Barriers to Family Planning Use in Malawi

Opportunities for Social and Behavior Change Communication

April 2012
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Contact Information
C-Change
FHI 360
1825 Connecticut Ave. NW, Ste. 800
Washington, DC 20009, USA
Tel: +1.202.884.8000
Fax: +1.202.464.3799
Website: [www.c-changeproject.org](http://www.c-changeproject.org)
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Acronyms, Tables, Figures, and Appendices

Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>BCC</td>
<td>Behavior change communication</td>
</tr>
<tr>
<td>SBCC</td>
<td>Social and behavior change communication</td>
</tr>
<tr>
<td>BLM</td>
<td>Banja La Mtsogolo</td>
</tr>
<tr>
<td>DHO</td>
<td>District health office</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus group discussion</td>
</tr>
<tr>
<td>FP</td>
<td>Family planning</td>
</tr>
<tr>
<td>HSA</td>
<td>Health Surveillance Assistant</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, education, communication</td>
</tr>
<tr>
<td>IUCD</td>
<td>Intrauterine contraceptive device</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
</tr>
<tr>
<td>TFR</td>
<td>Total fertility rate</td>
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</table>

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Executive Summary

Background and Purpose of the Study
The use of modern family planning (FP) methods is lower in sub-Saharan Africa than in any other region in the world. Malawi is considered a late adopter of FP and in spite of recent progress in the use of modern FP methods, Malawi’s total fertility rate (TFR) remains high. However, substantial progress has been made in the last two decades with a rise in use of modern FP methods by married women from 7.2 percent in 1992 to 42.2 percent in 2010.

The C-Change (Communication for Change) project commissioned this research study on the socio-cultural context in which FP decisions and fertility behaviors take place in Malawi. The study had two broad and interrelated objectives:

1. Identify factors that facilitate or constrain the use of modern FP methods in Malawi
2. Assess the availability and use of FP communication materials in health facilities

This study was conducted to generate evidence to inform the development of effective social and behavior change communication (SBCC) strategies and interventions to improve sexual and reproductive health (SRH) and the uptake of modern FP methods in Malawi.

Methods
The study was conducted in five districts in Malawi: Lilongwe, Mzimba, Dedza, Machinga, and Thyolo. Urban populations were sampled in Lilongwe and rural populations were sampled in all five districts.

Both qualitative and quantitative methods were employed. Twenty-five focus group discussions (FGDs) were conducted with men and women in two age groups (18–24 and 25 years and older) to gain a deeper understanding of prevailing barriers to and facilitators of FP use and identify community- and gender-related values and norms that sustain these barriers.

The quantitative component included a health facility survey that had three parts: exit interviews with 598 clients, interviews with 90 health workers, and an inventory and assessment of available FP communication materials in 30 health facilities. In addition to assessing the readiness of the facility to provide user-friendly FP services, the surveys also addressed the content and accessibility of the materials, their sensitivity to the local culture, and appropriateness in terms of gender, age, and language.

Results
There was a common perception among FGD participants that the ideal number of children a couple should have ranges from three to five. A smaller number of FGDs discussed having 6–10 children. While many reported that couples make decisions about the number of children they want to have, others noted that their parents and community leaders also play a role in determining family size. Factors that encouraged desire for large families included fear of loss of children to illness, desire to increase family income, and increased power and influence of clan/lineage. Economic and health factors were the most common drivers for small family sizes.

FGDs identified several perceptions that are barriers to FP use, including perceived decrease in sex drive as a result of FP use, perceived side effects as a result of FP use, opposition of husbands/male partners
and family members to the use of modern FP methods, and beliefs that the use of FP goes against certain religious beliefs.

The perceptions that facilitate FP use noted were that use improves the health of women and children, in particular because women have time to recover after pregnancies. They also indicated that some males looked favorably on FP use because women who use FP methods tend to be healthier and better able to contribute to her family’s well-being. While some community members discourage FP use, others advise women to adopt FP and see FP use as progressive.

The availability of FP communication materials in health facilities shed some light on one source of FP knowledge within communities. FGDs and facility surveys showed that posters and charts were the most widely available forms of FP communication materials. Other materials such as brochures, audiotapes, and videos, were less readily available.

Family planning use among client exit interview participants was high—76 percent reported that they had ever used an FP method to delay or avoid pregnancy, and 74 percent reported that they or their partner was currently using an FP method when they were interviewed. Most participants in FGDs stated that they access FP services from government health facilities, and NGO and private clinics. The most common method used across all data sources was injections, followed by pills, male condoms, and implants. These were also the same products that experience stock-outs, according to the facilities surveyed. FGDs reported that service quality and how patients were treated affected women’s access to FP and their continued use of FP services.

The future of FP use in Malawi according to FGD participants was optimistic since more women than ever were reported to be adopting modern FP methods, spacing their children, and avoiding problems associated with frequent pregnancy and childbirth. The numerous government- and NGO-sponsored TV and radio messages on FP and child spacing had contributed to this.

Conclusions and Recommendations
The study findings highlight that while progress in FP knowledge and use has been made in study communities, there are several opportunities for SBCC interventions and other FP programs to improve FP acceptance and use.

- **Decision making around FP:** Male partners and other family and community members exert significant influence over a woman’s fertility and FP decisions. In addition to women, it is important to develop an SBCC strategy targeting people who directly influence FP decisions including male partners, relatives, and community members. In particular, SBCC interventions must include separate messages targeting men to address sexual desire and performance issues relating to FP use and men’s roles in FP decision making. Communication and social mobilization efforts targeting family members and community leaders should address cultural preferences for large families, encourage support to young couples to plan their families, and emphasize the benefits of FP use. Religious and traditional organizations can also be targeted to include FP discussions in their activities.
- **Misconceptions and fears related to FP:** Misconceptions and fears related to FP—including perceived side effects of FP use—still persist and limit the widespread use of modern FP methods. SBCC interventions should include targeted campaigns, activities, and accurate messages to correct misconceptions and fears around FP use. Health providers must be adequately trained to provide...
information related to potential side effects of FP methods and able to counsel clients who experience side effects.

- **FP services and products:** In addition to socio-cultural barriers and knowledge gaps that constrain the use of FP, limited supply of popular FP methods and distance between communities and health facilities negatively impact FP use. Health facilities must ensure an adequate supply of FP methods at all health facilities to avoid frequent stock-outs. Health service providers should also establish outreach programs, using community health workers to raise awareness about the FP services available and to disseminate FP methods and FP communication materials to more remote communities.

- **FP communication materials:** FGDs and facility surveys showed that posters and charts were the most widely available forms of FP communication materials in health facilities. Other materials such as brochures, audiotapes, and videos, were less readily available. FGDs noted a number of ways to strengthen existing FP communication materials such as: ensuring that FP communication materials are culturally appropriate and target those who influence decisions around FP use, and that materials are accessible to clients with low literacy rates by incorporating more graphics and artwork. FGDs also noted the potential of videos as a means of disseminating FP messages. Further research is needed to examine the effectiveness of videos in delivering FP messages. The study highlighted much potential for more interactive forums to encourage dialogue and communication around the benefits of FP and address the socio-cultural barriers to FP use.
1. Introduction

1.1. Background

Malawi, a landlocked country in Southern-Central Africa, has an area of about 118,484 square kilometers, one-third of which is made up by Lake Malawi. Based on the United Nations Development Program’s 2011 Human Development Index, Malawi ranks 171 out of 187 countries and is classified as a low human development country (UNDP 2011). Select health, population, and development indicators of Malawi are presented in Table 1.

Table 1: Malawi: Health and Development Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (millions), 2011</td>
<td>15.4&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Population annual growth rate 2010–2015 (percent)</td>
<td>3.2&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>GDP per capita (PPP$), 2009</td>
<td>794&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Life expectancy at birth, both sexes (years), 2009</td>
<td>47&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100,000 live births), 2010</td>
<td>675&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Total fertility rate (per woman)</td>
<td>5.7&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Adult (age 15–49 years) HIV–prevalence rate (percent), 2009</td>
<td>11.0&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Contraceptive prevalence rate (modern methods) (percent), 2010</td>
<td>42.2&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Per capita total expenditure on health at average exchange rate (US $), 2008</td>
<td>18&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Physicians per 10,000 population, 2000–2010</td>
<td>0.2&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Nursing and midwifery personnel per 10,000 population, 2000–2010</td>
<td>2.8&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Source: <sup>a</sup> UNDP (2011); <sup>b</sup> WHO (2011); <sup>c</sup> NSO and ICF Macro (2010)

Malawi is in a group of countries that are considered to be late adopters of family planning (FP). The Ministry of Health (MOH) introduced the National Child Spacing Program in 1983. In 1989, the local NGO Banja La Mtsocholo (BLM) was established. It initially opened one clinic, then set up seven additional training centers for child spacing. After the transition to a multi-party democracy in 1994, the government’s population policy was launched, and many FP programs were established. The number of clinics providing FP services increased from two to 210 between 1983 and 2004 (Solo, Jacobstein, and Malema 2005).

The use of modern FP methods has increased significantly as evidenced by the upward trend of the contraceptive prevalence rate; the percentage of currently married women age 15–49 that use modern FP methods increased from 7.4 percent in 1992 to 42.2 percent in 2010 (NSO and ICF Macro 2010). This is far higher than the average figure for sub-Saharan Africa where the proportion of married women aged 15–49 using any method of contraception was 22 percent in 1998 (United Nations 2011).

Figure 1 depicts the use of various FP methods for the period 1992–2010 in Malawi and shows that the injectable FP method (Depo-Provera) is the most preferred method followed by female sterilization. Use of the pill has remained stable around 2 percent over the years.
Figure 1: Percentage of Married Women Using Various FP Methods, 1992–2010

Figure 1. Percentage of married women using various family planning methods, 1992–2010. (Implant data not available for 1992.)

1.2 The Problem
It is clear that Malawi has achieved significant progress in the use of modern FP methods. However, despite this achievement, the total fertility rate (TFR) in Malawi is still high at 5.7 children per woman (NSO and ICF Macro 2010). Furthermore, compared to women who use contraception, a greater proportion of women do not, and a significant proportion of non-users do not intend to in the future. Socio-economic differentials are also noted in contraceptive use. For example, use of modern contraception in 2010 was 48.4 percent among women in the wealthiest quintile compared to 34.9 percent in the least wealthy quintile. Similarly, use of modern contraception among women with post-secondary education was 49 percent, which is 12 percentage points more than that of women with no education (NSO and ICF Macro 2010). It is therefore important to address the social norm aspect of FP use and increase use of modern FP methods, especially among specific population groups in Malawi using effective social and behavior change communication (SBCC)\(^1\) interventions.

Several studies have identified barriers to modern FP use in Malawi including poor knowledge of how to use FP methods and misconceptions about some of them; side effects from some methods; inadequate counseling; disapproval of FP use by men and community leaders; poor partner communication; the need to travel long distances on foot to access FP services; and unaffordable costs of these services in some settings (Biska 2008; Lawrence 2002; Barden-O’Fallon 2005; Munthali, Chimbiri, and Zulu 2004). These studies being mostly quantitative in nature were not able to yield adequate information on the societal and community norms and values that produce and sustain these barriers. The few qualitative studies that have addressed societal norms underpinning these barriers to FP use did not seek advice from community members on what might be done to reduce or minimize them. Since messages in FP communication materials are likely to be more effective when they address the underlying norms/values that produce and sustain the barriers to a desired outcome, it is essential to not only identify the barriers to FP use but also to understand the social norms and values that produce and sustain the barriers.

1.3. Aim and Objectives of the Study
This study on the socio-cultural context of women’s and men’s FP decisions and fertility behaviors in Malawi was conducted to generate evidence to inform the development of effective SBCC strategies and interventions for improved sexual and reproductive health and the uptake of modern FP methods. Its specific objectives were to:

- Identify factors that facilitate or constrain the use of modern FP methods in Malawi
- Assess the availability and use of FP communication materials in health facilities

2. Methods
The study was conducted in five districts of Malawi: Lilongwe, Mzimba (Northern Region), Dedza (Central Region), Machinga, and Thyolo (Southern Region).

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\(^1\) SBCC makes a conscious and consistent effort to address social factors that influence health. While change often starts with an individual, it needs to be manifested in social norm change, group change, policy or structural change in order to be sustainable. SBCC, therefore, includes approaches like social mobilization and advocacy that are typically not included in traditional definitions of behavior change communication (BCC). BCC methodologies emphasize analysis of behaviors and their determinants to focus on negotiation with the individual or community for behavior change by affecting knowledge, attitudes, behavior, and practices. BCC is thus part of SBCC while SBCC builds on BCC. (Adapted from C-Change E-Learning Course for USAID)
Both qualitative and quantitative methods were employed. The qualitative component included 25 focus group discussions (FGDs) with adult men and women. The quantitative component included a three part health facility survey: a client exit survey with 598 clients; a health provider survey with 90 staff at different levels; and an inventory of the FP communication materials in 30 health facilities.

2.1 Focus Group Discussions
FGDs were used to: determine participants’ perceptions of current barriers to FP use; examine cultural and community beliefs, values, and norms that create and sustain these barriers; and obtain participants’ recommendations on what should be done to minimize or remove the barriers.

The study conducted 10 FGDs in Lilongwe urban, three in Lilongwe rural, and three each in the rural districts of Machinga, Mzimba, Thyolo, and Dedza. Participants were separated into 10 male groups and 15 female groups of six to eight participants. In each of these, all participants were either age 25 and older or between the age of 18 and 24.

FP coordinators in each district organized the FGDs and the venues in conjunction with the Health Surveillance Assistants (HSAs). All FGDs were digitally recorded and a note taker was always present to take notes and manage recorders. Pilot studies were conducted at the Chitedze and Diamphwe health centers to test the facility survey and FGD tools. Lessons learned from the pilots were incorporated into the final versions of the tools.

2.2 Health Facility Survey
The 30 health facilities selected for the health facility surveys were chosen from a list of all facilities providing FP services in the five districts. Except for Lilongwe urban, where all 10 facilities were included, four facilities were randomly selected in Lilongwe rural and each of the following rural districts: Machinga, Mzimba, Thyolo, and Dedza.

2.2.1 Exit Interviews
Exit interviews were conducted with female clients using a structured interview guide. Respondents were systematically selected until a maximum of 20 were interviewed. In addition to demographic data, respondents were asked about services received that day; FP communication materials that clients had seen or used: whether the materials were easy to read or understand; what they had learned from them; and whether they considered the materials to be appropriate for married and unmarried men and women of all ages.

2.2.2 Health Providers
Data from health providers was collected using a questionnaire that solicited information on the types of services the providers offered; number of years of experience; and whether they had received in-service training in the past year. The questionnaire also covered questions on providers’ awareness of stock-outs of FP commodities and the availability of FP specialists and asked for details on the facility’s FP communication materials: availability, use, and whether the providers considered the materials to be effective and appropriate for unmarried and married men and women of all ages. Interviewers selected two or three health workers providing various FP services from different cadres of staff in each of the 30 facilities for a total of 90 interviews.

2.2.3 Inventory of FP Communication Materials
The third component of the facility survey took an inventory of all FP communication materials on display and in stock in the 30 facilities, along with related equipment such as video and audiotape players. Since the study was conducted within the health facility context, the materials were limited to information, education, communication (IEC) materials primarily. These materials are only one component of what would be needed to develop effective SBCC strategies. Trained field workers visited each facility, met with the person in charge, examined public and storage areas where FP communication materials were kept. Moreover, they observed FP counseling and examining rooms and collected information on the number of women receiving different FP services at each facility, its operating hours, the availability of FP staff, and locations where FP services were offered.

2.3 Data Analysis
Although 25 FGDs were conducted, only 24 could be used in the analysis. One FGD with women 25 years and older conducted in Lilongwe urban was excluded because of poor recording and transcription. Data collected from the FGDs were analyzed using the computer package ATLAS Ti. Themes and concepts emerged, and codes were generated from the discussion guide and the transcripts. Once all transcripts were coded, matrices were developed to examine each code in detail for sub-themes, nuances, and patterns. Thematic analysis was conducted using ATLAS-Ti. FGDs were recorded, translated and transcribed from Chicewa and Chitumbuka into English.

2.4 Ethical Considerations
Ethical approval was obtained from the Institutional Review Board used by the C-Change project in Washington, DC, and from the National Health Science Research Committee in Malawi. Permission to conduct the study was also obtained from the respective district health offices (DHOs).

The study included no invasive or medical procedures of any kind, and participation was strictly voluntary. Training provided for research assistants emphasized the importance of obtaining informed consent and avoiding coercion of any kind. All those recruited were assured that refusal to participate in the study would not result in any loss of health services, and measures were taken to ensure the respect, dignity, and freedom of each participant. The purpose of the study was explained to all participants, and a short paragraph summarizing the study and their role in it was read to them before they were asked to sign a consent form or give verbal consent.

Consent forms were separated from the questionnaires and housed under lock and key. Information from the consent forms was not entered into the study database or recorded anywhere else. To guarantee anonymity, each individual questionnaire was identified with a code. Names of FGD participants, their addresses, and any other identifying information were not entered on recordings or transcripts. Each participant was assured of confidentiality and asked not to disclose or repeat any parts of the discussions. Respondents were also assured that the study did not seek to assess individual providers or their facilities.

3. Results

The study employed both qualitative and quantitative methods allowing for triangulation of findings across the four main data sources (FGDs, client and provider interviews, and facility inventories of FP communication materials). The findings are summarized in this section of the report by main study themes rather than by data source. This section begins with brief demographic characteristics of clients and providers interviewed, followed by the findings organized under the following sub-sections:
3.1 Demographic Characteristics of Respondents

3.1.1 Client Exit Interviews
A total of 598 female clients exiting the 30 selected facilities were interviewed. The mean age of respondents was 27.5 years (SD=7.6). About 90 percent of the respondents were less than 35 years old and reported they were married; 87 percent had primary or secondary-level education. Two-thirds of the sample (66 percent) was Protestant and less than 20 percent were either Catholic or Muslim respectively. The socio-demographic characteristics of the respondents are provided in Table 2.
Table 2: Socio-Demographic Characteristics of Female Client Exit Interview Respondents

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Percent</th>
<th>n=564</th>
</tr>
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<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18–19</td>
<td>11.2</td>
<td></td>
</tr>
<tr>
<td>20–24</td>
<td>28.9</td>
<td></td>
</tr>
<tr>
<td>25–29</td>
<td>27.8</td>
<td></td>
</tr>
<tr>
<td>30–34</td>
<td>21.3</td>
<td></td>
</tr>
<tr>
<td>35–39</td>
<td>9.0</td>
<td></td>
</tr>
<tr>
<td>40+</td>
<td>1.8</td>
<td></td>
</tr>
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<td>Total</td>
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<table>
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<tr>
<td>Primary</td>
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<td>Secondary</td>
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<td>Higher</td>
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<tr>
<td>Total</td>
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<table>
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<tr>
<td>Catholic</td>
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<td>Protestant</td>
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<tr>
<td>Muslim</td>
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<tr>
<td>Other</td>
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<tr>
<th>Marital status</th>
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<tr>
<td>Ever married</td>
<td>89.9</td>
<td></td>
</tr>
<tr>
<td>Never married</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

3.1.2 Health Provider Interviews
Of the 90 health providers interviewed, the majority were females with a mean age of 38 years (SD=11.6). Almost half of the sample was made up of nurse midwives (42 percent); HSAs or social workers were the second largest group (30 percent). The average number of years of experience was 13 years (SD=11), with a range of less than a year to 45 years. Most of the providers (54 percent) were employed in health centers with maternity wards and 26 percent worked in hospitals. The rest were employed in private and NGO health facilities, including BLM clinics. The demographic data and other characteristics of the health providers interviewed are depicted below in Table 3.
Table 3: Demographic Characteristics and Work Experience of Health Providers

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
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</tr>
<tr>
<td>20–24</td>
<td>11.5</td>
</tr>
<tr>
<td>25–29</td>
<td>37.7</td>
</tr>
<tr>
<td>30–34</td>
<td>21.3</td>
</tr>
<tr>
<td>35–39</td>
<td>19.7</td>
</tr>
<tr>
<td>40+</td>
<td>9.8</td>
</tr>
<tr>
<td>Total</td>
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</tr>
<tr>
<td><strong>Gender</strong></td>
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\(^2\) The “other” category includes reproductive health advisors, counselors, medical and clinical assistants, community nurses, clinical officers, and counselors involved in voluntary HIV testing and counseling.

\(^3\) “Other” includes clinical, public health, and outpatient departments; voluntary counseling and testing units; general and medical wards; maternity, pediatric, and under five departments; emergency units; TB registries; environmental community; and reception.
3.2 Marriage

3.2.1 Values and Norms Relating to Marriage
Most FGD participants stated that marriage is the norm for adults in Malawi. The exit interviews with female clients reflected this norm where 90 percent of the sample reported being married. With the exception of a few FGDs from Lilongwe and Dedza, where there are reportedly higher concentrations of migrant laborers and sex workers, FGD participants were in consensus that most adults in the study areas are married.

Most believed that the decision to marry is made jointly by a man and a woman in love. However, some participants indicated that the decision to marry is made by the man alone or by parents and that some marriages are arranged.

*Parents don’t usually get involved in choosing marriage partners.*
Female FGD 25+, Machinga

The most common reason for getting married reported by both women and men was that marriage allows sexual desires to be satisfied in an acceptable way. Other common responses included the need to help with household chores, fulfill expectations after reaching a certain age, and for love and companionship. A fewer number of FGDs reported that people also get married to promote unity; earn community respect; gain independence from parents or avoid difficulties with them; and escape peer pressure. Women also cited pregnancy and economic reasons to get out of poverty and have financial security as additional reasons for getting married.

3.2.2 Gender Roles in Marriage

FGD participants of both genders were asked about what they thought husbands, family, and community members consider the role of a woman, especially within marriage, to be. The most common role discussed by both women and men was that of performing household chores such as washing clothes, cooking food, drawing water from the well, etc. The participants also reported that in some places relatives of the man expect her to do almost all household chores for the man and the in-laws.

*It is the woman’s responsibility to make sure that there is harmony in the home, that food is available, and that the family is happy and healthy. She should also be able to welcome visitors, too.*
Female FGD <25, Machinga

*According to culture, relatives expect her to work for them more like a slave and not take part in any decision-making processes in the family. She should just be obedient to the husband and satisfy his needs. Even when it comes to the number of children the family is to have, it is the man that dictates almost all the issues in the house. Relatives would want the husband to be the one making decisions unilaterally.*
Male FGD 25+, Lilongwe urban

About half of the FGDs also mentioned that a wife is expected to be faithful to her husband and have sex with him whenever he wants. Women who refuse to provide sex to their men are viewed with suspicion by their husbands and are suspected of cheating.
The first duty, which a woman is expected to do, is to provide sex to her husband. The second duty is to offer help in the household chores...
   Male FGD 25+, Lilongwe urban

We are expected to have sex with them...There are some men who want to have sex all the time; as a woman you must provide...
   Female FGD 25+, Dedza

Women who refuse to have sex with husbands tend to raise suspicion that maybe they are having sex with other men... Such marriages tend to disintegrate or the man would start to seek gratification outside marriage.
   Male FGD 25+, Lilongwe urban

Bearing children was the third most cited expected role of a married woman.

As men, we would want our faces replicated; hence we want the woman to be able to give birth to our children.
   Male FGD 25+, Lilongwe urban

In addition, a common expectation of community members was that married women are friendly to people, cheerful, and active in the community. They believed that the general outlook of a family is expected to change when a woman arrives, and that she is expected to look after her family, do all the household chores, take care of her in-laws, participate in development/community work, and engage in small-scale business. She is expected to assist during funerals, provide marital counseling to other women, and be present when a chief calls for meetings.

3.3 Fertility Desires and Decision Making
Most of the FGDs reported that the ideal number of children that men and women want ranges from three to five. There were a handful of FGDs that reported that men and women want six to 10 children. For the most part, participants reported that a couple makes the decision about the number of children they want to have. In some cases, only the man decides, and occasionally relatives influence the decision.

In most families these days, it is the man and woman that agree on the number of children to have in a family. Relatives have no say; they just watch from a distance.
   Female FGD <25, Thyolo

This generally causes quarrels in the homes because when we ask for more children they always say, “Can’t you see that we already have enough children?” But because we have more power in the house, we still have the number of children we want.
   Male 25+, Lilongwe urban

3.3.1 Factors that Encourage Large Family Size
Although mostly a joint decision by the couple, pressure to have more children often comes from the husband and his relatives driven by social and cultural traditions such as:
• Fear of losing children to illness. Many couples saw the need to have more children than their desired number to compensate for those who might not survive childhood. This is related to parental hopes and expectations that their children will look after them in their old age, a strong tradition in Malawi.

> If you have only two children and God takes one, and then the measles finishes the other one, you will end up with no child.
  Male FGD 25+, Lilongwe urban

> ...for the poor, they think if they have more children, the children will help them in their old age; for the rich, they don’t quite care about support from children in their old age because they know they already have the wealth.
  Male FGD 25+, Machinga

• Desire to increase family income—a large family is a wealthy family.

> People say that children are wealth....Some of us would be happy if the number was reaching eight so that when children go for piece work, they can bring money that make you the man of the house indeed.
  Male 25+, Lilongwe urban

• Desire to increase power and influence of clan/lineage. Large clans can influence the appointment of village rulers or chiefs, and membership in one can contribute to political or social advancement.

> They usually want more children so that the clan grows. They want eight to 10 children, if you have four they are not happy.
  Female FGD 25+, Lilongwe urban

• Fear of losing husband to other women.

> They fear that the husband may go for other women. As a result, some women keep on having more children.
  Female FGD 25+, Mzimba

> Relatives expect the woman to bear children for the man and in the event that if she is unable to conceive, relatives find ways of making sure that he has children elsewhere.
  Male 25+, Lilongwe urban

Other reasons cited for having more children were to earn community respect or to have a child with the sex of choice. For example, in the Northern Region, some couples reportedly prefer to have female children because the lobola system exacts a bride price, usually in the form of cows, and more daughters improve the prospects of parental wealth.

> When you bear female children, you count that you have a lot of cows.
  Male FGD 25+, Mzimba

> Traditionally, when people get married, they are supposed to have children. If they have no children, the family is not respected.
  Male FGD 25+, Thyolo
FGD participants noted that a couple with no children may be called derogatory names and be taken to task by their relatives and their communities. Especially in rural areas, a married woman with no child may be ridiculed and her life made unbearable, and married men with no children may be considered to be not “man enough.” Some assume that couples who delay having children have been advised not to have them because one or both partners are HIV–positive.

*People would be laughing at them. Others will be saying that they are infertile; some would even coax the woman to have sex outside marriage in order to have a child.*
Female FGD 25+, Machinga

### 3.3.2 Factors that Encourage/Perceived Benefits of Small Family Size

Almost all of the FGDs cited the desire to provide quality care for their children and economic difficulties as the primary reasons for having fewer children.

*People are having fewer children these days because the cost of living is high, scarcity of land, school fees is not easy to get; that is why people are opting to have fewer children whom they can manage to provide for.*
Male FGD <25, Lilongwe urban

*In the past men wanted 10 to 15 children, but these days men are enlightened. They know how difficult it is to provide for the family, so most would want six, five, or even three children.*
Female FGD, 25+, Thyolo

*If there are many children in the house, there isn’t enough care; all the attention is on the newborn. The other children could easily die if they don’t get enough care from the parents.*
Male FGD, 25+, Thyolo

There was consensus that the major benefits of having fewer children was improved health for women and being able to send children to school and provide them with food and clothing.

*If there are more children, the woman gets weak and her health deteriorates. She is thus unable to take care of the home.*
Male FGD 25+, Thyolo

*Those that want four children say so because they want to be able to send them to school without problems.*
Male FGD +25, Machinga

Several FGDs also reported the delivery method (caesarian) as a factor in limiting more children.

*For instance in cases where a woman gives birth through an operation, the relatives get concerned and advise the woman to stop having children for fear of dangerous consequences such as death.*
Female FGD <25, Machinga
In the past, people could have 10 or 14 children. In the past, people never used to give birth through an operation; all deliveries were normal. These days, people have problems giving birth and many end up being operated on. The number of children one can have through an operation is limited: three or four children.

Female FGD <25, Mzimba

3.4 Perceptions that are Barriers to FP Use

FGDs highlighted several perceptions of men and women that are barriers to FP use. Common perceptions and misconceptions among both women and men included:

Perceived decrease in sex drive as a result of FP use.

*Some men do not like FP because it kills their sex drive. ...even for us women as well, we lose our sex drive. Sometimes we even reach the extent of refusing to have sex with our husbands due to the loss.*

Female FGD <25, Lilongwe urban

*Others say that it (FP) reduces sex drive in women using the injection. The husband as well loses his sex drive because the woman is no longer as exciting—sweet—as was previously the case.*

Female FGD <25, Lilongwe urban

Male FGDs reported that side effects are experienced by a man who has sex with a woman on a modern FP method, including faster ejaculation, frequent urination, and backache.

*In some cases, when we have sex with a woman who has had an injection, the sex is not as enjoyable and it is hard for us to ejaculate. It makes us afraid.*

Male FGD 25+, Thyolo

Female FGDs reported side effects from injections, contraceptive pills, and implants and some felt they had fallen ill much more often since starting FP. Some women reported that they used modern methods but discontinued their use because of perceived side effects. Moreover, many women who had been interested in FP use and heard about side effects became frightened and lost interest. Complaints included prolonged or non-stop menstrual periods, while others complained of persistent stomach pain, dizziness, headaches, swollen and painful legs, numbness in the hands, backache, nausea, breathlessness, vaginal pain, cessation of menstruation, and weight loss or weight gain.

*...Some women do not have their monthly period when they are using FP methods. The blood that was meant to come out in the form of monthly period thus accumulates in the stomach, and if the situation persists, it might lead to the woman’s death.*

Female FGD <25, Mzimba

*Some of us would wish to use the family planning methods, but drug side effects is the problem. It’s just that for some of us, our bodies react to the injection and it actually shows. A woman would have continuous menstruation until six months. After the six months even if you go to the hospital, you are not given any medication.*

Female FGD 25+, Dedza
Misconceptions also included the belief that contraceptive pills cause uterine tumors and that the injection causes cervical cancer. Long-time use of FP was also said to lead to stillbirths if users decided they wanted to have children:

...*Some think it (FP) causes tumors in the stomach and cervical cancer.*
Female FGD <25, Lilongwe urban

*Most people say that cervical cancer is brought about by the injectables, so for fear of the cancer, most women would opt to stop FP altogether.*
Female FGD 25+, Thyolo

*If you take the pill for long and get pregnant later on, the woman gives birth to a stillborn child. It is only when she tries a second time that she is able to deliver a live baby.*
Female FGD 25+, Machinga

Many women believed that husbands want their wives to keep having children out of selfishness, jealousy, possessiveness, and lack of trust of women who choose to use FP. There is a perception that if their wives were energetic and walking around instead of being busy with bearing and rearing children, other men might be attracted to them. To discourage use of FP methods, it was noted that men inform their spouses that the methods bring complications such as weight loss and problems like cancer.

Other reasons for male opposition to FP was that women using modern methods can have sex with other men without the fear of getting pregnant and being found out. This was reported as a pertinent issue for men in rural areas who leave their wives behind when they go to work in the mines in other countries. Before modern FP was introduced, wives who cheated on absent husbands were found out when they became pregnant. The injection was the modern method most opposed by men because of its reported tendency to prolong menstrual periods and cause them to be denied sex.

*Other men think that when a woman uses the injection, she wants to be sleeping around. For instance, if the man were to go to South Africa to work, maybe for five years, and leaves the woman behind, if the woman uses FP, people tend to think that she wants to be sleeping around and doesn’t want to get caught because she won’t be pregnant.*
Female FGD 25+, Machinga

The FGDs also brought to light the fact that men had opposed FP use by their spouses because they were not consulted by their spouses when making the decisions to use FP. Some men stated that they would have no problem with their spouses using FP had they been consulted earlier. With adequate consultation, they would have supported their wives using FP. This revelation highlights the importance of involving men in FP programs. Currently, most FP programs target women.

*If discussed and agreed to use FP, the husband has no problems. He would actually support FP because with fewer children, he is able to support the family well.*
Male FGD, <25, Lilongwe rural

The study shows that some women go for FP services without the knowledge of their husbands for fear that their husbands might oppose their use of FP methods. Even though the women know the benefits
of FP, their husbands might not, with the result that their husbands might not approve of them using FP methods.

*Yes there is a difference, all because of FP. People are now enlightened. Even if men refuse, women just sneak out and get an injection and stay put as if nothing has happened.*

Female FGD, <25, Machinga

FGD participants listed the following recommendations to encourage male involvement in decisions around family planning:

- FP counseling should involve both men and women as a matter of policy. Joint health education sessions should be held for men and women so both share FP concerns. Joint counseling will lead to improved attitudes and shared understanding of FP.
- Men should be targeted for awareness campaigns so that they become knowledgeable about FP.
- Men should be involved in door-to-door campaigns that educate people about FP and its advantages.
- FP clinics should take place during weekends to allow men to attend.
- Government should promote discussions of FP issues by taking advantage of gatherings that attract both men and women, such as talks in churches about HIV and AIDS. Approaches taken to create awareness about HIV and AIDS could work for FP.
- Chiefs should be lobbied to talk to men about FP whenever they have rallies in villages.
- Men who allow their wives to use FP should be identified and used as role models to speak to other men at functions in the villages.

FGDs also referred to family members who do not approve of FP because they want young couples to have more children than the couples themselves desire.

*In-laws from the husband’s do not like it (FP). Some relatives do confront the woman and accuse her limiting the growth of their clan.*

Male FGD 25+, Dedza

*For me, my parents- in-law are old and they keep telling me not to practice FP but rather keep bearing children.*

Female FGD 25+, Lilongwe rural

Family members are said to openly discourage the use of modern methods, especially if a couple has one or two children.

*They always ask, just one child and you want to start family planning?*

Female FGD 25+, Machinga

*They want to be like white people, just one or two children!*  
Female FGD < 25, Machinga

*Others ridicule you, saying that your peers have five children yet you only have two. What exactly do you do in your house?*  
Female FGD 25+, Machinga
FGDs reflected negative perceptions about FP use by many community members. Some reportedly consider FP use to be a sin and counter to the teachings of the Catholic church or other religious beliefs. Others mock women who use FP after having one or two children, accusing them of being afraid of childbirth or suggesting they use charms to conceive. FP opponents may also accuse women using FP of violating community norms. They may also predict drastic side effects, including premature death, later difficulties conceiving or delivering a child, and loss of sex drive.

They say you are slowing down the growth of the village population. They threaten you that FP will lead you to your premature death. As such the woman gets discouraged for fear of losing her life.
Female FGD 25+, Machinga

People tend to laugh at you when you get sick.... They say the sickness is due to the FP that you are using.
Female FGD <25, Lilongwe urban

3.5 Perceptions that Facilitate FP Use
Female FGDs referred to FP as enabling women and children to grow strong. Many stated that there is a perception that using FP for child spacing allows their bodies to take a break and regain strength before the next birth. Women who use FP look healthy and good and can also more easily engage in development work and small businesses and have the time and resources to meet the needs of their families.

It is good because we are freer. We can conduct businesses. There are some businesses that you can’t engage in when you have a small child.
Female FGD <25, Dedza

Most women are grateful. They know that with FP they will have good health and they will not be forced into unplanned pregnancies; giving birth up to 11 children. Those are things of the past when a couple could afford to have 11 children. Finding food is expensive these days unlike in the past. So, most women are grateful for the FP methods.
Female FGD < 25, Lilongwe urban

FGDs indicated that some men were positive about FP methods and felt that women using them were healthier and better able to contribute to the family’s well-being. This view is influenced by high rates of maternal mortality and poor health experienced by women who give birth frequently. Men were also said to appreciate that a woman on FP is more likely to look healthy and sexually attractive.

Other men, when they see their friend’s wife who is on FP, they tend to envy her because she looks good, strong, and healthy. They then ask as what they do to make the woman look so beautiful, and the husband says that the wife is on FP. The man then goes home and tells his wife to use FP.
Female FGD 25+, Machinga
For men who do not like using condoms, FP methods were preferred because sex can be enjoyed naturally.
Female FGD <25, Mzimba

It should be noted that not all family members discourage FP use. There are some who advise women, particularly those with many children, to adopt FP. Some family members advise a female relative to adopt FP because they want her to be healthy. Others are reportedly beginning to see the economic benefits of FP for their clans or communities.

Looking at what is happening these days, most relatives believe that FP is good. These days there aren’t much farm lands to go around; hence people have resolved to have fewer children.
Female FGD <25, Lilongwe rural

Other relatives would actually advise and encourage you to go for FP if they notice that the family has several of children and are still bearing more.
Female FGD <25, Thyolo

They are happy because they see a great change in you. You become young, strong, and happy and are able to engage in business. Sometimes you can even help with groceries and food whereas in the past you wouldn’t do any such things.
Female FGD <25, Dedza

Some community members recognized the benefits of modern FP, including that women have more time to participate in community activities and they and their children are healthier. FP use was seen by some community members as progressive and enlightened, and couples using it were seen to have fewer problems at home and more resources. Couples practicing child spacing were commended because their children are healthy and the women are attractive and serve as role models. Some participants in rural FGDs reported that children suffer from stunted growth, poor health, and malnutrition when it [FP] is absent.

3.5.1 Perceptions of the Benefits of FP and Its Future
FGDs reported the following perceived benefits of FP:

- Benefits for Couples, Families, and Communities: Child spacing enables parents to take good care of a small child before having another one. It also gives the woman time to regain her strength and promotes good health for her and her baby. This is particularly important if women have abusive husbands who do not take care of their families.
- A woman on FP looks attractive, sexy, and healthy, and her husband may not be tempted to have affairs.
- Women on FP can enjoy sex with their husbands at any time because they do not fear they will become pregnant. A couple also has more opportunities to have sex, due to temporary stoppages of menstruation that result from an FP method.
- The number of times a woman has to endure childbirth is reduced.
- Women on FP are able to contribute to the family income and community development through small-scale business and farming.

3.6 Availability and Quality of FP Communication Materials in Facilities
While FP knowledge was not a focus of this study, the availability of FP communication materials in facilities sheds some light on one of the sources of FP knowledge within the communities studied. Availability and quality of FP communication materials were assessed across all study components.

Most health providers (52 percent) stated that their facilities obtained their FP communication materials from district health offices (DHOs). Other main sources included MOH headquarters and Central Medical Stores (15 percent) and NGOs (13 percent). About two-thirds of the providers said that FP communication materials arrive at their facilities once a month. Five said they arrive once a year, three said once every six months, and three said once every three months. Over half the health workers (58 percent) said supplies of FP communication materials were adequate, while 42 percent said they were not adequate.

FGD participants acknowledged that their health facilities displayed educational materials on FP, including posters, videos, cassettes, books, flip charts, leaflets, and T-shirts.

> They would show us pictures of a woman who is pregnant but is carrying other smaller children, one on her back, another on her shoulder, yet she is also carrying a basket on her head. They then would ask us whether we believe that what we are seeing is true....

Female FGD 25+, Lilongwe rural

A few participants remembered being given a leaflet to take home. Some remembered seeing different FP methods being used as teaching aids and demonstrations on male condom use. Others said they were not shown any materials or teaching aids: health staff only talked about the subject. While a few participants said they had seen audiotapes and videos on FP at health facilities, no one said they had listened to an audiotape. Some reported that they watched videos that illustrated issues discussed during the consultation.

> No, they just explained. We were shown the actual FP methods, such as injection or pills, when one have chosen either of these methods. Otherwise we were not shown the materials.

Male FGD 25+, Machinga

> They would talk about the various topics and show us examples through video.

Female FGD 25+, Machinga

The perspective from client and health provider interviews provided more information on the types and quality of materials available and used in health facilities.

**3.6.1 Posters**

Most of the posters (>90 percent) were prepared in Chichewa and English languages. The posters displayed messages on different FP methods (34 percent), benefits of FP (32 percent), what FP is (10 percent), and how to use a particular FP method (10 percent).

Over 90 percent of health providers reported that the content was suitable for men and women of different ages. However, 37 percent of the health providers felt the posters were not culturally sensitive. Most health providers rated the posters as excellent in terms of content and ease of use and good in terms of their relevance and languages used. In addition, 32 percent of the health workers believed posters were the most effective communication materials available.
Over 61 percent of clients reported that they had seen FP posters in the health facilities and that the posters were located where everyone—not just clients seeking FP services—could see them. Among those, 44 percent reported learning about the benefits of FP; 22 percent learned about different FP methods; and 11 percent said they had learned how to use FP methods and where to obtain them. The majority of the respondents (83.7 percent) stated that the posters were suitable for married and unmarried men and women of all ages. About 91 percent of respondents felt that the content of the posters was easy to understand. However, this varied by area of residence; while 59 percent of those living in urban areas stated that the content was easy to understand, the corresponding figure for those living in rural areas was 47 percent.

3.6.2 Brochures
Though 31 percent of the health workers said that brochures were available in their facilities, only one in twenty clients (5 percent) said they had seen the brochure presented by interviewers. This could mean that brochures were kept in storage and not distributed.

Clients suggested that most brochures were in English and not in Chichewa, the widely used language in Malawi. Most brochures were seen to be excellent or good in terms of content, relevance, ease of use, and language used, despite the complaints about the use of English. Among health workers, 31 percent said brochures were ineffective in communicating FP messages, given the country’s high rate of illiteracy.

3.6.3 Charts
Charts were reported to be the most readily available FP communication materials in the health facilities. Most charts were prepared in Chichewa, English, and Chitumbuka. According to the inventory of FP communication materials, the charts conveyed messages similar to those of the posters and brochures mentioned earlier. The majority (91 percent) of the providers interviewed regarded the content of the charts as suitable for clients of all ages. Most health providers rated the quality of the charts as good or excellent for content, relevance, ease of use, and language and 28 percent referred to charts as the most effective among the different types of communication materials. About half (51.5 percent) of the health providers said that the charts were culturally sensitive.

3.6.4 Videos and Audiotapes
Very few health facilities had audiotapes and videos or the equipment needed to run the tapes. Only 10 percent of the health workers said these materials were available and only 3 percent of clients reported ever listening to an audiotaped message on FP during a health facility visit. Slightly more clients (7 percent) reported watching a video.

Most of the 30 health facilities had charts and posters on display at the time of the survey and few facilities had audiovisual materials on FP. Table 4 presents this information.
Table 4: Number of Health Facilities Displaying FP Communication Materials during the Survey

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<td>Brochures available for distribution</td>
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</tr>
<tr>
<td>Videos available</td>
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</tr>
<tr>
<td>Audiotapes available</td>
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3.7 Access to FP Services and Availability of FP Methods in Health Facilities

FGD participants reported that they could access FP services mainly from government health facilities, BLM clinics, and private clinics, some attached to farming estates. Moreover, mobile clinics staffed by personnel sent out by a nearby health facility distributed FP methods in their areas. These were said to be convenient because FP users did not need to walk long distances to access services. Cost was cited as an issue when choosing where to go to access FP services. When only fee-paying services are available, some women are not able to access them.

When asked to name FP methods they were aware of, the most common method discussed in all FGDs was injections, followed by condoms, implants, and pills. About half of the FGDs mentioned the “loop.” Methods that were cited by five or less FGDs were natural method (“you count the days and determine the fertile period”), vasectomy, tubal ligation, and traditional methods, which include the use of charms, roots, and herbs to prevent pregnancy. FGD participants stated that injections, implants, pills, male condoms, and IUCDs were available at their health facility. However, nearly all FGDs discussed the fact that access to methods is restricted when stock-outs of FP methods occur in facilities.

*Norplant—it is rarely available, and when it comes people have to book in advance.*

Female FGD <25, Mzimba

*S sometimes when you go for Norplant, they would tell you that they don’t have the material as such a person would go back empty handed and could sometimes get pregnant without planning.*

Male FGD 25+, Dedza

Stock-outs of FP methods also emerged in the health provider interviews. Close to half of the (13 out of 30) health facilities were reported to have had a stock-out of FP methods in the six months preceding the survey. Figure 2 depicts the FP methods that were reported in short supply in the health facilities according to health providers.
Figure 2: Family Planning Methods in Short Supply or Not Available the Past Six Months

![Pie chart showing family planning methods in short supply or not available in the past six months.]

FP methods reported to be in short supply such as Depo-Provera (injectable), the pill, implants, and male condoms may reflect high demand as suggested in other sections of this report.

About 60 percent of the exit interview clients reported that they had obtained FP services at the health facility where they were interviewed. Clients who did not obtain FP services provided various reasons including not liking FP and that the facility was too far from their house.

FGD participants made the following suggestions to improve access to FP services:

- Stock-outs of FP methods must be avoided. Female condoms should also be made available and women informed on how to use them.
- In health facilities, the rooms or areas where FP services are provided should be separated from those where antenatal services are provided to ensure privacy. A dedicated room and an adequate number of staff are needed.
- Facilities that offer FP services should open earlier and close later. Efforts should be made to have health workers visit people at home on weekends to talk to them about FP.
- Mobile FP clinics should be introduced to reach villages that are distant from health facilities, and clients should be made aware that they are there. HSAs could be used for FP distribution in very rural areas.
- There should be more awareness campaigns, T-shirts and other promotional materials, and videos and other educational materials in facilities. Messages should address potential side effects, where people can access services, and the benefits of FP.
- To be successful, the most popular FP methods must be available.
- Women’s forums should be created that share experiences with FP methods and their side effects. Associations or societies on FP should also be established in communities.

3.8 Quality of FP Services

This study assessed the quality of FP services from the perspective of FGD participants and using information obtained from health providers and the health facility inventories.

FP counseling were provided for an average of five days (SD=1.8): 13 health facilities opened for outpatient services six days a week; eight opened five days a week; and nine opened every day. Most health facilities provided services between the hours of 7:30 or 8 a.m. to 4:30 or 5 p.m.

Limited operating hours affected FP access for some FGD participants, who referred to FP services being available only once a week. According to FGDs, days and times for mobile clinics were not frequently or clearly communicated.

_They should be opening early enough and closing a bit late to enable people [to] do their household chores before leaving for the hospital._

Male FGD 25+, Lilongwe urban

Service quality and the reception provided at facilities were also seen to affect women’s access to FP services and continuance of these services. Female FGD participants said regular attendance for FP services at NGO–run health facilities such as BLM was encouraged because their staff were well trained and received clients warmly. In government health facilities and locations with few FP services, lengthy queues and long waiting periods were a particular issue. Participants said such queues had discouraged them from accessing FP in the past.

_...I have been to Mphezi Estate several times. The medical personnel are courteous and receive us warmly. They give us the injection and inform us about our next appointment date. When you go to the clinic, they treat us well and if you are having problems with a particular method, they assist you. They also explain to us the various methods available and ask us to choose the method that we like._

Female FGD <25, Dedza

_I stopped going to the government hospital because the health personnel would shout at me whenever I misplaced or lost the previous pack of pills that I had received. I thought the best_
option was to go to BLM and buy pills from there. At BLM they don’t ask questions about the previous packs....

Female FGD <25, Dedza

About half of the FGDs, especially the women FGDs, pointed to disrespect experienced from FP providers as an issue. In addition, FGDs testified that staff at government facilities with large numbers of clients often became emotional, treating clients disrespectfully and shouting at them and at times refusing to give them FP supplies for not understanding and following instructions. Some FGD participants said several providers in government facilities looked down on rural clients, while others reported chronic breakdowns in communication.

It is the rudeness of some health personnel, who send you back without assisting you. Sometimes they just shout at us for no apparent reason.

Female FGD <25, Lilongwe urban

The physical arrangement for FP consultations and cleanliness of the facilities were also important factors for service quality. FGDs indicated that privacy was compromised when the room was shared with antenatal and other services—integration of services with FP at the same location was something participants disliked about FP clinics.

The place should be dedicated to FP and not combined with other services as is the case now. Most people coming for FP would like to do it in secret, as opposed to being in public. The youth are one such group that require privacy when accessing FP methods. Usually they do not want their parents to know that they are on FP, thus mixing people tends to discourage would-be clients of FP.

Male FGD 25+, Lilongwe urban

The health facility inventories collected information on whether FP examination and consultation rooms in the health facilities afforded privacy to clients. Separate examination rooms for FP clients were provided in the majority (26 of 30) of the health facilities. Two facilities used barriers to separate consultation areas for FP and other clients, offering them visual and auditory privacy. Only one health facility had a shared examination room with no visible barrier.

Staffing for FP service provision in health facilities was also considered for the quality of FP services. Among health providers interviewed, 66 percent were from government health facilities and 18 percent belonged to BLM and NGO facilities. Half belonged to FP departments, nearly 20 percent were in maternal and child health departments, 7 percent were in HIV prevention and detection departments, and 23 percent were from other departments. Almost all (90 percent) of those interviewed said they provide FP services in their current positions. Most offered FP counseling, distributed contraceptives, engaged in HIV/AIDS counseling, and provided antenatal care. However, only 3.3 percent were FP specialists trained to treat and handle complications.

Training received by the health providers further reflects capacity issues. Only 18 percent of the health providers interviewed had received in-service training in FP in the 12 months prior to the interview.
FGD participants made the following suggestions on improving the quality of FP services:

- The practice of disrespecting or sending home women who did not properly follow instructions should stop. Managers of government facilities should educate the providers on communicating with clients and always treating them with respect.
- Health workers should have more FP training so they can recommend the right FP method.
- Health workers should also be open and inform women about possible side effects, rather than just relating the benefits of FP, and clients should be encouraged to report side effects they experience. Health facilities should also have a variety of FP methods available so that women experiencing side effects from one method can be given appropriate alternatives.
- In rural areas, communication problems between FP service providers and clients could be addressed through roundtable discussions.

### 3.9 Use of Family Planning

#### 3.9.1 FP Use among Exit Interview Respondents

The majority (76 percent) of the exit interview respondents reported that they had ever used an FP method to delay or avoid pregnancy. Furthermore, 74 percent said that they or their sexual partner were using an FP method on the day of the interview. Table 5 depicts FP use in relation to socio-demographic characteristics of exit interview respondents.
Table 5: FP Use in Relation to Socio-Demographic Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Ever use percent</th>
<th>p-value</th>
<th>Current use percent</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18–19</td>
<td>34.9</td>
<td>p=0.000**</td>
<td>86.4</td>
<td>p=0.324</td>
</tr>
<tr>
<td>20–24</td>
<td>74.2</td>
<td></td>
<td>78.2</td>
<td></td>
</tr>
<tr>
<td>25–29</td>
<td>85.4</td>
<td></td>
<td>75.4</td>
<td></td>
</tr>
<tr>
<td>30–34</td>
<td>84.2</td>
<td></td>
<td>71.3</td>
<td></td>
</tr>
<tr>
<td>35–39</td>
<td>80.4</td>
<td></td>
<td>68.3</td>
<td></td>
</tr>
<tr>
<td>40+</td>
<td>60</td>
<td></td>
<td>50.0</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>60.7</td>
<td>p=0.003*</td>
<td>59.5</td>
<td>p=0.145</td>
</tr>
<tr>
<td>Primary</td>
<td>78.4</td>
<td></td>
<td>74.2</td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>74.3</td>
<td></td>
<td>78.0</td>
<td></td>
</tr>
<tr>
<td>Higher</td>
<td>100</td>
<td></td>
<td>68.8</td>
<td></td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>79.3</td>
<td>p=0.017*</td>
<td>79.3</td>
<td>p=0.423</td>
</tr>
<tr>
<td>Protestant</td>
<td>77.6</td>
<td></td>
<td>72.3</td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>64</td>
<td></td>
<td>73.7</td>
<td></td>
</tr>
</tbody>
</table>

**p<0.001; *p<0.01**

As seen in Table 5, ever use of FP was more common among respondents 20 and older. However, among the 18–19 years olds who ever used FP, 86 percent were current users. FP was higher among Catholics and Protestants compared to among Muslims. A chi-square test showed a statistically significant association between ever use of FP and the three demographic characteristics: age (p=0.000), education (p=0.0026), and religion (p=0.0373). There is no statistically significant association between the demographic variables and current use of FP.

More than two-thirds of the respondents reported using injectable contraceptives, confirming the information received from the FGDs. IUCDs and female condoms were methods least used. Similarly, injectables were the most popular FP method among current users. Figure 4 presents the types of FP methods ever used and currently used.
Figure 4: FP Methods Ever Used and Currently Used by Exit Interview Respondents

Differences in ever and current use of implants, female sterilization, condoms, IUCDs, and the pill were observed. The proportion of those using injectables was the same.

Nearly 60 percent of clients reported that they obtained FP services at the health facility where they were interviewed.

3.10 The Future of Family Planning in Malawi

Facilitators of FGDs concluded discussions by asking for participant’s opinions on the future of FP in Malawi. Though some felt it was not bright because most women fear side effects and will not adopt modern methods, most were optimistic.

They stated that more women than ever are adopting modern FP methods, spacing their children, and avoiding problems associated with frequent pregnancy and childbirth. The numerous government- and NGO-sponsored TV and radio messages on FP and child spacing had contributed to this. Older women were also now educating their adolescent daughters about FP at home.

Participants said they had noted changes in FP use and child spacing patterns within their communities. Moreover, HIV–positive women are using FP to avoid HIV transmission. Fewer jobs, high prices, little disposable income, and the dwindling amount of land available for farming had also facilitated the adoption of FP and small-family norms.

Living examples in communities attest to the benefits of FP. Women who use modern methods are perceived to be healthier and more attractive, contribute more to their communities, and have children who are well cared for and healthy. Increasingly, men were coming to appreciate the benefits of FP and
cooperate with their wives to delay or avoid pregnancy, and this number of men is likely to grow, especially if more FP messages are directed to them.

4. Conclusions and Recommendations

The study findings highlight that while progress in FP knowledge and use has been made in study communities, several opportunities exist for SBCC interventions and other FP programs to improve FP acceptance and use.

Decision making around FP: Male partners and other family and community members exert significant influence over a woman’s fertility and FP decisions. In addition to women, it is important to develop an SBCC strategy targeting people who directly influence FP decisions including male partners, relatives, and community members. In particular, SBCC interventions must include separate messages targeting men to address sexual desire and performance issues relating to FP use and men’s roles in FP decision making. Communication and social mobilization efforts targeting family members and community leaders should address cultural preferences for large families, encourage support to young couples to plan their families, and emphasize the benefits of FP use. Religious and traditional organizations can also be targeted to include FP discussions in their activities.

Misconceptions and fears related to FP: Misconceptions and fears related to FP—including perceived side effects of FP use—still persist and limit the widespread use of modern FP methods. SBCC interventions should include targeted campaigns, activities, and accurate messages to correct misconceptions and fears around FP use. Health providers must be adequately trained to provide information regarding potential side effects of FP methods and be able to counsel clients who experience side effects.

FP services and products: In addition to socio-cultural barriers and knowledge gaps that constrain the use of FP, limited supply of popular FP methods and distance between communities and health facilities negatively impact FP use. Health facilities must ensure an adequate supply of FP methods at all health facilities to avoid frequent stock-outs. Health service providers should also establish outreach programs, using community health workers to raise awareness about the FP services available and to disseminate FP methods and FP communication materials to more remote communities.

FP communication materials: FGDs and facility surveys showed that posters and charts were the most widely available forms of FP communication materials in health facilities. Other materials such as brochures, audiotapes, and videos, were less readily available. FGDs noted a number of ways to strengthen existing FP communication materials such as: ensuring that FP communication materials are culturally appropriate, targeting those who influence decisions around FP use, and ensuring that materials are accessible to clients with low literacy rates by incorporating more graphics and artwork. FGDs also noted the potential of videos as a means of disseminating FP messages. Further research is needed to examine the effectiveness of videos in delivering FP messages. The study highlighted much potential for more interactive forums to encourage dialogue and communication around the benefits of FP and address the socio-cultural barriers to FP use.
5. References


