have been identified as an important predictor of contraceptive behaviour as well as an important source of contraceptive knowledge. Family and peers play a key role in mediating culture to the individual, providing the building blocks for making sense of one's experience as well as influencing the individual to conform to group norms (Hodgins 1999). Therefore, individual behaviour choices to use contraception are partly determined by how acceptable their significant others believe the behaviour to be. This means that an individual's behaviour responds to the behavior of others in his or her reference group (Kincaid 2000; Valente et al. 1997). For example, an individual is more likely to use contraception if there is a high rate of contraception use within their reference group than if there is not because individuals commonly rely on advice about contraceptive methods from those in their social networks (Behrman et al. 2002).

1.5.3 Diffusion of innovation theory (theory of perceived attributes)

Rogers (1962) diffusion theory' posits that the attributes of an innovation are significant predictors of the rate of adoption. Individuals are likely to adopt innovations which demonstrate the following attributes:

- a) They are better or produce better results than current technologies.
- b) They are compatible with existing societal values and practices
- c) They can be managed within the available resources
- d) They can be tested on a small scale without adoption
- e) They are able to produce observable results

The notion of perceived attributes can be used to explain or predict contraceptive use behavior. The way individuals in a social system perceive the characteristics of FP methods can influence use or non- use of contraceptive methods. Relative advantage has been shown to be the strongest predictor of the rate of adoption of an innovation. Available evidence has shown that concerns of side effects (especially fear of infertility) limit contraceptive use, forcing women to rely on traditional methods or abortion (Hubacher et al. 2008; Williamson et al. 2009). Where contraceptive use is associated with promiscuity, non-use of modern contraceptive methods is seen as a way of protecting one's reputation, social status, honor and pride. This is often a result of perceived promiscuity related to contraceptive use (Bawah et al. 1999; Kabagenyi et al. 2014; Ochako et al. 2015). Evidence show that individuals decision to adopt modern contraceptive methods is often influenced by assessment of compatibility/consistency with existing cultural values, beliefs and expectations: for example, growing up in a culture that places high value on child bearing for the survival and continuity of lineages may influence contraception decision-making in couples and also affect their ability to seek advice, information and services (Bigombe and Khadiagala 1990; Caldwell and Caldwell 1987). Similarly, cultural expectations regarding family and fertility results in community negative perceptions and disapproval of efforts that are aimed at limiting childbearing. Evidence shows that opposition from family or community plays a great role in contraceptive adoption (Casterline et al. 2001; Unger et al. 2000). Cleland et al. (2011) observe that methods perceived to rely on complex technology have not been widely accepted and used.

1.5.4 Health care utilization theory

This model is one of the most frequently used frameworks for analyzing use of healthcare services. It identifies three categories of determinants of health care use: predisposing factors, enabling factors and need.

Predisposing characteristics. The predisposing characteristics are demographic, social-structural and attitudinal-belief variables that affect decisions to improve health and utilize health care at the individual level (Ricketts and Goldsmith 2005). According to Andersen (1973), an individual is more or less likely to use health services based on her or his knowledge of the available health care choices and perceptions of cost of services (distance cost and the actual cost of services) (Ensor and Cooper 2004). An individual who believes health services are useful will likely utilize those services.

Enabling characteristics. These are the system and structural characteristics that affect use of health care. This looks at the attributes of the community where the individual lives that enable them to obtain services like geographical location of services; convenience of obtaining care (travel time to care); availability of health care services or actual number of services in the community (Frenk 1992; Penchansky and Thomas 1981). It also looks at the health care system resources and organization of care which include health personnel, structures where care is provided, equipment and materials (Andersen and Newman 1973) and the ease with which people can use care (clinic hours, waiting time, length of waiting time for an appointment, nature of service providers and processes of referral to other sources of care (Andersen and Newman 2005; Ricketts and Goldsmith 2005).

Need. Use of health care services usually depends on whether the individual identifies a ‘need’ and is willing and able to seek appropriate health care (Grossman, 2000). The term ‘need’ has been described as the biological imbalance of individuals and is considered an important determinant of health behaviour (Andersen, 1995). According to Frenk (1992) a person’s ability to utilize health care depends on a given a need and/or desire to obtain it.

Andersen and Newman’s theory can be applied to understand FP health seeking behaviours. Social characteristics of an individual and structural characteristics of the community and health care services play a role in utilization of FP services (Anson 2004:198 cited by Long et al. 2010). At an individual level, factors such as parity, age, place of residence, personal beliefs, the level of education and socioeconomic status are strong predictors of contraceptive use since they influence demand and uptake of contraception (Davanzo and Adamson 1998). At the health service level, access or availability of FP services and quality of care in relation to provision of contraceptive services are the key factors in the adoption of contraceptive use. Access to a full choice of contraceptive methods is essential if an individual’s right to control their fertility and protect their sexual health is to be maintained. Secondly, the choice of FP methods can be influenced by supply factors such as the volume of FP services (actual number of FP service delivery sites), volume of personnel trained in FP service provision and availability of FP commodity supplies in a given community (Babitsch et al. 2012; Ensor and Cooper 2004; Rodgers 1973): for example, availability of a variety of contraceptive commodity supplies will ensure that women and couples are able to choose, obtain, and use the contraceptive method that they want. Stock outs of contraceptive commodities precipitate decisions to discontinue

use of a service (Hodgins 1999). Similarly, the ease with which people can use FP services such as clinic hours, waiting time, length of waiting time for an appointment is a great source of motivation for continued use of contraception to avoid pregnancy. Excessively long waiting time could be a source of frustration for women who wish to seek contraception particularly in high volume clinics (Hodgins 1999). Finally, quality of care in relation to the provision of contraceptive services is postulated to result in a more committed clientele of satisfied contraceptive users which should raise contraceptive prevalence and lower discontinuity of use (Bruce 1990; Jain 1989).

Constructs from the theories of gender and power, the social cognitive and theory of perceived attributes, as well as health care utilization theory underpins this study. An analysis of the factors influencing contraceptive use or non- use among women with unmet FP needs can be viewed in the context of sociocultural determinants, individual characteristics influencing behaviour change and health system factors. Understanding the interrelationships between these factors is crucial in understanding contraceptive use or non- use. Use of the theory of gender and power helped inform understanding of power relations, gender inequality and the subordination of women within the cultural context of the patrilineal social structure. In addition, two behavioral change theories a) Bandura's (1986) social cognitive theory and theory of perceived attributes (diffusion of innovation theory) helped demonstrate the role of the social environment, social norms and values and social networks on contraceptive use behaviour and also how individual perceptions of attributes of contraceptive methods influence its adoption and use. In addition, the health care utilization theory by Andersen and Newman (1973) helped understand the factors that directly affect

use of health care services. The conceptual framework is graphically presented in figure 4:

A conceptual framework of non- use of contraception

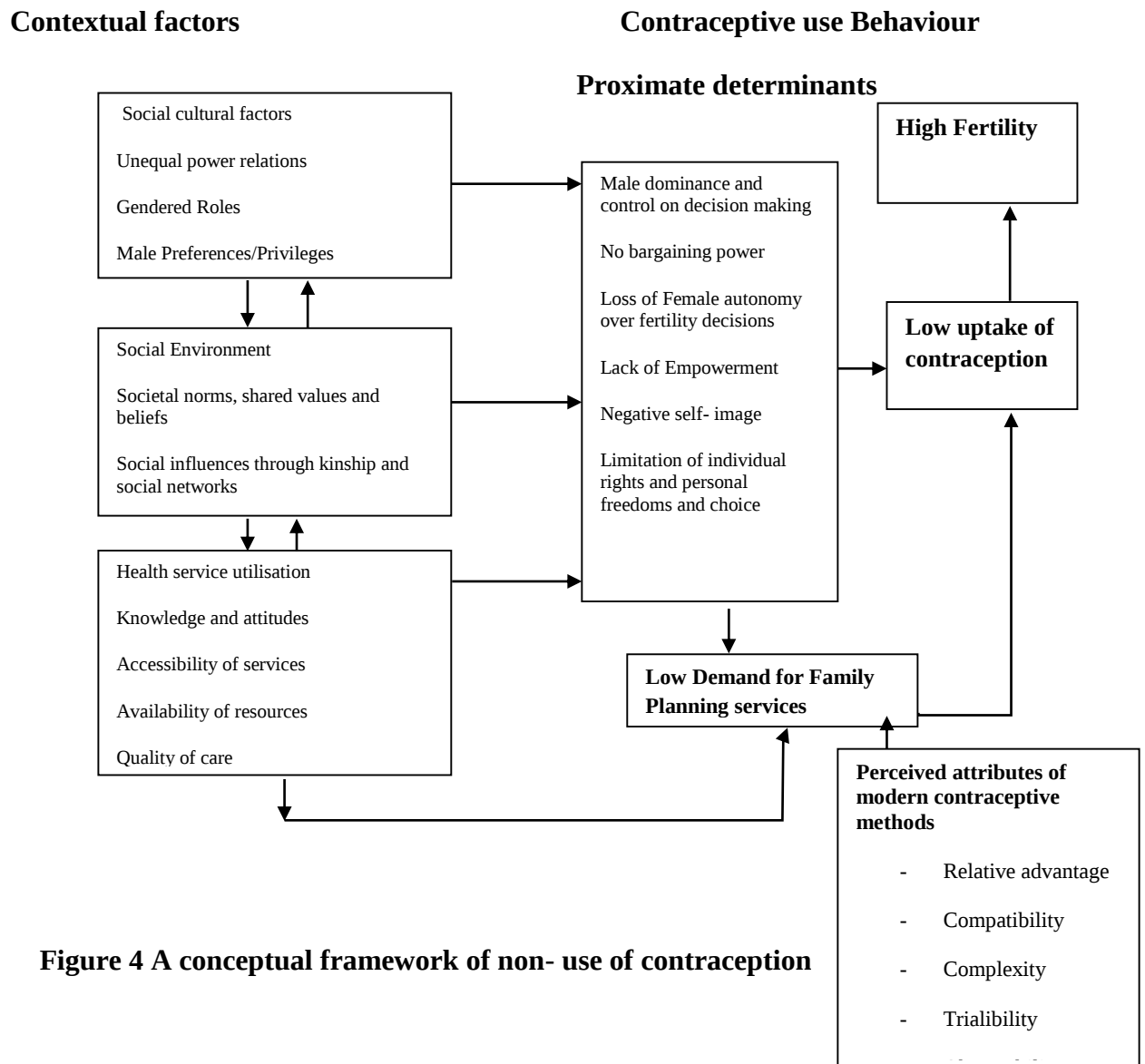


Figure 4 A conceptual framework of non- use of contraception

1.6 Significance of the study

The number of women who risk unwanted pregnancies in the developing world today is increasing and FP remains the major primary prevention strategy for unwanted pregnancies (Liu et al. 2008; Singh et al. 2009). FP has also emerged as a major public health intervention in improving women's health, through reduction of maternal mortality and survival of their children (Seltzer 2002; Choe et al. 1999). It has been established that although FP is a reproductive right and one of the fundamental pillars of safe motherhood, a significant proportion of married women who would prefer to avoid a pregnancy, are not using any form of contraception. This unmet FP need poses a serious challenge to public health policy makers and reproductive health programme planners. A clearer understanding of the context of unmet FP need and the reasons for non-use of modern contraceptive methods is instrumental in identifying new directions for FP programme activities in Malawi. This understanding can help focus FP programme efforts toward specific target populations and may guide the design of tailor made FP approaches to reach these specific populations effectively. This study is therefore a contribution to the growing social scientific body of knowledge on FP.

1.7 Limitation of the study

Malawi has three regions and 28 districts. This study focused on one region, the northern region. From that region only one district (Mzimba) was selected. As a cultural specific case study, its findings are not generalizable beyond the local context. Nevertheless, it is hoped that the study unearthed useful information that may have future impacts on the development and implementation of effective FP programmes and policies in Malawi.

1.8 Ethical considerations

FP issues are very sensitive in most communities in Malawi. Therefore before starting field work for this study, the research team strictly observed research ethics by protecting the confidentiality of informants. All the six interviewers were given adequate training on protection of human subjects and signed the confidentiality code. Study participants were given detailed information about the study, its benefits or research burdens if any. This enabled them make an informed choice regarding their participation in this study. Participants were reassured of the voluntary nature of the study. Privacy of clients' information was observed. In addition, ethical guidelines in data storage were followed. All transcripts were stored separately from the informed consent forms or any identification material. All completed transcripts were stored in cupboards which could only be accessed by the principal researcher. The research team also protected anonymity of participants by not identifying them with their names but codes. Since the topic of FP is a controversial subject, special care was taken in addressing FP issues with neutrality and anonymity and in arranging interview situations in such a way that they did not invite harmful interpretations from the family members or the neighbours. Approval from couples was sought for interviews that took place in the households. In the event that participants did not want to be interviewed in their homes, they were asked to choose a place where they would feel comfortable to be interviewed. Some actually preferred to be interviewed at a neutral venue and not their homes or when their husbands were around.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

This chapter reviews literature on population theories, the causes and consequences of rapid population growth. It also reviews literature on FP programmes and the factors that influence their successful implementation or failure.

2.2 Population growth and development: theoretical perspectives

The global population has increased rapidly over the course of the 20th century. Currently, the world population is at seven billion (UNFPA 2012) and projections show that the population will continue to grow and reach nine billion by 2050. In the sub-Saharan Africa region, the population in 2012 was estimated at 910.4 million (World Bank 2012). The population growth rates in sub-Saharan Africa are among the highest in the world ranging from 2.5 to 3.5 per year. This has resulted from high TFR at 5.2 children per woman compared to a world average of 2.5 per woman.

Thomas Malthus, an 18th century political economist, postulated a positive relationship between population and availability of resources. He focused on the impoverishing effects of scarce land and rising food prices. In his view the development of human kind was severely limited by the pressure that population

exerted on the availability of food. Malthus theory relied on the assumptions that food and passion were essential for human existence. He believed that the world's population tended to increase at a faster rate than its food supply and made the gloomy prediction that without adequate checks, scarce resources would have to be shared among an increasing number of individuals. He therefore argued that voluntary limitations to population growth could result when individuals made rational decisions based on the income they expected to earn and the quality of life they anticipated for themselves and their families: they chose not to marry and have children unless they could afford to support them.

The neo-Malthusians (Malthus's successors) supported Malthus's theory proposing that lower birth rates contributed to economic development and helped individuals and families to escape from poverty. They argued that high fertility and poverty went hand in hand. High birth-rates created large numbers of children relative to the number of working adults (age dependency ratio). This scenario according to neo-Malthusians, prevented countries from investing in infrastructure and development: instead all investments were diverted to meeting the immediate food, health care, housing and education needs of growing numbers of children and adolescents. Thus countries and families were unable to make long-term investments needed to help lift them out of poverty.

Consistent with the Malthusian theory, Ehrlich (1968) argued that the human population is too large and is a direct threat to human survival and the environment of the planet. Overpopulation or incessant human population growth was recognized as the root of so many community problems such as poverty, war and starvation. As such

birth control and FP was seen as the obvious solution to curb population growth and ensure each family's access to limited resources (Harkavy 1995; Hodgson 1983).

Contrary to the Malthusians' belief that high population growth condemned societies to poverty and underdevelopment, Karl Marx argued that population growth was not related to the alleged ignorance or moral inferiority of the poor, but was a consequence of the capitalist economic system. He pointed out that only in places where the production of food was not adequate did population growth become a problem (Conway-Gomez et al. 2010). It was further argued by followers of Marx that high fertility was a symptom, not a cause, of poverty and observed that radical transformation in the underlying causes of poverty would result in a rise in living standards and lower birth rates. These views were supported by Birdsall (1988) who argued that rapid population growth could slow development only under specific circumstances and generally with limited or weak effects. As such concerns that high fertility was linked with poverty were discounted by mainstream neo-classical economics which generally expressed scepticism about the strength of the relationship between high fertility and economic growth (Birdsall 1988). The economists pointed out that even if high fertility and high proportions of the population living in poverty were correlated, this correlation would not imply causality. In fact, the relationship could run in the opposite direction: poverty could be the cause of high fertility. Poor people often wanted more children because children represented wealth, provided household labour and were the only form of social security available to parents in their old age (Merrick 2002). However, a causal relationship existed between improved living standards such as urbanization, industrialization, improved educational standards and better health. These led to changed parental perceptions of the costs and benefits of children leading in turn to lower fertility (Sinding 2009).

2.2.1 Causes and consequences of rapid population growth

Generally, there is lack of consensus on the causes of population growth which have been described as multifaceted and complex (Shaw 1989). The rapid growth of the world's population over the past one hundred years has resulted from a difference between the rate of birth and the rate of death. During the 18th century, fertility rather than mortality was pointed out as the main determinant of population growth (Abramitzky et al. 2011). However, more recently, rapid population growth has been shown to result from increase in births and decline in mortality rates. During the pre-industrial era, although people had many children a large number of them died before age of five due to diseases and malnutrition and this kept the population stable (Goliber 1997; Kinder 1998). The post- industrial period, on the other hand, was marked by great advances in science and technology resulting in declines in death rates due to increases in food production, improvement in public health (water and sanitation), and medical technology (vaccines and antibiotics), along with gains in education and standards of living in a number of developing nations (Wasserman 1996). These discoveries and interventions contributed to lowered death rates and improvements in the quality of life for most people (Goliber 1997).

The growth in human population around the world affects all people through its impact on the economy and environment (Kinder 1998). Rapid population growth and high fertility go hand in hand and these potentially have negative effects on living standards and human welfare. Rapid population growth puts great pressure on economic productivity resulting in slow economic growth and poverty; unemployment; overcrowding in schools and clinics and an overburdened infrastructure (Katz 2013). Rapid population growth and high fertility also result in

poor health among women and children resulting in high rates of infant, child and maternal mortality as well as abortion (Birdsall 2001). All these are pressing health problems in many developing nations (Seltzer 2002; WHO et al. 2012).

Conway-Gomez et al. (2010) argue that rapid population growth also generates pressure on the natural resource base (food and water) and environments leading to the rapid depletion of environmental resources and climate change. From a conservationist perspective, peoples' health relies on their environment. Their surrounding ecosystem provides them with goods and services such as water, food, medicine, fuel-wood, building materials and other resources. Damage or disruption of these natural goods and services can have severe consequences for human health (Brown et al.1992).

2.2.2 Link between rapid population growth and FP

Before the 19th century, contraception was unknown, unpracticed and the limitation of population through measures of birth control was not welcome. Coitus interruptus¹ was an obvious, simple and effective method of preventing pregnancy (Langer 1975). The consequences of this was high birth rates, increased family size, more mouths to feed and more responsibility for childcare for women. A combination of these consequences had negative implications on family welfare and women's health, and provided a rationale for activism in birth control movements.

Feminists have linked FP with women's empowerment and basic freedoms. Birth control, it has been argued would give women control over their own bodies

¹ Coitus interruptus: stopping the act of having sex for a period of time in order to ejaculate outside the vagina

(Adamson et al. 2000; Seltzer 2002). One of the notable American feminist and birth control advocate, Margaret Sanger, challenged the classical economic theory that posited that poverty was the result of excessive population, and the belief that if the problem of hunger were solved, the question of overpopulation would take care of itself. Sanger was convinced that finding a solution to the problem of overpopulation and shrinking resources was not possible without including the issues of sex and reproduction. Birth control through the use of contraception was described as fundamental to controlling human population and a means by which women could attain basic freedom. She looked at the issue of birth control as a woman's issue and eventually formulated an ideology that linked eugenics and population issues to feminism (Katz 2013).

An examination of the relationship between rapid population growth and FP reveals that it is underpinned by economic, health, political and ideological considerations. Such considerations influence the structure of FP programmes.

2.3 Unmet FP need

FP and fertility survey data since the 1960's have indicated that substantial proportions of women who have wanted to stop or delay childbearing have not practiced contraception. This discrepancy is referred to as the 'unmet need for contraception' (Bongaarts and Bruce 1995). The concept of 'unmet need' has been described by health professionals as the proportion of married women who do not want to become pregnant but are not using any method of contraception (Ashford 2003; Bradley et al. 2012).

Unmet need is defined in two ways: unmet need for limiting childbearing and unmet need for spacing childbearing. Unmet need for limiting childbearing is the proportion of currently married women who do not want any more children but are not using an effective form of FP. Unmet need for spacing childbearing is the proportion of currently married women who want to postpone their next birth for two years or more but are not using an effective FP method (Westoff 2006). This means that the term unmet need includes both women who state that they want no more children in the near term ‘spacers’ and women who have reached their desired family size and are not using any method of contraception ‘limiters’. In any given population, the proportion of fecund, sexually active women who do not wish to become pregnant soon can be considered to have a potential demand for contraception. Among these women with a potential demand, some are practicing contraception and some are not (Bongaarts and Bruce 1995) .

Worldwide, the percentage of women who want no more children has steadily increased in most countries ranging from 20-60 percent (Westoff and Bankole 2000). Although this is the case, most recent estimates which include the unmet need for spacing births, show that 137 million women worldwide have unmet need for FP, meaning they are not using any method and report that they want to avoid pregnancy (Singh 2003). The general trend is that in most countries, unmet need is higher than current use of FP. The total demand for FP (current use plus unmet needs) ranges from 70 to 80 percent in Latin America, the Caribbean, Europe and Central Asia and North Africa but has remained lower in sub-Saharan Africa at 51 percent. In Africa, only 45 percent of demand is satisfied contrasting to 70-84 percent in other regions (Mills et al. 2010; PRB and APHRC 2008). Multiple factors influence non-use of

contraceptives among women who may not wish to become pregnant. Campbell et al. (2006) analysis of FP literature identifies health system based factors which constrains women access to technologies and correct information which they need in order to decide whether and when to have a child. These include limited method choice, cost of service (travel time, actual cost of service), medical and legal restrictions, provider bias, (misinformation) resulting from lack of correct information about contraceptive methods. These barriers are important in determining the pace of fertility decline or its delay as well as women's ability to avoid unintended pregnancy.

Some studies have shown that sociodemographic characteristics of the population influence adoption of contraception. These include area of residence, education and socio-economic status of women. Area of residence is one of the factors that identifies' women who are most likely to use or not to use contraceptive methods (Nazar-Beutelspacher et al. 1999; Okenzie et al. 2010; Uddin et al.1985). Korra (2002) observed that rural women have a higher prevalence of demand not satisfied compared with urban women because of the limited availability, accessibility, and acceptability of contraception in the rural community. Similarly, in Malawi, variations in contraceptive use have been noted between rural and urban women. Among women not currently using any method, 55.5 percent are from rural and 46.3percent from urban areas (NSO and ICF Macro 2011). Also poor access to FP services especially for rural residents has been reported (Barden-O'Fallon 2005; Bisika 2008; Lawrence 2002; Munthali et al. 2004).

The level of education has been identified as one of the determinants of contraceptive use (Cleland and Kauffman 1993; Jejeebhoy 1995; Tuoane et al. 2003; Uddin et al. 1985). High education is usually associated with lower fertility because education

tends to delay marriage and increases the likelihood that women engage in paid employment (Cohen 2000). It has been argued that basic education is not only a determinant of contraceptive use but it can increase the desire and use of health care services since it provides the consumer with the basis for evaluating whether they need care, where they can get the best services and also seek out the provider of their choice (Cleland and Kauffman 1993; Ensor and Cooper 2004). The 2010 MDHS also links education with contraceptive use. Use of modern contraceptive methods among women who had gone beyond secondary education was 49 percent which was 12 percentage points more than that of women with no education. Among women not currently using any contraception, 59.7 percent had no education (NSO and ICF Macro 2011).

Apart from area of residence and education, income is a determinant of unmet need. Available literature shows that the practice of contraception especially among women with low income in resource poor settings is limited (Campbell et al. 2006). A wide gap in contraceptive use is seen between the rich and poor (52 percent versus 35 percent, respectively) (Creanga et al. 2011). This gap between the rich and poor is more prevalent for women who reside in the rural areas. Better-off women want significantly fewer children than moderately or extremely poor women (Gómez de León and Hernández 1998; Schoemaker 2005). Evidence from Malawi shows contraceptive use increases with increase in wealth. Women in the lowest quintile are least likely to use contraception compared with women in the highest quintile (NSO and ICF Macro 2011).

Bongaarts and Bruce (1995) studies of unmet need found that the causes of unmet need go beyond the issue of access to contraceptive services. Cultural barriers to method use for women who want to protect themselves from pregnancy have been noted. Despite the lack of evidence linking behaviours and their cultural significance, many studies have shown that the high fertility in Asia and Sub Saharan Africa is primarily due to the regions' unique social and cultural structure (Bongaarts et al. 1984; Caldwell and Caldwell 1987; Campbell et al. 2006). Campbell et al. (2006) linked culture and contraceptive use by asserting that commonly, women's decisions to use contraception are considered to be influenced by culture and religious traditions. Culture may influence women's FP options more than preferences, because culture manifests itself through different forms like provider's bias, health service biases to use, attitudes and norms (Campbell et al. 2006). In Malawi, it has been noted that the cultural practices and beliefs that prevent condom use exist in many communities in Malawian societies. As a result, a condom does not seem to be a popular FP method. As reported by Chimbiri, a condom is an intruder in marriage (Bisika 2008; Chimbiri 2007).

As observed by Price (1996 and Price 1998), in many societies in Sub Saharan Africa, children often have an essential symbolic value and are important in the maintenance of the lineage which is of central importance in the social and political organization of many such societies (Price 1996; Price 1998). The Demographic and Health Surveys conducted in 13 sub- Saharan African countries (7 in West Africa and 6 in East Africa) have shown that West African countries are characterized by high fertility, high ideal family size and low contraceptive prevalence rates. Ideal family size reported by men was around nine children in West Africa and five in East Africa

and the proportion of men wanting more children ranged from 60 percent to 90 percent (Ezeh et al.1996). This has been attributed to the uniqueness of the African culture (Bongaarts and Bruce 1995). Both West and East African culture put great value on large families. Between one quarter and one third of men in West Africa are in a polygamous relationship. The prevalence of polygamy affects the mean number of children with a mean of 5 or more children (Ezeh et al.1996). Cross-cultural studies on values of children have demonstrated that the value of children affect fertility behavior by influencing the decisions on number of children (Sam 2001; Trommsdorff 1999). Where a premium is placed on large family sizes it is difficult for women to control their fertility.

Similarly, studies done in Malawi have noted the considerable cultural and social importance of childbearing particularly in rural areas (Yeatman 2009). In many communities in Malawi, high fertility is related to individuals achieved social status and children are a symbol of wealth (Hoffmann et al. 2008). This has been thought to contribute to the robustness of fertility desires. Among married couples there are variations in willingness to use contraception and the faithfulness with which contraception is used. Evidence shows that the number of children that couples desire in conjunction with their actual fertility accounts for failure rates to use contraception. Where actual fertility approaches the desired number of children, contraceptive efficiency improves. This generally shows that motivation to control the spacing of births is weaker than motivation to limit numbers (Sagi et al. 2011).

Apart from preference for large family size, (van Ballen and Inhorn 2003) noted that in many parts of the world, cultural values surrounding son preference /daughter discrimination exists. These are especially common in patrilineal cultures and

commonly manifest some discrimination against daughters. An analysis of DHS data in 244 countries from 1986 to 1995 has shown that son preference is most prominent in a band of countries stretching from North Africa, Near East and South Asia. Gender preferences are most extreme in countries like India, Bangladesh, Nepal, Egypt, Pakistan and Morocco and in sub Saharan Africa gender preferences are prevalent more especially in Kenya, Cameroon and Nigeria (Orubuloye 1987). A quantitative analysis in seven countries where son preference is most pervasive reveals that son preference can have a substantial influence on fertility and FP. In the absence of any gender preferences, it is estimated that contraceptive use in those seven countries would increase by 3 – 25 percent from its current level and pregnancy rates would decrease by 9 – 21 percent. Similarly, a study done among the Igbo women in Nigeria found that contraceptive use was inversely related to cultural variables such as acceptance of the Igbo strong son preference and living in a strong patriarchal setting. The Igbo women with son preference norms had 1.7 more children than those without (Isiugo-Abanihe 1994).

Another very important aspect of culture is the family structure. In most African societies the basic family structure is not the individual family but an extended family. The extended families are very important since they play a central role in the traditional social order which is based on the principle of kinship relations (Nanda and Warms 2004). An extended family includes people related by blood, marriage, age, language, tradition, distant relatives or non- blood friends and may include three or four generations. Although the available literature reveals that the social and economic changes in modern Africa have loosened the ties of traditional kinship, some people in many cultures still embrace them. The main reason given is that the

extended family system ensures that families support each other. Traditionally an extended family has provided an economic unit where each member takes on some responsibility. It also provides a rich network of marriage relationships and support in bringing up children and looking after older members as well as passing on family values and lineage (Mataranyika 2011). Apart from these benefits, it has been noted that the extended family unit plays a key role in the socialization of its members, reinforcing family norms and ensuring that no family member deviates from the norms (Metiboba 2003).

On contraceptive use, studies done in the traditional Pakistani patriarchal and patrilocal family structure found in that in the low-income squatter settlements of Karachi, a woman's mother-in-law appeared to have a strong influence on the couple's reproductive decision-making (Fikree et al. 2001). Similarly, demographic research in sub Saharan Africa has provided valuable information to the cultural context of fertility behavior. Evidence show that lineage-based systems are so coherent in sub Saharan Africa and these offer great resistance to the success of FP programmes (Caldwell and Caldwell 1987). Casterine and Sinding (2000) observed that social opposition is a major reason for non- use of contraception among women with unmet need. They assert that unmet need is more than just access and localizes salient causes other than those related to access, one of which is opposition mainly by primary relations (husbands and other persons like parents-in-law (especially mothers-in-law), other in-laws, neighbours and the local community. The opposition of these primary relations is a potential obstacle to contraceptive use. Kumar and Singh (2013) confirmed this observation in their studies in Bihar, India (see also Bibi et. al 2012,

for Pakistan; Bongaarts and Bruce 1995 for sub-Saharan Africa; Mekkonen and Worku 2011 for rural Ethiopia).

2.4 Conclusion

The literature review has revealed that the global population has increased rapidly over the course of the 20th century and projections show that it will continue to grow unless deliberate measures are taken to control it. The rapid population growth puts pressure on natural resources and compromises the ability of governments to provide social services to their people resulting in poor quality of life. Use of modern contraceptive methods is viewed as an effective means to control population growth. However, not all women who would wish to limit the number of children are able to do so. The various studies done in different parts of the world reveal that there is more to contraceptive use than mere access: there are personal, sociodemographic, sociocultural and institutional factors which influence the decision whether or not to adopt contraceptive use. The exact configuration of these factors tends to vary from area to area.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 Research design

This was a cross-sectional study aimed at examining the factors that explain the unmet contraception need in a rural community. A combination of descriptive and exploratory research design was used. The exploratory design aimed at gaining in-depth insight into the factors contributing to unmet need by investigating people's views on this problem. The focus was to understand why women who wanted to delay or stop childbearing were not using contraception. This design ensured that the understanding of unmet contraception need was grounded in the local context.

The descriptive design provided a thorough understanding of contraceptive use behaviours among WCBA in rural Mzimba by approaching the problem of unmet need from different angles. A survey, generally viewed as logical and organized means of data collection (Crane and Angrosino 1992) helped quantify distribution of variables of interest among currently married women. Client exit interviews focused on describing the problem from the health service delivery point of view, while case studies provided useful insights into the problem by documenting characteristics of a limited number of cases.

This mixed methods research design helped overcome inadequacies each research method could have through triangulation of data, thereby, promoting a better understanding of the phenomenon of unmet contraception need in rural Mzimba.

3.2 Study site

This study was done in Mzimba district, largely around the communities of TA Mzukuzuku. Mzimba District Headquarters, commonly known as Mzimba Boma was also included as an additional site especially for the survey questionnaire and client exit interviews. This was done to compare results and also identify any similarities or differences in contraceptive use between TA Mzukuzuku's area which is a remote rural site and Mzimba boma which was regarded as a semi-urban site. See Map of Mzimba district (Figure 5).

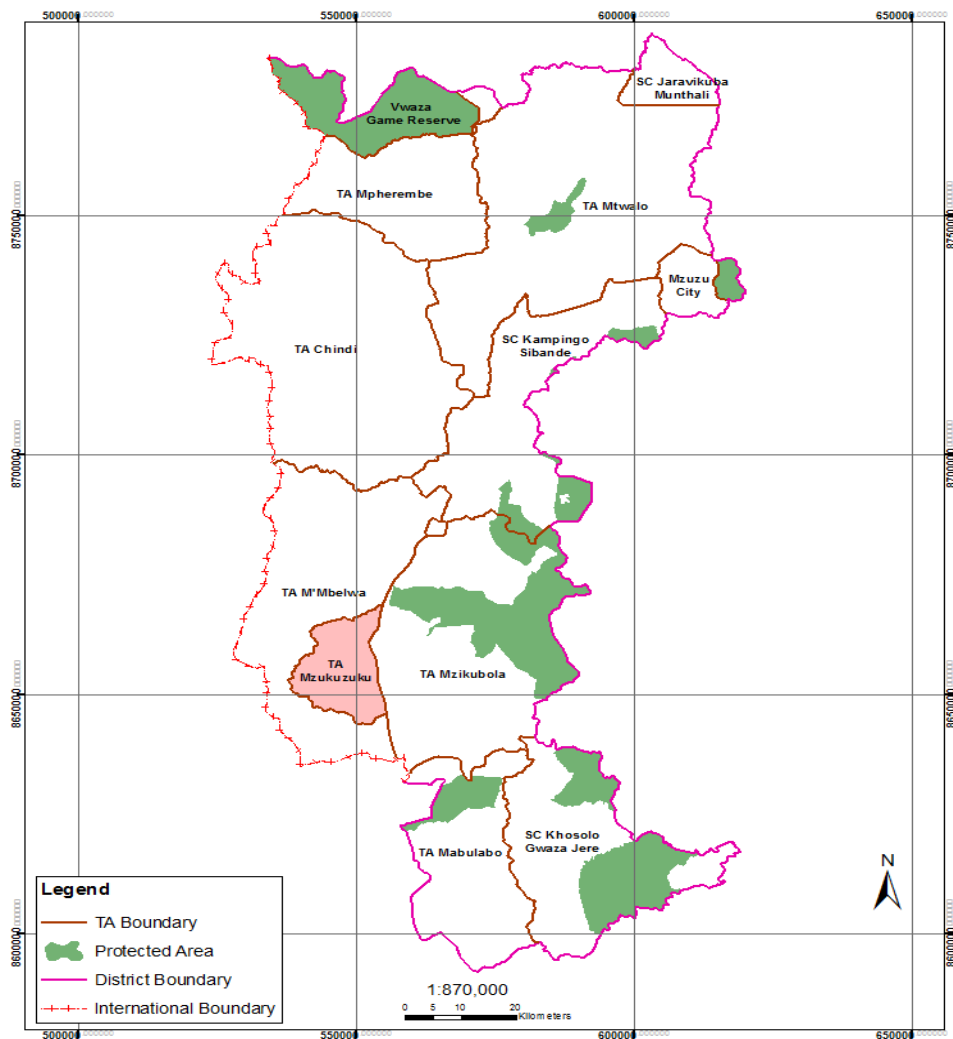


Figure 5 Map of Mzimba
Source: NSO, 2008

Mzimba is one of the six districts in the Northern region. According to the Population and Housing Census of 2008, it had a total population of 727, 931 people of whom 350,956 were males and 376,975 were females. The district had an intercensal growth rate of 3.4 percent between the year 1998 to 2008 compared to the national intercensal growth rate of 2.8 percent (NSO 2010). There are two main ethnic groups in the district, the Ngoni and Tumbuka, both of whom are patrilineal and follow a virilocal residence pattern which makes a woman a ‘stranger’ to her husband’s people and

village (Read 1956). The formation of marriage through the payment of *lobola* effectively transfers a woman's reproductive capacity from her own lineage to her husband's agnatic lineage. A woman is under obligation to bear children for her husband's lineage to ensure its continuity. Children in Ngoni society are a symbol of virility, power and control.

The study site was chosen for a number of reasons. Firstly, Mzimba district is located within the north health zone which has the lowest contraceptive use by region at 39 per cent compared to the central region (44 percent) and southern region (40 percent). Secondly, Mzimba district has a CPR of 34.3 percent which is the lowest among the five districts in the northern region (NSO and ICF Macro 2011). The specific area under TA Mzukuzuku was selected because it is a remote site, and as such it would provide a good case study for understanding the reality of contraceptive use in a rural setting where customs and tradition remain important determinants of behaviour. See Map of TA Mzukuzuku (figure 6).

There are three health facilities: Mabiri health centre, Embangweni Hospital and Vibangala Health centre. Mabiri and Embangweni belong to CHAM while Vibangala is a public facility. However, only Mabiri and Embangweni hospital were included in the study because the two facilities were providing SRH services including FP at the time of data collection for this study. Vibangalala had no trained FP provider and therefore no FP services were being offered at the facility except for provision of condoms by HSAs. The facility was also being used as an outreach site by BLM. This situation did not allow us to compare FP service provision between a public and CHAM facility. Communities around Mzimba district hospital and BLM clinic were additional sites for this study. The inclusion of the BLM clinic helped us to look at FP use from a private sector perspective since BLM is one of the leading NGO providing SRH services in Malawi.

3.3 Selection of enumeration areas

To select the targeted EAs, a list of all EAs in TA Mzukuzuku's area and around Mzimba Boma was sourced from NSO in Zomba and this was used as the sampling frame. The area of TA Mzukuzuku has 25 EAs. Three EAs around Mabiri Health centre and another three around Embangweni hospital were randomly selected. Although these EAs were randomly selected, geographic location of these sites was a major consideration of their inclusion in the study. In order to have a wider coverage of the population under study and diversity of views and opinions, the researcher made a decision to ensure that the selected EAs fairly represented the catchment areas of the health facilities of interest in this study.

In addition, three EAs around BLM clinic at Mzimba Boma were purposefully selected and included in the study. To select the three EAs at Mzimba Boma, consideration was made as regards the residence of the study participants since this would help us to compare FP use between rural residents on the one hand and urban/semi-urban residents on the other. Therefore, the EAs selected around Mabiri and Embangweni hospital represented the rural population while EAs selected around Mzimba Boma represented the semi-urban population.

3.4 The study sample and sampling techniques

To select survey respondents, a multi-stage cluster sampling technique was used. Firstly, a household listing exercise was done in all the three EAs and a list of households with women of childbearing age (WCBA) and currently married women was generated. This list was used as a sampling frame to identify the households that were included in the survey. The sampling interval was determined by dividing sample size with the population in the area. Then a blind random selection of a number from where to start selecting households from the list was done.

The assumption was that 120 households would be identified from each of the nine EAs to participate in the survey (that is 360 households around Mabiri catchment area, 360 households around Embangweni and another 360 in Mzimba Boma). This would yield a total of 1080 households. Systematic random sampling methods were used to elect households. The study determined the rate of use of contraceptive methods with a confidence interval of 95 percent and the sample size was calculated using a margin of error of 2.5 percent. The actual sample size was determined using the formulae for calculating Single proportion sample size (Naing et al. 2006):

$$n = p(100-p)/e^2$$

Where n = minimum sample size required in each study setting
 p = proportion of sample (currently married women) with outcome
 measure:
 using modern contraceptive methods in the area
 e = the acceptable margin of error

$$\begin{aligned} n &= \frac{34.3(100-34.3)}{2.5^2} \\ &= \frac{34.3 \times 65.7}{2.5^2} = 360.56 \end{aligned}$$

The sample size was justified based on the MDHS (2010), where the proportion of women of reproductive age that were currently using contraception in the study area was estimated at 34.3% and the difference with the contraceptive prevalence at national level (44%) was high. Although the sample size required for this study was approximately 1080 women of reproductive age, the actual sample size was 810 WCBA.

3.5 Training of research assistants

The study hired six Research Assistants and one Field Supervisor. A four day training of the Research Assistants was done in both qualitative and quantitative research methods and techniques, study set up and field modalities. This training took place at Embangweni Mission Hospital premises. Immediately after this training, pre-testing of the data collection tools was done. Training was undertaken by the researcher two weeks before the start of the data collection process. The Research Assistants were responsible for conducting a household listing exercise and administration of the questionnaire. The researcher conducted all focus group discussions (FGDs), in depth interviews with all key informants and ethnographic observations. In addition, she also provided overall direction to field work activities.

3.6 Pre-testing the study tools

Pre-testing the study tools was done around the communities of Chafisi which is in TA M'mbelwa's area in Mzimba. This community was selected because it was not within the study area but has almost similar characteristics with the study area such as language, cultural beliefs and practices and they also share the same health facilities. The survey questionnaire was administered to 10 women of reproductive age group (15-49). These women were conveniently selected to participate in the pilot study. The researcher organized one FGD and this comprised eight female participants. A male FGD was difficult to organize because most males were busy working in the vegetable gardens popularly known as *kudimba* in chiTumbuka during the month of September and they were not willing to participate because they believed that FP was a female issue. Only two interviews were conducted with selected key informants. Some of the interviews failed because people were not found in the homes. The explanation that was given was that apart from spending time in tomato gardens (the tomato gardens are commonly known as: *kumadimba ya tomato* in chi Tumbuka), market days which were organized on Tuesdays at Kamatawo, Thursdays at Jenda and Saturdays at Kapopo Mhlanga were a priority for most people. Pretesting did not only help validate the tools but also get feedback on areas that required strengthening before the main study commenced.

Before commencement of fieldwork, approval for this study was sought from the College of Medicine Research and Ethics committee (COMREC). Apart from this, permission was sought to conduct the study from the targeted communities. Permission was sought to conduct the study from Mzimba District Health Officer, Director of Embangweni Hospital, Officer in-Charge of Mabiri health centre and also

the Executive Director of BLM. This was also followed by personal visits by the researcher to the health facilities to learn more about the services they offered, size of catchment area, total population served and staff establishments. The visits were also used to book appointments with the selected service providers to be interviewed as key informants and also to organize for the client exit interviews and outreach visits.

At community level, traditional leaders as community gate keepers were first to be identified and visited by the researcher. The researcher visited TA Mzukuzuku at his Ephangweni headquarters to brief him about the study and seek his permission. After this visit, a programme was drawn to visit village heads in the selected EAs. After the village heads were visited, community meetings were organized to prepare the community members for the study. In total the researcher conducted eight community meetings. The purpose of the meetings was to inform community members about the study and also give them opportunity to ask questions. The researcher responded to their concerns regarding their participation in the study.

3.7 Field data collection

This study employed both quantitative and qualitative data collection methods. The quantitative methods involved questionnaire administration through a survey and client exit interviews. Qualitative methods involved focus group discussions, in-depth interviews and observations. Qualitative data collection was done in a purposefully selected area which comprised one EA around Mabiri health centre. This area was selected because of its proximity to Mabiri health centre and Embangweni hospital. The area is about 10 km away from Mabiri and about 16 kms away from Embangweni

hospital. The area is located within the boundary between TA M'belwa and Mzukuzuku. The nearest health care facility in TA M'belwa's area is 10kms away.

3.7.1 The survey questionnaire

A cross-sectional survey with currently married women within the reproductive age group (15-49) was done in all the nine selected EAs. The survey exercise started in EAs around Mabiri health centre, then Embangweni and Mzimba Boma. Although the expected sample size for this study was 1,080 households, after household listing the numbers of women of reproductive age and currently using contraception were much lower than expected especially around Mabiri area and only 810 households were identified to participate in the survey. Out of these households, 741 households successfully completed the survey giving a response rate of 91.9 percent. Administering the survey questionnaire was a challenge in most of communities selected since it required face to face interviews. This contributed to the lower response rates. Around Mabiri for example, it was somewhat difficult to find women in the households during the day time due to economic activities like beer selling at *Kabwandilo wa mowa* (this is a market place mainly for beer and meat) and selling farm produce. Expectant mothers and their guardians were at the hospital to wait for delivery. Others were not available because they were busy in vegetable gardens or attending funerals. Similarly, at Mzimba Boma, it was difficult to find women in their homes. This was an urban population and most women were actively involved with either paid employment or some kind of income generating activity. This population was also very mobile and sometimes the research team found that the household that was listed had moved out of that community and replacements had to be made. To ensure that the respondents would be found in their homes, the research

team had to make bookings in advance regarding date and time they would visit the household.

A structured survey questionnaire was developed which was used to collect data among currently married women of reproductive age group (15-49) in the communities around Mabiri health centre, Embangweni hospital and Mzimba Boma. The survey questionnaire sought to obtain information on socioeconomic and demographic characteristics of the study population, sociocultural and health system factors that may affect utilization of family planning services. In addition, information was obtained relating to knowledge, attitudes and behaviours affecting contraceptive use (Appendix 1c and 1d are informed consent forms and survey questionnaire).

3.7.2 Client exit interviews

Client exit interviews were mainly done in three health facilities that is Mabiri health centre, Embangweni hospital and Mzimba BLM clinic. To come up with the number of clients to be targeted in this study, we reviewed the daily register of FP clients in all the three facilities for both facility and outreach services. FP registers showed on average 12 clients attending the FP clinic at Embangweni Hospital, six at Mabiri Health centre and 10 at BLM clinic in Mzimba. All women exiting FP clinics were asked whether they were willing to participate after a brief introduction of the study. Further information about the study and informed consent procedures were done after they had shown willingness to participate in the study. A total of 110 clients were identified as follows: 25 at Mabiri health centre, 40 Embangweni and 45 BLM clinic. A few challenges were encountered in the recruitment of clients especially at BLM

clinic since the facility provides a number of SRH services apart from FP. To overcome this, service providers facilitated referral of FP clients to the research team. In addition, this being an urban site, clients were conscious about time spent at the facility. Clients were reassured about privacy and how much time will be spent on the interview.

A semi- structured guide was used to collect data from clients exiting FP clinics and this focused on obtaining information on provision of FP services and quality of services. Specifically, information was obtained on issues of access to FP services (number of FP service sites available, distance/travel time to services and cost of the services); availability of FP services (availability of a variety of contraceptive methods; contraceptives regularly supplied, contraceptive methods not regularly supplied); client assessment of the quality of the FP services in relation to information given to users of FP methods; clinic waiting times; provider training or competence; the friendliness of the service and the quality of infrastructure for maintenance of privacy and confidentiality (Appendix 2c & 2 d are informed consent and client exit interview guide respectively).

3.7.3 Focus group discussions

To select participants for the FGDs, household listing was done in selected villages in the three EAs. Women within the age group 15-49 years were identified and were asked to participate in a screening questionnaire where they were asked if they were currently using any contraception and whether they planned to use any contraception in future (Appendix 6c is a household listing and screening questionnaire). Then a list of women not using any contraception and those currently using contraception was

generated and this was used as a sampling frame to identify non-users and users of contraception. Around 96 participants were selected from the list using a simple random technique to ensure representativeness of the sample.

The plan was to conduct six FGDs with the non-users of contraception (three with women within the age group 15-24 and three with women of age 25-49) and that another six FGDs with identified users of contraception (three with women age 15-24 and three with women age 25-49). However, only eight FGDs were done mainly because it was difficult to find young women within the age group of 15-24 who were currently using contraception. Those that met the study criteria were not enough to be recruited for a FGD for users of contraception. Therefore, a few who were identified participated in in-depth interviews as key informants. All the three FGDs for men around the communities were done as planned. Unlike during the pilot where it was difficult to recruit men, the situation was different during the main study. More males wanted to participate in the study and it was difficult to sample only 8-10 people for each FGD. This overwhelming response was due to the community briefing meetings that took place just before field work started.

To conduct the FGDs, a discussion guide was developed for married men and women. This interview guide was intended for non-users and users of FP as well as married men in the selected EA. The FGD guides provided insights into the sociodemographic factors (such as family size and parity), economic factors and the cultural and religious factors that affect FP utilization. In addition, users of FP also shared their experiences related to FP use (Appendices 3c, 3d, 4a and 4b are interview guides for

non-users, users of contraception and males selected around the communities respectively).

3.7.4 In- depth interviews

In-depth interviews were done with selected key informants who were purposefully selected in the study area. A total of 25 interviews were done with key informants. This comprised eight non- users and four users of FP. We used a household listing and screening questionnaire to identify users and non- users of FP. In addition, a list of all influential people in the community and those responsible for FP programmes was generated. This comprised traditional leaders, traditional healers, traditional birth attendants, CDBAs, HSAs and selected professional health care workers. A total of 13 key informants were selected using this list and this comprised three traditional leaders and one traditional healer. It was difficult to identify traditional healers in the study area and this was why only one was selected. No other traditional healers were identified around Mabiri area. It was learnt during this study that people go to Kalikumbi and Dimi in TA M'mbelwa's area to look for traditional medicine. Also, nine health care workers were selected to participant in the study. These were two Medical Officers, two FP Coordinators, one FP service provider, one Senior Medical Assistant and three HSAs. It was not possible to interview an FP provider at Mabiri health centre because at the time of the study there was no nurse /midwife as earlier alluded to.

3.7.4.1 In- depth interviews with non- users and users of FP

An interview guide for non- users of FP was developed and information was sought in relation to personal histories, individual perspectives and experiences in relation to

use/non-use of contraception. Information was also obtained relating to their fertility preferences and attitudes towards FP methods. In case they ever used contraception, the non- users were also asked their experiences regarding use of contraception and factors that facilitated their discontinuation (Appendices 5c and 5d are interview guides for non-users and users of contraception). Interviews with the non- users were very complicated. Some of the non- users were skeptical on how we came to know that they are not using contraception and were not willing to be interviewed, while some wanted the interview to be done in secret for fear of their male family members. One of the non- users, a young married woman, actually refused to be interviewed saying that she was still new in the village and did not want the interview to spoil her relationship with her parents in-law.

Users of FP provided insights into the sociocultural barriers to FP use, contraceptive practices and experiences from the users' point of view; FP use dynamics at the household level (decision making, personal preferences, individual motivations to use FP methods) and views on FP service delivery.

3.7.4.2 In depth interviews with community health care workers and leaders

An in-depth interview guide was developed for relevant stakeholders such as community health care workers, volunteers involved with FP service provision and community leaders. The in-depth interview guide helped the researcher gain deeper insights into the community attributes that enabled the individual to obtain services and the prevailing norms of their society. It also generated information on the contributing factors to the failure of the health system to meet the need for family planning from a community perspective (Appendices 5e and 5f are in-depth interview

guides for community health workers and leaders respectively). Traditional leaders were interviewed together with their wives because that is what they preferred. Male traditional leaders felt incompetent to talk about the area of FP alone without their wives being present. To them FP was described as a woman's issue and they could not themselves give adequate information if their wives were not around.

3.7.4.3 In- depth interview with health service managers

An in depth interview guide for health service managers and policy makers was developed. These included Mzimba District Health Officer (DHO), District FP Coordinator, Mabiri Health Centre Officer In-charge, FP Coordinator (Embangweni Mission Hospital) and BLM clinic manager. The guide for the service managers provided insights into the FP service delivery (delivery of facility and outreach FP services, staffing levels at community and facility level, procurement and disbursement of FP commodities and the quality of the service (Appendices 5g and 5h are in-depth interviews guides for with health service managers respectively). However, securing appointments with service providers and managers was very difficult since most of them were reporting to be busy with other work apart from provision of FP services. The researcher had to arrange interviews outside the normal working hours.

3.7.5 Ethnographic observations

In order to better understand the issues on non-use of FP methods and also to gain deeper insights into issues that are sensitive or usually hidden, ethnographic observations were made. As team leader, the researcher kept field notes and collected anecdotal information around the study communities using a checklist. Basically, the

researcher took note of what people said about their experiences regarding modern FP methods; what the community said and felt about women who were currently using contraception. By living among the people of TA Mzukuzuku, the researcher took note of the terms that they used when talking about FP in the area and how FP was understood among men and women. Furthermore, the researcher accompanied health centre staff to the outreach clinics to observe the natural environment of FP service provision. Observations of the physical aspects of FP service provision in terms of space, confidentiality, clients reception, as well as the levels of contraceptive stocks in the pharmacy were also made in the two health facilities in TA Mzukuzuku's area (Appendix 7a is a checklist that was used to obtain ethnographic data).

The ethnographic part of this study helped to appreciate more the negative feelings people had towards use of modern FP methods in this community. This was noted through what people around the communities said about FP like: *wati vikujala mphapo* (meaning modern FP methods cause infertility). These concerns regarding use of FP methods were not hidden right from the time the community members were introduced to the research topic.

3.8 Data Analysis

Qualitative data collection and analysis was partly done concurrently. After each in-depth interview, the data was transcribed and entered in text form into the databases. Nvivo 8, a software programme for qualitative data analysis was used in qualitative data analysis. Content analysis of the transcripts was done to isolate emerging themes and then judgments, interpretations and meanings of the content were analyzed. The qualitative analyses mainly examined sociocultural factors that influence non- use of

contraception, acceptability of modern contraceptive use, use of traditional methods of contraception, decision making relating to use of modern contraception as well as barriers to use of contraception. Quantitative survey data was entered into a database and statistically analyzed with the assistance of computer programme SPSS version 16.0 for frequencies and associations. Description of categorical variables was done using frequencies and percentages, and continuous variables using means, medians, standard deviations and ranges. For bi-variate analyses, categorical variables were compared using Chi square tests and where appropriate the Fishers Exact test. Multivariate regression analysis using logistic regression model were conducted to identify the best model that predicts non- use of contraception. The key relationships that were explored using Chi-square tests included: a) effect of demographic characteristics on non-use of contraception; b) effect of gender related variables such as decision making and use of contraception; and c) service delivery factors such as quality of service, cost of service, supply of contraceptives and use of methods.

CHAPTER FOUR

FINDINGS

4.1 Introduction

The study which focused on Mzimba district set out to achieve four specific objectives, viz: to establish the level of unmet FP need; to identify sociocultural factors that influence unmet FP need; to identify health system factors that influence unmet FP need; and to explore the influence of community perceptions on use of modern contraceptive methods. This chapter presents the findings of the study in relation to each of the specific objectives.

4.2 Demographics of the study population

A total of 741 WCBA participated in the survey and these were identified within the catchment areas of Mabiri, Embangweni and Mzimba boma. The sociodemographic characteristics of the participants are presented in Tables 1 and table 2 below.

Table 1 Demographics of the study population

Age group	Frequency	Percent
15-19	65	8.8
20-24	151	20.4
25-34	318	42.9
35-49	207	27.9
Marital Status		
Married	709	95.7
Separated	30	4.0
Divorced	1	0.1
Widowed	1	0.1
Education		
Primary	521	74.1
Secondary	178	25.4
University	2	0.3
Main income earner		
Husband	650	86.8
Wife	40	8.1
Other	51	6.9

Table 2 Demographics and number of children born to a woman

Attended School or not	1-4 children	More than 4 children	P value
Attended school	75.9 (520)	24.1(165)	0.007
Not attended school	53.8 (21)	46.2(18)	
Marital status			
Currently married	74.2(514)	25.8(179)	0.099
Not married	87.5(28)	12.5(4)	
+			
Education level			
Primary school	70.3(360)	29.7 (152)	<0.0001
Secondary school	92.4(159)	7.6 (13)	
University	100.0 (2)	0.0 (0)	
Residence			
Mabiri	65.4(119)	34.6(63)	<0.0001
Embangweni	73.8(203)	26.6(72)	
Mzimba	82.1(220)	17.9(48)	
Earning income or not			
Earning income	79.0(109)	21.0(29)	0.531
Not earning income	76.5(449)	23.5(138)	

4.3 Unmet need for FP in Mzimba

The study findings show a high level of non-use of modern contraception among WBCA in Mzimba. By residence, 59 percent of women in Mabiri, 48 percent in Embangweni and 39 percent in Mzimba Boma were not using any modern contraceptive methods as shown in Table 3:

Table 3 Current contraceptive use

Current use of contraceptives	Mabiri	Embangweni	Mzimba Boma	(n)=
Not using contraceptives	58.8 (110)	48.4 (135)	38.9 (107)	359
Using Contraceptives	41.2 (77)	51.6 (144)	61.1 (168)	389
Total	100%	100%	100%	741

The findings further highlight unmet contraception need among WCBA in Mzimba. This was established by asking women who were pregnant at the time of the survey if they had wanted to become pregnant before they became pregnant then; or had wanted to wait until later or did not want to become pregnant at all. Although the majority of women wanted the pregnancy then, 20 percent of the women in Mabiri and 18 percent in Mzimba Boma wanted the pregnancy later while 19.2 percent in Embangweni did not want the pregnancy at all. These findings show that significant numbers of women in this society are exposed to unintended pregnancy and births (Figure 7 below).

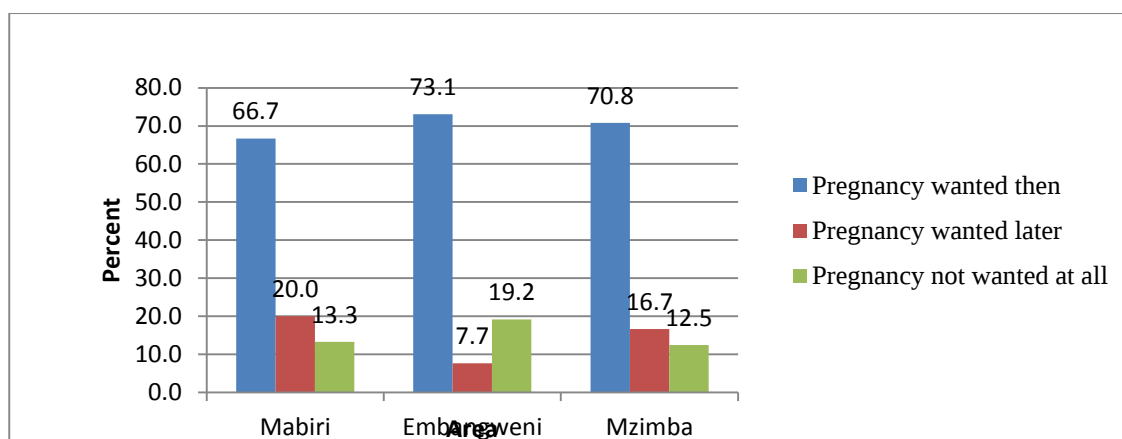


Figure 7 Intention to become pregnant

Out of 359 women who were not using contraception at the time of the study, 18 percent were pregnant. Those who wanted pregnancy later, or not at all were asked if they currently used any contraception. The results showed that 11 percent and 30 percent respectively, did not use any contraception (Table 4)

Table 4 Intention to become pregnant and use of contraception

	Current use of contraception		
Intention to become pregnant	Yes	No	Total
Pregnancy wanted then	65.2 (30)	34.8 (16)	100 (46)
Pregnancy wanted later	88.9 (8)	11.1 (1)	100 (9)
Pregnancy not wanted at all	70.0 (7)	30.0 (3)	100 (10)
Total number of women	45	20	65

Furthermore, all fecund women were asked whether they wanted to have another child or they wanted to stop having children. As figure 8 below shows, although the majority of the women wanted another child, a significant number wanted to stop having children. For instance, 40.8 percent of the women in Mabiri, 39.7 percent in Embangweni and 37.8 percent Mzimba Boma wanted to stop. These findings are

consistent with MDHS (2010) results which showed that nearly 46 percent of women in rural areas had no desire for more children and at regional level, 41 percent of women in the northern region wanted to limit births.

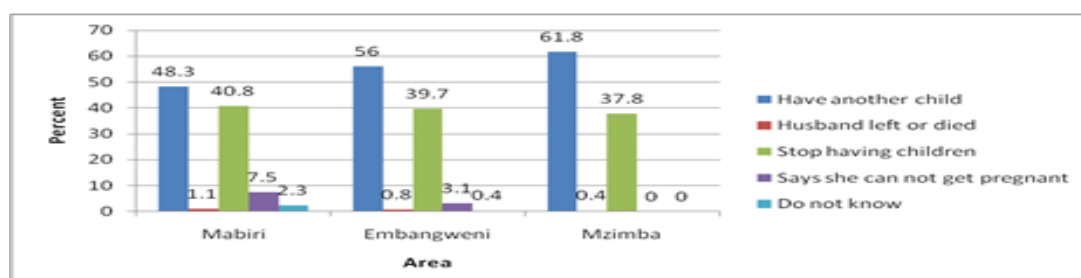


Figure 8 Wanting to stop having children by residence

Further analysis was done to verify whether women who chose to stop having children were currently using contraception. Out of 269 (39.3 percent) women who wanted to stop having children, 42.8 percent were not using any contraception as shown in Table 5.

Table 5 Current contraceptive use and stop having children

	Wanted to stop childbearing
Currently using contraception	57.2 (154)
Not using contraception	42.8 (115)
Total	100 (269)

Unwanted childbearing is the most direct measure of the extent to which women are able (or unable) to choose to become pregnant at that time or not to. Unwanted childbearing is common particularly among poor, rural and less educated women (Williams 1991).

4.4 Sociocultural factors influencing contraceptive use

4.4.1 The effect of culture on childbearing

The study findings show that the values of kinship and their continuity affect the childbearing practices of the Ngoni of Mzimba. In this study, the number of children born to a woman of reproductive age ranged from one to eleven. The number of children born to a woman increased with age and the majority of women in the age group 35-49 years (63.3 percent) had more than four children (refer to figure 9).

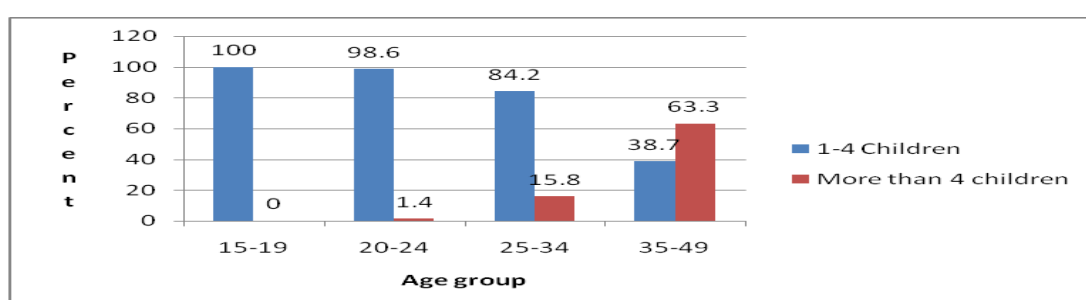


Figure 9 Number of children born to a woman by age group

These findings are consistent with the results of the 2010 MDHS which showed that at the national level and the whole northern region in particular, the average number of children a woman bears in her lifetime is 5.7. However, Mzimba district specific data shows on average 5.8 children are born to a woman in a life- time. This figure is slightly higher than at national level (NSO and ICF Macro 2011). This has been reported as largely being influenced by societal demands on women to comply with the ideal number of children. The quotes below highlight the views of men, traditional leaders and women on number of children:

We believe that a woman's role is to give us many children. Our culture puts no limit to the number of children that one can have but actually it encourages couples to have many children and this is also why men are allowed to marry as many wives as they want, so that they can have the number of children that they want (FGD older men, Mabiri).

According to the Ngoni culture, there is no limit and the number of children that one can have is not determined in advance. One can have as many children as they want or as what God gives without any limits. For us what matters is that our villages will grow and the number of subjects under one's chieftancy will also grow big. It is these days that we hear of the limits that a family can only have this number of children (IDI Traditional Leaders)

A woman can have as many children as she can bear until she stops on her own. A woman's duty is to bear children and stops naturally. Once she stops childbearing, she also stops menstruating" (FGD older women (25-49) Mabiri).

In addition, this society strongly believed that only God, the creator can limit a woman's fertility. It is only God who knows when one can stop having children and this happens when a woman is no longer fertile. It is thought an ideal family should have at least ten children or slightly below.

In this society, they leave it open whether you have 10 children. It is what God has given you. A woman should bear children until her womb can bear no more. They want all the children to come out of their womb (FGD Women 25-49 years).

I agree with what has been said here. Only God can control fertility and not us. Some may have nine or ten children and even give such names as 'Vinandi' (I have too many) to the child. One of our aunts called her child Vinandi (FGD Males 15-24 years)

When you have ten children in a household it is considered as a good number and the household is looked at as being lucky (IDI older female).

This study findings, confirm the observation by Read (1968) that Ngoni society puts a premium on its continuity. To this end, large families are deemed desirable and high levels of procreation are encouraged.

Bigombe and Khadiagala (1990) noted that in most African traditional societies, the perceived high infant and child mortality and the fear of extinction have encouraged

high procreation with the hope that some of the births would survive to carry on the lineage. Further evidence from a wide range of African countries suggests that African social organization, social institutions and shared values have supported high fertility and inhibited contraceptive adoption. High fertility is the logical consequence if a family line is to be maintained. This has to a large extent been persistent in both influencing and affecting reproductive decisions to use contraception (National Research Council (US) 1993). The high social value placed on child bearing and low contraceptive use are among the factors that have contributed to sustaining relatively high levels of fertility in most of sub-Saharan Africa (Bigombe and Khadiagala 1990).

4.4.2 Gendered socialization of children

Among the Ngoni and Tumbuka of Mzimba, the socialization processes impart the virtue of female submissiveness for the girl child and promotes the notion of male superiority among boys. Females in this society are socialized to perform feminine roles within the domestic sphere while boys are taught to be strong, aggressive and adventurous. There is an overemphasis on female domestic roles while supporting practical life skills and independence for males. This kind of socialization promotes social and economic dependence on males as females are socialized to believe that wife and mother roles are the ideal context for female self-actualization (Nelson 2006). Dependence on males supports high fertility due to females' lack of empowerment to participate in major household decisions, including fertility decisions which are basically within the male domain (Gage 1995).

4.4.3 Child preference norms

Son preference norms prevail. Both male and female informants indicated that people around the communities of TA Mzukuzuku, preferred to have more male children than female children. They believed that a male child is the owner of a household or village *Wati ndiwo wakumanga muzi* (male children build a village). These preferences have been maintained even after four decades since Read's (1968) observations among the Ngoni, who reported that they preferred a male child because *bakumanga muzi* (it is male children and not girls who will make their village or clan grow) and *kulutiska munthazi zina* (continue the family name) (Read 1968 cited by MHRC 2005).

These things indeed happen. If one has male children, they say that she has given birth to a clan (*wabala muzi*) and she has done very well. The majority of people in this area are happy when a daughter-in-law has given them male children. They say: she has done well because the village will grow (FGD Males 25-49 years).

Slight changes have been noted in some households preferring daughters to sons. This has been linked to the economic hardships that families are currently facing. Some of the parents explained that female children bring riches into the household in the form of cattle at the time of their marriage. Female children are basically regarded as sources of income for the household and still inferior to the sons. This means that female children are viewed as a means to an end and not an end in themselves.

Sometimes when you have girls parents are happy that more cattle will come and if you have boys they will not be happy since they will take some of the cattle to pay for his *lobola*. These days people want to have more girls because they want to gain more cattle (FGD with females 25- 34 years).

These son preference norms affect childbearing practices. It was reported that couples, their parents, other kin, and even their neighbours and friends would be

greatly concerned if a family did not have a son. Having a son is a social norm and basically, the family-building process was planned around the need for sons. No one was satisfied with having only daughters. Therefore couples who fail to have a son are under pressure to continue having children until a son was born. The case below explains how Mrs Botha (not real name) ended up with having eight children because she was looking for a son:

After I got married and we started having children, I found that I could only give birth to female children. My husband's parents and other members of his kin were not happy with me. I was regarded as a stranger in the village and was not considered to be part of them. They actually told me that: You are still at your parent's home and you are not part of this village. (In chiTumbuka this was said like this: *Uchali kwako nge m'muzi wanjila undanjile*).

This really affected me so I tried to keep on bearing children so that I can have a son in order to meet their expectations and please my in-laws. I found that I had six children, all girls. Then I kept on giving birth so that I may find a son and this is how I reached eight children.

Supporting her case, during FGD's women explained that if a woman does not have a male child, the parents' in-law are not happy and will always express dissatisfaction at her failure to give them a male child as explained below:

In most cases you find that a young woman has close to eight children it's because she was giving birth to girls only. You keep on trying from first pregnancy if you have a girl then you try to get pregnant again. Second pregnancy you give birth to a girl, third and fourth the same. Then you have the fifth pregnancy and you think that this time it will be a boy only to find it is a girl. You find that you are pregnant for the sixth time, another girl. They urge you to try again may be a male child will come and you have no say since these are demands from your parent in-laws. You get pregnant again and you a seventh baby girl. They still urge you to try in case a male child will come and they do not want you to rest, they refuse if you say you that you want to use contraception because you have many children. They still expect that you will give them a son. This is why most women just decide to use FP on their own. They fear that they are going to die as a result of childbearing (FGD Women 35-49 years).

These findings are similar to the findings of studies done in Vietnam (Haughton and Haughton 1995; Bélanger 2002) where it was found that sons are the markers of adult identity; they guarantee the continuity of the family line; and they represent survival in old age. In Vietnamese patriarchal societies' reproductive behaviour still reflects families' strong desire to have a son. Couples who do not have a son are much more likely than couples who have at least one to continue childbearing. The likelihood of practicing contraception was substantially reduced among women who did not have a son. Similarly, research in the northern province of Thai Binh, showed that women having only daughters tended to report higher rates of contraceptive failure (Johansson et al. 1996; Johansson et al. 1998).

4.4.4 The role of lobola (bride wealth)

Marriage practices of the Tumbuka and Ngoni of Mzimba have been linked with male authority and higher decision making power. In this society as well as the entire Northern region of Malawi, marriage practices are unique and clearly define the culture of its people. Marriage is legitimated by the transfer of *lobola* from the husbands to the wife's family.

The *lobola* custom has several social functions. Primarily, *lobola* is paid to symbolize the transfer of the woman to the husband's family and his clan. It confers marriage status to women and also serves as a token of appreciation to the woman's family for raising and bringing up the girl to a woman (Chireshe and Chireshe 2010; MHRC 2005). The effect of *lobola* is that a woman's reproductive capacity is transferred from her own lineage to that of her husband. Children born out of the marriage are

deemed to belong to her husband's lineage. This is in contrast to the situation in matrilineal societies where a woman reproduces her own matrilineage.

The payment of *lobola* as bride price has been linked with high fertility in Mabiri, Embangweni and Mzimba boma. Most women interviewed indicated that this traditional marriage practice puts them under pressure to bear more children to satisfy the demands of the husband's lineage. Basically the amount of *lobola* paid as bride price determines the number of children that one should have:

We talked about cattle before (participants laughed). The cattle which your parents' in-law gave to your parents whether they were four or more determines the number of children that you should have. If your parents in-law pay 4 cows for your *lobola* they would want you to produce many children (participants laughed) and they will be happy (FGD Older women 35 years above).

The case below shows how the payment of *lobola* influences the number of children that one can have in this society:

They told me that their cattle is multiplying at my parents' home and yet I am failing to bear more children for them. They actually said that they would be checking If I am pregnant or not by counting the number of years I take to get pregnant again. Because of this I ended up having 8 children and they were happy and said: *Ng'ombe zane zaseweza* (my cattle had yielded good results) because I have served them well.

The general belief among the people of Mzimba is that when a woman is married, her main duty is to bear children and they do not limit the number of children that a woman can have. In this type of social order, FP use is not easily acceptable since FP disturbs the deeply ingrained expectations about a woman's reproductive obligations. Similar evidence has been noted from the Navirongo experiment on the impact of FP

on gender relations in Northern Ghana which highlighted strains on gender relations resulting from contraceptive use in a society where payment of bride wealth signifies a woman's requirement to bear children. It was noted that contraceptive use resulted in physical abuse and reprisals from the extended family (Bawah et al. 1999).

Furthermore, as previously stated, the transfer of the woman from her home into a man's home consolidates male authority over her. This affects the power balance between males and females resulting in most females having low decision making power on house hold matters. Young women interviewed in this study lamented that:

When the husband's side pays *lobola* it is like now they have bought them and they want them to work for it. They will force them to give birth to 8 children or even more even when they themselves do not want to have many children (FGD:Younger women 15-24 years)

Bhebe (1973 cited by Chireshe and Chireshe 2010) also saw *lobola* as the purchase of a wife by a man for the purpose of begetting children. This dehumanized and relegated women to the status of commodities and thereby placing husbands' control over their wife's sexuality.

The case below depicts elements of male superiority and control in Mzimba

Mrs Asiya Mhone (not her real name), a 24 year old lady originally from Mwanza was living in Mzimba with her father who was working in the tobacco estates and ended up getting married in Mateyo village in Mzimba to Mr. Chimuwonechi Mhone (not real name) who was a farmer. Mrs Mhone was married following the Ngoni and Tumbuka tradition of *kulowola* (a marriage system that involves exchange of cattle). Since she came from a matrilineal background, Asiya Mhone had to go through sessions of *kulanga mwali* (counseling the new bride). In the Ngoni culture this is done by senior women in order to prepare her for marriage. She was counseled on various social norms and her position as *mkamwana* (daughter in -law) and what was expected of her. Basically she

was told that she is expected to be obedient, respectful to her husband and parents-in-law. She was also told that she is not supposed to talk when in the presence of men. On household decision making, she was told that her husband is the head of house and decision maker and would consult her if necessary. After her first child was born, she learnt from other women about modern contraception and wanted to try the methods so that she can have time to raise her child before another pregnancy. She decided to inform her husband who denied her to do that and told her that if she wanted to copy what other women were doing, she would go back to her parents. Her husband also informed his mother who also threatened her that if that's what she wanted, she should go back to her parents so that their son can marry another woman who can give them children. She did not raise this issue again and ended up having 4 children in a short time.

The *lobola* system has been noted as an important cultural component of African marriage and impacts women's as well as men's sexual behaviors in different contexts (Wojcicki et al. 2010). Evidence has linked bride wealth with reproduction since the payment of *lobola* has generally been associated with children and family lineage. As such it directly influences decisions about FP. According to (Caldwell and Caldwell 1987) in some societies, fertility limitation is seen as a threat to the bride-price agreement where the woman's relations might be required to forfeit valuable resources. Thus, the relatives on both sides may confront the contraceptive user and put pressure on her to stop using contraception. Furthermore, the influence of lineages in reproduction is such that women regard their reproduction as being the decision making province of their husbands and their husbands' families. A couple has to conform to the interests of the man's lineage.

This study explored how contraceptive use decisions are made. It was repeatedly mentioned during interviews with female key informants that it is the expectation of this society that a woman seeks permission from her husband first before using any

FP methods. The decision to use contraception has to come from the man who is head of the household, decision maker and bread winner. As household head, the man directs what should be followed in the home and decides that the spouse starts contraception when he sees that now they have the number of children they desired and wants the spouse to stop child bearing as said below:

A woman cannot decide on her own to use FP. According to our culture, it has to come from the man. A woman should just get the instructions from the man telling her that we should do this and that (FGD Married Men, 25-34 years).

A man is the one who has the power to decide because he is the one who faces a lot of problems like providing for the family needs while the woman is just on the receiving end. Therefore he decides on the number of children that you should have and if he feels that what you have is a good number then he asks you to go for contraceptive methods and you go with confidence (FGD Young Women 15-24).

However, it was mentioned that women may decide to use FP methods on their own but they risk adverse consequences such as physical and emotional abuse and also reprisals from the husband and the extended family who often issue threats. This is what was said during one of the FGD's with males in the community:

What we would like to emphasize is that our women today are very stubborn and they do not respect their husbands. They want to be on top of their husbands' heads not on the back which is at least near (participants laughed). She doesn't wait to get instructions from her husband but wants to do things on her own. The woman controls the household and it's like the man is resident in the woman's home (matrilocal residence). Some women forget that this is Ngoni culture and that she is supposed to be controlled by her husband who gives directions on what should be done. Sometimes these women get influenced by their friends when they meet to chat. Some men fail to do anything about it because they are very dull and naïve (participants laughed) (FGD Males 25-34 years).

She just wants to be wandering around without giving us children. She only eats and fills the toilet so she can as well go back to her parents (FGD older women 35 above).

The scenario described above is not only prevalent in patrilineal societies in Mzimba. Gonzalez et al. (2010) also noted that within the Hispanic culture, those that subscribe to a patriarchal ideology keep women subordinated to men, often through violence and exploitative reproductive behaviours. Her low status makes her vulnerable to the risk of unintended pregnancy and abortion (Gonzalez et al. 2010). Similarly, the MDHS 2010 has linked current contraceptive use and a woman's empowerment status. A woman who is more empowered to negotiate fertility decision making, has more control over her ability to access and use contraceptives and to space and limit births. According to MDHS 2010, women who do not participate in any household decisions have a higher desired family size than women who participate in one or more decisions (4.4 children compared with 4.2 respectively). Women who participate in decision making have a lower overall unmet need for FP (25 percent) compared with women who do not participate in any decision (27 percent) (NSO and ICF Macro 2011).

Similarly, in a FP and health project in northern Ghana, it was noted that payment of *lobola* created a situation where men believed they should have control over reproductive decisions and may refuse to use any contraceptives or practice safer sex (Bawah et al. 1999). This compromises females' ability to access and use SRH services and commodities resulting in high fertility. These views are supported by Kambarami (2006) who noted that *lobola* reduces the woman to the level of acquired property, breeds inequality and widens the gap between men and women, thereby placing women in a subordinate position. Since women have a lower status in society at large and in sexual relationships in particular and they are not expected to discuss or make decisions about sexuality. They are expected to trust their partners

unconditionally. This often prevents them from perceiving real risk, taking preventive measures and seeking safer sexual relations. Furthermore, the female powerlessness makes it difficult for many young women to be pro-active in negotiating safer sex. It is the men who decides whether to use condoms or not and even when sex takes place (PRB 2000).

Respondents' views from this study on the role of *lobola* on fertility decision making were triangulated with survey findings. Quantitative evidence showed no association between decision making power and contraceptive use. Bivariate analyses of the relationship between decision making and use of FP was statistically insignificant ($\chi^2 = 1.051$, $df = 2$, $p = 0.591$). Among women currently using contraception, the decision was mainly made by the individual woman as shown in Table 6 below. This basically challenges the conventional knowledge linking *lobola* with loss of females' decision making power on issues of reproduction.

Table 6 Decision to use modern FP methods

Decision to Use Contraception	Currently using contraception		
	No	Yes	Total %
Self	0.25(n=1)	48.7(n=187)	48.8(188)
Husband	0	33.5(n=129)	33.5(n=129)
Joint	0	17.7 (n=68)	17.7 (n=68)
Total	1	384	100 (n=385)

These findings are similar to findings of a study done to understand the impact of men's and women's behaviours on SRH in seven districts (Mwanza, Blantyre, Chiradzulu, Mangochi, Dedza, Mchinji, Nkhata Bay and Chitipa) in Malawi. This study revealed that generally men as heads of family are responsible for making

important decisions in a family. However, FP decisions in particular are made by women. In this study it was indicated that men do not usually mind about FP, but for women it is a personal matter. Men tend to take FP as a women's issue mainly because it is women who carry pregnancies and know how painful child bearing is and how difficult it is to take care of many children (Munthali and Chilimampunga 2011).

4.4.5 The practice of polygamy

The Tumbuka and Ngoni society in Mzimba practice polygamy (*mitala* in Tumbuka) where a man is allowed to marry more than one wife. Among the Ngoni societies of Mzimba, polygamous marriages are socially and culturally recognized, the children born in them are legitimate, and the co-wives are recognized and respected as married women (Chirwa and Chizimbi 2009).

In this study, 79.5 percent of the women of childbearing age said that they were in single union. However 20.5 percent of the women reported that they were in a polygamous union. The average number of wives per husband was two. Fifty seven point two percent (57.2 percent) of these were first wives while 38.2 percent were second wives) (Table 7 below).

Table 7 Polygamous union

Polygamous marriage	n=	%
1 wife	127	57.2
2nd wife	85	38.2
3rd wife	9	4.1
4th wife and more	1	0.5
Total	222	100

Interviews with males showed that polygamy among the Ngoni was mainly practiced in order to increase number of children, increase source of labour and also consolidate male power and control over women as highlighted below by males:

....Children are looked at as a source of labour. They help in so many ways and they can assist you in so many errands (IDI Married man).

People marry more than one wife in order to ease the burden of household labour. Our survival depends on farming so if you have two wives they will help each other in the gardens. I think this is one of the main reasons for marrying many wives (FGD Males 15-24 years)

The case below narrates how Mr. Mwale (not real name) felt about the essence of polygamy:

The main reason for marrying a second wife is disagreements between husband and wife in the family. Most of the time if the woman is stubborn and wants to be ruling, you as a man will not accept to be ruled by a woman since you are the one who brought her into the household. Why should she behave like she was born in that family; this is the problem. It is also difficult to send her back to her home and it may not look good so you decide to teach her a lesson: if she wants to rule me then I will marry another wife and the first wife will be ashamed of herself. She will realize that you have brought a second wife home because of her stubbornness. Secondly, some men marry because they are lazy. They want to have more children and wives who will be farming and he will just be like a Manager. Sometimes he will just be asking children to do farm work while he is just sitting around. Children will be a source of farm labour and he will be happy that, despite the fact that a large family presents with it feeding problems, it is helpful during farming which needs a lot of people.

It was noted that the practice of polygamy puts pressure on women to bear more children to protect their marriage and interests of lineage and those in a polygamous marriage competed among each other on the number of children to bear. The security

of women in this society was guaranteed by the number of children they gave to their husbands' lineage. This perception was supported by survey results which showed a close association between number of children born to a woman and whether a woman was in polygamy or not, chi square = 17.5, df =1, p value < 0.0001. Women in polygamy had more children than women who were not in polygamous union (Figure 10).

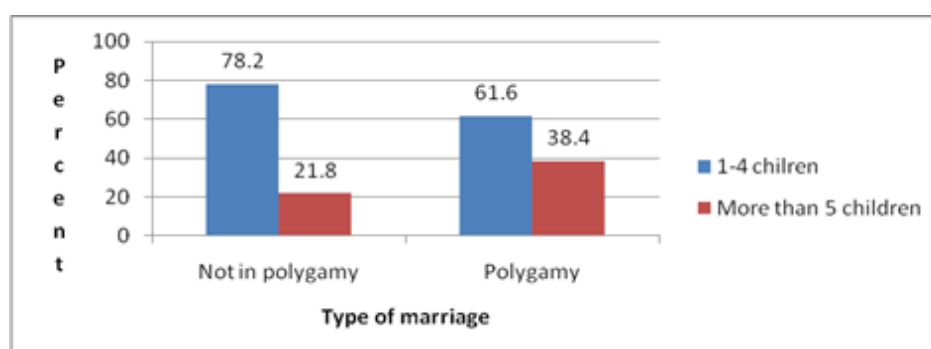


Figure 10 Polygamy and number of children

Furthermore, conception and pregnancy was seen by women as a guarantee that they would get more support from the husband and his family. Interviews with married women and men in rural Mzimba showed that a woman married in a patrilineal society was regarded as a stranger in the clan. As such, she was expected to be on her best behaviour in the first couple of years to please her husband and mothers in-law otherwise she risks her husband marrying another wife. This scenario resulted in uncontrolled fertility in order to meet fertility demands of husband and clan for their survival and recognition:

I am compelled to have more children because my husband wants many children. If I don't have more, my husband will marry another wife (IDI Female non- user of FP)

4.4.6 The effect of kinship networks on contraceptive use

The patrilineal extended family, based on the principle of kinship relations is the focal point and the main framework of personal and social identity of its members and it plays a large part in the everyday lives of the Ngoni people of Mzimba. The Ngoni society has patrilocal residence rules; that is the villages are set up in such a way that all lineally related kinfolk stay close to each other in the same homestead under the authority of the household head. Upon marriage a woman lives with her husband's family and is placed under the guidance of her *amamavyala* (mother in-law) and her husbands' elder brothers wives. The traditional pattern of authority and behaviour on issues to do with pregnancy and childbirth among the Ngoni, is played by senior women comprising the mother in-law, paternal grandmothers' and other senior women within the kin-group. Usually a married man and his wife are established within the social group of the mother's house and he acknowledges his mother's authority and control over his wife. Also a young woman upon marriage is advised by her own kin to remain obedient and humble and accept the authority of her husband's mother (Read 1968).

Young women and men interviewed in this study confirmed that their parents' especially paternal grandmothers and mother have a lot of influence on their family life especially on the number of children. It was mentioned that a woman married in this patrilineal society, was more accepted if she had children. Giving birth to many children earned women more power within the family, access to resources, prestige and respect. Grandmothers and mothers in-law were reported to put a lot of pressure on young couples to have many children. This was done through their persistent complaints if a couple is not conceiving as explained below:

After I got married and had two children, I wanted to start using FP methods but I was discouraged by my parents' in-law. They told me that it might take time for me to bear another child and they said that they cannot accept that I should reach old age with only these two children(IDI female non- user of FP).

Parents tell us that they regret that they have just lost their cattle when a wife has only given birth to 4 children. They want us to have seven or more. This is what they want.. (FGD Males 15-24 years)

This was confirmed through interviews with older women who mentioned that it was their duty to advise young couples about childbearing and even if one had many children, they will be taken care of by the wider family network. For them a child is not raised by one person. A qualitative study done in Zimbabwe explored the impact of other family members on women's reproductive decisions and on their ability to participate in the country's economic development process (Francis-Chizororo and Wekwete 1999). The study revealed that mothers in-law value and promote large families. This was done through advice and opinions which they offered regarding family size. Mostly older women wanted grandchildren, especially boys, to extend the family line, assist with household chores, and provide care for them in old age. The preference for a large family was more pronounced among rural women than their urban counterparts (Francis-Chizororo and Wekwete 1999).

Apart from kinship networks authority over their son and daughter in-law in relation to reproduction and family size, they also play a key role in contraceptive decision making. They have more power and rights to make these decisions than the conjugal household of their son and daughter in-law. The case below depicts the influence of parents in-law especially mothers and grandmothers on contraceptive use:

Mrs Ndhlozi (not real name) decided to use modern contraception after her third birth of a baby girl. She made this decision because she felt that the traditional methods that she was using after the delivery of her first and second baby had not worked. After her first delivery, she was told not to sleep on the same bed with her husband until the baby is a bit older. Then elderly women came after 6 months to perform a birth ritual signifying that they can start to have sex but the man should not ejaculate his semen inside her vagina but outside (withdrawal method) until the baby stops breast feeding. This did not work. This is what she said in her own words:

Nkhwakusuzga kulekana pala mwabatilirana. Nanga uti fumani nge wangazomera! It is very difficult to separate when you are interlocked during sexual intercourse. Even if you may tell your partner to withdraw, he cannot accept to come out and ejaculate outside !

So when her baby was nine months old she got pregnant. After the second baby was born the same advice was given but it did not work. She got pregnant again for the third time. She became the laughing stock among her colleagues for being good at ***kutumbirizga*** (not spacing her children).

One day she decided to discuss her decision to start using contraception with her husband after he had returned from his daily work. She waited for an appropriate time to talk to him after the evening meal. When she raised this issue with him, he said he cannot say yes because he has to consult with his mother. When her husband raised this with his parents, he was advised to talk to his grandmother who eventually came to counsel them and advised them against using modern contraceptives. The grandmother actually told them how in her days she was able to raise children without using contraception and why is it difficult for them. She blamed her that she is the source of the problem because she always wants to sleep close to her husband that is why she gets pregnant quickly and this does not give chance to the baby to grow.

Young women also shared their perceptions on the role of parents' in-law, elderly people and their husbands in ensuring survival of the lineage by discouraging use of modern FP methods. It was mentioned that young women are put under so much pressure to conform to the norms of childbearing. Young women revealed that those who use contraception are insulted or shouted at and this has resulted in most young

women not disclosing that they are using contraceptive methods. This is what young women said:

You cannot use contraception if you only have one child because if people in the village know about that they will say lots of bad things about you and your husband like you don't love your husband and that your husband is under you and he does feminine jobs in the house hold which you are supposed to perform (FGD Young women 15-24 years).

They don't know. I have never told anyone that I am using modern FP methods. Otherwise they would have discouraged me or even shout at me) (IDI User of FP 15-24).

Health workers added their views on the negative influences of the larger extended family (mothers in-law and grandparents) on contraceptive use:

FP use is not acceptable among older people. They still demand that an ideal household should have eight, nine, ten or more children. They are still holding on to what they believe in although we educate them on the importance of FP and the need to adjust according to the changing times (IDI with a Health Care Provider).

The available literature shows that fertility decisions are influenced by reigning social norms and institutions (Bongaarts et al. 1984; Rossouw et al. 2012). High fertility rates have been associated with collective norms and traditional institutions and structures that favour the interests of the extended family over that of the individual (Notestein 1953). Campbell and Campbell (1997) in their analysis of fertility in Botswana a sub Saharan African country, noted that in most African social systems fertility choices are influenced by the wider network of the kin. Within patriarchal systems, the lineage controls the productive and reproductive capacities of women. This means that the boundaries of the conjugal household are often penetrated by other kin thus weakening the bond between husbands and wives. The bonds linking

husband and wife in marriage are weak due to the claims on couples asserted by their respective lineages to conform to kinship norms (Caldwell and Caldwell 1987; Hollos and Larsen 2004; Larsen and Hollos 1997; Fikree et al. 2001; Mohammad et al. 2003).

4.5 Health system related factors influencing contraceptive use

4.5.1 Coverage of health care services

The area of TA Mzukuzuku serves a total population of 32,267 people and has the lowest number of health care facilities in the district compared to the size of its population. As explained in Chapter three, TA Mzukuzuku's area has only one public facility that is Vibangalala health post. This means that people have to depend on CHAM facilities namely Embangweni Hospital and Mabiri health centre for most of their health care needs. This situation is different from what is the case at national level.

Embangweni Hospital covers a population of 32,704 people and 23% of these are WCBA (Embangweni Mission Hospital 2011). This wide population coverage is a result of the geographic location of this facility which covers three TAs namely TA Mzukuzuku, M'mbelwa and Mzikubola. Embangweni hospital's catchment area covers Ephangweni, Embangweni, Kakoma, Mharaunda, Kalungulu, Etchiyeni, Mbawa, Dimi, Kalukumbi, Chiwondwe, Chikomeni, Zulanga, Esigondleni, Emazwini, Kachenyu, Thoza, Chizimba and St. Francis. The distance between these sites and Embangweni ranges from 5 kms to 35 kms. At national level, it is estimated that a health facility serves on average 13,824 people and for Mzimba district, estimates show that a facility serves 9,101 people (MoH 2007). On comparative basis,

Embangweni hospital is serving a much higher population compared with national and district estimates.

On the other hand, Mabiri health centre which is 15 kms West from Embangweni and 10 km South of Vibangalala health centre also belongs to CHAM and is under Embangweni hospital. It serves a total population of about 19,363 people covering part of TA Mzukuzuku and TA M'mbelwa. As with Embangweni, Mabiri health centre also serves a much higher population than an average estimate for a health facility in the district. One of the reasons for this high population coverage is the location of the facility. It is located close to the boundary between the southern part of TA Mzukuzuku, TA M'mbelwa and also part of Zambia. This means that the facility does not only cater for the population around TA Mzukuzuku's area. Furthermore, as part of Mzimba, the area of Mabiri has a higher population density of 70 persons per square kilometer compared to the northern region figure of 63 persons per square kilometer (NSO 2010). The catchment area of Mabiri covers a distance of 5kms to 18 kms extending from Zwangendaba, Kamalibwe, Kasulanthanga, Mtuzuzu, Chifwefwe, Kanyenyezi, Chikande, Makhosikazi and Matikija. The situation described above reveals the disparities between the number of health care facilities and population size in the area of TA Mzukuzuku and also the proximity of the health facilities to the population. The health care facilities in the study area serve a much higher population than the national estimates on the average number of people per facility and also the population density is much lower in Mzimba district than at national level. Evidence shows that facilities that serve high population size are more likely to face constraints on delivery of high quality services as well as in meeting the needs of the population served due to limited resources (Central Statistical Authority

(CSA) 1993). It has been recognized that population density matters in the delivery of services (United Nations 2011).

Evidence from clients exiting health facilities in the study area shows that the distance that women walk to get to the nearest facility range from 0.4 kms to 20 kms. This shows that in this rural setting some parts of the population live far away from a health facility. This is not in line with the health sector strategic plan which aims at improving access to and coverage of EHP services by ensuring that the majority of Malawians live within an 8 km radius of a health facility that provides free EHP services (MoH 2011a).

Study findings showed that on average 70 percent of women walk to get to the health facilities while only about 23 percent either cycle or are carried on a bicycle. For the majority of women especially around Mabiri area, it took them almost one to two hours to get to the nearest FP service sites as per Table 8.

Table 8 Time taken to get to the nearest facility

Time Taken	Mabiri	Embangweni	Mzimba	All places
Less than 30 minutes	12.5(15)	68.5(148)	67.5(160)	56.6 (323)
30 mins. to less than 1hour	53.3(64)	16.7(36)	22.4(53)	26.7 (153)
1 hour to less than 2 hours	26.7(32)	13.9(30)	10.1(24)	15.0 (86)
More than 2 hours	7.5 (9)	0.9(2)	0	1.9 (11)

Key informants indicated that distance to get to the health facilities was one of the discouraging factors for most women in Mzimba and it affected their uptake of FP methods. It was also pointed out that since women who use FP methods are generally healthy and not sick, they are not motivated to walk such long distances just to get FP methods at a health care facility. Further analysis was done to establish whether distance really affected current use of contraception. Results show that distance was related to adoption and use of contraception (Figure 11 below). There was association between distance to health facility and use of contraceptives (chi square = 33.23 df= 2, p value <0.0001).

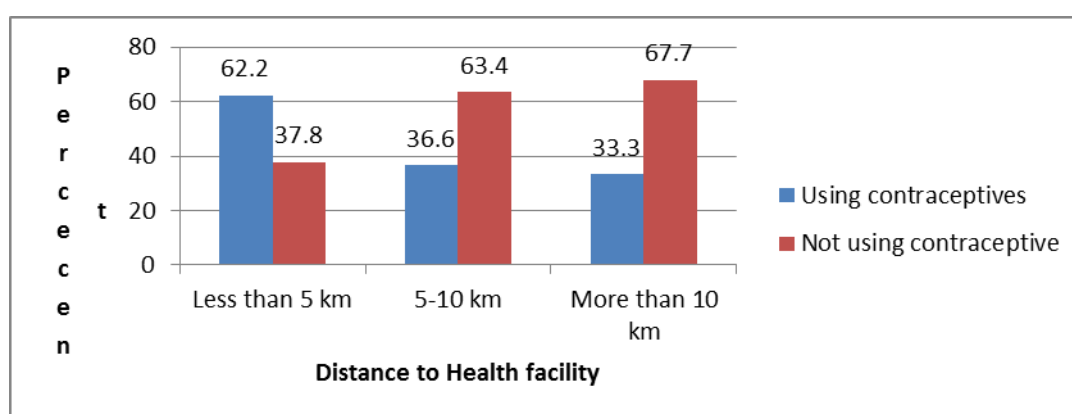


Figure 11 Distance and FP use

The relationship between distance and FP use has been noted elsewhere (Amooti-Kaguna and Nuwaha 2000; Bersamin et al. 2011; Fawcus et al. 1996; MoH 2007; Raghupathy 1996). For example, analysis of data obtained from the 2008-2009 Kenya Demographic and Health Survey and linked to the location of health facilities in the country found that among the respondents who lived more than 5 km from the nearest health facility modern contraceptive use was significantly less likely compared to women resident 5 km or less from the nearest health facility. Women from counties with higher health facility density were 53 percent more likely to use modern

contraceptives compared to women in counties with low health facility density. In this analysis it was concluded that physical access to health facilities is an important determinant of modern contraceptive use and unmet need in Kenya. Therefore to mitigate the challenge of distance to health facilities, innovative strategies such as delivering services by outreach and mobile services should be strengthened (Ettarh and Kyobutungi 2012).

The case below highlights the views of Mrs Nkuna (not real name) on the issue of distance:

Most women who seek FP services from this area walk either to Embangweni or Mabiri. It is very far away. When we go to Mabiri health centre which is about 15 kms away from here, we walk all the way one two one two (describing the steps they take). It is a long distance. For example, when we leave in the morning at 6 o'clock, we get there at 10 o'clock in the morning. If you are on a bicycle you get there at 9 o'clock. Very few women manage to walk such long distances. Only younger women and only those who really appreciate the importance of FP use can walk to Mabiri, otherwise some women are lazy and get discouraged. It also gets discouraging when you walk all the way to Mabiri and when you get there sometimes you find that there are no contraceptives and they tell you to go to Embangweni. Most of the times, when you go to Mabiri, you find no contraceptives. You go again the following month and again find that there is nothing. You just get tired of walking and then you discover that you are pregnant. This is our main problem here. What we want is that FP services should come near to us because where we go to get the FP methods is very far away.

4.5.2 Staffing levels and staff competence in health facilities

Available data shows that Mzimba district has the highest proportion of qualified health professionals in the northern health zone of Malawi. Of these 0.5 percent (n=15) are physicians, 2.4 percent (n=71) clinical officers, 2.1 percent (n=60) medical assistants, 15.7 percent (n=455) nurses. However, this study has shown that the area of TA Mzukuzuku operate with limited number of health care workers. At the time of

this study, two health facilities (Mabiri and Vibangalala health centre) within TA Mzukuzuku, had no trained nurse/midwife. At Matikija outreach site and Makhosikazi health post, the resident HSA had been moved away and no health worker was available. Table 9 below shows a summary of staffing levels (staff responsible for FP provision) in the health facilities included in this study:

Table 9 Staffing levels per health facility

Name of facility	Medical officer	Clinical officer	Medical Ass.	Comm. Nurse	Nurse midwife	HSA	CBD A
Mabiri HC	0	0	1	0	0	10	
Vibangala HC	0	0	1	0	0	3	
Embangweni Hosp (FP Dept)	1	2	0	1	4	20	12
Mzimba DHO (FP Dept)	1	1	0	3	9	40	21
BLM	0	1	0	2	2	0	0

The table above shows the number of professional staff responsible for the FP programme in all the three facilities mentioned above is lower compared with the given staffing norms for the delivery of EHP in Malawi of 2/2/1 (i.e. 2 nurses, 2 clinicians, and 1 environmental health officer) (MoH 2010). The lack of nurse/midwife at Mabiri and Vibangala health centre meant that the delivery of FP services was basically left in the hands of non- professional staff. Poor performance of the health indicators may be a result of health staff not being sufficient in numbers and this could lead to failure to provide care according to standards or not being responsive to the needs of the community and patients (Diellemann et al. 2006). Shortage of health care workers is therefore a barrier to the provision of high quality FP services.

Health worker census reports further shows that community health workers, who are key personnel in the delivery of community based FP services are very few in Mzimba district. Among community health workers, 19.3 percent (n=561) are HSAs, 3.27 percent CBDAs, and 0.9 percent (n=26) public health workers (MoH 2007; MoH 2011b). For Mabiri health centre alone, the ratio of HSAs to the population is 0.516². This is low compared to the population estimates for the area and national community health care worker (HSAs) ratio to 1000 population which is 0.77 (MoH 2007). This has been described by informants as a major barrier to FP service delivery in the area as below:

It is not easy to get FP methods here. It is our prayer that we will also have these volunteers (CBDAs) just like other Malawians since we hear this on the radios. We are wondering what happens that some districts have this door to door programme where these volunteers provide counseling and information on FP and not us here. How is it done? We want this program in our village because women walk long distance to get FP methods and this is not easy for some who have problems with walking. It is because of this that some women have children year in year out because FP services are far away. If services were near and people received information and counseling it would have been helpful to most women (FGD Men 25-49 years).

Evidence shows that Malawi as a country is facing a human resource (HR) crisis which has created a lack of capacity to deliver health services, especially in rural areas where primary health care is severely compromised (Manafa et al. 2009). According to (Muula and Maseko 2009) the shortage of health workers in Malawi is severe even by African standards. The average number of nurse/midwives in health

² The ratio of HAS to the population is calculated as follows:
 Total number of HSAs x1000 pop/ Total population of the area
 = 10 x 1000 /19363 = **0.516**

centres is approximately 1.9, an indication that many such centres are run with one nurse/midwife or none at all. These low staffing levels affect delivery of services. For example, the EHP scale-up was critically slowed, with only 10 percent of the 617 facilities satisfying the HR requirements for delivering EHP in 2003. Inadequate staffing levels also affected the planned rollout of antiretroviral treatment (ART) and other HIV/AIDS related services in Malawi (MoH 2004). Similarly according to Palmer (2006) the severe staff shortages arising from problems with retention and continued attrition in numbers of midwives, is proving to be an important obstacle to increasing coverage of maternal and reproductive health services by skilled attendants and puts at risk the gains in quality of care (Palmer 2006). The Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Malawi underscores staff shortages and weak human resource management as the first of multiple factors affecting levels of skilled attendance. Only 13 percent of health facilities in Malawi have 24-hour coverage by trained nurse/midwives who form the bulk of health care providers in Malawi (MoH 2006).

4.5.3 Availability of trained and competent staff

As earlier indicated, at the time of the study, these two facilities (Mabiri health centre and Vibangala health post) had no trained FP provider who is usually a nurse/midwife. FP services were provided by the HSAs. In the absence of a trained FP provider, HSAs played a major role in the provision of FP services. According to informants, HSAs are limited to providing pills and condoms and only a few have been further trained to provide depoprovera. This meant that clients are not able to get the contraceptive methods of their choice because of lack of a trained provider. Below are views of some service providers on FP service provision:

Most of the time the services I provide are depoprovera, pills and condoms. We used to have a nurse FP provider who was trained in norplant insertion and was visiting our facility for this service but not nowadays (IDI HSA).

Most of the times, I do stock condoms and contraceptive pills only. I do not stock depoprovera because I have not been trained to provide it. So I refer the women who come to me to either Mabiri health centre or Embangweni hospital (IDI HSA).

A study by Gage and Zomahoun (2012) on the influence of the service delivery environment on FP outcomes in Nigeria revealed that health worker training to provide FP services had a significant positive association with respondents' odds of ever using a modern method of FP (OR = 1.136; 95 percent CI = 1.043, 1.238; $p = 0.004$). This data offered an opportunity to examine the links between the availability of providers trained in key areas of FP/RH service delivery and contraceptive behavior (Gage and Zomahoun 2012). Evidence suggests that health worker training improves providers' skills in presenting clients with FP information, promotes attitudinal change among providers themselves and improves client satisfaction and providers' tendency to ask clients about their reproductive intentions and prior experience with contraceptive methods, and increases a client's likelihood to return for follow-up visits (Costello et al. 2001; Huntington et al. 1990; Kim et al. 1992; RamaRao et al. 2003).

In the absence of a trained provider especially at Mabiri and Vibangalala, some clients are referred to other facilities for FP services. In this study 50 percent of women who participated in client exit interviews indicated that they were referred to other facilities. The most common referrals concern clients seeking implants (48.2 percent) and IUCD (35.7 percent).

I would also want to be trained as a depoprovera provider since this is the preferred method for many women in this area. Women walk long distances to come here looking for depo only to find that I cannot provide that method and clients are referred to Embangweni or Kalikumbi which is also very far away. These FP methods should be available at all times please (IDI service provider).

Several studies have examined the importance of service providers' training in FP provision. For example, a study to assess FP providers' perspectives on FP service delivery in Ibadan and Kaduna, Nigeria revealed that many service providers lacked basic training in FP provision and this had a bearing on the quality of care and uptake of FP services (Herbert et al. 2013). Similarly, a study in Egypt examined the relationship between the availability of trained providers and contraceptive outcomes in Egypt. In service environments characterized by health facilities with few trained FP providers or a shortage of female providers, residents were significantly more likely to discontinue pill use compared with those residing in other service environments, after controlling for other factors (Ali 2001).

4.5.4 Contraceptive supply and service environment

Results show that a number of FP methods were offered in the health care facilities in Mzimba and these included oral contraceptive pills, injectable contraception (depoprovera), male condoms, implants, intrauterine contraceptive devices (IUCD), bilateral tubal ligation (BTL) and male sterilization (vasectomy). However, WCBA mentioned oral contraceptive pills, injectable contraception (depoprovera) and male condoms as contraceptive methods most commonly offered refer to Figure 12.

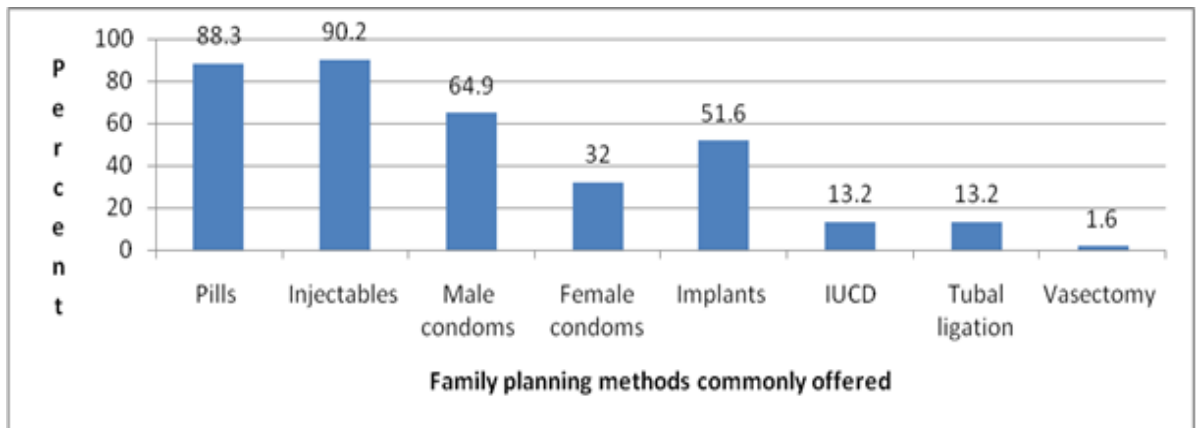


Figure 12 Family planning methods commonly offered

On methods always available, women exiting the three health facilities reported intrauterine contraceptive devices (IUCD), bilateral tubal ligation (BTL) and male sterilization (vasectomy) as not always available refer to Figure 13 below.

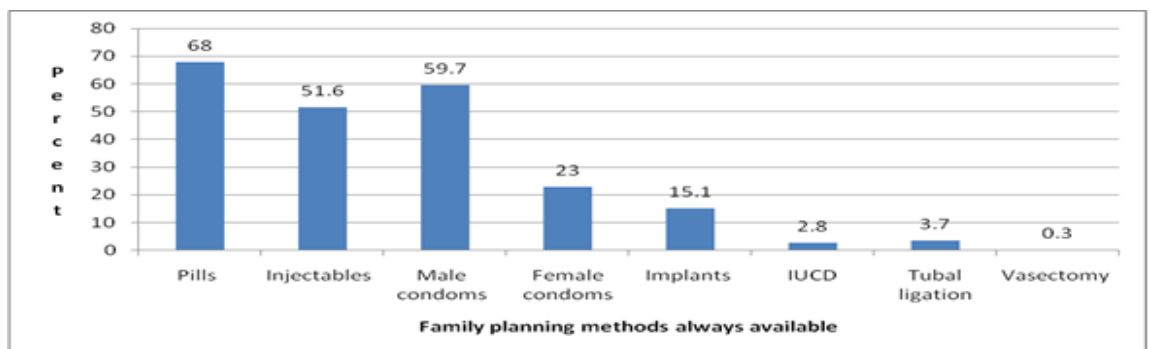


Figure 13 Contraceptives always available

These findings show that the contraceptive method mix is not balanced in the study area. The contraceptive methods always available are limited to injectable contraception, male condoms and pills. The limited availability of contraceptive methods therefore limits choice. For instance, in this study 64.5 percent of the clients exiting health care facilities mentioned that their method of choice was not always available. Available evidence from studies done in many African countries shows that couples do not have ready access to a variety of contraceptive methods. This

limits their choice of contraceptive methods and couples cannot easily choose the method that best suits their reproductive needs (Johnson and Macke 1996; Ross and Mauldin 1996; Ross et al. 1999). Women who are given a choice, exercise it and continue to use their chosen contraceptives to a greater degree than those denied their choices (Andrew et al. 2006).

According to client exit interview results from three health facilities where exit interviews were done (Embangweni hospital, Mabiri health centre and Mzimba BLM), 80.9 percent of the participants indicated that their facilities did not have a regular supply of contraceptives (Table 10 below). At Mabiri 84 percent of the clients, while 85 percent at Embangweni and 76 percent at BLM indicated that contraceptive methods were not regularly supplied.

Table 10 Whether contraceptive methods were regularly supplied

Whether contraceptive methods were regularly supplied	Health care facility			
	Mabiri	Embangweni	BLM Mzimba	Total
No	21	34	34	89
	84.00%	85.00%	75.60%	80.90%
Yes	3	4	11	18
	12.00%	10.00%	24.40%	16.40%
Do not know	1	2		3
	4.00%	5.00%	0.00%	2.70%
Total	25	40	45	110
	100.00%	100.00%	100.00%	100.00 %

Exit interview clients were also asked which methods were not regularly supplied and mostly scarce, 72.7 percent of women mentioned injectable contraceptives (Table 11).

Table 11 Contraceptives not regularly supplied as observed by clients

Type of method	Are contraceptives not regularly supplied		
	Yes	No	n
Pills	30% (33)	70% (77)	110
Injectables	72.7 % (80) *	27.3% (30)	110
Male condom	4.5% (5)	95.5% (105)	110
Female condom	3.6% (4)	96.4% (106)	110
Implants	33.6% (37)	66.4% (73)	110
IUCD	2.7% (3)	97.3% (107)	110
Tubal Ligation	0%	100% (110)	110
Vasectomy	0%	100% (110)	110

*Note that the percentages are calculated within responses for each type of method supplied. Since this was a multiple response question.

Qualitative interviews with users of contraception confirmed the above findings. Informants mentioned that the non-availability of FP supplies at the health care facilities was a major concern among users and also a barrier to FP use. At the time of the study, contraceptive users had not been getting their regular supply of contraceptives for some months and this problem was worse for those who resided far away from the health facilities since they would not know whether the supplies had come or not. Mrs Phiri (not real name) narrated her painful experience as she was searching for contraceptives:

For some months now, I have not received my supply of contraceptives. I do not find the contraceptive that I use when I go to the health facility. We are very far away from the health centre so when we get wind that the supplies have come by the time we get there we find that they are finished. We just move up and down, back and forth and now I am tired and have just stopped

going there. For example, in the month of September, I went to Mabiri health centre for my appointment, I found that there are no contraceptives and they told me to wait until they come for outreach clinic here at Matikija. I waited for the date of this outreach visit without taking any contraceptives and when I went to Matikija, I found that they have not brought any contraceptives. One day, I decided to walk with some of my friends to Embangweni which is 16 kms away and that is where we got the injectable contraception. Embangweni is very far away and this to me was a big problem. I feel that we are really in an area that is sidelined. The women who live near the health facility are better off because when the methods come, they rush and scramble to get the methods. But us here we just suffer.

Other women also added their views on the availability of contraceptive supplies:

Lack of supplies is the main problem. For example, it is now many months we just walk to the hospital and come back without anything, no contraceptive supplies at all. FP use is important but we have a problem (FGD User of contraceptives).

All the past months we have not been supplied with contraceptives. It was difficult to find the contraceptive supplies especially depoprovera (IDI User of contraceptives).

The above sentiments were supported by community health care providers who indicated that they find it difficult to offer a wide range of methods for their clients to choose from because of limited stock. In spite of the high demand for condoms, contraceptive pills and injectable contraception (depoprovera), these are not available all the time. It was also confirmed that injectable contraception which is often in very high demand was mostly out of stock. Informants indicated that for close to a year the health facilities have not received regular supplies of depoprovera and this affected adoption and use of contraceptives. Below are views of service providers on supply of contraceptives:

I do provide condoms and contraceptive pills but what I mostly have in stock are condoms. Even now I only have condoms (IDI HSA).

As I am talking, I have depoprovera but I do not have oral contraceptives. I have tried like I do sometimes to fetch from other health centres and Embangweni mission hospital but they also have nothing, so we don't offer this service. We are still pushing so that whenever the contraceptives come we should get them (HSA in DMPA provision).

Interruptions in the contraceptive commodity supply chain were cited as a major contributing factor to poor supply of contraceptives. This is mainly due to (a) lack of high quality data for estimating FP commodity requirements often due to reliance on use of manual registers (b) low stock levels at source of issue. In Mzimba district, health facilities get their supplies from Mzimba District Health Office (DHO) and what they issue is dependent on what they have in stock in the pharmacy. This has often resulted in limited disbursement of supplies to the health facilities (c) forecasting based on quantities consumed, resulted in poor estimates of demand due to lack of data on users.

The findings of a study done in Bangladesh have shown the impact of stock-out/shortage/irregular supply of three select FP commodities (oral pill, injectable contraception and condom) on childbearing. Evidence shows that irregular supply of contraceptives result in additional child birth due to unexpected pregnancy. Studies have shown that countries in which all couples have easy access to a wide range of contraceptive methods have a more balanced methods mix and higher levels of overall contraceptive prevalence than countries with limited access to various contraceptives (Magadi and Curtis 2003; Ross et al. 2001). A balanced method mix is also an

indicator that there is no systematic limitation of contraceptive choice (Sullivan et al. 2006).

Furthermore, the accurate quantification and forecast data is essential for ensuring that a wide range of contraceptive methods are available and that the procurement process result in the correct quantity of commodities that will best support the FP programmes projected needs. A forecast that is too low could result in stock outs which often trigger expensive emergency procurement creating a financial strain on limited health care budgets. A forecast that is too high can cause excess holding costs, storage capacity strain and increased chance of products expiring while on shelf. Furthermore, poor quality and inaccurate data affect forecast assumptions and contribute to forecast errors (USAID / Deliver Project 2011a). Forecasting based on actual quantities consumed is reported as an important step in improving quality of quantifications. However, this type of forecasting depends on availability of data on users. Where there is underutilization of services due to non- availability of commodities, user data may not be available. As such forecasting using actual consumption may not be predictive of future demand of the service. Demand forecasting is required to predict the quantity of commodities to be purchased based on need, demand, consumption and supply (USAID / Deliver Project 2011b). For contraceptives, forecasts can be based on simple calculations that consider demographic data (e.g. CPR, number of FP users, unmet need for FP); the country's current contraceptive commodity mix; consumption data (actual sales and use); geographic scope; logistics data and service statistics.

4.5.5 Affordability of services

The survey results as well as the client exit interviews have shown that generally women who seek FP services do not pay anything for the services. FP services are basically offered free of charge in both public and CHAM facilities except in rare situations where clients were asked to pay for the services. This practice which was outside the norm, amounted to a malpractice on the part of service providers and a barrier to access to FP services. The case below explains how Mrs Tontho (not real name) struggled to get contraceptives after she was asked to pay for the services:

This other month when I was due to visit the health facility for FP supplies, I was asked by my friends where I was going. When I said to collect my supplies it was then that they revealed to me that I need to carry money, about K500.00. My friends told me that nowadays they charge for one to get an injection (meaning injectable contraception was for sale). Again after 3 months when you are due to go back you have to pay another K500.00 again. I stayed for one year without visiting these outreach clinics to get FP methods. I went back to check if I can find free supplies. They told me that they charge for depoprovera and I was sent back. I then decided to go to Dimi³ which is about 10 kms away and this is where I got injectable contraception at no fee. I was surprised that I got depoprovera without paying anything. When I went home, I told my friends that depoprovera is still free and we are not supposed to pay for it. It took me one year without getting the contraceptives because I was told that there is a fee attached. This is how I discovered that some service providers cheat people. We get free services at Dimi. You can imagine that I spent one full year without getting the injections and I was throughout worried about getting pregnant again.

However, indirect costs associated with seeking care were reported: about 10 percent of the participants indicated to have spent money on transport while 15 percent spent money on health passport. The highest amount spent on transport ranged from MK

³ Dimi is an outreach clinic under Embangweni Hospital but it is within TA M'mbelwas area

30.00 to MK100.00 while a health passport was sold at MK20.00⁴. Other indirect costs were related to food expenses and this was reported by 21.7 percent of the participants. Informants confirmed that money spent on food and transport is considered as the major cost that women incur in accessing FP services. Some money is spent on transport especially when the woman does not have a bicycle of her own and has to hire one (*kabaza*) to take her to the health facility. Below are some quotes from in depth interviews and focus group discussions:

We do not spend money on FP methods but transport to Mabiri and back which cost us K100.00. This is expensive to us (IDI User of FP).

FP services are free but you need to hire a bicycle if you do not have one as long as you get what you want. If you have your own bicycle then you ride on it until you get to Embangweni (FGD Women 25-49 Boli).

The study findings show that 83 percent of women who were not doing anything to generate income were not currently using contraception. Results show a close correlation between income and use of contraceptives, chi-square = 1.1, df= 1, p value= 0.294. This means that women who have no source of income are less likely to pay for health passport, transport and food costs that are associated with seeking FP services. The 2010 Malawi DHS also found a close association between income and contraceptive use. Women in the lowest quintile were least likely to use a contraceptive method (39 percent) compared with women in the highest quintile (53 percent). Similarly, DHS analysis of 13 countries in Sub Saharan Africa which assessed changes in met need for contraception associated with wealth-related inequity; and also the relationship between the use of long-term versus short-term

⁴ In most facilities in the study area clients were given a half notebook to use as a health passport and this was sold at K20.00

contraceptive methods and a woman's fertility intentions and household wealth. In this study, it was found that women in the poorest quintiles were less likely not to practice long term contraception (Creanga et al. 2011).

4.5.6 Availability of FP information for users and non- users

Generally, results show FP clients are given information about the FP services available at the facilities and that knowledge of FP was high in the study area (90 percent). However, despite this, a large proportion (92.7 percent) of clients, were not satisfied with the information given. This was largely attributed to the fact that consultation with FP clients was done in a hurried manner and providers preferred to give FP information to groups of clients, denying clients quality time to receive one to one counseling about FP methods. Findings from studies assessing the performance of providers confirm that a short consultation time does not allow correct diagnosis or management of the condition for which clients/patients presented (Hashemi and Hossain 1995.; Hossain et al. 1991; Khanun 1994; Mabub et al. 1991; Whittaker 1993). The Malawi DHS 2010 noted that informed choice is an important tool for monitoring the quality of FP services offered to users. Information given to users in relation to side effects or problems they might have with a method, what to do if they experienced side effects and other methods they could use would assist users in coping with side effects and also decrease unnecessary discontinuations (NSO and ICF Macro 2011).

Information given to contraceptive users is an important aspect of quality of contraceptive services. According to a study among youth in two Ugandan districts, one plausible explanation for the low quality of services was limited capacity of the

health care providers to give information and services based on up to date scientific evidence. Although the providers mentioned the different contraceptive methods, they generally gave suboptimal information to users and frequently recommended specific methods to clients (Nalwadda et al. 2011a). Where information and instructions given to clients are incomplete, inaccurate and unclear, quality is compromised and it is often not possible for clients to make their own informed choice (Nalwadda et al. 2011b). Comprehensive and correct information enhances informed choice and this is a key feature in widening clients' knowledge and dispelling myths about contraception (Butler and Khanna 2004).

Apart from lack of adequate information given to FP clients, findings showed that males especially in Mabiri area lacked correct information on the modern FP methods since they are not exposed to any formal education or counseling about FP as narrated below:

Even when you have a child you have to teach them certain things. We do not know anything about FP and this is the first time someone like you has come here to talk to us about FP. If this was done regularly then men would use FP (FGD married men)

...Can men practice FP? Here men are really behind because the health facilities are very far away. What can be done so that we also get information about FP? (FGD married men)

Reports from male informants show that men unlike women do not usually visit the health facilities and their access to FP information is therefore limited. It was not common for men in Mzimba to seek health care services unless they are very ill. Men also indicated that the health facilities were very far away and they did not have the time since they were busy with other things. They also believed that the issue of pregnancy and childbearing was a female domain and therefore they saw no reason

why they should walk such long distances to get information about FP. Below are men's views on access to information:

In this village, it is rare for men to visit the health centre and this is why they have not been exposed to any information about these things. They do not know much about the FP methods and how they work. The only methods they are familiar with are condoms. But even then, it is the wives who bring the condoms from the health facilities. We do not even know whether there are any Pills or injectable contraception that men can use to limit childbearing? This is what we want to understand because men here do not know much about FP. We just guess because of lack of information (FGD Males 25-49 years).

Men are busy with a lot of things and three out of four men in this community are busy drinking beer. They do not have much time to care about these other things like FP (FGD Males 25-49 years)

Although most FP methods are used by women, frequently men are the decision-makers within the family unit. It is therefore important that men should be given appropriate information and encouraged to take an active role in the FP decision-making process. This will help ensure that joint responsibility is taken for FP decisions and will maximize acceptance of the programme within the community (UNFPA 2003). Provision of counseling and education to couples rather than just to women is one of the strategies used to involve men in FP decisions (Lundgren et al. 2012). Studies on FP interventions aimed at couples have established that couple interventions were more effective than those aimed just at women in terms of FP outcomes such as contraceptive use or continuation (Becker 1996).

An intervention that promoted male engagement was done in the Altiplano region of Guatemala. This intervention was designed with the input of men and with the

objective of encouraging men to space their children and support their wives use of FP methods. Men were also trained in fertility awareness and received counseling as a couple on other contraceptive methods. Interviews and focus groups with male and female users as well as project staff and volunteers suggested that the intervention successfully engaged men in FP resulting in increased contraceptive prevalence rates (Lundgren et al. 2012). Similarly, in Malawi a randomized intervention study using the information-motivation –behavioral skills was done among 400 men in Mangochi district. These were randomized into an intervention arm and a control arm. A survey on contraceptive use was administered at baseline and after the intervention. In-depth interviews were also conducted with a subset of intervention participants. After the intervention, contraceptive use increased significantly within both arms ($P < .01$), and this increase was significantly greater in the intervention arm than it was in the control arm ($P < .01$). Quantitative and qualitative data indicated that increased ease and frequency of communication within couples were the only significant predictors of uptake ($P < .01$). It was concluded that men facilitated contraceptive use for their partners (Shattuck et al. 2011). Involvement of men in FP programmes enables them to share the responsibility of FP with their female partners. Men have particular roles and responsibilities in terms of women's reproductive health because of their decision-making powers in reproductive health matters (UNFPA 2012). Also objections from the male partner contribute to high rates of discontinuation of contraceptive use (Goonewardene 2011; Shattuck et al. 2011). This suggests that programmes should emphasize appropriate counseling and involvement of male partners in decision making to increase contraceptive uptake and reduce discontinuation.

4.5.7 Infrastructure for FP service delivery

The study noted that Embangweni hospital and BLM Mzimba clinic, have modern infrastructure and the FP clinics have specific counseling rooms for FP clients. These are separate from other consultation rooms. However, Mabiri health centre did not provide adequate privacy to clients seeking FP services as per Table 12 below. This was confirmed by reports from key informants and observations made at the health care facility. The health facility still has old infrastructure with limited space and the FP clinic is situated in the same room where other general out- patient services are provided. According to the informants, in this kind of set up it is difficult to observe both audio and visual privacy. Table 12 shows ratings of privacy in the three facilities and Table 13 shows use of contraceptive methods by facility.

Table 12 Privacy in the health care facilities

	Health facility type			
	Mabiri	Embangweni	Mzimba BLM	Total
No	19	1	1	21
	76.0%	2.5%	2.2%	19.1%
Yes	6	39	44	89
	24.0%	97.5%	97.8%	80.9%
Total	25	40	45	110
	100.0%	100.0%	100.0%	100.0%

Clients waiting for FP services are made to queue outside the consultation room for FP and this makes them exposed and uncomfortable since people tend to identify them as the users of contraception. These findings are similar to findings in a study on factors interfering with the ability of Nova Scotia Pharmacists to provide emergency contraception which showed lack of privacy as one of the factors interfering most with providing Plan B consultations especially in counseling rooms (46.1 percent). In

this study the absence of proper infrastructure affected contraceptive adoption (Whelan et al. 2013).

Table 13 Current use of contraception by facility

Area of Residence	Not using contraceptives	Using Contraceptives	Total
Mabiri	58.8 (110)	41.2 (77)	187
Embangweni	48.4 (135)	51.6 (144)	279
Mzimba BLM	38.9 (107)	61.1 (168)	389

Quality of care is rated high when clients feel that their privacy and confidential information is protected. A study by Davida et al. (2011) measured clients' perceptions of quality of care and confidentiality was assessed by asking women how careful the staff had been with their personal and private information. Generally clients gave overall services a high rating and the majority (83 percent) rated the staff as 'very careful' with their personal and private information (Davida et al. 2011). In another study that explored barriers to involvement of clients in FP development in the UK, clinic users commented more on the waiting room than any other aspect of clinic use. Clinic users viewed their comfort and confidentiality as most important aspects of clinic visit (Baraitser et al. 2003). Insufficient confidentiality and lack of privacy has been reported as a factor which reduces use of FP services (UNFPA, 1994).

Health workers also shared their views on existing challenges to maintain privacy and confidentiality:

A health care worker mentioned that he has worked at this facility for two and half years. Right now the facility has no nurse/ midwife who is responsible for the FP services. So he combines everything and is supported by HSAs. He explained that their facility has problems and cannot offer private services because of

limited space. He indicated that the same room that they are using for FP is used for provision of Primary Care Services (PHC), HIV/AIDS Counseling and Testing (HCT) and other services as well. Sometimes FP services are provided in the labour ward because there was nowhere else that one could provide this service. This affected quality of the FP services and it was difficult to ensure confidentiality and privacy for FP clients because other patients/clients were able to know that such and such a woman came in this office for FP methods. This led to many women being stigmatized and prone to violence and abuse by their partners and family once it was known that the women came to the facility for FP services. To address this problem, a management decision was made to provide these services on a different day (Wednesday) so that they have this one room for a particular service for that day.

4.6 Community perceptions about family planning

4.6.1 Negative attitudes in general towards contraceptive use

General views regarding FP were negative and people showed lack of excitement about FP. This was expressed in a few words: *ka vyakulera ivi chomene- chomene vyavichi?* (these FP methods, what are they mainly for?)

For most people FP was viewed as a way of reducing their population size. They thought that government was deliberately doing this to stop families from bearing children or control number of children. This is against their culture which places high value on children as earlier explained. Their unhappiness about FP programs was expressed in this manner:

The government already has a fixed number of the children that they want us to have. Do you have to count the number of children one can have? It is up to God to give (Anecdotal notes from conversations of males in the community).

In addition, FP was generally perceived as a practice that was against people's intentions of having their desired number of children. It was mentioned during community meetings and interviews that as long as a family has food they can have as

many children as they want because what they care about is whether they have enough food and not the number of children they bear as said below:

Have you ever heard of food shortages here? We have so much land and we cultivate our land to feed our children and they are healthy (In Tumbuka it was said like: *banguti kuli njala? Kuno kulije njala, tinachalo chinandi, tikulima bana wakurya ndipo wakukhuta makola*) (Informal discussions of males in the community).

We fear hunger and not the number of children that we have (FGD Males 25-49)

The available literature suggest that such fears as expressed by the people in Mzimba, that the FP agenda could be a deliberate effort by government to limit family size cannot just be ignored. History shows that some governments are motivated to move the FP agenda because they have fear of the effects of a rapidly growing population especially in the developing world which could result in economic competition for scarce resources and cause social unrest (Morrison 1997). An example of this is China's one-child policy which was perceived as an effort to reduce China's rapid fertility. This policy was very successful in almost all urban areas but less successful in rural areas. The rural residents perceived this policy negatively because they considered its long term effects. They looked into the future, in that in the future, the elderly might not be able to rely on their children to care for them as they have in the past (US Library of Congress 2008; Xing 2009). The fears related with the implementation of health programmes have not only been associated with fertility issues.

4.6.2 Male attitudes towards FP

‘If I ever find my wife using these FP methods we would separate, send her away... I have heard very bad things about them’ (IDI Married man 20-24 years)

This is what was said by one of the married men during interviews in this study and the same sentiments have also been shared by many men who participated in this study.

Informants interviewed in this study confirmed that husbands indeed restrict their wives from using modern FP methods. The general feeling among women was that men in this area do not want their wives to rest or even stop bearing children. All they want is that women should not stop bearing children. For example, during FGDs with women, it was repeatedly mentioned that men are difficult; they do not want women to rest from childbearing and if the issue of FP is raised, women are insulted or shouted at and told to go back to their home because what they want from them are children. This is how it was summarized by women:

Men in this area are difficult to convince, they just want you to go on giving birth (FGD Women 25-49)

Informants also indicated that men become very suspicious when a woman is using FP methods. In some instances, these suspicions have made the marriages to be very unstable due to lack of trust. An example was given that in some households, when a woman leaves home for a short time she is asked to explain where she has been all this time resulting in quarrels. Women were actually afraid to use contraceptives because they feared that if their husbands know about this, he will lose trust in her and this would affect their marriage.

Similar findings were reported in a study of male attitudes towards FP in Mbeya region, Tanzania. In this study, men were suspicious of modern methods, doubted their safety, and feared that women would be unfaithful if allowed to use contraception (Mwageni et al. 1998). Also the Navirongo experiment in northern Ghana found that contraceptive use in marriage generates marital discord, wife beating, and opposition from members of the extended family. Violence against women was considered justified by 51 percent of female and 43 percent of male respondents if the wife used a contraceptive method without the husband's knowledge. Women feared that their husband's disapproval of FP could lead to withholding of affection or sex or even divorce (Bawah et al. 1999). These findings are similar to a study done in Uganda in Mityana and Mubende districts exploring obstacles, enablers and quality of services. The women recounted partner disapproval and verbal or physical abuse including violence if the man discovered that the woman used contraceptives. A man could abandon his girlfriend or wife if she insisted to continue using contraceptives (Nalwadda et al. 2010; Nalwadda et al. 2011a).

The views of men were also sought in this study. It was generally perceived among males that FP use was not good for the family since it limits their fertility, fuels a lot of partner disagreements and negatively affects the health of women. Males reported that it was not possible to have the number of children a family desired especially when their wives were using modern FP methods. The statements below highlight men's views in relation to number of children.

A person should have at least ten children and that is what we call proper childbearing (*In Tumbuka it was said: Munthu wababenge wana teni (10) ndiko tikuti kubaba*) (FGD Males 25-49 years). We are surprised these days to find a woman with only three children and you hear they cannot give birth anymore because they

think the numbers of children they have are enough. These are new concepts (FGD Males 25- 49 years).

Partner disagreements arose due to loss of trust. It was reported by male informants that most men in Mzimba were very skeptical about use of modern FP methods and would not allow their wife's to use them without their prior approval. Men were mostly worried that if their wives were not pregnant they could be having sex with other men or if their wife has no child on her back then other men will propose love to her.

FP use has brought a lot of disagreements between husband and wife and also between the woman and the husband's family. Men are jealousy and this is the source of problems (IDI Male Traditional leader).

Fears and concerns related to method use were reported by males as a discouraging factor for them to allow their wife's to use these FP methods (these will be discussed in detail later). Men indicated that they have heard a lot of discouraging things about modern FP methods and would rather use the withdrawal method or just abstain than use them.

The issue of FP is just being imposed on couples by government but it has a lot of problems. Some women who use FP find problems while using these new methods. Most women have side effects (FGD Males 15-49 years)

Survey data gathered from over 300 married women in 11 poor counties in Gansu, Ningxia, Qinghai, and Inner Mongolia, China has shown that wives generally expected to have less children than their husbands. Only 14 percent of the sample showed wives desiring fewer children than husbands, while only 1 percent of the sample showed husbands desiring fewer children than wives. The differences in

family size desired between husbands and wives were statistically significant (Jin 1995).

Similarly, in a study by (Odu et al. 2006) in a suburban and rural Nigeria, the attitudes of male respondents towards FP was relatively poor as only a moderate proportion of men supported the FP concept (52.7 percent) and the Nigerian Population Policy (54.8 percent) of 'four children to a woman'. The major reasons for non-approval of FP by men were the fear of side-effects (70.4 percent) and perception of FP as being against culture and religion (52.1 percent).

4.6.3 Female attitudes towards FP

Females' negative attitudes towards FP use have been reported in this study. Generally, older women played a key role in discouraging younger women from using contraception. The reasons often cited are: young age; still in the process of building a family and that childbearing was the purpose of life for women. The case below outline views of older women on FP use by young mothers:

Gogo Banda (not real name) pointed out that FP use among young women is not good. They can start using these methods at least after they have had a few more children. It is preferred that a couple should have at least three- four children before they can begin using contraception. This is what the Ngoni culture values. We want to see children first. It is acceptable in this society for young women to start using FP at age 25 and at that time they already have 4 children or more. For the newly married couple, it is advisable for them not to use modern family planning methods until they have a child. They should first use the natural methods that people in this community practice (the natural methods commonly practiced are withdrawal and abstinence). If not they should use condoms (they are allowed to use condoms to avoid an early pregnancy until the baby is two years).

Community disapproval of contraception among young married couples has also been reported elsewhere. For example, a study done in Maghreb, Tunisia has shown that contraceptive use for young married couples is almost nil and the same applies to teenagers and yet 46.6 percent of single mothers are 20 years old (Laajimi 1987). Similarly, a study exploring contraceptive use among young people in Uganda used open ended questions to establish views on provision of contraceptives to young people. Most providers (75 percent) said that contraceptives should not be provided to sexually active young people. More than a third of the providers said that they would not provide contraceptives to those less than 18 years of age, unmarried, still in school, and those without children.

4.6.4 Concerns related to modern FP methods

4.6.4.1 Unfaithfulness and or Promiscuity

Reports from key informants showed that concerns regarding unfaithfulness or promiscuity due to contraceptive use were very common in the study area. As such, FP use was viewed negatively and was described as a practice that was against their religious beliefs. FP was seen to be against their Christian faith that preaches against unfaithfulness and does not allow ‘adultery’ (*chigololo* in chiTumbuka) which have been associated with contraceptive use. Mostly males and mothers in-law believed that when women start to use modern FP methods, they want to start sleeping around with other men. It is believed that when a woman uses FP, it is like she has been given a license to be unfaithful or promiscuous. The general feeling among most respondents is that use of modern FP methods gives women the liberty to be unfaithful because they know that they cannot become pregnant. These findings are similar to the findings of the Navirongo experiment conducted by the FP and Health

project in Northern Ghana where some men had worries that their wives might be unfaithful if they used contraception or that contraceptive use might create conflict among multiple wives. The possibility that women may act independently was regarded as a threat to the strong patriarchal tradition (Bawah et al. 1999).

This study established that allegations of unfaithfulness or promiscuity come in when a woman who uses contraception takes time before they can get pregnant again. This makes their partners to become jealousy. Female informants mentioned that men believe that if a woman does not have a baby at her back, then she becomes promiscuous. They think that you cannot be going out with other men once you have a baby on your back. Mrs. Banda (not real name) narrates her experience:

In December last year I decided to start using contraception. At that time my husband had gone away to South Africa and was going to be back in a month's time. Since I had a one year old baby, I thought I should use FP so that I do not get another pregnancy quickly. I went to Mabiri and they gave me an injection. They told me to go back in three months' time. By the time my husband was coming I had used the method for two months. When he arrived, I explained to him that I am using injectable contraception so that I can avoid another pregnancy quickly, but he could not understand. He started asking that he suspects that I was going out with other men. He said he knew this because my skin was so soft and beautiful and I looked young. To him this meant that other men were buying cosmetics for me. I tried to explain that this could be the effect of the contraception but he was so upset with me and told me to stop this otherwise I will go back to my home. He called me names that I am a whore and 'chumba' (barren and would never give birth again). He threatened that he was going to leave me and marry another woman.

In Mzimba, it is generally believed that it is difficult to prove a woman's unfaithfulness unless she gets pregnant. People look for evidence of unfaithfulness and are especially happy when they find that a woman is pregnant while the husband

is not around. This is proof for their suspicions and the community will at this time say this in Tumbuka:

Tamukola sono!. Wahulanga!(Now we have evidence. She is a whore (IDI Traditional Leader).

Due to the negative attitudes, key informants mentioned that women who use contraceptive methods suffer a lot of stigma and discrimination. Most often women who use contraception are ridiculed and are called all sorts of names like “*mahule*” (meaning a whore), some are told that they are crazy. All this is done to discourage them from using contraceptive methods. Informants also reported that contraceptive use often results in violence and marriage breakdown. It was reported by informants that violence especially of emotional type was prevalent in the area. This is manifested through insults, and other verbal abuses that women who use contraception get from fellow women, their mothers in-law and husbands.

Fears of partner unfaithfulness related to use of contraception influence decisions not to use contraception. A community-based sample of 128 African American women 18-29 years old from a low-income neighborhood in San Francisco, California (US), found that women were more likely not to use condoms if they believed that asking their sexual partner to use a condom implied he was unfaithful (odds ratio [OR], 4.30; 95 percent confidence interval [CI], 1.30-14.3); if they had a partner who resisted condom use (OR, 3.4; 95% CI, 1.25-9.07) (Wingood and DiClemente 2000).

4.6.4.2 Infertility/Sterility

Concerns that use of modern contraception causes infertility or sterility were described as the main reason young women were discouraged from using modern

contraceptives. An example was given of how some women in the community suffered because of infertility following contraceptive use:

Some women who use FP methods have problems getting pregnant when they want to have another child. They cannot get pregnant and sometimes it takes them many years, some even cry until they go for traditional medicine called “chimika” (Participants laughs)(Mentions name of a woman who cried because she could not have another child).. So this is why some women get discouraged to use contraception. Some even think that they have been bewitched (FGD Women 25-49 years).

Young women interviewed in this study, showed no interest and were afraid to use modern contraceptive methods. They felt that once they started using contraception they might not be able to conceive again. They were worried about how they would replace children who might die after they have started using modern contraceptive methods in case they might not be able to conceive again. Young women also mentioned that it was not ideal for a woman in this society to have no child or to have very few children since this was a cause of conflict in the household. Most women were afraid that if they do not conceive again then there will be a lot of quarrels in their home and this may affect their marriage. Generally, in TA Mzukuzuku’s area, infertility is perceived to result from use of medicines aimed at avoiding pregnancies or induced abortion. Below is a case of a 17 year old mother and her views on contraceptive use:

It is not yet time for me to start using contraceptives. I just got married and have only two children. I think that it is not good for a young woman like me to start to use FP methods before bearing children first. Otherwise if I accept FP now and all my children die afterwards what will I do? I may not have another child especially if I develop complications caused by these FP. It is not good to start these things early because you might end up with no child at all (IDI Non user of FP).

DHS surveys have found that married teens are less likely to use contraception, but also have less unmet need. Particularly in South Asia and sub-Saharan Africa where pregnancy is socially accepted and is a source of identity, status, and reaffirms entry into adulthood, it is often important for married teens to prove their fertility as soon as possible (Khan et al. 2008; Presler-Marshall and Jones 2012). Similarly studies done in India, found that among the women who have never used any contraceptives 24.1 percent reported that they were scared to adopt any of the contraceptive methods. Around eight percent women were not interested at all to use modern contraception while around 4.8 percent mentioned that there was opposition from the husband and other family members for the use of contraception. Another study was conducted with 96 Shoshone and Arapahoe Indian women living on the Wind River Reservation in Central Wyoming and it was found that the contraceptive users tended to be older, married, and have as many children as they had wanted. A study of people's perceptions about FP in Andhra Pradesh, India revealed that fear of existing child or children's death affected adoption of permanent FP methods. Couples therefore tend to delay FP use or have extra children than they actually desire to provide for future losses through death (Khan et al. 2008).

Use of modern methods of contraception mainly injectable contraception (depoprovera) and pills has been associated with infertility in the study community. The injectable contraception is known to stop women from menstruation. Women believed that once they stop menstruating then their fertility is gone. This is what some women said about injectable contraception and fertility:

Some people who use these methods stop menstruating and cannot get pregnant again (mphapo yikumala is the common expression in Tumbuka when a woman cannot get pregnant). It happened to

....(name mentioned). She got the injection method and she stopped menstruating until today (FGD women 25-49 years).

For pills there was a common belief in this community that pills accumulate in the womb causing lumps or tumors inside the womb and this is how it was said in Tumbuka:

vikupanga chibulunga mthumbo (Pills form a lump in the uterus)(FGDs males 25-49).

Men and women in this community believe that once this lump has formed it is not possible for a woman to conceive because the baby will have nowhere to stay, sometimes they have to go for surgery to remove the lumps and the woman may die due to complications. Many studies have reported misconceptions and fears surrounding contraception and reproduction as the main reason for not using contraception. Most women within the childbearing age and young people believe that contraceptives interfered with fertility, and they were frightened to use something that could harm their ability to reproduce. A study done in Uganda found that misconceptions regarding contraception and reproduction were major barriers to contraceptive use. In this study, most married and unmarried women believed that pills caused infertility by burning the woman's eggs. Both male and female participants also believed that pills accumulate in the body causing swellings, cancer and destroy the fallopian tubes leading to infertility. Apart from pills, participants were also convinced that the intra uterine device could pierce the uterus (Nalwadda et al. 2010).

Although fear of infertility has been reported to influence use as well as choice of contraceptives among women in Mzimba, among currently married women who

participated in the survey, majority of women in all the age groups indicated modern methods as their most preferred method of contraception. However, a small percentage (6.8 percent) of women age 15-19 years preferred natural methods (abstinence and withdrawal methods) (Figure 14 below).

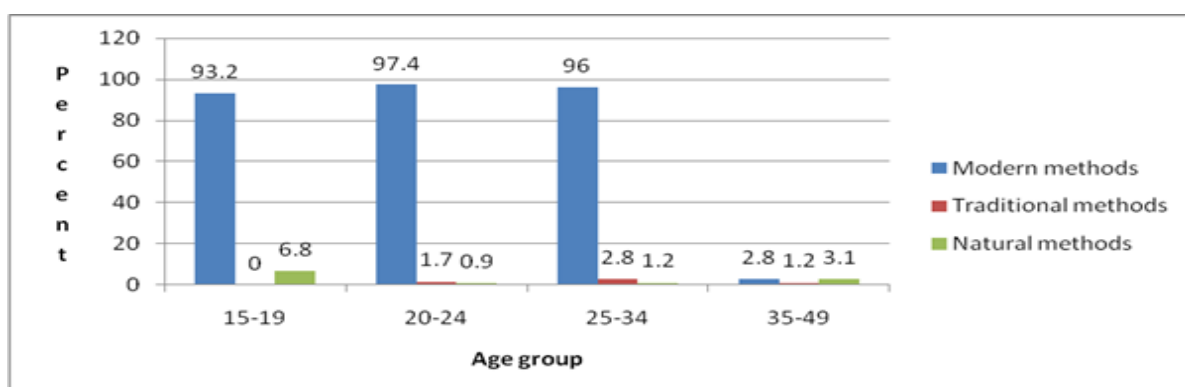


Figure 14 Preferred methods by age groups

These findings were confirmed by key informants who further pointed out that in their communities, younger mothers are encouraged and /or forced to use natural methods to prevent pregnancy. Only women who have acceptable numbers of children are allowed to use modern contraceptive methods. Women are advised to avoid sleeping on the same mat with their husband if they have a new born baby and are encouraged to abstain from sex. It was indicated that in most cases, the husband goes to work away from home probably for a period of one year or so. This gives a chance for the couple to abstain and allow the baby to grow (The practice of a husband leaving home when they have a new born baby is still being observed. However, slight modifications were noted in that men who are not able to abstain opt for polygamy). These findings are similar to a study in rural Uganda where natural methods such as sporadic abstinence are chosen to avoid pregnancy and high risky sex. ‘Sporadic abstinence’ was described in that study in terms of the strategies one could employ to

avoid risky sex, such as pretending to be ill, spending nights away from home, or facing the wall (Blanc et al. 1996).

Informants also indicated that when time is due for the couple to start having sex, older women advise the couple on how to prevent pregnancy and use the withdrawal method. This method is commonly practiced by young couples since it is not advisable for a woman to get pregnant especially when they have a newborn baby who is still breastfeeding. Therefore the man is advised to withdraw his penis from the vagina and ejaculate in the woman's thighs during sexual intercourse. To facilitate this, the woman is told to push the man away and also not to get very close to the man during sex so that it is easy for him to withdraw and ejaculate outside.

The case below highlights Mrs Shaba's (not real name) experience with use of natural methods:

After we had our first baby, we were advised by older women to use natural methods. We were encouraged to use the withdrawal method. They taught us this method when we had our first child that when you have a small child each time you have sex the man should withdraw and ejaculate outside. It was like this until I had my second baby. He continued doing the same- withdrawing during sex until the third child. The problem was that I had frequent births and this method is difficult to use. We were advised that when the man is near ejaculation, we should push him away. This was difficult because when you compare men and women, men are more powerful than women and because a woman does not have much strength, it is not possible to push the man away. As a result he doesn't withdraw and just ejaculates inside you. Then you find that you are pregnant while you have a baby who is just less than a year or a year six months only. This is why for me these natural methods have not been reliable and I was actually ashamed of myself when I got pregnant when the baby was still small since I had to tell my parents in-law about my situation.

Natural methods have been proven to be less reliable and less effective than modern methods. Increased use of these methods increases pregnancy rates and unwanted births (Hubacher et al. 2008). Therefore, it is important to replace the use of natural methods by more effective modern methods of contraception. Use of modern methods have well-known benefits for women, their families and society such as lower levels of unintended pregnancy, unsafe abortion, and maternal and child morbidity and mortality, as well as a slowing of population growth (Seiber et al. 2007).

A study was done in the United States to assess the frequency of perceived infertility among young adults using 2009 data from a nationally representative telephone survey of 1,800 unmarried men and women aged 18-29. Perceived infertility is an individual's belief that she or he is unable to conceive or impregnate, regardless of whether this belief is medically accurate. This perception may lead to contraceptive non-use, which may, in turn, lead to unintended pregnancy (Polis and Zabin 2012). In addition, these perceptions discouraging use of modern contraception may lead to continued use of traditional and natural methods which are unreliable and may lead to unwanted pregnancy and childbirth (Bitto et al. 1997).

4.6.4.3 Perceived side effects of contraceptive use

Apart from concerns related to unfaithfulness and infertility, perceived side effects of contraceptive use also discouraged women from using modern FP methods. Survey results showed that, 31.9 percent of the respondents indicated that side effects were a concern. Further analyses show that there is an association between concerns about side effects and use of FP methods ($X^2 = 34.607$, $df = 1$, $p \text{ value} < 0.000$). The main side effects that were of concern in the communities of Mzimba were prolonged

bleeding and irregular menses, delayed fertility and sexual displeasure due to too much lubrication and loss of male strength.

Informants indicated that most women who use the modern FP methods are concerned with prolonged/irregular menstrual periods. Young women especially indicated that injectable contraception (Depoprovera) causes heavy bleeding with big clots coming out during menstruation. This was a great concern because according to the Ngoni and Tumbuka culture, a woman who is menstruating is regarded as unclean. Therefore some restrictions are put on what she can do such as not putting salt in relish and sleeping on a separate mat from the husband. Management of menstruation also exerts a lot of pressure on women to make sure that they observe the necessary hygiene practices (bathing and frequent changing of menstrual cloth (*salu ya kumwezi* in Tumbuka)). Women were also concerned that their husbands were denied sex for most parts of the month due to heavy bleeding and that this could lead them to seeking sex elsewhere. They also feared that they may become anemic due to severe loss of blood and also that this heavy bleeding will make their womb to become weak and lose its elasticity and this could affect their ability to have children as said by some respondents:

They say FP use causes heavy bleeding. We hear a lot of negative things about FP when we are chatting with friends. When we want to start using FP methods like the contraceptive injectables or other methods, we are discouraged that we will be infertile or that the womb will be weak (FGD Younger women 15-25).

.... like myself, I have used FP methods before and when I was having my 4th baby, I had problems with delivery because my womb was weak. I delivered this baby on the way to the hospital through a traditional healer. This bad experience came because of modern contraception. So sometimes they are good but sometimes they are bad (IDI Younger woman 15-25).

The case below highlights the experience of Mrs Tembo (not real name) with prolonged bleeding after using injectable contraception:

The problem that I encountered mainly was the prolonged bleeding. After I started using the injectables for the first time I experienced heavy bleeding. I bled for 15 days and when I went to the health facility, they gave me pills and the bleeding stopped. Then I experienced good menses just for a short time. In the third month I bled again for 7 days but this continued for another 14 days before it stopped. The fourth month I had normal menses which only took 4 days. By the seventh day I was clean. But after 14 days I started again for another 4 days then stopped. This went on for quite some time then I found that I was pregnant. I continued to bleed even after I got pregnant (this is called ‘nthumbo yake yikawa yakugezera’ in Tumbuka) and when I gave birth, the placenta (known as *chaukulu* or *chakumanyuma* in tumbuka) was torn and dark and I linked it to the contraceptives that I used.

In this study, male informants reported diminished sexual pleasure and loss of sexual desire due to use of modern FP methods by their spouses. This was mainly associated with heavy or prolonged bleeding resulting in less time for sex, increased vaginal lubrication and loss of male strength. Interviews with men revealed male displeasure and unhappiness especially with the use of injectable contraception which to them was responsible for making the woman’s vagina very wet and cold. This was popularly referred to as: *Vimaji kapa kapa (too much water in her vagina)* which resulted in the man not feeling the heat within the woman’s body. Men lamented that with this, sex was unpleasant and not sweet: *Wakunowa yayi(sex with her is not sweet)*. Below are some of the views of men on the issues raised above:

The thing is love making is sweet and this is why you just want to do it all the time. It’s like something that you need every time you go to bed so that you can sleep better (participants laughed). One

cannot enjoy sex if half the month your wife is having menstrual periods and culturally this is not acceptable (FGD males 15-24).

Before my wife started using modern contraceptives our sex life was good but since she started using these methods, we face many problems and one of them is too much water /lubrication in the vagina and this is what forces us men to have sex with other women. We do not know how this problem comes about (IDI married man).

However, although female informants acknowledged that this was the general feeling regarding injectable contraception in this society, they felt that the issue of ‘water’ was exaggerated and men were just trying to discourage women from using FP methods. This is what women said:

Indeed some men refuse to allow their partners to use FP methods because they say that it makes the vagina too wet. And they say that the woman is not sweet. Women face a lot of problems because of this. But to say the truth, it is men who have problems. This is just an excuse to refuse their wives to use FP methods. We do not know what can be done so that our men can still enjoy sex while the woman is using FP methods (participants laughed) (FGD Women 25- 49 years).

The available literature asserts that contraceptive risk behaviours are shaped by perceptions of how contraceptive use reduces sexual sensation and enjoyment (Philpott et al. 2006). Data from online surveys of women’s sexual health and functioning examined how three categories of contraceptive use, that is, hormonal method only, condoms primarily, and dual use, influenced sexual enjoyment. The analyses found that male condoms were most strongly associated with decreased pleasure. Women who used hormonal methods alone were least likely to report decreased pleasure, but they also had significantly lower overall scores of sexual

satisfaction compared with the other two groups (this means that hormonal users reported weak sexual satisfaction) (Higgins et al. 2008). Women who felt that condoms undermined their sexual pleasure were less likely to use them than women who did not report condom-related reductions in pleasure (Higgins et al. 2008; Higgins and Hirsch 2007).

Apart from heavy/prolonged bleeding and too much lubrication, males in the study area also held strong views that use of some modern FP methods reduced male strength and this affected their sexual lives. Informants revealed that most men are not willing to use contraception themselves or encourage their wives to use because some of these methods affected their manhood and their ability to function as a man. An example was given that if vasectomy is done, there is loss of male strength and the man just sleeps like a bull:

Fwakalala (You are powerless) (participants laughed) (FGD Males).

It was generally believed that if a man has had a vasectomy, they will not be able to perform as a man because they cannot have an erection. This affected their sexual life because a man stays for a month or so without having sex. This was summarized as follows:

Are you a real man then? You cannot have an erection and it would be difficult to insert your penis into the vagina (In Tumbuka it was expressed like: *Ndiwe mwanalume po? Ngati ungagwazaso ngati?* (participants laughed) (FGD Males 15-24 years).

Similar findings have been reported in a study aimed at understanding users' dynamics for long acting and permanent methods of contraception (LAPM) in Kasungu and Dowa districts, Malawi. In this study, on the positive side, some participants equated permanent methods with sexual intercourse free from the worry of pregnancy, while on the negative side, some equated permanent methods with sexual dysfunction, particularly for men (Babalola et al. 2012). Similarly, a qualitative study with potential and actual sterilization clients in Kigoma region of Tanzania found that fear of decreased sexual performance as a result of the vasectomy procedure contributed to vasectomy decision making.

However, a variety of views have been noted in the available literature. A study on voluntary sterilization done in India found that most acceptors of voluntary sterilization experience no change in sexual activity, quality of marital relationships, or work-related behavior, and few regretted their choice. However, coercion, lack of adequate understanding of consequences of the procedure, health complications after sterilization, and those with unstable marriages experienced negative consequences (Philliber and Philliber 1985).

In this study, female informants also mentioned that information about side effects filters mainly through friends and older people in this community. It was established that a social network mostly of women who have not tried to use any of the available FP methods themselves assume an advisory role for women of child bearing age to promote negative messages about contraception. This is done mostly at the water wells, maize mills and other social gatherings. This often results in women getting discouraged to start using FP methods when they hear that they will have continuous menstrual bleeding and other side effects.

Worries that use of modern FP methods may cause delays in getting pregnant again were expressed by most respondents. It was reported that modern contraceptive methods are very powerful and it may take a long time before a woman can get pregnant again especially if she was using injectable contraception. Informants indicated that most women, especially younger women were not in favour of contraceptive use because sometimes they stay a long time without getting pregnant again and may get old without bearing enough children. As such, women recently married or with one child were afraid to use FP methods as indicated below:

She may take five years before she can get pregnant again. This is what men don't like and that is why they refuse their wives to use contraception. This is what happens (FGD Males 25-49 years).

Yes, I agree with these people because sometimes these methods are not favorable to some people and you may end up staying for a long time without being pregnant again. The other child can even start school so it's not good but at least when you are older because even if you don't bear a child again it doesn't matter (IDI Non user of FP).

Fear of adverse effects on subsequent fertility following reversible contraceptive use is an important concern for most women residing in rural communities. More risky contraceptive use behaviours have been related to fears and concerns about side effects (Frost et al. 2012). Literature supports the view that an essential feature of any reversible method of contraception is that it should not adversely affect future fertility. Any fertility delay or impairment following the cessation of a given contraceptive method may be associated with reduced use and poor user satisfaction especially in young women, where misconceptions and lack of information add to their general distrust of effective contraceptive methods (Hitchcock and Prior 2004; Sihvo et al. 1998).

These views were triangulated with the results of the survey. Age specific analyses were done to establish the level of contraceptive use among women of different age groups in the study area. These age categories were women 15-19, 20-24, 25-34 and 35-49. Generally, among all age groups, the percentage of women not using modern contraceptives were slightly higher compared to those currently using modern contraceptives. Women within the age group of 15-19 years had a much higher percentage of non- use of contraception as shown in Figure 15 below. The differences between use and non- use by age group was statistically significant: Chi square =21.5 degree of freedom=1, p value<0.001.

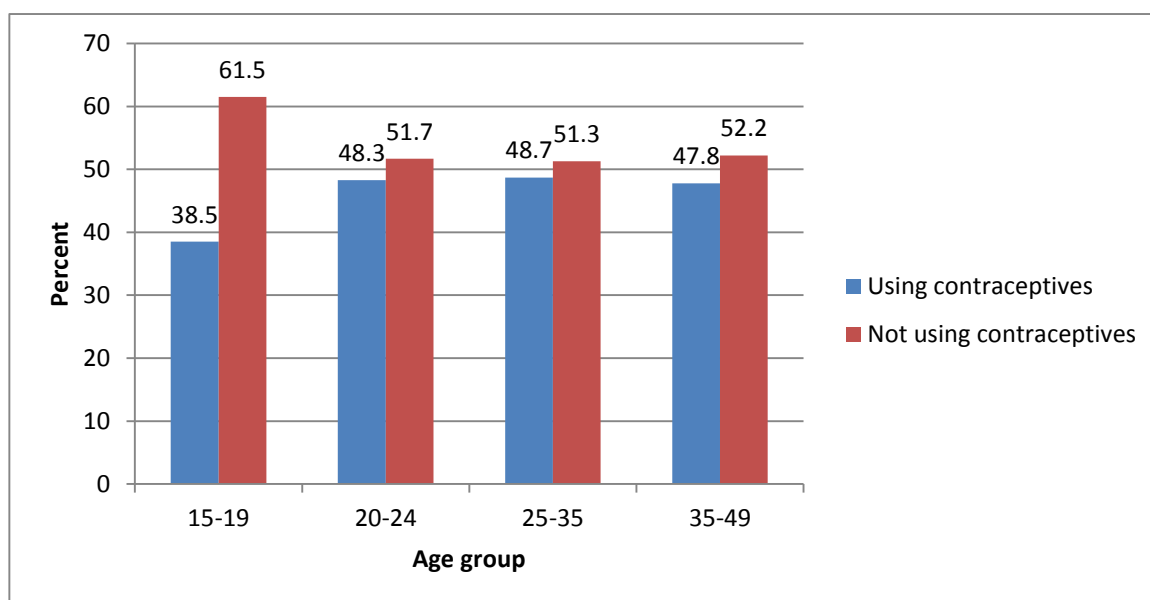


Figure 15 FP use across age groups

However, key informants have linked low contraceptive use among married women between ages 15-19, to the organization of patrilineal social structures in Mzimba district. As described earlier, in patrilineal societies, male children live in the same compound with their parents (the parents in-law take overall responsibility on all matters that affect their children and their families). One of the main reasons for not accepting FP use is the issue of financial resources to support treatment of infertility

or medical care in case of complications/side effects arising from use of modern FP methods. Key informants indicated that when parents discover that their daughter in-law has problems to conceive, they have to find money to take her to the hospital or even look for traditional medicine from traditional healers (culturally, infertility is believed to result from unnatural causes). This process demands resources as indicated by older women in one of the FGDs:

This is the main reason why they refuse because they are the ones who have to look for money when things go wrong (FGD Women 25-49)

On the other hand, DHS surveys have found that married teens are less likely to use contraception, but also have less unmet need. Particularly in South Asia and sub-Saharan Africa where pregnancy is socially accepted, it is a source of identity, status, and reaffirms entry into adulthood, it is often important for married teens to prove their fertility as soon as possible (Khan et al. 2008; Presler-Marshall and Jones 2012). A study which examined the relationship between fertility desires and eventual fertility of 1,047 men and 1,186 women in Gaborone, Botswana, found a strong correlation between family size and number of surviving offspring. For women as well as men, child survival is an important factor (Campbell and Campbell 1997). Similarly studies done in India, found that among the women who have never used any contraceptives 24.1 percent reported that they were scared to adopt any of the contraceptive methods. Around eight percent women were not interested at all to use modern contraception while around 4.8 percent mentioned that there was opposition from the husband and other family members for the use of contraception. Another study was conducted with 96 Shoshone and Arapahoe Indian women living on the Wind River Reservation in Central Wyoming and it was found that the contraceptive users tended to be older, married, and have as many children as they had wanted. A

study of people's perceptions about FP in Andra Pradesh, India revealed that fear of existing child or children's death affected adoption of permanent FP methods. Couples therefore tend to delay FP use or have extra children than they actually desire to provide for future losses through death (Khan et al. 2008).

4.6.4.4 Impact of negative attitudes towards contraceptive use

The study findings show that secret use of contraception among women of childbearing age is common in Mzimba. About 79 percent of women reported that they have ever heard of women using contraception without their husbands' knowledge (Table 14).

Table 14 Secret use of contraception

Ever heard of women using FP methods secretly	N	%
Yes	582	78.5
No	126	17.0
Do not remember	68	4.5
Total	745	100

In Mzimba district, 6 percent of currently married women report that their husband or partner did not know they were using a method of FP compared to five percent at national level (NSO 2011). The prevailing negative attitudes towards contraceptive use, husband and parental opposition, lack of economic support for both children and the woman were described as the main reasons for secret use of contraception. Evidence show that WCBA struggle with the decision to use or not to use contraception and are subjected to a number of risks such as physical or verbal abuse and/or marriage breakdown if they use contraception without husbands knowledge. Below are some of the notable quotes from key informant interviews and FGDs:

Women go to Dimi outreach clinic for antenatal care and while there they get contraceptive methods. Some do not even take a bath and are in a hurry to get the contraceptive methods quickly and they do not want people to see them in case they might report to their husband. (FGD Females 15-24 years).

...If a woman starts to use FP methods without the husband knowing. It may result into broken marriages and is the source of fights in the family. For example if a woman wants to tubal ligation (*kujala mphapo* in Tumbuka), the man has to consent by signing a form. If she goes to the facility on her own who else would sign this form for her? In short it is the man who has that authority to allow her to use FP methods (IDI Traditional Leader)

Secret use of contraception was also found to be prevalent in Ghana. A study in Navirongo, Ghana (a rural setting), provided a unique opportunity to compare family planning service records on contraceptive use with survey interview data from the same women and their spouses (survey interviews were conducted by interviewers who were not aware of the contraceptive status of the respondent). Among 57 percent of the couples in which the wife was a known contraceptive user, the wife reported in the survey interview that she was using contraceptives and her husband reported that she was not. If discordant responses were simply assumed to indicate covert use, then this finding suggests that more than half of contraceptive practice in this rural area consisted of secret use (Phillips et al. 1997). These findings are similar to a study done in an urban setting in Zambia among married women and their husbands. Women's covert use of contraceptives was estimated to account for 6 to 20 percent of all current contraceptive use, and it is more widespread when contraceptive prevalence is low. The multivariate analysis indicates that difficult spousal communication about contraception is the strongest determinant of covert use. Husbands' disapproval of contraception works through spousal communication rather than as a direct influence on covert use (Biddlecom and Fapohunda 1998). Studies

conducted in sub-Saharan Africa explored the issue of covert use of contraception and found that in Uganda, 15 percent of women who were using contraceptives were doing so without their partners' knowledge (Blanc et al. 1996). This fraction was much higher in rural areas than in urban areas (18 percent versus 7 percent). Evidence point to the fact that non acceptability of contraceptive use in rural communities plays a major role (Korra 2002). In a rural Kenyan setting, 20 percent of contraceptive users admitted to using without their husbands' knowledge (Rutenberg and Watkins 1997). In a study done in an urban area in Zambia, seven percent of women using contraceptives said they were covertly using, a figure similar to that for urban areas in the Uganda study.

4.7 Conclusion

What emerges from the findings is that societal pressure on women to have many children to satisfy the ideal number of children, as defined by their husband's and lineages led to delays in adoption of modern FP methods. Even where women might have wished to adopt modern FP methods they encountered stigma and institutional barriers such as frequent stock-outs of commodities and critical shortages of community health care workers.

CHAPTER FIVE

CONCLUSION

The main aim of this study was to understand the context of unmet need for modern contraceptive methods among currently married women in a rural community of TA Mzukuzuku in Mzimba district. The four major objectives set out to fulfill this aim were, firstly, to establish level of unmet FP need. Secondly, to identify sociocultural factors that influence unmet FP need. Thirdly, to identify health system factors that influence unmet FP need and fourthly, to explore the influence of community perceptions on use of modern contraceptive methods in this rural community.

The study established that level of non-use of modern contraceptive methods is high among currently married women with a potential demand for contraception in Mzimba. This unmet need for contraceptive use was manifested through high average number of children born to a woman of reproductive age as well as increase in unwanted childbearing among women. This is attributed to a number of factors:

- a) At the societal level, pressure on women to comply with ideal number of children resulted in excessive childbearing. The Tumbuka/Ngoni society places high value on children, traditionally and culturally valued as source of labour, income and security for the family. The premium placed on children delays use of contraception since couples are expected to have not less than five children before they can start using contraception.

Patriarchal marriage practices involving payment of *lobola* as bride price and polygamy consolidates male power over women and also puts women under obligation to bear many children to fulfill the expectations of male kin. WCBA are unlikely to use contraceptive methods due to negative attitudes in their reference group and fear of adverse social consequences and reprisals.

- b) Women's access to contraceptive services is limited due to a number of institutional barriers. The lack of an efficient system to forecast, procure and distribute contraceptive supplies timely has resulted in irregular supplies and frequent stock-outs of contraceptive commodities. This has contributed to the non-availability of a wide range of contraceptive methods, thus negatively impacting on contraceptive choices for WCBA. In addition, critical shortages of community health care workers affect the quality of FP service delivery at community level. Lack of professionally trained providers and limited number of community health workers limit coverage of FP services in the area.
- c) Negative attitudes towards contraceptive use are a major barrier to the adoption of modern contraceptive methods. This is manifested through general displeasure towards use of modern FP methods, misconceptions and concerns regarding use of modern FP methods. This led to non-acceptance and general disapproval of use of modern FP methods especially for young women who have not yet established their fertility. Apart from this, women using contraception were seen as deviants and were subjected to ridicule, stigma and discrimination. All this resulted in women's over-reliance on natural methods such as the 'withdrawal method' among young couples who did not want to go

against the wishes of their lineage as well as secret use of contraception especially among women who desired protection against pregnancy.

This study therefore concludes that a combination of cultural values and beliefs promoting high fertility, combined with health system barriers and negative perceptions of modern FP use contribute to high unmet contraception need in Mzimba. These barriers, which are complex, and intricately related to each other cannot be understood in isolation. A comprehensive analysis of these barriers through the integration of theories of gender and power, diffusion of innovation, social learning and health service utilization provides a holistic view of unmet need for contraception in Mzimba.

5.1 Policy implications

The findings of this study highlight the complexity of barriers to FP service utilisation. To address the existing FP unmet need, programming efforts should endeavour to minimize the barriers existing both at individual, societal and health system levels.

Evidence shows that gender inequalities and cultural values promoting excessive childbearing contribute to high unmet need for FP in a patrilineal society in Mzimba. A critical aspect of promoting equality is women's autonomy to manage their lives and empowerment. Increased female autonomy has been shown to confer other benefits like long-term reduction in fertility and improvement in females' ability to make autonomous decisions on number, timing and spacing of their pregnancies. Women's empowerment is an aspect of equality which is vital to the realization of human rights and personal freedoms. The imbalance of power between men and

women affects women's bargaining power resulting in loss of personal freedoms and rights for women (Mason and Oppenheim 1997). The lack of empowerment restricts women from pursuing their personal preferences regarding ideal family size. Thus women end up having large numbers of unplanned births in order to satisfy the interests of their husband's and lineages. It is crucial that FP programme efforts address the gender inequities and cultural barriers that lead to high fertility. FP programmes which attempt to reach women will have a higher probability of success if they also involve men or at least encourage such involvement. Interventions should target the imbalance of gendered-power in couple relationships and male understanding of the benefits of being involved in and supportive of women's health issues. The benefits of male involvement include increased spousal communication, better reproductive outcomes such as contraceptive use and less discontinuation of method use if both the husband and the wife are given FP education (Becker, 1996). Ultimately, an effective FP programme should be holistic. It should go beyond making available contraceptive commodities at health facilities to ensuring that such a programme enjoys support from all relevant stakeholders in the community.

5.2 Further research

This study has shown that there is much pressure on women to bear many children in the Ngoni and Tumbuka society of Mzimba to meet the expectations of their husbands' lineages who are important stakeholders in the marital union. Women in this context are constrained to make independent reproductive decisions. It is suggested that further research be conducted to assess the role of social capital in the transformation of attitudes towards FP programme. It would also be useful to do a comprehensive study in a matrilineal society.

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APPENDICES

Appendix 1a: Informed consent survey (English) Family Planning use study

Principal Investigator: Effie Chipeta is a PhD student with University of Malawi, Chancellor college- Centre for Social Research.

Supervisors: Dr. Allister Munthali, Associate Professor, Centre for Social Research; Dr. Peter Mvula, Research Fellow- Centre for Social Research, Professor Paul Kishindo, Director, Centre for Social Research.

Background: This study will investigate family planning use among currently married women in rural communities of Mzimba. The study will aim at understanding the contextual factors that influence non- use of modern contraceptive methods among within the age group 15-49. It will also examine the socio-demographic, economic and gender related factors, individual/community beliefs, attitudes/perceptions and preferences regarding use of contraception, the socio-cultural/religious factors and also the health services factors that facilitate non- use of contraception. The evidence we generate will be used to inform current family planning and reproductive health programs in Malawi.

As part of this study a cross-sectional survey with currently married women of reproductive age of 15-49 will be done in selected villages around Mabiri Health centre and Embangweni hospital and BLM clinic at Mzimba Boma. A total of 1080 women will be identified and 360 questionnaires will be administered in all these areas. You are one of the women that have been randomly selected to participate in this survey. If you agree to participate in this study, we will use a structured questionnaire to collect data on socio-demographic, economic, socio-cultural and health system factors that may affect utilization of family planning services. In addition information will also be obtained relating to knowledge, attitudes and behaviours affecting contraceptive use.

What you will be expected to do: If you decide to participate you will be able to ask the research team any questions you may have about the study. Once you are happy that you understand what is involved you will be given a consent form to sign.

Confidentiality: The answers you provide will be used only for the purposes of this study. All answers will be handled confidentially and none of the information collected will be able to be traced back to those providing the information. Any information we gather will be stored without using your name. We guarantee that your name will not be published and will not be disclosed to anyone outside the study group.

Participation: We hope that you will agree to take part in this research. However, participation is voluntary. If you do decide to participate in this study, you have the

right to withdraw at any time. You may also choose not to answer any questions that make you feel uncomfortable. If you decide not to participate, or if you withdraw, you will not be penalised.

Benefits/Risks: The answers we collect from you will provide important information on the factors that influence non- use of contraception among currently married women in Malawi. This information will inform current family planning and reproductive health programs and may have future impacts on the development and implementation of other services and policies. There are no risks involved in taking part in this study.

Compensation: Your participation in this study is voluntary and there is no payment for it. However, we will provide refreshments since the interviews may take a long time.

Permission: Approval to carry out this research has been sought from the Research Ethics Committee of the University of Malawi College of Medicine (COMREC).

Further information: You can get more information or answers to your questions about the study, your participation in the study, and your rights, from the project staff or you can contact the Principal Investigator on the following address:

Principal Investigator	Supervisor
Effie Chipeta (BScNurs., MA)	Dr. Allister Munthali (PhD)
College of Medicine- Centre for Reproductive Health	Centre for Social Research
P/Bag 360, Chichiri, Blantyre 3, Malawi	P.O. Box Zomba
Tel: 265 0888 792116	Tel: 265 0888822004

If you want to know more about your rights, safety and well- being in research, you may also contact: The Chairman, COMREC, P/Bag, 360, Blantyre 3 or on telephone number: 01 877 245/01877 291. E-mail: comrec@medcol.mw.

DECLARATION:

I have read, or had read to me, the above information for this project and I understand the objectives and purpose. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I clearly understand what I will be required to do if I take part in this study and I freely and voluntarily agree to be part of this research study.

Participants name	Participants Signature	Date
_____	_____	_____
Participants Thumbprint	Signature of Witness	Date
_____	_____	_____
Investigators Name	Signature	Date
_____	_____	_____

Appendix 1b: Informed consent: survey (Tumbuka)Family Planning use study

Ine zina lane ndine..... uyo nkhuwovwira bamama Effie Chipeta pa kafukufuku/vyakupenjapenja ivi. Bamama Chipeta wakusambira msambiro ghapachanya gha PhD kusukulu ya University of Malawi, Chancellor college- Center for Social Research. Ndipo agho wakusambizga mba Dr. Allister Munthali, Associate Professor, Centre for Social Research; Dr. Peter Mvula, Research Fellow- Centre for Social Research, Professor Paul Kishindo, Director, Centre for Social Research.

Mazgu wa Kwamba: Kafukufuku/vyakupenjapenja ivi vichitikenge kwa wamama awo wali panthengwa ndipo wali na vyaka 15-49 m'boma la Mzimba. Mkafukufuku uyu /vyakupenjapenja ivi tikukhumba tisange icho chikutondeska wamama kuti wagwirisye ntchito kulera.

Kafukufuku wasisanisani wachitikenge kwa bamama wavyaka 15-49 awo wali panthengwa ndipo wakukhala mizi iyo ili pafupi na Mabiri Health centre, Embangweni hospital na BLM clinic ku Mzimba Boma. Bamama 1080 wasankhikenge kuti wazgole mafumbo agho ghatovwirenge kuti timanye za iwo, banja lawo na maghanoghano ghawo na makhumbo ghawo pakhani ya kulera. Ivi vitovwirenge kuti Boma linozge makola nthito za kulera kuti ziwe za phindu kwa a Malawi.

Ivyo tikulindizga kufuma kwa imwe: pala mwazomera kupanga nawo Kafukufuku/vyakupenjapenja ivi mungafumba fumbo lililose lakukwasana na Vyakuyezgayeza ivi kwa wanthu awo wapangiska. Pala mwakhutira kuti mukumanya ivyo vikuchitika muvyakuyezgayeza ivi mungasayina chi pepala ichi.

Chisisi: mazgolo winu wadzagwiriskika ntchito Kafukufuku/vyakupenjapenja ivi mbwenu, ndipo palije uyo wazamumanya kuti ndimwe mwazgola mafumbo awa, vyose ivo muzamuyowoya wazamusunga mwa chisis kwambula zina linu. Ndipo tikumanyiskani kuti zina linu lizamuwoneka yayi palipose, lizamumanyika yayi kwa waliyose uyo wakuchitanawo yayi vyakuyezgayeza ivi.

Kunjiranawo: tikugomezga kuti muchitengenawo kafukufuku/vyakupenjapenja ivi. Kweni timumanyisye kuti ivi vingachitika pala imwe mwakhumba kuchitanawo. Muliso na ufulu kuleka nangauli mwanjiranwo kale. Pala mukhumba yayi kupanganawo ise tingamchichizgani yayi. Pala mwasanga kuti mafumbo ngakusuzga tiphalireni na agho mukuwona kuti mungazgola yayi. Kuleke kuchita nawo kafukufuku/vyakupenjapenja ivi kulije chakusuzga chilichose chakukhwaskana nawovwiri uwo mukupokera kuvipatala.

Uwemi/ Vyakukutondeska : mazgolo winu wazamuwovwira kusanga vinthu vya ukhaliro vakukwasana na nthowa zakulera izo zikupangiska wanalume na wanakazi awo wana wana wanayi kapena kujumphitsa apa m`Malawi muno kuti wakhale na wana walinga na vinyakhe vakukwasana na ubabilo. Vyakusangika

mkafukufuku/vyakupenjapenja ivi viwovwirenge kuti wovwiri uwo wanthu wakupokera wakukwasana na nthowa zakulera kweniso moyo wakukwasana na ubabilo ukhale uwemi. Vingawovwira kulutitsa munthazi ntchito zinyakhe za umoyo. Mkafukufuku/vyakupenjapenja ivi mulije chilichonse icho chingachitika chambula kuzomerezgeka, pala mwanjira nawo vyakuyezgayezga ivi.

Chakusangapo: Paliye malipiro ghaliwose pa kafukufuku/vyakupenjapenja ivi. Kuwongera kwithu tizamkumpani chakumwa na chakulyera.

Chizomerezgo: Chizomelezgo chakupangira kafukufuku/vyakupenjapenja ivi chapokereka kufuma ku komiti yakuona nthito izi ya kusukulu yamadokotala m`Malawi muno ya Research and Ethics committee (COMREC).

Vyakusazgirapo: mungasanga mazgolo wakusazgirapo pavakukwasana na ufulu winu wachibabiwa kufuma kwa wanthu wakugwira ntchito mkafukufuku/vyakupenjapenja ivi.

Principal Investigator Effie Chipeta (BScNurs., MA) College of Medicine- Centre for Reproductive Health P/Bag 360, Chichiri, Blantyre 3, Malawi Tel: 265 0888 792116	Supervisor Dr. Allister Munthali (PhD) Centre for Social Research P.O. Box Zomba Tel: 265 0888822004
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Pala mukukhumba kumanya vyakukwasana na ufulu winu, panji uwemi wa vyakupenjapenja ivi, fumbani wapampando wa committee iwo yikuona ntchito izi: The Chairman, COMREC, P/Bag, 360, Blantyre 3 or on telephone number: 01 877 245/01877 291. E-mail: comrec@medcol.mw.

Chizgomelezgo:

Nawerenga kapena waniwerengera Vyakuyezgayezga ivi ndipo napulikisiska za vifukwa vake. Nanguwa na mupata wakufumba mafumbo ndipo nakhutiskika na kuzgoleka kwake kake. Nazomerezga mwa ine nekha kupanganawo pavyakuyezgayezga ivi, Kwambula kukamizga kweni kuzomera nekha nga ufulu wane wa chibabiwa.

Zina	Signature	Date
_____	_____	_____
Chidindo	Signature ya Kaboni	Date
_____	_____	_____
Investigators Name	Signature	Date
_____	_____	_____

Appendix 1c: SURVEY QUESTIONNAIRE WOMEN ENGLISH)

INTERVIEW INFORMATION							
Date of Interview:							
Time Started:							
Time Finished:							
Interviewers ID:							
Checked by:							
Entered by: 1)							
2)							
3)							
VILLAGE/ENUMERATION ID:							
Client ID:							

SECTION 1: BACKGROUND QUESTION

Item No.	Question	Responses	Skip
	"I would like to begin by asking you a few questions about yourself."		
101	In what year were you born?	(YEAR): _____	
		Don't know..... 88	
	IF RESPONDENT DOES NOT KNOW YEAR OF BIRTH,	ESTIMATED AGE: _____	
	ESTIMATE AGE		
102	Are you now married or living with a man, or are you now widowed, divorced, or no longer	Currently married/living	
	living together?	together..... 1	
		Separated..... 2	
		Divorced..... 3	Skip 107
		Widowed..... 4	Skip 107
		Never Married..... 5	→END
103	Is this your first union or marriage?	Yes.....1	
		No.....2	
104	Does your husband/partner	Yes..... 1	

	have other wives		
	apart from yourself?	No..... 0	Skip to 106
		Don't know..... 88	
105	Are you the first, second.....wife?	1st Wife..... 1	
		2nd Wife..... 2	
		3rd Wife..... 3	
		4th+ Wife..... 4	
106	How long have you been in union	(YEARS): _____	
	with your current partner (this marriage)?	Doesn't Know..... 88	
107	Did you ever go to school?	Yes..... 1	
		No..... 0	Skip to Q 110
		Don't know..... 88	
108	What is the highest level of school you went to?	Primary 1	
		Secondary 2	
		University 3	
		Other..... 4	
		Don't know..... 88	
109	How many years of school did you	Years: _____	
	complete at that level?	Don't know..... 88	
110	What religion are you?	Catholic..... 1	
		Protestant..... 2	
		Revivalist..... 3	
		Moslem..... 4	
		Traditional African..... 5	
		Nothing..... 6	
		Other (Specify)..... 7	
111	What tribe are you?	Yao..... 1	
		Chewa 2	
		Lomwe 3	
		Tumbuka 4	

		Ngoni 5	
		Sena 6	
		Tonga 7	
		Senga 8	
		Other 9	
		(SPECIFY.....)	
		Don't Know 8	
112	Are you currently doing any work through	Yes..... 1	
	which you generate some income in cash or in kind?	No..... 0	Skip to Q 115
		Other (SPECIFY).....	
113	How much do you usually earn for this work?	_____ Kwacha	
	IF THE RESPONDENT IS NOT PAID IN CASH,	Don't know..... 88	
	ESTIMATE THE MONETARY VALUE OF THE	Other (SPECIFY).....	
	PAYMENT.		
114	Over what period of time do you earn this amount?	Per hour..... 1	
		Per day..... 2	
		Per week..... 3	
		Per month..... 4	
		Per year 5	
115	Who is the main income earner in your household?	Husband.....1	
		Wife.....2	
		Other (Specify).....3	
116	Who is the main decision maker on	Husband.....1	
	Household money use?	Wife.....2	
		Other (Specify).....3	

SECTION 2: KNOWLEGDE, ATTITUDES AND PERCEPTIONS ON FAMILY PLANNING

Item No.	Question	Responses	Skip
	Now I will ask you questions relating to your knowledge		
	attitudes and perceptions relating to FP use		
201	Do you know anything relating to contraception	Yes.....1	
		No.....2	
202a	What is your source of information about FP?	Health care facility.....1	
		CBDA.....2	
		HAS.....3	
		Traditional healer.....4	
		Radio/TV.....5	
		Newspaper6	
		Friends.....7	
		Other (Specify).....99	
202b	DO Service providers give information about FP	Yes..... 1	
	in this community?	No..... 0	
		Don't know..... 88	
202c	Do you think the information given is adequate	Yes..... 1	
		No..... 0	
		Don't know..... 88	
203	Which FP methods do you know?	Pills.....1	
		Injectables.....2	
		Male Condom.....3	
		Female Condoms.....4	
		Implants.....5	
		IUCD.....6	
		Tubal Ligation.....7	
		Vasectomy.....8	
		Traditional methods.....9	
		Other (specify).....99	

204	Where do people in this community go for FP services?	Health care facility.....1	
		CBDA.....2	
		Traditional healer.....3	
		Other (Specify).....99	
205	What is your attitude towards FP use	Favourable.....1	
		Unfavourable.....2	
		Don't Know.....88	
206	Have you ever had any contact with a	Yes.....1	
	FP service delivery centre?	No.....2	Skip to 209
207	If Yes, How often?	Regularly.....1	
		Casually.....2	
		Not at all.....88	
208	What was the purpose of contact with a	To get information about FP...1	
	FP service delivery centre?	For consultation in FP.....2	
		Follow up after traetment.....3	
		Other (Specify).....99	
209	Is your Husband in favour of FP use?	Yes.....1	
		No.....2	
210	Have you ever discussed with your	Yes.....1	
	husband about adoption of FP methods?	No.....2	
211	In your opinion, what is the ideal number of	1-2.....1	
	children for a family?	3-4.....2	
		5-8.....3	
		As many as one wants.....4	
		Don't Know.....99	
212	Do you think it is important to have an appropriate gap between births of children?	Yes.....1	
		No.....2	
		Don't Know.....99	
213	Do you think that standard of life can be raised	Yes.....1	
	by adoption of FP methods?	No.....2	
		Don't Know.....99	

SECTION 3: FERTILITY INTENTIONS and FAMILY PLANNING

Item No.	Question	Responses	Skip
	Now I will ask you questions relating to fertility		
	and reproductive behaviours		
301	Can you give me the total number of children you have	Number of children born _____	
	given birth to?	None	Skip to Q 303
	IF THE WOMAN IS RECENTLY MARRIED AND		
	CHILDLESS, SKIP TO C3A		
	IF THE WOMAN HAS BEEN MARRIED MORE THAN		
	FIVE YEARS AND HAS NO CHILDREN, SKIP TO F1		
302	How many are still living?	Number of children alive _____	
303	Are you currently pregnant?	Yes 1	
		No 2	Skip to Q306
		Don't Know 88	Skip to Q 306
304	At the time you became pregnant, did you want to become	Pregnancy wanted then.....1	
	pregnant then, did you want to wait until later, or did you	Pregnancy wanted later.....2	
	not want to become pregnant at all?	Pregnancy not wanted at all.3	
		Did not care4	
		Don't Know88	
305	After this child is born, would you like to have	Have a(another) child 1	Skip to Q 307
	another child or would you like to stop having children?	Stop, no more./none..... 2	
		Says she can't get	
		pregnant/ too old..... 3	
		Don't know..... 88	

306	Would you like to have another child or would you like to stop having children?	Have a(nother) child 1 Husband deceased, left..... 2 Stop, nomore./none..... 3 Says she can't get pregnant/ too old..... 4 Don't know..... 88	Skip to 308
307	How long would you like to wait before having this child?	As soon as possible..... 1	
	PROBE:	Less than 2 years..... 2	
	IF RESPONDENT SAYS SHE JUST WANTS TO REST,	More than 2 years..... 3	
	ASK IF SHE WANTS TO REST MORE THAN 2 YEARS	No preference/whenever.. 4	
	OR LESS THAN 2 YEARS	Don't know..... 88	
308	If you had the choice, how many living children would you like to have in your lifetime?	Number _____ _____ Don't know..... 88 Up to God/Non-numeric.. 99	
309	Have you ever done anything to plan time between births?	Yes..... 1	
		No..... 0	Skip to Q311
		Don't know..... 88	Skip to Q311
310	What are your preferred methods to plan time between births	Modern FP methods.....1 Traditional methods.....2 Natural methods.....3 Don't know..... 88	
311	What childspacing/ family planning method (s) have you ever used?	Pills.....1 Injectables.....2 Male Condom.....3 Female Condoms.....4 Implants.....5 IUCD.....6	

		Tubal Ligation.....7	
		Vasectomy.....8	
		Traditional methods.....9	
		Other (specify).....99	
312	Are you currently using anything	Yes..... 1	
	to delay or avoid a pregnancy?	No..... 0	Skip to Q 318
313	What contraceptive method are you	Pills.....1	
	currently using?	Injectables.....2	
		Male Condom.....3	
		Female Condoms.....4	
		Implants.....5	
		IUCD.....6	
		Tubal Ligation.....7	
		Vasectomy.....8	
		Traditional methods.....9	
		Other (specify).....99	
314	For how long have you been using	Less than one year.....1	
	contraceptive methods	2- 3 years.....2	
		4- 5 years.....3	
		More than 5 years.....4	
		Permanent method.....5	
315	Who made the decision for you	Self.....1	
	to start using FP methods?	Husband.....2	
		Joint decision.....3	
		FP Provider.....4	
		Other (specify).....99	
316	What are the reasons for your	ill health.....1	
	adoption of FP methods?	Economic problems.....2	
		Proper care of children.....3	
		Other (specify).....99	
317	Have you ever thought of not	Yes..... 1	
	using childspacing/family planning	No..... 0	
	methods?		

318	What are your biggest concerns using modern FP methods		
	DO NOT READ LIST, MORE THAN ONE ANSWER IS POSSIBLE		
	Method:	Yes	No
	A. Side effects	A 1	0
	B. Afraid could not give birth again	B 1	0
	C. Not effective	C 1	0
	Opposition		
	D. Husband/other relative opposed	D 1	0
	Clinics		
	E. Too far away	E 1	0
	F. Costs too much	F 1	0
	Fertility-related		
	G. Trouble getting pregnant	G 1	0
	H. Wants another child	H 1	0
	I. Desires many children	I 1	0
	Sexuality		
	J. promotes promiscuity	J 1	0
	K. Other reason (SPECIFY _____)	K 1	0
	L. Don't know	L 1	0
	M. Religious beliefs	M 1	0
319	Do you think that women who use modern child spacing/family planning methods might not be able to have more children when they want?	Yes..... 1	
		No..... 0	
		Don't know..... 88	
320	Have you and your partner ever talked about	Yes..... 1	

	using modern childspacing/ family planning?	No..... 0	
	IF WOMAN IS WIDOWED OR SEPARATED, ASK THESE QUESTIONS ABOUT THE TIME BEFORE HUSBAND'S DEATH OR SEPARATION	Don't know..... 88	
321	If you wanted to use modern childspacing/ family planning, do you think your partner would agree?	Yes..... 1	
		No..... 0	
		Don't know..... 88	
322	Some women use modern methods of childspacing/family planning without their husband knowing about it. Have you heard of women using modern childspacing/ family planning secretly?	Yes..... 1	
		No..... 0	
		Don't know/ no answer..... 88	
	About how many women do you suspect, know or have heard about who have used family planning secretly?	Number: _____	
	CODE "SEVERAL" AS 5,		
	CODE "MANY" AS 20		

SECTION 4: ACCESS, AVAILABILITY AND ACCEPTABILITY OF FAMILY PLANNING SERVICES

Item No.	Question	Responses	Skip
	Now I will ask you questions relating to access, availability, organisation of FP services		
	Geographic access		
401	Are you aware of any place where people from this community go to access family planning services?	Yes.....1	
		No.....0	End of Interview
402	What kind of a place is it?	Hospital.....1	
		Health Centre.....2	
		CHAM Facility3	
		Private Facility.....4	

		CBDA.....5	
		HAS.....6	
		Pharmacy7	
		Grocery Store.....8	
		Traditional healer.....9	
		Other (Specify).....99	
403	How far is it to get to the nearest FP service delivery point?	Estimate distance.....	
404	Have you ever accessed FP services at any of	Yes.....1	
	these service delivery points?	No.....0	SKIP TO 406
405	How long did it take you /does it take to	Less than 30 minutes.....1	
	get to the nearest FP delivery site	One Hour.....2	
		Two Hours.....3	
		More than three Hours...4	
	Economic access		
406	Do people in this community pay for FP services	Yes.....1	
		No.....0	SKIP TO 408
		Don't Know.....88	SKIP TO 408
407	If yes, How much do people pay for the following services	Service -----Amount	
		Pills	
		Injectables	
		Male Condom	
		Female Condoms	
		Implants	
		IUCD	
		Tubal Ligation	
		Vasectomy	
408	Are there any other costs that people who	Transport costs.....1	
	seek FP services usually incur?	Food costs.....2	
		Buying FP Supplies.....3	
		Buying Health Passport.....4	
		Other (Specify).....99	
409	What means of transport do	Walk.....1	

	people usually		
	use to get to the nearest FP service delivery point?	Bicycle.....2	
		Car.....3	
		Other (Specify).....99	
410	Do people pay for transport to get to the	Yes.....1	
	FP service point?	No.....0	Skip to 412
411	How much money is usually spent on transport?	Estimate amount.....	
	Availability of FP Services		
412	How many FP service delivery sites exist in	Number	
	your community?		
413	Can you name the FP delivery sites that	Name of facility/place.....	
	exist in your community?		
	(Name as many as you know)		
414	Apart from Health care facility, do you know	Traditional healer.....1	
	other sources of FP in this community?	TBA.....2	
		Other (Specify).....99	
415	Where do most people in this community	Hospital.....1	
	commonly access FP methods?	Health Centre.....2	
		CHAM Facility3	
		Private Facility.....4	
		CBDA.....5	
		HAS.....6	
		Pharmacy7	
		Grocery Store.....8	
		Traditional healer.....9	
		Other (Specify).....99	

416	Why do you think people prefer to access FP methods at that place?	Place is near.....1	
		Contraceptives always available..2	
		Providers Friendly3	
		Service is free.....4	
		Other (Specify).....99	
417	Do the FP service delivery points offer a wide range of methods?	Yes..... 1	
		No..... 0	
		Don't know..... 88	
418	Which methods are commonly offered?	Pills.....1	
		Injectables.....2	
		Male Condom.....3	
		Female Condoms.....4	
		Implants.....5	
		IUCD.....6	
		Tubal Ligation.....7	
		Vasectomy.....8	
		Other (specify).....99	
419	Does the facility have a regular supply of contraceptives?	Yes..... 1	
		No..... 0	
		Don't know..... 88	
420	Which contraceptives are always available at the facility?	Pills.....1	
		Injectables.....2	
		Male Condom.....3	
		Female Condoms.....4	
		Implants.....5	
		IUCD.....6	
		Tubal Ligation.....7	
		Vasectomy.....8	
		Other (specify).....99	
421	Which contraceptives are not in regular supply ?		
		Pills.....1	
		Injectables.....2	
		Male Condom.....3	
		Female Condoms.....4	
		Implants.....5	
		IUCD.....6	
		Tubal Ligation.....7	
		Vasectomy.....8	
		Other (specify).....99	

	Organisation of FP Services		
422	Is the FP clinic located at a convenient place	Yes..... 1	
	where it can easily be found?	No..... 0	
		Don't know..... 88	
423	Are clients seen as soon as possible	Yes..... 1	
	after they arrive	No..... 0	
		Don't know..... 88	
424	Are there easy appointment systems (there's		
	no need to wait too long?)	Yes..... 1	
		No..... 0	
		Don't know..... 88	
425	Are the opening hours convenient to most	Yes..... 1	
	people seeking FP services?	No..... 0	
		Don't know..... 88	
426	Is at least 20 minutes allocated for each	Yes..... 1	
	appointment?	No..... 0	
		Don't know..... 88	
427	Do providers receive feedback from	Yes..... 1	
	clients on services they provide?	No..... 0	
		Don't know..... 88	

Appendix 2a: Informed consent: client exit interviews

Principal Investigator: Effie Chipeta is a PhD student with University of Malawi, Chancellor college- Center for Social Research.

Supervisors: Dr. Allister Munthali, Associate Professor, Centre for Social Research; Dr. Peter Mvula, Research Fellow- Centre for Social Research, Professor Paul Kishindo, Director, Centre for Social Research.

Background: This study will investigate family planning use among currently married women in rural communities of Mzimba. The study will aim at understanding the contextual factors that influence non use of modern contraceptive methods among within the age group 15-49. It will also examine the socio-demographic, economic and gender related factors, individual/community beliefs, attitudes/perceptions and preferences regarding use of contraception, the socio-cultural/religious factors and also the health services factors that facilitate non use of contraception. The evidence we generate will be used to inform current family planning and reproductive health programs in Malawi.

As part of this study we will be interviewing clients exiting 3 selected facilities where SRH services including family planning are provided. Both static and outreach clinics will be visited at Mabiri health centre, Embangweni Hospital and BLM Clinic in Mzimba. It is expected that a total of 112 clients will be interviewed in four weeks. A structured guide will be used to collect data and you will be asked to provide your opinion on the provision of FP services and quality of services. Information will be obtained on access to contraception (number of family planning service sites available), distance/travel time to services, availability of contraceptive method mix, clinic waiting times, provider skills or competence, client-provider interpersonal relations, infrastructure for FP provision (privacy and confidentiality).

What you will be expected to do: If you decide to participate you will be able to ask the research team any questions you may have about the study. Once you are happy that you understand what is involved you will be given a consent form to sign.

Confidentiality: The answers you provide will be used only for the purposes of this study. All answers will be handled confidentially and none of the information collected will be able to be traced back to those providing the information. Any information we gather will be stored without using your name. We guarantee that your name will not be published and will not be disclosed to anyone outside the study group.

Participation: We hope that you will agree to take part in this research. However, participation is voluntary. If you do decide to participate in this study, you have the right to withdraw at any time. You may also choose not to answer any questions that make you feel uncomfortable. If you decide not to participate, or if you withdraw, you will not be penalised.

Benefits/Risks: The answers we collect from you will provide important information on the factors that influence non- use of contraception among currently married women in Malawi. This information will inform current family planning and reproductive health programs and may have future impacts on the development and implementation of other services and policies. There are no risks involved in taking part in this study.

Compensation: Your participation in this study is voluntary and there is no payment for it. However, we will re-imburse your transport costs since we will be interviewing you at the health facilities.

Permission: Approval to carry out this research has been sought from the Research Ethics Committee of the University of Malawi College of Medicine (COMREC).

Further information: You can get more information or answers to your questions about the study, your participation in the study, and your rights, from the project staff by contacting the Principal Investigator and Study Supervisor on the following address:

Principal Investigator	Supervisor
Effie Chipeta (BScNurs., MA)	Dr. Allister Munthali (PhD)
College of Medicine- CRH, P/Bag 360, Chichiri, Blantyre 3, Malawi	Centre for Social Research
Tel: 265 0888 792116	P.O. Box Zomba, Tel: 265 0888822004

If you want to know more about your rights, safety and well being in research, you may also contact: The Chairman, COMREC, P/Bag, 360, Blantyre 3 or on telephone number: 01 877 245/01877 291. E-mail: comrec@medcol.mw.

DECLARATION:

I have read, or had read to me, the above information for this project and I understand the objectives and purpose. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I clearly understand what I will be required to do if I take part in this study and I freely and voluntarily agree to be part of this research study.

Participants name	Participants Signature	Date
_____	_____	_____
Participants Thumbprint	Signature of Witness	Date
_____	_____	_____
Investigators Name	Signature	Date
_____	_____	_____

Appendix 2b: Informed consent: client exit interview (Tumbuka)

Ine zina lane ndine..... uyo nkhuwovwira bamama Effie Chipeta pa kafukufuku/vyakupenjapenja ivi. Bamama Chipeta wakusambira msambiro ghapachanya gha PhD kusukulu ya University of Malawi, Chancellor college- Center for Social Research. Ndipo agho wakusambizga mba Dr. Allister Munthali, Associate Professor, Centre for Social Research; Dr. Peter Mvula, Research Fellow- Centre for Social Research, Professor Paul Kishindo, Director, Centre for Social Research.

Mazgu wa Kwamba: Kafukufuku/vyakupenjapenja ivi vichitikenge kwa wamama awo wali panthengwa ndipo wali na vyaka 15-49 m'boma la Mzimba. Mkafukufuku uyu /vyakupenjapenja ivi tikukhumba tisange icho chikutondeska wamama kuti wagwirisyen nchito kulera. Tikhumbenge kuti tipulike maghanoghano ghawo na makhumbo ghawo pakhani ya kulera kukhwaskana na ukhaliro wapakaya, visambizgo vya mipingo, kupambana kwa zinchito za bamama na badada.

Bamama agho ghasangikenge pa vipatala vya Mabiri health centre, Embangweni Hospital and BLM Clinic in Mzimba apo wovwiri wa kulera wukuperekeka wazamphepeka kuti banjira mukafukufuku/vyakupenjapenja ivi. Tikugomezga kuti kuti bamama 112 clients wanjirenge nawo mukafukufuku/vyakupenjapenja ivi. Ndipo tizamuwafumba mafumbo ghakukhwaskana na umo iwo wakuwonera nchito za kulera pavipatala ivyo. Ivi vitiovwirenge kuti Boma linozge makola nchito za kulera kuti ziwe za phindu kwa ba Malawi.

Ivyo tikulindizga kufuma kwa imwe: pala mwazomera kupanga nawo Kafukufuku/vyakupenjapenja ivi mungafumba fumbo lililose lakukwasana na Vyakuyezgayezga ivi kwa wanthu awo wapangiska. Pala mwakhutira kuti mukumanya ivyo vikuchitika muvyakuyezgayezga ivi mungasayina chi pepala ichi, Ndipo wazakupani nambala ya chimanyisko cha imwe kweniso yokuwovwira kusunga chisisi cha vyose ivo mungayowoya vwakukwasana na Vyakuyezgayezga ivi.

Chisisi: mazgolo winu wadzagwiriskika ntchito Kafukufuku/vyakupenjapenja ivi mbwenu, ndipo paliye uyo wazamumanya kuti ndimwe mwazgola mafumbo awa, vyose ivo muzamuyowoya wazamusunga mwa chisisi kwambula zina linu. Ndipo tikumanyiskani kuti zina linu lizamuwoneka yayi palipose, lizamumanyika yayi kwa waliyose uyo wakuchitanawo yayi vyakuyezgayezga ivi.

Kunjiranawo: tikugomezga kuti muchitengenawo kafukufuku/vyakupenjapenja ivi. Kweni tumumanyisye kuti ivi vingachitika pala imwe mwakhumba kuchitanawo. Muliso na ufulu kuleka nangauli mwanjiranwo kale. Pala mukhumba yayi kupanganawo ise tingamchichizgani yayi. Pala mwasanga kuti mafumbo ngakusuzga tiphalireni na agho mukuwona kuti mungazgola yayi. Kuleke kuchita nawo kafukufuku/vyakupenjapenja ivi kulije chakusuzga chilichose chakukhwaskana nawovwiri uwo mukupokera kuvipatala.

Uwemi/ Vyakukutondeska: mazgolo winu wazamuwovwira kusanga vinthu vya ukhaliro vakukwasana na nthowa zakulera izo zikupangiska wanalume na wanakazi

awo wana wana wanayi kapena kujumphitsa apa m`Malawi muno kuti wakhale na wana walinga na vinyakhe vakukwasana na ubabilo. Vyakusangika mkafukufuku/vyakupenjapenja ivi viwovwirenge kuti wowwiri uwo wanthu wakupokera wakukwasana na nthowa zakulera kweniso moyo wakukwasana na ubabilo ukhale uwemi. Vingawovwira kulutitsa munthazi ntchito zinyakhe za umoyo. Mkafukufuku/vyakupenjapenja ivi mulije chilichonse icho chingachitika chambula kuzomerezgeka, pala mwanjira nawo vyakuyezgayezga ivi.

Chakusangapo: Palije malipiro ghaliwose pa kafukufuku/vyakupenjapenja ivi. Kuwongera kwithu tizamkumpani chakumwa na chakulyera.

Chizomerezgo: Chizomelezgo chakupangira kafukufuku/vyakupenjapenja ivi chapokereka kufuma ku komiti yakuona nthito izi ya kusukulu yamadokotala m`Malawi muno ya Research and Ethics committee (COMREC).

Vyakusazgirapo: mungasanga mazgolo wakusazgirapo pavakukwasana na ufulu winu wachibabiwa kufuma kwa wanthu wakugwira ntchito mkafukufuku/vyakupenjapenja ivi.

Principal Investigator	Supervisor
Effie Chipeta (BScNurs., MA)	Dr. Allister Munthali (PhD)
College of Medicine- Centre for Reproductive Health	Centre for Social Research
P/Bag 360, Chichiri, Blantyre 3, Malawi	P.O. Box Zomba
Tel: 265 0888 792116	Tel: 265 0888822004

Pala mukukhumba kumanya vyakukwasyana nan ufulu winu, panji uwemi wa vyakupenjapenja ivi, fumbani wapampando wa committee iwo yikuona ntchito izi: The Chairman, COMREC, P/Bag, 360, Blantyre 3 or on telephone number: 01 877 245/01877 291. E-mail: comrec@medcol.mw.

CHIZGOMELEZGO:

Nawerenga kapena waniwerengera Vyakuyezgayezga ivi ndipo napulikisiska za vifukwa vake. Nanguwa na mupata wakufumba mafumbo ndipo nakhutiskika na kuzgoleka kwake kake. Nazomerezga mwa ine nekha kupanganawo pavyakuyezgayezga ivi, Kwambula kukamizga kweni kuzomera nekha nga ufulu wane wa chibabiwa.

Dzina**Signature****Date**

Chidindo**Signature ya Kaboni****Date**

Investigators Name**Signature****Date**

**APPENDIX 2C: EXIT INTERVIEWS - FAMILY
PLANING CLIENTS**

SECTION 1: BACKGROUND QUESTION

Item No.	Question “I would like to begin by asking you a few questions about yourself.”	Responses	Skip
101	In what year were you born?	(YEAR): _____	
		Don't know..... 88	
	IF RESPONDENT DOES NOT KNOW YEAR OF BIRTH,	ESTIMATED AGE: _____	
	ESTIMATE AGE		
102	What is your Ethnic group?	Tumbuka..... .1	
		Chewa..... .2	
		Ngoni..... .3	
		Tonga.....4	
		Khonde.....5	
		Lomwe.....6	
		Sena.....7	
		Yao8	
		Other (SPECIFY)...99	
103	What is your place of residence?	Name of village or community	
	(Specify village or community)		
104	Did you ever go to school?	Yes..... 1	
		No..... 0	
		Don't know.... 88	
105	What is the highest level of school you went to?	Primary 1	
		Secondary2	
		University 3	
		Other..... 4	
		Don't know....88	
106	How many years of school did you complete at that level?	Years: _____	
		Don't know....88	

107	What religion are you?	Catholic..... 1	
		Protestant..... 2	
		Revivalist.....3	
		Moslem..... 4	
		Traditional African. 5	
		Nothing..... 6	
		Other..... 7	
		b(SPECIFY _____	

108	What is your marital status?	Currently married/living together..... 1	
		Separated.....2	
		Divorced..... 3	
		Widowed..... 4	
		Never Married...5	-END
109	In what year did you get married (this marriage)?	(YEAR): _____	
		Doesn't Know.... 88	
110	Do you have any children?	Yes.....1	
		No.....2	
111	How many children do you have?	Number.....	
112	Are you currently using anything to delay or avoid a pregnancy?	Yes..... 1	
		No..... 0	
113	What contraceptive method are you currently using?	Pills.....1	
		Injectables.....2	
		Male Condom....3	
		Female Condom.4	
		Implants.....5	
		IUCD.....6	
		Tubal Ligation....7	
		Vasectomy.....8	
		Traditional methods.9	
		Other (specify).99	

SECTION 2: ACCESS, AVAILABILITY OF FAMILY PLANNING SERVICES

Item No.	Question	Responses	Skip
	Now I will ask you questions relating to access, affordability and availability of FP services		
201	Please tell what services you came for today at this facility?	To get information of FP....1	
		To obtain FP supplies.....2	
	Please remember that the answers will be kept strictly confidential	For counselling.....3	
		Treatment.....4	
		Other (Specify).....99	
202	Did you get all the FP services you wanted today?	Yes.....1	
		No.....0	SKIP to 204
203	If not, why you did not get the FP services you wanted today?	Method not available.....1	
		Contraindications identified.2	
		No provider available to offer	
		method of choice.....3	
		Discouraged by SP.....4	
		Other (Specify).....99	
204	How long did it take you to get to this FP delivery site	Less than 30 minutes.....1	
		One Hour.....2	
		Two Hours.....3	
		More than three Hours....4	
205	Do you pay for transport to get to this facility?	Yes.....1	
		No.....0	

206	How much money do you spend on transport?	Estimate amount.....	
207	What means of transport did you use to get to this clinic?	Walk.....1	
		Bicycle.....2	
		Car.....3	
		Other (Specify)	
	Affordability of services		
208	Do you pay for FP services at this facility?	Yes.....1	
		No.....0	SKIP - 210
209	If yes, How much do you pay for the following services	Service ----- Amount	
		Pills	
		Injectables	
		Male Condom	
		Female Condoms	
		Implants	
		IUCD	
		Tubal Ligation	
		Vasectomy	
210	Do you think cost of services is one of the reasons for people not to use FP services in this community?	Yes.....1	
		No.....0	
		Don't Know.....88	
	Availability of services		
211	Does this facility offer a wide range of FP methods?	Yes.....1	
		No.....0	
		Don't Know.....88	

212	Which contraceptive methods are always available at the facility?	Pills.....1	
		Injectables.....2	
		Male Condom.....3	
		Female Condoms....4	
		Implants.....5	
		IUCD.....6	
		Tubal Ligation.....7	
		Vasectomy.....8	
		Other (specify).....99	
213	Is your choice of contraceptive always available at this facility?	Yes.....1	
		No.....0	
		Don't Know.....88	
214	Does this facility have a regular supply	Yes.....1	
	of contraceptives?	No.....0	
		Don't Know.....88	
215	Which contraceptives are not in regular supply ?	Pills.....1	
		Injectables.....2	
		Male Condom.....3	
		Female Condoms..4	
		5	
		IUCD.....6	
		Tubal Ligation.....7	
		Vasectomy.....8	
		Other (specify).....99	
SECTION 3: QUALITY OF FAMILY PLANNING SERVICES			
Item No.	Question	Responses	Skip
	Now I will ask you questions relating to choice of methods,		
	information given to FP users, interpersonal relations,		
	follow up or continuity mechanisms and appropriate counselling of services		
310	When you sought FP services for	Yes.....1	

	the first time at a health facility, did you get		
	your preferred method of choice?	No.....0	Skip to 303
302	If not, why you did not get your method of	Method not available....1	
	choice?	Contraindications identified....2	
		No provider available to offer	
		method of choice.....3	
		Discouraged by SP.....4	
		Other (Specify).....99	
	Information to FP clients		
303	When you sought FP services for the first time at a health facility, did the	Yes.....1	
	FP provider give you information about the available methods?	No.....0	
304	What information did the FP provider give to help you choose your method	Explained all available methods.1	
	of choice?	Side effects.....2	
		Contraindications.....3	
		Other (Specify).....99	
305	Do you think the information given was adequate	Yes.....1	
	to help you select a method of choice?	No.....0	
		Don't Know.....88	
306	Did the FP service provider give you chance to ask questions or seek		
	clarification?		
	Quality of services		
307	Is the FP clinic located at a convenient place	Yes.....1	
	where it can easily be found?	No.....0	
		Don't Know.....88	
308	Did the Service providers see you as soon as possible	Yes.....1	

	after they arrive	No.....0	
		Don't Know.....88	
309	Did you wait for a long time for an appointment?	Yes.....1	
		No.....0	
		Don't Know.....88	
310	If yes, How long did you wait before being attended by provider?	Minutes.....1	
		Hours.....2	
311	Did the Service provider take at least 20 minutes with you for this appointment?	Yes.....1	
		No.....0	
		Don't Know.....88	
312	Did you meet the Service provider in private?	Yes.....1	
		No.....0	
		Don't Know.....88	
313	Did you feel comfortable to ask questions when you met the service provider?	Yes.....1	
		No.....0	
		Don't Know.....88	
314	Are the opening hours convenient to you?	Yes.....1	
		No.....0	
		Don't Know.....88	
	Staff Competency		
315	Do you think FP is adequately trained to provide FP services to clients?	Yes..... 1	
		No..... 0	
		Don't know..... 88	
316	Are the existing FP service provider able to provide all FP services?	Yes..... 1	
		No..... 0	
		Don't know..... 88	
317	Do the FP service provider refer clients for other services?	Yes..... 1	

		No..... 0	
		Don't know..... 88	
318	For which services do they refer clients?	IUCD.....1	
		IMPLANTS.....2	
		VASECTOMY.....3	
		TUBAL LIGATION.....4	
		Other (Specify).....99	
319	Were you satisfied with the services you received from the FP provider?	Yes..... 1	
		No..... 0	
		Don't know..... 88	
	Staff Attitude		
320	Do the SP have a friendly attitude towards clients seeking FP services?	Yes..... 1	
		No..... 0	
		Don't know..... 88	
321	Do the SP treat clients with respect and dignity?	Yes..... 1	
		No..... 0	
		Don't know..... 88	
322	Are clients given a chance to receive FP from a SP of their choice?	Yes..... 1	
		No..... 0	
		Don't know..... 88	
	Follow up/continuity of care		
323	Does the facility follow up clients who discontinue FP use?	Yes..... 1	
		No..... 0	
		Don't know..... 88	
324	What means of follow up are often used?	Tracking system.....1	
		Home visits.....2	
		Other (Specify).....99	
325	Has the health facility put in place a feedback mechanism from clients seeking FP services?	Yes..... 1	
		No..... 0	
		Don't know..... 88	

Appendix 3a: Informed consent: focus group discussions

Principal Investigator: Effie Chipeta is a PhD student with University of Malawi, Chancellor college- Center for Social Research.

Supervisors: Dr. Allister Munthali, Associate Professor, Centre for Social Research; Dr. Peter Mvula, Research Fellow- Centre for Social Research, Professor Paul Kishindo, Director, Centre for Social Research.

Background: This study will investigate family planning use among currently married women in rural communities of Mzimba. The study will aim at understanding the contextual factors that influence non use of modern contraceptive methods among within the age group 15-49. It will also examine the socio-demographic, economic and gender related factors, individual/community beliefs, attitudes/perceptions and preferences regarding use of contraception, the socio-cultural/religious factors and also the health services factors that facilitate non use of contraception. The evidence we generate will be used to inform current family planning and reproductive health programs in Malawi.

As part of this study we will be interviewing currently married women within the age group 15-49. These women will be identified from the 3 selected EAs in Mzimba district and we will ask them to join other women in groups of 8-10 to participate in focus group discussions at a mutual location. The women will be asked to describe the level of knowledge on FP among women in this area, socio-cultural factors affecting contraception, family planning practice and experiences and also the quality of family planning services in health facilities that exist in the area. The evidence we generate will be used to inform current family planning and reproductive health programs.

What you will be expected to do: If you decide to participate you will be able to ask the research team any questions you may have about the study. Once you are happy that you understand what is involved you will be asked to consent to participate in this study. You will then be given a unique identity number so that your information can remain private.

Confidentiality: The answers you provide will be used only for the purposes of this study. All answers will be handled confidentially and none of the information collected will be able to be traced back to those providing the information. Any information we gather will be stored without using your name. We guarantee that your name will not be published and will not be disclosed to anyone outside the study group.

Participation: We hope that you will agree to take part in this research. However, participation is voluntary. If you do decide to participate in this study, you have the right to withdraw at any time. You may also choose not to answer any questions that make you feel uncomfortable. If you decide not to participate, or if you withdraw, you will not be penalised.

Benefits/Risks: The answers we collect from you will provide important information on the factors that influence non use of contraception among currently married women in Malawi. This information will inform current family planning and reproductive health programs and may have future impacts on the development and implementation of other services and policies. There are no risks involved in taking part in this study.

Compensation: Your participation in this study is voluntary and there is no payment for it. However, we will provide refreshments since the interviews may take a long time.

Permission: Approval to carry out this research has been sought from the Research Ethics Committee of the University of Malawi College of Medicine (COMREC).

Further information: You can get more information or answers to your questions about the study, your participation in the study, and your rights, from the project staff or you can contact the Principal Investigator on the following address:

Principal Investigator	Supervisor
Effie Chipeta (BScNurs., MA) College of Medicine- Centre for Reproductive Health P/Bag 360, Chichiri, Blantyre 3, Malawi Tel: 265 0888 792116	Dr. Allister Munthali (PhD) Centre for Social Research P.O. Box Zomba Tel: 265 0888822004

If you want to know more about your rights, safety and well being in research, you may also contact: The Chairman, COMREC, P/Bag, 360, Blantyre 3 or on telephone number: 01 877 245/01877 291. E-mail: comrec@medcol.mw.

DECLARATION:

I have read, or had read to me, the above information for this project and I understand the objectives and purpose. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I clearly understand what I will be required to do if I take part in this study and I freely and voluntarily agree to be part of this research study.

Participants name

Participants Signature

Date

Participants Thumbprint

Signature of Witness

Date

Investigators Name

Signature

Date

APPENDIX 3B: INFORMED CONSENT: FOCUS GROUP DISCUSSIONS (TUMBUKA)

Ine zina lane ndine..... uyo nkhuwovwira bamama Effie Chipeta pa kafukufuku/vyakupenjapenja ivi. Bamama Chipeta wakusambira msambiro ghapachanya gha PhD kusukulu ya University of Malawi, Chancellor college- Center for Social Research. Ndipo agho wakusambizga mba Dr. Allister Munthali, Associate Professor, Centre for Social Research; Dr. Peter Mvula, Research Fellow- Centre for Social Research, Professor Paul Kishindo, Director, Centre for Social Research.

Mazgu wa Kwamba: Kafukufuku/vyakupenjapenja ivi vichitikenge kwa wamama awo wali panthengwa ndipo wali na vyaka 15-49 m'boma la Mzimba. Mkafukufuku uyu /vyakupenjapenja ivi tikukhumba tisange icho chikutondeska wamama kuti wagwirisye nthito kulera.

Bamama wavyaka 15-49 awo wali panthengwa wasankhikenge kuti wakhale m'magulu gha banthu 8-10 kuti tidumbiskane nawo pamalo agho ghazomerezgeka. Tikhumbenge kuti tipulike maghanoghano ghawo na makhumbo ghawo pakhani ya kulera kukhwaskana na ukhaliro wapakaya, visambizgo vya mipingo, kupambana kwa zinthito za bamama na badada. Ivi vitiovwirenge kuti Boma linozge makola nthito za kulera kuti ziwe za phindu kwa a Malawi.

Ivyo tikulindizga kufuma kwa imwe: pala mwazomera kupanga nawo Kafukufuku/vyakupenjapenja ivi mungafumba fumbo lililose lakukwasana na Vyakuyezgayeza ivi kwa wanthu awo wapangiska. Pala mwakhutira kuti mukumanya ivyo vikuchitika muvyakuyezgayeza ivi mungasayina chi pepala ichi.

Chisisi: mazgolo winu wadzagwiriskika ntchito Kafukufuku/vyakupenjapenja ivi mbwenu, ndipo palije uyo wazamumanya kuti ndimwe mwazgola mafumbo awa, vyose ivo muzamuyowoya wazamusunga mwa chisis kwambula zina linu. Ndipo tikumanyiskani kuti zina linu lizamuwoneka yayi palipose, lizamumanyika yayi kwa waliyose uyo wakuchitanawo yayi vyakuyezgayeza ivi.

Kunjiranawo: tikugomezga kuti muchitengenawo kafukufuku/vyakupenjapenja ivi. Kweni tumumanyisye kuti ivi vingachitika pala imwe mwakhumba kuchitanawo. Muliso na ufulu kuleka nangauli mwanjiranwo kale. Pala mukhumba yayi kupanganawo ise tingamchichizgani yayi. Pala mwasanga kuti mafumbo ngakusuzga tiphalireni na agho mukuwona kuti mungazgola yayi. Kuleke kuchita nawo kafukufuku/vyakupenjapenja ivi kulije chakusuzga chilichose chakukhwaskana nawovwiri uwo mukupokera kuvipatala.

Uwemi/ Vyakukutondeska : mazgolo winu wazamuwovwira kusanga vinthu vya ukhaliro vakukwasana na nthowa zakulera izo zikupangiska wanalume na wanakazi awo wana wana wanayi kapena kujumphitsa apa m`Malawi muno kuti wakhale na wana walinga na vinyakhe vakukwasana na ubabilo. Vyakusangika mkafukufuku/vyakupenjapenja ivi viwovwirenge kuti wovwiri uwo wanthu wakupokera wakukwasana na nthowa zakulera kweniso moyo wakukwasana na

ubabilo ukhale uwemi. Vingawovwira kulutitsa munthazi ntchito zinyakhe za umoyo. Mkafukufuku/vyakupenjapenja ivi mulije chilichonse icho chingachitika chambula kuzomerezgeka, pala mwanjira nawo vyakuyezgayezga ivi.

Chakusangapo: Paliye malipiro ghaliwose pa kafukufuku/vyakupenjapenja ivi. Kuwongera kwithu tizamkumpani chakumwa na chakulyera.

Chizomelezgo: Chizomelezgo chakupangira kafukufuku/vyakupenjapenja ivi chapokereka kufuma ku komiti yakuona nthito izi ya kusukulu yamadokotala m`Malawi muno ya Research and Ethics committee (COMREC).

Vyakusazgirapo: mungasanga mazgolo wakusazgirapo pvakukwasana na ufulu winu wachibabiwa kufuma kwa wanthu wakugwira ntchito mkafukufuku/vyakupenjapenja ivi.

Principal Investigator Effie Chipeta (BScNurs., MA) College of Medicine- Centre for Reproductive Health P/Bag 360, Chichiri, Blantyre 3, Malawi Tel: 265 0888 792116	Supervisor Dr. Allister Munthali (PhD) Centre for Social Research P.O. Box Zomba Tel: 265 0888822004
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Pala mukukhumba kumanya vyakukwasyana nan ufulu winu, panji uwemi wa vyakupenjapenja ivi, fumbani wapampando wa committee iwo yikuona ntchito izi: The Chairman, COMREC, P/Bag, 360, Blantyre 3 or on telephone number: 01 877 245/01877 291. E-mail: comrec@medcol.mw.

CHIZGOMELEZGO:

Nawerenga kapena waniwerengera Vyakuyezgayezga ivi ndipo napulikisiska za vifukwa vake. Nanguwa na mupata wakufumba mafumbo ndipo nakhutiskika na kuzgoleka kwake kake. Nazomerezga mwa ine nekha kupanganawo pavyakuyezgayezga ivi, Kwambula kukamizga kweni kuzomera nekha nga ufulu wane wa chibabiwa.

Zina	Signature	Date
_____	_____	_____
Chidindo	Signature ya Kaboni	Date
_____	_____	_____
Investigators Name	Signature	Date
_____	_____	_____

Appendix 3c: Focus group discussion Guide with Non Users of Family Planning methods

Family planning Knowledge

How can you describe the level of knowledge on FP among women in this area?

Are you aware of any FP services offered in this area?

Do you know the available FP choices that exist in this community?

What are the main sources of FP information in this community?

Do people receive information on how best to use FP services, or where to get services in this area?

Socio-cultural factors affecting use of contraception

Do you think culture has an influence on women's intention to use contraception in this area?

Probe: What cultural beliefs exist in this community that may influence contraceptive use?

Do you think religion has an influence on women's intention to use contraception?

Probe: What are these religious beliefs or values that affect contraceptive use?

Do women in this community have power to make decisions relating to use of health services?

Is it common for women to access FP without husbands' approval?

Do women in this community face opposition related to use of contraceptives?

Probe: The main source of opposition: Husbands, mother in-laws, elders

Who do you think has a final say on use of household resources in this area?

Family planning use

When I mention family planning, what is the first thing that comes to your mind?

Probe: How did you learn about it? How do you feel about family planning?

How does your husband feel about family planning? How does your community feel about family planning? Do you think that FP is of any benefit to individuals or households?

Probe : What are the benefits? Can you provide your understanding of the decision process about family planning in your household? Who makes the final decision relating to FP use?

What are your sentiments towards contraception? Do you approve or disapprove?

What are your preferences regarding FP use? Modern methods or traditional methods?

What are some of the reasons for non- use of contraception in this area?

Probe: Fear of side effects, health problems, How they perceive the risk of pregnancy
Husband opposition, Child replacement, Cost of services, location of services
Attitude of service providers, What do you think are some of the benefits for using FP methods?

Appendix 3d: Focus Group Discussion with non-users of FP methods (Tumbuka)

1. Kugwiliska ntchito kulera

Maghanoghano ghinu ghali uli pa vyakulera? Mukuzomerezga panji yayi?

Kasi muli kugwiliskapo nthowa za kulera kuti mukwaniske kubaba pa nyengo iyo mukunkhumba umo muli kutengwerela?

Fumbiskani; (womama wekhawekha awo walikuzomelezga kugwiliska ntchito kulera ndiwo wafumbike)

Ni nthowa mbuni yakulera iyo walikugwiliskapo ntchito?

Wagwiliska ntchito nyengo itali uli?

Wakumanapo na vichi apo wakulera?

Kasi wakalekerachi fulera (fumbiskani: viheni vichankhe, kukumana na masuzgo pa umoyo wawo, wafumu panji wabale kukana, kulipira ndalama pala wakukhumba wovwiri, malo agho wovwiri uwu wukusangika, kapokelelero ka awo wakugwila nichito).

2. Pala wandagwiliskepo nthowa zakulera fumbani vinandi pa:

Vifukwa ivyo vikuchitiska kuti iwo waleke kugwiliska nthowa zakulera umo walikutengwera?

Fumbiskani: vikhulupiriro vyawapapi , na vya mpingo

Kopha kuti wangakumana na masugzo yanyakhe na yazaumoyo wawo. Kasi agha ni ngani?

Wafumu panji wabale kukana?

Kasangiro ka ndalama (kulipira ndalama kuti wawovwirike, mendelo, ndalama izo zikunangika pakugula vyakurya pala wakukhumba wovwiri kuchipatala,

Uwemi na kasangilo kawakuwawovwira (Mtunda, uko vyakuwawovwila vili, nkhalo ya awo wakuwawovwira).

Kukhumba kuwa na wana wanandi

Fumbani kuti mumanye pala mama uyu wakughanaghana zakuyamba kulera m'nthazi muno?

Icho chingawachitiska kuti wayambe kugwiliska ntchito nthowa zakulera m'nthazi muno tchivichi?

Kasi nthowa zakulera izo wakukhumba ni zini? Nthowa zasono panji za wapapi wakale?

3. Kupokera uthenga wakukhwaskana na vya kulera

Kasi mungalongosola kuti mukumanyapo vichi pa nkhani ya kulera?

Kasi mukumanya nthowa zakulera zakupambanapambana izo zikusanginga m'chigawa chinu muno?

Kasi mulikuphalilikapo kuti ni khu uko mungasanga nthowa zakulera, kasi ivyo mungakhumba vilipo, panji umo mungagwiliskira makora vyakulera? Kasi mulikupulika nkhu chomenechomene?

Kasi mulikulongsolerako za uwemi wakugwiliska ntchito nthowa za sono zakulera?

Kasi pali mahumuhumu yakukhwaskana na kugwiliska ntchito nthowa zakulera?

Appendix 4a: Focus group discussion with Users of Family Planning methods (English)

1. Family planning Knowledge

How can you describe the level of knowledge on FP among women in this area?

Are you aware of any FP services offered in this area?

Do you know the available FP choices that exist in this community?

What are the main sources of FP information in this community?

Do people receive information on how best to use FP services, or where to get services in this area?

2. Socio-cultural factors affecting use of contraception

Do you think culture has an influence on women's intention to use contraception in this area?

Probe: What cultural beliefs exist in this community that may influence contraceptive use?

Do you think religion has an influence on women's intention to use contraception?

Probe: What are these religious beliefs or values that affect contraceptive use?

Do women in this community have power to make decisions relating to use of health services?

Is it common for women to access FP without husbands' approval?

Do women in this community face opposition related to use of contraceptives?

Probe: The main source of opposition: Husbands, mother in-laws, elders

Who do you think has a final say on use of household resources in this area?

When people get married, do they talk about the number of children they want in this community?

How important is it for couples to discuss number of children they want to have?

3. Family Planning (Contraceptive) Practice and Experiences

When I mention family planning, what is the first thing that comes to your mind?

Probe: How did you learn about it?

How do you feel about family planning?

How does your husband feel about family planning?

How does your community feel about family planning?

Do you think that FP is of any benefit to individuals or households?

Probe : What are the benefits?

Can you provide your understanding of the decision process about family planning in your household? Who makes the final decision relating to FP use?

Can you share about your experiences with using contraception:.

Do you use family planning to plan time between births?

What motivated you to start using contraception?

After having how many children did you/do you plan to start to use family planning to plan time between births?

After having how many children did you/do you plan to start using a more effective contraceptive method to plan time between births?

Have you experienced any problems since you have started using contraception?

4. Family planning health service delivery

How do you feel about FP services offered to women in this area?

Probe: How long do people walk to get FP services

How much do people spend to access services? Transport, Food, Buying FP supplies

Are FP services friendly to women?

Where do women prefer to get FP services in this area? Compare Facility and traditional healers

What makes FP attractive to women in this area? Probe: Low cost of service, short distance, friendly care

Appendix 4b: Focus group discussion with users of family planning (Tumbuka)

1. Kugwiliska ntchito kulera

Kasi womama wa m'chigawo chino wakumanya makora yene pa nkhani yakulera?

Kasi mukumanyapo za nthowa zakulera izo zikusangika m'muzi mwinu muno?

Kasi mukumanya nthowa zakulera zakupambanapambana izo zikusangika m'chigawa chinu muno?

Ka nkhani zakulera chomenechomene mukuzimanyira nkhu m'mchigawa muno?

Ka wanthu wakuphalirika umo wangagwiriskila nthowa zakulera panji uko wangakasangako wowwiri uwu m'chigawa muno?

2. Vikhulupiliro na Kankhaliro ka Wanthu ivyo Vikukhwaska Kugwiliska Ntchito Nthowa za Kulera

Kasi mukughanaghana kuti kakhaliro ka wanthu kakupangiska womama kugwiriska ntchito nthowa za kulera?

Fumbani: ni vyaukhaliro mbuni ivyo vingachitiska womana kugwiriska ntchito kulera?

Kasi mukughanaghana kuti tchalitchi lingawa na gawo lakukopa womama kugwiriska kulera?

Fumbani:kasi ni vya tchalitchi mbuni ivyo vingakhwaska kagwiliskiro ntchito kulera?

Kasi womama muno wanamazaza yakuyanayana pa iwo wekha za nthowa izo wangalondezga pa umoyo wawo?

Kasi chawa chakutchuka kuti womama wakatolenge nthowa zakulera kwambula wafumu wawo kumanya?

Ka womama m'chigawa chino wakukumana na kukanizgika kulikonse pakugwiliska ntchito kulera?

Fumbiskiskani: awo wakukana chomene; wafumu, wapongozi, walala.

Ka mukughanaghana kuti ninjani uyo wanamazaza yose pakugwiliska ntchito vinthu ivyo vikusangika panyumba m'muzi muno?

Kasi wanthu pala watolana , wakudumbilanapo kuti wawe na wana walinga m'chigawa chino?

Kasi mukuona tchiwemi mbuni kuti wanthu awo wali panthengwa wadumbilanenge kuti wawe na wana walinga?

3. Kugwiriska nthowa za kulera na ivyo wanthu wakukumana navyo

Pala nazunula nkhani yakulera, tchivichi icho chikwiza mtima winu?

Fumbiskani: Kasi mulikumanya uli?

Kasi mukukhwasika uli na nkhani yakulera?

Kasi wafumu winu wakukhwaskika wuli na nkhani yakulera?

Kasi chigawa chinu chikukhwasika uli na nkhani yakulera?

Ka mukughanaghana kuti nthowa zakulera zikuwovwira wanthu pa iwo wekha panji m'nyumba zawo?

Fumbiskiskani: Phindu lake ni vichi?

Ka mungaphalako kapulikiskiro kinu m'nyumba mwinu pa nkhani zakulera?

Kasi ni njani uyo wanamazaza yonse pakugwiliska ntchito nthowa zakulera?

Ka munganiphilirapo ivyo mwakumana navyo pakugwiliska ntchito nthowa zakulera?

Kasi mukugwiliska ntchito nthowa zakulera kuti mubabe nyengo iyo mukunkhumba?

Icho chikampangiskani kwamba kulera tchivichi?

Mukayamba kulera mwati mwawa na bana walinga?

Mukayamba kugwiriska ntchito nthowa yakudalilika yakulera mwati mwawa na wana walinga?

Ka mwakumanapo na suzgo lililonse umo mulikuyambila kugwiriska ntchito nthowa zakulera?

4. Kasangikiro ka nthowa za kulera muvipatala

Kasi mukuona mbuni pa nthowa zakulera izo zikupika kwa womama m'chigawa chino?

Fumbiskiskani: Kasi wanthu wakwenda mtunda utali mbuni kuti wasange nthowa zakulera?

Ka wanthu wakugwiliska ntchito ndalama zilinga kuti wasange wovwiri? mendelo, chakurya na kukhula vyakulelera.

Kasi womama wali pa ubwezi na nthowa zakulelera?

Ka ninkhuni uko womama wakutemwa kutola kulera m'muzi muno? Yaniskani malo agha nayakwa sing'anga?

Kasi tchivichi icho chikukopa womama kugwiliska nthowa za kulera m'muzi muno?

Fumbiskiskani: kutchipa kwa makhwala, kufupika kwa mtunda na kupokeleleka kuwemi.

Appendix 5a: Informed consent: In-depth interviews (non- users of FP, community key informants, service providers)

Family Planning use study

Principal Investigator: Effie Chipeta is a PhD student with University of Malawi, Chancellor college- Center for Social Research.

Supervisors: Dr. Allister Munthali, Associate Professor, Centre for Social Research; Dr. Peter Mvula, Research Fellow- Centre for Social Research, Professor Paul Kishindo, Director, Centre for Social Research.

Background: This study will investigate family planning use among currently married women in rural communities of Mzimba. The study will aim at understanding the contextual factors that influence non use of modern contraceptive methods among within the age group 15-49. It will also examine the socio-demographic, economic and gender related factors, individual/community beliefs, attitudes/perceptions and preferences regarding use of contraception, the socio-cultural/religious factors and also the health services factors that facilitate non use of contraception. The evidence we generate will be used to inform current family planning and reproductive health programs in Malawi.

As part of this study we will be interviewing purposefully selected individuals around the communities of TA Mzukuzuku as well as health service program managers. This will help us to get in depth understanding of the factors that influence non use of contraception in the selected communities.

What you will be expected to do: If you decide to participate you will be able to ask the research team any questions you may have about the study. Once you are happy that you understand what is involved you will be given a consent form to sign.

Confidentiality: The answers you provide will be used only for the purposes of this study. All answers will be handled confidentially and none of the information collected will be able to be traced back to those providing the information. Any information we gather will be stored without using your name. We guarantee that your name will not be published and will not be disclosed to anyone outside the study group.

Participation: We hope that you will agree to take part in this research. However, participation is voluntary. If you do decide to participate in this study, you have the right to withdraw at any time. You may also choose not to answer any questions that make you feel uncomfortable. If you decide not to participate, or if you withdraw, you will not be penalised.

Benefits/Risks: The answers we collect from you will provide important information on the factors that influence non use of contraception among currently married women in Malawi. This information will inform current family planning and reproductive health programs and may have future impacts on the development and

implementation of other services and policies. There are no risks involved in taking part in this study.

Compensation: Your participation in this study is voluntary and there is no payment for it. However, we will provide refreshments since the interviews may take a long time.

Permission: Approval to carry out this research has been sought from the Research Ethics Committee of the University of Malawi College of Medicine (COMREC).

Further information: You can get more information or answers to your questions about the study, your participation in the study, and your rights, from the project staff or you can contact the Principal Investigator on the following address:

Principal Investigator Effie Chipeta (BScNurs., MA) College of Medicine- Centre for Reproductive Health P/Bag 360, Chichiri, Blantyre 3, Malawi Tel: 265 0888 792116	Supervisor Dr. Allister Munthali (PhD) Centre for Social Research P.O. Box Zomba Tel: 265 0888822004
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If you want to know more about your rights, safety and well being in research, you may also contact: The Chairman, COMREC, P/Bag, 360, Blantyre 3 or on telephone number: 01 877 245/01877 291. E-mail: comrec@medcol.mw.

DECLARATION:

I have read, or had read to me, the above information for this project and I understand the objectives and purpose. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I clearly understand what I will be required to do if I take part in this study and I freely and voluntarily agree to be part of this research study.

Participants name	Participants Signature	Date
_____	_____	_____
Participants Thumbprint	Signature of Witness	Date
_____	_____	_____
Investigators Name	Signature	Date
_____	_____	_____

Appendix 5b: Informed consent: In-depth interview (non- users of FP, community key informants, service providers) (Tumbuka)
Family Planning use study

Ine zina lane ndine..... uyo nkhuwovwira bamama Effie Chipeta pa kafukufuku/vyakupenjapenja ivi. Bamama Chipeta wakusambira msambiro ghapachanya gha PhD kusukulu ya University of Malawi, Chancellor college- Center for Social Research. Ndipo agho wakusambizga mba Dr. Allister Munthali, Associate Professor, Centre for Social Research; Dr. Peter Mvula, Research Fellow- Centre for Social Research, Professor Paul Kishindo, Director, Centre for Social Research.

Mazgu wa Kwamba: Kafukufuku/vyakupenjapenja ivi vichitikenge kwa wamama awo wali panthengwa ndipo wali na vyaka 15-49 m'boma la Mzimba. Mkafukufuku uyu /vyakupenjapenja ivi tikukhumba tisange icho chikutondeska wamama kuti wagwirisye nthito kulera. Tikhumbenge kuti tipulike maghanoghano ghawo na makhumbo ghawo pakhani ya kulera kukhwaskana na ukhaliro wapakaya, visambizgo vya mipingo, kupambana kwa zinithito za bamama na badada.

Banthu bamozabamoza awo wakufumira m'dera lino la TA Mzukuzuku na bakugwira nthito zachipatala tawapempha kuti tipulike maghanoghano ghawo pa nkhami za kulera mdera lino. Ivi vitiovwirenge kuti Boma linozge makola nthito za kulera kuti ziwe za phindu kwa ba Malawi.

Ivyo tikulindizga kufuma kwa imwe: pala mwazomera kupanga nawo Kafukufuku/vyakupenjapenja ivi mungafumba fumbo lililose lakukwasana na Vyakuyezgayezga ivi kwa wanthu awo wapangiska. Pala mwakhutira kuti mukumanya ivyo vikuchitika muvyakuyezgayezga ivi mungasayina chi pepala ichi, Ndipo wazakupani nambala ya chimanyisko cha imwe kweniso yokuwovwira kusunga chisisi cha vyose ivo mungayowoya vwakukwasana na Vyakuyezgayezga ivi.

Chisisi: mazgolo winu wadzagwiriskika nthito Kafukufuku/vyakupenjapenja ivi mbwenu, ndipo paliye uyo wazamumanya kuti ndimwe mwazgola mafumbo awa, vyose ivo muzamuyowoya wazamusunga mwa chisisi kwambula zina linu. Ndipo tikumanyiskani kuti zina linu lizamuwoneka yayi palipose, lizamumanyika yayi kwa waliyose uyo wakuchitanawo yayi vyakuyezgayezga ivi.

Kunjiranawo: tikugomezga kuti muchitengenawo kafukufuku/vyakupenjapenja ivi. Kweni timumanyisye kuti ivi vingachitika pala imwe mwakhumba kuchitanawo. Muliso na ufulu kuleka nangauli mwanjiranwo kale. Pala mukhumba yayi kupanganawo ise tingamchichizgani yayi. Pala mwasanga kuti mafumbo ngakusuzga tiphalireni na agho mukuwona kuti mungazgola yayi. Kuleke kuchita nawo kafukufuku/vyakupenjapenja ivi kulije chakusuzga chilichose chakukhwaskana nawovwiri uwo mukupokera kuvipatala.

Uwemi/ Vyakukutondeska : mazgolo winu wazamuwovwira kusanga vinthu vya ukhaliro vakukwasana na nthowa zakulera izo zikupangiska wanalume na wanakazi awo wana wana wanayi kapena kujumphitsa apa m'Malawi muno kuti wakhale na wana walinga na vinyakhe vakukwasana na ubabilo. Vyakusangika mkafukufuku/vyakupenjapenja ivi viwovwirenge kuti wovwiri uwo wanthu

wakupokera wakukwasana na nthowa zakulera kweniso moyo wakukwasana na ubabilo ukhale uwemi. Vingawovwira kulutitsa munthazi ntchito zinyakhe za umoyo. Mkafukufuku/vyakupenjapenja ivi mulije chilichonse icho chingachitika chambula kuzomerezgeka, pala mwanjira nawo vyakuyezgayezga ivi.

Chakusangapo: Palije malipiro ghaliwose pa kafukufuku/vyakupenjapenja ivi. Kuwongera kwithu tizamkumpani chakumwa na chakulyera.

Chizomerezgo: Chizomelezgo chakupangira kafukufuku/vyakupenjapenja ivi chapokereka kufuma ku komiti yakuona nthito izi ya kusukulu yamadokotala m`Malawi muno ya Research and Ethics committee (COMREC).

Vyakusazgirapo: mungasanga mazgolo wakusazgirapo pavakukwasana na ufulu winu wachibabiwa kufuma kwa wanthu wakugwira ntchito mkafukufuku/vyakupenjapenja ivi.

Principal Investigator	Supervisor
Effie Chipeta (BScNurs., MA)	Dr. Allister Munthali (PhD)
College of Medicine- Centre for Reproductive Health	Centre for Social Research
P/Bag 360, Chichiri, Blantyre 3, Malawi	P.O. Box Zomba
Tel: 265 0888 792116	Tel: 265 0888822004

Pala mukukhumba kumanya vyakukwasana nan ufulu winu, panji uwemi wa vyakupenjapenja ivi, fumbani wapampando wa committee iwo yikuona ntchito izi: The Chairman, COMREC, P/Bag, 360, Blantyre 3 or on telephone number: 01 877 245/01877 291. E-mail: comrec@medcol.mw.

CHIZGOMELEZGO:

Nawerenga kapena waniwerengera Vyakuyezgayezga ivi ndipo napulikisiska za vifukwa vake. Nanguwa na mupata wakufumba mafumbo ndipo nakhutiskika na kuzgoleka kwake kake. Nazomerezga mwa ine nekha kupanganawo pavyakuyezgayezga ivi, Kwambula kukamizga kweni kuzomera nekha nga ufulu wane wa chibabiwa.

Zina	Signature	Date
Chidindo	Signature ya Kaboni	Date
Investigators Name	Signature	Date

Appendix 5c: In-depth Interview Guide with Non Users of Family Planning methods

Family planning use

What are your sentiments towards contraception? Do you approve or disapprove?

Have you ever used any contraception to plan time between births since you were married?

Probe : **(Note that only women who agree to have ever used contraception will be probed here)**

What contraceptives they have ever used?

Length of time they used contraception?

Their experiences while using contraception

Why they discontinued use of contraception (Probe: on side effects, health problems, Husband or family opposition, Cost of services, location of services, attitude of service providers)

If they have never used any contraception, find out more on:

The reasons for not using any contraception since they have been married.

Probe: Cultural factors, Religious factors

Fear of side effects or other health problems. What are these?

Husband or family opposition

Economic factors (Cost of services, transport, food expenses associated with health seeking

Quality and accessibility of services (Distance, location of services, attitude of service providers)

Desire for more children

Find out if the woman intends to use contraception in future?

What would motivate them to use contraception in future?

What are their preferred methods of contraception? Modern methods or traditional methods?

Access to Family planning Information

How can you describe your level of knowledge on FP?

Do you know the available FP choices that exist in this community?

Have you ever received any information on where to get FP services, what FP alternatives are available or how best to use FP services? What are the main sources of FP information?

Have you had any information on the benefits for using modern FP methods?

Are there any myths associated with FP use in your community?

Appendix 5d: In-depth interview with non-users of FP methods (Tumbuka)

1. Kugwiliska ntchito kulera

Maghanoghano ghinu ghali uli pa vyakulera? Mukuzomerezga panji yayi?

Kasi muli kugwiliskapo nthowa za kulera kuti mukwaniske kubaba pa nyengo iyo mukunkhumba umo muli kutengwerela?

Fumbiskani; (womama wekhawekha awo walikuzomelezga kugwiliska ntchito kulera ndiwo wafumbike)

Ni nthowa mbuni yakulera iyo walikugwiliskapo ntchito?

Wagwiliska ntchito nyengo itali uli?

Wakumanapo na vichi apo wakulera?

Kasi wakalekerachi fulera (fumbiskani: viheni vichankhe, kukumana na masuzgo pa umoyo wawo, wafumu panji wabale kukana, kulipira ndalama pala wakukhumba wovwiri, malo agho wovwiri uwu wukusangika, kapokelelero ka awo wakugwila nichito).

2. Pala wandagwiliskepo nthowa zakulera fumbani vinandi pa:

Vifukwa ivyo vikuchitiska kuti iwo waleke kugwiliska nthowa zakulera umo walikutengwera?

Fumbiskani: vikhulupiro vyawapapi , na vya mpingo

Kopha kuti wangakumana na masugzo yanyakhe na yazaumoyo wawo. Kasi agha ni ngani?

Wafumu panji wabale kukana?

Kasangiro ka ndalama (kulipira ndalama kuti wawovwirike, mendelo, ndalama izo zikunangika pakugula vyakurya pala wakukhumba wovwiri kuchipatala,

Uwemi na kasangilo kawakuwawovwira (Mtunda, uko vyakuwawovwila vili, nkhalo ya awo wakuwawovwira).

Kukhumba kuwa na wana wanandi

Fumbani kuti mumanye pala mama uyu wakughanaghana zakuyamba kulera m'nthazi muno?

Icho chingawachitiska kuti wayambe kugwiliska ntchito nthowa zakulera m'nthazi muno tchivichi?

Kasi nthowa zakulera izo wakukhumba ni zini? Nthowa zasono panji za wapapi wakale?

3. Kupokera uthenga wakukhwaskana na vya kulera

Kasi mungalongosola kuti mukumanyapo vichi pa nkhani ya kulera?

Kasi mukumanya nthowa zakulera zakupambanapambana izo zikusanginga m'chigawa chinu muno?

Kasi mulikuphalilikapo kuti ni khu uko mungasanga nthowa zakulera, kasi ivyo mungakhumba vilipo, panji umo mungagwiliskira makora vyakulera? Kasi mulikupulika nkhuni chomenechomene?

Kasi mulikulongosolerako za uwemi wakugwiliska ntchito nthowa za sono zakulera?

Kasi pali mahumuhumu yakukhwaskana na kugwiliska ntchito nthowa zakulera?

Appendix 5e: In-depth Interview Guide with community key informants on Family planning use

Family planning Knowledge

How can you describe the level of knowledge on FP among women in this area?

Are you aware of any FP services offered in this area?

Do you know the available FP choices that exist in this community?

What are the main sources of FP information in this community?

Do people receive information on how best to use FP services, or where to get services in this area?

Socio-cultural factors affecting use of contraception

Societal norms

How acceptable is the use of contraception in this community?

What are the Fertility preferences that exist in this community? Probe on family size, son preferences, child replacement

How are Decisions relating to FP use made at household level in this community? Do women in this community have power to make decisions relating to use of health services?

Cultural/religious beliefs, values and practices

Do you think culture has an influence on women's intention to use contraception in this area?

Probe: What cultural beliefs exist in this community that may influence contraceptive use?

Do you think religion has an influence on women's intention to use contraception?

Probe: What are these religious beliefs or values that affect contraceptive use?

Is it common for women to access FP without husbands' approval?

Do women in this community face opposition related to use of contraceptives?

Probe: The main source of opposition: Husbands, mother in-laws, elders

Who do you think has a final say on use of household resources in this area?

Family planning use

What are some of the reasons for non use of contraception in this area?

Probe: Fear of side effects, health problems, Perception of the risk of pregnancy vs FP use

Husband opposition, Child replacement

Cost of services, location of services, Attitude of service providers

Appendix 5f: In-depth interview with key community informants on family planning use (Tumbuka)

Kugwiliska ntchito kulera

Kasi womama wa m'chigawo chino wakumanya makora yene pa nkhani yakulera?

Kasi mukumanyapo za nthowa zakulera izo zikusangika m'muzi mwinu muno?

Kasi mukumanya nthowa zakulera zakupambanapambana izo zikusangika m'chigawa chinu muno?

Ka nkhani zakulera chomenechomene mukuzimanyira nkuni m'muzi muno?

Ka wanthu wakuphalirika umo wangagwiriskila nthowa zakulera panji uko wangakasangako wovwiri uwu m'chigawa muno?

Vikhulupiliro na Kankhaliro ka Wanthu ivyo Vikukhwaska Kugwiliska Ntchito Nthowa za Kulera

Kasi wanthu walikuchipokelera mbuni vya kugwiliska ntchito nthowa zakulera m'chigawa chino?

Kasi wanthu wakughanaghana uli zakababiro kawo m'chigawa muno?

Fumbiskani: kukula kwa banja lawo, kukhumba bana wanalume, kunkhumba kuwezgera wana

Kasi chisankho chakugwiliska ntchito nthowa zakulera pa nyumba chili mbuni m'chigawa chino? Ka womama m'chigawa chino wanamazaza ya kusankha ivyo wakukhumba pa kukhwaskana na vyaumoyo?

Mukughanaghana kuti vyachikhalidwe cha wanthu chikupangiska womama kuyamba kugwiliska ntchito nthowa zakulera?

Fumbiskani: ni vyachikhalidwe vini ivyo vikupangiska womama kuyamba kugwiliska ntchito nthowa zakulera

Kasi mukughanaghana kuti tchalitchi lingawa na gawo lakuchitiska kuti womama wayambe kugwiliska ntchito nthowa zakulelera?

Fumbiskani: Ka vi vikhulupiliro mbuni vya tchalitchi ivyo vikukhwaska kagwiliskiro ka nthowa zakulera?

Kasi chawa chakutchuka kuti womama wakatolenge nthowa zakulera kwambula wafumu wawo kumanya?

Ka womama m'chigawa chino wakukumana na kukanizgika kulikonse pakugwiliska ntchito nthowa zakulera?

Fumbiskiskani: awo wakukana chomene; wafumu, wapongozi, walala.

Ka mukughanaghana kuti ninjani uyo wanamazaza yose pakugwiliska ntchito vinthu ivyo vikusangika panyumba m'muzi muno?

Ivyo vikutondeska kugwiliska ntchito kulera

Kasi mukughanaghana kuti ni vichi icho chikupangiska wanthu wanyankhe kuleka kugwiliska ntchito nthowa zakulera m'chigawa chino?

Fumbiskani:vinyankhe viheni, suzgo pa umoyo wawo, kusachizga kukumana na masuzgo pa munthu wanthumbo na kugwiliska ntchito kulera, wafumu wawo kukana, kuwezgera wana.

Kulipira ndalama pakusanga wowwiri, uko wowwiri ukusangika, nkhalo ya awo wakugwira ntchito.

Appendix 5g: In-depth interview guide: Health service program managers

This guide is intended to assess the functioning of the Family planning program, policies, standard operational plans and guidelines. The guide targets key policy and programme decision makers.

1. Access and availability of FP services

- What are your views relating to the following:

Coverage of FP services (number of FP service sites)

Distance between FP service sites

Actual number of FP service providers at district level

Quality of Infrastructure for FP provision

What plans have been put in place to improve access, coverage and quality of FP services in the district?

2. Quality of FP services

- What are your views on the following:

Volume of service providers for FP services?

Training of first line providers of FP ?

Location of FP services (Is privacy of clients guaranteed?)

3. FP Logistics management

- To what extent do logistics systems support or hinder effective family planning service-delivery ?

- How is planning and supply of FP commodities (e.g. condoms, PILLS, injectables, IUCD done)

- What system has been put in place to ensure that health facilities have a regular supply of FP commodity ?

- How does the system ensure availability of contraceptive method mix?

- Who is responsible for procurement of FP commodity supplies at health centre, district and national level?

- How are projections made to meet the contraceptive needs of the population?

- How are FP commodities distributed in various health facilities?

- What are the sources of funding for procurement of FP commodity supplies?
- What data is available to help project on the contraceptive needs of the population?
- How is this data collected?

4. FP Supervision and monitoring

- What data is collected to help monitor the performance of the FP program?

Probe on specific indicators that are used to capture data on FP use?

- How does the system capture data on:

Access to FP services?

Uptake of FP services? Quality and Client satisfaction?

- How is this data used to improve the FP program?
- How is supervision and monitoring of FP programs done at the following levels:
Program, Service and community level?

5. Funding and Budget support

- What are the main sources of funding for FP programs?

Possible prompts:

Government? Donors?, Private sector? Communities?, Faith-based organizations?

Out-of-pocket family/client contribution?

- What proportion of the health budget is allocated to FP programs?
- How much is allocated to procurement of FP commodities (female and male condoms and other contraceptives in the FP budget?

Appendix 5h: In-depth interview guide for health service programme managers (Tumbuka)

Chakulata cha ndondomeko iyi tchakukhumba kuona umo mapulogalamu ya kulera yakwendera, malamulo, nthowa zakuzomerezgeka zakendeskerero na ndondomeko zake. Ndongomeko iyi chomenechomene yikukhumba kufikira awo wakunozga ndondomeko na awo wakuona umo ntchito ikwendera.

1. Kasangikiro ka wowwiri wakulera

Kasi maghanoghano ghinu ngakuti uli pa ivi?

Malo agho nthowa zakulelera zikusangika (nambala ya uko kukusangika nthowa zakulera)

Mtunda uwo ulipo kufuma pa chipatala cha kulera na chinyankhe?

Nambala yeneko gha awo wakupereka wowwiri pa boma?

Kuwa na malo yakuzengeka makola yakuperekera vyakulera?

Ka ni ndondomeko uli izo zayikika pa boma kuti wakwezge kasangiro, kafikiro na uwemi wa vyakulera?

2. Uwemi wa wowwiri uwo ukuperekeka

Kasi maghanoghano ghinu ghali uli pa vinthu ivi?

Unandi wa wanthu wakupeleka vyakulelera?

Kusambizga awo wali pakwamba kupereka vyakulelera?

Malo agho kukusangika vyakulera (kasi malo agha ngachisisi kwa awo wakovwirika?)

3. Kendeskero kawemi Kuti nthowa za kulera zisangike

Ka mukughanaghana kuti nthowa izo zikulondezgeka zokovwira uli panji kutimbanizga kendeskero kawemi ka vyakulera?

Kasi ndondomeko ili uli pakupereka vyakulera (e.g. makondomu, mapilisi, majakisoni na umo yikupangikira IUCD)

Kasi payikikapo upangiri uli kuti pachipatala pawenge vinthu vyakulera nyengo zose?

Ka ndondomeko iyo yikulondezgeka yikuoneskeska uli kuti pali nthowa zakulera zakupambanapambana?

Ka ninjani uyo wakuona vyakugula vinthu vyakulera pa chipatala chidoko, chaboma na chikulu cha wanthu wose?

Ka vyakunkhumbika panji vyakulondezga pakuoneskeskeka uli kuti wanthu wakusanga nthowa zakulera izo wakukhumba?

Ka vinthu vyakulera vikugawika mbuni mu vipatala?

Kasi ndalama zikufumira nkhu kuti mugule vaykelelera?

Ka nivakowavwira uli ivo vilipo kovwira awo wakuyendeska vyakulera kuti wamanye kukwaniska vyakukhumba vya wanthu?
Ka vakuwawovwira ivi vikusangika mbuni?

4. Kulondolozga ntchito za kulera

Ka nivichi ivyo vikutoleka kovwira kuti ntchito ya vyakulera yende makola?
Fumbani; ka nivilingolera vini ivyo vikugwiliska ntchito pakutola ivyo vikukhumbikila pa kugwiliska ntchito vyakulera?
Ka nthowa izo zikulondezgeka zikutola uli vyakovwira pa:
Kusanga nthowa zakulera?
Umo nthowa zakulera zikutolekera?
Kunkholeska wakovwirika na uwemi wake?
Ka nthowa izo zikugwiliska ntchito zikuovwira mbuni pa mapulogamu ya kulera?
Ka kulondezga na kuona umo mapulogalamu yakulera yakwendera yakukwaniskika uli pa:
Mapulogalamu?
Wovwiri uwo ukupelekeka?
M'chigawa?

5. Ndalama za kovwira pa ntchito za Kulera

Ka ndalama chomenemene zikufumira nkhuni kuti mwendeskere mapulogalamu yakulera?
Ivyo vingawa:
Kuboma?
Wakutovwira wakuwalo?
Makampani yaboma yayi?
M'vigawa?
Mabungwe ya mipingo?
Kusanga kufuma kumsokhamsokha wa mabanja/awo wakovwirika kusunzika?
Ka nichigawa uli cha bageti tchi cha bageti ya zaumoyo zikupelekeka ku vyakulera?
Kasi ni ndalama zilinga izo zikuperekeka kuti zigulikire vyakulera (makondomu yawanakazi na wanalume na vyakulera vinyankhe pa bageti ya kulera?).

APPENDIX 6A: INFORMED CONSENT: HOUSEHOLD LISTING AND SCREENING (ENGLISH)

Family Planning use study

Principal Investigator: Effie Chipeta is a PhD student with University of Malawi, Chancellor college- Center for Social Research.

Supervisors: Dr. Allister Munthali, Associate Professor, Centre for Social Research; Dr. Peter Mvula, Research Fellow- Centre for Social Research, Professor Paul Kishindo, Director, Centre for Social Research.

Background:

A Household Listing and screening exercise will be done in selected villages around Mabiri Health centre, Embangweni hospital and BLM clinic in Mzimba Boma. The purpose of this HH Listing and screening is to help identify women of reproductive age between the age 15-49 to participate in the study. The households that will be selected will be asked to participate in a survey, focus group discussions and in-depth interviews. If they agree to participate they will be asked questions on which will help us to determine their age, marital status and whether they have/are using contraceptives or intend to use in future. The evidence generated through this study will be used to inform current family planning and reproductive health programs in Malawi.

In case you have some questions please feel free to ask and if you need further information about the study, you can contact Mrs Effie Chipeta on telephone number: 0888 792 116.

Permission: Approval to carry out this research has been sought from the Research Ethics Committee of the University of Malawi College of Medicine (COMREC).

If you want to know more about your rights, safety and well- being in research, you may also contact: The Chairman, COMREC, P/Bag, 360, Blantyre 3 or on telephone number: 01 877 245/01877 291. E-mail: comrec@medcol.mw.

DECLARATION:

I have read, or had read to me, the above information for this project and I understand the objectives and purpose. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I clearly understand what I will be required to do if I take part in this study and I freely and voluntarily agree to be part of this research study.

Participants name	Participants Signature	Date
_____	_____	_____
Participants Thumbprint	Signature of Witness	Date
_____	_____	_____
Investigators Name	Signature	Date
_____	_____	_____

APPENDIX 6B: INFORMED CONSENT: HOUSEHOLD LISTING AND SCREENING (TUMBUKA)

Family Planning use study

Ine zina lane ndine..... uyo nkhuwovwira bamama Effie Chipeta pa kafukufuku/vyakupenjapenja ivi. Bamama Chipeta wakusambira msambiro ghapachanya gha PhD kusukulu ya University of Malawi, Chancellor college- Center for Social Research.

Mazgu wa Kwamba:

Kalembere wachitikenge khomo na khomo kuti tisange bamama wavyaka 15-49 awo wali panthengwa ndipo wakukhala mizi iyo yasankhika kuti injile nawo mu kafukufuku/ vyakupenjapenja ivi. Mizi iyo ili pafupi na Mabiri Health centre, Embangweni hospital na BLM clinic ku Mzimba Boma yisankhikenge mwamaere. Ndipo mabanja agho ghasankhika tiwapemphenge kuti wazgole mafumbo agho ghatovwirenge kuti timanye za iwo, vyaka vyawo na maghanoghano ghawo na makhumbo ghawo pakhani ya kulera. Ivi vitovwirenge kuti Boma linozge makola nthito za kulera kuti ziwe za phindu kwa a Malawi. Ili liwenge gawo la kwamba la kafukufuku uyu.

Pala muli na fumbo lililonse mungamanya kunifumba na kuti pala mundakholwe navvyolo lane mungafumba ba mama Chipeta pa nambala iyi: 0888 792 116.

Chizomelezgo: Chizomelezgo chakupangira kalembere uyu chapokereka kufuma kwa dokotala mulala m'boma ili la Mzimba na komiti yakuona nthito izi ya kusukulu yamadokotala m'Malawi muno ya Research and Ethics committee (COMREC).

CHIZGOMELEZGO:

Nawerenga panji waniwerengera vya kalembere uyu ndipo napulikisiska za vifukwa vake. Nanguwa na mupata wakufumba mafumbo ndipo nakhutiskika na kuzgoleka kwake kake. Nazomerezga mwa ine nekha kupanganawo kalembere uyu, kwambula kuchichizika kweni kuzomera nekha nga ufulu wane wa chibabiwa.

Dzina	Signature	Date
_____	_____	_____
Chidindo	Signature ya Kaboni	Date
_____	_____	_____
Investigators Name	Signature	Date

Appendix 6c: Family Planning use in rural Malawi- Household Listing and Screening Questionnaire(ENGLISH and TUMBUKA)

Household ID: **Interviewers**

Code:..... **Village:**.....

Date of Interview:..... **Time** **of**
Interview:.....

In this study I would like to identify women who are currently married and find out if they are using/not using contraceptive methods. **(Pavyakupenjapenja ivi tikukhumba kuwonana nawomama awo bali panthengwa kuti tifumbe pala wagwirisya nthowa za kulera zamtundu wuliwose).**

1.	I would like to know if this household has a woman who is currently married and live here together with their partner? (Nate nimanye kuti panji pakhomolino pali bamama awo wali panthengwa ndipo bakukhala pano limoza na bafumu bawo?)		Yes = 1		
			No = 2	If no, End of interview	
	If Yes, Interview the woman/women				
2.	Name of the woman (Mazina gha bamama awo wali panthengwa ndipo wakukhala limoza pano)	Total number of living children	Age Range 14 years or less = 0 15-24 years = 1 25- 49 years = 2 Above 49 years = 3	Contraceptive use Yes = 1 No = 2	If no, contraceptive use in future Yes = 1 No = 2
	1.				
	2.				
	3.				
	4.				
	5.				
	6.				

Appendix 7a: Checklist for ethnographic questions

(For use by PI only). The PI will use this guide as a framework to help understand better the issue of non-use of contraception.

Descriptive questions

a. Experiential

- What do people say about their experiences using modern FP methods?

(Kasi wanthu wakuti uli pa ivyo iwo wali kusanganapo navyo umo pakugwirisya ntchito nthowa za kulera?)

- What are peoples' perceptions regarding FP use in the study area?

(Maghanoghano ghabanthu pankhani za kulera yakuti uli?)

- Find out more about the reasons for not using any contraception among some women

(Fumbiskiskani chomene pa vifukwa ivyo wamama banandi wakutondekera kugwiriska ntchito kulera?)

b) Hypothetical questions (For situations where participants have no experience about FP)

- Check what people say about women who are currently using contraception

(Kasi wanthu wakuyowoya kuti uli za bamama awo wakugwiriska ntchitoo kulera panyengo ya sono?)

- Check what males say about FP use

(Kasi badada bakuti uli pankhani zakulera)

c) Native language descriptions

- What terms do people use when they talk about FP in the area?

(Kasi wanthu wakugwiriska ntchito mazgu uli pakuyowoya za kulera?)

- How is FP use understood in this community?

(Wanthu bakuti kulera ni vichi mchigawa chino?)

Observations

- Observe the physical aspects of FP service provision in terms of space, confidentiality, reception of clients.

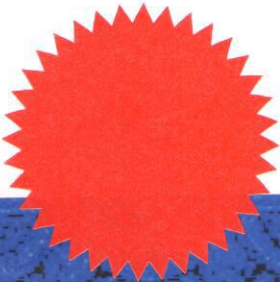
(Onani na kulawiska makora malo agho ntchito zakulera zikuperekekerera. Kasi malo ghakuperekerako kulera ghalipo, ngachisi, banthu wakupokerereka uli?)

Checklist

	Yes	No
1. Understood what people say about their experiences using modern FP methods		
2. Understood peoples' perceptions regarding FP use in the study area?		
3. Explored reasons for not using any contraception among some		

women		
4. Check what people say about women who are currently using contraception		
5. Check what males say about FP use		
6. Explore what terms do people use when they talk about FP in the area?		
7. Explore how FP use understood in this community?		
8. Observe the physical aspects of FP service provision in terms of space, confidentiality, reception of clients.		

Appendix 8: COMREC Ethical Approval Certificate



CERTIFICATE OF ETHICS APPROVAL

This is to certify that the College of Medicine Research and Ethics Committee (COMREC) has reviewed and approved a study entitled:

P.09/11/1128 – Family Planning Use in Rural Malawi: Understanding the Context in which Non-use of Contraception is Experienced. Version 3, dated September 2012 by Mrs. Effie Chipeta

On 4th October

As you proceed with the implementation of your study, we would like you to adhere to international ethical guidelines, national guidelines and all requirements by COMREC as indicated on the next page


Dr. G. Kalandia – Vice-Chairperson (COMREC)

Approved by
College of Medicine

04 OCT 2012
(COMREC)
Research and Ethics Committee

Date
04 October 2012