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The influence of service provision barriers on contraceptive use and method choice among young married women in Malawi

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Abstract

Despite high levels of awareness about contraception and modern contraceptive methods, the levels of use have remained low, and method mix has been limited among young (15-24 years) married women in Malawi. This has culminated in persistent high adolescent fertility.The 2024 Malawi Demographic and Health Survey (MDHS) revealed Age-specific fertility rates (ASFR) among women aged 15–19 to be 136, while the 20–24 age group had the highest at 216 births per 1000 women, among all age groups in Malawi. Consequently, they contribute disproportionately to the country's high total fertility of 3.7 children per woman. However, there has been a dearth of studies that have focused on what influences the sexual, reproductive and contraceptive practices of young married women as a distinct group. The study investigated the influence of barriers to service provision on young married women's contraceptive use and method choices. This was a qualitative study that used Key Informant Interviews (KIIs) as the data collection tool hence the results emanate from 24 KIIs with health workers from 12 health facilities in the districts of Ntcheu, Zomba and Mangochi. The study used a framework approach and ATLAS.ti 7 to analyse and interpret the data thematically. The results have revealed several service-related barriers. Service providers, particularly those located in rural communities, harbour negative attitudes towards young women's use of contraceptives. There are impositions of restrictions based on parity, partner consent or onset of menstruation to prevent young married women, particularly the nulliparous or those with only one child, from accessing and using contraceptives such as hormonal methods, whose use they deem premature and inimical to their future reproductive capacity. These mainly stem from social and cultural norms that influence providers and their practices, and are also shaped by their concern about reactions from the communities. To enhance young married women's utilisation of contraceptives in the early stages of their reproductive lives, there is a need to broaden the reach through community-based interventions that are inclusive of parents and community religious and traditional leaders. The engagement of these gatekeepers would play a critical role in shaping social and cultural norms pertaining to values attached to childbearing and children.

Introduction

As a consequence of reduced mortality and a lag in fertility reductions, Malawi, a landlocked country of nearly 22 million people, has a youthful population structure with a median age of 17 years. Close to two-thirds of the

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population is under 25 years old. The structure entails that every year, a large wave of female youths enters the childbearing ages, while others reach the peak of their childbearing lives (Government of Malawi, 2018). However, Malawi has made progress in the sexual and reproductive health realms. This has been noticeable in its remarkable reduction in total fertility rate (TFR) from 5.7 in 2010 to 3.7 in 2024. The reductions were observed across all age groups. This notwithstanding, the age-specific fertility rate (ASFR) among women aged 15–19 decreased by only 11% (from 152 to 136 per 1000 births), compared with at least an overall 19% reduction in the other 5-year age groups of women during the same period. It was also noted that the 20–24 age group had the highest age-specific fertility rates (ASFR) among all age groups in Malawi. Additionally, the percentage of women aged 15–19 who have begun childbearing rose from 25.6 in 2010 to 29.0 in 2014, and this age group has the highest unmet need for contraception among sexually active women of reproductive age.

The demand for contraceptives among young married women is 60.3 percent and 74.0 percent for age groups 15–19 and 20–24 respectively. Despite apparent high levels of awareness of contraceptive methods, the level of use has remained low among young married women. Only 38.1 percent and 55.6 percent use contraceptives in these respective age groups. The unmet need is 19 percent overall; it is 22.2 percent among the young married women aged 15-19. In terms of contraceptive method mix, the latest studies using MDHS data have shown that injectables (long-acting (3-month) Depo-Provera) are the most prevalent method among married women in the country, with a prevalence of 30 percent, followed by implants at 12 percent and female sterilisation at 11 percent. This reveals that these three methods account for 91.4 percent of all contraceptive use in Malawi (NSO & ICF Macro 2017).

Consequently, early marriage among girls and young women is a common phenomenon in most of the rural areas of Malawi and is tied to early sexual debut. Within the cultural set-up, attainment of menarche is construed as readiness for sex and marriage. The 2016 MDHS indicated that marriage is nearly universal, with women marrying about 5 years earlier than men, on average. The median age at first marriage is 18.2 years for women and 23.0 years for men aged 25-49. Early marriage is one of the most adverse SRH risks as it is also tied to early sexual debut and increased early and unintended pregnancies. This further entails early childbearing and early exposure to the risk of contracting STIs, including HIV (Mon & Liabsuetrakul, 2012; Levandowiski *et al*., 2012). This is because, unlike unmarried ones, young married women experience early, more frequent and unprotected marital sex (Cleland *et al.*, 2006; Munthali *et al.*, 2006). The benefits of contraceptive use among young married women are particularly prominent. For example, family planning practice prevents unintended, often high-risk pregnancies among this group of women. It also contributes to the fight against HIV and AIDS in the sense that some barrier methods of contraception, such as condoms, also provide protection against sexually transmitted infections (STIs), including HIV. This entails further protection of the next generation from HIV infection by reducing levels of childbearing among HIV positive young women. In the process, this eliminates and reduces mother-to-child transmission (Cleland *et al*., 2006; Smith *et al*., 2009).

The current set-up for family planning service provision is that services are provided free of charge in all government and Christian Health Association of Malawi (CHAM) facilities. The public sector is the predominant source of contraceptives, catering for 74 percent of all users. *Banja la Mtsogolo*, a local affiliate of Marie Stopes International, Family Planning Association of Malawi (an affiliate of International Planned Parenthood Federation), are also a main player as a non-governmental organisation (Government of Malawi, 2013). The country's family planning and contraceptive guidelines are covered in the Sexual and Reproductive Health Policy of 2017-2022, which states that every sexually active individual is free to access contraceptive information and services voluntarily, irrespective of age, marital status or parity (Ministry of Health & Population, 2017).

There has been a dearth of studies, particularly in Malawi, that have specifically focused on understanding the attitudes and practices of service providers towards contraceptive practices of young (15-24) married women as a distinct group with peculiar circumstances, challenges and contexts. The study has been anchored on the core assertion that as cohorts of young women, arising from past and current high fertility levels in the country, enter into childbearing age bracket, their sexual, reproductive and contraceptive attitudes and practices are likely to

shape and determine the pace of the country's population growth and size and the overall social and economic development of the country. Understanding what influences their sexual, reproductive and contraceptive practices is critical in coming up with evidence-based policy directions and programme interventions.

Data sources and methods

The aim of this qualitative study was to investigate service providers' attitudes and practices that can influence contraceptive use and method choice among young (15-24) married women in Malawi. To investigate these attitudes and practices, focus group discussions and in-depth interviews with young married women and key informant interviews with health workers (family planning service providers) were conducted in Ntcheu in the central and Mangochi and Zomba in Southern Malawi as part of a larger study on SRH risks and contraceptive practices among young married women in Malawi.

The study was a qualitative cross-sectional one and used data from 32 key informant interviews with health workers from 12 health facilities and 12 focus group discussions (FGDs) with young married women drawn from 12 communities surrounding the health centres in the three districts. Data being collected was mainly on the attitudes and practices of family planning service providers and how they influence contraceptive use and method choices of young married women. Focus group discussions (FGDs) were chosen to gather information from the perspective of young married women, providing insights into collective and consensus views within their communities. Being issues that are sensitive but important to the participants, the FGDs helped open the young married women up, engage with each other, and generate their own opinions.

Four female research assistants, unknown to the communities, were recruited based on their knowledge and experience in conducting, transcribing and translating interviews and discussions; their strong conversational and writing skills, and their general ease and openness to discussing sensitive issues. All FGDs were conducted in Chichewa (the national local language) and audio taped after obtaining verbal consent from the study participants. All KIIs were conducted in English. The taped KIIs and FGDs were transcribed verbatim, and the FGD scripts were also translated into English.

The data were analysed using thematic analysis, which involved creating and applying codes to the data (Gibson, 2006). The transcripts were uploaded into ATLAS.ti Version 7 (Mohamad, 2014), a qualitative data analysis software used to code textual data by themes and to network themes and codes. The results are presented through selected quotes or excerpts that best capture the themes' substance and align with the study objectives.

Results

Parity restrictions

The study established that improvements in the availability and accessibility of contraceptive methods might not be sufficient to spur initiation and continuation of contraceptive use among young married women. It became clear from the interviews that there were some service providers who displayed negative attitudes and behaviours towards young married women. The attitudes militate against young married women's resolve and right to contraceptive choice and use. It transpired in the interviews that there were some service providers, especially those serving in the rural communities, who demonstrated strong feelings against young married women, particularly those without children or with only one child, using hormonal contraceptive methods such as injectables. In this respect, whether from a lack of adequate knowledge or deliberately, unnecessary parity restrictions are imposed on young married women regarding hormonal contraceptive methods such as injectables. Consequently, nulliparous women or those with only one child would be strongly discouraged from using this method under the pretext that it would lead to 'infertility' because of delayed conception after use. It became clear in the interviews that they would be so anxious about this method such that they would swiftly recommend method discontinuation or switching should women experience heavy or prolonged menstrual bleeding or amenorrhea fearing that it would disturb their reproductive system at such a tender age that may lead to possible fertility

problems in future. Other service providers hinted that they provide counselling in which they exaggerate the likelihood of side effects occurring with the intention of dissuading them from choosing and using hormonal methods. Some service providers expressed fears of living with a guilty conscience should the woman fail to have children in future after hormonal contraceptive use. The reported fear was that should the effects occur, the young married women would be socially affected and even isolated in a society that puts great value on childbearing and children. In this respect, they would urge the women to use condoms regardless of their circumstances, needs and contrary to their preferences. What could be deciphered from the discourse was that the service providers, just like the communities in which they operate, are also influenced by the prevailing social and cultural norms and beliefs on the value of childbearing and children in spite of their levels of education and professional training. These negative influences of health workers on contraceptive use were captured in the excerpts as below:

> *It happens that we provide Depo to these women and they come back and say we are not experiencing our menses; others come and say we are experiencing heavy flow. So, for a young woman who has not yet born a child, her body can be disturbed and fail to work properly. It is like making her body do tasks which it is not supposed to do at that time. It is too early for her body to do this work of using contraceptives.* [KII: Health Centre Worker, Zomba]

> *Actually you have a lot of feelings that this one does not have a child but comes to the clinic asking for injectables. It gives you a lot of questions as a provider because when we are learning about these family planning methods, we know that there are other methods that are not good due to prolonged monthly periods. For someone who has not given birth in her life time, she may have some complications in the future. This leaves us in a dilemma on how can I continue giving this person, she has no child but she is seeking contraceptives.* [KII: Health Centre Worker, Mangochi]

> *Every method has got its side effects. We are taught about advantages and disadvantages of all these methods. But when we start using them, one can experience the effects of these methods. So for one to start using these methods before giving birth, especially injection, I see that this can be a problem. One can develop uterus fibroids. We meet those problems. Others have ovarian cysts*. [KII: Health Centre Worker, Mangochi]

Spousal consent

It was also found that there were some service providers who still subjected young married women to unwarranted spousal consent restrictions, contrary to the country's family planning policy and contraceptive guidelines, which liberalised the provision of and access to contraceptive services by all women who need them. It was clear in the interviews that they felt ambivalent and uncomfortable providing contraceptives to nulliparous or one-child young married women who have not discussed their contraceptive use with their husbands. What could be deciphered from these interviews was that these service providers were in a dilemma between their professional knowledge about the benefits of contraception and the prevailing cultural norm of seeking husbands' consent as heads and decision makers of their families. It was found that the demand for husbands' consent was not necessarily because it was required, as per the guidelines, but because of fear of being accused by young married women's partners that they were promoting sexual immorality or were being accomplices in their women's sexual misbehaviours. It was noteworthy that this dilemma was common in communities where the health worker was the only family planning service provider at the health centre, or where the health worker's place of origin was in the same community. The expressions of the dilemma are captured below:

> *We have these restrictions that women should always come with their husbands to the clinic when they come to start using contraceptives so that men should also have the opportunity of receiving the advice on these contraceptives so that there can be no quarrels when some effects start to appear.* [KII: Health Centre Worker, Zomba]

> *For those who have their husbands around, we demand that they come with them because some of these methods have side effects. For the interest of these husbands, we ask for their presence or acceptance in case something happens.* [KII: Community Health Worker, Mangochi]

> *During community meetings we make sure to have both men and women discussing family planning methods. We do not want women to use the methods without the knowledge of their husbands.* [KII: Community Health Worker, Zomba]

During the study, some service providers reported cases where they had been confronted by the men or mothers-in-law of young married women. These cases, though not widespread, occurred particularly in Mangochi district, where many young husbands are absent due to temporary migration to South Africa for employment. They had suspicions that their wives or their daughters in-law were using contraceptives secretly with their encouragement. There were cases of some service providers who had been warned against promoting promiscuity among these women and were threatened with being held responsible should anything strange happen to the young women.

Proof of menses

There were also some providers who restricted young married women's access to contraceptives by requiring proof of menstruation as a precondition for providing a hormonal contraceptive method. It became apparent during the individual interview with young married women that this requirement restricted their access to contraception until their next menses appear hence running the risk of an unintended pregnancy in the interim. However, the World Health Organisation (2010) guidelines indicate that hormonal methods pose no danger to women or their pregnancies if unknowingly used while pregnant. What could be discerned was that these restrictions were mainly emanating from cultural norms that put great value on childbearing that they would not dare be jeopardised through careless provision of contraceptives to such young married women in the early stages of their reproductive and married lives. It was clear from the interviewees that these restrictions were causing a great deal of consternation among young married women who had already surmounted other difficulties including strong partner opposition to come for contraception. The subsequent quotes capture some of these women's experiences:

> *When you want to go to the hospital and have family planning methods, you should make sure that you are alright. You should not be pregnant or on your menses but should wait until you have experienced your monthly periods. At the hospital, we are only allowed to take family planning methods after fining the menstrual period.* [IDI: 22, 3 children, Mangochi]

> *The nurse said that since other bodies can respond immediately soon after stopping a method and be pregnant. They tell us that if you are using these methods while you are pregnant, you will have problems. So, they say that they always want to be sure.* [IDI: 19, 1 child, Ntcheu]

Lack of privacy and confidentiality

The study also found a lack of privacy and confidentiality in most health centres. This was particularly problematic for young married women, some of whom might want to use contraceptives without the knowledge of their spouses or would like to hide their use from family and community members. In all the health centres visited across the districts, it was found that the service providers had set days and times in a week and designated rooms for family planning services. What was clear from the study participants was that this arrangement limited their access to these services because it was hard for them to hide their use, as everyone would know that their visits or presence at health facilities on those days and times of the week were for the purposes of family planning. Both scenarios were found to be posing challenges as are aptly captured as below:

> *At the health centre where family planning services are provided it is the same space where we conduct antenatal and under-five clinics, so it is like we are doing many things in one room. And in this room, there are a lot of people. Some women use contraceptives in secret. They do not want people to know*

that they are practising family planning. It happens that they come to the health centre for contraceptives, but because of the people they find out, and in the room, some of whom can be their neighbours, they go back without getting these contraceptives. [KII: Health Centre Worker, Mangochi]

There are problems we encounter when we come to get the methods from this health centre because people would discuss you when they see you there. They say, "You are not supposed to obtain family planning methods because you are still young." [IDI: 20, nulliparous, Mangochi]

We have had some incidences such that some men would follow their wives to the clinic to see if they are getting Depo since we only provide the service on clinic days. [KII: Health Centre Worker, Ntcheu]

Heavy workload

From the interviews with the service providers, it became apparent that their quality of service provision was compromised by competing roles they must contend with. Their priority and people's expectations were that they must attend to patients with more pressing or life-threatening health conditions. The situation was found to be more desperate in facilities where there was only one health worker on hand to care for all clients across diverse services and patients with various ailments. It was also found that even in well-established health centres, family planning services were not treated as a priority, as they could only be provided on specific days or in the afternoon hours, when there would be reduced pressure from patients with more pressing medical needs. It was apparent that at the health centres, family planning clients were not taken as seriously as patients suffering from ailments such as malaria or pneumonia. This was found to be a great disincentive for they young married women as it took them a great deal of agency to overcome a myriad of hurdles to come to the health facility just for contraceptives when they were not even sick only to be met by poor or no services. They indicated that, due to their unique circumstances, they would want to be able to access contraceptive services at any time and whenever they visit a health facility for whatever reason. The subsequent quotes from a young married woman and service providers elaborate on these scenarios:

I opted for injection at that time because when you have it this month, you spend three months before having another injection. I noticed that regular visits to the hospital were problematic. As of today, I came early in the morning, but I found the nurses busy and up to now I have not received any help. [IDI: 20, 2 children, user, Mangochi]

A woman walks 10 kilometres going to a health centre expecting to be attended to at the right time. She finds the nurse is very busy with patients and she is only attended to very late after 12 noon. So next time she will be reluctant to go again. [KII: Community Health Worker, Zomba]

In interviews with service providers, it was also found that even in health centres with sufficient number of health workers, not every health worker was trained to be a family planning service provider. It also became clear that even among the trained service providers, not everyone was skilled in administering all the methods. For example, it was reported that most providers at community and health centre levels could not administer long-acting methods such as IUD and implants. This was found to be a serious constraint to accessing those methods by young married women because those particular health centres can be the only sources of family planning services in those communities. The effect of inadequate skilled staff is highlighted in the excerpts below:

We refer the woman to another facility where nurses are trained if she chooses a method that we did not have training in, such as the loop or Norplant. [KII: Health Centre Worker, Zomba]

The problem we face concerns the dates when we are supposed to go and have these methods. For example, with Nor-plant, which is inserted on the upper arm, this is supposed to be done by experts who know their work very well. When the trained person is not available, we are sent back without being assisted or we have to travel to a far hospital to get it. [FGD with 20–24, Mangochi]

> *When a woman has chosen a method of her choice, she is given that one as long as there is a nurse who was trained in that method. If there are no nurses, the client is given another date. If they come to me for Norplant, I simply refer them to the nurses because I am not trained to provide methods such as Norplant.* [KII: Health Centre Worker, Ntcheu]

Discussion

The study reveals that even after overcoming cultural and social restrictions and opposition from partners and family, young married women who present themselves for contraceptive services at service delivery points still face service-related barriers that hinder their access, use, and ability to choose a preferred method. There are attitudes and practices of some service providers, particularly those located in communities that harbour negative attitudes against young married women using contraceptives. These manifest themselves through the imposition of unnecessary restrictions such as parity, partner consent or onset of menstruation to prevent young married women, particularly the nulliparous or those with only one child, from accessing contraceptives or certain types of methods such as hormonal methods, whose use they deem inimical and premature. What could be deciphered was that the source of those attitudes was mainly social and cultural norms that influenced the provider's own beliefs, or through their consternation and concerns about reactions from the woman's family or community. In a study among service providers in Uganda (Nalwadda, 2011), similar findings were found where 38 percent of service providers requested consent from either a parent or a spouse or both when young women under 18 years requested contraceptives. On the issue of the onset of menses, a study in Rwanda (Brunie *et al.*, 2013) found that the practice of relying on direct observation of menses for ruling out pregnancy exposed post-partum women to unplanned pregnancies and discouraged initiation of contraceptive use.

Conclusion

These restrictions imposed on young married women as found in the current study are clear manifestations of the dilemmas some health service providers encounter between their cultural and societal beliefs and norms on one hand and the existing contraceptive policies and guidelines and the need to respect sexual and reproductive health rights of young married women on the other. This study has found that the former takes precedence. Similar findings had been reported in a study among service providers in Nigeria (Ahanonu, 2014) where, despite clear policies, more than a third of service providers did not perceive that contraceptives were meant for all individuals (married and unmarried) who need them. What can be asserted from the study is that refresher trainings, for example, that would simply provide evidence about contraceptives, and their safety, would be inadequate to eliminate these provider negative attitudes and practices. Broader community-based interventions that work with families and community leaders is critical. This is because these gate keepers play critical roles in shaping norms and traditions pertaining to value placed on fertility and children that influence service providers attitudes and practices and contraceptive use and method choices of young married women.

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