Factors Influencing Sexual and Reproductive Health Risks and Contraceptive Use Among Young Married Women in Malawi

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Thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Population Studies at the Mafikeng Campus of the North-West University

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November, 2015

Declaration

I declare that 'Factors Influencing Sexual and Reproductive Health Risks and Contraceptive Use Among Young Married Women in Malawi' is my work. It has not been submitted for any degree or examination in any other University and that all the sources I have quoted have been indicated and duly acknowledged by complete references.

Full Name : Benjamin Ndaziona Kaneka

Signed---------- **Date:**14/04/2016

) 2016

Dedication

To my mother who was instrumental in instilling the spirit of self confidence in me from a very tender age

Acknowledgements

This thesis is a result of accumulated support of many people that have collectively contributed to its completion. I am foremost profoundly grateful to my supervisor, Professor Akim J. Mturi who has been providing support and guidance throughout the course of conceptualising and writing of the thesis. There were countless times when I would be low and lost but his consistent and unwavering encouragement and support lifted me up and pulled me through. I really appreciate the timely and untiring reading and correcting, at times many times, of the pieces and the whole of this document. That superior level of patience is heartily acknowledged.

The study expenses were funded by the Research Focus Area (RFA) bursary in the Faculty of Human and Social Sciences, North West University (Mafikeng) while the financial contribution to my fieldwork costs was provided by the same bursary and the Faculty of Social Sciences at the University of Malawi, Chancellor College. My special thank you is extended to the then Director of the RFA, Professor Akim J. Mturi and later Professor Martin E Palamuleni and Mr. G. Mandere and Dr. L. Chiwaula, Head of Population Studies Department and Dean of Faculty of Social Sciences, University of Malawi, Chancellor College respectively for that financial and moral support.

I also express my heartiest gratitude to the young married women, community leaders and health service providers from the study sites in Ntcheu, Zomba and Mangochi districts who spared their time and trust to provide ideas and insights that have shaped the contents of this thesis. I am also indebted to the District Commissioners and District Health Officers in the three study districts, who facilitated the field data collection by providing permission and introductory letter that enabled the research team to visit the study sites and collect the data successfully.

The research would not have been possible without the hard work and dedication of the research team comprising Emmanuel Souza (Lecturer in Population Studies, University of Malawi) who

was the field supervisor, Binna Msiska, P. Gowoka, Mercy Mapemba and Bessie Msiska who were the research assistants. I thank you all.

I would also like to thank the entire academic and support staff in the Population Research and Training Department of the North West University (Mafikeng) for the various ways in which they supported me during the course of my studies. Special thanks to my colleagues Mica Katuruza, Charles Lwanga, Kudzaishe Mang'ombe, Kamil Fusien, Ken Machira, Elizabeth Nansubuga and Phidelia Doegah for being there for each other and support one another. I will always appreciate our sharing of ideas and the general friendship that kept us going even in hardest of times.

I am also indebted to the family of Professor and Dr Materechera for their parental, moral and spiritual support throughout the study. The leadership and membership of Montsioa International SDA Church in Mafikeng and SDASM at Northwest University (Mafikeng) is being appreciated for their spiritual support. I was not lost at all.

Lastly, my deepest gratitude goes to my wife Ellenata for her undying love, perseverance and understanding during the painful lonely days we shared while apart and also to my sons Brisco, Bornwell and Bryon for giving me the very reason and impetus I needed to persevere and finish the project that led to this thesis. I thank you guys.

List of Acronyms

AIDS	Acquired Immuno Defiency Syndrome
CHAM	Christian Health Association of Malawi
FGD	Focus Group Discussion
FP	Family Planning
HIV	Human Immuno Defiency Virus
ICPD	International Conference on Population and Development
IDI	Individual In-depth Interview
IHS	Integrated Household Survey
IUD	Intra Uterine Device
KII	Key Informant Interview
LAM	Lactational Ammernhorrea Method
MDHS	Malawi Demographic Health Survey
NGO	Non Governmental Organisation
NSO	National Statistical Office
PRB	Population Reference Bureau
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TRA	Theory of Reasoned Action
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WMS	Welfare Monitoring Survey
WHO	World Health Organisation

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Definitions of terms

The definitions of the terms youth, adolescents and young people often overlap in the ages being referred to. *Youth* are defined as persons aged 15-24 years while *young people* are defined as persons aged 10–24 that also comprise adolescents (10–19) and *young adults* (20–24) (WHO, 2006; Bankole & Malarcher, 2010). The focus of the study is what is being described as, for lack of a better terminology, young married women of the age group of 15-24.

Sexual health is the positive approach to human sexuality in which health care is to the enhancement of life and personal relations and not merely counselling and care related to reproduction and sexually transmitted diseases (WHO, 2007). What this entail is that sexual health is more encompassing than just sexual intercourse.

Sexual and reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes (WHO, 2007).

Sexual and reproductive rights imply that people are able to have a satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Pertaining to their rights, they are to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility and prevention of sexually transmitted infections including HIV. The rights include the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of sexual health, including access to sexual and reproductive health care services; seek, receive and impart information related to sexuality; sexuality education; respect for bodily integrity, choose their partner; consensual marriage; decide whether or not, and when, to have children; and pursue a satisfying, safe and pleasurable sexual life (WHO, 2007).

Sexual and reproductive health (SRH) risks include early sexual debut, early marriages, multiple sexual partnerships (serial or concurrent), early childbearing, unsafe abortion, inconsistent

condom use, unprotected sex, non use of other barrier or non barrier contraceptive methods, sex with non regular partner, sex under the influence of alcohol or drugs and coerced sex (Mon & Liabsuetrakul, 2012). The study limits itself to SRH risks of early sexual debut, early marriages and early childbearing.

Early or child marriage is described as a formal marriage or informal union in which a girl lives with a partner as if married before the age of 18 (UNICEF, 2010). Although, the early customary marriages in the rural areas continue to take place in total disregard of the country's legal age at marriage of 18 years, the study uses this internationally recognised age of less than 18 to describe early marriages.

Early sexual debut is defined differently by different scholars. Some scholars (Madkour *et al.*, 2010; Cavazos-Rehg *et al.*, 2010) have put early sexual debut to mean sex before the age of 16, others (Mmbaga *et al.*, 2012; Harrison *et al.*, 2005) have put it at 15 years. The legal age at first sex in Malawi is 16. This study has defined early sexual debut as sex that was initiated before attaining the age of 15.

Early childbearing is that childbearing that occurs before the age 18.

Contraception is defined as any deliberate practice undertaken to reduce the risk of conception by sexually active women (and their male partners) (Ngalinda, 1998).

Contraceptives are defined as any means or tools capable to prevent or reduce the frequency of conception (Akintade, 2011; Ngalinda, 1998).

Modern contraceptives method refers to contraceptives that are based on scientific knowledge of the process of conception (Akintade, 2011).

Injectables refer to the long acting (3 month) depot medroxyprogesterone acetate (Depo Provera).

Abstract

Young married women contribute a disproportionate share of Malawi's high total fertility of 5.7 children per woman. However, there has been dearth of studies that have focused on sexual, reproductive and contraceptive practices of young married women in the country as a distinct group. Using quantitative and qualitative methodologies, the study investigated factors that influence sexual and reproductive health risks and contraceptive practices among young married women in the country. Quantitative data drawn from the 2000, 2004 and 2010 Malawi Demographic and Health Surveys were used to analyse the levels and trends in timing of first sex, marriage, childbearing and contraceptive use and method choice among young married women. Individual in-depth interviews and focus group discussions with young married women and key informant interviews with traditional community leaders and health service providers were the methods used to generate qualitative data used for the study.

The study asserts that sexual and reproductive risks and contraceptive practices among young married women are a function of a multiplicity of influences most of which are external to young married women's control and agency. Such influences emanate from a range of sources that include partners, family members, friends and acquaintances individually or severally and are buttressed by the social, cultural and economic milieu young married women find themselves in. From the findings, it is concluded that young married women need multipronged and multi sectoral interventions that support the realisation of their sexual, contraceptive and reproductive health needs and rights beyond mere provision of information and services in these prime times of their reproductive years. Their situation is affected by the fact that they are young women who are in the early stages of their marital and reproductive lives. The study proposes a new mode of delivery of sexual and reproductive health and contraceptive interventions targeting married women by treating young married women as a special and underserved group with peculiar challenges and needs. In addition, the interventions should also be directed towards critical secondary audiences that include their partners, family members, community leaders and health service providers in a concerted and multisectoral approach.

CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.1 Introduction

In 2012, there were an estimated one billion young people aged 15–24, making it the world's largest cohort of young people ever (UNFPA & PRB, 2012). Early marriages (before age 18) are a common feature in the developing world. Approximately one in three adolescent women gets married before age 18 in the Sub-Saharan Africa (UNFPA & PRB, 2012). Young women who enter into marriage early face sexual and reproductive health risks as the state of being married early entails early exposure to frequent and unprotected sex, early pregnancies and early childbearing with their concomitant adverse outcomes (UNFPA& PRB, 2012; Cleland *et al.*, 2006a). Contraceptive use among young married women in Sub-Saharan Africa is low at less than 30 percent and is a major contributing factor to the high rates of pregnancies among this group of women (Munthali *et al.*, 2006a; Mon & Liabsuetrakul, 2012).

The World Health Organisation (WHO) estimated that over 16 million babies are born worldwide to adolescent women aged 15–19 and 1 million among women below the age of 15 each year accounting for a fifth of all births (WHO, 2014). Almost 95 percent of these births occur in low and medium income countries with the highest levels of adolescent childbearing recorded in sub-Saharan Africa (WHO, 2014) where more than half of women aged 20–24 were found to have had given birth at least once before attaining age 20 (Ppopulatioin Reference Bereau, 2013). The total number of births to young women may decrease more slowly than might have otherwise been the case because the sheer numbers of young women continue to grow as cohorts born in the past eras of high fertility reach the 15-24 age group. The largest cohorts of young people in sub-Saharan Africa's

history have currently been entering and moving through their reproductive years (Prata, 2009).

There has been a growing trend of falling in age at menarche, which implies earlier onset of sexual maturity and the ability to engage in sexual intercourse and procreate. In 2011 the average age range for the attainment of puberty was 12 (a range of 9-14) for boys and 10 (a range of 8-13 for girls) (Population Reference Bureau, 2013). Consequently, girls are increasingly becoming biologically mature enough to engage in sexual activity and expose themselves to early pregnancies, early childbearing and STIs including HIV infection at earlier ages; although they may not be emotionally and psychologically mature enough to understand the implications of their sexual activity and its attendant challenges (Munthali *et al.*, 2006b). This study examines the factors that influence the sexual and reproductive health risks of early sexual debut, early marriage and early childbearing and contraceptive practice among young (age between 15 and 24) married women in Malawi.

1.2 Statement of the problem and substantiation

The latest census of 2008 had shown that Malawi has a youthful population structure with a median age of 17 years. Close to 65 percent of the population is below the age of 25 years (Government of Malawi, 2009). The structure entails that every year a big wave of female youths enter into the childbearing ages while others reach the peak of their childbearing lives (Government of Malawi, 2013). 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. The 2010 MDHS revealed that a big proportion of young women had their first sexual experience at first marriage. This is an indication that early sexual debut is mostly tied to early marriage. The median age at first sex was estimated to be 17.3 years while for first marriage was 17.9 years, a small difference of half a year (NSO & ICF

Macro, 2011). The close relationship between early sexual debut and early marriage becomes further evident upon observing the sexual activity patterns among young women. For example, among girls aged 15-17 years, about 20 percent have had sexual intercourse, of those approximately 60 percent had it with a regular or in union partner (NSO & ICF Macro, 2011).

The 2010 MDHS found that among women aged 20-49, 75 percent had entered into marriage by the age of 20 and 13.5 percent of them before the age of 15 (NSO & ICF Macro, 2011). Using the MDHS 2010 data, the United Nations estimated that 26.2 percent of 15-19 year old women have ever been married, divorced or widowed. In addition, 50 percent of women between the ages of 20 and 24 were married or in union before they were 18 years old (United Nations Statistics Division, 2013). Within the cultural set up, attainment of puberty is seen as readiness for marriage; particularly for young girls. Further, many poor families in rural areas choose to marry their daughters off very young to improve the financial status of their daughters and themselves as parents (OECD, 2014).

Related to early sexual activity is the risk of early childbearing. The levels of fertility among young women aged 15–24 years in Malawi are high (Government of Malawi, 2013). The 2010 MDHS found that there were 152 and 269 births per 1000 women aged 15–19 and 20–24 respectively. It was also found that by 20th birthday; about 64 percent of women had already started the childbearing process, 57.2 percent had at least a live birth while 6.5 percent were pregnant with the first child. The median age at first birth was 18.9 years. It was also estimated that 34 percent of all births had occurred among young women aged 15 to 24. This means that fertility of young women continues to greatly contribute to the country's high total fertility rate of 5.7 per woman (NSO & ICF Macro, 2011).

The consequences of early pregnancies in Malawi are dire. Hospital-based data show that teenage pregnancies contribute in large measure to the high maternal mortality rates in the country. It is estimated that nearly 20 percent of all maternal deaths occur to young women below 20 years of age, while a combined group of 15– 24 year olds accounts for up to 40 percent of all maternal deaths in the country (Munthali *et al.*, 2006a). In addition, most of the pregnancies among young women are found to be unplanned; both unwanted and mistimed (NSO & ICF Macro, 2011). This often leads young women to seek unsafe abortions. Abortion is largely illegal in Malawi, except when the life of the woman is in danger (Levandowiski *et al.*, 2013) as such correct estimates are hard to come by. However, in a study by Levandowiski *et al.* (2012), it was found that half of the patients seeking post abortal care in the country's major referral hospitals were young women below the age of 25. It was also revealed in the same study that that 81 percent of all women seeking post abortal care were married, an indication of low contraceptive use and high unmet need for contraception including among young married women.

Early pregnancies and their consequences are not the only problems associated with early sexual activity among young women in Malawi. A study by Munthali *et al.* (2006b) revealed that young women who begin sexual activity early were also at a higher risk of contracting STIs including HIV. They contended that this is mainly because they are more likely to have sex with high-risk partners or multiple partners and are less likely to use protection. It is also reckoned that the presence of STIs is not only indicative of the level of unprotected sexual activity but that young women with STIs are more susceptible to HIV infection. The 2010 MDHS found that 8.9 percent of young women aged 20–24 reported having an STI or an STI symptom in the 12 months prior to the survey (NSO & ICF Macro, 2011). These self reports could possibly be underestimates because young people are often unwilling to reveal having an STI, they are mostly unaware of having it

and that many STIs tend to be asymptomatic particularly among females (Munthali *et al.*, 2006a). Further, it was also found that HIV infection rates were found to be highest in the age group of 15–24 with rates being higher among younger women than those of young men. The prevalence among women aged 15–24 years was 15.3 percent compared to 7 percent of the young men of the same age group (NSO & ICF Macro, 2011).

The analysis of 2010 MDHS data has shown that while young married women's levels of awareness about pregnancy, STIs and HIV preventive methods were high, the use of contraceptives for pregnancy and STIs (including HIV) prevention was low (NSO & ICF Macro, 2011). Over 95 percent of women aged 15–24 have heard of AIDS and almost all (99 percent) were aware of modern contraceptive methods[1] but only 26 percent and 38 percent of married women aged 15–19 and 20–24 respectively use modern contraceptives. In addition, unmet need for family planning is high at 24.9 percent and 26.5 percent among women aged 15–19 and 20–24 respectively (NSO & ICF Macro, 2011). What is apparent is that high levels of family planning awareness have not translated into use of contraceptives among this age group. This calls for investigations into the factors that are particular to this group of women that would explain this scenario.

There are demographic, social and economic reasons that make the study of SRH risks and among young women pertinent. For example, early marriage is one of the most adverse SRH risks as it is also tied to early sexual debut and increased early and unwanted pregnancies. This further entails increased recourse to induced abortions, 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,

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[1] Modern contraceptives include male and female sterilisation, oral contraceptives, the IUD, the injectables, the implant and male and female condoms (NSO & ICF Macro, 2011)

young married women experience early, more frequent and unprotected marital sex (Cleland *et al.*, 2006a; Munthali *et al.*, 2006a). 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 hence reducing their recourse to unsafe abortions (Smith *et al.*, 2009). 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.*, 2006a; Smith *et al.*, 2009). At a national level, contraceptive use can engender reduced fertility, slow population growth and reduce poverty and hunger (Bongaarts, 2011; UN Millennium Project, 2005).

There have been studies that showed that young married women are in a precarious situation. As explained above, their early entry into marriage entails exposure to risks of early sexual debut, unprotected sex, early pregnancies, unsafe abortions, early childbearing and possible early HIV infection (Munthali *et al.*, 2006b; Mon & Liabsuetrakul, 2012; Levandowiski *et al.*, 2012). Further, the gender dynamics, particularly in the rural areas, favour men such that young married women cannot make independent decisions about sexual, reproductive and contraceptive practices outside the influence of their marital partners (Hartmann *et al.*, 2012). Furthermore, there are always strong social and cultural pressures and expectations for young married women to start the process of childbearing immediately after they get into marital union (Zulu, 1998). Of critical importance is the fact that these young women do not always enter into marriage voluntarily as there are a

number of culturally dictated marriage arrangements[2] that precipitate early entry into marriages (MHRC, 2006; Sear, 2008).

Except for Jimmy-Gama (2009) and Munthali *et al.* (2006a), these studies have mainly been presentations of the descriptive analyses of these SRH issues. In addition, they have not interrogated the social and cultural contexts in which young people find themselves in as those can also influence these SRH risks and contraceptive practices. Further, whether they have targeted all women or focused on the young people, they have been generic in their target groups with little focus on young married women as a distinct group. This is the knowledge gap in the current body of literature. This study fills this knowledge gap by focusing on the mostly neglected, both in research and interventions, group of women, young married women (15–24) who, by virtue of both being young and married, find themselves in peculiar economic, social and cultural contexts quite distinct from other women groups.

It is further reckoned that most of these cited studies in Malawi that have focused on young women have been collecting information mostly from the young women. However, in most of these studies (for example, Jimmy-Gama, 2009, Kaphagawani, 2008, Mphaya, 2005) the young women have indicated that their attitudes and behaviours related to SRH risks and contraception have been shaped by the beliefs , norms and behaviours of significant others that include partners, family members, friends and health service providers. As highlighted above, these contexts can influence their SRH risks and contraceptive practices. The current study departs from that pattern by also collecting information from the perspectives of these significant others that include traditional leaders and health service providers.

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[2] A detailed description of these cultural arrangements is presented in chapter 2 on early marriages.

It is also reckoned that in the realms of SRH and family planning, the implementation of interventions has been guided by a number of policies and programme frameworks. Overall they have aimed at improving maternal and child health in line with the sustainable development goal (SGD) 3 (United Nations Organisation, 2015). These policies include the National Population Policy and the Reproductive Health Policy while the programmes include family planning, expanded access to Emergency Obstetric Care (EmOC) services and Youth Friendly Health Services (YFHS) (Government of Malawi, 2013; Jimmy-Gama, 2009). However, these studies, policies and programme have been generic in nature without focusing on young married women as a distinct group.

The study is meant to generate evidence that would inform and guide the development of effective and target specific policy and programme interventions aimed at the amelioration of sexual and reproductive health outcomes, increase levels of contraceptive use and reduce fertility among this underserved but critical group of women in Malawi. By targeting young married women some of whom are at their peak of childbearing, the new knowledge will contribute to the development of strategies that will improve the maternal and child health outcomes that will contribute to the attainment of SDG 3 in the country.

The study's core relevance is premised on the assertions by Bankole & Malarcher (2010) stating that as large cohorts of young women, arising from past and current high fertility levels, enter the childbearing years, their current sexual and reproductive behaviours will determine the growth and size of a particular population and the overall direction of social and economic development of a country.

As an academic pursuit, the findings contribute to knowledge and better understanding of relationships between early sexual debut, early marriage, early childbearing and contraceptive behaviour among young married women and the role they play in shaping

the country's fertility and population dynamics. By understanding these factors and their contexts, the study seeks to generate knowledge and provide evidence that will inform academic debate in the fertility, contraception and population realms.

1.3 Research questions and objectives

1.3.1 Research questions

The study addresses the following questions:

1. What have been the levels and trends in timing of first sex, first marriage and first birth among young married women in Malawi from 2000 to 2010?
2. What have been the levels and trends in contraceptive use among young married women between 2000 and 2010?
3. What are the factors that are associated with SRH risks among young married women?
4. What are the factors that are associated with contraceptive use and method choice among young married women?
5. What are the service delivery factors that influence SRH services' availability and accessibility among young married women in Malawi?

1.3.2 Research Objectives

The overall objective of the study is to identify factors that influence sexual and reproductive health (SRH) risks and contraceptive practices among young married women in Malawi. Specifically, the study set out to:

1. examine levels and trends in timing of first sex, first marriage and first births among young married women in Malawi from 2000 to 2010,
2. examine the levels and trends in contraceptive use and method choice among young married women from 2000 to 2010,

3. identify factors that are associated with contraceptive use and method choice among young married women?
4. investigate factors that influence SRH risks among young married women,
5. explore service delivery factors that influence SRH services' availability and accessibility by young married women

1.4 Study context

Malawi is a small land locked country situated in Southeast Africa covering an area of 118,464 square kilometres, a third of which is covered by the waters of Lake Malawi. It shares borders with Mozambique to the east, south and southwest, Zambia to the west and Tanzania to the north (Government of Malawi, 2013). The 2008 Population and Housing Census enumerated a total population of 13.1 million. The population had grown from 9.8 million people enumerated in 1998, giving an inter censual growth rate of 2.8 percent per annum (Government of Malawi, 2009; Government of Malawi, 1999). This rate of growth is rapid. A population growth rate is deemed rapid if its annual increase is 2 percent or more, equivalent to a doubling of population size every 36 years (Cleland *et al.*, 2006a). The recent (2012) population projections by the Population Reference Bureau estimated the population to be more than 15 million hinting that at the current rate of growth, the population would reach 45 million by 2050 (Population Reference Bureau, 2013). That size of population will likely have implications of increased pressure on social services and natural resources (De Negri & McKee, 2012; AFIDEP and PAI, 2012).

Administratively, the country is divided into Northern, Central and Southern regions that are subdivided into 28 districts (Palamuleni, 2011). The population density as per 2008 census is 139 persons per square kilometre. The population is predominantly rural with only 14 percent of the total population living in the urban areas (Government of Malawi,

2009) However, there are indications that the country is urbanising at a fast rate of 7 percent per annum. The United Nations Population Division projections show that by 2050, about 32 percent of Malawians will be living in urban areas (AFIDEP and PAI, 2012).

There are more than 20 ethnic groups in Malawi. However, the MDHS identifies nine major ethnic groups that include Chewa, Tumbuka, Lomwe, Tonga, Yao, Sena, Nkonde, Ngoni; Nyanja with the rest categorised as 'other' (NSO & ICF Macro, 2011). Each of these ethnic groups has its own customs, beliefs and norms and also varies in demographic and socio-economic characteristics. For example in terms of marital and kinship systems, the Northern region and the Lower Shire valley districts practice patrilineal system of kinship and also pay bride wealth as part of their marriage transactions while the rest of the districts are matrilineal and do not pay bride price (Palamuleni, 2011; Sear, 2008; Chimbiri, 2007). In terms of faith groups, about 55 percent of the population belong to a wide range of protestant churches, about 20 percent to the Catholic Church; another 20 percent to Islam and about 4 percent follow traditional religious practices (Government of Malawi, 2013).

The 2010 MDHS estimated the total fertility rate (TFR) to be at 5.7, a decline from 7.6 in 1992 (NSO & ICF Macro, 2011). With this high fertility, there are prospects that the population would continue to grow for another five decades or so even after attaining replacement level fertility of 2.1 children per woman due to the effects of population momentum as there is already high concentration of young people who are already born and are yet to go through reproduction (AFIDEP and PAI, 2012).

Malawi is generally underdeveloped. With a Human Development Index of 0.418, lower than the average of 0.475 for Sub-Saharan Africa, the country ranks 170 out of 187

countries assessed in the 2013 Human Development Report. The Gross National Income (GNI) per capita stood at $774, far below the average for sub-Saharan Africa of $2,010, and sixth from the bottom among the 207 countries worldwide (United Nations Development Programme, 2013). The most recent (2011) Integrated Household Survey (IHS) revealed that half (50.7 percent) of the country's population is poor and lives below the poverty threshold of $2 per day (NSO, 2012). The economy is heavily reliant on agriculture as about 81 percent of the population earn a living from agriculture and 80 percent of the nation's food comes from subsistence farming. In addition, agriculture accounts for 90 percent of all export earnings, 45 percent of the Gross Domestic Product and 67.3 percent of the total income of the rural poor (Government of Malawi, 2013).

Malawi's health system is overstretched due to rapid increases in population and high morbidity rates. The health situation analysis of Malawi is based on indicators such as childhood mortality rates, maternal mortality ratio and life expectancy at birth. Infant mortality rate is still high at 66 per 1000 live births; under-five mortality rate is at 112 per 1000 live births while maternal mortality rate is 675 women per 1000,000 live births (NSO & ICF Macro, 2011). Further, Malawi is one of the countries in sub-Saharan Africa with a high prevalence of HIV. The 2010 MDHS put the estimate of adults (15+years) living with HIV at 10.6 percent far much higher than the overall rate for Sub-Saharan Africa at 7.5 percent. Life expectancy at birth is at 51.4 years for females and 48.3 years for males (Government of Malawi, 2013; NSO & ICF Macro, 2011).

The health sector experiences a critical shortage of human resources that is worsened by inequitable distribution of services that favours urban areas at the expense of the rural areas where 85 percent of the population reside (Malawi Government, 2013). The inadequate number of both health centre and community based health services providers in

public facilities constrain the country's capacity to satisfy the demand for basic health demand including contraceptives and meet the country's family planning goals. The shortages of drugs, including contraceptive commodities and other medical supplies, also continue to be major challenges in the health sector. In this respect, most district health offices would run out of contraceptives because the inadequate funding allocated to their respective districts are directed towards the purchase of more pressing curative and preventive drugs. The arrangement is that the District Health Offices run the District Hospitals and the health centers in the communities and mobile outreach clinics (Government of Malawi, 2013).

Family planning services were first introduced in Malawi in the early 1960s by the government and international partners particularly the UNDP. However, due to poor presentation of its scope and objectives, public misconceptions ensued that forced the government to discontinue the services. It was only in 1982 that the Government approved the National Child Spacing Programme which focused on reducing maternal, infant and child mortality through lengthening of birth intervals (Chimbwete *et al.*, 2005). The first National Population Policy was approved in 1994 while the National Family Planning Policy and Contraceptive Guidelines were adopted in 1996 liberalising the practice of family planning in the country (Chimbiri, 2007; Solo *et al.*, 2005; Government of Malawi, 2013; Government of Malawi, 1996). Currently, family planning guidelines are covered in the Reproductive Health Policy of 2002 which highlights that every sexually active individual or couple is at liberty to voluntarily access contraceptive information and services irrespective of age, marital status or parity (Ministry of Health & Population, 2002; Government of Malawi, 2013). This entails that the country's reproductive health programme targets everyone, including young people, in tandem with the 1994

International Conference on Population and Development (ICPD) Plan of Action (United Nations Population Fund, 1996).

The current set up for family planning service provision is that the services are being provided free in government and Christian Health Association of Malawi (CHAM) facilities (Chimbwete *et al.*, 2005). The public sector is the predominant source of contraceptives catering for 67 percent of all users. *Banja La Mtsogolo*, a local affiliate of Marie Stopes International, is the most widely used private service provider and supplies 13 percent of all contraceptives in the country. Family Planning Association of Malawi (an affiliate of International Planned Parenthood Federation) is another main player in the private category of service providers. These Non Governmental Organisations charge low fees and use a number of service delivery options that include fixed clinics, outreach mobile clinics, community based distribution agents (CBDAs) and social marketing. Population Services International (PSI) concentrates on social marketing of some contraceptive methods (Government of Malawi, 2013; Solo *et al.*, 2005).

In terms of contraceptive prevalence rate and method mix, latest studies using MDHS data have shown that only 42.2 percent of all married women in the country use a modern contraceptive method. The injectables (long acting (3 month) Depo-Provera) are the most prevalent method among married women in the country with a prevalence of 26 percent while female sterilisation follows at 9.7 percent among married women. This reveals that only two methods (injectables and female sterilisation) account for 77 percent of all contraceptive use in Malawi (Chintsanya, 2013; NSO & ICF Macro 2011).

1.5 Organisation of the Thesis

The thesis is organised into nine chapters. The current chapter outlines the introduction to the study, statement of the problem and significance of the study. It also presents the socio-

demographic setting and context of the country. This information is critical to the understanding of SRH risks and contraceptive behaviour of young married women in Malawi. The objectives and research questions that guide the study are also presented.

Chapter two presents a review of literature on young people's SRH risks and women's contraceptive practices with focus on Sub-Saharan Africa and Malawi. The theory of reasoned action (TRA) as the overarching theory that anchors the study is also discussed. Analytical themes drawn from the reviewed literature have informed the adoption of the conceptual framework that outlines the factors associated with SRH risks and contraceptive use among young married women at individual and contextual levels.

Chapter three details the design of the study and discusses the data sources and methods that have been used in the generation and analysis of information on the factors that influence SRH risks and contraceptive practices as they relate to young married women. It details the MDHS quantitative analysis and the primary qualitative data collection methods (FGDs, KIIs and IDIs) and their analyses. The subsequent chapters present the results.

Chapter Four: *Trends and factors influencing SRH risks among young married women in Malawi.* The chapter is the first analytical chapter in which the results of the analysis of timing of first sex, timing of first entry into marital union and timing of first birth among young married women have been presented and how these phenomena have changed over time using the MDHS data sets. It then presents the social, cultural and economic factors influencing early sexual debut, early marriage and early age at first birth using qualitative data sources.

Chapter Five: *Trends and determinants of contraceptive use and method choice among young married women in Malawi*. This chapter highlights the quantitative presentation of the levels and trends of contraceptive use and method choice among young married

women using the MDHS datasets. Differentials in contraceptive use are also investigated with respect to the socio-demographic characteristic of the young married women to isolate the groups of young married women who are most likely to use contraceptives Further, contraceptive method choices are analysed where levels of and determinants of contraceptive method choices are presented.

Chapter Six: *Social and cultural factors influencing contraceptive practices.* This chapter explores the social and cultural factors that influence contraceptive use and method choices. It also examines young women's decision making processes pertaining to use or not to use contraceptives and the choice of methods to use. It then highlights specifically presents the influence of perceived partner influence and secret contraceptive use and how these influence contraceptive use and method choices among young married women.

Chapter Seven: *Fear of contraceptive side effects and contraceptive myths and misconceptions.* This chapter presents the socially and culturally driven fears of side effects and myths and misconception about contraceptive use and methods and how they shape attitudes and act as barriers towards contraceptive use among young married women.

Chapter Eight: *Contexts and constraints to contraceptive services' access and utilisation among young married women.* This chapter examines services related factors that include availability and accessibility and how their influence on contraceptive practices of young married women.

Chapter Nine: *Synthesis of the study findings.* This is the summary chapter that isolates and discusses the major findings of the thesis in tandem with the statement of the problem, study questions and the conceptual framework. It draws conclusions and provides future research, policy and programme implications of the study.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of studies on SRH risks as they relate to young women and their contraceptive practices. These studies are from various parts of the developing world with a focus on sub-Saharan Africa. The literature reviewed here exposes gaps and dearth of studies, particularly in Malawi, that have specifically focused on sexual and reproductive risks and contraceptive practices of young (15-24) married women as a distinct group with peculiar circumstances, challenges and contexts. The dearth of studies focusing on young married women in Malawi is the gap in knowledge that the present study set out to address and fill.

The chapter is arranged in four parts. The first part sets the pace for understanding young married women's contexts by presenting the status of women and the various cultural and traditional marriage practices that characterise and precipitate early marriages in Malawi. The second part highlights the situation of SRH risks (as defined in the terms) among young women and highlighting the social, cultural and economic contexts and factors that influence these risks. The third part presents the review of the economic, demographic, social and cultural factors that influence contraceptive perceptions, attitudes and practices among married women. The last part discusses the theoretical framework that underpins the study by adapting the theory of reasoned action (TRA) as proposed by Ajzen & Fishbein (1980).

2.2 Background

2.2.1 Status of women in Malawi

In order to appreciate the economic, social and cultural constraints that young married women encounter and militate against their enjoyment of sexual, reproductive and contraceptive rights in sexual and marital relationships, it is deemed critical to present a broad picture of the status of women in Malawi. As highlighted below, social and economic status of women in Malawi, when compared to men, is lower and some indicators demonstrate how poverty and illiteracy turn out to be central to women's lack of autonomy and decision making powers in families and communities. The 2011 Integrated Household Survey (I.H.S) found that there were higher levels (43 percent) of illiterate adult (aged 15 and above) women than males (26 percent). Among the unemployed, women had higher unemployment rates (12 percent) compared to males (7 percent). There are also more females who were self employed as mere peasant farmers (***mlimi***) than there are males (National Statistical Office, 2012). In a study in Northern Malawi, Floyd *et al.*, 2008 found that women are restricted in their access to both land and education. This resonates with I.H.S that showed that households headed by males had larger cultivated land (4 acres) compared to female headed households (2 acres) (National Statistical Office, 2012). In the recent Welfare Monitoring Survey (2011) it was found that more females (70 percent) than males (60 percent) had not acquired any formal educational qualification. Consequently, due to truncated education and lack of economic opportunities, women form the majority of the poor and the ultra poor in the country (National Statistical office, 2013). Under these situations, Mkandawire-Valhmu *et al.* (2003) suggested that marriage may become the only viable option for survival in both matrilineal and patrilineal communities of the country. The government came up with a readmission policy for girls

who fall pregnant while at school. This policy faces hurdles such as poverty among girls and parents, parents' reluctance to take care of the baby and teachers' and learners stigmatisation and discrimination of these young mothers in school (Ministry of Education, 2010).

2.2.2 Marriage practices

Culturally, it is tricky to provide a precise meaning of marriage because of the variations in concepts of marriage by different communities in the country. Contrasting with white weddings as understood in the Western world, a customary marriage is a complex institution that can take some stages (Ngalinda, 1998). In case of Malawi, these stages might include ***kutomera*** (betrothal), ***chinkhoswe*** (engagement) and ***ukwati*** (marriage) and their durations can vary in length from months to years. While there are variations by various ethnic groups in Malawi, for the purposes of this study, marriage is operationalised as to have commenced the moment a traditional marriage rite called ***chinkhoswe*** has taken place for matrilineal societies or when the ceremony to pay part or full bride wealth has been conducted for patrilineal societies. Marriage in Malawi can be entered into under common and customary laws. As such the country also recognises customary marriages, for which no minimum age is set. It is also reckoned that in the rural communities most marriages are contracted under the customary arrangements and are not formally registered (Kathewera- Banda *et al.*, 2005).

There are a number of marriage related cultural practices that can limit young women's freedom to delay marriage and sexual debut and in the process prevent them from exercising their sexual and reproductive health and rights. While the legal age at marriage is 18 years[3] (it has always been 15 until 2015) and the legal age at first sex in Malawi is 16,

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[3] Malawi Divorce and Family Relations Act No.3 of 2015

there are a number of cultural arrangements under which young women enter into marriages earlier than the stipulated legal age. These arrangements are inimical to sexual and reproductive health and rights of young women because under these circumstances, it is not always the case that a girl or a young woman would enter into such a marital union willingly, with a partner of her choice or of own age cohort. Munthali *et al.* (2006a) found that young married women tend to be usually younger than their husbands creating age and status disparities that have implications on the general spousal communication and reproductive and contraceptive discussions. This is because power relations entail the dominance by the older man and culminates into lack of empowerment on the part of the young woman to demand or put into practice her own needs and rights regarding fertility and family planning (Mkandawire-Valhmu *et al.*, 2013). In Malawi, there are a number of marriage related cultural practices that precipitate early marriages and the attendant sexual and reproductive health risks. The most prevalent ones are discussed as follows:

There is a cultural practice called *kupimbila (*in lieu of payment*)* among some tribes in Northern Malawi. Under this practice, the parents of a girl can accumulate debts and fail to settle. As a form of payment, they would offer their girl in marriage to the creditor as payment (Mkandawire-Valhmu *et al.*, 2013; MHRC, 2006). In their study, MHRC (2006) established that the girls could be as young as 9 years old while the man could be as old as 40 years or older. There is another cultural practice called *nthena* (replacement of deceased wife) whereby a bereaved husband marries a younger sister or niece of his deceased wife as a replacement. The young girl would be persuaded by her parents to marry the brother in- law; for example, in areas where bride price is paid, because they would not be able to pay it back should the husband's family ask for it. Some parents were found to engage in this practice because they thought that the death of their daughter would prevent them from accessing the wealth of the son-in-law if he were to marry elsewhere. Just as is the

case with *kupimbila*, the girl could be as young as 15 years old and the man might be as old as 50 years or more (MHRC, 2006).

Mbirigha (bonus wife) is another custom mainly practiced in communities that also practice polygynous marital system. The husband is given a younger sister or niece of his wife to take in as a second wife. Mostly, parents offer the young girl as a sign of gratitude to the son-in-law who has been very generous or has taken good care of both their daughter and them as parents in-law. This was also found to be for the purposes of bearing children for the husband in cases where the elder sister is either barren or has stopped bearing children for whatever reason. At times, if the husband is rich, the wife may want to protect the wealth by rather letting her younger sister join her than letting the man go and marry elsewhere. The young girl can be as young as 15 if not younger depending on the age at which she would attain puberty (MHRC, 2006).

Another cultural practice is polygyny. This is a marriage system that involves marrying more than one wife and is widely practiced among the tribes in Northern Malawi and the Yao dominated districts in the Lake Shore areas (Kerr, 2005; Sear, 2008). The practice contributes to early marriages as older men tend to marry young women some of whom can be withdrawn from school (Makinwa-Adebusoye, 2001). It is also a trend that each new wife would turn out to be younger than the preceding one (Makinwa-Adebusoye, 2001; Munthali *et al.*, 2006b). The Malawi Human Rights Commission (2006) study found that was principally for fertility related reasons. For example, a new wife can be sought when the first one is failing to bear children, a son or when the man wants more children to carry on the lineage or provide material security in old age. The need for more children is premised on the understanding that considerable expansion of membership enhances the power and prestige of the lineage and reduces its extinction through death (Makinwa-

Adebusoye, 2001). In another study in Northern Malawi (Doskoch, 2013), it was found that women in polygynous marriages were less likely than their counterparts in monogamous marriages to use modern contraceptives. They were also more likely to have been previously married, had a greater number of children and were less likely to have at least a secondary education. Although polygyny is not allowed under common law marriages, customary laws allow for this type of marriage (Kathewera-Banda *et al.*, 2005). The 2010 MDHS found that polygynous marriages account for 14 percent of all marriages with the highest levels (21 percent) being found in the northern region of the country (NSO & ICF Macro, 2011).

Another practice is called *kutomera* (betrothal) that involves a man offering to marry a girl when she is still of a tender age, in some cases as young as 5 years old. This offer is made through the parents of the young girl and involves periodic provision of gifts such as clothes to the young girl, as part of taking care of her, as would be the case with a real wife. As soon as she attains puberty, she would be forced to join the man as his wife (MHRC, 2006).

All these marriage practices exacerbate SRH risks of early sexual debut and early childbearing because under the circumstances of their entry into marriage, there is always social pressure on these young married women to bear children soonest such that the issue of contraception does not come into the picture (Palamuleni, 2008; Zulu, 1998). For young women in polygynous relationships, the decision to use contraceptives is also constrained by the competition for attention, through childbearing and bearing sons, that ensues among co-wives (MHRC, 2006).

Sexual and reproductive health and family planning realms have received considerable attention from researchers in Malawi. There have been some studies (Chintsanya, 2013;

Chipeta *et al.*, 2010; NSO & ICF Macro, 2011) that have investigated the levels, trends and determinants of early sexual debut, early marriage, early childbearing and contraceptive use mostly among women of childbearing age bracket of 15–49 and have used age and marital status as some of the covariates. There have also been other studies that have focused on the levels, trends and determinants of SRH risks (Munthali *et al.*, 2004; Munthali *et al.*, 2006b; Chonzi, 2000) and barriers to access and utilisation of reproductive health services (contraceptives, STI management and HIV testing, counselling) among young people in Malawi (Kaphagawani, 2008; Jimmy-Gama, 2009; Mphaya, 2006;). These studies have shown that sexual and reproductive health needs, risk factors and susceptibility to negative SRH outcomes and access to contraceptive information and services vary considerably depending on, among other factors including income status, place of residence, family structure (whether living with biological parents or not), school status (whether in school or out of school) age and marital status of the young people. Similar variations were also found in studies in Uganda (Asiimwe *et al.*, 2014) and Namibia (Indogo, 2007).

2.3 Sexual and Reproductive Health Risks

2.3.1 Early sexual debut

Studies have identified early age at first intercourse as one of the intermediate variables of exposure to other SRH risk. For example, a strong association was established between age at first intercourse and exposure to the risks of childbearing and contracting STIs including HIV (Zuma *et al.*, 2010). This is because the likelihood of using preventive measures at first sex rises with increasing age such that the older the age at first sexual intercourse, the more likely is the practice of family planning (Jimmy-Gamma, 2009). It is also contended that girls' first sexual experiences are often unplanned and can be at times forced (Gueye

et al., 2001; Jimmy-Gama, 2009). In the realms of increased early exposure to the risk of contracting STIs including HIV, studies have found an earlier age at first intercourse to likely lead to an increased lifetime number of sexual partners, an increased likelihood of multiple and concurrent sexual partnerships and a lower probability of using protection (Mmbaga *et al.*, 2012; Zuma *et al.*, 2010; Cavazos-Rehg *et al.*, 2010).

It is further contended that by the very fact that the women are still young, young age at first sex is also related to lower knowledge of the risks associated with sexual acts, means and sources of prevention, reduced agency to seek and access preventive information and services and lack of skills and self efficacy to negotiate contraception and resist peer pressure (Kayongo, 2013; Mmbaga *et al.*, 2012; Manda & Meyer, 2005). Early sexual debut was also found to be associated with a higher propensity to enter into high risk multiple partner relationships such as polygynous marriages or to experience higher levels of marital instability and breakdown (Zaba *et al.*, 2009). A study by Meier, 2007 had posited that there are direct effects of early sexual debut on education. This was particularly so not only in relation to disruptions that can be caused by early pregnancies but also due to less effort and interest that is invested in education in the wake of competing attention paid to sexual activity, dating and worries about pregnancies or STIs.

In Malawi, there are also cultural practices that promote early sexual debut among young women. Research has shown that although social and cultural norms prohibit early (mainly premarital) sexual debut, there were cultural practices such as initiation ceremonies among young girls and boys that subtly promote early sexual debut as part of the rites of transition from childhood to adulthood. Studies conducted in Mangochi district (Gondwe, 2008; Jimmy-Gama, 2009) had found that apart from the moral lessons that are inculcated into the young boys and girls, there were also instructions that were given to initiates to the

effect that they had to practice sex as part of the culmination of the rites of passage. Other studies (Khaila *et al.*, 1999; Chirwa, 1996) had found that in some parts of southern Malawi, particularly among the Yao and Lomwe tribes, where detailed and long initiation ceremonies (for males it also involves circumcision) are conducted, both female and male initiates were considered unclean soon after initiation. In this respect, they were expected and were covertly forced to engage in sex to cleanse themselves as a final ritual to complete the process of transition from childhood to adulthood. In these cases it was found that the initiates would be threatened that failure to conduct the sexual act could result in them or their parents being sick on even dying. The sexual rituals are commonly known as *kusasa fumbi* (shaking off dust) among boys and *kuchotsa mafuta* (spilling oil) among girls (Gondwe, 2008; Jimmy-Gama, 2009). A similar practice called *unyago* (initiation) marking girls transition from childhood to adulthood and that includes education on motherhood and households roles has also been reported in Tanzania (Ngalinda 1998). Kenya and Botswana have also reported similar rites of passage that include sex education (Balmer *et al.*, 1997).

Early sexual debut was also found to be precipitated by a phenomenon of sugar daddy that force young women, particularly those in school, into having early sexual relationships and intercourse by cajoling them with money and other financial inducements. Due to poverty, peer pressure and lack of advice from parents, these girls fail to resist the temptation to get this money (Mwale, 2008; Kalipeni & Gosh, 2007).

2.3.2 Early marriages

Age at first marriage is one of the most pivotal proximate determinants of the aggregate level of fertility in a population (Bongaarts & Potter, 1983). It forms the basis for family formation and marks the beginning of regular exposure to the risk of pregnancy and

childbearing. In this respect, they are associated with higher fertility and population growth rates through increasing or decreasing the duration of exposure to the risk of childbearing and the period that women are married and sexually active (Palamuleni, 2011). In addition, early marriage might lead to early age at first pregnancy or fist birth before the completion of the girl's physical and psychological growth, development and maturity for motherhood (Jensen & Thornton, 2003). A study in Malawi (Munthali *et al.*, 2006b) found that childbearing followed shortly after marriage as the first birth usually occurred after an average of 0.9 years of marriage. This could be attributed to marriage being regarded as a socially and morally acceptable institution for childbearing in the Malawian society(Chimbiri, 2007; Zulu, 1998) and where contraception is rarely used before any childbearing (Palamuleni *et al.*, 2008). Globally, large proportions of early marriages are found in sub-Saharan Africa and South Asia. In 2012, it was estimated that in the next decade more than 100 million young women would enter into marital union before reaching the age of 18 years of which about 15 million would do so by the age 15 (UNFPA & PRB, 2012). This is likely to have a great impact on the demographic and economic development of the most affected countries (Cleland *et al.*, 2006*b*; Erulkar, 2013).

Early marriage is also one of the adverse SRH risks because of its close ties to early sexual debut, early childbearing and early exposure to the risk of contracting STIs including HIV arising from early, more frequent and unprotected sex that takes place in marriages (Erulkar, 2013; Levandowski *et al.*, 2012; Raj *et al.*, 2009. Analysing evidence from sub-Saharan Africa, Raj *et al.* (2009) indicated that women who marry early have an increased risk of HIV infection. It was found that the infection rate among married adolescents was 50 percent higher than that among their unmarried, sexually active women of the same age group. The higher rate of infection among married than unmarried adolescents are linked

to having lower rates of condom use in marriage and having partners who were older and more sexually experienced (Erulkar, 2013).

Further, early age at marriage is a barrier to further education since young married women have to drop out of school to devote time to the care of the husband and the family, or to childbearing and childcare which often times lead to subsequent economic hardships (Jensen & Thornton, 2003, Okerere *et al.*, 2013). Studies have further contended that since young married women mostly have truncated education, there are limited opportunities for them to be employed or have access to material resources of their own hence they have low status in the family (Kathewera-Banda *et al.*, 2005). In addition, early marriages are characterised by large husband-wife age gap that has an effect on husband-wife relationship. Women who marry young and who marry much older men are less capable of asserting themselves and have a voice in their families and this culminates in less power, status, agency and autonomy to make certain decisions and take actions on issues affecting them within families (Jensen & Thornton, 2003). In such circumstances, childbearing tends to be the single most important element of the woman's status that motivates them to prove their fertility as soon as they get into marital union to earn some status (Mwalabu, 2014). Studies in Senegal (Villareal, 1998) and Mali (Castle, 2003) had found that women traditionally acquired high status principally through marriage and childbearing.

In addition, early marriage was found to curtail the girl's childhood and rob her youth as she is required to take up roles for which she is not psychologically or physically prepared for (Bayisenge, 2010). Besides having a negative impact on the young women and their children, early marriages have also been found to have negative consequences on families and the society as a whole. There are burdens of population pressure, increased health care costs and lost opportunities for human development that families and the society have to

shoulder because of early marriages accompanied by early pregnancies and childbearing (Okerere *et al.*, 2013; Bayisenge, 2010).

However, other studies have shown some social and economic advantages of early marriages. In Malawi, for example, Mwalabu (2014) had found that some parents would look at early marriages as a way of protecting their daughters from the threat of premarital sex and childbearing that would be humiliating to the young women and their families resulting in their reduced chances of getting married in future. Masanjala (2007) also found that other families would cajole their daughters into getting married to alleviate their families' economic hardships. Similar positive elements of early marriages were reported in a study in India. Prata (2009) also found that in places where crime and violence are prevalent, parents would view early marriage as a way of protecting girls from violence particularly sexual violence. It was also found that there was great demand for younger brides among men so that they can benefit from their longer reproductive lives during which they can bring forth many children. It was further contended that men and their families would view younger brides as more desirable because they could be more easily controlled and less assertive because of their lack of physical, mental and emotional maturity. It was also found that younger brides were preferred because they were less likely to have had previous sexual contact, which, due to social norms and the prevalence of sexually transmitted diseases, including HIVAIDS, may be considered important or essential to the groom and his family. Related to this issue of HIV and AIDS, Bongaarts (2007) found that later ages at marriage in sub-Saharan African countries where marriages occur at later ages showed longer periods of premarital sex and hence higher HIV prevalence rates.

2.3.3 Early childbearing

The age at which a woman gives birth for the first time has implications on a number of issues including fertility and mortality. A study in Nigeria found that mothers who had their first birth before age 20 years were more likely to have significantly higher number of children ever born compared with mothers who had their first birth from age 20 years and above (Oyefara, 2012). Early childbearing is also associated with subsequent higher fertility, larger family sizes and rapid population growth at household and national levels. Scholars such as Ngalinda (1998) have argued that the direct effects of early child bearing are seen in the high total fertility and generally youthful populations, short duration between generations and a short doubling time of the population. This is due to shortened time between generations that ensue such that even when family planning practice were to be widespread, the timing of first births can affect completed family size where contraception is used mainly for spacing and not for limiting births (Haque & Sayem, 2009).

Early childbearing is also linked to higher maternal and child mortality rates as it is associated with higher total fertility that is achieved at the end of women's reproductive years. This is because higher fertility rates raise the supply of pregnant women and live births that potentially can be at risk of maternal and child mortality (Palamuleni, 2013). Studies have further asserted that two of the leading causes of morbidity and mortality among young women globally are related to early childbearing (Erulkar, 2013). Worldwide, women aged 15 to 19 years give birth to about 17 million of the 131 million children born each year (WHO, 2007). Young mothers are exposed to greater challenges than adult women and these results in increased risks for adverse pregnancy and perinatal outcomes (Bearinger *et al.*, 2007). Complications of pregnancy and delivery were found to be the leading causes of death among females aged 15-19 (Bearinger *et al.*, 2007; Fathalla

et al., 2006). In a study (Erulkar, 2013), it was posited that young women who bear children before age 15 are five times as likely as older mothers to die of pregnancy-related causes.

There is also evidence to the effect that early childbearing is associated with poor socio-economic outcomes. As adolescent childbearing hinders young mother's educational attainment, it also jeopardises her long term social and economic chances of self advancement leading to reduced economic opportunities for the mother and the household as a whole hence living in poverty (Hindin, 2012). Education on the other hand plays a major role in rising age at first birth. Education either delays first intercourse or subsequent births or affects the acceptance of contraception to delay first conceptions (Zaba *et al.*, 2009). Further, it provides motivation for women to question some traditional norms and offer alternative choices to childbearing even in marriages (Haque & Sayem, 2009). Pregnant adolescents and unmarried adolescent mothers were also found to be psychologically ill-treated at their parents' homes and also suffer from stigma in their communities (Atuyambe *et al.*, 2005).

2.4 Contraception

Family planning implies the ability of individuals and couples to voluntarily decide on the number, timing and spacing of births and is achieved through contraception (Akintade, 2011). Contraception could be defined as any deliberate practice undertaken to reduce the risk of conception by sexually active women (and their male partners) (Ngalinda, 1998) while contraceptives are defined as any means or tools capable to prevent or reduce the frequency of conception (Akintade, 2011; Ngalinda, 1998). Contraceptive use has been described as one of the most important proximate determinants of fertility in a population.

It is contended that substantial differences in the levels of contraceptive use help to explain the variation in fertility among populations (Ngalinda, 1998).

2.4.1 Categorisation of contraceptive methods

In understanding contraceptive use dynamics, scholars have categorised contraceptive methods in various ways. Some (Akintade, 2011; Palamuleni, 2008; NSO & ICF Macro, 2011) have categorised them into modern and traditional, others (Creanga *et al.*, 2011) have grouped them into long-term (intrauterine devices, implants and sterilisation) and short-term (pills, condoms, spermicides, injectables, other modern methods and all traditional methods). Magadi & Curtis (2003) categorised them into short-term modern (Short-term modem injectables, oral contraceptives, and barrier methods (including male and female condoms, foam and jelly, but mainly male condoms), long-term modern (intra-uterine device (IUD) and hormonal implants), permanent methods and traditional methods. (Do & Kurimoto (2012) have categorised them into female only (the pill, IUD, injectables, lactational amenorrhea, female sterilisation and implants) and couple (male and female condoms, diaphragm, foam, jelly, withdrawal and periodic abstinence). The later requires at least the awareness of and a certain degree of support and cooperation from the sexual partners. The focus of the study is on modern contraceptives as outlined in the MDHS data sets (NSO & ICF Macro, 2011).

2.4.2 Purpose of contraception and attributes of a desirable contraceptive method

There are three broad categories of the purpose for contraceptive use based on the individual woman's or couple's reproductive intentions (Mills *et al.*, 2011). Mills *et al.* (2011) asserted that contraception can be used for the purposes of postponing onset of childbearing as practiced by women who have not yet started childbearing and want to wait for some time interval. It can also be used for spacing births as practiced by women or

couples who desire to have more children but would like to wait for some time. It can further be used for limiting births as practiced by women or couples who desire no more children. In this study, due to the target group being studied, the focus is much more on the use for the purposes of postponing onset of childbearing and spacing of births.

On the attributes of an ideal contraceptive method, studies have found that a prospective contraceptive user would look for particular attributes of an ideal contraceptive method. These attributes can have a bearing on whether contraception would be used and more importantly on what method would be used. Studies in Malawi and Nigeria (Babalola *et al.*, 2012) and in Malawi (Woodsong & Alleman, 2008) have revealed that women look for methods that are effective, safe and would not come in the way of the couple enjoying their sexual lives.

It was further contended that, for women, while considerations around their own sexuality were important, their ideal method choices mostly revolved around the sexual needs of their partners. As such, women would look for contraceptive methods that would not interfere with sexual intercourse with their sexual partners. For example, in a study in Malawi (Woodsong & Alleman, 2008), it was noted that in choosing female sterilisation, women equated this method with continued sexual intercourse free from worries of pregnancy. On the other hand, the choice of hormonal methods such as combined oral contraceptive pills and injectables was associated with disruption of menstrual flow was the main cause for concern among contracepting women. Studies (Nalwadda *et al.*, 2010; Chipeta *et al.*, 2010; Bisika, 2008; Woodsong & Alleman 2008) have also found that prolonged and excessive menstrual bleeding was of great concern because it interferes with normal sexual activities. These concerns are buttressed by the cultural beliefs, for example in many Malawian communities, that prohibit sex during menstruation because

the man can get seriously damaged internally if the blood gets in contact with him or goes inside his body (Bisika, 2008). In that respect, contraceptive methods that may result in prolonged periods of bleeding may be sidelined by women for fear of keeping their husbands waiting for long periods for resumption of sex (Chipeta *et al.*, 2010).

2.4.3 Benefits of contraceptives

Contraceptive use can have a bearing on the risks of early pregnancies and early childbearing even in situations where there has been early sexual debut or early marriage. For example, if contraceptives were to be used within a premarital sexual relationship or marriage through the use of contraceptives, young women would still be protected from pregnancies regardless of the timing of their first sex or age at marriage (Ngalinda, 1998). In this respect, studies have proffered a range of benefits for family planning. It is contended that family planning programmes, for example, have the potential to reduce fertility and slow down population growth in high fertility countries and also reduce poverty and hunger in poor countries (Bongaarts *et al.*, 2011; Smith *et al.*, 2009). It also saves women's lives and protects their health by preventing unintended and often high-risk pregnancies. Further, it saves lives of adolescent women by aiding them to avoid childbearing during this high-risk time and its attendant health and economic consequences. The practice of family planning also reduces women's recourse to unsafe abortions (Smith *et al.*, 2009). By reducing birth rates, family planning can also create a demographic dividend that boosts economic growth by increasing the size of the labour force, as the proportion of the population of working age rises, relative to both young and old dependents in the process contributing to poverty reduction and improvement of people's lives (Government of Malawi, 2013; Cleland *et a.*,, 2006b; UN Millennium Project, 2005).

2.5 Factors influencing contraceptive practice

For the purposes of clarity and on the basis of the reviewed literature (for example, Nalwadda *et al.*, 2011; Eaton *et al.*, 2003) factors that influence contraceptive practice can be identified and categorised into individual, proximal contextual and distal contextual. However, it is noteworthy that these categories are largely artificial. These categories are discussed as follows:

2.5.1: Individual factors

These are ongoing individual conditions, experiences and personality traits that are within the young married woman's life. These factors can result in variations in contraceptive use and method choices among individual women. In this study these factors are limited to demographic and socio-economic characteristics.

i) Current age of the woman

Studies (Chintsanya, 2013; NSO & ICF Macro, 2011) have shown the association between the current age of the woman and contraceptive practice. Specific to young women, a study by Mon & Liabsuetrakul (2012) found that women aged 20–24 were more likely to use contraceptives than those aged 15–19. Further, women would be least likely to practice contraception with effective methods when fecundity is low at the extremes of the maternal ages. The relationship between age and contraceptive use has an inverted U shape peaking at age 29 (NSO & ICF Macro, 2011; Kaphagawani, 2008; Palamuleni, 2011). The demand for contraception is often highest for women at the peak of their reproductive cycle, but lower for youngest and oldest women in the reproductive age bracket (Kaphagawani, 2008; Chonzi, 2000; Palamuleni, 2011). Women towards the end of their reproductive span are less fecund and may also have sex less frequently making them less likely to use contraception (Munthali *et al.*, 2004; Cohen, 2000). In a study in Malaysia,

DaVanzo (1986) found that there was an increase in acceptance of sterilisation with increasing age, the average age being 29 years for sterilisation compared to an average age of 26 years for spacing methods. These variations by age were also attributed to differences in the level of knowledge pertaining to contraception. While some scholars (Guiella & Madise, 2007) have argued that greater knowledge about contraceptive methods does not always lead to use, others (Mon & Liabsuetrakul, 2012) have contended that the levels of knowledge are still critical for women to initiate discussions about contraception and later use. They posited that high knowledge levels about specific contraceptive methods and where to obtain them was associated with higher use of such methods.

ii) Spousal age differences

Age differences between spouses have a bearing on women's contraceptive use and method choices. In a study by Sarkar (2009), it was found that in unions where the husband is much older (>10 years), young women, particularly adolescent ones, had lower levels of contraceptive use compared to young married women whose partners' age differences were smaller. Other studies have revealed that since partners of young women that enter into early marriages tend to have a huge age and status differences, there are implications on spousal communication and contraceptive discussions because the household power dynamics favour the older men (Munthali *et al.*, 2006b; WHO, 2007). In this respect, these young married women's decision making powers are almost nonexistent principally due to their low status (Mkandawire-Valhmu *et al.*, 2013) and are subjected to the decisions of their partners and their husbands' family members (Klingberg-Allvin *et al.*, 2012). In Nigeria, Ibisomi (2014) suggested that large spousal age gaps were accompanied by differences in maturity, life experiences, social position and financial resources which can make the marital relationships inherently unequal and a source of

sexual and reproductive risks to the woman. A study in Bangladesh (Haque & Sayem, 2009) found that lower age gap was associated with more participation of women in decision making with their husbands thus denying the family pressure and demands for childbearing soon after marriage. In India, Prata (2009) found that older men and their family members were able to manipulate or exert control over the younger women in early marriages. It was further revealed that such behaviour, attitudes and power relations that are formed early in marriages tended to persist over time (Prata, 2009; Jensen & Thornton, 2003). These circumstances constrain young married women from negotiating and initiating contraceptive use and limit their method choices due to unequal power relations (Klingberg-Allvin *et al.*, 2012; Paz Soldan 2004).

iii) Socio-legal status of the relationship

Contraceptive use and the method chosen can also be influenced by the type of sexual relationship a woman is involved in. For example, studies have revealed that within cultural circles, condom as a contraceptive method is least likely used between partners who are married to each other (Chimbiri, 2007; Zulu, 1998). There are strong beliefs that use of condoms within marriage contradicts the core of marriage as an institution for mutual satisfaction of sexual desires that can not be achieved by use of a barrier method such as a condom regardless of intentions for use (Chimbiri, 2007; Kathewera-Banda *et al.*, 2005). In this respect, studies have found that the choice and use of condoms as a contraceptive method among married men and women tended to be mostly for extramarital sexual relationships (Chimbiri, 2007; Munthali *et al.*, 2006a; Kathewera-Banda *et al.*, 2005).

A study (Kathewera-Banda *et al.*, 2005) further posited that the use of condoms in these extra marital sexual relationships was usually motivated by the need to prevent pregnancy

and not necessarily to prevent infection. This was found to be a reflection of men's control over women's sexuality and power over the women with whom they want to have sex but do not want to bear the responsibility of childbearing. It was further contended to be a reflection of men's power and control to decide on when, where, with whom and how to have sex (Kathewera-Banda *et al.*, 2005). However, in situations where men use condoms, results from a study in Rakai District in Uganda (Lutalo *et al.*, 2000) were that the prevalence of condom was higher among those who felt to be at risk of HIV infection that included the younger, better educated, unmarried men and among those who reported to have multiple sexual partners or extra marital partners.

iv) Levels of income

There have been studies that have come to the conclusion that levels of income have a bearing on access and utilisation of contraceptive services regardless of whether the services are offered for free or not. For example, in Malawi, studies (Adebowale *et al.*, 2014; Hennink & Madise 2005) had found that contraceptive use was lower among poor women in the lowest wealth quintiles compared to those who were well off. This was because there are always costs of, for example, transportation to get to the service delivery points. With respect to method choice, studies have posited that there are also variations by levels of income with the costs being higher for methods that require constant resupplies or attention of trained and skilled providers. Creanga *et al.* (2011) had contended that even when childbearing intentions were controlled for, women in the richest wealth quintile were more likely than women in the poorest wealth quintile to use long-term contraceptives, which are more expensive than short-term ones and usually provided at clinics by trained providers.

In a study in Malawi (Hennink & Madise, 2004) found that some women contrasted the more affordable financial costs of temporary methods (pills, injections) against the relatively expensive monetary costs of sterilisation. Women felt that the cost for sterilisation was harder to bear. A study in Uganda (Nalwadda *et al.*, 2010) found that the cost for transport and contraceptive commodities made it prohibitive, especially for young women without a disposable income, to access and use contraceptives and if they were to use at all, they were more likely to use cheaper and at times less effective methods. It was also a similar case in a study in Pakistan (Ross *et al.*, 2002) where it was found that family income had a positive effect on the choice of pills and condoms as they require constant resupply and sterilisation because of the need for specialised expertise to administer. In another study in Bangladesh (Phillips *et al.*, 1988), it was revealed that the odds of choosing sterilisation were inversely related to one's measure of income and economic status.

v) Levels of education

One of the most consistent findings on the socio-economic determinants of contraceptive use has been the strong correlation between the level of educational attainment and contraceptive use. Studies in Malawi (Kinoshita, 2003; Kaphagawani, 2008; NSO & ICF Macro, 2011; Chintsanya, 2013) and Burkina Faso (Guiella & Madise, 2007) have shown that use of modern contraceptives is higher among women with secondary or higher levels of education than those with primary or no education. For example in Burkina Faso, adolescent women who achieved a secondary school or higher educational levels were three times more likely to use condoms compared to women without any education.

The relationship between level of education and method choice is also well understood. In a study in Malawi by Cohen (2000), it was found that education had a positive association

with the likelihood that sterilisation would be practiced on the understanding that educated couples were more likely to be aware of this method among other methods and may also view unwanted births as more costly. A study in Kenya (Magadi & Curtis, 2003) found that the highly educated (secondary or higher) women were the most likely to use long-term modern methods while those with no formal education were the most likely to use traditional methods. A similar study in Malaysia (Da Vanzo *et al.*, 1986) found that increases in women's education were associated with increases in condom use.

Scholars have vouched some explanations for the effects of education on contraceptive use. Cohen (2000) posited that greater women's education is associated with greater empowerment to make independent decisions and improved ability to practice contraception. In addition, more educated women are more likely to appreciate the advantages of having fewer and better educated children; were less likely to be fatalistic towards contraceptives' side effects and more likely to be knowledgeable about various methods of family planning and their potential side effects. Further, she contended that highly educated women tend to take part in family decision making and would be able to get their husbands to appreciate and accept more responsibility for family planning. Skirbekk and Samir (2012) have further explained that higher educational levels increase opportunity costs of having children and increase the extent to which childbearing choices are made in a voluntary manner. They also contended that education lowers women's propensity to adhere to social, cultural or religious norms that value high fertility and prohibit contraceptive use as part of beliefs and practices. However, Mon and Liabsuetrakul (2012) have argued that lower contraceptive use among young married women with lower levels of education might be as a result of the effects of attrition from the education system, given that entry into marriage in itself usually leads to the curtailment of the educational process that would have otherwise equipped the young

women with knowledge and skills to increase their understanding on a range of issues including contraception.

vi) Place of Residence

Place of residence (urban vis-à-vis rural) has been found to influence contraceptive practice particularly on the basis of availability and proximity to family planning services. Studies in Malawi (Palamuleni, 2008; NSO & ICF Macro, 2011); South Africa (Eaton *et al.*, 2003); Burkina Faso (Guiella & Madise, 2007) and Kenya (Magadi and Curtis, 2003) have shown variations in levels of contraceptive use between the rural and urban women with the later having higher levels. For example, in Burkina Faso, it was found that young women in the urban areas were more than twice as likely to use condoms as those in rural areas. This was mainly on account of accessibility as the urban areas have easier access than the rural areas. Further, in the urban areas, incomes and educational levels were higher and the desired additional fertility was lower (Guiella & Madise, 2007). In Kenya (Magadi & Curtis, 2003) found that use of long-term methods was higher in the urban than rural areas. In a similar study in Malaysia (Da Vanzo *et al.*, 1986), it was found that urban residents, who lived near to family planning clinics that offered IUD, implants and sterilisation, were more likely to use these methods while rural residents that were served by programmes that provided pills, condoms and injectables were more likely to use such methods.

There are other scholars who have posited that the place of residence (community) can also affect perceptions and attitudes towards contraception due to the prevailing social and cultural norms and the information that can be propagated pertaining to sexual, reproductive and contraceptive matters. For example, studies in Malawi (Chipeta *et al.*, 2010; Paz Soldan, 2004) had suggested that the adoption of contraception and choice of a

method to use were mainly influenced by discussions that prevailed and information passed on among women in particular communities about various methods and their benefits and side effects.

vii) Religion

The matters of fertility and contraception have been found to invoke reactions among some religious faiths that can be inimical to contraceptive use and limit method choices among women. There have been studies in Malawi that have revealed sentiments to the effect that Christian scriptures commanded people to be fruitful and multiply of which contraception is like acting against God's will (Chipeta *et al.*, 2010; Bisika, 2008) and also that pregnancy is a pre ordained and inevitable condition that cannot be prevented (Kaler, 2004). Similar findings were found in other countries. In Tanzania (Ngalinda, 1998) it was found that some religious denominations such as Catholicism have negative attitudes towards the use of modern contraceptives while Protestantism was found to have a more liberal stand. In Mali, it was found that that there were strong beliefs to the effect that childbearing and the number of children are predetermined by God or destiny. In that respect, any endeavour to change that course would be futile. They also contended that people believed that Islam regard contraceptive use to have been condemned by the Koran such that any quest to avert child birth would be regarded as sinful (Kane *et al.*, 1998).

There have also been studies in Malawi that have established associations between particular religious denominations and faiths and choice of particular contraceptive methods. Yeatman andTrinitapoli (2008) found that Muslim women were less likely to use modern contraceptives than Christian women. In a study by Zulu (1998), it was found that the Catholics were mainly in favour of natural methods while the Protestants were for

modern methods. Similar results were obtained in Malaysia where the Hindus were more likely to practice sterilisation than Moslem women (Da Vanzo *et al.*, 1986).

viii) Number of living children

It is contended that the number of living children does not only influence contraceptive use but also determines method choice depending on the purpose (to postpone the onset of childbearing, increase birth spacing or limiting number of births) of using contraception. Studies have shown that women with high parities were more likely to use contraceptives to avoid future pregnancies than those with low parity (Chintsanya, 2013; NSO& ICF Macro, 2011; Palamuleni, 2008; Kaphagawani, 2008). Palamuleni (2008), for example noted, that women in Malawi used contraceptive methods mainly for spacing births and that limiting of births would only be thought about after 5-6 children. In situations where son preference was strong, the sex composition of the living children also influenced contraceptive use such that on the overall, women who had fewer or no male children were less likely to use contraceptives compared to those who had a fair mix of children or more sons.

In Nigeria, Babalola *et al.* (2012) found that women who had fewer children because they were using contraceptive methods were looked at as weird who just wanted to enjoy having sex without the responsibility of childbearing. Creanga *et al.* (2011) also observed that acceptance of a permanent method increased with the number of living children. They found that the majority of women who had chosen a permanent method (female sterilisation) were women with two or more children. In a study in Malaysia, Da Vanzo *et al.* (1986) posited that the desire to have no more children was the most powerful influence on the couples' decision to choose a permanent form of contraception and that the pill and the condoms were mainly used by those desiring more children.

2.5.2: Proximal contextual factors

These are factors that relate to the individual's immediate environment such family relations, neighbourhood and service delivery. In these instances the individual can only have limited control and influence of what happens within the environment. The current study limits itself to service delivery factors within the individual woman's environment. There are a number of service related factors that influence contraceptive use and method choices among women. These include availability of a variety of methods and skilled personnel to administer them; policies and guidelines and attitudes and behaviours of service providers. These factors have an immediuate bearing on initiation, switching and continuation of contraceptive practice. The most common programmatic factors are discussed as follows:

(i) Availability of a variety of methods

Studies have shown that for women to enjoy a choice among contraceptive options, a range of methods must be available as the ability to choose a satisfactory contraceptive method depends on ready access to a variety of methods (Magadi & Curtis, 2003). It is also contended that when individuals and couples are constrained from accessing and choosing a method that best meet their reproductive needs, it can, in the extreme, lead to non use of contraceptives at all (Ross, *et al.*, 2002). In addition, it is argued that adequate contraceptive mix is another gauge of the quality of services and of the family planning programme as a whole and an indication of how women's sexual and reproductive rights are recognised and respected (Bruce, 1990; Diaz, 1999 as cited in Magadi & Curtis, 2003). It is further posited that adequate contraceptive method mix validates the effectiveness of contraceptive practice in impacting fertility levels of a particular population or country (Chintsanya, 2013) on the basis that use of more effective methods even by a smaller proportion of eligible couples can produce greater impact, for example in accelerating

fertility decline, than use of less effective methods even by a larger proportion of couples (Shah, 1991 as cited in Magadi & Curtis, 2003).

Studies have also revealed that prevalence of use of each method is tied to its availability such that widening the choice of contraceptive methods increases the overall contraceptive prevalence as women easily get the methods that suit their fertility intentions (Ross *et al.*, 2002). It is also contended that prevalence of use of particular methods is high where access is also uniformly high (Nalwadda *et al.*, 2011; Ross *et al.*, 2002; Cohen, 2000). For example, Ross *et al.* (2002) found that, except for condoms, the use of each method was high where availability and accessibility of that method were also high. A study in Malawi (Cohen, 2000) found that proximity to a primary health care facility in the rural areas was associated with greater use of modern contraception among the less educated and younger women.

In a different perspective, there is also evidence that proximity of family planning service delivery points and their type affect the couple's information about family planning and time and money costs of fertility control (Da Vanzo *et al.*, 1986). In this respect, the distance to the nearest contraceptive service delivery point determines not only the use of contraceptives but also the type of method to be used (Hennink & Madise, 2005). A study in Nigeria and Zimbabwe (Cohen, 2000) found that the combined factors of access, price and quality of services were influential in the adoption of modern contraceptives. It was also contended that the availability and quality of family planning in the community were associated with higher rates of use of modern contraceptive methods particularly so among the less educated women. In a similar study in Malaysia (Da Vanzo *et al.*, 1986), it was also found that proximity to family planning clinics encouraged contraceptive use particularly for the purpose of birth spacing. Family planning clinics within the vicinity of

the women places of residence were found to be the most effective in promoting contraceptive use for birth spacing by less educated women and were more associated with increased use of sterilisation by couples who desired no more children.

However, there have been other studies that have come to different conclusions. For example, a study in Malawi (Heard *et al.*, 2004) found that distance to family planning services did not explain contraceptive use variations among women. Another study (Hennink & Madise, 2004) also found that some urban women were willing to travel long distances, at times passing nearby government facilities, in search of quality services at a far *Banja La Mtsogolo*, an affiliate of Marie Stopes international, clinic.

ii) Cost of contraception

Costs in terms of transport, time and the cost of contraceptives constrain women's access to contraceptive services. A study in Malawi (Hennink & Madise, 2004) found that when the subsidies were removed by a donor on the family planning services at *Banja La Mtsogolo* (BLM) clinics, the number of clients fell. In another study by Hennink and Madise (2005), it was found that the cost of transport to a family planning service delivery point was a barrier to contraceptive use. Not only did it have implications on use but also on method choice as poorer women opted for more affordable temporary methods of contraception even though they would have preferred more expensive long acting or permanent methods that were only available at distant service delivery points. Similar results were also reported in other countries. In a study in Uganda, it was found that the cost for transport and contraceptive commodities made it prohibitive for young women, without a disposable income, to access and use contraceptives as they had to rely on their husbands, as sources and controllers of household resources, to provide them with the required money (Nalwadda *et al.*, 2010). A study in Swaziland recorded a 32 percent decline in client numbers after the Ministry of Health increased contraceptive prices by

300-400 percent (Yoder, 1989). In another study in Pakistan (Stephenson *et al.*, 2003), it was noted that even in situations where family planning services were free, the services still incurred costs in the form of transport and absence from household economic activities.

iii) Service providers' attitudes

Studies (Kinaro *et al.*, 2015; Nalwadda *et al.*, 2011) have shown that contraceptive practice can also be influenced by service delivery factors particularly those related to attitudes and behaviour of service providers and poor supply of contraceptive commodities. For example, a study among service providers in Uganda (Nalwadda *et al.*, 2011) found that, contrary to clear policy and guidelines, there were some service providers who were not prepared to provide contraceptives to young women who were less than 18 years of age, those who were unmarried, still in school, and those who were though married but had no children. Some providers were found to hold strong beliefs that if young women used contraceptives early in life, they could have long term side effects such as infertility.

Other studies (Mbizvo & Phillips, 2014; Jimmy-Gamma, 2009) found that providers did not respect young women's choices of methods as some providers indicated that they would firmly discourage the use of the injectables to young women due to its side effects while others demanded spousal consent before issuing them. In another study among young people in Uganda (Nalwadda *et al.*, 2010), young women indicated no trust in the service providers to respect their privacy and confidentiality. They had fears that they would report them to their partners, family members, parents and even teachers. In Nigeria (Ahanonu, 2014) found that over a half of the service providers in the study held the opinion that providing contraceptives to unmarried adolescents would promote sexual promiscuity instead they were telling the sexually active adolescents to abstain.

2.5.3 *Distal contextual factors*

These are predisposing factors which are at a distance from the locus of control of the individual. These include cultural traditions and practices, social forces and networks and economic conditions.

i) Marriage practices and kinship systems

Research has shown that social and cultural beliefs and practices can have an influence on SRH risks and contraceptive practices among women. In Malawi, studies have found that there are elements of kinship and marriage transaction systems that can influence young woman's reproductive and contraceptive behaviour. There are two dominant types of kinship systems that are followed in Malawi. The northern region, lower Shire districts of Nsanje and Chikwawa in southern Malawi and some areas in the central region follow the patrilineal system. In the patrilineal system, the woman moves out of her family and lineage and becomes part of her husband's family and the children belong to the husband's lineage. In terms of decision-making, the woman is under her husband and his family (Mkandawire-Valhmu *et al.,* 2013; Chimbiri, 2007; Malawi Human Rights Commission, 2006). The matrilineal descent systems are the customary norm for a majority of the population in Malawi (Kerr, 2005). People in the central region and most of southern region follow this matrilineal system in which kinship is traced through the mother and the man relocates to the wife's village to establish residence and is largely under the control of the extended family of his wife (Kerr, 2005; Sear, 2008).

In terms of decision-making on a wide range of matters, the woman is under the control of the extended family (clan) head (mostly uncles) and exercises some considerable degree of leverage over her husband (Zulu, 1998; Chimbiri, 2007; Sear, 2008). In patrilineal societies, there is emphasis on women bearing sons to perpetuate the husbands' family

lineages (Kerr, 2005, MHRC, 2006) while in matrilineal societies; women are not under any pressure to have children of a particular sex. In the later system, women are under their uncles or the eldest brother's control as heads of the clan and the woman and her children belong to her clan or family (Chimbiri, 2007; Sear, 2008; Zulu, 2001). In both systems, children are valued as economic assets to perform labour and take care of parents and other relatives in old age although their motivations and sex preferences differ (Kerr, 2005; Sear, 2008, Chimbiri, 2007).

Related to the kinship system is the nature of marriage transactions. In the patrilineal system, marriage involves payment of bride wealth locally called *lobola* or *malowolo* in which the reproductive rights of the woman are transferred to the lineage of her husband. The woman is detached from her lineage and becomes part of her husband's family and the children belong to her husband's lineage (MHRC, 2006; Sear, 2008; Mkandawire-Valhmu *et al.*, 2013). In a study by MHRC (2006) women complained that the system treats them as if they were bought and worth nothing more than a breeding apparatus for their husbands' families. This was the case because upon voluntary dissolution of the marriage, for instance, *lobola* could be requested back but the amount returned would be commensurate with the number of children borne out of the union. In the patrilineal kinship, social pressure to bear children, particularly sons, for one's lineage is strong, hence put pressure on young women to commerce childbearing as soon as they get into union or keep on bearing children until the desired sex ratio of the children is achieved. Thus, by the structure of the patrilineal system, reproduction is heavily stressed and a man may demand refund of his cattle (bride wealth) should his wife fail to bear him children (MHCR, 2006; Sear, 2008).

ii) Value for childbearing

Studies have shown that childbearing is very much valued socially and culturally and that there is great fear about infertility in the communities in Malawi (Zulu, 1998). In this respect, early proof of fertility is very critical to such an extent that voluntary barrenness arising from contraceptive use particularly among young married women can be abhorrent (MHRC, 2006; Sear, 2008). Studies (Chimbiri, 2007; Zulu, 1998) have found that failure to bear children can be an issue of concern in a particular union, within the extended family and the entire clan lineage. These studies have contended that newly married women are always under pressure to have children immediately after marriage such that when some period (usually six months) elapses without any sign of pregnancy, there is search for means to make the woman conceive (Zulu, 1998). For example, if the woman does not become pregnant within the prescribed period of time, the elders would suggest or prescribe treatment for the couple to undergo in order to start having children. If that fails and if it is the man who is suspected to be infertile, the elders among her husband's relations and mostly without his knowledge would arrange for another man to make the wife pregnant. If it is the woman who is suspected to be barren, the husband's family would urge the man to divorce her and marry another one or would urge the woman's family to bring in a relative to procreate for the husband and his family or where bride wealth was paid, the woman's family might be asked to pay back. It can also be a reason for the man to go into polygamy (Chimbiri, 2007; Zulu, 1998).

Other scholars elsewhere have also highlighted the value placed on childbearing by the social and cultural set up. In a study among community members in Tanzania (Mbeba *et al.*, 2012), young people indicated that adults were against young women using contraceptives fearing that some methods particularly injectables would affect their fertility to such an extent that they will be unable to get children in future. In a study in

Mali, it was also found that young unmarried women's reluctance to use hormonal methods was driven by their quest to maximise future fertility that will enhance their status in their families (Castle, 2003). Similar findings were obtained from studies in Asia. For example, in a study in Bangladesh (Haque & Sayem, 2009), the mean age at first birth was found to be lower among young women under family pressure to have a child as soon as they got married compared to those without such pressure. In a study in Nepal (Adhikari, 2010), it was posited that traditionally the Nepalese society looked at children as a symbol of both social and economic well being such that it is viewed as a disgrace for a couple, particularly for the wife, not to have children.

iii) Gender Inequalities

Gender is defined as common societal beliefs, customs and practices that define the characteristics, behaviours and roles of being male or female (Connell & Connell, 2000; Campbell, 2003). Gender roles have been defined as society's shared beliefs that apply to individuals on the basis of their socially identified sex related characteristics and are thus closely related to gender stereotypes while stereotypes are descriptive aspects of gender roles, as they depict the attributes that an individual ascribes to a group of people (Eisenchlas, 2013). Gender relations are defined as a social construction of roles and relationships between women and men with respect to power, decision-making, control over resources and freedom of action (Simtowe, 2010). The gender relations in Malawi show that there is general unequal status of women vis-à-vis men. This is shaped by inter-locking factors that include general poverty, discriminatory social and cultural beliefs, practices and treatment in the family and wider society (Kathewera-Banda *et al.*, 2005). Both matrilineal and patrilineal systems of kinship and marriage are found to perpetuate discrimination against women in the family and society with respect to access to and control over resources (Kathewera-Banda *et al.*, 2005). This is exacerbated by the fact that

women in Malawi generally fare worse than their male counter-parts on most social and economic indicators including wage labour force participation, and access to secondary and tertiary education (Kamlongera, 2008). This, then, affects the nature of their participation in the wider economic and social opportunities (Kathewera-Banda *et al.*, 2005). There exist traditional and cultural beliefs that hinder women's self-worth, and influence society's perception of women not being much more than housewives or mothers (Kamlongera, 2008).

Studies have concluded that within the Malawian society, regardless of marital and kinship system, women are culturally socialised from an early age to be subservient to men (Moore *et al.*, 2007; Zulu, 2001). This is a trait of an upright and cultured woman that is cherished by the community but plays a critical role in shaping the gender roles and forms an important part of moulding and influencing sexual partnerships and relations later on in married life (Jimmy- Gama, 2009). These skewed, in favour of men, gender relations are also noticed in the socialisation for productive roles where males are encouraged to become economically independent at an earlier age by sourcing own material needs while girls are socialised to help out in non paying domestic chores hence inculcating material and economic dependence on others (Masanjala, 2007; Mwalabu, 2014).

Gender in sexuality identifies the social roles, expectations and relations associated with being male or female. They define what males and females can do in society. These gender roles and values underlie sexual behaviour and can contribute to the vulnerability of young married women to adverse sexual and reproductive outcomes (Connell & Connell 2000). In most male dominated societies, men are instrumental in decisions made about the number of children the couple should have, whether to use contraception or not and the method of contraception to be used (Decker & Constantine, 2011). In such cases, women

who want no more children may not protect themselves from pregnancy because of their partner's desire to have additional children (Hartmann *et al.*, 2012; Bogale *et al.*, 2011). In Malawi, males are in control while females are controlled in heterosexual relationships. Women are culturally taught to be submissive to male partners in all domestic matters more particularly in sexual and reproductive matters (Jimmy-Gama, 2009; Chimbiri 2007).

Consequent to this social orientation, females do not have the autonomy on matters of their own reproductive and contraceptive practices as they are urged to always seek approval of their male partners although most of the contraceptive methods in Malawi are female based (Kathewera-Banda *et al.*, 2005, Jimmy-Gama, 2009). This is exacerbated by the society's regard, irrespective of being patrilineal and patrilineal, of reproduction as the primary function of women and the number of children a man fathers is often taken as an indicator of his virility (Sear, 2008; Chipeta *et al.*, 2010; Hartmann *et al.*, 2012). In this respect, females tend to be traditionally limited in their decision making and easily succumb to partners' wishes in matters of sex, childbearing and contraceptive use (Jimmy-Gama, 2009; Moore *et al.*, 2007; Hartmann *et al.*, 2012).

These inequalities constrain married women from negotiating and initiating contraceptive use and limit their contraceptive method choices. Studies in Uganda (Nalwadda *et al.*, 2010) and Malawi (Lindgren *et al.*, 2005, Hartmann *et al.*, 2012) found that young women felt that initiating discussions about protection against pregnancy and STIs including HIV with their partners was generally difficult and that such discussions would be construed as immoral and an admission of the woman's wayward behaviour. In addition, young women restrain themselves from seeking information about contraception fearing that the sexual partners would be suspicious of the sexual history of a young woman who is already knowledgeable about contraception and its methods (Nalwadda *et al.*, 2010; Pulerwitz *et*

al., 2010). Other studies have also found that conflicts with husbands and his family members particularly in-laws tend to be severe whenever family planning issues were raised leading young women to look at all matters to do with fertility as being outside their control (Chimbiri, 2007; Watkins, 2004; Munthali *et al.*, 2004).

iv) Partner Opposition

Studies have revealed that women find it easier to use contraceptives in situations where they have the ability and agency to control their sexual and reproductive lives and have autonomy with regard to decision-making in these matters (Do & Kurimoto, 2012; Hartmann *et al.*, 2012; Bogale *et al.*, 2011). It has also been argued that women's successful contraceptive use is enhanced by support, communication, discussions and approval of their partners (Decker & Constantine, 2011; Castle *et al.*, 1999).

In Malawi, the family planning policy and contraceptive guidelines are liberalised giving individuals or couples liberty to use any contraceptive method of their choice. The liberalisation was meant to remove restrictions, including parity and partner's consent, on all methods except sterilisation (Government of Malawi, 1996; Ministry of Health and Population, 2002). The change in policy was in reaction to the fact that some women who had wanted to use contraceptives were not able to get their partners' consent to do so (Chipeta *et al.*, 2010, Kaphagawani, 2008). However, in spite of this liberalised policy, studies on contraceptive use dynamics (trends, levels, determinants and barriers) in Malawi have consistently revealed partner opposition as one of the most prominent barriers to women's uptake of contraceptive services (NSO & ICF Macro, 2011; Bisika, 2008; Chimbiri, 2007; Chonzi, 2000).

In spite of programmes such as advocacy campaigns for male involvement that have been conducted to increase knowledge, induce positive attitudinal changes and enhance male

motivation to use contraceptives, studies in Malawi (Babalola *et al.*, 2012; Chipeta *et al.*, 2010) and South Africa (Stephenson *et al.*, 2008) have revealed that married women still need permission from their husbands to use contraception or risk abandonment or divorce. Studies in Malawi (Bisika, 2008; Kaphagawani, 2008; Chimbiri, 2007) and Uganda (Nalwadda *et al.*, 2010) have also found partner opposition to be one of the major reasons for married women's failure to use contraception, resorting to secret use or have limited method choices. In relation to unmarried women, studies have revealed that there were overall unfavourable perceptions and opposition to their contraceptive use particularly from parents and teachers. Under such unfavourable environment, young unmarried women were also found to resort to secret use to meet their specific sexual needs (Kinaro, 2015).

Studies have also shown that partner opposition can be for contraception entirely or for particular contraceptive methods and have gone further to proffer reasons for such opposition. It has been asserted that family planning practice tend to be in conflict with men's interests and desires to have many children, especially in situations where there was exchange of bride wealth, to compensate for the wealth transferred to the woman's family at marriage (Decker & Constantine, 2011; Watkins *et al.*, 1997). Related to that, there were also issues of gender differences in fertility preferences whereby husbands were found to generally want more children and want them sooner than did their wives (Bogale *et al.*, 2011; Chimbiri, 2007).

As has been elaborated above, partner opposition is one of the crucial barriers to young married women's contraceptive use. Under such circumstances, studies have found that some women would vouch to practice contraception secretly (Decker & Constantine, 2011; Biddlecom & Fapohunda, 1998). There are various reasons why women opt for

secret contraceptive use. Studies have found that some women opt for secret contraceptive use because it is difficult or almost impossible to communicate with their partners on most of the domestic issues particularly so on matters of childbearing and contraception (Stephenson *et al.*, 2008; Biddlecom & Fapohunda, 1998). Other women find these issues to be too culturally embarrassing to be discussed at all (Biddlecom & Fapohunda, 1998). Other studies have also shown that secret use is more prevalent in situations where there is reported physical violence between spouses in the family (Bogale *et al.*, 2011; Stephenson *et al.*, 2008; Kinoshita, 2003).

v) Secret Contraceptive Use

Secret contraceptive use was also found to determine and limit the choice of contraceptive methods to be used and was linked to the predominant use of specific contraceptive methods. In Malawi, Bisika (2008) observed that the majority of secret users had used the injectables method because they had some degree of control over it, was convenient as it would not be taken on a daily basis and more importantly, it was a method that could easily be used without being easily discovered by their partners. Similar results were obtained by scholars in other countries. In Uganda (Nalwadda *et al.*, 2010), it was noted that most young women who were using contraceptives secretly had tended to rely on the injectables because of their ease to hide. In Kenya (Magadi & Curtis, 2003) also found that women whose partners disapproved of family planning were highly likely to use traditional methods of family planning. In Zambia (Biddlecom and Fapohunda 1998), it was found that women who indicated to be using contraceptives without their husbands' knowledge were using methods that could be hidden easily.

Apart from choosing the methods that can be easily hidden, it was also found that women had fears of using certain methods. Studies had shown that the most prominent fears of

secret were in relation to being discovered by partners because of the contraceptive side effects that can ensue. For example, the perceived side effects such as irregular and heavy menstrual flow that may result from use of hormonal methods such as injectables were particularly worrisome to women (Biddlecom and Fapohunda, 1998). As they interfere with the normal sexual relations with their spouses they were fears that their secret contraceptive use could be easily discovered (Biddlecom and Fapohunda, 1998; Castle *et al.*, 1999).

vi) Myths, misconceptions and fears about contraceptives

Studies have shown that awareness about contraception among women is high but in-depth knowledge about how different contraceptive methods work is elusive. This explains the existence of a myriad of fears, myths and misconceptions about contraception in general and of particular methods. These fears and misconceptions were found to be emanating from women's, partners' and peers' perceptions and experiences (Nalwadda *et al.*, 2010; Kaphagawani, 2008; Gueye *et al.*, 2001). With respect to young women, it was found that they tended to put more weight on the real and perceived side effects of contraceptives than on the advantages of contraception (Nalwadda *et al.*, 2010) and that some young women would be more afraid of the side effects of contraceptives than pregnancy itself (Guiella & Madise, 2007). Studies in Uganda (Nalwadda *et al.*, 2011) and Malawi (Kaphagawani, 2008) found that young women generally perceived contraceptives to be harmful and detrimental to their health and harbour great fears of infertility once they start using them. Other studies in Nigeria (Babalola *et al.*, 2012) and Malawi (Zulu, 1998) revealed common beliefs that if a woman does not give birth to all of the children in her womb, she may develop some problems in her womb. De Negri and McKee (2012) also asserted that both men and women in Malawi generally feared loss of sexual drive due to

contraceptives. Similar fears about contraception's effect on menstruation and fertility were also found in South Africa (Ehlers, 2003).

While the above studies have focused on myths and misconceptions about contraception in general, some studies have found fears, myths and misconceptions associated with particular contraceptive methods as explained below:

a) The pill and injectables

In a study in Malawi (Chonzi, 2000), it was found that there were some myths and misconceptions concerning the contraceptive pill. These included that pills cause the abdomen to swell as they accumulate in the womb and that a woman can die of that. Further, it was also found that if the woman were to get pregnant, she would not deliver normally and would have to undergo an operation and would even die from that surgery. Furthermore, if she were to deliver, then the child would be born with defects or with polio. It was also reported that pills could cause cancer. A study in Uganda (Nalwadda *et al.*, 2010) revealed that young women believed that pills burn the woman's eggs and accumulate in the body causing swellings such as fibroids, cancer and destruction of the fallopian tube. Studies in Malawi also found that injectables were shunned in some communities in the country due to its cause of prolonged, severe and frequent vaginal bleeding (Bisika, 2008; Sarkar, 2009). In addition other studies have shown that there are fears of infertility among women who use injectables (Chonzi, 2000; Kaphagawani, 2008).

b) Intra Uterine Device (IUD)

This method is one of the least known and used one in the country (NSO & ICF Macro, 2011). The method is associated with a number of misconceptions that would have a bearing on its choice for contraception. Studies in Malawi have highlighted the beliefs that the IUD moves about and lodges in the woman's heart (Chonzi, 2000). There were also

beliefs that the method is not suitable for women who are in polygynous unions, have multiple sexual partners, or have partners who have multiple sexual partners (Babalola *et al.*, 2012). Further the IUD was also alleged to cause discomfort or pain to men during sexual intercourse and could get into a woman's blood stream and cause death (Chonzi, 2000). It was also reported that both female and male young people felt that IUD could pierce the uterus and cause problems and could also cause cancer (Babalola *et al.*, 2012; Chonzi, 2000; Nalwadda *et al.*, 2010).

c) Condoms

There have been many studies world over that have found myths and misconceptions pertaining to condom use in general and as a contraceptive method in particular. In Malawi, there was a national large scale condom promotional campaign in the early 1990s that coincided with the emergence of HIV and AIDS epidemic. In this respect, condoms have mostly been associated with prevention of HIV in spite of the fact that the country's contraceptive guidelines list it as one of contraceptive methods (Kaler, 2004; Government of Malawi, 1996). In this case, the general misconception is that condoms are meant for prostitution or other forms of illicit sexual encounters (Chimbiri, 2007). In addition, there are misconceptions that condoms disappear in the woman's body (Chonzi, 2000), their use is against God's law and that only prostitutes use them (Kaler, 2004; Paz Soldan, 2004). Others allege that condoms burst too easily and expose users to infections; have very tiny holes where sperms and woman's fluids can pass through to either partner and that condoms would cause cancer or genital sores (Watkins 2004; Kaler, 2004). In a study in Uganda (Nalwadda *et al.*, 2010), both male and female young people expressed beliefs that condoms get stuck in the reproductive tract, damage the uterus and cause death. In addition, they held a belief that 'Whites' had infected condoms with HIV and also that

condoms have pores or grooves with actual perforations that allow transmission of HIV. Others believed that once a young man uses a condom, he will not sire children in future.

The issue of loss of sexual pleasure has also been found in many countries. Studies in Malawi (Kaler, 2004, Munthali *et al.*, 2006b; Chimbiri, 2007; Muula *et al.*, 2015) have found that people particularly boys and men refuse to use condoms because of the misconception that with condoms, one does not feel sexually satisfied. Similar results were found in other countries. In a study among sex workers in Lao, Andrews *et al.* (2015) it was found that the main reason for shunning both male and female condoms among clients was that they reduced pleasure. A study in Mali had also established that some young people felt that one would not have the same feelings during sex when using a condom because they were said to reduce pleasure (Guiella & Madise, 2007).

d) Sterilisation

There have also been myths and misconceptions associated with permanent methods of contraception. A study (Babalola *et al.*, 2012) found that women had the misconceptions that once they use sterilisation, their partners would no longer find them sexually satisfying or they would lose own sexual desire and would not want to have sex with their partners. In addition, there was also misinformation about female sterilisation among both men and women as it was generally perceived to be a method that a woman would not use by choice but rather out of necessity if other methods are unsuitable or if another future pregnancy could threaten her life.

2.6 The theoretical framework

2.6.1 Introduction

There are a number of theories or models that have been propounded and applied by scholars to explain or predict attitudes and behaviours pertaining to health in general and SRH risks and contraceptive practices in particular. These include health belief model (HBM), for example, explains and predicts behaviours by focusing on the individual's beliefs about his or her vulnerability to a particular health problem and his or her beliefs about the consequences of such a health threat (Janz & Becker, 1984). It postulates that an individual's desire to taken a certain action (avoid an illness or get better) would be influenced by the belief that such action would culminate into positive outcomes (avoidance or amelioration of an illness). However, because of its emphasis on cognitive rationality, it does do not adequately capture the contextual (beyond the control of the individual) that reviewed literature has demonstrated to be very critical in predicting the behaviour of young people.

In relation to the behaviour of adolescents and young people, some scholars have adopted and used the social constructionism and ecological models. The social constructionism approach is used to gain in-depth understanding of people's lived experiences, the local labelling and meanings placed on a particular phenomenon by the society or community and how the ensuing tensions, values and beliefs influence the adoption of positive behaviours (Jimmy-Gama, 2009) by young people. It also asserts that a particular behaviour is created and enhanced through social processes and institutions and that through social interaction, people learn social and cultural norms and values and ultimately exhibit behaviour that conforms to these beliefs and practices (Ngalinda, 1998). Thus, social constructionism is based on shared meanings to describe, explain or account for the

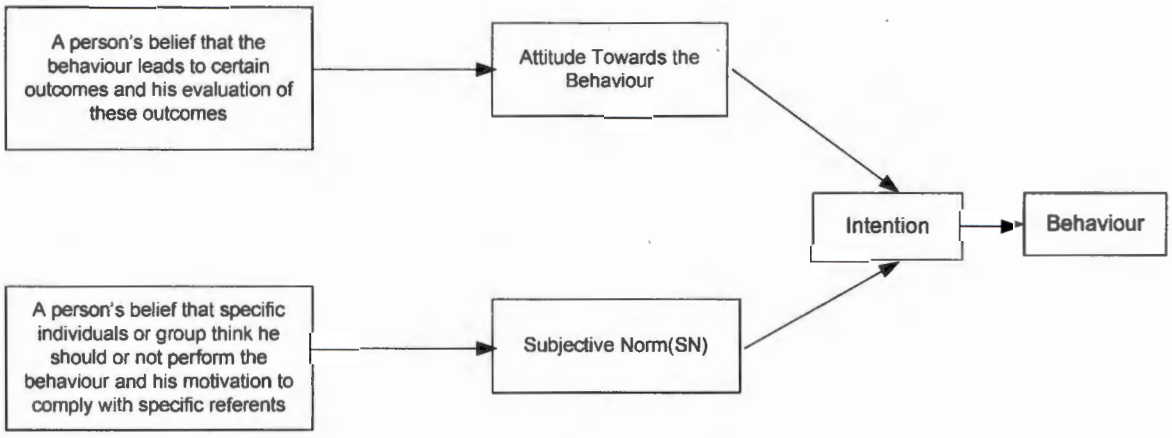
understandings attached to customised social beliefs, attitudes, values and actions which are communicated symbolically in a society. It challenges the pure scientific explanation and rationality and objectivity of thought in human behaviour (Gergen 2003).

The ecological model was elaborated by Bronfenbrenner (1979) to highlight the influence of the environmental and policy contexts in shaping young people's behaviours. It therefore leads to the explicit consideration of multiple levels of influence, thereby guiding the development of more comprehensive interventions. These contexts include socio-economic factors, cultural background and the general social environment that provides social norms, models, opportunities and reinforcements for young people's behaviours (Millstein & Igra, 1995). The model reflects a set of interrelated elements of the social and policy environment with which young people interact directly and shape, reinforce or influence their behaviours (Garbarino, 1985). Amoateng & Kalule-Sabiti (2015) had highlighted the roles of the family particularly parenting styles (lack of parental support, control or supervision of teenagers), peer pressure and role modelling that constitute important social contexts that influence adolescent's negative attitudes and behaviours.

In this study there has been a search for a single theory or model that can broadly capture, explain and predict SRH risks and contraceptive practices of young married women. While these three models are robust in their respective areas of emphasis, they do not individually capture all the factors and adequately explain the attitudes and behaviours pertaining to SRH risks and contraceptive behaviours being investigated in this study. In this respect, the study adopts the Theory of Reasoned Action (TRA) as propounded by Ajzen & Fishbein (1980) due to its wider coverage of inherent elements that would explain and predict SRH risk behaviours of early sexual debut, early marriage, early childbearing and contraceptive use among young women. The TRA postulates that a particular desired

behaviour or action would be influenced by one's belief about the outcomes of the intended actions, one's assessment if those particular behaviours or actions are desired by significant others and one's own motivations to comply with views of the significant others (Downs & Hausenblas, 2005). It is called a Theory of Reasoned Action because it underpins the fact that people consider the implications of particular behaviours before taking actions (Albarracin *et al.*, 2001). Figure 2.1 presents the schematic diagram of the theory.

Figure 2.1: The Theory of Reason Action (TRA)



Source: Ajzen, I. & Fishbein, M. (1980).

Figure 2.1 shows that attitudes towards a particular behaviour stem from underlying beliefs concerning that behaviour. The intention to undertake an action is in turn determined by the attitude towards performing that particular behaviour and perceived social pressures to perform such behaviour (subjective norms). The individuals would intend to perform a particular behaviour when they evaluate them positively and when they believe significant "others" approve their performing of those actions. In summary, the theory postulates that individuals decide to take particular actions on the basis of their attitudes towards that behaviour as determined by beliefs and outcome evaluations and their perceptions of what it is, that important referents feel about their taking those actions. The behaviour is adopted

on the basis that the important referents would approve and would encourage such behaviour (Azjen & Fishbein, 1980; Albarracin *et al.*, 2001; Downs &Hausenblas, 2005).

2.6.2 Application of the theory to the study (conceptual framework)

As highlighted in the literature review, sexual and reproductive health risks and contraceptive practices are not only linked to the behaviour of the concerned individuals but are also a consequence of a myriad of contextual factors that include social and cultural environments and influences of the beliefs, attitudes and behaviour of significant others. In the current study, the significant others include partners, peers, family members, health service providers and cultural or traditional leaders.

Studies (De Negri & McKee, 2012; Hennink & Madise, 2005; Zulu, 1998; Hartmann *et al.*, 2012) have posited that decisions pertaining to SRH risks and contraceptive practices are made in contexts in which women may not be the ultimate decision makers. In such contexts, decisions tend to be made in situations in which these significant others would exert overt and covert influences that, at times, may not be in tandem with the woman's sexual and reproductive health and rights. For example, there are cultural beliefs that a woman's principal role in marriage is to bear children (Nalwadda *et al.*, 2011; Hartmann *et al.*, 2012). Such cultural norms oftentimes result in family and societal pressure on the woman, even against her wishes and plans, to have children immediately after marriage (Zulu, 1998; Guiella & Madise, 2007; De Negri & McKee, 2012).

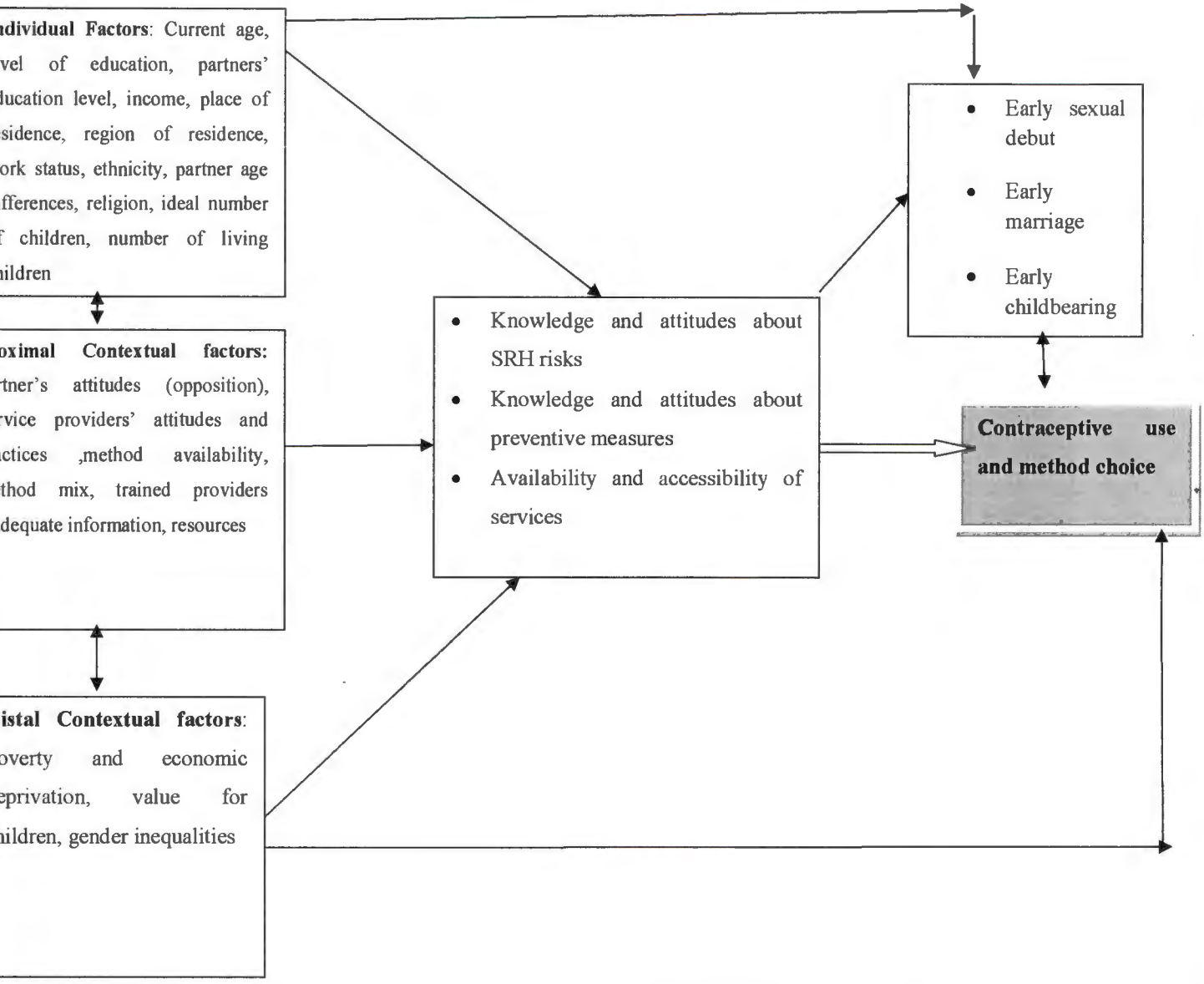
In addition, studies have also found that decisions to use contraceptives tend to evolve over time, and that women usually make such decisions after consulting with a wide range of people with whom they discuss reproductive issues (Watkins, 2004; Zulu 1998; Paz Soldan, 2004). For example, Paz Soldan (2004) found that women's choices of which methods to use were mainly influenced by discussions that prevailed and information that

was shared among women concerning particular method's benefits and side effects such that women who perceived that others in their immediate network were using particular contraceptives were more likely to use such contraceptive methods. Chipeta *et al.* (2010) also found that the majority of both young men and women indicated that peers were their main source of information about family planning's health concerns and side effects. Similar results on the importance of social influence on contraceptive use and method choice were obtained in Cameroon (Valente *et al.*, 1997) and Myanmar (Mon & Liabsuetrakul, 2012).

Applying TRA to this study, it is hypothesised that there are both personal and contextual factors that would explain young married women's SRH risks and contraceptive practice. A young married woman would take action to use contraceptives, for example, if she believed that contraceptive use would protect her from early pregnancies and childbearing. Further, the action would be taken if the significant others would not want her to be exposed to early childbearing, and that she gets convinced that her action would fall in line with the views of the significant others. The schematic diagram in Figure 2.2 summarises the framework to be used to explain the connections between woman's characteristics, the socio-cultural contexts, services' access, sexual health risks and demand and use of contraceptives.

As can be seen from the diagram, the factors that influence SRH risks and contraceptive use among young married women are grouped into three sets. The three groups are the underlying factors that are described as demographic and socio-economic (individual), programmatic (proximal contextual) and the third group is social and cultural (distal contextual).

Figure 2.2: Conceptual Framework for understanding sexual and reproductive health risks and contraceptive use among young married women in Malawi



Source: Researcher's construct as adapted from Ajzen &Fishbein (1980)

From the conceptual framework, these underlying factors' influence on the dependent variables is assumed to operate through the proximal factors of knowledge about SRH, knowledge about contraceptives (myths and misconceptions, fear of side effects) gender inequalities (partner opposition and secret contraceptive use, cultural and social norms (fear of infertility) to influence SRH risks and contraceptive perceptions, attitudes and practices.

2.7 Conclusion

This study is anchored on the assertion that young married women find themselves in distinct cultural, social and economic contexts that predispose them to and exacerbate their sexual and reproductive health risks and limit their demand for, access to and utilisation of methods for prevention of pregnancies and sexually transmitted diseases. From the literature reviewed here, it can be summarised that there are a multiplicity of factors that affect SRH risks and contraceptive practices. However, most of these studies have not targeted young married women as a distinct group. From the literature reviewed here, it can be summarised that due to prevailing cultural and social norms, particularly in the rural traditional communities, females have fewer opportunities and socio-economic activities outside home, other than marriage and childbearing that would enhance their status and value. Consequently, from early ages, girls are socialised and bound by social and cultural practices and norms that precipitate their early exposure to sexual and reproductive health risks of early sexual debut, early marriage and early childbearing. These risks are further compounded by the low contraceptive use that is exacerbated by, among some factors, the social and cultural norms that oppose contraceptive use. They are also worsened by negative perceptions about contraceptives and opposition that prevail among young married women, their husbands or partners, families, their communities and service providers.

CHAPTER THREE: STUDY METHODOLOGY

3.1 Introduction

This chapter presents sources of data for the study. It proffers the justification of using multiple methods (quantitative and qualitative) and details the three methods of qualitative data collection and their relevance for this study. The chapter also highlights the primary data collection process, data analysis techniques, ethical considerations and the limitations of the study.

3.2 Data sources

The study's design was cross-sectional with a mix of quantitative and qualitative data sources. Research on sexual, reproductive and contraceptive behaviour, particularly for young married women in the rural areas, can potentially be a challenging and difficult undertaking. This is because issues of sex and sexuality and reproduction are shrouded in secrecy due to culturally embedded norms that regard sexual discussions, even among spouses, as taboo (Jimmy-Gama, 2009). Scholars such as Darbyshire *et al.* (2005) have argued for the importance of using multiple methods in researching on topics that touch on personal attitudes and experiences because it not only provides alternative data but also offers complementary insights and understandings that would be hard to access through reliance on a single approach to data collection. They contend that a mix of quantitative and qualitative methods strengthens robustness and reliability of the results as it allows each research method's weaknesses to be overcome by the strengths of the other method. In this study, the multiple methods are used principally to supplement, contextualise, compare and validate the findings of quantitative results by qualitative ones.

The quantitative analysis (Phase one) of the study uses secondary data from the 2000, 2004 and 2010 Malawi Demographic and Health Surveys. These datasets are used to analyse

levels and trends of SRH risks (early sexual debut, early marriages and early births) and levels, trends and determinants of contraceptive use and method choice among young (15-24) married women. The analysis of these phenomena forms the basis for investigations in the second phase of the study using qualitative methods. The qualitative methods are used to complement and fill some gaps in information from the MDH Survey that are critical to be objectives of this study. For example, these surveys have no data pertaining to reasons, decision-making processes and social and cultural contextual factors that can influence SRH risks and contraceptive practices. Furthermore, information related to constraints to access of SRH information and services as they relate to young married women was also not collected in the MDHS. In this respect, the qualitative sources of data provide an opportunity to broaden the understanding of the SRH risks and contraceptive practices of young married women beyond their quantitative descriptions. The qualitative data were collected from young married women through individual in-depth interviews (IDIs) and focus group discussions (FGDs) and from health service providers and traditional leaders through key informant interviews (KIIs). The subsequent sections detail the quantitative and qualitative data sources and their analyses.

3.2.1 Secondary Data

The data (three sets of MDHS) for the quantitative analysis were downloaded from the web-platform of measuredhs after approval was obtained from measuredhs (the data originators). In all these surveys, women were asked about their background characteristics, sexual, reproductive and contraceptive histories and practices, fertility preferences and their partners' background characteristics. In addition, these surveys have been consistent in collecting information about SRH risks as they relate to timing of first sex, age at first marriage and age at first birth that are the areas of focus in this study. The quantitative data were taken from the MDHS individual women questionnaire where

information was collected from women aged 15–49. Only data for young married women aged 15–24, the target group for this study, are used for analysis. The MDHS data are rigorously collected with a sample selection that is representative of the country. Detailed information on the technical aspects involved during the Demographic and Health surveys are available in the final survey reports (NSO & Macro International, 2001; NSO & OCR Macro, 2005; NSO & ICF Macro, 2011).

3.2.1.1: Description of variables

3.2.1.1.1 Dependent variables

The dependent variables for this study are obtained from the questions in the woman questionnaire of the MDHS that ask about current contraceptive's use and method used. These are age at first sex (<15 or 15 and above) age at first marriage (<18 or 18 and above) and age at first birth (<18 or 18 and above). The substance of the study on the SRH risks was not necessarily to come up with their determinants using individual women's characteristics but rather to explore the connections between age at first sex, age at first marriage and age at first birth. In this respect, there was no bivariate and multivariate analysis between these three dependent variables and the independent variables.

However, the current practices of contraception by young married women were analysed using the dependent variables and the independent variables. The dependent variable of 'current use' is categorised as 'use' or 'non use' and 'contraceptive method choice' is categorised into three as 'no method', 'injectables', and 'other modern methods'. These 'other modern methods' were lumped together because they were being used by small numbers of young married women. These are basically condoms and the pills.

3.2.1.1.2 Independent variables

The independent variables have been selected on the basis of the literature review. They are grouped into three categories. The first group of variables include those described as individual factors that include current age of the woman (15-19 and 20-24), number of living children (0, 1and 2+) , ideal number of children (2 and below, 3-4 and 5+), next birth waiting period (within 2 years, after 2 years and want no more) , husband's fertility desires (both want the same, husband wants more, husbands wants fewer, don't know), husband's presence (yes and no), marital duration (less than 5 years and five years and more), woman's highest level of education (no education, primary, secondary), level of income (wealth index (poorest, poorer, middle, richer and richest), woman's working status (yes and no) and husband's level of education (none, primary, secondary). The other variables are contextual that include ethnicity/tribes (Chewa, Tumbuka, Yao, Lomwe, Ngoni and other), region(North, Centre, South), religion (Christians and Moslems), place of residence (rural and urban), number of co-wives (0 and 1+), number of previous unions (0 and 1+) and spousal age difference (less than 5 years and 5 years or more). All the independent variables were obtained from the various sections on the women questionnaire. In the MDHS wealth index was constructed using the following household assets data: electricity, radio, TV, bicycle, motorbike and car. Each item was given a score and it was summed across items for each household. Individual wealth was ranked along the dimesnsions of poor, middle and rich based on the total score (IFC Macro & NSO (2011).

3.2.1.2 Quantitative data Analysis

Quantitative analysis was done using Statistical Package for Social Scientists (SPSS) (version 22), a computer software package (IBM Corp., 2013). Descriptive analysis was done on the variables and summary statistics are reported in tables and graphs. The

analysis process was in three areas of focus. The first analysis was based on 3,258 young married women in 2000; 3,071 in 2004 and 5,240 young married women in 2010 on the timing of first sex, timing of first marriage and timing of first birth and how they have been changing over the three survey periods. The second phase of analysis involved examining the characteristics of young married women who use contraceptives and their determinants of contraceptive use. These numbers of all young women were also used in the analysis of the outcome variable of 'contraceptive use' (whether the young married woman is using a contraceptive or not). In the third area of focus, only data from contracepting young married women being 1,041 in 2000; 1,403 in 2004 and 1,786 in 2010 were used to examine the characteristics of young married women who chose particular contraceptive methods and the determinants of their contraceptive choices.

Multivariate analysis was used to allow for the simultaneous examination of the effect of different variables on the other variables (Rubin & Babbie, 2011). Multivariate analysis was done by using two regression models: binary logistic regression for identifying the determinants of modern contraceptive use and multinomial regression models for investigating the determinants of method choice. Multinomial logistic regression is an extension of the binary logistic regression and caters for situations where the dependent variable has more than two categories (Starkweather & Moske (n/d). In the current study contraceptive use has two categories while method choice variable has three categories. The regressions established that the dependent variable is related to the independent variables and the error term. The form of model is as below:

$$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \ldots\ldots\ldots + \beta_p X_p + E \quad \ldots\ldots\ldots\ldots\ldots\ldots (i)$$

where Y represents the dependent variable in this case 'contraceptive use' and 'method choice'. Contraceptive use was defined dichotomously as *'use'* and *'non-use'* among

women aged 15-24 years. The method choice was multinomially defined as '*no method*', '*injectables*' and '*other modern methods*' with no method as a reference category in order to determine between injectables and use of other methods in turn. X_1, X_2, X_3, X_4,X_p represents the independent variables used in the study and E is the error terms. The result of the logistic regression models were represented using odds ratio and the relative risk ratio was used to explain the multinomial outcome of the effect of one unit change of the independent variable with respect to each dependent variable respectively (Montgomery *et al.*, 2012; Raftery *et al.*, 1997).

3.2.2 Primary data

As elaborated above, qualitative methods were the principal data sources for the study. The subsequent sections highlight the process of data collection and analysis.

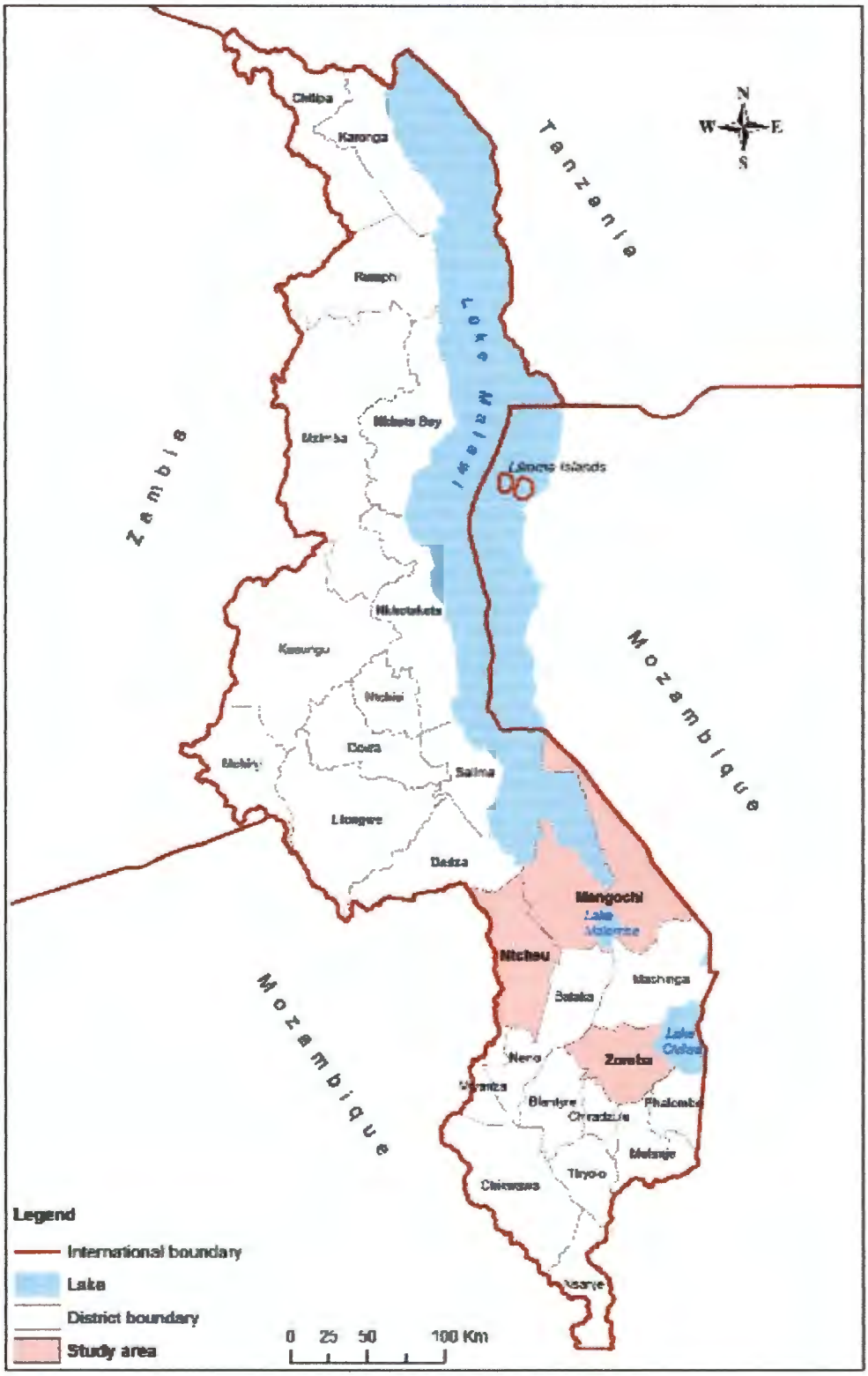
i) Selection and description of study districts

The sample was selected using a two stage selection design to reflect the demographic, social and cultural diversity of the study districts. Purposive selection was done to come up with three divergent districts of Ntcheu, Zomba and Mangochi from the 2010 Malawi Demographic and Health Survey (MDHS) list of the country's total of 28 districts (refer to Map in Figure 3.1). The purposive sampling technique is the deliberate choice made in accordance with set criteria (Tongco, 2007). The criteria used were contraceptive prevalence and fertility rates, marriage and kinship systems, economic activity, ethnicity, language and religion as reported in Table 3.1. These differences in characteristics ensured heterogeneity of the study areas and participants.

Mangochi district is located on the southern tip of Lake Malawi in the southern region and is a predominantly matrilineal society. Because of its large Muslim population, Mangochi is also highly polygynous (Jimmy-Gama, 2009). It is one of the districts where a lot of

young men migrate to South Africa to look for employment. Ntcheu district is located in the Central region and is dominated by the Ngoni tribe and they are predominantly patrilineal with a mix of polygynous and monogamous marriages. Dating back to the colonial days, a lot of young men migrate to South Africa for employment. Zomba is predominantly rural but also has one of the four major urban areas in the country (Government of Malawi, 2013). In the City, there is a mixture of patrilineal and matrilineal systems of kinship depending on the residents' districts of origin. Its young men have a lower propensity to migrate to South Africa compared to these other two districts. Its rural areas are matrilineal and monogamous but with some areas practicing polygyny because of the presence of a sizable Muslim population

Figure 3.1: Map of Malawi showing the study districts



While there might have been other districts that also matched the above criteria, these districts were conveniently selected to match with the availability of resources (financial and time) at the disposal of the researcher and the easy logistics of reach to the study areas and conduct the study. In addition, these three districts had no running district or area specific SRH and family planning special projects either by government or Non Government Organisations that would have otherwise set them apart from the other districts and hence influenced the study findings. Table 3.1 presents a summary description of these districts:

Table 3. 1: Characteristics of the study locations

District	Variations in Contraceptive practices	Fertility rates	Urban representation	Main Marriage system	Main Kinship system	Main economic activities	Main tribes	Main Language	Main Religions	Study sites
Mangochi	Low CPR (below national average)	High TFR (higher than national level)	Less than 5 percent	polygynous	Matrilineal	Fishing and farming	Yao	Chiyao	Islam	Malindi, Nankumba, Lingamasa , Mpondasi Chowe,
Zomba	Average CPR (same as national average)	High TFR (higher than national level)	About 10 percent)	monogamous	Matrilineal	Vending and farming	Mixed	Chiyao and Chichewa	Mixed	Lamburira. Thondwe, Mwandama, Domasi, Makwapala
Ntcheu	High CPR (greater than national average	average TFR (same level with national level)	Less than 10 percent	Mixed	Mixed	Farming	Ngoni	Chichewa	Christian	Bilila, Lizulu, Biriwiri, Mlangeni, Nsiyalundzu

ii) Selection of study sites

Stage two of the selection was that a quota of five study sites (health centres), as entry points, was purposively selected from each district (as shown in Table 3.1 above) irrespective of its size. The purposive selection for the health centres took into consideration that the centre provides family planning and maternal and child health services as part of their routine services and that the selected centres are properly dispersed

geographically. The selection of the health centres was done in consultation with the District Health Officers that had a list of all the health facilities in their districts from which the study sites were drawn. It is at these health centres where young married women and health workers were selected to participate in individual in-depth interviews and key informant interviewees respectively. An Enumeration Area (EA) as mapped by the National Statistical Office was randomly selected within the environs of the selected health facility. In each of the selected EAs, key informant interviews with traditional leaders and community health workers and focus group discussions with young married women were conducted.

iii) Field Work

Four female research assistants (RAs), all of them less than 24 years old, were recruited among third year female students from the Research Methods class in the Population Studies Department at the University of Malawi. Recruitment was based on knowledge and experience in conducting, transcribing and translating interviews and discussions, fluency in both English and Chichewa (local language), good writing skills (in English), good conversational skills, and a general ease and openness to discussing sensitive issues. All the study participants were found to be conversant with and understood Chichewa as a national language as such all the interviews and discussions, except with service providers, were conducted in Chichewa. They were transcribed verbatim and translated into English. For service providers, the interviews were conducted in English and transcribed verbatim also. The data collection team underwent a four day training session conducted at the University of Malawi, Chancellor College campus in Zomba. The training was aimed at ensuring standardised level of knowledge on the part of the RAs. The last day of the training was for pre- testing of the data collection instruments and pilot testing of the data collection process. The pilot testing was done on the individuals with similar

characteristics as those of the study participants. It was done at Bimbi Health Centre in Zomba and its adjacent EA of Kupitakusya village. These study sites were not included in the real data collection. The pilot testing involved conducting one FGD with young married women aged 20-24 as they were easily identified and gathered, 4 IDIs with young married women and one interview each of health centre service provider and traditional leader as key informants. Data collection process in the study districts was carried out from June to August, 2014 for a period of 10 weeks with 7 to 9 days breaks in between the districts. The breaks were spent in the study districts to enable the RAs complete the verbatim transcriptions and translations of data scripts and follow up on any missing information with the study participants. Each interview or discussion lasted an average of one and a half hours.

iv) Data collection methods and selection of study participants

Data collection was done using individual in-depth interviews, key informant interviews and focus group discussions guides. The development of these semi-structured data collection tools was informed and guided by the Theory of Reasoned Action as a framework; the literature, study objectives and the research questions. Using these sources, themes were generated that guided the flow of questions in the data collection tools. The initial guides were constructed in such a way that they explored broad themes and questions aimed at allowing the study participants discuss subjects of sexuality, reproduction and contraception among young married women. The questions were revised and refined accordingly during the pilot testing in response to emerging issues from the study participants' narratives. During the field work, there were emerging themes that were not in the initial questioning route but arose from the interviews and discussions and these were further followed and investigated. For example, the questioning route did not envisage that secret contraceptive use would be an issue among young married women but

it later emerged during the study as one of the major themes in young married women's contraceptive practices. Similarly the issue of social and cultural constraints experienced by contraceptive service providers in the provision of contraceptives to young married women had to be pursued as an emerging theme because it kept on recurring among the study participants. The justification for each method used is provided in the discussion of each method. Both English and Chichewa versions of the IDI, FGD and KII guides are attached in the appendices.

The selection of the sample sizes for the study participants was guided by the principle of thematic saturation. This is a point where no more new information or themes can emerge. Guest *et al.* (2006) had suggested that not less than 12 interviews per group would yield thematic saturation. In this respect, a sampling matrix was used to ensure that the perspectives of a variety of study participants were captured and included. However, it emerged during the analysis that in case of young married women, it was only the variables of parity, contraceptive use and to some extent the study district that were showing some variations in the contraceptive attitudes and practices. There were no variations in the narratives by kinship system and age of the study participants. The study methods and selection of study participants are discussed as below:

a) Individual In-depth Interviews (IDIs)

The IDI method is used to obtain more detailed information pertaining to individual perceptions and reasons behind the interviewees' statements through probing (Kitzinger, 1995). It is also pertinent for topics that are sensitive as they provide a more confidential context for self revelation (Fitzpatrick & Boulton, 1994). In this study, IDIs are appropriate to facilitate collection of information about individual's opinions, knowledge, attitudes and more importantly experiences in the matters being investigated. In addition,

the sensitive nature of the issues under investigation requires unrestricted conversations with individual young married women for thorough understanding of their perceptions, attitudes and experiences. In this respect, it allowed for a deeper understanding of the factors influencing SRH risks, contraceptive practices and the constraints they encounter as young married women.

The selection and recruitment of the IDI participants was as follows: At the selected health centre, four young married women (15–24) clients were approached to participate in individual in-depth interviews (IDI) among the young married women who had visited the health facility for antenatal, family planning or postnatal services on the day the research team visited. The research assistant (RA) approached a potential interviewee as she went out after being attended to at the health facility in the community. She asked for her consent to participate in the study after being given full information about the study. The RA disclosed that she was not connected to the facility and assured the prospective participant that her responses remained confidential; and that her participation and responses in the study were not, in any way going to jeopardize or influence her future engagement with or access to the facility's services. Upon her consent, the RA recruited the woman for the IDI. It was planned that four IDIs would be conducted at each health facility yielding 20 in each district and 60 IDIs for the whole study. However, the researcher found some critical information leads that were deemed to be enriching to the study by interviewing more young married women such that some districts had more IDIs as presented in Table 3.2. A total of 68 IDIs were successfully conducted for the study with their analysis distinguished by district, parity, contraceptive use and age.

b) Focus Group Discussions

Focus groups discussions (FGD) as a method of qualitative data collection drives its strength from the communication and interaction that ensue among the study participants in a group as they engage each other, comment on, exchange experiences provides insights into group dynamics and norms in relation to the issue under discussion (Kitzinger, 1995). It is also used because of its usefulness in exploring a people's knowledge and experiences in their communities and provides explanations for group meanings and social norms and normative behaviour (DiCicco-Bloom & Crabtree, 2006). In this study FGDs were chosen and used to generate information from the perspective and in the words of young married women that provided insights into collective and consensus information. Being issues that are secretive but of importance to the participants, the FGDs helped to open the young married women up and generate their own opinions. Twelve young and married women in each of the selected EAs were conveniently selected to participate in the focus group discussions in either of the two homogenously composed groups arranged by age (15–19 and 20–24). In cases where the numbers were falling short, snowball method of selection was used in which the available young married women would be the initial reference points to get more young married women fitting the criteria. The selection of young married women from the communities was meant to include, in the study, some young married women who could not come to the health centre for services. The distribution of FGDs for the study is reflected in table 3.2 below.

Table 3.2: Data Collection Districts and distribution of sample study participants

District	Young married women IDIs	Young married women FGDs	Traditional Leaders KIIs	Health workers KIIs
Mangochi	24	7	6	11
Zomba	21	6	5	11
Ntcheu	23	5	8	10
Total	**68**	**18**	**19**	**32**

c) Key Informant Interviews (KIIs)

Key informants are deliberately chosen due to the qualities they possess. They are observant, reflective members of the community of interest who know much about the culture and the practices of a particular group of people and are willing to share their knowledge (Tongco, 2007). In this respect, it is the researcher who decides what needs to be known and sets out to find people who can and are willing to provide the information by virtue of their knowledge or experiences. In this study the KII method was chosen and used because as outlined in the framework, the study also sought to understand the social and cultural contexts in which SRH risks and contraceptive practices among young married women happen. In this respect, key informant interviews were conducted with traditional leaders to understand their attitudes and perceptions about early sexual debut, early marriage, early childbearing and contraceptive use as they relate to young married women from the angle of social and cultural norms, traditions and practices. KIIs were also used to examine the service delivery factors such as provider's attitudes and practices and contraceptive service accessibility that can facilitate or hinder contraceptive practices among young married women. Consequently, service providers from the already selected health centres as explained above and health workers in the communities were recruited as key informants based on their experiences in providing contraceptive and other maternal and child health services and their availability and willingness to participate at that point in time. Table 3.2 displays the distribution.

While the explanations for each method as outlined above highlight the strengths of these qualitative data collection instruments, it is also pertinent to state that there are also limitations with these methods. The data from these methods may suffer from potential bias both at the time of collection and in the analysis as it is subject to the interpretation of the researcher (Stewart & Shamdasani, 2014). However, in this study that risk was

minimised by use of four research assistants who collected, transcribed and translated the data. The researcher only used the translated scripts for analysis.

v) Data analysis

Qualitative data analysis was done using thematic analysis. Thematic analysis is an approach that involves the creation and application of codes to data (Gibson, 2006). Coding was based on both deductive and inductive processes (Teram *et al.*, 2005). This means that the analytical process used both the already formulated themes (deductive) and the emerging ones (inductive) that were generated in the process of collecting and interrogating the data (Scott & Dowell, 2008; Teram *et al.*, 2005). Each theme was assigned codes. However, due to the vast amount of data collected, the researcher also resorted to open coding of the transcripts to ensure that no useful information is left out due to restricted number of codes. The scripts (documents) were uploaded onto Atlas Ti Version7 (Mohamad, 2014) for coding the textual data by themes and networking the themes and codes. Themes were compared between and among subgroups such as age, parity, contraceptive use and district to identify similar threads and variations in the responses. The results are presented through the selection of associated quotes or excerpts that best capture the substance of the themes and answer the research questions.

3.3 Ethical Issues

In accordance with the ethical guidelines for protecting human subjects in research, the study was presented to the North-West University's (Mafikeng) Ethics Committee where the Ethical Clearance was issued authorising the carrying out of the study. In Malawi, permission to conduct the study in the study districts was requested and obtained from the discussions with the District Commissioners and District Health Officers. At community levels, verbal permission was obtained from the traditional leaders (village headmen) and Officers In-charge of each of the health centres visited in each district and study site. In

addition, informed consent was verbally obtained from all the study participants after reading a consent statement to them. The study participants were given full information about the nature and purpose of the study and were assured of confidentiality of the provided information. This was verbally explained. The study team ensured that study participants did not provide information under duress and that they would not suffer any consequences as a result of their participation in the study. They only participated upon obtaining their voluntary verbal consent and were at liberty to opt out at any point in time in the interviews or discussions. The participants were also given an opportunity to ask questions before and after the interviews and discussions on any issue pertaining to the study. The tape recorded information from IDIs, FGDs and KIIs was anonymised by removing all the names and other identifiers to make it impossible for an outsider to relate who said what and were kept as strictly confidential material for one year during the analysis and report writing.

3.4 Study Limitations

There are a number of limitations to this study. Firstly, it was designed to investigate SRH risks and reproductive and contraceptive practices mainly from the perspective of young married women (FGDs and IDIs), community leaders and service providers (KIIs). Reporting of information about sexual, reproductive and contraceptive practices might at times be biased on the basis that in most rural areas sex related discussions are still culturally regarded as a taboo. In this respect, there is a possibility that participants may endeavour to provide responses that they feel are socially acceptable. In addition, they may withhold some information about their own sexual, reproductive and contraceptive practices that would be deemed stigmatizing and non conforming to the prevailing social norms.

Another possible limitation is that the study did not collect information from these women's husbands. Studies (Babalola *et al.*, 2012, Magadi & Curtis, 2003) have shown that spouses play important and influential roles in matters of reproductive and contraceptive behaviour (contraceptive use and method choice). It would have been ideal to understand the perceptions and experiences of the young married women's partners or men in general on these issues. At times the women may have difficulties to know some information pertaining to their spouses such as age or attitudes towards a certain phenomenon. However, the scope of this study was that it was actually the young women's perceptions and experiences that were being investigated.

A further limitation is that the MDHS quantitative data was collected in 2000, 2004 and 2010 while the qualitative data was collected in 2014. It shows that there is time lag in the collection of these two types of data. This might affect the applicability of the qualitative study findings to those of the MDHS. However, the matters under investigation take time to register changes in the population. Hence there is still robust connection of the quantitative and qualitative results that have formed the basis of this study' findings.

The above notwithstanding, each data source has made up for the limitations of another. The secondary data (MDHS) and the primary data complement each other to provide adequate information and findings that have adequately answered the study questions on the factors that influence SRH risks and contraceptive use among young married women in Malawi.

CHAPTER FOUR: SEXUAL AND REPRODUCTIVE HEALTH RISKS

4.1 Introduction

This chapter has examined the interconnectedness of the SRH risks of early sexual debut, early marriage and early childbearing and how these affect and are affected by each other. The chapter does not focus on establishing associations between these risks as dependent variables and a set of independent variables and come up with determinants of these phenomena. Rather, the focus is on investigating and understanding, through results from the qualitative methods, the social, cultural and economic contexts that influence these SRH risks. The chapter is organised into two parts. The first part highlights the levels and trends in SRH risks by presenting their timing of sexual debut, first marriage and first births among the young married women across the three MDH surveys. The second part presents the factors that influence these SRH risks with a particular focus on the social, cultural and economic contexts of the young women. .

4.2 Univariate Analysis

An analysis of the characteristics of the respondents is essential for deeper understanding and interpretation of the results of a study. Table 4.1 presents a summary of the characteristics of young married women who were respondents in the 2000, 2004 and 2010 MDH surveys respectively and a distribution of some of the covariates used in the analysis of contraceptive use and method choice in these three surveys.

Table 4.1: Percentage distribution of young married women by selected background characteristics, Malawi 2000-2010

Background Characteristics	2000	2004	2010
Current age			
15–19	28.7	25.7	25.2
20–24	71.3	74.3	74.8
Level of education			
None	18.6	12.5	8.3
Primary	71.7	72.3	73.6
Secondary and higher	9.7	15.2	18.1
Region			
Northern	11.1	12.8	12.9
Central	38.7	39.3	41.8
Southern	50.2	47.8	45.3
Wealth quintile			
Poorest	na	16.2	18.4
Poorer	na	23.6	23.0
Middle	na	23.3	22.9
Richer	na	19.9	18.9
Richest	na	16.9	16.8
Religion[4]			
Christians	86.5	84.2	84.9
Muslims	13.5	15.8	15.1
Place of Residence			
Urban	15.1	17.5	16.5
Rural	84.9	82.5	83.5
Woman working			
Yes	52.6	54.2	48.6
No	47.4	45.8	51.4
Ethnicity			
Chewa	30.9	34.6	34.7
Tumbuka	7.1	8.6	10.0
Lomwe	19.0	17.9	15.7
Yao	13.9	12.3	14.6
Ngoni	12.2	10.6	10.8
Other	16.9	16.0	14.3
Husband's fertility desires			
Both want the same	48.8	55.6	62.0
Husband wants more	14.5	11.5	11.9
Husband wants fewer	18.8	8.6	8.6
Don't know	17.9	23.1	17.6
Waiting Period			
Within 2 years	20.6	18.6	18.1
After 2 years	60.5	65.3	66.4
Want no more	18.8	16.1	15.5
Ideal number of Children			
2 and below	18.5	18.1	17.5
3-4	59.8	63.0	67.0
5+	21.7	18.9	15.5
Number of living children			
0	22.4	19.4	15.9
1	44.1	40.5	41.6
2+	33.5	41.1	42.5
Number of Co-wives			
0	90.0	91.4	93.6
1+	10.0	8.6	6.4

[4] Only muslims and Christians were showing variations. So this variable was recoded into these two codes.

Previous Unions			
1st Union	87.5	90.1	90.8
Previous one	12.5	9.9	9.2
Husband Present			
Yes	84.1	89.9	84.0
No	15.9	11.1	16.0
Partner education			
None	11.6	9.2	6.9
Primary	64.1	59.9	58.5
Secondary and above	24.3	30.8	34.6
Spouses age differences			
5 years and below	59.0	62.2	64.0
More than 5 years	41.0	37.8	36.0
Total (Percentage)	**100**	**100**	**100**
Total (Women)	**3257**	**3071**	**4639**

na= data not collected

Source: 2000, 2004 and 2010 MDHS data sets.

Table 4.1 shows that across the survey years, the majority (73.6 percent) of the young married women were aged 20–24 while only a quarter were aged 15–19. The results also present a picture that the levels of education among young married women were generally low. However, perhaps due to age differences, it is noted that the young married women's partners had better educational levels compared to them. For example, while primary education has consistently been the highest level of education for close to three-quarters (73.0 percent) of young married women, the percentage of their partners with primary as the highest level of education is above 60. However, the trend shows that the percentage of young married women with secondary and higher education has increased nearly from 12.4 in 2000 to 18.1 in 2010 but still much lower than 34 for their partners.

The results also show that about 15 percent of young married women had absent husbands (who do not live in the same house) perhaps as a consequence of labour migration. There are also indications of propensity to divorce and remarry as the results show that about 10 percent of young married women have had one or more previous marriages. Looking at partner age differences, the results show a trend whereby the overall of young married women who got married to partners within the same age cohort (<5 years) has been modestly increasing from 59.0 percent in 2000 to 62.2 percent in 2004 and 64.0 percent in

2010. The results also show that 36 percent of young married women were in unions with partners who were more than 5 years older. The results in Table 4.1 also show that polygynous marriages are not widespread in this age group as only between 6.4 percent and 10 percent of the young married women had reported to have co-wives.

In terms of fertility, there are strong indications of early childbearing. An average of 84.1 percent of young married women, in the three surveys, had at least one child. The results show that childbearing in this age group has been rising over the years. For example, it is interesting to note that the percentage of young married women with a living child has been increasing from 77.6 percent in 2000 to 84.1 percent in 2010.

Looking at geographical dispersions, the results reflect the fact that more than 80 percent of the respondents lives in the rural areas. The highest number (45 percent) of respondents lived in the Southern region followed by the Central and the Northern regions. Although there are many ethnic groups, the majority (34.7 percent) of the respondents belonged to the Chewa tribe, the biggest single tribe in the country occupying most of the Central region (Malawi Government, 2009).

Without considering the type of work, results in Table 4.1 also show that slightly close to a half (49 percent) of the respondents engaged themselves in work of some sort. However, the levels of poverty were still high. For example, the proportion of young married women in the lowest two wealth quintiles (poorest 40 percent) has remained high at around 41 percent across the surveys.

4.3 Timing of sexual debut

The study investigated the patterns and trends in mean age at first sex among young married women. Table 4.2 summarises the results.

Table 4. 2: Mean age at first sex for young married women (15–24) by their current age

Current Age	2000	2004	2010
15	13.6	14.2	14.0
16	14.7	14.5	14.8
17	15.1	15.1	15.4
18	15.7	15.8	15.8
19	15.9	16.1	16.2
20	16.3	16.1	16.3
21	16.1	16.3	16.4
22	16.5	16.8	16.3
23	16.8	16.9	16.4
24	17.0	16.8	16.6
Overall	**16.3**	**16.3**	**16.1**

Source: 2000, 2004 and 2010 MDHS data sets.

The trend across surveys shows that the mean age at first sex for all young women has remained low at around 16 years. Specifically, the overall mean age at fist sex was 16.3 years in 2000 and 2004 and a small decline of 16.1 years in 2010. Minimum age at sex (not in the table) is low at 10 for 2000 and 2004 and at 8 for 2010. These slight declines in both mean age at first sex and minimum age at first sex is indicative of a trend towards earlier ages at first sex between 2000 and 2010. It could be a consequence of changes in the onset of menarche (not collected in MDHS for analysis) among later cohorts of young women. The issue of earlier onset of menarche has been highlighted in section 4.7 where qualitative results of the factors that influence early sexual debut are reported.

4.4 Timing of first marriage

The study was also meant to look at the levels and trends in timing of first union across the surveys. Table 4.3 presents a summary of trends in mean age at first marriage by the current age of the young married women. From the results, it is noteworthy that the general trend is that the mean age at marriage has been slightly declining over time. With socio-

economic changes (increases in education levels) that have ensued over the years, the opposite was anticipated.

Table 4.3: Trends in mean age at first marriage among young married women (15–24) by their current age at the time of the survey

Current Age	Survey Year		
	2000	**2004**	**2010**
15	14.2	14.2	14.5
16	15.2	14.9	15.3
17	15.8	15.5	15.8
18	16.2	16.4	16.3
19	16.7	16.5	16.6
20	16.7	16.8	16.7
21	17.1	16.8	16.7
22	17.4	17.4	17.1
23	17.7	17.4	17.2
24	17.6	17.7	17.4
Overall	**17.0**	**16.9**	**16.8**

Source: 2000, 2004 and 2010 MDHS data sets.

Overall, the mean age at first marriage is around 17 years across the surveys. The minimum age at marriage was 10 years in 2000 and 2004 and reduced to 9 years in 2010 while the maximum has been 24 years in all the survey periods. In addition, the results show the pattern that the mean age at first marriage has been lower among the younger women (15-19) than older women (20-24). For example, in 2000, the mean age at first marriage was around 14 years for women aged 15 years rising to around 18 years for women aged 24 years. This is indicative of the fact that the more young women (15–19) had entered into marriage at tender ages compared to young adult (20–24) married women. It was not clear from the study why age at marriage has not been rising. However, a study in Malawi (Ueyema & Yamauchi 2009) proffered two explanations that attributed this to pressures created by the HIV/AIDS epidemic. They hypothesize that in the marriage search process, the higher risk of adult mortality associated with the HIV epidemic raises the "cost" of a prolonged marriage search. This leads young women to marry at younger

ages, in order to find a "safe" spouse. The other explanation could be that the HIV epidemic (high HIV prevalence rate of as high as 20 percent among young people of this age against the national adult (15-49 years) prevalence of 11 percent) may be encouraging men to marry younger women who have had less sexual experience and are considered less likely to already be infected with HIV at the time of marriage.

It is interesting to note that young married women started to have sex on average one year before they were married. This practice in the absence of consistent contraceptive use can entail increased exposure to the risk of early premarital pregnancies and HIV infection. Detailed information about factors influencing early sexual debut is presented in the second part of this chapter.

4.5 Timing of first birth

The study investigated the patterns and trends in the timing of first birth by looking at mean ages at first birth among those who have had a birth. The results presented in Table 4.5 show the mean ages at first birth for young married women of various ages at the time of the surveys. The results, overall and across surveys, corroborate the assertions that early entry into marriage is a precursor to early childbearing. The trend shows that the overall mean age at first birth among young married women has not been changing much over the years as it is around 18 years. Specifically, the mean age at birth has been minimally declining from 17.9 years, 17.8 years and 17.7 years in 2000, 2004 and 2010 respectively.

Table 4.4: Mean age at first birth among young married women (15–24) by their current age

Current age	2000	2004	2010
15	14.3	14.4	14.4
16	15.3	15.2	15.5
17	16.0	15.7	16.1
18	16.6	16.8	16.7
19	17.3	17.3	17.2
20	17.6	17.5	17.6
21	17.9	17.6	17.6
22	18.2	18.2	17.9
23	18.6	18.2	18.0
24	18.6	18.5	18.4
Overall	**17.9**	**17.8**	**17.7**

Source: 2000, 2004 and 2010 MDHS data sets.

The minimum age at first birth has been marginally rising from 10 years to 11 years and 12 years among young married women in 2000, 2004 and 2010 respectively. The mean ages at first birth show a pattern that young married women in lower ages had lower ages at first birth compared to those who were in older ages. This pattern holds true almost across all ages. For example, in 2000, the mean age at first birth among the 24 year old married women was 18.6 years compared to 14.3 years for the currently married women aged 15. This is not surprising because early entry into marriage exacerbates the risk of early childbearing due to higher frequency of unprotected sex and the social and cultural pressure to prove fertility soon after marriage and lower contraceptive use.

4.6 The SRH risks' continuum and linkages

It is already known from Tables 4.2, 4.3 and 4.4 that the mean ages at first sex is 16 years, at first marriage is 17 while at first birth is 18 years. These events are on average just one year apart. What this entails is that early sexual debut culminates into early marriage within an average of one year that also leads into early birth within an average of one year after marriage.

Table 4.5 presents the results that depict a general picture of a strong link between early sexual debut and early marriage in the country. This becomes clear when one looks at the percentage of young married women who indicated to have had their first sexual experience at first marital union.

Table 4.5: Trends in percentage distribution young married women who had sex at first union by their current age

Current Age	Young Married Women Had Sex at First Union		
	2000	2004	2010
15	26.0	16.7	22.9
16	19.1	25.9	30.6
17	19.2	28.0	28.5
18	20.0	27.0	29.0
19	18.7	23.7	28.9
20	25.4	26.2	30.8
21	20.0	26.1	33.2
22	26.3	25.5	31.4
23	38.8	21.8	32.4
24	38.0	26.7	31.5
Overall	**26.3**	**25.4**	**31.1**

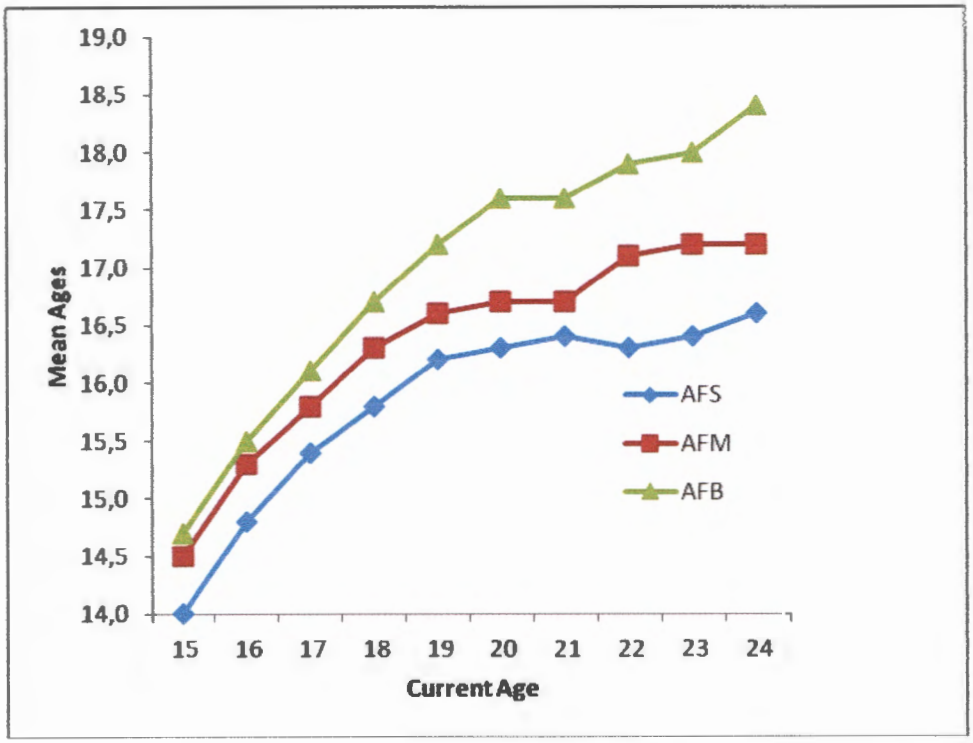
Source: 2000, 2004 and 2010 MDHS data sets.

Due to socio-economic changes (increased levels of education among females) that have taken place over the years, the expected direction was that there could be continued decline in the proportion of young women having first sex at first union and in increase in the levels of premarital sex. However, contrary to those expectations, results in Table 4.3 show that the percentage of young women who have had their first sex at first union increased from 26 in 2000, slightly decreased to 25 in 2004, to 31 in 2010. It is not clear if this is indicative that more young women are practicing sexual abstinence until marriage than before. There is also a pattern across the surveys that shows higher proportions of young married women at older ages (20–24) who had had sex at first union compared to the

married women at lower ages (15–19). This link between early sexual debut and early marriage is a cause for anxiety because it has the potential to increase levels of early childbearing since contraception at early stages in marriage is not the normal practice in the country. This general pattern would however be beneficial to the country's quest for reduction in total fertility rate if it were accompanied by increasing ages at first marriage.

Figure 4.1 presents finer details of the connection between early sexual debut, early marriage and early childbearing among young married women aged 15–24. It depicts mean ages at first sexual intercourse, first marriage and first birth for young married women in the 2010 MDHS.

Figure 4.1: Mean age at first sex, first marriage, and first birth by current age of the young woman, Malawi 2010



Source: 2010 MDHS Data set

The study found the average age at first sexual intercourse to be 16 years; age at first marriage to be 17 years, while average age at first child bearing was estimated to be 18 years. It shows that there is a narrow gap between mean age at first sex (AFS) and mean

age at first marriage (AFM) in the early ages but the gap widens for young women aged 21 years or above. A similar pattern is noted between mean age at first marriage and mean age at first birth (AFB) where the gap is narrow and widens up from age 20. The short average duration between first marriage and first birth can also be an indication that contraceptive use is hardly used between the first marriage and the first birth among these young married women that were below 20 years. However, those who had fist intercourse and first marriage after age 20 showed wider gaps. This is an indication that late entry into marriage is beneficial as contraception is more likely to be used.

In addition, while age at first marriage is often used as a proxy for the onset of women's exposure to the risk of pregnancy, the results in Figure 4.1 are also indicative of the fact that young women are also becoming sexually active before marriage as the gap between AFS and AFM becomes wider for women at ages 20 and above. This means that the age at which young women initiate sexual intercourse should be regarded as the beginning of their exposure to reproductive risks rather than looking at the timing of marriage alone.

4.7 SRH risks

The results from the quantitative analysis have shown the levels and trends in young married women's experiences of early sexual debut (marital or premarital), early marriages and early childbearing. The subsequent sections present factors that influence these risks in Malawi. These are the results of the qualitative enquiry.

The role of initiation practices in SRH risks

The cultural practice of initiation ceremonies was consistently coming out in the discourse about SRH risks. It was apparent from the study participants that this cultural practice is regarded as a very critical rite of passage in the communities that marks girls' transition from childhood to adulthood. It was established in all the study districts that this transition starts on the onset of puberty as marked by the commencement of first menses. This onset of menses at puberty was found to be looked at in the communities as a landmark transformation of the girls into the adult sexual realm, as they would now be biologically ready for sex and childbearing. It became clear during the study that the details pertaining to the conduct of these initiations ceremonies were varied. However, it was common from the interviews that these ceremonies were mostly conducted immediately or within a short period after attaining menarche. Since the age at menarche varies, these ceremonies were found to mostly take place among girls aged between 10 and 15 years. As will be demonstrated later in the chapter, these ceremonies play important roles in influencing the SRH risks being investigated in this study.

As already stated, it was established that there were variations in the details of these initiation practices across the study districts. In Mangochi and Zomba (matrilineal societies), the ceremonies were reported to be more elaborate. They involve the bringing together of a number of girls who have attained menarche around the same period. They

are taken to a secluded place (be it a house or a camp called *tsimba*) once a year as a cohort for a period of time ranging from two weeks to a month to be initiated. The last day is elaborately celebrated in the communities in welcoming the initiates into the adult world. In Ntcheu (patrilineal), it was found that when a girl has attained menarche, the mother would arrange for some traditional counsellors (*anankungwi*) in her village and a personal advisor (*phungu*) to counsel her. The girl would be isolated in a hut within the extended family compound for a week where instructions are passed on to her and celebrations and final instructions are given on the last day, after which the process is finished.

In both arrangements, it was learnt that information is passed on through songs, riddles, puzzles and dances to help the initiates retain the messages. What was clear from the interviews was that the information and instructions given were not to be divulged to anyone particularly so to prepubescent girls as it was a preserve of those who have attained puberty (locally referred to as *kutha msinku).* In addition, it was also found that because some of the instructions passed on to the young women were related to sex education, it was culturally inappropriate for their mothers to be involved in the giving out of such instructions since it was a taboo for parents and children to be discussing sexual matters. From the study participants' narratives, it was clear that those who had undergone these ceremonies would feel a sense of achievement and maturity and would be strongly prohibited from associating with those who have not undergone the ceremonies as they were still regarded as children regardless of their ages.

The picture that emerged throughout the study was that, in spite of differences in the phenomena, initiation ceremonies were a great and important mark of transition from childhood to adult hood in all the study districts. However, during the study it was noted

that the instructions that are given during these ceremonies are shrouded in secrecy and confidentiality. The initiates are threatened not to disclose whatever transpired and discussed to those who had not been initiated or indeed to anybody, lest they bring a misfortune on themselves or their families. This was evident during the interviews with traditional leaders and the FGDs and IDIs with young married women. This was also confirmed during the study as the young women could not disclose even to female research assistants the content of the information they received during their initiation ceremonies. In this respect, it was hard to establish what goes on at the ceremonies from those that were directly involved in them. In this study, information pertaining to initiation ceremonies and their influence on SRH risks was mainly obtained from health workers who have been in these communities and are well versed and authoritative as key informants.

4.7.1 Early sexual debut

One of the cardinal areas of focus in this study is to understand factors influencing young women to engage in sexual intercourse while they are still young (15 years or below) in spite of adverse effects associated with such behaviour. As has already been shown in Table 4.2, the mean age at first sex is low, which is an indication that there is a great deal of sexual activity among young girls in the country. The factors, as presented below have been broadly categorised to include sexual feelings and pressure from early onset of menarche, cultural practices, peer pressure, poverty and economic deprivation, inadequate parental care and exposure to sexually explicit mass media products. The subsequent sections elaborate these factors from the narratives of the study participants.

i) Early onset of menarche and sexual feelings

In the interviews with key informants, particularly traditional leaders, they expressed strong feelings that in their communities, girls were attaining menarche early and even earlier than was the case in the distant past. They hinted that as such their sexual feelings were also being aroused early. They felt that this situation increased their risk of early sexual debut as they are naturally inclined to satiate those feelings. They expressed strong beliefs that a girl who has attained puberty early tended to have higher libido for her age and can be more physically and sexually attractive to men for her age. This was indicated to engender greater propensity to engage in sexual intercourse earlier than those who attain menarche later. They held beliefs that because of this early onset of menarche, girls had an early sexual debut in response to those early sexual feelings in spite of a myriad of social, cultural and moral prohibitions of such behaviour. The connection between this natural occurrence of menarche and risk of early sexual debut was aptly captured in the interviews with traditional leaders as below:

> *Some girls start their menses earlier than expected. This leads to this behaviour of starting sex while still young. It is like they develop some sort of sexual madness which leads them to this behaviour.* [KII: Traditional Leader, Ntcheu]

> *For other girls, it happens that they have everything at home but they are fond of engaging in sexual relations while still young not because they are poor but that they just have those strong sexual feelings.* [KII: Traditional Leader, Mangochi]

> *Some girls consider sexual intercourse as a normal thing to do in response to those feelings they have. In so doing they accept any man who approaches them and this brings the problem of unplanned pregnancies.* [KII: Traditional Leader, Zomba]

It was difficult from the narratives to establish mechanisms for linking early menarche and early sexual intercourse. However a study in Tanzania (Ngalinda, 1998) had vouched both biological mechanisms and social processes that link early menarche to early sexual debut and early births. These biological mechanisms include increased release of sex hormones at puberty leading to increased libido and consequently early urge to have sexual intercourse. In addition, those young women with early puberty were also said to be more fecund than women with later puberty leading to earlier births for a given exposure to the risk of pregnancy. The pubertal hormones were also said to lead to early development of secondary sexual characteristics, which are attractive to males and provide early opportunities for intercourse. In addition, parents and peers provide encouragement for early intercourse or marriage to the woman with early menarche, as parents want to see their daughters married. This is due to the fact that parents would not like their daughters to have out of wedlock pregnancies, and also they would like to get their bride price as early as possible.

In the discourses, it was intriguing to learn from the traditional leaders that in their communities, having sexual feelings was regarded as something that was culturally celebrated as an indication that the girl was normal in her body. It was further revealed that parents, especially mothers, would get worried if their daughters were taking long to attain menarche. They would also get worried if, once matured, they were not rumoured to have a sexual relationship or were shunned by boys as it was interpreted as a sign that something was terribly wrong with their daughters. Moreover, having many boys or men interested in a girl was interpreted in the communities as a sign of beauty on the part of the girl. However, that can be a driving force for girls' multiple sexual relationships. There were no clear directions from the narratives of the traditional leaders as to how such sexual feelings would be acted out and gratified without encountering SRH risks and their adverse

consequences. What could be discerned is that these seemingly contradictory sexual expectations can place young women in awkward situations that can incapacitate their agency to avoid these SRH risks and their concomitant adverse outcomes.

ii) Cultural practices

As already elaborated above, the cultural practice of initiation ceremonies was found to be very important in the lives of young women in all the study districts. It became clear from the interviews that the onset of menarche that lead to the initiation ceremonies, the instructions given at these initiation ceremonies and the great value and the meanings that are attached to these ceremonies by the young women, their families and the communities singularly and in combination prepare the stage for the young women to engage in early sexual debut. Although these ceremonies may vary in the details of content, their effects on the sexual behaviour of those who undergo these ceremonies appear to be similar in all the study districts. The substance of the influence of these ceremonies on early sexual debut is elucidated by the community health workers as captured below:

> *In the Ngoni culture of Ntcheu, when a woman reaches puberty she is put in a secluded place* ***(mbindikiro)*** *for a week with her counsellor* ***(phungu)****. During this time any girl or woman who is already initiated* ***(kuviniridwa)*** *can come and sing songs and dance to her and give her any counsel she may think of in the process. There is no structured content for instructions. I know that something pertaining to sex is taught because after these initiations, these girls do not at all look shy to talk to men and they start sleeping with boys and men.* [KII: Community Health worker, Ntcheu]

> *Here there is this initiation ceremony called* ***'nsondo'*** *where the girls are initiated and given information about many issues including those concerning sex. When these girls go there and come out, they do not fear men but want to try what they were taught practically. That's why they are involved in early sex.* [KII: Community Health Worker, Mangochi]

In this community, when girls go for initiation ceremonies, they are taught ways of handling sexual activities as such they are instructed to practice by having sex with boys or men when they get out in order to mature into real women. They are assured that they are now ready to satisfy men sexually. [KII: Community Health Worker, Zomba]

It was also found that in addition to and attached to the practices of initiation ceremonies; there were also various traditional dances some of which form part of the initiation ceremonies that are conducted. They were found to be providing an opportune environment for these young women to engage in early sexual encounters. These dances were found to be common in Mangochi and Zomba districts where elaborate initiation ceremonies take place. The dances take place at night and the young women were reported to go out to these places with or without knowledge of their parents or guardians. Their connection to early sexual debut was elaborately explained by the health workers as below:

It is because of their involvement in traditional dances such as ***manganje*** *and* ***mganda****. In most cases, these dances are performed at night where these girls meet men and end up having sex. They participate in these dances at night without the knowledge of their parents for they just sneak out of the houses. It is at these times when the girls are exposed to sexual activities because there is no supervision from the parents.* [KII: Health Centre Worker, Zomba]

In this community there are traditional dances such as ***m'bwiza*** *which people, young and old converge at night to dance in pairs. In these cases young women find a chance to engage in sexual activities and influence others to follow suit. The situation is always open for even young girls to engage in sex for the first time.* [KII: Community health worker, Mangochi]

During the months of July and August, this community is engaged in cultural activities such as initiation ceremonies. Girls and boys go for ***manganje*** *dances during the nights of these ceremonies. It is at these times when the girls are exposed to early sexual activities with men or boys.* [KII: Community Health Worker, Zomba]

iii) Social and Economic factors

It became established from a variety of study participants that economic problems were the most common and widely cited factors influencing early sexual debut among girls in the study districts. These problems ranged from poverty at individual and household levels, lack of parental care, opharnhood and a quest for social mobility through acquisition of financial and material symbols of modern living from the sexual partners. As discussed below, it was clear from the narratives with young married women and other study participants that young women's sexuality was regarded, both positively and negatively, as a source of relief for the young woman and her families' economic distress. Three scenarios emerged. It was found that young women could be overtly or covertly forced by her parents or guardians, the girl could force matters upon herself after assessment of her and her family's economic situation or it could be out of her own volition to pursue luxuries. These scenarios are elucidated in the subsequent sections.

a) Poverty

The results across study districts were consistent in pinning down poverty at individual or family levels as a critical factor influencing young women to engage in early sexual debut. Young women would react to poverty situations by seeking relief through engaging in sexual partnerships early particularly after attaining puberty with the intention of alleviating their family's poverty situation. These situations were aptly highlighted by young married women in these quotes:

It is poverty that pushes us to start to have sexual partners so that we should have basic needs. In cases where you do not proceed with education due to lack of fees, you get involved in sexual relations to get support. [IDI: 18, 1 child, Zomba]

May be they have a problem of lack of food and if a man comes to her with money, she ends up engaging in a sexual relationship with him even if she is still young and in school. [IDI: 24, 2 children, user, Ntcheu]

Most households here are poor so this poverty forces the girls to have sexual relationships with men who are well off to assist them getting what they need in their lives. [KII: Community Health Worker, Mangochi]

Most of the girls start sexual intercourse at a very tender age, even at 12, because parents do not question their children when they bring home various items. They like to receive what their children are giving them such as money. They do not question because they are poor. [KII: Traditional Leader, Zomba]

It was further revealed that due to the same problem of poverty, parents and guardians would openly force their daughters to be independent by insisting that they fend for necessities on their own. It was also found that in extreme cases the young woman would be compelled to move out of the house and be on her own. It became clear that the intention is to reduce the number of children in the house that would in turn entail reduced economic burden on the family. In the absence of any source of support these girls would engage in early sexual relationships in order to secure the support they need to sustain themselves. It was also noted that the parents would also look forward to benefit from the financial and material support that would be given to their daughters by their sexual partners.

Girls are told to move out of the house and depend on themselves. In that case they start to have sexual relationships with men so that they get money for their needs. [FGD: 20–24, Ntcheu]

At home there can be 8 children. All those children are supposed to be taken care of by a single mother. So when the girl is a bit grown up in that home, she finds ways to help herself because the support in the home is not there. So she starts having sexual affairs but she is only 13 years. [FGD: 20–24, Mangochi]

It was however established during the study that there were parents who, though poor, would not want their daughters to indulge in sexual relations and would want to assert their authority on them in dissuading them from early sexual relationships, but were helpless because of their failure to provide for the basic needs of the family let alone those of young women in the households.

b) Inadequate parental care

The study found that lack or limited parental support to young women was also a pervasive problem in the rural communities. It was learnt from the interviews with traditional leaders that young women's needs as they grow up tend to be more than those of the boys in families. It was also revealed that, regardless of the poverty situation in their families, there was a cultural belief and practice that at a certain age, especially after puberty, a young woman was expected to fetch for her own minute basic needs such as soap, lotions, cosmetics and lingerie. She is not supposed to ask these items from parents. It was also interesting to learn of a cultural practice, among the matrilineal societies in Mangochi, that a father, after the girl reaches a certain age, mainly after menarche and initiation, is expected to keep a distance from his daughters. In this respect, he is not supposed to engage in conversations with them or directly buy clothes or other necessities without mother's knowledge. The reasons behind these practices were not clearly forthcoming

from the narratives with the study participants but could be speculated that perhaps it has all to do with preventing incestuous sexual liaisons as the man would not feel restrained since the children basically do not belong to him but rather to the woman's clan. However, it was clear that these practices can lead to deprivation of young women and that lead some of them to engage in early sexual relationships to secure support for these basic materials that their fathers, though not necessarily lacking, may neglect to provide under the guise of keeping a distance from their daughters. These sentiments were elucidated by the traditional leaders and community health workers as follows:

> *Some fathers do not provide for their girls. This forces them to source their necessities on their own, so the easiest thing for them is to engage in sexual relationships with men in order to get money for buying their basic things such as soap and clothes.* [KII: Traditional Leader, Ntcheu]

> *Some girls have step fathers who do not want to provide support to them; as a result they look for men who can support them with money.* [KII: Traditional Leader, Mangochi]

> *In this community women are the ones who manage households because most men are in South Africa[5]. As a result young girls are forced into early sexual relationships so that they source money to sustain themselves as they get nothing from their fathers.* [KII: Community Health worker, Mangochi]

> *Some young girls engage in early sex because of the treatment they receive from parents. When they need soap, they are told that they are old enough and can find soap on their own.* [FGD: 15–19, Mangochi]

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[5] Republic of South Africa is the largest economy in the Southern African region and attracts migrants from the almost all the countries in the region. In Malawi, young men from quite a number of districts migrate to look for mainly informal employment. In the case of the study, a big proportion of young men from Mangochi and to a lesser extent from Ntcheu migrate to South Africa for this purpose.

c) Orphanhood

The study results show that the state of being an orphan was a condition, in itself, that increases one's vulnerability to economic and social deprivation. It became clear that regardless of whether the household was poor or not, orphaned children suffer neglect and discrimination in the families where they stay. It was found that most of orphans lived with distant relatives or non related guardians who provide less support or no support at all to the orphans compared to their own children. Some orphaned young women were found to be living alone with siblings in child headed households where the young women by default assume parental roles. Under these circumstances, these young women are compelled to get involved in early sexual relationships with men for both economic and psycho social support. The subsequent excerpts capture those situations:

> *When the parents have passed away and you are being raised by somebody, the treatment given to children in the house is different. The guardians favour their own children and you are put aside. If they are buying things for the children, you are not considered, so if you are being proposed to for a sexual relationship, you do not hesitate to accept so that you should be getting assistance.* [IDI: 22, 2 children, user, Zomba]

> *They do not have parents, so they lack support. All what they think they can do is to get involved in sexual relationships in order to have money.* [IDI: 18, 2 children, non user, Mangochi]

> *Orphanhood is a big problem in this community. Most children live with their grannies that are unable to source their daily needs for the home, as a result girls engage in sexual relationships so that their partners should meet their daily needs.* [KII: Community Leader, Mangochi]

iv) School dropout

The study results show that pursuing education had preventive effect on young women's early initiation of sexual relationships and intercourse. It was found that dropping out of school and staying idle, for whatever reason including poverty, was one of the causes of early sexual debut among young women across the study districts. They would actively seek sexual relationships and engage in early sex ostensibly to fill the void, preoccupy themselves or increase their chances of getting a marriage partner because they have nothing to do and have no other means of validating their self worthiness and esteem. These situations were aptly captured as below:

> *Some girls dropped out of school and do not have anything to do as a result they just engage in sexual relationships and end up having pregnancies.* [IDI: 18, 1 child, non user, Zomba]

> *Some girls do not go to school instead they engage in sexual relationships with men so that they should have money.* [IDI: 20, 2 children, non user, Ntcheu]

> *The issue here is that most girls have no interest in education. There are many girls who are school dropouts in the ages of 11 to 17 who do not have anything to do at their homes and what follows their staying at home is just to engage in sexual activities.* [KII: Health Centre Worker, Zomba]

While economic reasons have been mentioned as barriers to continuing with education and a motivator for early sexual debut among young women, it was interesting to come across some young married women who had involved themselves in early sexual relationships when they were still in primary school for the very purpose of securing financial and material support to enable them to meet the scholastic necessities required for them to continue with their education. From their narratives, it could be deciphered that this was a desperate move to use their sexuality to get support meant to secure long term

opportunities. However, it was found that most of them failed to proceed with their education due to early pregnancies and marriages that eventually ensued. The subsequent quotes capture such situations:

> *You can ask for books from your parents and the parents would tell you that they cannot afford. You find a sexual partner so that he can give you money for buying books and pens.* [IDI: 23, 2 children, Zomba]

> *At self boarding schools, girls decide to have boyfriends so that they have money for upkeep and in the end they engage in sexual activities. This happens because parents of such girls do not provide them with school necessities.* [IDI: 23, 3 children, user, Ntcheu]

v) Peer pressure

Studies have found that young people in general are susceptible to pressure from peers that, at times, is exacerbated by low self esteem and low image of themselves (Kalembo *et al.*, 2013). It is contended that girls, especially those that have just attained menarche, tend to be at a stage where they yearn to belong to and identify themselves with groups of peers and be independent from parental control. These peers are taken as role models on a wide range of issues including sexual behavioural expectations (Kalembo *et al.*, 2013; Mmbaga *et al.*, 2012).

The study established that young women would succumb to pressure from peers to engage in early sexual debut ostensibly to conform and belong to a circle of friends who also engage in the same behaviours. It was found that this peer pressure can have different effects on these young women. For example, while some young women would engage in early sexual debut just to conform to their peers' behaviour, others being dissatisfied with their parents' support would engage in early sex in a quest to acquire attractive things that are comparable to those possessed by their friends just to fit in with their peers. The effects

of peer pressure on early sexual debut were expressed by traditional leaders and community health workers. The subsequent excerpts aptly capture such sentiments:

> *These girls when they meet in the communities or at school, they are of different levels. There are some who come from well to do families while others come from poor families. Those from poor families tend to engage in sexual relationships so that they are given money to use to buy things their friends have.* [KII: Community Health Worker, Ntcheu]

> *Girls who are engaging in sexual relationships may look nice in fashionable clothes. This influences other girls as they also want to look good like their friends as such they indulge themselves in sleeping with men while still young.* [KII: Community Leader, Zomba]

> *Many girls are coming from poor families so they get involved in sexual partnerships so that they get their needs from those partners in order to suit with friends from well to do families.* [KII: Health centre worker, Zomba]

It was also found that engaging in sexual activities among the young women particularly those in the urban areas was like an avenue to attain modernity or an elevated quality of life through acquisition of symbols of modernity such as money, musical equipment, fashionable clothes, and technological gadgets such lap tops and smart phones. It was also found to be a way of proving to peers that they were equally attractive and sexually appealing to men. In these cases, having a boyfriend who gives them money and other incentives was regarded as a symbol of an elevated social status among the peers. The subsequent quotes from discussions with young married women and an interview with a community health worker provide examples of these sentiments:

Girls who have sexual relationships look good, well groomed and attractive. This influences other girls to look for men to support their need to look good like their friends. This is the reason for starting sex while of tender age. [FGD: 15 –19, Zomba]

It is about fashionable life. Girls admire what their friends are possessing such as mobile phones and fashionable clothes. So they indulge in sexual relationships so that the sexual partners should provide these to them because they cannot afford on their own due to poverty. [FGD: 20–24, Ntcheu]

The girls nowadays make sure that they are in relationship with boyfriends in order to be at a certain high level with their peers. [KII: Community Health Worker, Mangochi]

vi) The dynamics of the transactions in the sexual relationships

Regardless of the reasons and circumstances of engaging in early sexual relationships, the study participants provided an explanation of the nature and pattern of the economic transactions that ensue in these liaisons. It became clear from the interviews and discussions that young women were conversant with the expectations their sexual partners have pertaining to the modus operandi of these sexual relationships. The young woman would need to make herself available to the man for sex while the man or the boy would need to provide money and other economic incentives to the girl or young woman in return. In Mangochi, it was found that it was a social norm that in any male-female relationship giving out of material incentives and money to a female was expected as a way of expressing love and commitment to the relationship such that a male who would not give out such incentives would be looked at as someone who is not serious with the relationship. What the study deciphered was that this arrangement is different from commercial sexual transactions as understood in the western cultures because there is no direct exchange of money with sex. It was found that such incentives can be given out

without immediate expectation of sex or sex can occur even without incentives being given out immediately before or after.

It was also established that because of the circumstances (to secure financial and material support) under which these sexual relationships are entered into, particularly among the adolescent women, the relationships were deciphered to be characterised by gender inequalities in which boys or men had dominating powers in those relationships. It was clear from the narratives that these young women tend to be in desperate and inferior positions that predispose them to easily succumb to their partners' sexual demands leading to early unprotected sexual intercourse. It was found from the interviews that young women in these relationships were always on guard not to make demands for protection against pregnancy or sexually transmitted infections for fear of being dumped, in the process lose the source of material support, for other young women who would not make such demands. Under such circumstances, the pervasive view among the study participants (young married women and key informants) was that the whole transaction was largely predicated and duly embedded in exchanges of financial and other material incentives on one hand and unprotected sex on the other. In the course of the interviews and discussions with young women, it was clear that although they were worried about the dangers of HIV, they were not keen to discuss that in relation to their sexual behaviours.

vii) Exposure to mass media

It became clear from the study participants that young people were being exposed to a range of mass media products and social network outlets that give out explicit sex information. These sentiments were expressed by both traditional leaders and young married women across the study districts. It was revealed that these media sources provide varied sources of sexual information to young people that are at variance with the

restrictive traditional sources that have hitherto regulated sexual information in the communities. It became apparent from their narratives that this unrestricted access to sexual information was influencing early sexual activity among young women. There were sentiments to the effect that these young women were being exposed to such material at the time when they have just reached menarche and have started to experience heightened sexual feelings without means of satiating them. The subsequent quotes elucidate these sentiments:

> *These girls are fond of watching pornographic movies in these local video show rooms. These films are not good. Girls are accompanied by boys when they are going to watch these movies, after watching these, they say let us practice*. [FGD: 20–24, Zomba]

> *When they watch those pictures, they want to do what they see. Young people come late at night from watching these pornographic films. As they are maturing, these arouse their desires to do those things before their time*. [IDI: 18, 1 child, non user, Zomba]

> *Here there are video shows. When children watch those things, they think that those things are for fun. When they see, they also want to do the same*. [KII: Traditional Leader, Zomba]

In a nutshell, it was disconcerting to learn from the interaction with young married women that although engaging in early sex in these sexual relationships appeared to be the norm and anticipated, they were so much worried about the inevitability of pregnancy and childbearing that may ensue. In terms of protection against pregnancies and STIs including HIV, the young women tended to be helpless because, under the circumstances of their engaging in these sexual relationships, they were much controlled by the sexual demands and preferences of their partners who were materially supporting them. They appeared to know and acknowledge their vulnerability but failed to act due to fears of potential loss of

benefits should they introduce the issue of using protection. What can be deduced is that young women's sexual decision making agency is undermined not only by their young ages but also by the considerations of the financial and material support they get from their sexual partners. This lack of control of their sexual lives was found to be the precursor to the risk of unprotected early sexual debut, early marriages and early childbearing that are discussed in the subsequent sections as follows:

4.7.2 Early marriage

In the course of data collection and analysis, it became clear that most of the factors that influence early marriages were similar to those already discussed in relation to early sexual debut. As highlighted in this chapter, early marriage can be a precursor for early sexual debut as some young women experience their first sex at first union. It can also be a consequence of early sexual debut that has resulted in early pregnancy. As discussed in detail below, the issue of early pregnancies arising from early sexual debut as a precursor for early marriages has been found to be the most common factor influencing early marriages irrespective of the study district or kinship systems. The subsequent sections elucidate other factors ranging from cultural practices, peer pressure and poverty situations that influence early marriages.

i) Cultural practices

As was the case with early sexual debut, the cultural practice of initiation ceremonies was found to be another factor influencing early marriages among young women. As highlighted earlier, it was found that once the girls get out of these initiation ceremonies, they feel that they are mature and ready to handle the sexual demands of a married woman. What was eminent from the narratives of the community health workers was that the whole institution of initiation ceremonies and the information that is passed on gives the

initiates the impression that they are matured and adults. These observations and sentiments were aptly expressed by community health workers as follows:

> *When they come of age and have gone for initiation, then feel that they are ready for married life. This is happening to girls of thirteen or fourteen years of age.* [KII: Community Health Worker, Ntcheu]

> *When a girl comes of age they take her to a ritual known as* ***'chinamwali'*** *(initiation camp). At the initiation, part of what she is told pertains to how to take care of men sexually. So the girls have those feelings that when they get out of the initiation, they are now adults on the basis of what those people were telling them. So a girl finds that in that feeling of being a grown up, she starts meeting boys and men. Soon she gets pregnant and enters into marriage.* [KII: Health Centre Worker, Zomba]

> *When they go for initiation ceremonies, they are taught about these sexual issues. When they come out they feel ready to sleep with men as they were told. In the process some end up in marriage when they are not even mature for it.* [KII: Health Centre Worker, Mangochi]

ii) Economic reasons

In a similar manner as was the case with early sexual debut, it was also found that there was a great deal of social and economic pressure that is placed on young women that leave them with no option or alternative avenues other than getting married. It became clear from the narratives of young married women that some parents would overtly or covertly force their daughters into early marriage not only to relieve themselves of the burden of looking after them but also in anticipation of material support that would potentially come from their prospective sons in-law. It was clear from the narratives that in households where there are many children, a young woman would be looked at as both an economic

burden due to the high cost of bringing them up and potential source of economic relief upon marriage. This force would take the form of deliberate material deprivation or actual chasing out of the reluctant young woman from the household into marriage under the pretext that she is old enough to find ways of taking care of her needs. This was found to be particularly common in matrilineal communities where the husband would relocate and stays with his wife's family hence the prospective husband's material support would be guaranteed: These situations are captured thus:

> *I was in school and then a man asked for my hand in marriage, I denied it in the first place. He then went ahead and asked my parents. They accepted. Bearing in mind that I had nowhere to go, I bowed down to my parents and the husband's demands.* [IDI: 20, 2 children, user, Mangochi]

> *It happens that a man may propose marriage to a girl and if she resists that she is still young, her parents would scorn her because the man had already started helping the family with money and other gifts. Parents force their daughters to get married to such people so that they are also assisted materially and this practice is happening in this community.* [FGD: 20–24, Ntcheu]

> *Some girls are forced by their parents to get married so that they eat well at the household. This happened to me. I got married at the age of sixteen. It was because my parents could even beat me for refusing to get married. Had it been that it was not the case, I would not have entered into marriage when I was still young for I wanted to go ahead with my education.* [IDI: 18, 2 children, user, Zomba]

While in the above cases, parents would actively force their daughters into early marriages, the study on the other hand found that there were also some young women who would not in any way be forced by parents but would force themselves into early marriage to escape the dire situation of deprivation of basic needs at home arising from poverty in the

household. In these circumstances, it was noted that young women would find that the only option available to them would be to get married so that their husbands would provide for their material needs.

> *You come across a man who has got money. Even though you are young, you can still get married to him as you need to get help.* [IDI: 19, 2 children, user, Ntcheu]

> *It is poverty that brings many challenges at home, such as lacking of basic things as food, groceries and clothes. What comes in your mind is to get married as soon as possible so that you should be provided with support to buy soap and other things needed in your daily life.* [IDI: 18, 1 child, non user, Zomba]

> *When a girl experiences different problems, she thinks that when she enters into marriage, the problems she faces from her parents' house will come to an end, because she has a friend in the house as a husband who will be helping her.* [FGD: 20–24, Ntcheu]

It was clear from the discourse that both young women and key informants were very particular about the established traditional gender roles of each spouse in a marital union. These roles were divided in such a way that the husband would be the source of support while the woman would be the dependant. It was in this vein that young married women's expectations were that they would want to get married so that their husbands would take care of them and provide for their daily needs. It can be surmised that there is an enduring trait of dependence that characterise most of these early marriages. It was therefore clear that this dependence and expectations turned out to be of great influence in the sexual, reproductive and contraceptive decision making and practices of these young married women. This situation was found to lead to husbands being in a position of dominance over these young married women in these sexual, reproductive and contraceptive matters. The traditional leader and health workers expressed themselves on this matter as below:

*It is because of poverty in the house of their parents. Parents just advise them to get married in order to have food. They tell them that if you receive a man who wants to marry you accept his proposal; I can not manage to take care of yo*u. [KII: Traditional Leader, Mangochi]

Parents are happy if the girl is bringing material things to their homes. Sometimes, if the parents come to know the boy who is going out with their daughter, they start patronising him by calling him in-law so that more things should come. [KII: Health Centre worker, Ntcheu]

In this community young women lack basic items such as soap, sugar, clothes and food as a result they get enticed by men who give them money in the end they have sex with them and get pregnant. If this happens, they are forced to enter into early marriages. [KII: Health Centre worker, Ntcheu]

iii) Forced marriages as a consequence of early pregnancy

From the discussions and interviews with various categories of study participants, it became clear that a majority of marriages that take place early (before age 18) could be described as 'forced' particularly so in cases where there has been a premarital pregnancy. Although childbearing and children have been found to be culturally valued in both matrilineal and patrilineal societies in the study districts, it was also found that childbearing was only socially and culturally celebrated and accepted when it occurs within the confines of a recognised marital union regardless of the age of the woman. It is also established that childbearing is accepted if the pregnancy or the child is acknowledged and accepted by the responsible sexual partner and his family and that the putative father was willing and ready to eventually marry the girl. It was apparent from the discussions with traditional leaders and young married women that the state of being pregnant out of wedlock was frowned upon and deemed to have brought shame to the girl and her family such that the girl or young woman herself, her parents or the community would all push for

early marriage because of the social stigma attached to premarital or out of wedlock childbearing. The subsequent sections highlight both covert and overt forms of these early 'forced' marriages emanating from early pregnancies and childbearing.

It was found that there was ambiguity on the issue of premarital pregnancy and childbearing arising from early sexual debut. While it has been established in this study that social and cultural factors such as rites of passage practices (initiation ceremonies) have influence on early sexual debut that can lead to early pregnancies, the same cultural set up strongly abhors out of wedlock or premarital childbearing. It became clear that the absence of acknowledged ownership of a pregnancy or paternity of a child places heavy social and economic burden on the young woman and her family. In this respect, it has been revealed that the putative father of an out of wedlock child also come under social pressure to marry the pregnant young woman or the mother of the child. These social and cultural arrangements were found to be common in Ntcheu and Zomba districts where there are traditional local courts that would pass judgements compelling the responsible boyfriend to marry the impregnated girl or young woman to rectify the anomaly. This scenario of forced marriage is captured as below:

> *Once a young girl is made pregnant by a boy or man, the issue goes to the village chief where both parties are invited and an agreement is reached that they should marry each other.* [KII: Community Health Worker, Zomba]

> *If a girl is impregnated, the man responsible for that pregnancy is compelled* ***(kumunyanyarira)*** *by the parents of the young girl to marry her, it means the marriage will start at that tender age just like that.* [FGD: 15–19, Ntcheu]

The study results have consistently shown that forced marriages were culturally viewed as an inevitable outcome of a premarital pregnancy or childbearing. It also became clear that

a child born out of wedlock can be stigmatised and can lack basic needs. In this respect, forced marriages are meant to ensure that the material support for the child is also secured. These marriages were found to be contracted irrespective of the ages of the partners as long as there is a pregnancy or a child. These cultural arrangements are a critical factor influencing early marriages in these study districts. The scenarios are captured thus from the study participants:

> *It happens that, when she is in school and gets impregnated, the parents just think of chasing the girl into marriage saying "just get married, you were impregnated, you have a child, go ahead with the marriage."* [FGD: 20–24, Ntcheu]

> *Once a girl is found pregnant, the parents chase her from their home. As a result, most girls enter into marriages as they have nowhere to go.* [IDI: 20, 2 children, user, Zomba]

> *Young women get sexual partners to get money so that their problems should be addressed. As a result they are impregnated and the parents force them to marry.* [KII: Health Centre Worker, Ntcheu]

> *Most parents in this community do not want to take care of their pregnant daughters, so when the girl sees that she is lacking support; she goes to stay with her boyfriend. She is forced into marriage in that way.* [KII: Community Health Worker, Mangochi]

While the society and parents would force pregnant young women to enter into marriage, the study also established that because of the adverse environment at home and the social pressure from the communities, the pregnant girl or young woman would virtually find it inevitable to force herself into marriage with the putative father. It became apparent in the study narratives that it was an established tradition, regardless of being in patrilineal or matrilineal communities that once a young woman becomes aware that she is pregnant, the immediate reaction is to relocate and stay at the responsible boyfriend's place. She is

forced by her state of being pregnant to enter into that early marriage. These personal experiences highlight the substance of these arrangements:

> *I was involved in a sexual relationship with a certain boy before I wrote my Malawi Schools Leaving Certificate exams. I failed to write the exams because I was pregnant. When I delivered my child I just agreed with the man to get married.* [IDI: 20, 3 children, non user, Mangochi]

> *For my first child, I was impregnated while I was in school, I dropped out and found myself in marriage in which I am up to today.* [IDI: 20, 1 child, user, Ntcheu]

> ***Res**: I was in love with a certain boy when I was in school. He later on impregnated me and we got married because there was no way out. At that time I was in primary school*
> ***Int**: Did your parents persuade you to enter into that marriage?*
> ***Res:** Not. They just told me that it could be difficult for them to take care of me since I was pregnant. I just forced myself to marry my boyfriend*
> ***Int:** How old were you at that time?*
> ***Res**: I was seventeen years old*
> [IDI: 20, 2 children, non user, Mangochi]

However, it became clear from the discussions and interviews with young married women and some traditional leaders that they were very much perturbed by this practice of forced marriages because of its propensity to perpetuate family problems such as poverty. There were sentiments to the effect that these early marriages disturb the future of both the young woman and her boyfriend by cutting off their educational and occupational aspirations that would eventually limit their chances of employment and self development. The situation was found to be more problematic for the young woman who gets impregnated by a married man who is not ready to take another wife. It was learnt that the matter is taken to

traditional courts where the man is made to pay damages to the girl's parents for impregnating her.

iv) Fear of out of wedlock pregnancies

The study found that parents and guardians of young women would always be concerned and anxious about the adverse social and economic effects of premarital and unacknowledged pregnancies and childbearing as discussed above. It was in this light that some parents and guardians would rather force their daughters into early marriages than face the prospects of premarital pregnancies and births in their families. This was found to be particularly the case when their daughters were having sexual partnerships, display some kind of wayward behaviour related to sexual relations such as multiple sexual partners or are involved in any such sexual scandals. They regarded these as warning signs of the prospects of an out of wedlock pregnancy such that any further delay would increase the risk of them having out of wedlock pregnancies and births. As highlighted above, a premarital birth is dreaded because it also turns out to be an economic and social burden on the part of both the girl and her parents. Further, it was found to be damaging to the reputation of the girl and her siblings, the parents and the family as it is regarded as a failure in parenting on the part of the parent. The stigma attached to out of wedlock childbearing was so strong such that it was found that the chances of the young woman getting married would be greatly reduced and if it so happens that someone would seek her hand in marriage, her bride wealth (in patrilineal communities) would be reduced. Under such circumstances, the parents would rather force the girl into early marriage as a less dreadful evil than risking an out of wedlock pregnancy or childbearing. These sentiments are captured below:

Some parents force their daughters to be married when they discover that they are in sexual relationships, for fear of premarital pregnancy, without minding her. [FGD: 15–19, Ntcheu]

Because the child is already engaging in sexual relations, this scares the parents and they pressure her to better get married. They fear that she may become pregnant out of wedlock and the parents are too poor to even afford giving her a ***chitenje*** *(a wrapping cloth) to cover her pregnancy.* [IDI: 22, 2 children, user, Zomba]

Some girls are just promiscuous. They are advised not to be engaged in sexual relations but they do not listen. So the parents force them to get married and be settled with one man as a husband. [FGD: 15–19, Mangochi]

Once the girl has reached puberty stage and seeing how she is behaving, parents would force her to get married failing which she is told to leave their home. [FGD: 15–19, Mangochi]

v) Opharnhood

As has been highlighted in the early sexual debut section, the state of being an orphan is a state of being vulnerable to varied social and economic problems. The study found that female orphans shoulder a disproportionate share of the burden of any social and economic problems that ensue in their families. In this respect, they are more susceptible to early marriages or be forced by their guardians to do so. It also became apparent from the narratives that the orphans were mostly neglected not only in terms of material support but also guidance for appropriate behaviour. It was noteworthy that this kind of neglect of orphans was found to be common irrespective of the study district and kinship system. Looking at variations in kinship systems, the situation would be different in largely matrilineal communities of Mangochi and Zomba districts where children belong to the woman's clan and that orphans could be easily absorbed into the clans' extended family

systems. However, this was found not to be the case. It also emerged in the interviews and discussions that girls or young may be compelled into early marriage in situations where children are left to take care of themselves after being double orphaned (lost both parents) in which case even the community leaders would regard such early marriage to be in the best interest of the young woman and her siblings. Such marriage is viewed as bringing possible financial certainty and stability to the young married woman. The subsequent excerpts capture the situations of orphans that compel them into early marriages as elucidated by a young married woman and traditional leaders:

> *After I lost both parents, there was no one who could support me in terms of my daily needs and I eventually found myself having a man who promised to marry me in the process he impregnated me and that led to the beginning of our marriage.* [IDI: 18, 1 child, non user, Zomba]

> *When there are orphans in the house, guardians tell them to get married in order to be on their own. Because they are just children and do not have parents, they follow that advice.* [KII: Traditional leader, Zomba]

> *If the children are taking care of themselves as orphans, we see that it is good for the eldest girl to get married as early as possible.* [KII: Traditional Leader, Mangochi]

vi) Peer pressure and lack of role models

It was also revealed in the study that both marriage and childbearing play significant roles in defining the social status of young women. It was noted that when a girl gets married and later on becomes a mother, her social status positively changes as she then attracts respect as she is taken as an adult. Besides, the young woman's mother's social status also changes among her peers by virtue of becoming a grandmother which is cherished greatly among women in these communities. Related to that, it was also revealed that in these rural communities, there were no female role models in education and employment that

would otherwise demonstrate and convince the young women and their families that there are also other avenues for social mobility, such as education or employment, available to them other than marriage and motherhood. It was established from the discussants and intervieews that in these communities for many young women and their families, marriage and childbearing appeared to be more attractive than education. This was because they could not see any girls who had drawn any benefits from pursuing education and would act as their role model. On the contrary, many uneducated young men (particularly in Mangochi) would travel to South Africa and bring back attractive materials for their young wives that place them in an enviable position compared to unmarried young women in school. This was found to raise the benefits of early marriages in the eyes of young women in these communities. The influence of peer pressure on early marriages is captured in the quotes below:

> *There is a tendency of laughing at each other when you are not getting married. Some married women even think that you are going out with their husbands. You get married in order to avoid being laughed at by married women.* [IDI: 23, 2 children, user, Zomba]

> *Some young women admire what their friends have. For instance, many young men work in South Africa so they bring expensive items to give to their wives and the unmarried ones when they see that, they try their best to get married so that they should also have goods from South Africa. Some parents are also involved in this by even searching men for their daughters.* [KII: Health Centre Worker, Mangochi]

> *Here in our community, we do not have role models. For example, I reached Form 4 (school certificate level), but I am just staying without a job. So when these girls see things like these, they conclude that school is useless.* [IDI: 24, 2 children, non user, Mangochi]

The problem here is that people are not interested in school. So when girls go through puberty, the only thing is to get married so that they get the respect that they are married women. [KII: Community Health Worker, Mangochi]

vii) School dropout

The study has established that it was not always the case that young woman would be forced into marriage by parents or guardians or that the marriage could be preceded by a premarital pregnancy or birth. Early marriages were found to be the only option available to some young women who have dropped out of school and have nothing to do. It was noted that these young women would yearn to get married as a means to fill the vacuum created by being out of school for whatever reason. In this respect, a young woman would enter into marriage at a tender age out of her own volition in a quest to lead what can be described from the narratives as more 'meaningful' life in the absence of any better alternatives. It was also found that under these circumstances, there were some young women who would deliberately fall pregnant with the intention of trapping a boyfriend or a man into marriage. This was particularly the case if the boyfriend was from a well to do family or was working. The state of being out of school was found to be a precursor to early marriages as elucidated below:

My parents were not in good health so I was lacking money. When I was 15 years a certain man came to propose marriage to me since by then I was not schooling, we got married and I had my first child when I was 17 years old. [IDI: 19, 2 children, user, Ntcheu]

***Res**: It was very easy, when I started experiencing menstruation that is when I had a chance of getting married.*
***Int**: Were you forced to get married?*

***Res**: No, it was my wish to get married because I was no longer going to school.*

***Int:** How old were you when you entered into marriage?*

***Res**: By then I was 16 years old*

[IDI: 18, 1 child, user, Ntcheu]

Here in Mpondasi if a girl reaches standard 8(primary school leaving level) in most cases she does not have school fees to proceed to secondary school so she drops out and what parents say is "just get married otherwise what will you be doing here?" [KII: Health Worker, Mangochi]

Some parents do not encourage their girls to go to school. They are just staying or if they go to school, once they are in standard two or three, have come of age and have gone for initiation, and then they feel that they are ready for married life. This happens to girls of thirteen or fourteen years of age. [KII: Community Health Worker, Ntcheu]

However, the discussions and interviews with young married women and key informants in both matrilineal and patrilineal communities showed that having an education and securing employment were the expected modern means of social mobility they would desire to elevate the social status of young women. They felt that failure to proceed with education and secure employment away from their communities was what was influencing early marriages in their communities. They hinted that once they move out of the communities to the urban areas, they would also move away from the social and cultural pressures such that their entry into marital unions would rather be out of own volition and not due to pressure or force. In addition, they expressed feelings that even where an out of wedlock pregnancy would occur, young women would not be forced into early marriages. In this respect, some traditional leaders expressed feelings of regret about early marriages occurring in their communities.

In this community, we are only happy when the girl goes to school and finishes her education. When this happens, we have no reason to stop her from getting married. [KII: Traditional Leader, Mangochi]

We want a girl to grow up to 21 years of age as she concentrates on her studies. May be after finishing her education, it is when she can be in marriage. [KII: Traditional Leader, Zomba]

Here in our village education is our priority, it is just that some girls do not understand but there is a local bylaw which empowers village headmen to ensure that at village level, there should be no one who will be engaged in early marriage. This is not allowed but they should continue with their studies and grow with good behaviour. [KII: Traditional Leader, Ntcheu]

However, discussions with young married women had shown that these bylaws do not deter early marriages in their communities as girls continued dropping out of school due to pregnancies and eventually be made to get married to the boy or man responsible by the very same traditional leaders.

It was clear from the narratives that once married and have children, young women would be welcome to some social activities and networks that are only a preserve of those who were married and have children, as they would now be regarded as adults, regardless of their ages. Similar results were found by Kamlongera (2008) who asserted that there are common expectations among community members that a married woman, regardless of her age, should be active in the community and be able to assist during funerals, provide marital counselling to other women and be present when a chief calls for meetings. So early marriages or childbearing are culturally rewarded with increased recognition and respect in the society.

4.7.3 Early childbearing

From the interviews and discussions, it became clear that most of the factors that influence early sexual debut and early marriages were the same ones that predispose young women to the risks of early pregnancies and births. These include cultural practices such as initiation ceremonies, poverty, and peer pressure. The study has shown that early sexual debut (out of or within marital union) and early marriages (voluntary or forced) were the main factors influencing early childbearing because, as highlighted in the literature review, contraception is rarely used in early sexual relations or in early marriages. Consequently, early sexual debut can lead to early marriage that in turn can lead to early pregnancies and childbearing. The study has also found that sometimes early sexual debut can lead to early pregnancy that can in turn culminate in early marriage while at other times early marriage can lead to early sexual debut that can lead to early pregnancies. The statements below highlight these interlinkages:

> *Most of us girls increase our poverty in the sense that when we meet men who show us that they have money, we start sleeping with them, and end up in having pregnancies while still young.* [IDI: 20, 1 child, user, Ntcheu]

> *When a girl is initiated and she is out of the initiation ceremony, she does not have much interest in school. For her to continue with her education, it is like a waste of time. What she feels she needs is to be involved in a sexual relationship as a result it happens that she enters into marriage earlier and also become pregnant early.* [KII: Health Centre Worker, Mangochi]

> *Once they are married definitely they become pregnant and they give birth. So it is because they get married while very young. As a nurse, I have seen 16 year old ones coming for delivery. Others are 18 years old. I see many of these teens coming for deliveries. It is because they are*

getting married while they are still young. [KII: Health Centre Worker, Mangochi]

Young women start childbearing at a tender of 15 or 17 years old. By that age they already have a child because they have nothing to do at home. They do not go to school and the result is having sexual partners that end in pregnancies and bearing children. [KII: Traditional Leader, Mangochi]

In a nutshell, while it has been revealed in this study that both young women and the community leaders disapprove of early childbearing, it was paradoxical to see that the same community and parents were unequivocal in causing forced early marriages among young women as consequence of either early premarital pregnancy or observed or perceived early premarital sexual activity. It can be surmised that, by forcing a girl or a young woman to get into marriage early, the young couple would thus be provided with a socially and morally sanctioned milieu for further childbearing hence increasing the levels of early childbearing in the population. While out of wedlock early pregnancy and childbearing were by and large abhorred by both the parents and communities, what could be deciphered from the narratives was that culturally early (adolescent) pregnancy and birth were not necessarily problematic as long as the putative partner acknowledged ownership of the pregnancy or out of wedlock child in anticipation of marriage or when pregnancy or birth occurs within the confines of a recognised marital union.

4.8 Conclusion

The study has established that there is a continuum from early sexual debut, early marriage that culminates in early childbearing. The mean age at first sexual intercourse among young married women in Malawi was 16 years, age at first marriage was 17 years while mean age at first birth was estimated at 18 years. On average, young women marry one

year after first sexual experience and get first child after one year of marriage. This means that childbearing occurs two years on average after first sexual intercourse. Overall, the results show that the examined SRH risks are intertwined and can be attributed mainly to the socio- cultural, economic or structural rather than individual factors that play significant roles in the initiation and perpetuation of these risks. There are factors such as cultural practices, poverty and economic deprivation, orphanhood, peer pressure and influence of mass media that have been found to precipitate and exacerbate young women's vulnerability to these risks.

The pursuit of education has been pinned down as a very critical factor in delaying sexual debut, marriage and the ensuing childbearing. The results point to the fact that failure to continue with education is what is largely fuelling early marriages and early childbearing in the study districts. The level at which a girl drops out of the education system, for whatever reason, principally marks the timing of sexual relations (for those that have not already started), timing of marriage and subsequent childbearing. The study has also found that among girls and young women, there is competition between furthering education and entering into marriage or childbearing as sources of social status and mobility. This corroborates with a study in Tanzania (Ngalinda, 1998) that posited that higher education was found to have provided young women with status or opportunities that reduce the importance of early child bearing (Ngalinda, 1998).

CHAPTER FIVE: TRENDS AND DETERMINANTS OF CONTRACEPTIVE USE AND METHOD CHOICE

5.1 Introduction

This chapter presents the socio-demographic determinants of contraceptive use and method choice among young married women in Malawi and how these have been changed over the years (2000, 2004 and 2010). The chapter sets the pace for the discussions of the contextual factors that influence young married women's sexual, reproductive and contraceptive practices that are presented in the subsequent chapters 6 and 7. As has been consistently stated, there is a need to understand the contraceptive practices of these young married women because of the fact that being young, married and in the earliest stages of their marital and childbearing lives, their current sexual, reproductive and contraceptive practices have the potential to shape the demographic and development future direction of the country (Bankole & Malarcher, 2010).

5.2 Trends in contraceptive use

Current contraceptive use is an element of contraceptive behaviour, as a proximate determinant of fertility, which is crucial to the understanding of fertility dynamics in a particular population (Bongaarts & Porter, 1983). To examine the levels, trends and determinants of modern contraceptive use among young married women, cross tabulations of the current contraceptive use by young married women of different characteristics were done. Table 5.1 presents the percentage distribution of young married women who used contraceptives by their socio-demographic characteristics across the three survey years. All the results were found to be significantly correlated at the Chi-square's (p) value of 0.05.

Table 5.1: Percentage distribution of young married women who were currently using modern contraceptive methods by background characteristics

Background Characteristics	Current use of modern methods		
	2000	2004	2010
Current age			
15–19	12.9	16.6	26.4
20–24	22.7	25.4	38.0
Level of education			
None	14.9	15.9	28.6
Primary	19.9	22.1	33.5
Secondary and above	29.7	34.2	44.2
Region			
Northern	18.8	26.8	30.2
Central	19.5	22.9	37.4
Southern	20.5	22.3	34.3
Wealth quintile			
Poorest	na	15.6	35.1
Poorer	na	18.8	38.2
Middle	na	23.6	39.2
Richer	na	24.5	38.2
Richest	na	33.7	42.2
Religion			
Christians	20.1	22.7	37.4
Muslims	17.7	16.0	21.9
Place of Residence			
Urban	29.1	27.9	42.1
Rural	18.3	22.2	33.7
Woman working			
Yes	18.3	22.9	34.6
No	21.4	23.4	42.7
Ethnicity			
Chewa	20.9	21.4	43.4
Tumbuka	20.9	28.9	37.1
Lomwe	21.3	25.9	39.8
Yao	17.8	21.2	28.6
Ngoni	16.6	26.6	33.7
Other	18.2	18.9	42.5
Number of Co-wives			
None	20.1	23.5	35.8
One or more	15.9	19.4	24.7
Previous Unions			
1st Union	20.5	23.4	36.3
Previous one	15.9	20.0	22.9
Partner education			
None	9.9	12.4	27.9
Primary	17.9	20.9	33.2
Secondary and above	29.7	30.8	39.8
Spouses age differences			
5 years and below	13.6	11.8	14.1
More than 5 years	16.3	20.5	33.3
Ideal number of Children			
2 and below	21.7	26.6	37.2
3-4	21.4	23.2	36.4
5+	14.2	19.8	26.7
Husband Present			
Yes	20.0	23.9	38.2
No	19.2	17.3	18.6
Marital Duration			

Less than 5 years	17.6	20.2	32.8
5 years or more	25.0	28.5	38.9
Husband's fertility desires			
Both want the same	22.3	27.9	37.7
Husband wants more	15.8	22.1	34.1
Husband wants fewer	210	24.3	39.1
Don't know	13.1	11.1	22.7
Waiting Period			
Within 2 years	7.4	11.6	19.5
After 2 years	23.2	26.1	38.8
Want no more	22.9	29.6	38.5
Health Decision Making			
Woman herself	21.8	24.0	35.3
Joint with partner	22.9	30.4	38.1
Husband alone	19.5	22.4	33.0
Number of living children			
0	1.6	1.5	4.1
1	22.3	25.1	37.2
2+	29.2	31.7	44.6
Percentage (Women 15–24)	**19.9**	**23.2**	**35.1**
Total number of women	**3257**	**3071**	**4639**

na= data not collected,

Source: The 2000, 2004 and 2010 MDHS data sets

The trend as shown in the table is that the levels of modern contraceptive use among young married women has continued to be lower across surveys compared to older married women and sexually active young unmarried women of the same age group. Results in Table 5.1 show that on the overall contraceptive prevalence has steadily increased from almost 20 percent in 2000 to 35 percent in 2010; these levels continue to be lower than that of older women. For example in 2010, the contraceptive prevalence for young married women was 35 percent compared to 51 percent for older (25-39 years) married women and 48 percent for young unmarried women of the same age group (not shown in the table). The results mean that up to 65 percent of young married women were not using any contraceptive method. Of interest to program planners and implementers are the steady rises among certain groups of young married women. For example, the highest increases were noted among young married women in the poorest wealth quintiles where their use increased by 20 percentage points compared to only 9 percentage points for the richest wealth quintiles between 2004 and 2010. There were also greater increases (20 percentage

points) among non working young married women compared to only 9 percent for working women during the same period.

The results also show significant association between contraceptive use and the age of the young married woman. For example, young adult women (20-24) were more likely to use contraceptives than their adolescent (15-19) counterparts. As will be explained in Chapter six and eight, adolescent married women are more likely to be the newlyweds that succumb to intense social and cultural pressure to prove their reproductive ability as soon as they enter into marriage and also face barriers to access contraceptives due to the fact that a majority of them may have no or only one child and service providers may feel socially and culturally constrained to provide contraceptives services to such young women.

It is also shown in Table 5.1 that there is a positive relationship between contraceptive use and the level of education. This is the case for both the level of education of the young married women and that of their partners. Across the surveys, young married women who had secondary or higher levels of education used modern contraceptives more compared to other young women. For example in 2010, only 28.6 percent of young married women with no education were using contraceptives compared to 44.2 percent of those with secondary or higher education. It is also shown that partners level of education has similar influence where only 27.9 percent of young married whose husbands had no education compared with 39.8 percent (secondary or higher) were using contraceptives. However, data analysis (not in the table) has shown that most educated women were married to men of the same level of education or higher Consequently partner's level of education highly correlated to the level of education of a woman. In this respect, the understanding is that it

is more of the education level of the woman that has a greater bearing on her contraceptive use than that of her husband.

The results also show variations of contraceptive use among young married women of different ethnic groups. For example, in 2010, it is shown that there was close to 15-percentage point difference in contraceptive use between the Chewa and Yao young married women. Similar variations are also noted, although not consistent, among regions of the country. For example in 2010, the central region has the highest levels of contraceptive use while the northern region had the lowest percentage of users. These variations may be related to different cultural practices pertaining to sexuality, marriage practices and value attached to childbearing and different sexes of children.

Various religious faiths tend to have different doctrines and teachings that might relate to sexual, reproductive norms and behaviours. These doctrines may have an effect on the attitudes and practices pertaining to contraception. The results show consistently that Christian young married women have higher levels of contraceptive use compared to Muslim young married women. For example in 2010, 37.4 percent of Christian young married women were using contraceptives compared to 21.9 percent of Muslims young married women.

The results also reveal that fertility related factors are strongly correlated with contraceptive use among young married women. The numbers of young married women who use contraceptives increases with the increasing number of living children across all the three surveys. In 2000, only 1.6 percent of young married women without a living child were using contraceptives compared to 29.2 percent of those with 2 or more children. Similar results were obtained in 2004 and 2010. Variations in contraceptive use are also noted on the basis of the ideal number of children the woman would like to have. Those

with low ideal number of children were found to be using contraception more than those whose ideal number of children was high.

There are also partner related factors that explain variations in contraceptive use where, for instance, there are higher numbers of young married women whose husbands currently stay in the house who use modern contraceptives compared to those whose husbands are absent. In situations where the husband wants fewer children than the wife, the results show that higher proportions of young married women use contraceptives than in situations where the husband wants more children. Perhaps, due to competition that ensues among co-wives, the results also show that young married women in polygynous relationships use contraceptives less compared to those in monogamous relationships. The results also show that a higher proportion of young married women whose age difference with their spouses was 5 years or more were using contraceptives compared to young married women whose spousal age differences were more than five year. These results show this trend across all the surveys.

5.3 Determinants of contraceptive use

There was a need to confirm the above associations in a multivariate perspective. This section presents the results of a multivariate analysis using regression models. In the models, the dependent variable is dichotomous with a value of 1 for contraceptive use and 0 for non use. The models only include independent variables that are significantly associated with contraceptive use in that particular survey as tested at the significant level of 0.05. Overall, Table 5.2 presents the models that show variables that significantly determine contraceptive use.

Table 5.2: Regression models for current use of modern contraceptives among young married women, Malawi 200-2010

Characteristics	Odds Ratio		
	2000	2004	2010
Current age			
15–19 (ref)		1.00	1.00
20–24		0.74*	1.44*
Level of education			
None (ref)	1.00	1.00	1.00
Primary	1.53*	1.51*	1.12
Secondary and above	2.58*	2.64*	1.92*
Wealth quintile			
Poorest (ref)		1.00	
Poorer		0.98	
Middle		1.30	
Richer		1.23	
Richest		1.97*	
Religion			
Christian(ref)			1.00
Islam			0.51*
Waiting Period			
Within 2 years (ref)	1.00	1.00	1.00
After 2 years	1.85*	1.41*	1.53*
Want no more	1.28	1.14	0.99
Husband's fertility desires			
Both want the same (ref)	1.00	1.00	1.00
Husband wants more	0.66*	0.61*	0.95
Husband wants fewer	0.96*	0.83	1.08
Don't know	0.72*	0.40*	0.64*
Place of Residence			
Urban(ref)	1.00		1.00
Rural	0.54*		0.63*
Woman working			
No (ref)	1.00	1.00	1.00
Yes	1.31*	1.24*	1.31*
Number of Co wives			
None (ref)			1.00
One or more			0.71*
Number of living children			
0(ref)	1.00	1.00	1.00
1	18.38 *	20.71*	17.20*
2+	30.89*	38.41*	33.08*
Previous Unions	-		
1st Union (ref)			1.00
Previous one			0.55*
Ideal number of Children			
2 or less (ref)	1.00	1.00	1.00
3-4	0.79	0.63*	0.77*
5+	0.47*	0.66*	0.53*
Ethnicity			
Chewa(ref)			1.00
Tumbuka			0.71
Lomwe			0.93
Yao			1.11
Ngoni			0.72*
Other			1.08
Husband Presence			
Yes(ref)		1.00	1.00
No		0.60*	0.37*

Source: The 2000, 2004 and 2010 MDHS data sets, *p< 0.05, na= data not collected, ref=reference category

It is interesting to note that the number of significant variables had been increasing from 7 in 2000 to 9 in 2004 and 13 in the 2010 survey. It is also noted from the results that there are differences in variables that are significant to specific surveys. In 2000, it was woman's level of education, woman's working status, next birth's waiting period, husband's fertility desire, place of residence, number of living children and ideal number of children that were significant. In 2004 the results show the significant influence of age of the woman, level of income and husband's presence while in 2010, age of the woman, religion, place of residence, number of co-wives, ever had a previous union and ethnicity have shown to significantly influence contraceptive use.

The overall results also show that current and expected fertility variables (number of living children, ideal number of children and waiting period for next birth and husband's fertility desires), woman's working status and levels of education were the most common variables that were found to significantly influence the likelihood of using modern contraceptive methods across all the three surveys. It is also noteworthy that the variable of age of the woman was significant in 2004 and 2010 with conflicting results. For example, while there was less likelihood (OR=0.74) of a 20-24 year old married woman using a modern method compared to the 15-19 year old married woman in 2004, the 2010 model shows that the opposite was true. The likelihood was greater (OR=1.44).

It is also noted that place of residence was only significant for 2000 and 2010 while religion, number of co-wives, whether the woman had married before (previous unions) and ethnicity were only found to be significant in 2010.

The results also show that the number of living children has consistently been found to be the most significant determinant of contraceptive use among young married women in all the survey periods. For example, young married women with two or more living children

were 31, 38 and 33 times more likely to use modern contraceptive methods than those with no child in 2000, 2004 and 2010 respectively. Related to that, it is also shown that the higher the ideal number of children, the lower is the likelihood of using a contraceptive method. The odds of using a contraceptive method were less (OR=0.47, OR=0.66 and OR=0.53) for young married women whose ideal number of children were 5 or more compared to those whose ideal number was 2 or less children in 2000, 2004 and 2010 respectively. The results also show that the desired waiting period before another child is born was significantly associated with contraceptive use. Compared with women who want a child within two years, the odds of using contraceptives were greater (OR=1.85, OR=1.41 and OR=1.53 respectively) for those who wanted another child after two or more years. Similarly, across the surveys, in situations where the husband wanted more children, the results show that there are lower percentages of young married women using contraceptives compared to situations where the husband and the wife have the same ideal number of children. These results might arise from the fact that even with changing time periods (from 2000 to 2010); the value placed on having children in a marriage has not waned. Being young women who are in the early stages of their marriage, the significance of current and future fertility related factors can be attributed to their initial pressing desire to prove their fertility arising from the cultural expectations of immediate childbearing after getting married. The discussions on the role of the cultural value for children are detailed in Chapters 6 and 7.

Results in Table 5.2 also show the significant influence of the woman's level of education on contraceptive use across surveys. It is noted that the odds of a young married woman using a modern contraceptive method were 2 times (OR=2.58, OR=2.64 and OR=1.92 respectively) greater if the woman has a secondary or higher level of education compared to the situation when she has had no education. This is might be as a result of early entry

into marriage that curtails a young woman's chances of furthering her education and limits her chances of acquiring more knowledge and developing positive attitudes towards contraception in the course of the longer period being spent in acquiring higher education. It is also noted that across surveys, working young married women have higher likelihood of using contraceptives (OR=1.31, OR=1.24 and OR=1.31) in 2000, 2004 and 2010 respectively compared to women who were not working.

In terms of place of residence, living in urban areas was associated with higher contraceptive use in 2000 and 2010. In 2000, the likelihood of young married women in the rural areas using contraceptive was lower (OR=0.54) than those in the urban areas while in 2010 the odds ratio were 0.63. This can be attributed to the poorer access to services that characterise most rural areas in the country. In addition, in the urban areas there are more service delivery points that are within reach of the woman and that can be easily accessed.

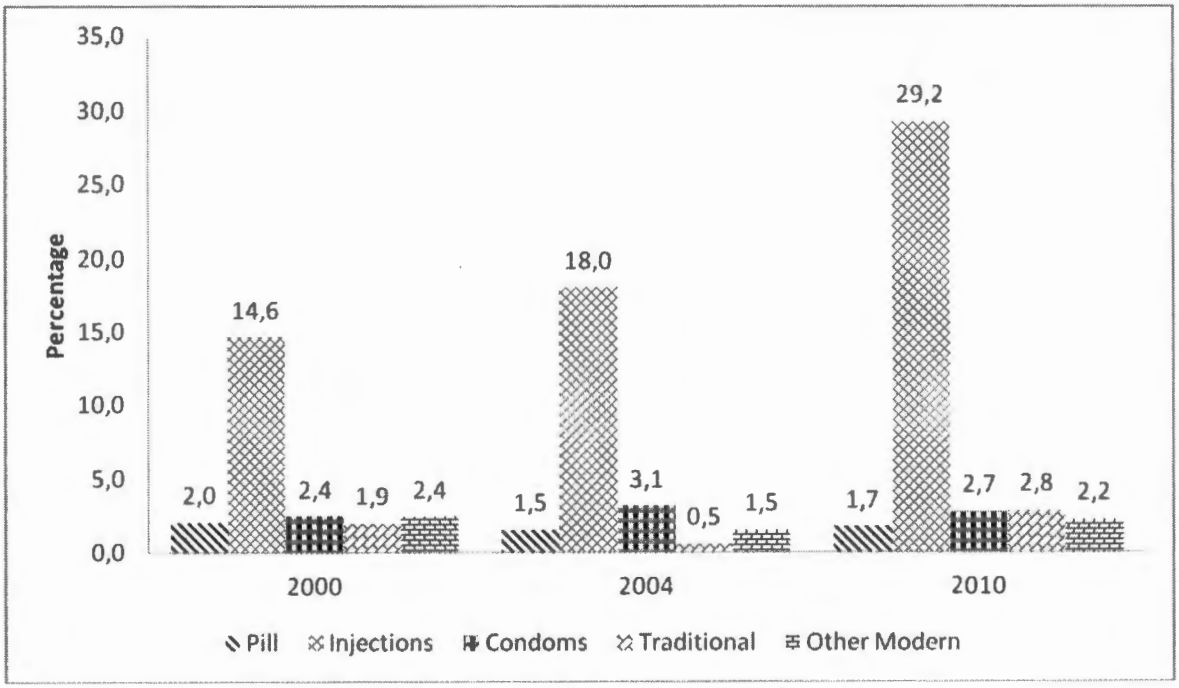
5.4 Trends in contraceptive method choice

Contraceptive method choice is critical for one to get maximum benefits from contraceptive practice. This can even be more critical for young married women who would require certain methods that meet their specific needs at that particular stage of their reproductive lives. Figure 5.1 presents the contraceptive method mix among young married women in Malawi.

The figure shows the consistent trend of limited method choices among young married women in the country. There are only three dominant modern methods. These are injectables, pills and condoms that are used by these women. For example in 2010, these three methods accounted for over 90 percent of all contraceptive use among these women. However, while the levels of use of the most preferred method (the injectables) has been

rising from 14.6 percent in 2000 to 29.2 percent in 2010, the levels of young married women using pills, condoms and 'other' modern methods have consistently remained low at a combined 7.7 percent of young married women users. What it means is that actually there is only one dominant method being used.

Figure 5.1: Percentage distribution of young married women by the contraceptive method used, Malawi 2000-2010



Source: The 2000, 2004 and 2010 MDHS data sets

In 2010 the injectables alone accounted for close to 81 percent of all their contraceptive use. What it means is that the increase in modern contraceptive use between 2000 and 2010 could be attributed mainly to rises in injectable use. As will be elucidated in chapters six and seven, in spite of its side effects, it is a method of convenience for a majority of this group of young married women as it can be easily hidden if faced with opposition from partners or other family members. The traditional methods such as periodic abstinence had not shown any discernible trend and had continuously been shown to be used by less than 3 percent of young married women.

5.5 Determinants of method choice

The multivariate analysis of the determinants of contraceptive method choice has used multinomial logistic regression modelling to assess the relative ratios of the associations of each independent variable with method chosen for the latest survey of 2010. The dependent variable (method choice) has been categorised into 'non use', 'injectables' and 'other methods' (all other modern methods have been categorised as such). All the independent variables were included to examine the determinants of method choice and that only variables that were found to be significantly associated with method choice are presented in the models in Table 5.3. Results in the models presented in the table show that on the overall, the likelihood that a woman would choose injectables or other methods over non-use of contraceptives is significantly influenced by the woman's number of living children, current age of the woman, place of residence; woman's working status, previous unions and woman's level of education. It is also noteworthy that there are more significant variables (11) for the choice of injectables' compared to the choice of other methods (7).

It is noted that for both injectables and other methods' use, the number of living children is found to be the most significant factor influencing method choice. For example, young married women with one living child were almost 58 and 11 times more likely to use injectables and other methods respectively than those with no child.

Table 5.3: Odds ratios (RRR) from multinomial logistic regression analysis examining associations between background characteristics and contraceptive method choice, Malawi, 2010

Background Characteristics	Injectables	Other modern methods
Current age		
15–19 (ref)	1.00	1.00
20–24	0.73*	0.56*
Level of Education		
None (ref)	1.00	1.00
Primary	1.84*	2.29*
Secondary	1.61*	2.27*
Region		
Northern (ref)	1.00	1.00
Central	1.62	0.36
Southern	1.07 *	1.09*
Place of Residence		
Urban (ref)	1.00	1.00
Rural	0.73*	0.68*
Woman working		
No (ref)	1.00	1.00
Yes	1.22*	1.91*
Number of living children		
0(ref)	1.00	1.00
1	57.7 *	10.9*
2+ (ref)	1.95*	1.74*
Ideal number of Children		
2 or less (ref)	1.00	1.00
3-4	0.52*	0.56*
5+	0.65*	0.87
Number of Co-wives		
None (ref)	1.00	1.00
One or more	0.67*	0.91
Ethnicity		
Chewa (ref)	1.00	1.00
Tumbuka	1.07	1.43
Lomwe	1.72*	1.66
Yao	1.20	1.80*
Ngoni	1.14	0.63
Other	1.69*	1.13
Previous Unions		
None (ref)	1.00	1.00
One or more	0.54*	0.49*
Husband Presence		
Yes (ref)	1.00	1.00
No	0.42*	0.19*
Waiting Period		
Within 2 years(ref)	1.00	1.00
After 2 years	1.04	0.89
Want no more	0.60*	0.90
Husband's fertility desires		
Both want the same (ref)	1.00	1.00
Husband wants more	0.64*	0.60*
Husband wants fewer	0.68*	0.58
Don't know	0.64*	0.37*

***p<.0.05. , ref=reference category**

Source: The 2000, 2004 and 2010 MDHS data sets

The reasons for the gap between injectable use and 'other method' use might not be clear but can be surmised that young married women with no child may be under pressure to prove their fertility soon and may be scared to use the hormonal method (injectables) because of its association with delayed return to fertility after use (Chapter 6 covers that in detail).

However, after having a child, they may want to use an effective reversible method to delay the next birth. The results also show that in terms of levels of education, the likelihood of a young married woman choosing injectables or other modern methods over non use was lower among women with no education than those with secondary education. The odds ratio was 1.61 for injectables and 2.27 for other modern methods.

The results also show that husband's fertility desires do not appear to sway contraceptive method choice in either direction. For example, in the choice of injectables over non use, the odds ratios are not quite different. The likelihood of choosing injectables is less (OR=0.64 and OR=0.68) than non use when the husband wants more and fewer children respectively than when both man and the woman want the same number.

Furthermore, the results show that place of residence was a strong determinant of method choice. Women who resided in the rural areas were less likely (OR=0.73 and OR=0.68) to choose injectables or other modern methods over non use respectively than those resident in the urban areas. It is also interesting to note that husband's presence in the house has a strong influence on woman's choice of a contraceptive method. It is observed that women whose husbands were absent had a lower likelihood of choosing other modern contraceptive method than non use (OR=0.19). The odds ratio choice of injectables was 0.42.

5.6 Conclusion

The results showed low levels of contraceptive use among young married women in Malawi across the surveys. While there has been an overall steady increase in the use of modern contraceptives between 2000 and 2010, the levels for married young women have still been low at 35.2 percent of all young married women. The challenge is that those young married women who are using are relying on short-acting methods to prevent pregnancy, while the majority (65 percent) do not use any contraceptive method at all. There is poor contraceptive method mix among the young married women as there is concentration on use of injectables (81 percent of all use) even among young married women who already have two or more children. As will be highlighted in the subsequent chapters, there are both supply and demand reasons for this poor contraceptive mix. On the supply side, unlike other long acting methods, the injectables are the most readily available female based short term methods in the country and can be easily accessed even in the rural areas as its administration was liberalised such that they can be dispensed by even the lowest cadres of health workers (Health Surveillance Assistants) through outreach service delivery outlets (It was also one of the first family planning methods to be introduced and promoted through community based distribution programmes that were prevalent in the 1990s (Chimbwete *et al.*, 2005, Bisika, 2008). On the other hand, it is also an issue (as highlighted in Chapter 8) that other long-acting methods such as IUDs and Implants (Norplant) are in short supply due to a number of reasons that include limited stocks, cost and lack of expertise to administer them.

On the demand side, it is a method they claim it can be secretly used even in situations where the spouse disapproves of contraceptive use. In addition, it is clear that young married women at those ages appear to be more likely to use contraception to space rather than to stop childbearing altogether hence the use of this short term method. Nevertheless,

for young married women, the overreliance on a single method has potential risks. It would be a big drawback should there be serious side effects of or any other problem with this most preferred method. As they have limited choices, they would be discouraged from further contracepting at the peak of their childbearing lives.

Both contraceptive use and method choices among young married women are largely determined by fertility related factors such as number of living children, waiting period before the next child and ideal number of children the woman would like to have. These results are corroborated by other findings reported in this study that posit that early marriage provides a socially and culturally sanctioned milieu for having children and that childbearing and children are an integral part of a marital union regardless of the age of the woman (Kathewera-Banda *et al.*, 2005; Zulu, 1998). Consequently, young married women tend to be under intense social and cultural pressure to prove their fertility soon and enhance their relevance and status in the extended family system and benefit from upward social mobility in the wider community networks (Mwalabu, 2014, Jimmy-Gamma, 2009).

As a consequence of strong gender inequalities, partner related factors have also emerged as one of the important determinants of contraceptive use and method choice. Where fertility preferences of the husband were in favour of contraceptive use, the woman was more likely to use contraceptives than otherwise. This underlines the critical role partners play in decisions about reproductive and contraceptive behaviours and corroborates other studies in Malawi (Kathewera-Banda *et al.*, 2005; Chimbiri, 2007; Palamuleni, 2013) that have also highlighted the great influence partners and husbands exert on their spouses in as far as contraceptive use and method choices are concerned. Similar results were also recorded in a study in Rwanda (Brunie *et al.*, 2013) where most of the contracepting women indicated that their contraceptive use was a joint decision with their husbands.

CHAPTER SIX: PERCEIVED PARTNER OPPOSITION TO AND SECRET USE OF CONTRACEPTIVES

6.1 Introduction

This chapter addresses the research question on the social, cultural and economic contexts that influence young married women's sexual, reproductive risks and contraceptive decision making and practices. It presents social and cultural milieu as it relates to value for childbearing and gender inequalities and how these influence young married women's reproductive and contraceptive decisions and practices. As highlighted in the framework, the study pursues the hypothesis that young married women's decisions and practices in matters of sexuality, reproduction and contraception are made and taken in a myriad of social and cultural contexts in which the individual young married woman's agency and capacity to act out her sexual, reproductive and contraceptive needs and rights tend to be limited. Drawn from IDIs and FGDs with young married women and KIIs with traditional leaders, the results in this chapter attach meanings and explanations to the results on the determinants of contraceptive use and method choice that were presented in Chapter 5.

The chapter is divided into two parts. The first section describes the underlying social and cultural beliefs and practices that place the issues of childbearing and children at the centre of defining the women's status and the validity of marital relationships in these communities among young married women in their early years of marriage. It also explores how gender inequalities and the low status of women, among other issues, influence SRH risks and contraceptive practices. The second part examines how gender inequalities in marital unions manifest themselves in partner opposition to young married women's contraceptive use. The study was only able to explore the motivations of

'perceived' partner opposition from the perspective of young married women. In that respect, in this study they are referred to as 'perceived' because they are what the women think or perceive about the issue of partner opposition. The chapter finally presents the motivations and challenges of secret contraceptive use and how it affects contraceptive method choices among young married women.

6.2 Social and cultural context

6.2.1: Value for childbearing and children

It was established during the discussions and interviews that regardless of the variations in kinship and family systems, there was great value placed on childbearing and children in all the study districts. It became clear from the narratives that young married women were always under pressure to bear children to fulfil the role of replenishing and safe guarding the continuity of their clans or families. Interviews with traditional leaders revealed of their worries about the survival of their families and villages due to the observed increases in deaths in their communities as a result of HIV and AIDS. What could be deciphered from the narratives are the high expectations that communities have that young married women, regardless of age, would fulfil the social obligation of bringing in more members, through births, into the family lineages or clans to save them from being depleted. This makes it difficult for young married women to postpone childbearing through early use of contraception.

The study also found that in the largely patrilineal and polygynous communities of Ntcheu and Mangochi respectively, young married women felt constrained to use contraceptives because of the pressure for childbearing, especially for male children that come to bear in patrilineal communities and competition that ensues among co-wives in the polygynous marriage. It was clear that young married women would wish to safeguard their positions

and status within the husbands' family or in the wider polygynous extended family through childbearing. The cultural pressure put on young married women to have children early is illustrated in these quotes:

> *If there are many people in the clan who died and maybe you only remain with your grandmother, you cannot use contraceptives. The grandmother would say "do not use contraceptives. As you can see most, houses are vacant. There are no people there. You want to use contraceptives and disturb potential children. Who do you think will be staying here?' So you are urged to fill the house with children so that the clan should be big again.* [FGD: 20–24, Zomba]

> *Some women want to be many in their families because they are few. Their relatives passed away, so by bearing many children they increase the family clan.* [IDI: 24, 4 children, non user, Zomba].

> *There is peer influence in the sense that there is that competition among young married women in the extended family in that the one who produces more children, her marriage will survive because the husband and his family members will value those children most.* [IDI: 20, 2 children, non user, Ntcheu]

> *It happens that you are in a family and that you are just giving birth to girls, up to 3 children. The husband tells you that I will not allow you to disturb your system through injections until you bear me a boy. You are forced to agree on this to save the marriage.* [FGD: 20–24, Ntcheu]

The study established that there was also economic value that is placed on childbearing and children. Although it was acknowledged by the study participants that things are changing in the realms of inter-generational interdependence and flow of resources from children to parents particularly in the urban areas; it was found that in these rural communities across the study districts, children are still being looked at as a potential economic resource for support. The support is both current in terms of readily available

labour for farming and herding and managing livestock and in the future when the parents grow old. The study participants expressly indicated that once they have children, their economic support in old age would be guaranteed regardless of whether the child will be educated or not. The general picture of the economic value for children in captured in these quotes:

> *If you educate them, when they grow up, if they get employed, they will be giving you money or buying you things. That's why our elders tell us that children are wealth.* [IDI: 19, 1 child, non user, Ntcheu]

> *In this community we live with the elders such as our grandparents and mothers. They tell us that children are a source of support so we must have many children. I will wait until I have maybe three or four children then I can start thinking about contraceptives.* [IDI: 21, 2 children, non user, Ntcheu]

> *I would want many children because when you grow old these children will be the ones to lift you up.* [IDI: 18, 2 children, non user, Mangochi]

> *Men are the ones who want many children as a result they do not want their wives to go for contraception. In this community, they expect a woman to bear children for they are considered economically valuable for the husband and his family. So if they see nothing happening in the house, they get worried.* [FGD: 20-24, Ntcheu]

It was clear in the study that the economic value of childbearing is cherished in both patrilineal and matrilineal communities and for both male and female children. In patrilineal communities, it was found that sons were valued because they stay with their families upon marriage and would take care of the parents in times of need and in old age. In relation to daughters, they were found to be valued because they would bring wealth to their families in form of bride wealth in form of cattle, goats or money upon marriage. In matrilineal communities on the other hand, it was found that female children were greatly

valued because upon marriage they bring their husbands into their parents' families. These sons in-law support their wives' families with cultivating gardens and other economic activities and also help in keeping and taking care of their wives' parents when they are old.

The study also established that there were general societal expectations that once young women get married regardless of their ages, childbearing would take place. In this respect, any postponement of onset of childbearing through the use of contraceptive methods was viewed as unacceptable within the social and cultural realms. This was found to emanate from the perceptions that as young married woman, they have not even ascertained whether they are fecund or not and what their fertility patterns were likely to be in terms of natural spacing of births. The sources of pressure and influence were found to be mainly from extended family members and wider community circles of friends and acquaintances. The influence was found to be strong such that young married women's contraceptive use was described as 'premature' as it would be practiced so early in their married and childbearing lives. These sentiments are aptly captured from the narratives of young married women and traditional leaders as below:

> *It is the parents in-law who prevent young women from using contraceptives. Once one gives birth to the first child, they say that maybe the first pregnancy was not for their son so they want the second born for them to be sure that the first born was really for their son and that the pregnancy was really his.* [FGD: 20–24, Zomba]

> *As long as she has not yet born a child, all people who are related to her will expect to see a gift of a child in her marriage. If the woman is using injections before giving birth, people would be suspecting that in the house* ***tambala sakulira*** *(the husband is not functioning). They are not having sex in that house.* [KII: Traditional Leader, Zomba]

It is not good to start using family planning methods while you have given birth to one child only. Using contraceptives is like you are disturbing other children in the womb wanting to come out. It will happen that when you stop taking the methods and want to conceive again, you cannot conceive anymore, that's the end of your childbearing. [KII: Traditional Leader, Zomba]

If she use contraceptives before giving birth, she can face problems because she doesn't know her fertility whether it is high or low. For her to start by using contraceptives childbearing to her can turn out to be a problem later, she can fail to bear children anymore. [KII: Traditional Leader, Ntcheu]

6.2.2 Gender Inequalities

Young married women discussed the decision making powers their husbands wield in all matters in the family but more particularly on sexuality, reproduction and contraception as heads of the family. It became clear from their narratives that these biased gender relations were inimical to young married women's agency and capacity to access and use contraceptive methods. Young married women and the traditional leaders expressed strong expectations and beliefs that men have and should have powers to make decisions in their families. On the other hand, it was also clear that there were expectations that a married woman of virtue should be obedient and respectful of her husband and abide by the decisions he makes in the family. The general picture of these gender inequalities is captured as follows:

Husbands tell us that they are family heads. If you do not obey them then it will be a mess. You are obeying the husband because he has told you that there should be no contraceptive use in this house. You listen because he threatens that "I will go away and will not stay with you anymore if you do not listen". [IDI, 20, 2 children, non user, Mangochi]

Men insist that they married in order to have children. They do not allow their wives to use these methods until the number of children they want is reached. Women just follow that for the sake of marriage as it is not easy to get married again if the husband leaves you. [FGD: 15–19, Ntcheu]

I have a neighbour who is not using contraceptives because the husband tells her that he has a lot of power to produce more children through her so she is always afraid of being divorced. [FGD: 20–24, Zomba]

6.3 Perceived partner opposition

In relation to great value placed on childbearing and children and the gender inequalities, the study has established that irrespective of the study district or kinship system there was widespread partner opposition to young married women's contraceptive use. It was an issue that was being raised spontaneously and simultaneously in the discussions and interviews with all groups of the study participants. What was clear was that whether overt or covert, partner opposition was critical to young married women's reproductive and contraceptive decision making and practices.

6.3.1 Motivations for partner opposition

The study has established, from the variety of study participants, that reasons for partner opposition could be diverse. However, for easier explanation in this study, they have been grouped into two broad categories: exerting control over women's sexuality and to ensure stability and security of the marital union. These motivations are elucidated in the subsequent sections.

i) Exerting control over women's sexuality

It emerged from the discussions and interviews with the young married women and some community health workers that they perceived that partners' opposition was principally

motivated by men's' desire to exert control over the sexual and reproductive lives of their wives. Their narratives pointed to strong perceptions that men, regardless of the kinship system, considered the use of contraceptives by their wives as something that would lead them to lose control over their wives' sexuality and fertility. As discussed in the section on gender inequalities above, there are cultural expectations that men should have and exercise decision making powers in all matters in their families. What could be discerned from the study participants' narratives was that there were fears among men that once their spouses start using contraceptives, they would be free and in control of their sexual and reproductive lives hence water down the control and powers of their husbands on these matters in a marital relationship. There were also some extreme perceptions that men have fears that contraceptive use would relieve young married women of the stress and fear of becoming pregnant and would hence enabled them to engage in and conceal extramarital sexual activities easily. The fears emanate from the fact that the young married women would be less worried of being discovered through pregnancy. What came out clearly from the study participants was that men believe that this exerting of this sexual and reproductive control on their young women was critical and important in these initial stages of their marital and childbearing lives. The subsequent quotes exemplify the understanding of this control:

> *It is because of fear of encouraging promiscuous behaviour. They think that their wives would be able to sleep around with men without becoming pregnant.* [IDI: 19, 2 children, non user, Ntcheu]

> *Men fear that women who are using contraceptives may behave like prostitutes as they will not conceive and therefore can sleep with anybody.* [FGD: 20–24, Mangochi]

Some think that if a young married woman is using contraception, it is a sign that she does not want to become pregnant because she is involved in promiscuity. [KII: Health Centre Worker, Zomba]

ii) Stability and security of the marital union

The discussions and interviews with young married women also revealed that there were some beliefs among not only married women themselves but ironically among men too that childbearing would strengthen and assure the stability and sustainability of their marriages. The young married women expressed perceptions that men harbour strong feelings of jealousy and believe that once a woman starts using contraceptives she would have better chances of taking care of herself and become more attractive to other men due to the fact that there is less burden being exerted on her by constant childbearing. Consequently, to protect their marriages from instability, men were perceived to oppose use of contraceptives so that the constant childbearing and a large number of children would preoccupy the woman's time and take a toll on her physical appearance. It was further expressed that constant childbearing would make the woman have less time and opportunities to get out of the home and would be less attractive to other men. The elements of these perceived fears and control are captured thus:

To prevent her from immorality, they want the woman to be put under pressure by having a child every year. She should not find time to go and flirt with other men. [IDI: 19, 2 children, user, Zomba]

Men are just jealous. They just want women to bear them many children in order for them not to be free. They should be busy with taking care of their children. This is what men want. [FGD: 20-24, Mangochi]

It is because the aim is that she should always be kept busy with pregnancies and childbearing so that she can have no chance of sleeping with other men. [KII: Community Health Worker, Ntcheu]

It also became clear during the discussions and interviews that partner opposition was more pronounced in polygamous unions. This was noted to arise from the fact that the cardinal characteristic of this type of marriage was that second or higher order wives tend to be much younger than their men. This arouses fears and jealous tendencies among the men in those relationships that the wives can be going out with younger men without fear of being discovered through pregnancy.

What was interesting was that some young married women indicated that men's fears about their wives' use of contraceptives for ulterior motives of engaging in extra marital affairs were not necessarily unfounded. It was revealed during the IDIs that some young married women have had friends and relatives who had used contraceptives not only secretly but also rather to enable them engage in extra marital affairs without the possibility of being discovered by their husbands through pregnancy. The following example from an IDI captures this issue:

> *Someone is married and her husband has gone to South Africa. What she felt was that she should not be impregnated but should be free to have sexual activities. She was afraid that she could be pregnant. She went for family planning methods fearing that if she became pregnant things would not go well with her husband.* [IDI: 20, 2 children, non user, Mangochi]

6.3.2 Support for partner opposition

While partner opposition was negatively expressed in most of the discussions and interviews with the study participants, it was intriguing to find that some of the young married women were in support of partner opposition. It can be surmised that this was a reflection of the entrenched social and cultural context and norms pertaining to the value for childbearing and gender inequalities in the communities. In the discussions and

interviews, some young married women justified partner opposition on the grounds that childbearing was supposed to be an integral part of a marriage and also that men, as heads of the family, should be left to make decisions on these matters of fertility and hence are justified in opposing contraceptive use if need be . The issues were aptly captured in the following excerpts:

> *If you get married it means you have accepted to bear children. Using contraception is just as good as telling your husband that I am not ready for marriage because I have other things to do.* [IDI: 23, 3 children, never user, Ntcheu]

> *As long as you are in marriage you are not supposed to use family planning methods because you really do not know what the future holds for you in terms of childbearing. It was your choice to get married so why do family planning. Just by accepting the husband you also accepted pregnancies.* [IDI: 17, 1 child, never user, Mangochi]

> *The decision maker is the husband. He is the one who decides how many children to have. There is no need for a young woman to do something like taking contraceptives* [IDI: 21, 2 children, never user, Zomba]

Study participants also revealed that partner opposition tended to be common in situations where the husband and the wife do not stay together or where the woman resides at her husband's village. From the narratives, it was surmised that it was for the same purpose of controlling the woman's sexuality. It became clear that it would be easier to monitor the woman's movements when they stay together or when the woman stays at the man's place than when the husband was absent or she resided at her place. This was particularly noteworthy in Mangochi district where many young married men periodically migrate to South Africa to seek employment and leave their wives behind. What emerged from the interviews with young married women and the traditional leaders was the general conviction that contraceptive use would lead to promiscuity. While the subtle references to

this general picture were widespread, the study could not establish their origins from the discourses. The subsequent quotes highlight the fears that contraceptive use might bring:

> *Men believe that when you are using contraceptives, it means that you want to get involved in promiscuous behaviours, especially in our families where husbands are away from homes working elsewhere. This is common to families where the women are not accompanying their husbands to the place of work.* [IDI: 24, 2 children, non user, Mangochi]

> *I have not been using any contraceptive method because my husband is in South Africa. People would have said many bad things. This time he is coming and this is why I have decided to come and take contraception here at the hospital.* [IDI: 22, 1 child, Mangochi]

> *These young women do this mostly because their husbands here went to South Africa, so they want to blind them as if they were not engaging in sexual activities. How can a person whose husband is not here use contraceptives?* [KII: Traditional Leader, Mangochi]

In the course of the study and in Mangochi district, for instance, it was intriguing to note that although culturally the man is supposed to relocate to his wife's place upon marriage, young married women had relocated to their husbands' villages when their husbands had temporarily migrated to South Africa for employment. From the discussions, it became clear that this was ostensibly a way of monitoring young married women's movements and watching over their possible sexual escapades.

In the study, there were also perceptions that partner opposition arise from the need for these young men to have uninterrupted childbearing with their wives. These young men often have very short periods of vacation (mostly two months in every two to three years) from their employment in South Africa. What could be discerned from the study participants was that young men's expectations were that they needed to leave their wives

pregnant at the expiry of each of their short holidays. When they returned, they needed to always find their wives in the best of form for an immediate conception. This would not be possible if she were to use contraceptive methods some of which can cause delayed conception. Any such subsequent pregnancy was perceived as part of a broader strategy of the control of their wives sexuality by ensuring that she is preoccupied with pregnancies and children.

It also became clear from the narratives that there were some strong cultural beliefs that support partner opposition to contraceptive use. In the study districts, there were beliefs that a pregnant woman cannot and should not sleep with other men than her husband lest she experiences a spontaneous abortion or have serious difficulties during childbirth. It was further expressed that she could not and should not sleep with other men while lactating for fear of bringing diseases to the child that can cause death. In addition, there were also cultural beliefs to the effect that once a married woman gets impregnated by someone other than her husband, the woman will have difficulties or might even die during childbirth unless she reveals the identity of the man responsible for the pregnancy. It could be surmised that all these cultural beliefs were meant to still exert control on women's sexual and reproductive lives and ensure marital stability. These cultural beliefs were aptly expressed as below:

> *A pregnant woman who has sex with other men would cause the pregnancy to abort, would have difficulties delivering the child and can only be saved by mentioning the man she was cheating with. Any difficulties in the pregnancy and delivery are attributed to the woman's cheating.* [KII: Traditional Authority, Zomba]

The husband left for South Africa. In his absence the wife can be having high sexual feelings and would want to have a sexual affair but bearing in mind that she might get pregnant, the only option is for her is to use family planning methods. [KII: Community Health Worker, Mangochi]

A woman cannot have sex with other men when the child is still breast feeding, the child can develop serious diseases such as ***tsempho***[6] *and die.* [FGD: 20–24, Ntcheu]

6.4 Secret contraceptive use

As has been elaborated in the last section, partner opposition is one of the critical barriers to young married women's contraceptive use. Under such circumstances, some women tend to practice contraception secretly. In the study, secret contraceptive use is restricted to the use of contraceptives by young married women without the knowledge of or consultation with their husbands.

6.4.1 Motivations for secret contraceptive use

The results show that a majority of young married women (from 12 FGDs and 39 IDIs) expressed positive attitudes and were in favour of secret contraceptive use under certain circumstances. However, participants revealed that secret contraceptive use was such a painstaking and risky endeavour that could only be embarked on under extremely desperate situations and with very strong motivations. The following sections highlight what study participants proffered as motivations for secret use.

i) Fear of abandonment

Although one of the adverse consequences of secret use (as highlighted in the appropriate section below) was that a married young woman can be abandoned for another woman

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[6] *a kwashiorkor like debilitating disease in children*

once her secret contraceptive use is discovered by her husband, it was intriguing to note from the study results that there were some young married women who indicated that they have used contraceptives secretly in order to keep their bodies in shape so that their husbands should not abandon them for other women due to incessant childbearing that can affect their body shape and physical appearance.

It was apparent from the study participants that their clandestine use was motivated by the quest to keep their husbands attracted to them hence safeguarding their marriages. In addition, they also wanted their men not to stray to other women more particularly during the traditionally sanctioned long waiting period between child birth and the resumption of sexual intercourse that can range from 6 months to 2 years. There were common assertions among young married women in the study that constant childbearing and having many children make their bodies to deteriorate such that they would be looking too old for their ages.

We know that they would abandon us because they want younger women. Some of us use contraceptives in secret to ensure that our men do not to run away. They should be happy with the way we look and they should enjoy sex. [FGD: 20–24, Ntcheu].

I started using contraceptives without his knowledge because I noticed that if I give birth more often the result would be that my husband will not love me anymore. Now that I use contraceptives, we are able to enjoy sex in the house. We have sex freely. We are happy. *[IDI: 22, one child, user, Zomba].*

> *When one gives birth to many children, the childbearing is done often and when the man sees that he has given you many children, he leaves you for another woman and the marriage ends there. So we just decided to go for the methods anyway. In this way we keep our marriages.* [FGD: 20–24, Zomba].

We are always told by our grandmothers that when a woman has given birth, she has to stay away from sex for 6 months. However, at the hospital they are saying after 6 weeks one can resume sex. It happens that at home; the husband would be pestering the wife after that period of 6 weeks. In order not to refuse, she sneaks out to a clinic so that when having sexual intercourse with him, she is already on a contraceptive method to prevent getting another pregnancy while the child is still small. [FGD: 20–24, Ntcheu].

ii) Reaction to marital instability

The study revealed that some young married women used contraceptives clandestinely as a reaction to the adverse marital environment in which they found themselves. It was clear from their narratives that they would not want to continue childbearing in a marital environment that was hostile and unstable. It was found that this instability would be triggered by men's mistreatment of the wives and children as well as promiscuity. However, it was clear during the discussions that this clandestine use was not meant to fight back on their husbands' misbehaviours, but rather as a precautionary measure in the midst of marital instability and in a marriage that was breaking. There were expressed fears that continued childbearing would turn out to be disadvantageous to them, as mothers with small children, as they might be left taking care of many children in the event of a marital dissolution arising from the marital instability. These following sentiments were expressed by participants:

It is just ill-treatment from men. You have to be clever enough to have only two children you can manage to support even if he divorces you. [IDI: 22, 2 children, user, Zomba].

When my friend noticed that her husband had started going out with other women, she knew that she will end up with many children with a man who is not good. This made her to start using contraceptives secretly. [IDI: 20, 1 child, user, Ntcheu].

> *When the man indulges in promiscuous behaviour, with your contraceptive use you are not worried much with that. You leave him to do what he is doing because you know that you are taking precautions and that you cannot conceive.* [FGD: 20–24, Mangochi].

However, it was intriguing to note that in spite of their complaints of their husbands' suspected and real extra marital sexual affairs, the issue of the dangers of HIV and AIDS did not come up in the discussions. Even in situations where it was raised, there was lack of enthusiasm among the study participants to discuss the subject at length in relation to the importance of using condoms for protection of both pregnancies and HIV infection. The reasons could not be discerned but possibly it is due to the fact that condoms cannot feature in the realms of secret contraceptive use.

iii) Lack of or poor spousal communication

Young married women in all the districts discussed the difficulties they encountered in their quest to initiate and engage in discussions with their husbands on many issues let alone those to do with sex, childbearing and contraception. Although the reasons for these difficulties were not clear from these discussions, it could be surmised from the reviewed literature (Kathewera-Banda *et al.*, 2005; Chimbiri, 2007; Kamlongera, 2008) that there are gender inequalities that place decision making powers in the hands of men, as heads of the families. Young married women expressed sentiments to the effect that any attempt to have such discussions would raise doubts about their characters and would be construed as a sign of bad external influence from relatives or wayward friends. What became clear in their narratives was that secret use was somehow triggered by lack of alternative ways of satisfying their needs for contraceptio at a particular point in time and lack of opportunities to engage their husbands on the same. They expressed sentiments to the effect that the lesser evil for them was to use contraceptives secretly than risking engaging in a

discussion on issues that would invoke suspicions and tensions in the family. These sentiments are discerned from these quotes:

> *We are afraid that if we tell them about contraceptives, they would become a problem, and would not allow us to go ahead with our plans. That's why we use these contraceptives without their knowledge. We do this secretly. We use injections. Our men just see that the pace of childbearing is slowing down* [FGD: 20–24, Ntcheu].

> *Some men are always furious and tough. For us to discuss contraception with them, it is a problem. They just go out while they are angry and for us to have courage and talk more to them, we fail. They would say "what are you saying? Are you the one who is feeding these children? I am the bread winner, so what are you saying?" You then just know what to do on your own.* [FGD: 15–19, Zomba].

> *As a woman you are always afraid of the husband who will question where such ideas are coming from. This can go to the marriage counsellors or sometimes he can beat you up. In these cases, you are bound not to mention or discuss the issue with him, but just sneak out and do it yourself.* [IDI: 21, two children, user, Zomba].

iv) Inadequate household support

The study also found that young married women felt justified to be using contraceptive secretly when their husbands were unable to support them and take care of the already born children due to laziness or drunkenness. In all the study districts, secret use was found to be a way of limiting additional births that would add to the families' economic burden. However, in matrilineal communities of Zomba and Mangochi, the study participants further indicated that secret contraceptive use would limit the extra burden shouldered by the young woman and her extended family since the children belong to the woman's family and clan and the man would leave the children behind upon marital dissolution.

As women, we tell them about contraceptives, but they refuse to hear about it. So looking at the problem of raising many children, we just decide to sneak out and get the methods. [FGD: 20–24, Zomba].

The man who gave you the children is failing to support you and the children. I want the children to grow in good health. I would rather go for contraceptive methods on my own than face poverty problems. [IDI: 23, 3 children, user, Mangochi]

Some husbands are drunkards who know only to sire children but fail to support them. They just go out to drink daily. Looking at the level of poverty in the home, as women, we just go for family planning on our own to have a small number of children. [FGD: 20–24, Mangochi].

v) Uncertainty over husbands' return dates

It became apparent during the study, particularly in Mangochi and Ntcheu districts, that many young men often migrate to South Africa to seek employment and stay there for two to three years leaving their young wives at their (men's) parents' homes. However, because of the temporary and fluid nature of the tenure of their informal employment in South Africa, these young men can come back home any time. It was learnt during the study that young married women, particularly those who have small babies, would use contraceptives secretly so that should their husbands return suddenly, they should not fall pregnant prematurely while their babies are still small. However, they indicated that this could land them into serious problems, including being chased away from the husband's parents' place, if discovered. It was found that they would be accused by their husbands' family members of engaging in extra marital sexual relations even in the absence of any proof. The subsequent quotes highlight those sentiments:

Your husband can come back from South Africa just suddenly while you are breastfeeding and he may need to have sex with you. If you had not used contraceptive methods, then it is likely you can become pregnant.

But when people see you using contraceptives, they think you are just doing this to be engaging in promiscuity. [IDI: 19, 1 child, user, Mangochi]

Most young men in this community go to South Africa in search of greener pastures leaving behind their pregnant spouses. Soon after giving birth, some women go for a contraceptive method because they do not know when their husbands would show up. When people see this, they think this woman is promiscuous and they ask 'why is she taking the methods when her husband is abroad?' [FGD: 20–24, Ntcheu].

vi) To safeguard own health

While husbands have, as discussed above, culturally more powers in sexual and reproductive decision making and practices in marital unions, the study participants indicated that the burden of suffering from the physical and emotional costs of pregnancy and childbearing was disproportionately placed on their shoulders as women. In this respect, interviews with young married women revealed that they can be motivated to go for secret contraceptive use in order to safeguard their own health. They indicated that their general health deteriorates due to pregnancy induced conditions such as high blood pressure and anaemia that can emanate from loss of blood during delivery. These sentiments were captured thus:

It happened to me. I saw that this won't help me. It is me who gives birth. The end of it is that I'll have problems. I just started it alone behind his back, without his knowledge with the aim that I stay in good health. It is better for me that I am assisted because I am the one who suffers birth pains while he is seated at home. [IDI: 23, 2 children, user, Ntcheu].

Your man goes back home leaving you at the entrance to the labour ward; you are the one who experiences problems in the labour ward. It is not good to have children every year and every year losing blood. This idea of using contraceptives secretly is the way to preserve your health. [IDI: 21, 3, user, Zomba].

Most of these husbands are so stubborn that they do not want a woman to go for family planning methods. All they think about is having children yearly without considering the problems caused on the woman. As a child bearer, I just do what I feel is good for me as far as my health is concerned. [IDI: 20, 1 child, user Mangochi].

6.4.2 Negative attitude towards secret contraception

It was evident from the discussions and interviews that there were mixed feelings about secret contraceptive use among young married women. While some were in agreement under certain circumstances, there appeared also opposition to any secret contraceptive use regardless of the justifications; describing it as a sign of disrespect for the husband and equated it to open confession of engaging in extra marital sexual liaisons. These sentiments are aptly captured in these subsequent excerpts:

These women who use contraceptives secretly have relationships outside their marriages, so in order for their partners not to know what they are doing, they use contraceptives in hiding to be free to go out with other men. She would just say "I am going to the bus depot, while she knows that she has an appointment with another man". [FGD: 20–24, Ntcheu].

There is no reason for contraceptive use if your husband went to Johannesburg[7] *because you are not sleeping with any man. But because some women wish to be wild as the man is far, they do not want to be caught that they have been messing around. So for them they feel it is*

[7] Johannesburg is a big city in the Republic of South Africa. By Malawian standards, these young men tend to be financially well off. They bring home money, household items such as fridges and TVs and others even bring cars.

good to go and get a secret injection in order not to get pregnant. [IDI: 20, 2 children, user, Ntcheu].

We as onlookers would know that she is practicing prostitution and what she is afraid of is pregnancy. By practicing family planning, she is promoting her prostitution[8]. [FGD: 20–24, Mangochi].

6.4.3 Strategies for hiding use

It was apparent from the young married women's narratives that secret use required a great deal of effective strategies that would reduce the chances of being discovered by the husband or family members. These strategies included hiding their visits to health centres, avoiding being seen at the health centres and hiding any family planning information that would give them away as secret users. These fears of being discovered were common and compelled young married women to go to great lengths to ensure that their contraceptive use is kept a secret. The results also show that there was collusion between the young married women and some service providers whereby the later would assist in hiding contraceptive use from the young women's husbands or other family members. One of the most prevalent strategies is the maintaining of two health passport books where one is for family planning, while the other is for general health. It was revealed that when they visit health centres for contraceptives, they would agree with the service providers to keep the family planning books for them at the health centres, while they take the general health passport book home to show to their husbands. The following quotes aptly summarise these strategies:

My husband did not allow me to practice family planning, but I managed to do that secretly. I bought a book which I left at the hospital whenever I visited the hospital and have Depo secretly. If there is another method

[8]Loosely used by community members to refer to any practice of having extra marital affairs or multiple sexual partnerships

which my husband cannot be involved in apart from the injection, I would love to use that method after I deliver this child. [IDI: 24, 2 children, Ntcheu].

You go to the hospital and explain your situation to the doctor. The doctor provides a paper so that when you have your injection you leave the paper there at the hospital, even the health passport book, you leave it there, and they keep all those for you. [FGD: 15–19, Zomba].

The health passport books where records of family planning are found are left at the health centre so that husbands should never see them. Sometimes they are hidden where baby nappies are kept. When the appointment is due, we feign illnesses so that the husbands are hoodwinked into believing that we have gone to the clinic to access treatment for an illness. [FGD: 20–24, Ntcheu].

The study also established that not all relatives would be against the young married woman's contraceptive use. In addition, to friends and neighbours, there were also sisters who could be used to hide any evidence of the secret use. These are trusted confidants within the young married woman's network. They were also found to be sources of information on contraceptive experiences as well as opinions about particular methods. They use the same strategy of using two health passport books with the contraceptive one being kept at the relatives or friends' place while the general health one being taken home to be shown to the husband. This is reflected in the following quotes.

It happens like that because other men do not like their spouses to use contraceptives so women make a plan of having two health passport books, so that the nurses should be recording the contraceptive use in another book that is kept by your neighbour. [FGD: 20–24, Mangochi].

You can as well keep the health book for family planning at your friend's or sister's house. You know that she will keep it as a secret. [IDI: 18, 1 child, user, Ntcheu].

6.4.4 Challenges of secret use

The study revealed that there are a number of challenges associated with secret contraceptive use. The most prominently mentioned ones were limited contraceptive choices and side effects.

i) Limited contraceptive method choices

It was found that most young married women who were using contraceptives secretly were using injectables. They proffered reasons for the preference of this method. They indicated that the method's administration ensures greater secrecy as it does not require them to carry any commodities home as is the case with other methods such as pills (Adetunji, 2011). It is a method that is administered once in three months as such it only requires the woman to visit the clinic mostly once in three months. It was also said to be a short term method that can be easily discontinued if one need to conceive again. More importantly, it was said to be the most secretive method that can be hidden easily from their husbands or family members. The other methods such as the pill and Norplant were also mentioned but it was clear that they were not as favoured because of the likelihood of being easily discovered by partners. The pill was said to be highly demanding because it has to be taken daily and also that one can easily forget the pills at a place where the partner can easily see and ask about them. As for the Norplant, it was said that the conspicuous marks on the woman's upper arm can be easily noticeable and give the woman away when questions are asked. It was also said to be a long acting method which they indicated might be difficult to reverse if desired so.

ii) Side effects

It was apparent from the discussions that young married women were always worried about the possible side effects of the injectables as their chosen method for secret contraceptive use. The concerns mainly centred on the disruptions in the menstrual cycle, caused by the

injectables that at times could lead to prolonged bleeding, spotting or amenorrhea. While they expressed concerns about these effects on their health, it was noted that their worries were much more to do with fear of being discovered. It was also revealed that even if the effects may be taking a toll on their health or comfort, the young married women would still persevere and be hesitant to tell their husbands or seek treatment for the problem. It was also indicated that because the husband is not aware of the woman's contraceptive use, it could cause a great deal of consternation on the part of the man as he would be going about looking for treatment for his wife's purported illness.

The discussions also centred on the cultural beliefs pertaining to menstruation. It was established that prolonged spotting or bleeding would restrain young married women's husbands from having sexual intercourse with them as it was culturally prohibited for a man to have sex with a menstruating woman. In addition, it is also culturally believed that a menstruating woman should not put salt into food lest she brings in serious illnesses (for example swollen feet) that can affect everybody who eat that food in the family. Thus, constant spotting or bleeding may alert not only the husband, but also other family members about her secret use as she would not be able to perform her sexual and social functions. Likewise, prolonged amenorrhea due to contraceptive use would lead a husband to suspect that the wife may be pregnant or has been afflicted by an illness. These situations are aptly illustrated in the following statements from the study participants:

> *For one to start using contraceptives without the knowledge of the husband, this is a problem, because some women when they use the injection method they experience continuous bleeding throughout the month. It becomes difficult to tell their husbands the cause of the abnormal menses. As a result, the husband would start to consult traditional healers in different places thinking that the woman has been bewitched, while she knows that it is this injection she is using which has caused all that. It is*

like you confuse the husband instead of just being open to him and tell him the truth. [FGD: 20–24, Ntcheu].

It may be good to sneak and go for injection for contraception, but it does not always go well with some women. They experience continuous menstruation and husbands find it hard to sleep with them. Some husbands would tell their parents or their wives' parents to investigate the cause of the problem and because of fear of worsening the matters; they just disclose that they went for contraception. [IDI: 20. 2 children, non user, Ntcheu].

Sometimes one would experience problems due to the use of contraceptives, maybe one falls very sick due to heavy menstruation. You fail to tell your husband that the sickness is from the use of contraceptives because you are taking them without his knowledge. Had it been that the husband was aware of this, you would have discussed this issue properly and the husband would have taken you to the hospital where you can be helped. [FGD: 20–24, Zomba].

Maybe one has injection and experiences continuous bleeding which can happen daily from first day of the month to the last day. So if the husband wants sex, it happens that this fails because the wife always says "I am on my period", so the husband says "why is it that you are experiencing continuous periods in all these days, you were not experiencing this before". As a result you reveal it to him yourself that you are using injections and things turn sour. [FGD: 20–24, Mangochi].

The other challenge as revealed in the study emanated from young married women's misunderstanding of the reasons for sexual abstinence of between 4 and 7 days they indicated to have been advised by the service providers when they get the injection as a contraceptive method for the first time. While the reason might be to allow the drugs to settle in the woman's body and become effective, it was clear that the study participants interpreted that to mean that the drug was so powerful such that without observing that period, the potency of the drug could actually harm the man's sexual organs rendering them too weak to function. These fears of the purported side effects were expressed as a

challenge to secret use because under normal circumstances, the husband would know why he has to abstain for those days. These scenarios are illustrated below:

> *Using contraceptives without the knowledge of the husband is problematic. When you receive instructions from the hospital that after getting the injection when you go home you should avoid having sex for four days, if you refuse to have sex, you know that he will discover that you are using contraceptives. It so happens that you accept to have sex with him as a result the husband will have problems in his body because of the drug that is in the injection.* [IDI: 23, 2 children, non user, Ntcheu].

> *We go for contraceptives without the knowledge of our husbands. We are given instruction that after taking this method, we should not have sex for some days, so back home, you fail to deny him sex when he wants it, in so doing the drug in the woman destroys his manhood.* [IDI: 20, 2 children, former user, Mangochi].

6.4.5 Risks of secret contraceptive use

It became clear from their narratives that young married women were always troubled in their decisions to use contraceptive secretly because of what would befall them once discovered by their husbands or family members. It was also found that there would be very little family support for young married women who take such a decision to go into secret contraceptive use. It was surmised that the young married woman would be rebuked by her family for acting as if she were not married or for going against her husband's rules, both of which were said to be unacceptable in marriage and indefensible even among her own family members. What became apparent in the discussions was that secret contraceptive use, if discovered, could put the woman and her whole family into shame since marriage, in their cultural context, was not about the two individuals but rather a union of two families. A young married woman in Mangochi explains this:

Everyone would be laughing at you for insisting on contraception contrary to your husband's wishes. This is not acceptable in marriage and can put your own uncle (the clan head) and the whole family into shame and disrepute such that they cannot back your actions for whatever reason. [IDI: 24, 3 children, non user, Mangochi].

It was found that there could be extreme consequences of secret contraceptive use once discovered that included marital conflicts, withdrawal of support (abandonment) and even divorce. What could be discerned from the young married women's narratives was that husbands would feel undermined, threatened and betrayed by the wife's actions that with further feelings of loss of control and diminished powers in the marital union. The excerpts below express those feelings:

Some husbands are so violent that they count the number of months to check if you are getting pregnant or not. They will force you to go to the hospital to have a check up. When they discover that you have been going behind their backs, accusations will arise because it is like you are challenging him. [FGD: 20–24, Ntcheu].

When the man notices that you are not conceiving, he suspects that this woman is cheating on him. He thinks that maybe these children we have are not his own." How come she is failing to conceive again" So he would say "ooh those pregnancies were not mine, there is someone who impregnated you" So the man ends the marriage because you are using contraceptives secretly and he feels worried about your intentions. [IDI: 23, 2 children, non user, Ntcheu].

6.5 Conclusion

The results in this chapter have shown that there is cultural, social and economic value for children such that there are always societal expectations and social pressure on young married women to prove their fertility once they get into marriage. It is a clear confirmation that the society still look at entry into marriage, regardless of age of the

woman, as marking the initiation of childbearing .These results corroborate those found in a study in Tanzania (Ngalinda, 1998) where after some few months of the first marriage close relatives would start asking if the marriage has answered, a disguised way of asking if the newly married woman is pregnant. These findings on the value for children are also in tandem with 'wealth flow theory' as propounded by Caldwel (1976) to explain the high levels of fertility in sub-Saharan Africa where he argued that children in traditional societies are generally considered as assets that help working on the land and are involved in the collection of firewood and water even at a tender age. He also argued that their value is great as they also provide security for their parents when they become older and infirm.

The results have shown that the dominant perceptions about partner opposition to young married women's contraceptive use were principally bordered on men's quest to exert control on their wives' sexual and reproductive lives, maximise their own sexual and reproductive benefits and minimize the risk of marital instability at this early stage in their marital and reproductive years. This quest for control is buttressed by widespread social and cultural beliefs that place great value on childbearing and children and ostensibly regard childbearing as the ultimate and inevitable outcome of marriage regardless of the ages of the marital partners.

While there have been no marked variations in the extent of and reasons for partner opposition by age and district, the results demonstrate that young women married to a polygynous husband would face widespread opposition to contraceptive use. This corroborates previous study (Malawi Human Rights Commission, 2006) that found that polygyny was principally there for fertility related reasons. For example, a new wife could be sought when the first one is failing to bear children, a son or when the man wants to produce more children to carry on the lineage or provide security in old age (Malawi

Human Right Commission, 2006). It is reckoned that in this type of marital relationship, pressure on the young married woman to bear children is always enormous such that partner opposition becomes more intense. However, the study found no variations in perceptions about partner opposition between young married women in matrilineal and matrilineal kinship systems. Contrary to other studies (Chimbiri, 2007; Kerr, 2005; Zulu, 1998) who have found those in matrilineal system to have some leverage over their husbands, the present study found that those in matrilineal kinship system did not appear to have any more decision-making powers pertaining to reproductive and contraceptive practices within their households compared to their counterparts in patrilineal system. This might be attributed to the facts that these are still young married women who experience intense pressure to prove their fertility regardless of the system.

The results have also shown that secret contraceptive use was one of the strategies young married women use to counter partner opposition to contraceptive use. It was clear that secret contraceptive use was such a risky undertaking with dire consequences that could only be embarked on under extremely desperate situations. When a young married woman engages in contraceptive use without knowledge or approval of her husband, it was likened to challenging the authority of the husband and his control over his wife's sexual and reproductive realms as the head of the family. That notwithstanding, some young married still embarked on it and their core motivations were mainly externally driven by factors such as poor family care (poverty), and ironically to safeguard their marriage from instability and dissolution and not necessarily their internal desire and quest to meet and enjoy her sexual and reproductive health rights.

The issue of safeguarding their marriages takes the form of dissuading their husbands from seeking sexual gratification elsewhere under the pretext that their women were no longer

sexually attractive due to constant childbearing. In other cases, it was in a quest to still provide sexual gratification to their husbands during the long wait (culturally a minimum of 6 months) before resumption of sexual liaisons after child birth. Related to this is the use of contraceptives secretly as a reaction to the husband's promiscuity and mistreatment and failure to provide support to the children. This was done to ensure that the young married woman would not be left with many children in the event of divorce. Secret contraceptive use was also found to be an option in situations where the woman would want to safeguard her health bearing in mind that the bulk of physical and emotional consequences of childbearing rest upon her shoulders. Further, young married women would go for the method secretly because of the difficulties in communicating their reproductive desires to their husbands due to fear of confrontation.

Fear of side effects particularly irregular menstruation was the commonest challenge faced by secret users. Their main concern was more about the disruptions that can cause to their husbands' sexual lives than their own health or convenience. The concern is also fear of being discovered by the husband or other family members with accompanied risks of marital conflicts, abandonment or divorce. However, the study asserts that secret contraceptive use denotes the fact that not all young married women are passive victims of male control and that they always succumb to their husbands' sexual, reproductive and contraceptive decisions and pressures. In spite of its risks, opposition and pressure, secrete contraceptive use is a demonstration of some level of agency among young married women to act out their reproductive and contraceptive needs when need arises. These findings corroborate the results in a study among rural women in Malawi (Schatz, 2005) where it was found that women had the agency and capacity to divorce their husbands in a quest to protect themselves from HIV in situations when the husbands were continually being promiscuous.

One thing that has been consistently noted in discourses is the absence of discussions among young married women pertaining to their risks of contracting STIs including HIV in spite of their anxiety about their partners or husbands' extramarital sexual escapades. Since it is a serious problem in the country (11 percent of adults are infected), it would have spontaneously come out without being probed. It can be surmised that this is a culturally sensitive area because the state of being married provide some sense of safety and the issue of condom use in marriage is controversial as was found by other studies (Chimbiri, 2007; Zulu, 1998).

CHAPTER SEVEN: FEAR OF SIDE EFFECTS AND CONTRACEPTIVE MYTHS AND MISCONCEPTIONS

7.1 Introduction

Through the analysis of the young married women's IDIs and FGDs, this chapter presents the results of the investigation that situate young married women's contraceptive decisions and practices in particular social and cultural contexts. It explores how socially and culturally driven fears of contraceptive side effects and myths and misconceptions about contraceptive methods shape their perceptions and attitudes towards contraceptives in general and particular methods. The chapter also highlights how these fears and myths and misconceptions turn out to be barriers to their contraceptive use and limit their method choices in these early stages of their marital and reproductive lives as young married women. The chapter also sheds some light on the dynamics of contraceptive use among young married women and why some contraceptive methods are more commonly used than others as presented in Chapter 5.

7.2 Fear of side effects

The issue of menstrual disruptions as a side effect of hormonal contraceptive methods was simultaneously and spontaneously raised during the interviews and discussions across the diversity of the study participants. It turned out to be one of young married women's most common and feared side effects of use of hormonal contraceptive methods such as injectables among young married women. Young married women complained that hormonal methods cause all the forms of menstrual disruptions (heavy and continuous bleeding, spotting and amenorrhea) and that all these disruptions were a cause of great concern and consternation among young married women in different ways. As highlighted in Chapter 6, heavy and continuous bleeding and spotting were of great concern to young

married women because of their effects on their social and sexual lives. It was clear from their narratives that young married women's concerns were more on the inconveniences and disruptions these side effects would cause on their marital sexual obligations to their husbands rather than the discomfort and anxiety they would occasion on them as women. Their fears were that these side effects would come in the way of their husbands enjoying their conjugal rights hence raising the risks of causing marital instability as the deprived men would seek sexual gratification elsewhere. These fears of menstrual disruptions are captured thus:

> *It happens that you get an injection this month after discussing the importance of family planning with your husband but in the following months when you experience periods, it takes long. When you start on the first day of the month, it continues up to the next month. The husband then complains and demands that you stop this Depo method because of experiencing menses for a long time and failing to have sex as if you are on holiday. The man says this is not family planning but destroying the family.* [IDI: 24, 3 children, former user, Mangochi]

> *Some women are experiencing continuous periods for almost a month. This makes many marriages to break down as men distaste these women because of this continuous menstruation.* [FGD: 20–24, Ntcheu]

> *Most women who are getting family planning methods do monthly periods frequently as a result men cannot have sex with them. This makes these men to be angry. This threatens marriages' continuity.* [FGD: 20–24, Mangochi]

The discussions on amenorrhea as a side effect of hormonal contraceptives elicited mixed views. Some young married women expressed happiness with the absence of menses not necessarily because they would no longer suffer from the discomfort they have to undergo every month but rather more importantly because their husbands would be able to enjoy

sexual liaisons without interruptions. However, it became clear that a majority of young married women feared amenorrhea as a side effect of contraceptive use. They indicated that they get worried because they fail to decipher what could be the cause. It was clear that young married women would be always anxious because they would look at amenorrhea as a sign of method failure and subsequent pregnancy. They also expressed worries that it could be an indication that something might be terribly wrong with their reproductive system. They expressed fears that there might be some health problems that would occur to them because menstruation is what they felt defined what a normal woman should experience. A participant in adolescent women's FGD expressed those sentiments.

> *What happens to those using contraceptives is that they stop menstruating. Because they cannot see their monthly periods, some complications develop because the body of a woman was made to menstruate.* [FGD: 15–19, Mangochi]

The study also established that young married women had fears that the chemicals contained in the hormonal contraceptive methods would affect the woman's reproductive system to such an extent that it would cause the woman's private parts to be 'cold' and 'watery'. What was clear from the narratives was that these fears were mainly in relation to what their partners had complained about not necessarily what they felt or had experienced as women. The focus group discussions centred on their partners complaints that due to these side effects, the young married women were said to be unable to sexually satisfy their husbands because the contraceptives have made them lose their 'sweetness'. It was apparent that young married women were anxious about this loss of 'sweetness' as it could lead to marital instability as unsatisfied men would pressure them to abandon contraceptive use or would want to seek sexual satisfaction from non contracepting

women. These fears were common among young married women across the study districts and are illustrated as follows:

> *I will correctly interpret this. When they say 'cold', it means the injection has gone to settle in the womb of the woman. When having sexual intercourse, the man doesn't feel the way he is used to everyday. When he goes to another woman who doesn't take contraceptive methods, he finds her warm during sexual intercourse and all goes well there. That is why men say "if you continue taking contraceptive methods, I will go to another woman who is warm".* [IDI: 20, 1 child, never user, Mangochi]

> *Some men say that when women are using contraceptives; they develop water in their private parts. They complain of having difficulties to insert the penis inside their women. The place is very slippery and the penis fails to enter inside. A husband would say "it is better for the wife not to use contraceptives".* [FGD: 20–24, Zomba]

> *People say that if a woman is on contraception, their husbands do not feel the sweetness from them. Women would think that their partners will be engaging in extra marital affairs if they use contraceptives as a result they shun contraceptives to protect their marriages.* [FGD: 20–24, Ntcheu]

Another component of the fear of side effects that was coming out very strongly was the delayed return to fertility (delayed conception) upon stoppage of use of a hormonal contraceptive method. The WHO (2010) indicated that return to fertility for those using injectables, depending on the type, can average between 6 and 10 months delay from the last day of injection irrespective of duration of use. This side effect of delayed return to fertility was found to be critical and of particular consternation among young married women, some of whom had just married and were yet to start childbearing while others have had only one child. In this respect, it was less surprising to find that these fears were strong among these young married women when one understands them in the context of

the great value placed on childbearing in the communities. The fears related to delayed or disruption of fertility is captured below:

> *If I start using contraception now by the time I would want to have a child, I will have problems and this is why I am waiting until I have a child then I will go for contraception, so that my child should grow up well.* [IDI: 17, nulliparous, non user, Zomba]

> *When she is on contraceptives of injection, she may face difficulties when she wants to have a child, and it may take a long period of time to have a child.* [IDI: 23, 2children, non user, Zomba]

> *Once she starts using these family planning methods, she will find difficulties to conceive because we believe that using contraceptives disturbs the system and fertility.* [FGD: 15–19, Ntcheu]

With these fears, it was less surprising to find that most young married women and even traditional leaders were against use of contraceptives before childbearing or when the woman has only one child. The dilemma of wishing to postpone births for those without children or space births for those with only one child on one hand and the fears of experiencing delayed return to fertility on the other was acute and influenced initiation of contraceptive use among these young married women. The subsequent statements highlight this dilemma and the fears:

> *Sometimes it happens that a person has taken a contraceptive method to space for five years but what happens is that after those five years she fails to have another child until after 15 years. I have seen women getting old after having only one child. Seeing that, I cannot even think about contraceptives now.* [IDI: 20, 1 child, non user, Mangochi]

> *I do not see any reason of using these methods because I have not yet born a child. I hope to start using them when I have a child.* [IDI: 19, nulliparous, non user, Zomba]

A woman is supposed to start family planning when she has given birth to at least one child and then she will be waiting for the time to have another child in order to have enough time to raise the first one. [FGD: 15–19, Ntcheu]

Because sometimes one can use the methods while the almighty God created her to last three years from one birth to another pregnancy. Maybe she was created that after 3 years, it is when she can have another pregnancy without using contraceptives. After the first child, they are not supposed to start using contraception. They should wait. They should watch if she will have another pregnancy earlier. If the pregnancy comes earlier, it is when she can choose to start using contraceptives after seeing how her body functions. [KII, Traditional Leader, Zomba]

While most of these side effects might be dismissed as mere misconceptions arising from misinformation and disinformation, it was revealed that this might not always be the case. The study found that there were some young married women or their friends and acquaintances in the communities who have been using the hormonal contraceptives and had actually experienced these side effects. For example, there were some contracepting young married women who had actually experienced or know of friends and acquaintances that had experienced delayed return to fertility for long periods after the stoppage of injectables. What was clear from the narratives was that young married women had concerns about these side effects regardless of whether they were real or purported. It became apparent that young married women would need positive assurances to dispel their fears particularly at these early stages in their marital and reproductive lives. In this respect, it is asserted that it might not be prudent to dismiss all complaints about side effects young married women may complain of as mere misconceptions. These quotes illustrate experiences with side effects:

At first, when I was using the injection, I was alright, but nowadays I feel dizziness, sometimes my heart would be beating fast. I feel pain in my heart, later the pain goes down in the stomach. I am not experiencing my menses as normal menses, it is different. Most of the times, my body is weak due to the injection. [IDI, 24, 3 children, user, Ntcheu]

I have seen some of my friends taking longer to have another child after these contraceptives. [IDI: 22, 2 children, non user, Mangochi]

It was apparent from the discussions and interviews that young married women in these communities felt helpless and mostly in a dilemma as they perceived the side effects from contraceptive use to be common and inevitable. From their narratives, these fears of side effects affect and influence their initiation and continuation of contraception in general or certain methods in particular. The inevitability of some side effects was aptly acknowledged in the interviews with health service providers. They elaborated that just like any other medicines taken into the body, contraceptives have side effects too particularly the hormonal methods such as the injectables and that these effects vary from individual woman to the other depending on one's 'blood'. It was established from the service providers that there was lack of understanding among young married women that these side effects were not universal to every woman and that the emphasised side effects might not be typical for all users after all. The realities of contraceptive side effects were expressed by service providers as below:

With contraception of injection, it delays conception. Some young married women take two months, four months, some even five years without getting pregnant. This is how things can be. [KII: Health Centre Worker, Zomba]

Some women complain that they are not experiencing their menses anymore. We tell them not to worry because if you are not experiencing menses, it means the egg is not yet matured because of the drug found in

that method of family planning, the injection. These drugs make the egg to fail to mature in order for the woman to experience menstrual periods. We tell them not to worry. [KII: Health Centre Worker, Mangochi]

We tell them about the side effects of the methods because if we do not tell them and they experience them, they tell their friends in a manner of scaring them. But if we tell them, then if they experienced the same they are not scared and they take it as normal. [KII: Health Centre Worker, Ntcheu]

7.3 Contraceptive myths and misconceptions

While there were fears of side effects that can indeed arise from contraceptive use and can be acknowledged and scientifically explained by the service providers, the study also established that there were a myriad of myths and misconceptions pertaining to contraception in general and specific methods that had no scientific basis and connection to contraceptive use. What could be deciphered from the study participants was that these myths and misconceptions were critical in forming and shaping young married women's contraceptive opinions, attitudes and practices. It was clear from their narratives that once exposed to these myths and misconceptions in the communities, young married women would shun contraception altogether or particular methods. The myths and misconceptions were found to be propagated mainly by the husbands' family members (in patrilineal communities) or by her family members (in matrilineal societies) meant to discourage them from contraceptive practice. However, it was intriguing to find out that, in spite of these myths and misconceptions, some young married women would still initiate and continue with contraceptive practice if they know of their friends and acquaintances or relatives within their social networks who were using contraceptives and had chosen the same methods. A young married woman in an FGD illustrates the nature of their discussions as below:

The discussions when we meet are about the dangers of contraceptives that those who are using these methods will be in trouble. They will suffer from cancer. They tell us more about what people experience when using modern contraceptive methods. [FGD: 20–24, Zomba]

The study revealed a range of myths and misconceptions most of which are directly or indirectly linked to or are an exaggeration of the real contraceptive side effects. Although, there were indications by some young married women that they regarded these myths and misconceptions as on the overall false, it was found that these myths and misconceptions were widespread. In this respect, they should not just be dismissed but should be cleared because of their intensity within the young women's social networks and dominance in the discourses of the community members.

It was also established in the study that the most predominant and prevalent myths and misconceptions were related to the strong beliefs that contraceptive use can negatively affect current and future fertility prospects for the young married women. Throughout the study and across the diversity of the study participants, there was a common myth to the effect that use of hormonal methods would lead to infertility in women. It is surmised that this myth is arising from the real side effect of delayed return to fertility (conception) that is misconceived as infertility. The issue of infertility was found to cause a great deal of consternation among young married women in these early stages of their reproductive lives. These quotes as captured below illustrate the myth:

We hear that when you get one Depo injection it lasts five years while still working. So if you get six injections, it means you will stay for 30 years without conceiving. For these 30 years to last, it will be the time when you are old. [FGD: 15–19, Mangochi].

You may have been on a family planning method for 5 years thereafter you find that you are failing to become pregnant. These methods are making women infertile. [IDI: 24, 4 children, non user, Mangochi]

Some people say that when you are using contraceptives, you are disturbing your uterus; therefore you end up being barren. [FGD: 20–24, Zomba]

Because of the value that is placed on childbearing, the study found that this myth about infertility was so much feared among young married women that they regarded contraceptive use while having no child or only one child as potentially dangerous. It became apparent from the discussions and interviews that a majority of the study participants expressed the belief that any contraceptive use before childbearing or when the woman has only one child was anathema. As can be discerned from the quotes below, this myth about causing infertility is an exaggeration:

Parents tell us that we are young because we have never given birth and this may cause the reproductive system ***kuuma*** *(to dry up) as a result it will be hard to have a child in future.* [IDI: 19, nulliparous, non user, Ntcheu]

If a young married woman with only one child is on injection, she will no longer bear another child but she should start contraception once she has two or three children. [FGD: 20–24, Zomba]

It was also clear from the discussions and interviews with the young married women and traditional leaders that there were myths and misconceptions to the effect that current contraceptive use, if it does not cause infertility, can negatively affect future pregnancy outcomes and the health of the yet to be born children. They made associations between contraceptive use and young married women's experiencing miscarriages, difficulties in

delivery, delivering stillbirths or premature babies; bearing twins or babies born with disabilities. Each of these myths is captured in the quotes below:

> *When one uses contraceptives and stops in order to conceive, when she gets pregnant, the pregnancy gets aborted on its own without any known cause.* [FGD: 15–19, Mangochi]

> *I agreed with my husband in the first place that we should not have a child for some time. We spent almost a year without having a child. I was using pills then. The time came when we agreed that we should have a child and I stopped taking the pills. I ended up having twins and they died.* [IDI: 22, 2 children, user, Ntcheu]

> *Those who use contraceptives for, let's say 10 years, end up having twins. That defeats the purpose of using family planning to have fewer children.* [FGD: 20–24, Ntcheu]

> *What happens is that when one uses family planning methods and decides to have a child may be after 3 years; the baby is born with disabilities.* [FGD: 15–19, Ntcheu]

Apart from these fertility related myths and misconceptions, there were also dominating myths and misconceptions to the effect that contraceptive use would result in general poor health to be suffered by the contracepting young married woman. The most prevalent effects were in relation to the use of hormonal methods of pills and injections. These were the most commonly known and used methods among young married women in these districts. These purported effects on the health of the woman ranged from minor ailments such as stomach pains to serious problems such as cancer. The range of each of these myths and misconceptions is captured as below:

> *Injection is bad because it causes a swelling in the stomach. If you are to be operated on the swelling, it means you will never give birth again.*

Since we are still young, we want to give birth. We cannot go for contraceptives for fear of stomach swellings. [FGD: 15–19, Ntcheu]

Women get seriously sick when they are expectant because the contraceptives pile up at one place. These contraceptives of tablets cause problems in the stomach and can even lead to death. [FGD: 15–19, Zomba]

If a young woman starts using contraceptives, she experiences stomach pains. When she goes to the hospital, she is told that, she has a tumour, so she should undergo an operation. Even doctors would question why was it that this one started using contraceptives before she had started bearing children. [KII: Traditional Leader, Mangochi]

Once the loop is tied inside the uterus, the stitches enter inside the stomach, as a result one is destroyed from inside and this can cause death. [FGD: 15–19, Mangochi]

When the Norplant is inserted on the arm, it enters inside the body and it is difficult to remove it. This also causes problems. It causes sickness in people's bodies that are using this method. [IDI: 24, 3 children, non user, Zomba].

One can die due to the use of these methods because a young woman has many eggs inside her. When you take contraceptives you disturb children to be born from you as a result one can die. [IDI: 16, 1 child, non user, Zomba]

The study has also revealed that one of the most spontaneously mentioned consequence of contraceptive use is reduced or loss of libido on the part of the women once they start contraceptive use. In the course of the study, it became difficult to classify whether loss of libido was a side effect or just a myth. Although some young married women stated that their use of hormonal contraceptives was responsible for their reduced sexual drive and interest, it was intriguing to find that their anxiety was more on the complaints men make

that their wives' contraceptive use was what was responsible for their (husbands) reduced or loss of libido. This is what qualifies loss of libido to be a myth because there is no scientific explanation on how the wife's contraceptive use can affect her husband's sexual prowess. The study participants indicated that men had strong fears that their wives' use of hormonal contraceptive methods affect their bodies too and ruin their private organs and sexual lives. These sentiments were persistently expressed across all categories of young married women, an indication of their widespread prevalence in the communities. The subsequent excerpts aptly capture the hallmark of these sentiments:

> *I just heard from women that their husbands were complaining that they have no power when they want to have sex with them due to use of contraceptives.* [IDI, 16, 1 child, non user, Ntcheu]

> *When women use family planning methods, men compare their spouses' situation with the past. For example, in the past he used to have three rounds of sex but now with her use of injections, he just has it once and then he experiences tiredness and goes into deep sleep. To him, this becomes a problem in his life.* [FGD: 20–24, Zomba]

> *Men would say "it is because of contraception you are using that is making me to sleep a lot after having sex". Men come up with a condition of having sex only if you do not go for contraception or having no sex if you go for contraception.* [IDI: 24, 2 children, former user, Mangochi]

It was also established during the discussions and interviews that the study participants could not explain how the woman's contraceptive use and its effects can cascade to their husbands. However, it was established that in the communities these myths were also shared by some young married women who indicated to have experienced the contraceptive effects in their bodies extended to their husbands' bodies. They expressly indicated that during sexual intercourse, their husbands actually lose their sexual prowess

and become too weak to perform satisfactorily. They could link that to the beliefs that there is exchange of fluids (referred to as 'blood' in the narratives) that take place during sexual intercourse makes it possible to share the effects of the drugs found in hormonal contraceptives between the sexual partners. The substance of this misconception is captured below:

> *My husband was not aware of anything until he experienced weaknesses in his body. He discovered that his penis was becoming cold so he asked me what was happening for his penis to be failing to function normally. When he discovered that it was because of the family planning method I am using, he just accepted it. But now the injection seems to be working properly in my body, the penis of my husband is working normally as in the past; it stands firm and no more losing its strength.* [IDI: 24, 3 children, user, Zomba]

> *They advise us to spend 7 days before having sex with our husbands because when you have sex with your husband when you have just been injected, the organs of your husband fail to function properly.* [FGD: 20–24, Mangochi]

The results have also revealed that these fears of reduced or loss of libido were strongly expressed and taken seriously because of the perception that these can have dire repercussions on sexual relations in the marital union. It also became clear during discussions that there were fears that the loss of libido would degenerate into impotence or complete sexual dysfunction. These purported effects were said to scare men as they not only feared that the women might abandon them due to non performance but worse still they might be spreading information about their impotence. This would render them targets of ridicule in the community and among friends hence reducing their chances of securing any future sexual relationships. It was also mentioned, sporadically though, by some young married women that some men also believe that their wives' contraceptive use

could be a strategy to reduce their husbands' sexual demands from the onset in their marital unions. The diversity of these feelings is aptly captured thus:

> *Some men complain to their friends that when their wives are using contraceptives, they fail to perform well in bed; they say that their reproductive parts die due to their wives' use of injections.* [FGD: 20–24, Mangochi]

> *They do not perform well when having sex. Others even fail to have sex and no ejaculation takes place. Contraceptives destroy their power.* [IDI: 20, 1 child, non user, Mangochi]

> *Men believe that when a woman uses family planning methods, then she wants her man to have reduced sexual desire so that she should not be bothered much in the house.* [KII: Traditional Leader, Zomba]

The study also established that the fears of sexual impotence among men, emanating from the social and cultural value placed on childbearing, were so intense that some spouses of the young married women would not want to be associated with anything real or suspected to be for contraception. For example, in Ntcheu district[9], it was found that men were refusing to sleep under the donated mosquito nets for malaria[10] prevention for fear of turning impotent because of the beliefs that these nets were laced with contraceptive chemicals. The beliefs had perhaps emanated from the fact that it was Population Service International (PSI)-Malawi, with headquarters in the USA, which was implementing the project of promoting use of mosquito nets to prevent malaria through social marketing of the nets. Coincidentally, it is the same organisation that the communities have all along

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[9] At the time of the study, the project was being carried out in Ntcheu, among other districts, but not in the other two study districts

[10] Malaria is endemic throughout Malawi. It is a major public health problem and the leading cause of morbidity and mortality in children under age 5 and among pregnant women. It is estimated that Malawi experiences about 6 million episodes of malaria annually (Ministry of Health, 2011).

known and associated with the promotion and social marketing of branded condoms for HIV and pregnancy prevention. This underscores the extent of myths and misconceptions about contraceptives in these communities. The myth is illustrated below:

> *Here we received mosquito nets but our men are refusing to sleep in these nets thinking that the nets have drugs. They say that once they sleep in these nets, they just stay until morning without doing anything. There is no sex. They refuse to sleep in these nets they says "you will sleep yourself with your child not me". Some reach the stage of just removing the net and let everyone sleep without the nets.* [FGD: 20–24, Ntcheu]

> *They say that in the nets, they put contraceptive drugs for men as one way of family planning, when they are in these nets, they fail to ejaculate. Some even fail to have sex with their wives.* [FGD: 15–19, Ntcheu]

While there were myths and misconceptions about the other methods as highlighted above, the study established that there were also particular myths and misconceptions about the condoms which principally bordered on its shortfalls as a product. These included misconceptions that condoms were too small, porous and not strong enough such that they can easily burst during use and also that they contain poisonous oils that destroy the woman's sexual organs. The range of these myths and misconceptions and their purported inherent dangers are captured below:

> *If the penis is small, the condom doesn't fit. The condom gets removed during the intercourse because the penis is not fitted well. Once it gets removed during the act, then it goes inside the woman's stomach. It becomes difficult for that condom to be removed from the stomach. As women, we are afraid.* [FGD: 15–19, Zomba]

> *People say condoms contain dangerous oil. When the man puts on this condom and have sex with his woman, the oil remains inside the private*

parts of the woman as a result it causes problems in the woman's body. [FGD: 20–24, Mangochi]

Condoms are not hundred percent safe because they have small holes at the tip and it bursts during sex and results in the death of the woman. [FGD: 15–19, Zomba]

Even if we give them condoms, they claim that condoms cause ***mauka***[11] *(itching). As a result, they would rather have plain sex without any protection.* [KII: Community Health Worker, Zomba]

The study also found that there were myths and misconceptions specifically on using condoms as a contraceptive method. These misconceptions were mainly related to the condom as being disruptive to the enjoyment of the act of sexual intercourse. Because it is a barrier method that precludes skin contact and exchange of fluids during the act, young married women harboured the misconceptions that condoms affect sexual intimacy and performance by reducing pleasurable sensations and 'sweetness' that can only be achieved without a barrier method. It is interesting to note that in this study it is young married women expressing these negative views about condoms because in other studies in Malawi (Kaler, 2004; Muula *et al.*, 2015), similar results about loss of pleasure due to condom use were expressed by men and boys. These myths and misconceptions about condoms are captured as below:

When one is using a condom during sex, she does not feel sweet compared to sex without a condom; one does not eat a sweet while it is in its wrapper. [FGD: 15–19, Mangochi]

During sexual intercourse, the sperms of the man do not reach the woman and likewise her fluids do not reach the man so men say that

[11] A local name for an STI that causes itching in the private parts of a woman

there is nothing that they feel and gain from the act. [FGD: 20–24, Zomba]

What could be deciphered from the discussions and interviews was that due to these myths and misconceptions related to real contraceptive side effects, there were general feelings that contraceptive use had inherent potential to cause problems in one way or the other. It was also established in the study that there was a general tendency in the communities to attribute any reproductive or health problems or even death encountered by contracepting women to the effects of their contraceptive practices. This was noted to be the case in all the study districts and among a variety of the study participants. These myths and misconceptions cause fears and anxiety among young married women who are in the early stages of their reproductive lives. These general myths and misconceptions about contraceptives are aptly expressed in these excerpts:

If at first they had no complications during delivery, with the use of contraceptives, they face problems and end up in an operation theatre, because of the complications of family planning methods. [FGD: 15–19, Ntcheu]

Once one is pregnant and complains that she is not feeling well, people say, "look, it is because of contraceptives you used, we told you not use these contraceptives". [FGD: 15–19, Ntcheu]

When a woman becomes sick or dies while on a contraceptive method, they say, "you see that's the outcome of using injection for family planning". [FGD: 20–24, Ntcheu]

If you have ten injections and you become pregnant after that period of use, it becomes difficult for you to deliver. Others even reach twelve months before they deliver instead of nine. Everyone believes that it is the family planning method that caused that. [FGD: 20–24, Mangochi]

Maybe it would have happened that in their normal lives, they would not have a child or only one child but because they used contraceptives and see that they are no longer conceiving, they think that it is the contraceptives that have caused it. [KII: Health Centre Worker, Zomba]

7.4 Conclusion

The results have shown that fear of side effects, for both hormonal and barrier methods, is widespread among the study participants. The fears were emanating from negative information about contraception in general and of particular methods being disseminated in the networks of women in the villages but also from own past experiences and those of their acquaintances

Whether connected to the real side effects or not, the results showed that there are a horde of myths and misconceptions that create fears and distaste for contraceptives among young married women in the study districts. Predominant myths and misconceptions were related to the association of contraceptive use with loss of libido in men and women, impotence in men and infertility in women. The study has also established that in these communities, family planning practice is prohibited for young married women for varied reasons prominent among them being fear of side effects, myths and misconceptions and value for children and childbearing. What this entails is that contraception is only used for the purposes of spacing and limiting births and not for postponing of the onset of childbearing.

It can be surmised that the young married women and their spouses would not want to take risks with contraceptives that would jeopardise their chances of having children in the present or in future at such early stages in their marital and childbearing lives.

CHAPTER EIGHT: CONTEXTS AND CONSTRAINTS IN ACCESSING CONTRACEPTIVE SERVICES

8.1 Introduction

This chapter presents the results of the factors that influence access and utilisation of family planning services among young married women from the perspectives of young married women and the family planning service providers. The focus is on understanding young married women's perceptions, attitudes and experiences in accessing, choosing and using contraceptive methods. It also highlights service providers' perceptions, attitudes and behaviours pertaining to young married women's contraceptive use in general and method choices in particular. The results in this chapter have also provided some explanation as to why certain methods are more prevalent than others and also on some determinants of contraceptive use and method choice among young married women as presented in Chapter 5.

8.2 Lack of correct information on contraceptive methods

From the discussions and interviews with young married women, it was established that young married women rely mostly on the discussions they have and information that is passed on from relations, friends and acquaintances to form and shape their opinions and attitudes about childbearing and contraception. Such information was found to be critical such that it greatly influences their reproductive and contraceptive decision making and practices. It became clear that, in spite of other sources of information, it was principally the attitudes, perceptions, opinions and experiences of relatives, friends and acquaintances that mattered most to young married women's learning about and evaluating contraceptive use and method choices. It was further revealed that young married women's dominant sources of information (network of relatives, friends and acquaintances) had both positive

and negative influences on their contraceptive practices. This influence was found to be crucial such that in spite of having varied experiences with the chosen methods, the pattern of use and chosen methods appeared to be similar and never changing even when other equally effective methods were introduced in the communities. The case in point was found to be the predominance of injectables as the most commonly used method across the study districts even when long lasting and equally effective methods such as Norplant are also available. The influence of friends and acquaintances as relied upon sources of information is captured in these quotes:

> *The thing is that maybe you want Norplant but your friends are always telling you that Norplant is not a good method. They say do not try it and that if you want to practice family planning then use injections. In this way, one fails to use Norplant.* [FGD: 20–24, Zomba]

> *Some are told by their friends who accompany them to the clinic to choose another method of family planning instead of the method they had planned to take. You are told "I do not take Depo, I take pills"* [FGD: 15–19, Mangochi]

> *My friend advised me to take that method, but the choice of my heart was Norplant because it takes 5 years while it is still working, but because my friend told me I just took this method of contraception which is the injection. My friend assured me that she was not experiencing any problems with it; her child is now in Standard 2 and is seven years of age.* [IDI: 20, 2 children, user, Ntcheu]

> *I heard from those who have used before that injection is good because you only suffer for 10 days and then you become alright. I just told the nurse that I want an injection.* [IDI, 18, 1 child, user, Mangochi]

It was also found that most service providers would not bother to provide information about the methods they did not stock at their health centres or the methods that, though available at their centres, had no knowledge or skills to administer.

The discussions and interviews with the study participants also revealed that information and experiences of relatives and friends was so important to these young married women such that whether the information passed on to them by those dominating sources was correct or not was immaterial. There were sentiments to the effect that they would only take information from other sources into consideration if the information did not conflict with the information sourced from and discussed with their friends and acquaintances. This lack of correct information and reluctance to accommodate new and correct information was found to be frustrating service providers' efforts to improve contraceptive service provision. The subsequent quotes capture the general picture of these sentiments:

> *I did not want to be told anything by the service providers. I just told them that I wanted a method of injection.* [IDI, 18, 1 child, user, Ntcheu]

> *The problem is that when women come to the clinic, they are already decided and focused on a particular method that their friends use and in spite of information about other methods, they do not want to choose other methods.* [KII: Health Centre Provider, Ntcheu]

It was intriguing to decipher from the discussions, particularly with non user young married women, that they looked at other sources of information particularly service providers, with much suspicion. The subsequent quote summarise those sentiments:

> *I was told that nurses and doctors are not using these contraceptives because they know that they are harmful to their bodies. These methods destroy.* [IDI, 22, 2 children, non user, Mangochi]

Although there was this reliance on women's networks in the communities as sources of information on contraceptives, it was found from the young married women narratives that they believed that it is at the family planning clinics (health centre and mobile outreach) particularly at the antenatal, postnatal and under-five clinics where they get full contraceptive information and services including methods eligibility, contraindications and general health checkups. However, it became clear from the discussions that these clinics were not accessible to newly married young women some of whom become automatically excluded by virtue of not having children yet hence have no reason to visit these health centres. The centrality of these clinics as sources of information was captured thus:

> *Within the village, we have a community health worker who during under-five clinic days explains to us about family planning methods. He tells us that contraception is good, it helps families to prosper.* [IDI: 23, 2 children, user, Ntcheu]

> *Contraceptive information is given to those who have come to the clinic. This means that they have already made a decision about family planning and the method they want to use. We do not cater for those who do not come here such as recently young married women and the unmarried ones.* [KII: Health Centre Worker, Ntcheu]

> *The problem is that in under-five clinics, young married women with no children do not come; messages and methods are provided during those sessions.* [KII: Health Centre Worker, Zomba]

8.3 Long distances

The study also established that young married women's access to contraceptive services was restricted by long distances to the service delivery points. The long distances meant that, even in situations where the services are free as is the case in the country's public facilities, a cost would still be attached to contraceptive use, in terms of transport expenses.

This would eventually mean that contraceptive use would be constrained by unavailability of money, a common thing among most young married women, who are mostly dependent on their husbands for financial support. It was also found that the long distances to service delivery points were also restricting the choice of the type of methods to be used. These long distances, for example, made it difficult for young married women to chose methods such as pills that require constant resupply and long acting methods such as Norplant that can only be accessed at district hospitals or private clinics located even further from the young married women's rural places of residence. This is because these methods require specialised training and expertise. The constraining effects of long distance are captured below:

> *At first, I was using pills. After giving birth, I could not go for pills considering the distance from where I stay to this health facility. I opted for a long lasting contraception so that I do not come here frequently and this contraception is that of three years, it is fixed on the arm and is known as Norplant.* [IDI, 24, 3 children, user, Ntcheu]

> ***Int**: How long does it take for you to reach this place?*
> **Res**: *I may not know but if I started off around nine o'clock in the morning, I get here past eleven. It is not easy for I stay very far. I walk because I do not have money for transport.*
> [IDI, 22, 2 children, user, Mangochi]

> *I did not choose injection because I stay far away from this hospital and by the time I arrive here, it is already late and the injection is finished because many women take this method. Because I cannot manage transport expenses, I opted for Norplant that once I have it done then it will take me 3 to 5 years without coming here.* [IDI: 24, 3 children user, Mangochi]

This health centre has a big catchment area. Some women stay very far from here so to just come here for only contraception, they see it as not worth it. [KII: Health Worker, Ntcheu]

It became clear during the discussions that young married women had great concerns about these long distances to the health centres as they would spend long periods of time spent travelling to the facility and back. They feared that this might raise suspicions, due to long absences from home, of their spouses or other family members. These fears were more pronounced among those young married women who were hiding their contraceptive practices from partners and family members.

8.4 Limited method mix and contraceptive commodity stock outs

The 1994 International Conference on Population and Development (ICPD) stated that a robust family planning programme should enable individuals and couples have universal access to a range of contraceptive methods that are affordable and of good quality to enable them choose methods that meet their current and future sexual and reproductive needs and goals (Mbizvo and Phillips, 2014; Magadi & Curtis, 2003). This was based on the fact that method choices vary according to individual's age, parity, family size preferences, reproductive stage and intention or purpose of use (Chintsanya, 2013).

The results from this study have established that most of the public facilities, particularly health centres located in the rural areas; stock only a limited number of contraceptive methods. For example, the mobile and outreach clinics only provide pills, condoms and injectables, the health centres have Norplant added, although not all service providers are trained in providing this method. It was found that it was only at the District Hospitals and private clinics where all the methods including IUD and sterilisation were available. The study has also revealed that there was inconsistent supply of even those limited methods in these health centres. It was found that at best of times, most of the health centres in the

communities would stock only pills, male condoms, injectables and occasionally Norplant. It was apparent from the discussions and interviews that this inadequate diversity of choices compromises young married women's access to particular methods that can meet their specific needs. It was clear from their narratives that limited contraceptive mix and stock outs were defeating their resolve, in spite of socially and culturally driven opposition, to practice contraception and use particular methods in accordance with their specific needs. What could be surmised from the discussions was that a majority of young married women were unable to readily choose and use methods that best suit their sexual and reproductive needs and this had an effect on the overall contraceptive use among this group of women. The following excerpts highlight the situations of limited access:

> *We are always concerned with lack of contraceptives, because if there are no contraceptives, men cannot afford staying for a month without having sex, so there is a danger that one can get pregnant when the other child is still small.* [FGD: 15–19, Zomba]

> *When the date reaches to have another injection and you find that there are no supplies at times up to three months, you become anxious that you would easily get pregnant.* [IDI: 20, 2 children, user, Ntcheu]

> *I experienced it. I found that there were no condoms either. It was difficult for my husband to wait until Depo came because we would not know when the Depo was to be available. I got pregnant at a time when I was not ready for it.* [IDI: 23, 2 children, non user, Mangochi]

In light of the fact that some young married women would want to use the contraceptive methods without their partners' knowledge, the stock outs were noted to raise fears among young married women that their consistent travels to the health facilities to check on the methods' availability would easily give them away and have their secret contraceptive use discovered. This was aptly captured in this statement by a health worker:

When we tell them that they should come again on a certain day due to unavailability of the needed contraceptive, they say "no we will not come because our husbands will be suspicious that we come here today and come again the next day". [KII: Health Centre Worker, Zomba]

The study also found that in the wake of a preferred method being out of stock as was mostly the case, there were three options availed to young married women. Firstly, they would be offered any available method, particularly pills and condoms as they were the most readily available methods, as an interim relief while waiting for the chosen method. This is contrary to their needs and circumstances. However, the general picture emerging from the interviews with the service providers' was that it was better to provide some protection against pregnancies to young married women who have already resolved to use contraception than waiting for the preferred method to be available because it might take months to be supplied. The following quotes summarise the reasoning of the service providers:

When we do not have such methods we just advise the woman to use condoms as a temporary method. If her method comes, she would go back to that method. [KII: Health Centre Worker, Zomba]

In situations where a woman chooses a method that is not available, she is given condoms as a temporary method while waiting for the availability of the chosen method. [KII: Community Health Worker, Ntcheu]

If a woman prefers injection and it is not available, we advise her to use condoms while she is waiting for her method to come. If she is not willing to use condoms, we tell her to go to a private hospital. [KII: Health Centre Worker, Ntcheu]

The provision of alternative methods such as pills and condoms, while providing temporary relief and an opportunity for contraception, was found to invoke concerns

among young married women. It was discerned that this arrangement leave them frustrated and helpless about the whole contraceptive practice. However, notwithstanding the frustrations, it was found that some young married women, particularly those with two or more children would, out of desperation and necessity, would rather accept what was available than risk unwanted pregnancies. What was also clear from the narratives of young married women was that the whole burden of contraception was heaped on them such that without them taking the initiative to prevent pregnancies, there can be no contraception in their families. Although men are the heads and decision makers in the families, it was established that it was young married women who were more worried about unwanted pregnancies than their husbands. These subsequent quotes aptly captured those scenarios:

> *I went to the hospital for the contraception of injection. When the injection was not available, I just went for the one available for I was stranded and feared of what is going to happen when my husband comes back.* [IDI: 21, 2 children, user, Ntcheu]

> *Sometimes it happens that a month passes without having my method of contraceptive to avoid pregnancy and because I am worried that if we have sex, pregnancy will occur, I just take the condoms to avoid an unexpected pregnancy.* [IDI: 20, 2 children, user, Mangochi]

> *It happens that when you refuse and leave that method which is in stock such as pills, when you go home without any method, you get pregnant while waiting for the supply of the injection. We just use pills to protect ourselves rather than just staying, because men cannot wait to impregnate us.* [IDI: 19, 1 child, user, Mangochi]

The study also established that although pills and condoms were the most available of all the methods, their use was a cause of a great deal of consternation particularly among young married women who wanted to be on contraception without knowledge or

involvement of their partners. Specific to condoms, apart from being a male controlled method, it was also found to pose difficulties for young married women who, though their contraceptive practice might have been accepted by their husbands, they did not want the husband to be involved at all. Female condom has not been fully embraced and its use is yet to be noticeable in Malawi (Bisika, 2009). It would have been interesting to find out in future studies if similar sentiments about female condom use would be expressed by young married women.

What was revealed from the discussions was that young married women found it challenging to take and introduce condom use to their husbands upon return from the health centres mainly because of its association with promiscuity. The young married women were also reluctant to take condoms for fear of making their husbands get used to using them hence not afraid to engage in extra marital affairs knowing that they now know how to be protected. It also came out in their discussions that in cases where they get the condoms and their husbands agreed to use them; young married women would keep the condoms in a secret location and only bring them out at an appropriate time to ensure that their husbands would not take and use them with other women. There was a general feeling among the study participants that it was stigmatising for them as married women to be taking condoms as a contraceptive method as all along condoms have been known to be associated with prevention of STIs and HIV transmission. To be seen to collect condoms from the health centre was said to risk raising some suspicions that either of the partners or both might be HIV positive.

However, it was intriguing to learn from the young married women narratives that their partners would readily agree to use condoms during the time when they were menstruating for the sake of ensuring that they continue to enjoy uninterrupted sexual intercourse during

this period. As discussed in the previous chapter on contraceptive side effects, this is contrary to cultural dictates that forbid sex throughout the period when a woman is menstruating. This could be construed as abuse of contraceptive methods to circumvent observance of cultural dictates. The subsequent sentiments capture the salient issues pertaining to condom use as a contraceptive method.

> *These men do not use condoms with us because they know that we are their wives and they use these with other women because they are afraid to make them pregnant.* [IDI: 19, 1, user, Mangochi]

> *Sometimes, someone comes for an implant and unfortunately we do not have it in stock. We always tell that client that we provide that method but we do not have it in stock at the moment. We tell her to choose any other method. Otherwise, we advise her to go to the district hospital or Banja La Mtsogolo.* [Health Centre Worker, Mangochi]

> *If the injection is out of stock at our facility we try to convince them about other methods. But if they are still interested in their choice, we give them a date which we think the injection will be available or we tell them about other places where they can go and have the method instead of just sending them back without assisting them. One becomes worried. We try our best to help.* [KII: Health Centre Worker, Mangochi]

> *Sometimes it happens that Depo runs out of stock and I fail to provide that method. Other women choose methods that I do not offer and what I do is to send them to the district hospital.* [KII: Health Centre Worker, Mangochi]

> *If somebody comes for the method of loop at the clinic, we advise that person may be to go to Banja la Mtsogolo or to a district hospital to get such a method.* [KII: Health Centre Worker, Mangochi]

In situations when the preferred method was out of stock, the study found that the second option available to young married women was to be referred to alternative sources of

family planning services particularly the district hospitals or private facilities such as *Banja La Mtsogolo* clinics where the chosen method might be found. However, it was noted in the study that this alternative was still restrictive to young married women as it was fraught with a myriad of constraints, the most prominent being poor access due to costs (contraceptive and transport). This was found to be the case because almost all private clinics are located in the urban and semi urban areas. In addition, while services in government facilities are free, they are not free at these alternative sources of services. Although the user fees at *Banja La Mtsogolo*, for example, were found not to be exorbitant, their services could still not be accessed by young married women, particularly those who are solely dependent on their partners financially, who would not be able to pay for those services even though their preferred method might be available at those private clinics. In this respect, when there is unavailability of particular methods at the government facilities, sending young married women to these alternative sources was found to be tantamount to curtailing their access to such contraceptives. The constraints of this option are aptly captured in these quotes below:

> *We have problems when accessing contraceptives from private clinics because of the high costs as we have problems getting money.* [FGD: 15–19, Mangochi]

> *You go to the hospital and you are not able to get injected because of scarcity of medicine. In this case you are supposed to go to a private clinic. The problem is that you cannot go there because of money. You are unable to raise funds.* [IDI: 20, 1 child, user, Ntcheu]

> ***Res 8**: If you do not have money, it is difficult you cannot get injection. In those days it was at two hundred kwacha*[12]*. I do not know how much it is as of now.*

[12] Local currency at the current exchange rate of 1 US$ = 520 Kwacha

***Res10**: It is at five hundred kwacha*

[FGD: 15–19, Ntcheu]

It is not difficult to access contraception of pills or injections from our centre here but if I want to have Norplant then I have to get it from a private facility. It requires money. [IDI: 19, 2 children, user, Zomba]

The study established that when the preferred methods were not available, the third option for young married women was just to go back home without a contraceptive method. What was clear from the discussions and interviews was that this option was demoralizing to young married woman whose contraceptive use might have already been shrouded in controversy due to partner opposition and other social and cultural prohibitions. It was also found to affect the initiation and continuation of the whole contraception practice. Young married women felt helpless and worried about unwanted pregnancies because their husbands would not abstain from having sexual intercourse with them while waiting for the supply of the contraceptive methods. The variety of such sentiments is aptly elucidated below.

If you do not find the method you are worried, because when you are using Depo it means you do not want to conceive. If you find that there is no Depo, you get worried that, if you have sex, you will be pregnant because you are not using any method. You are not protected. This destroys marriages because it is difficult to tell a man to stop having sex because you are not using any method. This really destroys marriages. [IDI: 23, 2 children, user, Ntcheu]

When you go back home you still need to fulfil the call of nature. You do not return at all as you find eventually that the story is different. You see that you are pregnant. [IDI: 23, 2 children, user, Mangochi]

Because of the unavailability of contraceptives, some women even go home without taking any contraceptives and even stop coming here to get contraceptives any more. [KII: Health Centre Worker, Ntcheu]

If they find that contraceptives have run out they go home without any help. When they go home, they cannot just stay without having sex with their husbands waiting for the contraceptives to be available. So contraceptives come at the time when the woman is already pregnant. [KII Community Health Worker, Ntcheu]

Throughout the study, it was clear that young married women, in spite of being in the rural areas; focus their discussions about contraception mainly on modern contraceptives and even those who use contraceptives were mainly using modern contraceptives. However, it was noted that some young married women, though a few, out of desperation arising from modern contraceptive and specific methods' stock outs, would resort to traditional methods that have a higher risk of failure. In spite of this, it was apparent in the discussions that there were mixed feelings about the efficacy and effectiveness of these methods as elucidated below.

When I went to the hospital to take contraceptives, I found that they were out of stock. When I went back and told my mother, she gave me a traditional method of a string to tie around my waist. While I was using this method, I found myself pregnant, but the string was still in the waist. [IDI: 21, 3 children, user, Ntcheu]

The traditional methods of using beads help. You just follow your menstruation dates. I turned to this method. I have not given birth for the past two years. [IDI, 24, 3 children, user, Ntcheu]

You can still become pregnant while the string is right there on your body. At times it goes well that you do not become pregnant. But the string cannot be relied on because it can get cut then you become pregnant. Then you haven't done any family planning. [IDI, 23, 2 children, user, Ntcheu]

8.5 Staff shortage and lack of skills to administer contraceptives

The study established that young married women would get to the service delivery points but would fail to access the services due to long waiting hours that come about mainly as a result of large numbers of clients and few service providers. From the interviews with the service providers, it became apparent that their level of service provision was compromised by competing roles they have to contend with. Their priority and people's expectations were found to be that they have to attend to patients with more pressing or life threatening health problems. The situation was found to be more desperate in facilities where there was only one health worker at hand to take care of all clients for diverse services and patients with various ailments. It was also found that even in well established health centres, family planning services were not taken as a priority as they could only be provided at particular days or in the afternoon hours when there would be reduced pressure from patients with more pressing medical needs. It became clear at the health centres that family planning clients were not taken as seriously as patients suffering from ailments such as malaria or pneumonia. From the discussions with young married women, it was surmised that this shortage of staff was very discouraging to them. This was because it took them a great deal of courage to overcome all other hurdles to come to the health facility just for contraceptives when they were not even sick only to be met by poor services. They indicated that, due to their unique circumstances, they would like to be able to access contraceptive services anytime and whenever they visit a health facility for whatever reason. The subsequent quotes from a young married woman and service providers elaborate 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 a problem. 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 not be encouraged to go again. [KII: Community Health Worker, Zomba]

Even at the District hospital, they have shortage of staff. They combine antenatal with family planning services. They find themselves getting very tired because every day they are knocking off late. Staff is not enough compared to the number of clients to be assisted and because it is a free government hospital, it receives many people. There is too much work. [KII: Health Centre Worker, Zomba]

In the interviews with the service providers, it was also found that even in health centres where there are a good 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 noted 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 in the rural areas those particular health centres can be the only source 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 the method that we did not have training in such as 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. If the well 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]

It also became apparent from the interviews with service providers that the main reason for young married women's limited access to services emanating from limited method mix, contraceptive stock outs and inadequate service providers was lack of or limited financial resources made available for family planning programmes in the various districts of the country in the wake of competing demands in the health sector. It was noted that at times, a chosen contraceptive method might be available but the unavailability of some required materials that are used in administering particular methods would be the reason for failure to administer the method hence no access by the young married women who need such a method. These scenarios are captured thus:

Money is the problem. Every month, the District Health Office is supposed to make plans and put aside some money for purchasing contraceptive methods. But because there is high demand for contraceptives due to big numbers of women in the communities, the money they have is not enough to purchase the required quantities. [KII: Health Centre Worker, Ntcheu]

Women fail to get Norplant at our health facility because the supply of materials to be used in planting them comes from the district hospital. Because the service is free of charge, it happens that the materials are out of stock quite often. It happens that the real Norplant is there, but materials that support its planting such as cotton and ligonpen are out of

stock. We tell them that we have the Norplant here but the materials are not available. [KII: Health Centre Worker, Mangochi]

There are times when we experience method stock-outs. Sometimes we run out of syringes such that we are unable to provide injections. In such circumstances, we fail to serve the women [KII: Health Centre Worker, Zomba]

The young married women expressed mixed feelings about the services provided in the public health centres. Although there have been consistent complaints about limited method mix, commodity stock outs and general poor services, they still felt that these static health centres were better for them in the communities compared to other sources of services such as outreach clinics or community based distribution agents. They indicated that at least, these static clinics would be able to offer more methods than just condoms, pills and injectables as is the case with the outreach clinics. Aside having fewer method options, they also indicated that most of the outreach family planning clinics are principally meant to serve antenatal and under-five children's services such that young married women, particularly those without children, are excluded from coming into contact with these kind of services because they have no children yet. What could be discerned from the discussions and interviews with young married women was that the whole set up of service provision appeared to be aligned towards women who have had children already. This is systematic exclusion of the newly married and nulliparous young women.

These women make a plan that they will have Depo when they go for under-five clinics. Moreover, men do not accompany them to clinics. [IDI, 23, 2 children, Mangochi]

You pretend of going to the under-five clinic with a child and at the same time you receive the method because the reason behind is to space your births. [IDI: 19, 2 children, user, Ntcheu]

It is hard for young women without children to come and ask for contraceptives but women who have children find it is easy because they come with their children at the under-five clinic and at the same time they take their contraceptives. [KII: Community Health Worker, Zomba]

8.6 Providers' attitudes and practices

The study has established that even improvements in the availability and accessibility of contraceptives methods might not be sufficient to spur initiation and continuation of contraceptive use by young married women. It became clear from the discussions and interviews with young married women and service providers that there were some service providers who show negative attitudes and behaviours towards young married women. These militate against young married women's enjoyment of their right to contraceptive use and to choose a method of their preference. It transpired in the discussions that there were some service providers, especially those serving in the communities, that demonstrate strong feelings against young married women, particularly those without children or with only one child, using hormonal contraceptive methods such as injectables for fear of what the side effects would be for these young married women. For example, in the interviews, some service providers indicated that they were always afraid and reluctant to provide injectables to young married women because of the possibility of adverse long term effects such as long periods before return to fertility or worse still infertility that would possibly occur upon use. It was indicated 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.

Other service providers hinted that they would provide strong counselling and exaggerate the likelihood of the side effects occurring to young married women with the intention of dissuading them from choosing and using these hormonal methods. Some service providers expressed fears of living with a guilty conscience should the young married woman fail to have children in future after hormonal contraceptive use. What could be deciphered from the discourse was that the service providers 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. Consequently, they pay little attention to young married woman's reproductive and contraceptive needs and rights. These negative influences of health workers on contraceptive use were captured in the excerpts as below:

> *Sometimes on humanitarian grounds I feel sorry for these young women without children because in the long run they might spoil their reproductive system.* [KII: Community Health Worker, Mangochi]

> *It happens that we provide Depo to 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 having contraception.* [KII: Health Centre Worker, Zomba]

> *One is supposed to use family planning methods when at least they have given birth to one child. One cannot use contraceptives when she does not have a child. It is not good to give someone who doesn't have child family planning methods.* [KII: Community Health Worker, Mangochi]

The study also found that in relation to the fear of these side effects, some service providers either due to lack of adequate information or deliberately, would impose

unnecessary parity condition on young married women before providing them with injectables as a family planning method. Consequently, nulliparous or those young women with only one child would be strongly discouraged from using this method under the pretext that it would possibly lead to infertility because of its long delay to return to fertility (delayed conception after use). It became clear in the interviews with service providers that they would be so much anxious about this method such that they would swiftly recommend method discontinuation or switching should young married women experience any side effects such as heavy and prolonged menstrual bleeding or amenorrhea fearing that it would disturb their reproductive system at such a tender age that may lead to fertility problems in future. They would urge the young married women to use condoms or pills regardless of their circumstances, needs and contrary to their preferences. Both service providers and young married women's sentiments about these restrictions are aptly captured as below:

> *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]

The nurse will ask how many children do you have and if the answer is none, you are not provided with the method. [IDI: 19, non user, Zomba]

I was told that one is not supposed to start using contraceptives while she has only one child. It is only until you give birth to the second child. One is supposed to monitor her fertility first and then it is when she can start using contraceptives. [IDI: 19, non user, Ntcheu]

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 that liberalised the provision of and access to contraceptive services by all women and men who need them. It was clear in the interviews that they felt ambivalent and uncomfortable to provide contraceptives to nulliparous or one child young married women who have not even 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 the families. It was found that the demand for husbands' consent was not necessarily because it was required so 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 service provider at the health centre or in cases where the health workers' places of origin were in the same communities. This was found to be a service related factor that constrains access and utilisation of contraceptives and particular methods by young married women. 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, particularly in Mangochi district where many young married men are absent husbands due to temporary migration to South Africa for employment, reported of cases, though not widespread, where they had been confronted by men or mothers-in law of young married women. 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 were been warned against promoting promiscuity among these women and were threatened to be held responsible should anything strange happen to the young women.

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 contraceptive method. It became clear during the discussions 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 need not be jeopardised through careless provision of family planning methods to such young married women in the early stages of their reproductive health lives. It became clear 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, user, 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, 1child, user, Ntcheu]

8.7 Lack of privacy

The study also found that there was lack of privacy and confidentiality in most of the 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 particular dates and times in a week and designated rooms for family planning services. What was clear from the discussions and interviews with young married women 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 the health centres on those particular days and times of the week were for the purposes of family planning. In addition, some health centres or outreach clinics were found to be located in the communities or villages close to people's homes. Both scenarios were found to be posing challenges as are aptly captured as below:

> *At the health centre where family planning services are provided is the same place 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 practicing family planning. It happens that they come to the health centre for contraceptives but because of the people who they find in the designated room some of whom can be their neighbours, they go back home without getting these contraceptives. The woman had come to the health centre for contraceptives but she is afraid of being seen by neighbours.* [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, non user, 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]

8.8 Conclusion

The results in this chapter have asserted that there are situations when young married women, even after surmounting cultural and social restrictions and opposition and presenting themselves at the service delivery points to get contraceptive services; fail to access and use contraceptives, let alone chose a preferred method, due to service related constraints. From the study, these constraints can be categorised into facility based and

provider based. On the facility based constraints, the study has found that there is widespread poor access to contraceptive services as demonstrated by poor method mix, persistent commodity stock outs and inadequate trained personnel particularly in the rural areas where the majority of young married women reside. There are also constraints related to accessing the services that include long distances to service delivery points and lack of privacy and confidentiality in the service facilities arising from providing services in designated places or rooms and on specific days. All these have been found to discourage young married women from initiating and continuing with contraceptive use.

On the provider based constraints, it has been established that even in situations where contraceptive methods could be available and accessible, young married women would still be constrained from use due to inadequate skills among service providers in the rural health centres and community outreaches. Not all service providers had expertise to provide all types of contraceptive methods. The lack of competence in providing a range of contraceptive methods was also found to be a serious constraint in a study among service providers in Uganda (Nalwadda, 2011). It was found that providers considered themselves as highly competent to provide only pills, progestin-only injections and condoms and did not feel competent enough to provide IUDs, implants, emergency contraceptives and other barriers methods than condoms. In addition, some services providers, particularly those located in the communities, harboured negative attitudes and behaviours that were ostensibly driven by their social and cultural orientation. These attitudes and behaviours systematically dissuade young married women from practicing contraception or use particular methods. This was manifested through 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 deemed premature. 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 of less than 18 years requested contraceptives. On the issue of 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. .These eligibility restrictions imposed on young married women as found in the current study is a 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 hand. This study has found that the former take precedence. Similar findings had been reported in a study among service providers in Nigeria (Ahanonu, 2014) where, in spite of 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.

Overall, these negative attitudes and behaviours of service providers posed serious hurdles to young married women's access and use of the services. The general conclusion is that even after surmounting strong cultural and social restrictions and partner opposition, young married women would still not be able to access and use contraception, let alone chose a preferred method, due to these service related constraints that are also embedded in the social and cultural realms of the communities, families and service providers.

CHAPTER NINE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

9.1 Introduction

The study had set out to answer the questions pertaining to factors that influence sexual and reproductive health risks and contraceptive use among young (15-24) married women in Malawi. Young married women are neglected group of women, both in research and interventions, and yet they face a myriad of SRH risks and their contraceptive practices are poor. Using quantitative and qualitative sources of data, the study has filled a gap in knowledge by investigating the factors that influence SRH risks and contraceptives practices of these young married women who, being young and married, are affected by economic, social and cultural issues that are quite distinct from other categories of women. 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 required policy and programme interventions.

The chapter is organised into two parts. The first part highlights the major findings drawn from the themes of the research questions as presented in the five analytical chapters. Apart from the descriptive presentations of the SRH risks trends and linkages, levels, trends and determinants of contraceptive use and method choice among young married women, the findings have also highlighted the attached social and cultural meanings and interpretations of young married women's sexual, reproductive and contraceptive

perceptions, attitudes and behaviours. The second part of the chapter presents conclusions and recommendations for policy and program interventions. It also highlights the study gaps that can inform future research undertakings on the same or similar areas of inquiry.

9.2 Summary of findings

The summary of findings is drawn from the five analytical chapters as follows: Trends and factors that influence SRH risks; trends and determinants of contraceptive use and method choices; social and cultural contexts of SRH risks and contraceptive use (value of child bearing, gender inequalities, partner opposition); fear of contraceptive side effects and myths and misconceptions about contraception; and constraints in accessing family planning services among young married women. They are arranged in accordance with the study's themes emanating from the study's objectives and the research questions.

i) What are the factors that influence SRH risks?

The study has found that it is more of the proximal and distant contextual than individual factors that influence the risks of early sexual debut, early marriages and early childbearing. These risks also become precursors for other challenges in reproductive and contraceptive practices that young married women face in their marriages. Young women are exposed to cultural practices such as initiation ceremonies, poverty situations and gender inequalities that precipitated and exacerbated these SRH risks.

The study has also pinned down the intervening role of education as very critical in delaying timing of sexual debut, marriage and birth. The level at which a young woman drops out of the education system has been found to be principally a precursor to SRH risks. Upon dropping out of the school system, young women's options narrow down such that early sexual relationships or early marriages become inevitable alternatives and child bearing becomes a means to gain social status and recognition in the rural communities in

the absence of other alternatives for social fulfilment. A study among women in Malawi (Mkandawire-Valhmu *et al.*, 2013) also found that lack of economic opportunities and gender inequalities that manifest themselves in poor access to land, education and employment among women, marriage turns out to be a viable option for survival. Consequently, communities would rather reward marriage and childbearing more than they would promote the pursuit of education among young women due to the uncertain nature of the rewards of education and lack of role models among young married women. Once the woman gets married, her social status positively changes as she is regarded as an adult who can now participate in groups and activities that never married woman, even of the same age group, would be barred from. In a similar fashion, a young woman with a child has her status elevated within the extended family and community and her social status is also enhanced such that she is welcome to fully participate in groups and activities that a childless woman, regardless of her age, would be precluded. Other studies in Malawi also found that early proof of fertility enhanced young married women's relevance and status in the extended family system and benefit from upward social mobility in the wider community networks (Mwalabu, 2014, Jimmy-Gamma, 2009).

What the study has brought forth is the understanding of the underlying factors that incentivise, force or constrain young women to act in certain ways in the realms of SRH risks. SRH risks are intertwined and there is a continuum from early sexual debut to early marriage that culminates into early pregnancies and childbearing.

ii) What are the trends and determinants of contraceptive use among young married women?

Although there has been an overall steady increase in the use of modern contraceptives between 2000 and 2010 among young married women, their levels have still been low at

35.2 percent of all young married women. What this means is that close to 65 percent of young married women do not use contraceptives at all and yet the levels of early marriages and early childbearing remain high in the country. In addition, there is poor contraceptive method mix among the young married women as up to 81 percent of all contraceptive use among them is dominated by one method -injectables. This is a temporary short term method. It means that their contraceptive use is mainly for spacing births even among young married women who already have more than two children and is not meant to reduce fertility levels. It is also reckoned that this over reliance of a single method even for the purposes of spacing births has potential risks in the realms of family planning. It would be problematic should there be serious side effects or any other negative issues associated with this most preferred method. As they have limited choices, they would be discouraged from further use of contraceptives and yet they are at the peak of childbearing.

There have been consistent and strong associations between contraceptive use and method choices on one hand and fertility related factors such as number of living children, waiting period before the next child and ideal number of children the woman on the other hand. These three factors have been found to consistently determine contraceptive practices among young married women. As would be elaborated in the section on social and cultural context below, there is great social, cultural and economic value placed on child bearing and children in these communities such that young married women's contraceptive use and method choices are just for spacing births not for the purposes of postponing first births or stopping childbearing. The social and cultural pressure to have children among young married women is always intense. Studies in Malawi (Kaphagawani, 2008; Kathewera-Banda *et al.*, 2005) have also found that marriage provides a socially and culturally sanctioned milieu for having children and that childbearing and children are an integral part of a marital union regardless of the age of the woman.

Further, fertility preferences of the husbands were one of the determinants of contraceptive use among young married women. Where fertility preferences of the husband were in favour of contraceptive use, the woman was more likely to use contraceptives than otherwise. This underlines, as evidence of gender inequalities, the critical role partners play in decision making about reproductive and contraceptive behaviours and corroborates a study by Palamuleni (2013) who found that partners are also critical in contraceptive use among women of all ages.

iii) What are the social and cultural factors influencing contraceptive use?

There are a number of social and cultural beliefs and practices that strongly discourage what is described as 'premature' contraceptive use. This is use of contraceptives before onset of childbearing or when having only one or two children. Within the communities, there is great value placed on childbearing and children than can accrue to the young married woman herself, her partner, the extended family and the community as a whole. What was critical in the study was the fact that once a young woman gets into early sexual relationship or marriage, it is inevitable that pregnancy and childbearing would sooner than later occur because of the social, cultural and economic value of childbearing and children. As a result, there are fears of the real or purported negative contraceptive side effects such as irregular menstrual flows that cause concern about the disruptions that can cause to their husbands' sexual lives and more importantly their association with causing disruptions on the young married woman's onset or subsequent fertility. The predominant myths and misconceptions are mostly related to the effects of contraceptive use on sexuality (loss of libido) and fertility (delayed conception). While these can be dismissed as mere misconceptions without any biological basis for explanation connecting a woman's use of contraceptives to a man's loss of sexual prowess or impotence, these myths and misconceptions are widespread in the communities and scare young married women away

from initiating or continuing with contraception. They and their spouses would not want to take chances with contraceptives that would jeopardise their chances of having children in the present or in future at such early stages in their marital and childbearing lives.

The study asserts that although children are socially and culturally valued in both patrilineal and matrilineal kinship systems in the country, it is celebrated when it occurs within a recognised marital union regardless of the age of the woman. This underlines the role early pregnancies and childbearing plays in increasing the levels of early marriages as young people are forced into early marriages once they have a premarital pregnancy or child.

Gender inequalities are manifested in marital relationships in which decision making powers in matters of sex, reproduction and contraception are the preserve of male partners. As a consequence of big partner age differences and lack of means of economic independence, young married women are conditioned to anticipate material and financial support from their husbands. This economic dependence increases their vulnerability to SRH risks and reduces their agency to negotiate for preventive measures against pregnancies and STIs including HIV. A study by Mkandawire-Valhmu *et al.* (2013) on the experiences of HIV infected women found that lack of power within marriage place women at risk of spreading HIV.

iv)Partner opposition and secret contraceptive use

As a manifestation of gender inequalities, perceived partner opposition is widespread and one of the most commonly cited barriers to contraceptive use among young married women. However, contrary to expectations and literature reviewed here (Jensen & Thornton, 2003; Kathewera-Banda *et al.*, 2005) that young married women lack agency to act out their reproductive and contraceptive aspirations, the study found that secret

contraceptive use was one of the strategies young married women use to counter partner opposition. It is a manifestation of great zeal on the part of these young married women to access contraception regardless of the risks. Their main concern was fear of being discovered by their husbands or other family members. This is an area that family planning program implementers can deal with issues of partner involvement and inclusion and increased privacy and confidentiality in service provision to increase contraceptive prevalence among this group of married women. The kind of support to be provided is elucidated in the recommendations section.

v) Constraints to contraceptive services to access

There is widespread poor access to contraceptive services as demonstrated by poor method mix, persistent commodity stock outs and inadequate trained personnel particularly in the rural areas where the majority (85 percent) of young married women reside. These bottlenecks constrain their access and utilisation of contraceptives. However, the study has found that it is the negative attitudes and behaviour of some service providers particularly those located in the communities. Under the influence of their social and cultural backgrounds, they systematically dissuade young married women from practicing modern contraception or use particular methods that posed the hardest hurdles. This was done through the use of unnecessary restrictions such as parity, partner consent or onset of menstruation to constrain young married women, particularly for the nulliparous or those with only one child from accessing contraceptives. These reservations and eligibility restrictions imposed on young married women were 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. The former appeared to take precedence among some health workers particularly those in the

rural health centres. The findings are that access and utilisation of contraceptives among young married women would require more than availability of information and commodities.

9.3 Study's contribution

As highlighted in the statement of the problem, the study has been one of the few that have used both quantitative and qualitative methods of inquiry and focused on young married women as a distinct group. Most of the studies (NSO & ICF Macro, 2011; Kaphagawani, 2008; Munthali *et al.*, 2006a; Munthali, 2006b; Chonzi 2000; Mphaya, 2009; Jimmy-Gama, 2009) that inform the current understanding and debates on issues pertaining to SRH and family planning in Malawi have largely been based on all women or, in some cases, never married young women. They have had little focus on young married women as a distinct group. In addition; the cited literature has been limited in their scope and methods of data collection. Most of them have mainly been descriptive presentations with limited or total exclusion of the social and cultural contexts that require qualitative enquiry. This is the lacuna in the current body of literature that this study has endeavoured to fill. It has focused on the hitherto neglected group of young married women (15–24) who, by virtue of both being young and married, find themselves in distinct and adverse social, cultural and economic contexts that precipitate and exacerbate their vulnerability to SRH risks and poor contraceptive practices. Further, the study had taken a broader approach to understanding these phenomena by including a range of study participants (significant others). Apart from young married women themselves, it has also targeted community leaders and family planning service providers as study participants in one study. This is clear departure from the previous studies in Malawi.

The findings from this thesis as presented above come at an opportune time to make significant contributions to the body of knowledge, understanding and conjures up debate among population and development practitioners in Malawi on the current and future impact of the country's youthful population structure on the socio-economic development of the country. Specifically, it has revealed the factors that influence SRH risks, reproductive and contraceptive decision making and practices among young married women in Malawi. These are women who are at the beginning of their sexual, reproductive and contraceptive lives. In this respect, these findings contribute research based evidence that inform the debate and guide current and future policy and programme interventions targeting young people's SRH in general and young married women's SRH risks and contraceptive practices in particular. The study asserts that as large cohorts of young women arising from past and current high fertility levels, enter into childbearing bracket or reach the peak of childbearing ages, 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 direction of the social and economic development of the country. The following specific issues highlight its uniqueness in the field of population studies:

- The results as presented above are about young married women in Malawi but can also be applicable to other African countries with similar social and cultural set up. In addition, the levels and trends in contraceptive use and method choice among young married women supports the current broad family planning research endeavours in Malawi and contributes to the understanding of women's reproductive and contraceptive behaviour at the time when contraceptive use has been steadily rising while the total fertility rate has only changed marginally. The findings also contribute to the academic understanding and debate on how to deal

with high levels of SRH risks and low contraceptive use among young married women. Malawi has a youthful population structure. The previous neglect of the group culminated in a dearth of policies, guidelines and programme interventions that could have been drawn specifically to meet the needs and rights of this distinct group of women.

- Secondly , by focusing on young married women mainly from the rural areas (small number of study participants were drawn from Zomba city as only one health centre was sampled) , the study had an opportunity to critically investigate and interrogate the social and cultural trajectories in communities where they appear to be more prevalent and more influential in shaping the perceptions, attitudes and practices of people on many issues but more particularly so on young married women in relation to SRH, reproduction and contraception. A great deal of insights in these trajectories would have been missed had the study concentrated in the urban areas where most of these cultural and traditional dictates are giving way to modern lifestyles and ideas.

- Thirdly, it is one of the very few studies that have conducted qualitative investigation and focused on the meanings and nuances of some socially and culturally influenced SRH risks and barriers to contraceptive use. It has also investigated the supply side (access to family planning information and services). Being a largely qualitative study, it also offers an opportunity to demonstrate that qualitative methods and data can also provide robust results in the field of demography, a largely quantitative field of study, as a methodological approach to the understanding of some issues, particularly the nuanced social and cultural

contexts that the traditional quantitative methods would fail to successfully capture and interrogate..

9.4 Conclusions and recommendations

As highlighted in the theoretical framework, the study has revealed that SRH risks and contraceptive practices among young married women are a function of a multiplicity of influences most of which are external to young married women's control and agency. The study has also consistently revealed that it is more of proximal and distal (e.g. culture, poverty) than individual factors that influence SRH risks and contraceptive practices. What this entails is that even in situations where young women have convinced themselves of the need to avoid SRH risks, have made a decision and resolved to take preventive measures and have ready access to the means to do so, they would still be constrained by various economic, social and cultural factors. What the study asserts is that the adoption of positive behaviour among young married women would require more than the availability and accessibility of SRH and contraceptive information and services. As consistently shown in the study results, economic, social and cultural contexts place the significant others such as partners, family members, peers and acquaintances in a position to validate and influence young married women's sexual, reproductive and contraceptive practices in these early stages of their years. Social and cultural contexts also constrain health service providers from providing the required contraceptive support to young married women particularly those who decide to use contraceptives secretly.

The study further suggests that young married women need multipronged and multi sectoral support to meet and realise their sexual and reproductive health needs and rights beyond just provision of information and services. It further argues that unless SRH and contraceptive programs and interventions have the capacity to transform the social,

cultural and economic contexts young married women find themselves in and also influence significant others such as partners, family members to change their social and cultural beliefs and practices, those efforts will yield little in dealing with SRH risks and contraceptive behaviour of young married women in Malawi. The following recommendations are proffered:

SRH access and service provision

- The health service providers are expected to be agents of change of some of the social and cultural norms that perpetuate and exacerbate young married women's SRH risks and low contraceptive use. However, from the study findings, that is not the case. There is a need for service providers to be trained in matters relating to SRH rights of young married women, urge them to set aside their cultural beliefs and act according to the dictates of their profession in providing services to young married women. This will enable them to be empathetic to young married women and desist from imposing unnecessary restrictions that constrain young married women from accessing contraceptives. The study also proposes a shift from the current generic nature of family planning service devivery to a model for family planning delivery that will be empowering to individual young married women to achieve their sexual and reproductive goals through guaranteeing of utmost secrecy, privacy, confidentiality and special support for their contraceptive practices and the choices they would make on whether to use contraceptives overtly or covertly. In this respect, the model for service delivery should include a policy of integrating family planning services with general health services as opposed to the current practice of having family planning services provided at designated places and on particular days and times within the health facility or

integrated with maternal and child health services that exclude women without children.

- Inadequate resource (human, financial and commodities) provision for the FP services is problematic. In this respect the government and other stakeholders should enhance family planning services in the country by providing adequate resources and expertise to ensure contraceptive commodity security and availability of skilled providers particularly at health centre levels in the rural areas, where 85 percent of the country's population live, to counter the problems of limited method mix, persistent contraceptive stock outs and inadequate skilled providers.

Partner involvement

- Looking at the critical role husbands play in young married women's contraceptive decision making and practices, as revealed in the study, it is crucial to develop advocacy and information, education and communication (IEC) strategies targeting men that would engender behavioural change in terms of gender equality and respect for their wives' sexual and reproductive health and rights. There should be a shift in family planning programme delivery in the country from the current individual married women's focus at antenatal, postnatal or under-five clinics to an inclusive one that enhances the involvement and inclusion of husbands or partners in the communities and clinics in the designing and implementation of reproductive and contraceptive information and service interventions that target young married women as a distinct target. It is critical that both partners should understand and appreciate the benefits of controlled fertility and contraception at such an early stage in their marital and reproductive lives. Further, there should also be SRH and family planning IEC campaigns that bring men and women together for joint education and counselling

sessions. They should be able to share their understandings and concerns about family planning that would lead to positive attitudes and improved contraceptive practices.

Social Mobilisation (advocacy and IEC)

- Young married women, on the basis of being both young and married, find themselves in unique situations that require targeted interventions. Their early entry into marriage, early exposure to the risk of childbearing and the constraints they face in accessing and using contraceptives can entail high early fertility. Hence the interventions that are devised to promote SRH rights and contraceptive use among young married women would need to operate within the prevailing social and cultural milieu that would eventually promote lower desired family sizes. In spite of opposition from partners, the phenomenon of secret contraceptive use is an indication that young married women are ready to take risks, if need be, to meet their pressing reproductive and contraceptive needs. Family planning interventions can utilise those openings and niche to support young married women who, regardless of their circumstances, would like to use preventive measures any way.

- There should be IEC, advocacy and social mobilisation efforts that would target the agents that promote social and cultural norms that include family members and traditional leaders to address the issues of value for children and the conflicting standards on the issues of early sexual debut, early marriages and early childbearing. The cultural acceptance of early sexual debut (for example at initiation ceremonies) and early childbearing as long as it occurs within the confines of marriage regardless of age needs to be challenged and addressed, through community dialogues and involvement of other agents of changes such as

religious establishments with emphasis being put on girls' education and the benefits of taking preventive measures against early pregnancies.

- The beliefs and propagation of fears of contraceptive side effects and myths and misconceptions have been found to largely emanate from the cultural value for childbearing and children that is fuelled by inadequate knowledge about women's reproductive system and how contraceptives function in that system. The IEC and advocacy interventions should be structured in such a way that they counter these myths and misconceptions about contraceptive use and provide accurate and consistent information about contraceptive side effects. These have been shown to be largely the basis for non use of contraception, partner opposition and restricted method choices. These sustained IEC and advocacy interventions would empower young married women to distinguish between facts and falsehoods and real side effects from myths and misconceptions.

Policy and programme implications

- The current National Population Policy's main goal is to reduce the rate of population growth through reduced TFR and increased contraceptive demand and use (Government of Malawi, 2013). The Policy is due for review in 2017. From the study's findings', it is asserted that young (15-24) married women will have to be identified as a unique and underserved group of women that require own specific and policy statements, strategies and targets for increased contraceptive prevalence and reduced fertility. However, since early marriages and child bearing are consequences of other SRH risks such as early sexual debut, the policy should also include statements, strategies and targets for increased age at sexual debut, reduced proportions of married adolescents and young women, increased age at first

marriage and increased contraceptive use among the youth regardless of their marital status.

- Education has been consistently found to have a critical role in reducing the propensity of the occurrence of SRH risks. The need for policy initiatives that increase educational opportunities for poor girls and young women who are more likely to engage in early sexual relationships, leave school for early marriages and begin child bearing early. In a multisectoral collaboration, there should be policy and program interventions to retain girls in school at least until they complete secondary school. Girls' education should be supported by providing resources to cover educational costs that include tuition fees, scholastic materials (books and uniform), accommodation and upkeep. While in school, the current Ministry of Education policy of prohibiting the provision of contraceptives to girls in primary and secondary schools needs to be reviewed. Schools provide an excellent opportunity for provision of SRH education and services to young women since a big proportion of prepubescent (14years and below) girls attend school and would benefit from such SRH education and services before or at the initiation of sexual activity. This policy shift will need to take cognisance of the study's findings that sexual debut among young women in Malawi occurs early and is mostly a precursor for early marriages and early pregnancies and childbearing. There is already an existing supportive policy environment for providing SRH services to girls and young women in schools as Malawi's Reproductive Health Policy and Contraceptive Guidelines removed all restrictions to contraceptive access and utilisation such that individual and couples who need them are free to do so.

- There is a need for the development of policies and interventions that would improve the economic status of women in general and young married women in particular. There should be sustainable income generating activities targeting young married women (whose employment prospects are minimal due to truncated education) that would be critical in minimising their heavy economic dependence on their partners and enhance their agency to make their own sexual, reproductive and contraceptive decisions.

9.5 Future research implications

- Scholars have found that there are variations in the kinship systems regarding value for children and sex preferences (Mkandawire-Valhum, 2013; MHRC, 2006, Sear, 2008). In this study, such differences were not salient among young married women. It can be assumed that this might have been due to the fact that the study was concentrating on young married women (15–24) who were in the early stages of their reproductive years. Such being the case, the pressure to prove fertility and continue childbearing, regardless of kinship differences, might have been responsible for this lack of diversity in attitudes and practices since all of them were still young. Nevertheless, this is a gap in knowledge that requires further investigation in the other parts of the country such as the Northern region and the Lower Shire valley where they also practice patrilineal system of kinship.

- While the sampling strategy used produced a sample of young married women, traditional leaders and contraceptive services providers drawn from the three districts that are heterogeneous in their social and economic contexts (as elaborated in the methodology chapter) , the study has fallen short of making comparisons between urban and rural young married women. The social and cultural contexts in

the analytical accounts produced in this thesis would limit the applicability of the results to young married women residing in major urban areas. The urban settings with the influence of high levels of education, new lifestyles (nuclear family as opposed to extended family) and more female labour force participation in formal employment would have provided perhaps provided different results on SRH risks and contraceptive practices among urban young and married women. On this basis, there is a need for more investigations of SRH risk outcomes and contraceptive behaviour of young married women in these urban settings. This calls for studies that would capture their experiences in their own right or in comparison with those in the rural areas.

- The findings from the study have consistently shown the critical roles sexual partners and husbands play. They have been consistently cited by young married women to be influential in these phenomena (for example, partner opposition and secret contraceptive use; value for children). This study has mainly captured the perspectives and experiences of young married women. Although there have been instances when the study participants cited the perceptions, beliefs and behaviour of their husbands, these findings may not adequately represent the perspectives of these partners. It is possible that the perspectives and experiences of the partners could turn up to be different or they could share some similarities. An investigation that interrogates the knowledge, attitudes, perceptions and experiences of husbands or partners would be a useful in confirming the perceptions of their wives and obtain a broader picture of the gender issues that have been revealed in this study.

9.6 Chapter Conclusion

This chapter has presented a summary of major findings, conclusions and implications of the study. It has presented the young married women's experiences with regards to early sex, early marriage and the gender dynamics associated with reproductive and contraceptive decision making and use. The study participants' views and experiences on the available SRH services and attitudes and behaviours of the service providers have also been discussed. There has also been an expose of the study's contribution to academic debates and provision of evidence based information for policy and program interventions. The conclusions that have been drawn from the study and the recommendations for policy and program interventions on the basis of the study findings have been proffered. Within the limitations of the study, gaps and areas for further research inquiry have also been identified.

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APPENDICES

APPENDIX ONE: DATA COLLECTION PARTICIPANT'S CONSENT FORM

Population Training and Research Unit, North West University (Mafikeng)
Factors influencing sexual and reproductive health risks and contraceptive use among young married women in Malawi

Good Morning/afternoon. My name is _____. Thank you for taking time to talk with me. Mr. Benjamin Kaneka is conducting this study to investigate factors that influence contraceptive method choice among women in Malawi. The study will provide information that will be critical in improving the family programme in Malawi aimed at contributing to reductions in fertility rates, childhood and maternal mortality and enhance overall development of the country. You have been selected to participate in this study by means of a chance selection process, much like picking an orange out of a basket without looking.

Your participation in this study is important and completely voluntary. If you agree to be interviewed, I will be asking you questions about your knowledge, attitude and use of family planning in general and of particular methods. I will also focus on factors that influence women to choose one method over the other. It is important that you be honest and truthful in answering these questions, as the information will be used to help develop better interventions in family planning and population not only in this area but also in other areas of the country. Your answers will be confidential and only the research assistant and the investigator will have access to this information. It is important that you participate; however, you can stop the participation at any point during the interview. The interview will be done privately and will last between 60 and 90 minutes. Please feel free to ask me questions if you do not understand before we start the interview. You will not be identified by name but only an identification number.

If you may have any questions pertaining to this study, please do not hastate to contact Benjamin Kaneka of Chancellor College, University of Malawi Tel. 0888 358 982 /bkaneka@cc.ac.mw or Professor Aim J Matura , Northwest University (Mafikeng), Faculty of Human and Social Sciences Tel. 0027 79473 7050 /Akim.Mturi@nwu.ac.za, South Africa.

Do you agree to participate in this interview? Yes/No

"I have read the consent form completely before the respondent and the interviewee has voluntarily agreed to participate in the study."

_____

Signature of Interviewer

Date:----------

APPENDIX TWO: DATA COLLECTION TOOLS (ENGLISH)

Population Training and Research Unit, North West University (Mafikeng)

Factors influencing sexual and reproductive health risks and contraceptive use among young married women in Malawi

A: Individual In-depth Interview Guide (young married women)

Introduction

Good morning/afternoon. My name is _____.

Thank you for sparing your time to talk with me. Mr. Benjamin Kaneka, a student at North West University, is conducting this study to investigate factors that influence sexual health risks and contraceptive use among young married women in Malawi. This study is being carried out in three districts of the country. You are one of the many young married women selected to share your views and experiences about early sexual debut, early marriage, and early childbearing and contraceptive use. While the study is for academic purposes, it is envisaged that the information will also be critical in improving the sexual and reproductive health interventions for young married women in Malawi.

We expect that you will provide information on what you know, how you perceive, feel and understand the issues in the discussions as they relate to young married women like yourself in this community. We request your honest responses. You are assured that all what you say here will be kept confidential and anonymous. Just in case we cannot write everything down on paper, we would like to tape record our conversation. No one except me and the research team will listen to the tape. Our interaction will take about one and a half hours. Let me stop for a moment to respond to any question you may have. [Pause – Answer Any Questions].

May I turn on the tape recorder? [Turn on Tape Recorder)

Let us begin by getting to know a little about each other. Please introduce yourself (first names only and age) and tell us:

- What do you do on daily basis?
- How long have you lived in this community?
- What were the circumstances that led to your being found in a marital union?

General questions about Family Planning knowledge

- Which family planning methods do you know (Probe: Sources of information, all methods known)
- What can you say about each of these methods (probe for advantages and disadvantages, benefits and side effects of each method?)
- Sexual health risks
- What do you think are reasons why young girls engage in early sex in this community (Probe: culture, poverty etc)
- Why do young women enter into marital unions so early in this community (Probe: culture, poverty etc)
- What makes young women have pregnancies and bear children when they are still young (culture, poverty etc)
- Contraceptive practice

Method availability and accessibility

- Why are you not practicing family planning *(for non current users)*
- (Probe: partner opposition, cultural reasons, fear of side effects, lack of information, not enough children)
- Why are you practicing family planning *(for current users)* (Probe: reasons)
- When you came for a method ,were you informed about all possible methods (Probe: which methods)
- How long did it take you to come to this clinic (probe costs)
- When you came for contraceptive methods, what information was given to you by the service providers in relation to your status as a young married woman

Method Choice (current users)

- What method did you choose (Probe: reasons)
- Did you have an opportunity to choose your preferred method among many?
- Was this the method you had preferred /planned to use (Probe: Reasons for this method and those opted out)
- Who influenced you to use contraception and to choice a particular method (Probe: friends, family members, service provider, partner)
- What reasons were given to persuade you to start using contraceptives and choose this method (Probe: benefits, fear of side effects)

- What plays a critical role in your decision making process to use contraceptives? A particular method?

Pregnancy prevention (non *users)*

- What measures have you or your partner taken to prevent pregnancy? Why?
- What factors hinder you from adopting modern methods to prevent pregnancies?
- Do you discuss with your partner issues related to sex, childbearing, and contraception? Why? What is discussed?
- What factors prevent most young married women from using contraceptives in this community?
- What do you think could be done so that more young married women even without children should use modern contraceptives?

This marks the end of our conversation. Thank you very much for sparing your time

END

Population Training and Research Unit, North West University (Mafikeng)

Factors influencing sexual and reproductive health risks and contraceptive use among young married women in Malawi

Focus Group Discussion Guide (young married women)

Hello everyone. My name is _____. Thank you for sparing time for these discussions. Mr. Benjamin Kaneka, a student at North West University, is conducting this study to investigate factors that influence sexual health risks and contraceptive use among young married women in Malawi. While the study is for academic purposes, it is envisaged that the information will also be critical in improving sexual and reproductive health of young married women in Malawi.

I would like request for your honest views of how you perceive, feel about and understand the issues that we will be discussing. It is also imperative that you give honest responses even if you feel that some people in this group may not agree with them. I ask you to feel free to say whatever you think about the issues under discussions. I also want to assure you that whatever you say here will be kept confidential.

I will be guiding the conversation and my colleague here will be writing down what is said but will not write your names down. Everything you say will be anonymous. As it may not be possible to write everything down on paper, my colleague would like to tape record this discussion. No one except me and the research team will listen to the tape. Our discussions are expected to last one and a half hours.

Let me stop for a moment to respond to any question you may have.

[Pause – Answer Any Questions].

May I turn on the tape recorder? [Turn On Tape Recorder)

Let us begin by getting to know a little about each other. Please introduce yourself (first names only and age) and tell us:

- What do you do on daily basis?
- How long you have lived in this community?

General Discussions about sexual health risks

- What do you think influences young women in this community to start engaging in sexual intercourse while they are still young (Probe: culture, poverty, peer pressure)

- What do you think influences young women in this community to enter into marriage at tender ages(Probe: culture, poverty, forced marriage)

- Why do you think young women become pregnant and bear children when they are still young (early marriage, cultural practices)

- In general, young married women who practice family planning in this community, what reasons do they give for using contraceptives (probe for postponing onset of childbearing, space births or limit family size)

Family Planning practice

- What contraceptive methods do you know (Probe for all methods they know)
- What can you say about each of these methods (probe for advantages and disadvantages, of each method?)
- When young married women in this area want to access contraceptive methods of their choice , would you say it is easy or difficult to get them (probe reasons and challenges)
- Are there situations when a young married woman would want to practice contraception but fails to do so (Probe for reasons: opposition from partner, family members, cultural reasons , preferred method not available)
- Are there situations in this area when a young married woman would want to use a particular method but end up failing to use that method and use another one instead(probe : non availability, fear of side effects, provider advice/bias)
- Are there any reasons why you think young married women without children should not use certain methods or methods at all
- What do you think prevents young married women in this community from discussing sexuality, childbearing and contraceptive use with their husbands (Probe: how? Why? challenges)
- What factors prevent most young married women from using contraceptives in this community?

This marks the end of our conversation. Do you have any comments on what we have discussed? Thank you very much for sparing your time

Population Training and Research Unit, North West University (Mafikeng)

Factors influencing sexual and reproductive health risks and contraceptive use among young married women in Malawi

Key Informant Interview Guide (Family Planning Service providers)

Introduction

Good morning/afternoon. My name is _____.

Thank you for sparing your time to talk with me. Mr. Benjamin Kaneka, a student at North West University, is conducting this study to investigate factors that influence sexual health risks and contraceptive use among young married women in Malawi. This study is being carried out in all the three regions of the country. You are one of the chosen experts whom we feel can provide information about childbearing and contraceptive use they relate to young married women in Malawi. While the study is for academic purposes, it is envisaged that the collected information will also be critical in improving the sexual and reproductive health interventions among young married women in Malawi.

We expect that you will provide us with information of how you perceive, thing and understand about childbearing, contraceptive use and method choice in relation to young married women. It is also imperative that you give us honest responses..

You are assured that all what you say here will be kept confidential and anonymous. Just in case we can not write everything down on paper, we would like to tape record this interview. No one except me and the research team will listen to the tape. Our interaction will take about one and a half hours.

Interviewing Route:

Ice breaker

- What is your name and your work designation
- For how long have you been working in this community

General Questions

- What do you think influences young women in this community engage in sexual activity early in their lives? (culture, poverty, lack of knowledge about dangers)
- What do you think young women in this community enter into early marriages (Probe: cultural practices, poverty, gender based violence)

- What do you think young women become pregnancy and bear children when they are still of tender age (cultural practices, poverty)
- Contraceptive use and young married women
- From your experience, do young married women(15–24) in this community come to this facility for family planning information and services (Probe: magnitude and reasons)
- What methods do most young married women prefer to use (Probe: Reasons)
- When young married women come to a facility for contraceptives, what advice is given to them (Probe: methods, benefits, side effects)
- When young married women come to this facility and choose a particular method, are they given the method of their choice (probe for reasons: provider bias, non availability)
- Are there situations when a young married woman chooses a particular method but fail to provide such a method (what can be the reasons: probe stock outs, lack of equipment, lack of trained providers, provider bias)
- Studies have shown that most young married women do not use contraceptives, as someone who stays in this community, can you tell me reasons that prevent these young married women from using contraceptives and particular methods (fear of side effects, partner opposition, social/cultural pressure)
- What factors do you think hinder young married women's access and use of contraceptive services at your facility? Any other facility?
- What do you think are the attitudes of most family planning service providers towards provision of contraceptives to young married women including those without children
- In your experience in this community what influences young women to engage in early sexual debut
- As someone in this community, what influences young women to enter into early marriages
- What are your views pertaining to early childbearing among young women in this community
- What are your views pertaining to provision of contraceptive methods to young married women some of whom may not even have children

This is the end of our interview. Thank you very much for your time and views.

Population Training and Research Unit, North West University (Mafikeng)

Factors influencing sexual and reproductive health risks and contraceptive use among young married women in Malawi

Key Informant Interview Guide (Community Leaders)

Introduction

Hellow. My name is _____. Thank you for sparing your time to talk with me. Mr. Benjamin Kaneka, a student at North West University, is conducting this study to investigate factors that influence early sexual debut, early marriage, and early childbearing and contraceptive use among young married women in Malawi. This study is being carried out in all the three regions of the country. You are one of the leaders whom we feel strongly can provide information about issues to do with marriage and family planning as it relates to young married women in Malawi from your perspective as a traditional leader. While the study is for academic purposes, it is envisaged that the collected information will also be critical in improving the sexual and reproductive health interventions among young married women in Malawi.

We expect that you will provide us with information of how you see, feel about and understand early sexual debut, childbearing, contraceptive use in relation to young married women. It is also imperative that you give us honest responses. We would like to understand what you really feel about the matters will be discussing. You are assured that all what you say here will be kept confidential.

Everything you say will be anonymous. Just in case we can not write everything down on paper, we would like to tape record this interview. No one except me and the research team will listen to the tape. Our interaction will take between one hour and one and a half hours.

Questioning and interviewing Route

- What are your cultural views relating to early sexual debut
- What are the cultural views pertaining to early marriages (Probe: perceptions)
- What are your views pertaining to young women who start childbearing early
- What are your communities' views about young married women who use contraceptive methods?

- From your cultural understanding, what could be the factors that might be influencing young married women to use contraceptives?
- What are the cultural related factors that might be influencing young married women not to use contraceptives?
- What can you say about your communities' attitudes towards early sexual debut, early marriages, and early births and provision of contraceptives to young married women some of whom may not have born a child yet.
- What are your thoughts about young married women who use contraceptives as a traditional leader?
- Do you think young married women should be using modern contraceptives?
- Are there any cultural reasons that are in support of early sexual debut, early marriages, early childbearing and why young married women should not use contraceptives?
- Under what circumstances do you think a young married woman can use contraceptives?
- What fears do you have about contraceptive use among young married women from your traditional perspective?
- Finally what are your thoughts about childbearing and contraceptive use among young married women? Let us discuss.

This marks the end of our conversation. Do you have any comments on what we have discussed? Thank you very much for sparing your time.

APPENDIX THREE : DATA COLLECTION TOOLS (CHICHEWA)

Population Training and Research Unit, North West University (Mafikeng)

Factors influencing sexual and reproductive health risks and contraceptive use among young married women in Malawi

Individual In-depth Interview Guide (young married women)

Mau Oyamba

Muli bwanji? Ine dzina langa ndine _____.

Simoom kwambiri chifukwa chondipatsa mpata kuti ndicheze nanu. Ophunzira wa za Chilengwero Cha anthu ku North West University, Mr.B.Kaneka akupanga kafukufuku oyang'ana ndi kumvetsetsa zinthu zimene zimawapangangitsa amayi omwe ali pabanja mdziko muno kuti adzilepherea kugwiritsa ntchito njira zolerera kuti mimba zosaziyembekezera. Kafukufukuyu akuchitika mu zigawo zones za dziko lino. Inuyo ndi mmodzi wa amayi achichepere a pabanja omwe mwasankhidwa kuti tikambiranane nanu ndikumva maganizo anu pa nkhani zogonana, banja, ubereki ndi njira zolerera. Ngakhale tili ndi chidwi chachikulu pa mayankho anu ku mbali ya maphunziro, zomwe muti mutiuze zidzathandizanso kupitsa patsogolo mchito za ubereki ndi uchembeere wabwino wa amayi achichepere a pabanja mdziko muno.

Tikukupephani kuti mutiuze zomwe mukudziwa, mmene mmaonera, kommanso mmemne mmamvetsetsera zinthu zomwe tikambiranezi mmene zikuwakhudzira amayi achichepere a pabanja ngati inuyo mdera lino. Pempho lathu ndi lakuti inu mungotipatsa mayankho oona basi. Pakuti nkutheka kuti sitingathe kulemba zones zomwe tingakambirane, timapempha kuti tigwiritse ntchito kotolera mau (tape recorder) kuti tisunge bwino zonse zomwe zikambidwe. Palibe wina aliyense yemwe akamvetsere tepiyi kupatulapo ineyo ndi anzanga ena ochepa amene akupangitsa nawo kafukufukuyu. Zokambirana zathu zikuyembekezera kutenga ola limodzi ndi theka. Panopo muli ndi nthawi yoti mukhoza kundifunsa mafunso okhudzana ndikafukufukuyu amene mungakhale nawo/. [Kuyima kaye – Kuyankha Mafunso].

Ndingayatseno Chokokera mauchi (tape recorder? [Yatsani Tape Recorder)

Tiyambe ndikudziwana. Chonde chulani dzina lanu (loyamba lokha) ndipo mutiuze:

- Zaka
- Kodi mumuagrwira ntchito zotani zikuthandzizani pa moyo wanu wa tsiku ndi tsiku?
- Mwakhala muli mu dera lino kwanthawi yaitali bwanji?
- Kodi malowedwe anu a mmabnja anali otani/munapezeka bwanji muli mmbanja?
- Munali ndi zaka zingati panthawiyo

Mafunso okhudza za kulera

- Kodi ndi njira ziti zolerera zomwe mumazidziwa? (Funsitsitsani: Komwe munalandira uthenga wa za kulera, njira zonse zomwe akuzidziwa)
- Kodi mungandiuze zotani za njira ili yonse yolerera mwatchulayo? (Funsitsitsani ubwino ndi zovuta ndi phindu la njira iliyonse)
- Zokhudzana ndi kugonana
- Kodi mukuganiza kuti ndi zifukwa ziti zomwe zimapangitsa kuti asungwana achichepere aziyamba zogonona anaakali ang'ono mdera lino.
- Kodi mukuganiza kuti pali zifukwa zanji zomwe zimapangitsa asungwana amdera lino kuti azilowa mmbanja ali aang'ono.
- Nanga chimawapangitsa nchiyani kuti asungwana azitenga mimba nkumabereka anakali aang'ono.
- Kulera
- Kodi munayamba mwagwiritsapo/mukugwiritsa ntchito njira yolerela (Funsitsitsani zifukwa zogwiritsira/kusagwiritsa njira zolera.
- Kodi nthawi yomwe munapita kukatenga njira yolerea, munaauzidwa za njira zonse zomwe zilipo (Fusitsitsani: Njira zake ziti, zitchuleni)
- Kodi zinakutengerani nthawi yaitali bwanji kuti mufike kuno ku malo otengera njira zolerera. (Fusitsitsani: mayendedwe ndi zofunikira zina)
- *Kusankha njira*
- Kodi inu munasankhana njira yanji yolerera (Funsitsitsani : Zifukwa)
- Kodi munali ndi mwayi osankha njira yomwe munaikondetsetsa pakati pa njira zambiri?
- Kodi iyi inali njira yolerera yomwe munaikonda/ munakonza kuti muzigwiritsa ntchito (Fusitsitsani: Zifukwa zosankhira njira imeneyi ndi zifukwa zokanira njira zinazo)

- Kodi alipo amene anakuuzani kuti muzigwiritsa njira zolerera. Nanga kuti musankhe njira yomwe munasankhayo (Funsitsitsani: nzanu, ogwira ntchito zopereka njira zolerera, amuna anu)
- Kodi munauzidwa zifukwa ndi mfundo zanji zomwe zinakupangitsani kuti muyambe kulera ndipo nkusankha njira yomwe munasankhanyo (Fusitsitsani: ubwino wake, kuopa zovuta zobwera chifukwa chogwiritsa ntchito njira zina)
- Kodi ndi chiyani chomwe chinakukopani kuti mupange chisankho chakuti muyambe kugwiritsa ntchito njira zolerera? Nanga njira yomwe munasankhayo?

Mmmene amapewera mimba (kwa iwo omwe sakulera)

- Kodi inuyo kapena amuna anu mumagwiritsa ntchito njira zanji kupewa kutenga mimba yosakonzekera? Pali zifukwa zanji?
- Kodi ndi zinthu ziti zomwe zimakulepheretsani kuti musayambe kugwiritsa njira zokutetezani ku mimba?

Kukambilana zakulera

- Kodi mumakambirana ndi amuna anu nkhani zokhudzana ndi kugonana, kubereka ndi kulera? Chifukwa chiyani? Ngati mmakambirana, mmakambirani ziti ndipo motani?
- Kodi ndi zinthu ziti zimene zimawalepheretsa amayi achichepere ambiri amene ali pabanja kuti asamagwiritse ntchito njira zolerera mu dera mwanu muno?
- Kodi maganizo anu ndi otani pa amayi achichepere apabanja, ena a iwo oti anakalibe mwana, kutenga njira zolerera
- Pali abambo ena omwe amaletsa akazi awao kulera, kodi inu mukuganiza kuti nchifukwa chiyani amatero? Nanga mayi angatani pamenepo? (Funsitisitsani: zifukwa.
- Kodi mpofunika patachoitika zotani kuti amayi achichepere ambiri a pabanja ngakhale omwe anakalibe ana kuti azigwiritsa ntchito njira zolerera kupewa mimba?

Awa ndiye mathero a zokambirana zathu. Zikomo kwambiri chifukwa chopereka nthawi yanu ku zokambiranazi. Zikomo.

Population Training and Research Unit, North West University (Mafikeng)

Factors influencing sexual and reproductive health risks and contraceptive use among young married women in Malawi

Focus Group Discussion Guide (young married women)

Mau Oyamba

Muli bwanji nonse? Ine dzina langa ndi _____.

Zikomo kwambiri chifukwa chondipatsa mpata kuti ticheze nanu. Ophunzira wa za Chilengwero Cha anthu ku North West University , Mr.B.Kaneka akupanga kafukufuku oyang'ana ndi kumvetsetsa zinthu zimene zimawapangangitsa amayi omwe ali pabanja mdziko muno kuti adzilepherea kugwiritsa ntchito njira zolerera kuti mimba zosaziyembekezera. Kafukufukuyu akuchitika mu zigawo zonse za dziko lino. Inuyo ndi gulu limodzi la amayi a pabanja omwe mwasankhidwa kuti tikambiranane nanu ndikumva maganizo anu pa nkhani zogonana, banja, ubereki ndi njira zolerera. Ngakhale tili ndi chidwi chachikulu pa mayankho anu ku mbali ya maphunziro, zomwe muti mutiuze zidzathandizanso kupititsa patsogolo nchito za ubereki ndi uchembere wabwino wa amayi a pabanja mdziko muno.

Tikukupemphani kuti mutiuze zomwe mukudziwa, mmene mmaonera, kommanso mmene mumamvetsetsera zinthu zomwe tikambiranezi mosayang'anira kuti ena mgulumu sangagwirizane ndi mfundo zomwe mukuperekazo. Inu ingokambani momasuka za mmene mukuzidziwira zinthu zomwe tidzikambiranazi. Pempho lathu ndi lakuti inu mungotipatsa mayankho oona basi. Tikukutsimikizirani kuti china chili chonse mungakambe pano chidzasungidwa mwa chinsinsi ndipo sizidzadziwika kuti wakuti wakuti ananena zakuti zakuti. Pakuti nkutheka kuti sitingathe kulemba zonse zomwe tingakambirane, timapempha kuti tigwiritse ntchito kotolera mau (tape recorder) kuti tisunge bwino zonse zomwe zikambidwe . Palibe wina aliyense yemwe akamvetsere tepiyi kupatulapo ineyo ndi anzanga ena ochepa amene akupangitsa nawo kafukufukuyu. Ineyo ndizitsogolera zokambiranazi ndipo anzangawa adzilemba zomwe tikukambiranazi koma salembapo mayina anu ayi. Zokambirana zathu zonse zikuyembekezera kutenga ola limodzi ndi theka. Panopo muli ndi nthawi yoti mukhoza kundifunsa mafunso okhudzana ndikafukufukuyu amene mungakhale nawo/. [Kuyima kaye – Kuyankha Mafunso].

Ndingayatseno chotengera mauchi (tape recorder? [Yatsani Tape Recorder)

Tiyambe ndikudziwana. Chonde chulani dzina lanu (loyamba lokha) ndipo mutiuze:

- Zaka
- Kodi mumagwira ntchito zotani zokuthandizani pa moyo wanu wa tsiku ndi tsiku?
- Mwakhala muli mu dera lino kwanthawi yaitali bwanji?

Zokhudzana ndi umoyo ogonana

- Kodi mukuona kuti ndi zinthu ziti zomwe zimapangitsa asungwana kapena amayi achichepere kuti aziyamba zogonana anakali aang'ono (Funsitsitsani: chikhalidwe, umphawi, kutengera anzawo)
- Kodi mukuona kuti ndi zinthu ziti zimene zimapangitsa kuti amayi azilowa mbanja anakali aąng'ono mdera mwanu muno (Fusitsitsani: chikhalidwe, umphawi, ukwati okakamiza)
- Kodi muukuona kuti nchifukwa chiyani asungwana ndi amayi achichepere amatenga pakati adaakali aang'ono (Fusitsitsani: kukwatiwa msanga, miyambo yathu)
- Kodi amayi achichepere omwe amagwiritsa ntchito njira zolerera mdera muno, kodi ndi zifukwa ziti zomwe amapereka pa nkhaniyi (Fusitsitsani: Kuti asayambe kubereka msanga, kuti ana azibadwa patali patali kapena kufuna kusiya kubereka.
- Kodi amayi ambiri omwe amagwiritsa ntchito njira zolerera mdera muno, kodi ndi zifukwa ziti zomwe amapereka pa nkhaniyi (Fusitsitsani: Kuti asayambe kubereka msanga, kuti ana azibadwa patali patali kapena kufuna kusiya kubereka.
- Kodi amayi achichepere omwe sagwiritsa ntchito njira zolerera mdera muno, kodi ndi zifukwa ziti zomwe amapereka pa nkhaniyi.
- Zokhudzana ndi za kulera
- Kodi amayi apabanja ngati inuyo mumazimva kuti nkhani/ mumapeza kuti zithandizo zosiyana siyana zokhudzana ndi kulera mdera lino. (Fusitsitsani: Ku chipatala, oyenda khomo ndi khomo, amabungwe omwe amafika kumudzi ndi zipatala zoyenda yenda, ku golosale kapena ku msika, malo a zipemphedzo, kuchokera kwa mafumu)
- Kodi inu ngati amayi a mdera muno, ndi njira ziti zakulera zomwe mumazidziwa (Fusitsitsani : Njira zonse zomwe akuzidziwa)
- Kodi maganizo anu ndi otani panjira ina iliyonse yomwe mwatchulayo (Funsitsitsani: ubwino ndi kuvuta kwa njira iliyonse yachulidwayo?)
- Kodi amayi achichepere mdera lino amakapeza/amakatenga kuti njira zolerera zakumtima kwawo akazifuna? Tingati ndizovuta kapena zosavuta kuzipeza (Funsitsitsani : zifukwa ndi zolepheretsa)

- Kodi pamapezeka nthawi zina pomwe mmayi wa pabanja angafune kutsata njira zolerera koma nkulephera kutero (Funsitsitsani: zifukwa (abambo kukaniza, achibale kukaniza, chifukwa cha zipembedzo, miyambo ndi chikhalidwe njira yoifuna osapezeka)
- Kodi mukuona kuti pali zifukwa zomwe amayi achichepere apabanja omwe sanaberekepo sangagwiritsire ntchito njira zina zolerera kapena osagwiritsa ntchito nkomwe.
- Kodi zimachitika mdera muno kuti mmayi wachichepere wapabanja akufuna kugwiritsa ntchito njira yolerera yakuti yakuti koma mapeto ake nkulephera kugwiritsa ntchito njira yomwe akufuna ija ndipo nkupezeka kuti akugwiritsa nchito njira ina mmalo mwake (Funitsitsani zifukwa: kusapezeka kwa njirayo, kuopa zovuta zina zobwera chifukwa chogwiritsa ntchito njirayo, malangizo ochokera kwa opereka njira zakulera, kukondera kwa njira zina komwe opereka zakulera angakhale nako)
- Kodi mukuganiza kuti amayi okwatiwa mdera mwanu muno amatha kumakambirana ndi amunawo nkhani zokhudzana kugonana, ubereki ndi za kulera. (Funsitsani: zokambiranazi zimayenda bwanji, chifukwa chiyani amakambirana kapena sakambirana , zolepheretsa)
- Kodi azibambo ena amene amaletsa azikazi awo kulera, kodi zikufukwa ziti zomwe amapereka.
- Kodi tingatani. Titakhala tikufuna kuti azimayi ambiri achichepere apa banja azigwiritsa ntchito njira zakulera, tingatani?
- Kodi anthu amanena kuti chani zakuipa kwakugwiritsa ntchito njira zakulera kwa amayi achichepere.
- Kodi mdera lino, chisankho cha njira zakulera chimayamba bwanji? (funsisitsani: zonse zomwe zimayambitsa)
- Kodi mukuganiza bwanji pa zakugwiritsa tchito njira zakulera popanda abambo kunyumba kudziwa (ubwino ndi kuipa kwake)

Zikomo kwambiri chifukwa chopereka nthawi yanu ku zokambiranazi.

Population Training and Research Unit, North West University (Mafikeng)

Factors influencing sexual and reproductive health risks and contraceptive use among young married women in Malawi

Key Informant Interview Guide (Traditiona Leaders (Mafumu)

Mau Oyamba

Muli bwanji ? Ine dzina langa ndi _____. Zikomo kwambiri chifukwa chondipatsa mpata kuti ticheze nanu. Ophunzira wa za Chilengwero Cha anthu ku North West University, Mr.B.Kaneka akupanga kafukufuku oyang'ana ndi kumvetsetsa zinthu zimene zimawapangangitsa amayi omwe ali pabanja mdziko muno kuti adzilepherea kugwiritsa ntchito njira zolerera kuti mimba zosaziyembekezera. Kafukufukuyu akuchitika mu zigawo zonse mdziko muno. Inuyo ndi mmodzi wa atsogoleri omwe amakhala ndi anthu kumudzi amene tikukhulupilira kuti mutiunikira bwino bwino nkhani imeneyi ndikutipatsa maganizo anu okhudzana ndi nkhani za kulera pokhudzana ndi amayi achichepere a pabanja komano pogwirizana ndi mmene mukuonera ngati mfumu yosunga chikhalidwe chathu. Ngakhale tili ndi chidwi chachikulu pa mayankho anu ku mbali ya maphunziro, zomwe muti mutiuze zidzathandizanso kupitsa patsogolo mchito za ubereki ndi uchembeere wabwino wa amayi achichepere a pabanja mdziko muno.

Tikukupephani kuti mutiuze zomwe mukudziwa, mmene mmaonera, kommanso mmemne mmamvetsetsera zinthu zomwe tikambiranezi mosayang'anira kuti anthu ena kapena dziko likutinji pa nkhani zimenezi. Inuyo mungokamba momasuka za mmene mukuzidziwira zinthu zomwe tidzikambiranezi. Pempho lathu llakuti inu mungotipatsa mayankho oona basi. Tikukutsimikizani kuti china chilli chonse mungakambe pano chidzasungidwa mwa chinsinsi ndipo sizidzadziwika kwa wina aliyense kupatulapo ife ochita kafukufuku. Pakuti nkutheka kuti sitingathe kulemba zones zomwe tingakambirane, timapempha kuti tigwiritse ntchito kotolera mau (tape recorder) kuti tisunge bwino zonse zomwe zikambidwe . Palibe wina aliyense yemwe akamvetsere tepiyi kupatulapo ineyo ndi anzanga ena ochepa amene akupangitsa nawo kafukufukuyu. Zokambirana zathu zikuyembekezera kutenga ola limodzi ndi theka. Panopo muli ndi nthawi yoti mukhoza kundifunsa mafunso okhudzana ndikafukufukuyu amene mungakhale nawo/. [Kuyima kaye – Kuyankha Mafunso].

Mafunso okambirana

- Kodi chipembedzo/chikhalidwe chanu chimati chani pa nkhani yokhudzana ndi msinkhu oyamba 1) kugonana mayi anakali wachichepere 2) msinkhu oyamba kubereka mayi

anakali wachichepere 3) za kuwatiwa amayi adakali achichepere? 4) Komanso kugwiritsa ntchito njira zolera kwenikweni pakati pa amayi achichepere omwe ali pa banja?

- Kodi pali zifukwa za chikhalidwe/chipembedzo zomwe zimalimbikitsa kuyamba kugonana munthu anakali wang'ono, kukwatira msanga, kubereka mwansanga ndipo nchifukwa chiyani amayi achichepere omwe ali pabanja asamagwiritse ntchito njira zolerera?
- Kodi inu kapena anthu mdera muno angamuone bwanji mayi wachichepere wapabanja yemwe akugwiritsa ntchito njira zolerera?
- Kodi mmayi wachichepre akalowa mbanja ziyembekezo za anthu zimakhala zotani pa kumbali ya ubereki?
- Mukumvetsa/mkukuona kwanu, kodi ndi zinthu ziti zomwe zingampangitse mmayi wapabanja wachichepere kuti adzigwiritsa ntchito njira zolerera. ?
- Mukumvetsa/mkukuona kwanu, kodi ndi zinthu ziti zomwe zingamulepheretse mayi wapabanja wachichepere kuti asamagwiritse ntchito njira zolerera (Probe: Miyambo yathu?
- Kodi munganeneko zotani zokhudza ndi mmene anthu mdera lino amaganizira/amazionera zinthu izi zokhudzana ndi nsinkhu oti msungwana angathe kuyamba zogogana, angathe kulowa mmbanja, kuyamba kubereka komanso kupereka njira zolerera kwa amayi achichepere omwe ali pabanja ena akuti sanayambe kubereka.
- Kodi inu maganizo anu amakhala otani pokhudzana ndi amayi achechepere apabanja kugwiritsa ntchito njira zolerera inu ngati mfumu/tsogoleri wa chipembedzo.
- Kodi mukuganiza kuti amayi achichepere apabanja adzigwiritsa ntchito njira zolerera kupewa mimba?
- Kodi mukuganiza kuti ndi nthawi ziti zomwe mayi wachichepere angayenere kugwiritsa ntchito njira zolerera? (Fusitsitsani: Zifukwa). Kodi pali njira zolerera zomwe angathe kugwiritsa ntchito?
- Kodi ndi nkhawa ziti zomwe mungakhale nazo zokhudzana ndi mayi wachipepere wapabanja akamagwiritsa ntchito njira zolerera kumbali yanu ngati mfumu/ tsogoleri wa chipembedzo?
- Kodi muli ndi maganizo ena aliwonse okhudzana ndi kubereka komanso kulera pakati pa amayi achichepere apabanja? Tiyeni tikambiraneni pamenepa.

Awa ndiye mathero a zokambirana zathu. Mungakhalepo ndi mau kapena ndemanga zotsiliza pa zomwe takambiranazi. Zikomo kwambiri chifukwa chopereka nthawi yanu ku zokambiranazi.

APPENDIX IV: PROPOSAL CERTIFICATE OF APPROVAL

Private Bag X2046,
Mmabatho, 2735
Mafikeng
Republic of South Africa

Tel: (018) 389-2333
Fax: (018) 389-2220
E-mail: Ishmael.KaluleSabiti@nwu.ac.za

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
MAFIKENG CAMPUS

Faculty of Human and Social Sciences
School of Research and Postgraduate Studies

APPROVAL OF RESEARCH PROPOSAL (2013)

Student Name	Benjamin Kaneka
Student Number	24864484
Degree	PhD – Population Studies
Supervisor **Co-Supervisor**	Prof A.J. Mturi
Registered Research Title	Factors influencing sexual health risks and contraceptive use among married young women in Malawi

The Higher Degrees Committee of the Faculty of Human and Social Sciences has carefully studied your revised proposal and the correction report submitted February 2014.

I am glad to inform you that the Committee is generally satisfied with the revised version of your proposal and hereby grants you permission to officially proceed with your research. Please note that your registered title cannot be changed without the written approval of the FHDC.

The committee further approved Professor Akim Mturi as your study supervisor.

May I take this opportunity to wish you all the best with your research.

Kind regards

Dr B.M.P. Setlalentoa
Director: School of Social Sciences
Faculty Higher Degrees Committee Member

APPENDIX FIVE: ETHICAL APPROVAL

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Private Bag X6001, Potchefstroom
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Web: http://www.nwu.ac.za

Ethics Committee
Tel +27 18 299 4849
Email Ethics@nwu.ac.za

ETHICS APPROVAL OF PROJECT

The North-West University Research Ethics Regulatory Committee (NWU-RERC) hereby approves your project as indicated below. This implies that the NWU-RERC grants its permission that provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: Factors influencing contraceptive use among married young women in Malawi

Project Leader: **Prof AJ Mturi**
Student: **BN Kaneka**

Ethics number: N W U - 0 0 2 1 7 - 1 4 - A 9
Institution Project Number Year Status
S - Submission R - Re-submission Provisional Authorisation A - Authorisation

Approval date: 2014-06-06 **Expiry date**: 2019-06-05

Special conditions of the approval (if any): None

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- *The project leader (principle investigator) must report in the prescribed format to the NWU-RERC:*
  - *annually (or as otherwise requested) on the progress of the project,*
  - *without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.*
- *The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-RERC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.*
- *The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-RERC and new approval received before or on the expiry date.*
- *In the interest of ethical responsibility the NWU-RERC retains the right to:*
  - *request access to any information or data at any time during the course or after completion of the project:*
  - *withdraw or postpone approval if:*
    - *any unethical principles or practices of the project are revealed or suspected,*
    - *it becomes apparent that any relevant information was withheld from the NWU-RERC or that information has been false or misrepresented,*
    - *the required annual report and reporting of adverse events was not done timely and accurately,*
    - *new institutional rules, national legislation or international conventions deem it necessary.*

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

Yours sincerely

Prof Amanda Lourens
Chair NWU Research Ethics Regulatory Committee (RERC)

APPENDIX IV: PAPERS EXTRACTED FROM THE DISSERTATION

1.0 Motivations and consequences of secret contraceptive use among young married women in Malawi

- The paper has been published the African Population Studies (APS) Journal. It can be accessed on http://aps.journals.ac.za.

2.0 Trends and determinants of Contraceptive use and method choice among young (15-24) married women in Malawi.

- The paper was presented at the 2014 Annual Population Association of Southern Africa (PASA) Conference that took place from 30 September to 3 October, 2014 at Walter Sisulu University, South Africa.

3.0 Perspectives of young married women in Malawi on the motivations for partner opposition to the use of modern contraceptives.

- The paper was presented at the 2015 National HIV and SRH International Conference to be held in Lilongwe, Malawi from 20th to 24th Novemeber, 2015