

**MALE AND FEMALE INVOLVEMENT IN
CONTRACEPTIVE DECISION-MAKING,
USE AND DISCONTINUATION IN
RURAL MALAWI**

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EXECUTIVE SUMMARY

Background

Malawi has a high fertility rate of 6.7 and a low usage of contraceptives. In 1992, the government of Malawi adopted a National Population Policy which supports family planning and implements strategies to reduce the total fertility and increase the contraceptive prevalence rate from 7% to at least 15% by 1998 (National Family Welfare Council, 1994). In a recent nation wide survey, Malawi Knowledge, Attitudes and Practices in Health (MKAPH, 1996), there was evidence of high attrition of women using modern contraceptives. In addition, from a series of studies focusing on women's experiences with modern contraceptives, there was evidence suggesting that in one urban area of Malawi, women discontinued modern contraceptives in readiness for another baby (Namate and Kornfield, 1997).

High attrition rates among contraceptive users may suggest that Malawi family planning programme is not effectively protecting women from unintended pregnancies; or, there may be additional explanatory factors to discontinuing modern contraceptive use besides wanting more children. With the paucity of information explaining why Malawi women prematurely discontinue contraceptive use, this study was designed to identify factors that would give direction for planning effective family planning programmes and strengthening the existing ones.

Study Objectives

The overall objective of this study was to describe the contraceptive decision-making of men and women and within this context to determine factors which contribute to individual's discontinuation of contraceptive use. The specific objectives were to:

1. Identify the decision-making process of contraceptive use to isolate factors which influence acceptance or non acceptance.
2. Describe men's role in the contraceptive decision-making process and use.
3. Identify social, cultural, economic and medical factors which contribute to discontinuation of contraceptive use.

METHODOLOGY

Study Design

An exploratory ethnographic study was conducted in six sites, two from each region of Malawi (Nsanje, Mangochi, Ntcheu, Mchinji, Karonga and Rumphu). Sites were chosen based on the contraceptive acceptance rate (CAR) and the contraceptive prevalence rate (CPR) of the districts in each region. From each region, one district with a relatively high CPR and another with the lowest CPR were selected.

A purposive convenience sample of 165 women (mean age 32 years) and 103 men (mean age 38 years) from a low income background and were willing to participate were selected. Their sources of income were from fishing, small businesses and subsistence farming. Women who discontinued contraceptives were identified using their FP clinic records and by a Snow Ball Method. Women who were recruited first identified others who also discontinued modern contraceptives. Recruitment was done in participants' homes and HSAs guided the team to these homes. Women were recruited if they ever used and discontinued using one or more methods of modern contraceptives. Men participated if their wives met the inclusion criteria.

Data were collected through Focus Group Discussions and In-depth Interviews of exclusively female only and male only groups. SPSS 6.1 PC on Windows 95 was used to analyze the quantitative data. Qualitative data were analyzed by Reduction, Display, Conclusion Drawing and Verification. Data on the use and discontinuation of modern contraceptives were analyzed across and within Study Sites.

FINDINGS AND CONCLUSION

Socio-Demographic Characteristics of Study Participants

Many participants were married and had medium to large families with 5 to 10 children. Some families appeared unstable because of frequent separations, divorce, re-marriages, indulgence in extra marital relationships, death of spouses and excessive beer drinking among men. Households were headed by men and women. It appears that marriages between older men and younger women were common in the northern region and in Nsanje. There were significant age differences among women and not men. Women from Rumphi were younger than the rest. Approximately three quarters of the participants had some primary school education. Significant education differences were noted. Women and men from Rumphi had significantly attained more years of formal education than women from Nsanje and men from Ntcheu respectively.

Contraceptive Decision-Making

The results seem to suggest two parallels to contraceptive decision-making for men and women. Women engaged the decision-making process from an experiential perspective while men entered from an influential perspective. Variations in contraceptive decision making appeared to be a function of: age differences of couples; educational background, men's perception of their role in controlling reproductive decisions; fertility locus of control, types of family, communication within the family, and women's determination to take risks in using modern contraceptives without the knowledge of their spouses.

Couples decided their own family sizes without much external influence from family members. Despite this autonomy, participants used modern contraceptives after they had four or more children in the hopes of avoiding adverse effects of modern contraceptives they believe could cause secondary infertility and consequently reduce their ideal family size.

The Role of Men in Contraceptive Decision Making and Use

Men's roles were contingent on factors such as: being in a monogamous or polygamous relationship; number of times men had married; family size; age; education; and, their attitude toward family planning. Men appeared to play four roles; (1) supporting their wives to start, sustain the use, or discontinue using contraceptive methods, (2) initiating the decision for their wives to start contraceptives when men felt the need, (3) prohibiting women from using contraceptives and (4) directing their wives to stop using contraceptives when they (men) wanted more children. It would appear that men played both supportive and unsupportive roles, however, between the two, the results seem to suggest that men made the greatest impact on their unsupportive roles.

Factors Influencing Use of Modern Contraceptives

There are six groups of factors identified by levels one to six. Most of the factors directly or indirectly influenced women's contraceptive use (see Figure 2, p.15).

Level 1. Four dominant traditional values and fertility practices which seemed to affect contraceptive decision-making are: 1) male dominance over reproductive issues; 2) women's submissive behaviour; 3) family factors and communication dynamics; and, 4) fertility preferences and practices characterized by the participants' high value for children. Men exhibited influential power (Influential Perspective) in all horizontal relationships among the first level factors.

Level 2. Three immediate effects emerged from effects of interactions from the first level resulting in 1) unsuccessful traditional methods; 2) unintended pregnancies and 3) frequent childbearing. At this level, women experienced the effects of the four factors from level one. Women become the recipients of both positive or negative developments from the first level (Experiential Perspective begins to unfold).

Level 3. Six problems resulting from frequent childbearing, unintended pregnancies and failed traditional contraceptive methods manifest through: 1) wife's low self-esteem; 2) women's lack of control in reproductive affairs; 3) health concerns for mother and children; 4) lack of social and financial support from family and spouse; 5) childbirth complications; and, 6) child-care burden (mainly experiential).

Level 4. Five driving forces influenced participants to seek assistance through: 1) encouragement from significant family members; 2) desire to improve self esteem; 3) need to gain control over fertility issues ; 4) desire to have families similar to those of successful users of FP services; and, 5) desire to avoid the suffering that their parents experienced because they had many children.

Level 5. Four dangers of not acting on their problems were anticipated. These reflect the amount of suffering women endured or how much suffering they expected to endure if they did not use modern contraceptives. Such consequences were: 1) the pressure from managing large families; 2) suffering due to the lack of support; 3) perceived vulnerability to ill health, poverty and death of the mother/wife; and, 4) missing the opportunity of personal gains from using contraceptive methods.

Level 6. The last level involved seeking, interpreting and using information about contraceptives operationalized by women actually using FP services. In their pursuit for the services, participants reported using factual, presumptive and experiential knowledge to make decisions to use and select contraceptive methods they desired.

Who initiated Contraceptive Decisions

The results suggest that individuals involved in contraceptive decision making varied including wives, husbands, FP providers and family members. However women initiated most of the discussions to use modern contraceptives. In fewer families, husbands, nurses and other family members initiated the discussions. From the study sites, 69% of women from Nsanje; 72% of women from Mangochi; 81% of women from Ntcheu; 68% of women Mchinji; 78% of the women from Karonga and 58% of the women from Rumphi initiated the discussions to begin using modern contraceptives. The responses they received were both positive and negative but most of them were positive. Among the men, most of those who initiated were from Rumphi (21%), Mchinji (18%) and, Mangochi (17%). The least among men, were from Nsanje (7%), Ntcheu (5%), and Karonga (4%).

It appears that there was not much substantial discussion about contraceptives between husbands and wives if they talked about it at all. Rather, the process was more of information giving than a discussion. When either a husband or wife initiated, talked and reached an agreement, usually family members were only informed of a decision already made by the wife and husband.

Contraceptive Decision-Making Models

These models describe who had the power to influence, the process used, why initiate the discussion, the likelihood of being supported and the effectiveness of the model. The results suggest that there were four models of contraceptive decision-making classified according to the individual who had the power to influence. The types of Models are: 1) Wife/Mother-Driven; 2) Husband-Driven, 3) Care provider-Driven; and, 4) Support member-Driven. Of the four models, the Wife Driven model was commonly used yet it received less support from the husbands unless there was tangible evidence of a family crisis. The Husband Driven, was almost 100% supported by wives; the Care Provider-Driven was almost fully supported by wives and husbands; and the Support Person-Driven was partially supported by couples.

Types of Contraceptives Used

Women reported using six types of contraceptive methods: 1) Oral contraceptive pills; Depo-Provera; 3) Condoms; 4) Vaginal Foam, 5) IUCDs and 6) Tubal Ligation (TL). Of the methods mentioned, OCPs and Depo-Provera were used the most. One woman used and discontinued vaginal foam , two women used and discontinued IUCDs and two others had a TL after using Depo-provera. Five families used condoms as a backup to the first cycle of OCPs or at sexual intercourse when women had prolonged bleeding. Many women used OCPs and Depo-Provera.

OCPs: Women used OCPs as a primary method or they switched to it after using Depo-Provera. OCP users were ranked from high to low: 1) Mchinji 77% (n= 20); 2) Mangochi 52% (n= 16); 3) Nsanje 45% (n= 15); Rumphu 39% (n=11); Ntcheu 35% (n=9) and Karonga 28% (n= 6).

Depo-Provera: More than half of women in five sites used Depo-Provera. Their ranking is as follows: 1) Karonga 81% (n= 17); 2) Nsanje 64% (n= 21); Ntcheu 62% (n=16); Rumphu 61% (n= 15), Mangochi 55% (n= 17) and Mchinji 15% (n= 4).

Experiences Using Modern Contraceptives.

Participants reported both positive and negative experiences such as: 1) couples were able to delay, attain or space pregnancy as they desired; 2) women had extra time to do other chores such as business without worrying about pregnancy ; 3) couples enjoyed having sexual intercourse without the fear of pregnancy; 4) couples had free time to themselves ; 5) parents were able to manage and educate their children with limited resources. All these were positive results.

The negative aspects reported were: 1) women bled excessively and continuously for 3 weeks up to 3 months; 2) they had scanty and unpredictable bleeding cycles; 3) some had no periods at all; 4) others experienced severe abdominal pain due to Depo-Provera and IUCD; 5) physical side effects such as nausea, high blood pressure, anaemia, general fatigue and declining health; 6) family conflicts; 7) sexual dissatisfaction; 8) desertion by husband ; 9) separation; 10) divorce, 11) messy experience with vaginal foam and 12) resistance in using condoms as a primary method of contraception by married couples.

Women reported experiencing more adverse effects with Depo-Provera than they did with OCPs yet they preferred to use Depo-Provera. Women using Depo-Provera, from Nsanje to Karonga consistently complained of a class of problems with these characteristics:

Heavy and prolonged vaginal bleeding accompanied by blood clots; atypical severe abdominal pains; they reported feeling the sensation which was like being cut inside their abdomens with a sharp razor blade, or they felt a pulling and tightening sensation inside their abdomens (sharp and colic). They also complained of supra-pubic pains and backache. Women described the pain as uncharacteristic of the pain they usually felt when they had regular menses. Women experiencing this phenomenon reported a sequence of events At the onset of the pain, they first felt a band of heat wave across the abdomen, radiating to the back and the vulva. This was followed by excruciating abdominal pain, then a burning sensation on the vulva, followed by a discharge of clots and an immediate relief soon after. The events were repeatedly occurring during the time they reported having heavy menses.

Women could not distinguish if they bled more than what is expected for Depo-Provera. Their responses lacked concrete information to guide them make the distinction. The effects of bleeding were a source of sexual conflicts in some families leading to desertion, neglect or abuse. Women having no menses were unhappy because they believe in the cleansing effect of discharging blood every month so that having no menses meant that the blood was accumulating in them. Men were also unhappy because they believe that bleeding makes a woman complete. Although a few men reported to have used condoms when their wives had prolonged bleeding, they expressed sexual dissatisfaction using them.

Reasons Participants Attributed to Discontinuing Modern Contraceptives

OCPs: Of the 165 women, 77 (47%) from all sites discontinued OCPs. They discontinued OCPs after one to three cycles or after two or more years with an average duration of one year prior to discontinuation. Women who discontinued OCPs after a short period reported having problems, but those who used OCPs a little longer reported having minimal problems. In order of frequency, their reasons for discontinuing OCPs were: 1) method side effects; 2) desired pregnancy 3) rumours about side effects; 4) social reasons, 5) bleeding problems; 6) method failure; 7) other factors; and, 8) provider's attitudes. Differences were noted by site.

Depo-Provera: Of the 165 women, 114 (69%) from the all sites discontinued Depo-Provera. Their reasons were: 1) bleeding problems; 2) method side effects not related to bleeding; 3) severe abdominal pains and backache; 4) social reasons; 5) rumours about adverse effects of Depo-Provera; 6) negative provider attitudes; 7) service provision problems; 8) low self esteem; 9) pregnancy; 10) child related factors, 11) directives from husbands; 12) breach of power boundaries in decision making (wives deciding on their own); 13) marital conflicts including sexual dissatisfaction, separation, marrying other wives; 14) death of a spouse (15) desire to salvage a marriage; and, 15) fear of dying from complications of Depo-Provera.

Many men appeared insensitive to the reasons why their wives discontinued using modern contraceptives. Sometimes they were the major cause because they did not support their wives, they deserted and abused them and made unnecessary sexual demands without caring about what problems their wives were experiencing. Women who discontinued Depo-Provera demonstrated lack of knowledge in four areas: 1) how soon fertility returns; 2) how to interpret cessation of menses; what they needed to do following the absence of menses; 3) how much bleeding was heavy bleeding; 4) the definition of prolonged bleeding in days, weeks or months.

Conclusion

The recurrent theme anchoring the decision to use and discontinue using modern contraceptives is "**Suffering.**" The results suggest that family planning was not an integral part of family formation in many families but was used late in the child bearing period as a means of solving problems associated with having and managing large families. Men seemed less involved in supporting their wives to use modern contraceptives but were influential in discouraging their wives from using or sustaining the use of contraceptives. Results also suggest that women were more likely to sustain the use of modern contraceptives if they experience fewer problems with a method and had not desired a pregnancy within a short period.

These findings underscore the importance of counselling husbands and wives together; providing clients with thorough factual information using practical examples and relating these to the experiential and presumptive knowledge clients have; involving men in FP matters, encouraging men to support their wife's to use contraceptive methods and empowering women in negotiating skills.

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BT	Blantyre
CAR	Contraceptive Acceptance Rate
CBD	Community Based Distribution
CP	Clinical Officer
CPR	Contraceptive Prevalence Rate
DT	Dental Technician
FGD	Focus Group Discussions
FP	Family Planning
IUCDs	Intra-Uterine Contraceptive Devices
JSI-STAFH	John Snow Incorporated-Support to AIDS and Family Health
KCN	Kamuzu College of Nursing
LCH	Lilongwe Central Hospital
MCH	Maternal and Child Health
MKAPH	Malawi Knowledge, Attitude and Practices in Health
MOHP	Ministry of Health and Population
MOWACA	Ministry of Women, Children Affairs, Community Development and Social Welfare
NFWC	National Family Welfare Council
NFPCM	National Family Planning Council of Malawi
NSO	National Statistical Office
OCPs	Oral Contraceptive Pills
RNM	Registered Nurse-Midwife
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

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INTRODUCTION

Background

Malawi has a very high fertility rate and low usage of contraceptives. From the Malawi Demographic Survey (1992), the fertility rate is 6.7 and the contraceptive usage is 7% among married women. Previous series of economic shocks that have hit Malawi government have resulted in a severe decline in real per capita income. This raised the government's awareness of the rapid population growth and its effect on economic and social development of the country (UNFPA, 1994). In 1993 the Government of Malawi adopted a National Population Policy which supports family planning (FP). A five-year comprehensive strategy for the Malawi family planning programme was developed. The strategy is directed at increasing involvement in family planning and expanding services at all levels and across all sectors in the private, government, parastatal and non-governmental organizations.

The overall goal of the National Family Planning Strategy is to reduce the total fertility from an estimated 6.7 in 1992 to 6 or less by 1998. Also, to increase the contraceptive prevalence rate from 7% in 1992 to at least 15% by 1998 (National Family Planning Council of Malawi, 1994). The 1996 Malawi Knowledge, Attitude and Practices in Health (MKAPH) survey showed that the use of modern contraceptives had risen to 14.4% (National Statistical Office (NSO), 1996). If the government is to indeed reduce fertility, use of modern contraceptives has to increase. Increase in use of contraceptives will come about not only through continued intense recruitment of new clients, but also through sustaining an increased number of continuing clients. Knowledge of reasons for discontinuing contraceptive use will therefore be valuable to policy makers and family planning programme designers.

Literature Review

A recent study which followed a group of family planning clients for a period of one year showed that by the end of the year, only 8.3% of the clients were continuing to use modern contraceptives and the other 91.7% had all discontinued (Kornfield and Namate, 1997). This illustrates that although there may be high motivation for acceptance of family planning, an individual's ability and desire to use contraceptives on a sustained basis is minimal. In a related study which examined contraceptive experiences of family planning clients (Namate and Kornfield, 1997), the major reason given for discontinuing use of the different methods of contraception was the desire to have another child.

While it is understood that throughout the life of a couple their needs may evolve, the study did not indicate whether the desire to have another child was expressed by the husband or the wife. Kornfield and Namate's study also demonstrated that counselling was a key element in both initiation of family planning and follow-up visits to the family planning clinic for sustained use. The 1996 MKAPH demonstrated that the use of contraceptives increased with increasing age of the

woman, reaching its peak at ages 35-39 years. Use of modern contraceptives was found to be higher among urban women than among rural women and the use of contraceptives was strongly linked to a woman's level of education. The more educated a woman was, the more likely she was to use modern contraceptives (NSO, 1996).

Several studies have been conducted in other countries examining reasons for contraceptive discontinuation. Ali and Cleland's (1995) study which used Demographic Health Survey data from six developing countries found that for all methods, a third of the couples stopped using their contraceptive method within one year of acceptance, and one half of them stopped within two years. Three major reasons were identified and these were desire for a child, method failure, and health concerns, which included side effects. The study further found that Intrauterine Contraceptive Device (IUCD) users were more likely to continue using the method than were users of other hormonal contraceptives and they were less likely to report method failure.

A similar study conducted in Niger and Gambia on discontinuation of contraceptives found that some women discontinued contraceptive use due to external forces such as social and religious norms and forces peculiar to providers or the clinics, which included poor counselling, inappropriate methods, side effects and poor logistics (Cotten, Stanback, Maidouka, Taylor-Thomas and Turk, 1992).

A study conducted in rural Kenya found that lack of access to high-quality services, prevalence of method side effects, poor compliance and method failure, and opposition from family and peers were some of the factors which accounted for the difference between actual and desired family size (Ferguson, 1992). Another study in Kenya demonstrated that knowledge and approval of family planning, husband-wife communication, desire for more children and ideal family size were all significantly associated with current contraceptive use. The wife's perception of her husband's approval of family planning was also highly associated with current contraceptive use (Lasee and Becker, 1997).

These studies demonstrate that various socio-economic factors may influence acceptance and use of contraceptives. Women's sense of control, or their perception of their ability to control or make changes in their life's conditions and events in general and in family planning and fertility practices in particular, may also influence whether or not they continue or discontinue contraceptive use.

Other factors associated with discontinuation of contraceptive use include fertility preferences of the couple or the community, social and cultural norms, and issues related to the clinic itself or those providing the services. It is necessary for Malawi to identify those factors which are applicable to the Malawian setting in order for effective programme implementation in family planning to occur. No studies have been done in Malawi to determine the reasons for the high discontinuation rate of contraceptive use.

Significance

High rates of discontinuation of contraceptive use suggest that Malawi's family planning programmes are not effectively protecting women from unwanted pregnancies. Further, it was anticipated that barriers which cause family planning clients to discontinue contraceptive use for reasons other than a desired pregnancy would be identified.

The overall objective of this study was to describe the contraceptive decision-making process of men, and women and within this context, to determine factors which contribute to individual's discontinuation of contraceptive use. The specific objectives were to:

- 1 Identify the decision-making process of contraceptive use to isolate factors which influence acceptance or non-acceptance.
- 2 Describe the role of men in the contraceptive decision-making process and contraceptive use.
- 3 Identify social, cultural, economic and medical factors which contribute to discontinuation of contraceptive use.

METHODOLOGY

Study Design

This ethnographic study was designed to explore through focus group discussions (FGD) and in-depth interviews issues surrounding the use and discontinuation of modern contraceptives among Malawian couples in six sites, two from each region of Malawi.

Based on the contraceptive acceptance rate (CAR) and contraceptive prevalence rate (CPR) of the districts in each region, six sites were chosen. One district with relatively high CPR and another with the lowest CPR were selected. Using that criteria, Nsanje, Mangochi, Ntcheu, Mchinji, Karonga and Rumphu were selected. The sites represent some main ethnic groups such as Sena, Yao, Ngoni, Chewa, Tumbuka and Nkhonde.

Forty-six FGD of men and women and 43 in-depth interviews of married couples were conducted in the six sites depending on the availability of participants. Male members of the research team collected data from male participants and female members from female participants. FGD of male and female participants were conducted separately but in concurrent sessions. Paired husbands and wives were interviewed simultaneously but separately so that their views would not influence each others' responses.

Training of Data Collectors

The research team was trained in qualitative data collection and management. Instruments were revised, translated in Chichewa and Tumbuka and pre-tested.

Instruments

Three data collection tools were used: 1) a questionnaire on demographic characteristics of the group; 2) FGD guides (for males and females); and, 3) In-depth interview guides also for males and females. The interview guides addressed men and women's motivation for child bearing, fertility preferences, contraceptive decision-making, experiences with contraceptives, reasons for discontinuation, partner's involvement in decision to use contraceptives, communication between partners, and community's perspectives of modern contraceptives. In addition to these areas, the interview guides for in-depth interviews addressed the general family planning and fertility locus of control items.

Recruitment of subjects

Participants were recruited by the Principal Investigator (PI) and the Research Officer from National Family Planning Council of Malawi (NFPCM) in consultation with the District family planning coordinator, Community Health nurse or family planning (FP) providers. FP records of defaulters or a list of women who discontinued using FP methods were used to trace participants in their homes. Health Surveillance Assistants (HSAs) also assisted in identifying these women and their husbands where applicable.

Women were included if during their child bearing period have used and discontinued use of one or more modern contraceptive methods. Women were excluded if they, 1) did not use any modern contraceptives; 2) were using their first contraceptive method and had no interruption from its use since they started; and 3) were intending to begin using modern contraceptives for the first time. Men were included if their current or previous wives/sexual partners met the above inclusion criteria and excluded if their partners satisfied the exclusion criteria.

Potential female participants were approached with an explanation of the purpose of the study and a request for their husbands to participate. If a wife and husband were available at the same time, both were requested to participate and were only included with their consent.

Recruitment was difficult because; 1) the study targeted women who had discontinued using modern contraceptives; 2) the inclusion of husbands posed feasibility and logistic problems especially finding a husband and wife at the same time; 3) recruiting female clients posed ethical dilemmas when husband and wife were both at home but the husband was not aware that his wife ever used modern contraceptives. When approached, generally participants were suspicious about the motives of the study

Data were collected using a questionnaire, FGD and in-depth interviews. Information was solicited on fertility preferences, contraceptive experiences, reasons for using and discontinuing FP methods, men's involvement in decision-making, communication with partners, general, FP and fertility locus of control. The FGD addressed similar areas except the locus of control items.

Each team had one facilitator, one note-taker and one interviewer. A tape recorder was used to compliment the note-taker. Each team conducted two focus group discussions and each interviewer conducted three to four in-depth interviews at each site.

Data Analysis

Quantitative data on participants' demographic characteristics were analyzed using descriptive and inferential statistics using SPSS 6.1 for windows. Qualitative data were analyzed in two stages. First, concurrent data analysis was done through daily debriefing sessions during feed back sessions with data collectors. Content analysis was used for the final analysis. Data were analyzed for all sites and within sites for general and unique responses. The process of analysis involved data reduction and identification of recurrent patterns of behaviour and themes.

FINDINGS AND DISCUSSIONS

Results and discussions are presented concurrently in the following sequence:

1. Selected Demographic Characteristics of the Sample.
2. Contraceptive Decision-Making Process: Factors Influencing Contraceptive Use.
3. Models Of Contraceptive Decision-Making Process and the Role of Men in Contraceptive Decision-Making.
4. Types of Contraceptives Used and Reasons Attributed to their Use.
5. Women's and Men's Experiences with Contraceptives Used.
6. Discontinuation of Modern Contraceptives: Factors Associated with Discontinuation of FP Methods Used.
7. Summary of Major Findings.

DEMOGRAPHIC DATA

Sample size

A total of 268 married men and women participated. Of these, 103 were males and 165 females. Eighty-one men and 144 women participated in FGD; 22 men and 23 women participated in the in-depth interviews (Table1, p.6).

The total number of male and female participants in FGD and in-depth interviews was 225 and 43 respectively. Of the planned sample of 336, 80% (n=268) was

The total number of male and female participants in FGD and in-depth interviews was 225 and 43 respectively. Of the planned sample of 336, 80% (n=268) was achieved. The shortfall was mostly from males. Instead of 24 men from each study site, there were only six and eight men who participated in FGD from Mangochi and Rumphhi respectively. From the research team's observation, men tended to respond negatively when approached to discuss family planning issues.

In all study sites especially Nsanje, Mangochi, Ntcheu, Karonga and Rumphhi, men were not available in their homes despite making earlier arrangements with them. In other of parts of Mangochi, Karonga and Rumphhi, men were available but they either expressed their lack of interest in discussing FP issues, hid in their houses at the time of the appointment, or left homes when the recruiters appeared. In Nsanje, Mangochi and Karonga, some men had more than one wife therefore, were difficult to locate.

Table 1

Actual Numbers of Focus Group & In-depth Interview
Samples for All Participants

Site	M-FGD	F-FGD	M-In-d epth	F-In-d epth	Total
Nsanje	19	29	4	4	56
Mangochi	6	29	3	2	40
Ntcheu	19	22	3	4	48
Mchinji	16	22	4	4	46
Karonga	13	18	3	3	37
Rumphhi	8	24	5	4	41
Total	81	144	22	21	268

By the socio-demographic indicators, this sample comprised rural, low income families with unreliable sources of income. Their main sources of income were subsistence farming, fishing and small scale businesses.

Age of participants

Participants were aged 19 to 70 years, the range was 51. The youngest female participant was 19 years old and the oldest male participant was 70 years old. The 70 year old man's eligibility for the study was based on his marriage to the 19 year old woman. Apart from these extreme examples, the rest of the male and female participants were aged 20 to 65 years old (Table 2, p.7).

The age distribution for females was as follows: 1) 7.3% (n=12) were not aware of their ages; 2) 10.3% (n=17) were in early childbearing ages of 19 to 24 years; 3) almost half 49.1% (n=81) were between 25 and 35 years and one third 33.2% (n=56) were over 35 years old. The information suggests that over half of the women 55% (n=91) who discontinued contraceptives were between 31 and 62 years

old. The over 50 year old women participated because they were married several times. However, this study did not focus on the ages at which participants discontinued the first or subsequent FP methods.

Male participants' age distribution was: 1) 4.9% (n=5) were unable to recall their ages; 2) 1% (n=1) was 22 years old; over one quarter, 28% (n=29) were between 25 and 35 years; slightly over a third, 35% (n=36) were between 36 and 45 years old and close to a third, 31.1% (n= 32) were between 46 and 70 years (Table 2).

Table 2

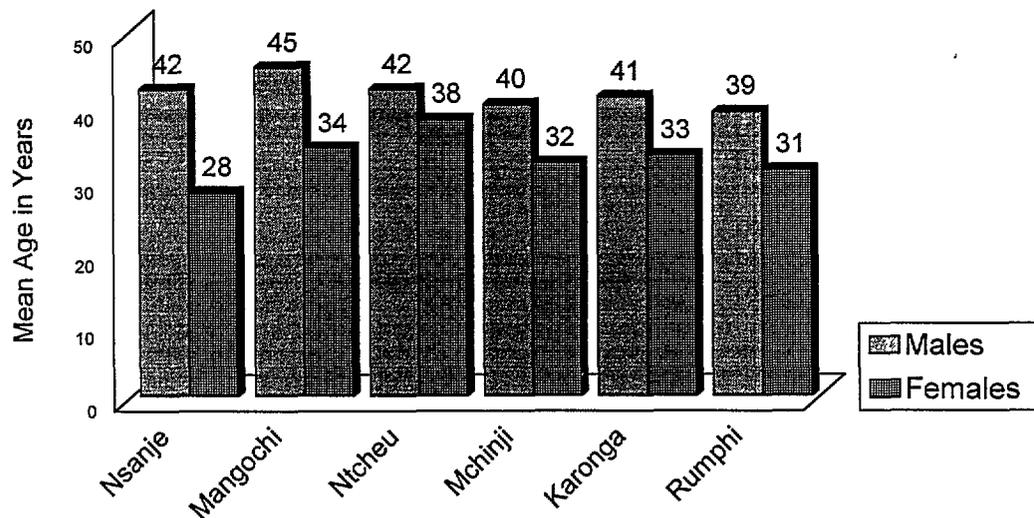
Age of Participants

Age Group	Females (N = 165)	% of Females	Males (N = 103)	% of Males
Not Known	12	7.3	5	4.9
19-24 years	17	10.3	1	1
25-30 years	45	27.3	13	12.6
31-35 years	36	21.8	16	15.5
36-40 years	38	23.1	18	17.5
41-45 years	6	3.6	18	17.5
46-50 years	8	4.8	14	13.6
51-70 years	3	1.8	18	17.5
Total	165	100	103	100

Mean Age Differences

Figure 1

Mean Age of Study Participants:
Differences by Gender and Study Site



The mean age for women was 32 years with a standard deviation of 7.4; mean age for men was 41 years, and a standard deviation of 9.2. An analysis of variance (ANOVA) was used to determine if there were age differences in men and women by study sites. Also, a Post Hoc analysis using Scheffe test with a significance level set at .05 identified which study sites had participants with significant age differences.

Mean age differences in females and males were calculated separately, and are presented above, (Figure 1, p.7). Women from Nsanje (mean age 28 years) and Rumphi (mean age 30.8 years) were significantly younger than women from Ntcheu (mean age 37.8 years), $F = 5.66$, $DF (5)$, $p < .001$. There were no age differences among men from all sites studied.

There may be partial evidence to explain age differences among female participants. Some men from Nsanje and Rumphi tended to marry more than one wife, and among the Co-wives, some were young. In Rumphi, women also have high levels of education and this seems to have contributed to their early use of modern contraceptives.

Except for women from the Henga Valley (Mhujju and Phwezi in Rumphi) other women from Bolero area also in Rumphi, reported starting to use contraceptives when they were young couples. Families in Ntcheu were typically monogamous. Women from Ntcheu reported feeling the pressure when one wife started to manage a large family as the number of her children grew. This seems to have contributed the reason women from Ntcheu delayed in using contraceptives.

Educational Background

The MKAPH study demonstrated a linear positive relationship between education and the use of contraceptives in Malawi (NSO, 1996). Education was expected to account for differences in fertility preferences, communication about contraceptive decision-making and support in use of contraceptives. However, results varied.

Table 3

Educational Levels of Study Participants

Educational level	Females (N = 165)	% of Females	Males (N = 103)	% of Males
No formal school	28	17	11	10.7
Primary 1-5 years	47	28.5	20	19.4
Primary 6-8 years	68	41.2	42	40.8
Junior Secondary	10	6.1	15	14.6
Senior Secondary	9	5.5	12	11.7
Adult literacy	3	1.7	0	0
University	0	0	1	1
Vocational training	0	0	2	1.9
Total	165	100	103	100

More than three quarters of all participants had formal education. More men than women attained secondary school education. More men than women had formal education. Of the women, 17% (n=28) had no formal education compared to their male counterparts 10.7% (n=11). These findings compare favourably with the current trend of education in Malawi (DHS, 1992). Eighty-three percent of women (n=137) and 89% of men (n=92) had attained formal education (Table 3, p.8).

Education by Study Site and Gender

Table 4

Percentage of Women with Formal Education:
Differences by Study Site (N= 165)

Years of school	No Formal Education	Primary School (1-5 years)	Secondary Primary (6-8 years)	Junior Secondary School	Senior Secondary School
Nsanje	43	34	4	10	0
Mangochi	18	17	19	20	22
Ntcheu	25	26	8	0	22
Mchinji	7	6	28	10	12
Karonga	7	6	19	0	22
Rumphi	0	11	22	60	22

Table 5

Percentage of Men with Formal Education:
Differences by Study Site (N= 103)

Years of school	No Formal Education	Primary School (1-5 years)	Primary School (6-8 years)	Junior Secondary School	Senior Secondary School
Nsanje	18	20	31	7	17
Mangochi	18	25	0	13	0
Ntcheu	27	45	17	13	8
Mchinji	18	0	26	33	17
Karonga	18	10	9	20	25
Rumphi	0	0	17	13	33

Education for female participants varied significantly; 43% (n=14) of females with no formal education and 34% (n= 11) with one to five years of junior primary school were from Nsanje. By contrast, 60% (n=17) of females with Junior secondary education were from Rumphi. These findings are significantly different; Chi-square = 66.5, (DF) 20, p<.001. Women from Rumphi attained the highest level of formal education while women from Nsanje attained the lowest level of formal education.

The differences in education for females are in line with the country's demographic characteristics which record that a high percentage of women with more education are from Rumphu.

Responding to why women in Nsanje did not pursue further with formal education, participants identified four limitations that: 1) girls frequently fall pregnant while in school; 2) girls get married early; 3) once married, women do not control family earnings; and 4) women do not assist their parents financially without seeking the approval from their husbands. Since parents perceive that girls have no decision-making power, they do not feel obliged or consider it rewarding to invest in the education of their girls.

For male participants' educational attainments, there were also statistically significant differences. Twenty-seven percent (n= 6) of men without formal education and 45% (n= 10) with only one to five years or junior primary school were from Ntcheu. All male participants from Rumphu had attained primary school education of six to eight years or more. These findings were significantly different, Chi-square = 39.2, (DF)20, p<.0. The findings are also similar to the trend in education for males in the country which demonstrate that many men from the northern region (including Rumphu) are more educated than men from central and southern regions.

Occupation of Male and Female Participants

With the exception of five women who are teachers and HSAs, all female participants reported that they were housewives. The breakdown of occupations for the 165 female participants was the following: 1) 44% (n= 73) housewives; 2) 35% (n= 58) farmers; 3) 8% (n= 13) small scale businesses; 4) 7% (n= 12) no occupations; 5) 2% (n= 4) doing other things; 6) 2% (n= 3) teachers and 1% (n= 2) HSAs.

Occupation for male participants was not very different from that reported by women except in a few categories. More than half of the men, 53% (n= 56) were farmers, 4.9% (n=5) fishermen, 8% (n= 8) businessmen mostly selling fish, 5% (n=5) each teachers and HSAs; 4% (n= 4) watchmen, 2% (n= 2) policemen, 2% (n= 2) no occupations and 16% (n= 16) doing other things.

Religion

There were two categories of religion and one group with no religion for both female and male participants. For the female participants, 82% (n= 135) were Christians and 12% (n= 10) Moslems. The other group comprises 6% (n= 10) who reported having no religion. For males; 90% (n= 92) were Christians, 5% (n= 5) Moslems and 5% (n= 5) reported no religion. The denominations represented in both samples of women and men are; Roman Catholics, Protestants (Church of Central African Presbyterian), Seventh Day Adventists, Church of Christ, Assemblies of God,

Anglicans and others. There were no religious values reported that directly influenced the use and discontinuation of modern contraceptives.

Marital Status

Many participants were married. Of the 165 women, 91% (n= 150) were married and 9% (n= 15) were not married. Of the 150 who were married, 73% (n= 110) were in monogamous marriages and 27% (n= 40) were not. Women were married for an average of 12 years with a standard deviation of 7.2 years.

Table 6

Number and Percentage of Times Women were Married (N = 165)

Study Site	Married once	%	Married twice	%	Married 3 or more	%
Nsanje	20	16.8	10	25	3	50
Mangochi	18	15.1	13	32.5	0	0
Ntcheu	21	17.6	5	12.5	0	0
Mchinji	22	18.5	4	10	0	0
Karonga	17	14.3	3	7.5	1	16.7
Rumphhi	21	17.6	5	12.5	2	33.3
Total	119	100	40	100	6	100

Table 7

Number and Percentage of Times Men had Married (N = 103)

Study Site	Married once	%	Married twice	%	Married 3 or more	%
Nsanje	10	15.4	9	34.6	4	33.3
Mangochi	5	7.7	4	15.4	0	0
Ntcheu	18	27.7	3	11.5	0	0
Mchinji	16	24.6	3	11.5	1	8.3
Karonga	7	10.8	3	11.5	6	50
Rumphhi	9	13.8	4	15.4	2	33.3
Total	65	100	26	100	12	100

Women who were not in monogamous relationships stated that their husbands have one or two other wives. More women from the southern region sites were married for two or more times. Of these, 25% (n=10) from Nsanje, 32.5% (n= 13) from

Mangochi were married for the second time. Of the women married for the third time, 50% (n=3) were from Nsanje (Table 6, p.11). The 27% (n=40) of women who were in polygamous marriages reported having one to three Co-wives.

Many men were married too. Of the 103 men, 63% (n= 65) married once only; 25% (n =26) married two times and 12% (n =12) married more than two times (see Table 7, p.11). Further, 68% (n = 70) of the married men still had their first wives and, 32% (n= 33) did not.

Of the men who did not have their first wives, 21% (n=7) reported their wives to have died; 42% (n= 14) divorced their wives; 6% (n= 2) divorced and returned to their wives; and 30% (n = 10) married other women without divorcing their first wives so from time to time the men would just come and ask their previous wives to have children by them. Women who reported this experience said they decided to get married after they were deserted by their former husbands. Even with the knowledge that the women were also married the insisted not to have divorced them so they claimed their rights as husbands. This behaviour was frequently reported in Nsanje where men tended to disappeared to Mozambique and after months or a year came back to claim their wives.

Men who were still married to their first wives had been married for an average period of 15 years and a standard deviation of 7.6 years.

A statistically significant difference was observed in the number of times men married; Chi-square, 24.2, DF(10), $p < .01$. A majority of from Ntcheu 27.7% (n =18) married once only and of the men who married more than two times, 50% (n= 6) were from Karonga (see Table 7, p.11).

CONTRACEPTIVE DECISION-MAKING.

Conceptualization of Contraceptive Decision-Making

Contraceptive decision-making refers to the cognitive processes and behavioral actions influencing individuals to use, sustain the use of or discontinue using modern contraceptives. The contraceptive decision-making process was explored from two perspectives. First, the study examined reasons influencing families or individual women to use modern contraceptives and what exactly happens in the process of making such decisions. Secondly, the study focused on the context within which women experienced and discontinued contraceptive methods. All women were asked how and why they started to use modern contraceptives; men participating in concurrent sessions were asked how and why their wives used and discontinued modern contraceptives.

Although Malawi is a very traditional society, due to the current socioeconomic changes and developments occurring in the country, it was hypothesized that husbands and their wives would be fully and equally involved in making contraceptive decisions. The results partially support this hypothesis.

Women reported experiencing problems communicating with husbands their intent to use modern contraceptives. The determinants of the difficulty in the communication process varied from one site to the other. Some of the difficulties women reported experiencing occurred because; 1) women reported that some of their husbands had already prohibited their wives from using contraceptive methods; 2) contraceptive use is associated with promiscuity so that women who wanted to use the FP services for a good cause reported having a dilemma in even suggesting using contraceptives to their husbands; 3) women also reported that they considered the opportunity cost of using contraceptives versus that of not using them, and they reported having a hard time deciding. Two of the costs which many women reported to have seriously considered were their reproductive capacity (for fear of infertility) and, how their husbands would interpret their wife's use of contraceptives. In sites where men customarily marry more than one wife, women feared that if they had a few children and became infertile from using modern contraceptives, their husbands will marry other women.

Throughout the discussions and in all sites, the concern for women in their contraceptive decision-making was fear. Apart from the fear emanating from lack of concrete knowledge about the effects of different modern contraceptives and that individuals respond differently to a method, women reported fearing: 1) how to break through and talk convincingly to their husbands that their intent for using contraceptives was for a good cause; 2) what the husband's expected response was going to be especially for women whose husbands had already stated their position about using modern contraceptives; 3) how women, despite their husbands' position, wanted to use contraceptives without arousing suspicion in their husbands; and, 4) how women would live with the consequences if their husbands eventually discovered that their wives used FP methods despite being prohibited from doing so.

Variations in contraceptive decision-making were noted and attributed to: 1) men's perception of their role in reproductive decisions; 2) how women perceive the amount of control they have over their reproductive capacity and responsibility; 3) the amount of determination in women taking the risk of making the decisions to use modern contraceptives or initiating some dialogue with their husbands to start using modern contraceptives; and 4) the nature of family relationships and the number of times women were married.

The decision-making process is presented in the following sequence: 1) factors influencing contraceptive decision-making; 2) the process of making decisions; 3) individuals participating in contraceptive decision-making; and 4) models of contraceptive decision making.

Factors Influencing Contraceptive Decision-Making

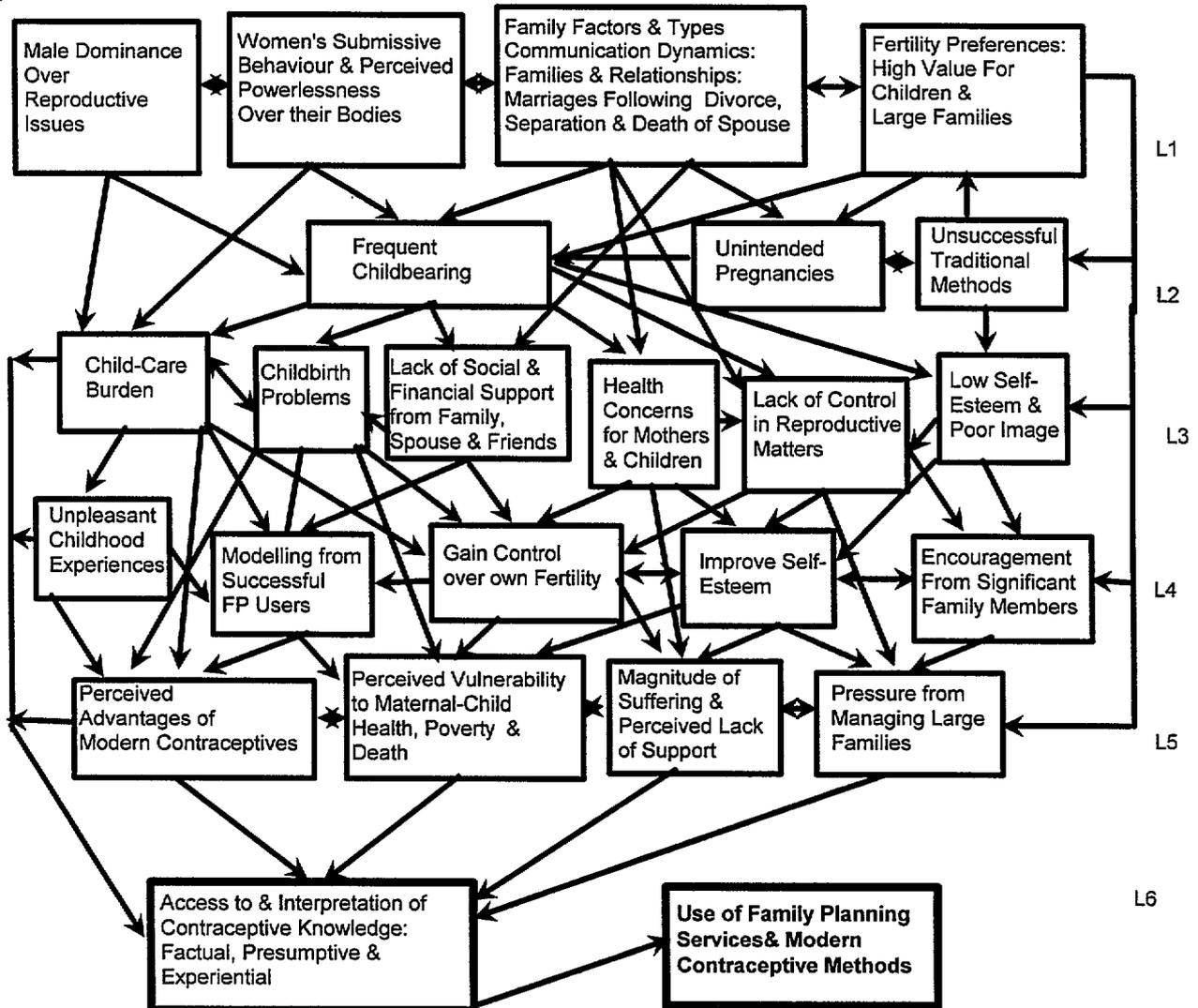
Factors emerging from this data were classified in six groups and identified by levels (see Figure 2, p.15) Some factors positively and or negatively influenced contraceptive decision-making. Also, individuals were directly or indirectly influenced by single or multiple factors from all levels as shown in the figure 2.

- Level 1.** Dominant traditional values and fertility practices.
- Level 2.** Effects of the dominant factors (traditional values and fertility practices).
- Level 3.** Problems resulting from frequent childbearing, unintended pregnancies and failed traditional contraceptive methods.
- Level 4.** Driving forces influencing women and men to seek assistance to space their children.
- Level 5.** Perceived dangers of not acting (Perceived vulnerability)
- Level 6.** Seeking, interpreting and using information about contraceptives and family planning services.

There are two parallels to the contraceptive decision-making. Women entered the process from an experiential perspective while men entered it from an influential perspective. Women and men crossed their power boundaries. Some women reported doing this knowingly and stating that they had no other alternatives.

Figure 2

**Factors Influencing Contraceptive Decision-Making Among Women
Discontinuing Modern Contraceptives in Rural Areas of Malawi.**



- Levels of factors are shown at the right hand side of the figure.
- Arrowheads indicate the direction of relationships participants described
- Double headed arrows indicate a dual relationship.

Definitions of the levels

Each level is designated by a letter and number. Levels one to six are identified as L1, L2, L3, L4, L5, and L6.

L1. Dominant Traditional Values and Fertility Practices

Dominant factors are characteristic values, beliefs and traditional practices affecting reproductive decisions which women and men reported from all the six sites. Figure 2 shows that at L1, there are four factors: 1) male dominance over reproductive issues; 2) women's submissive behaviour; 3) family factors and communication dynamics; and, 4) fertility preferences and practices characterized by the participants' high value for children and large families. At the first level men exhibited influential power in all horizontal relationships of the factors (Influential Perspective for men).

L2. Effects of Dominant Factors (Effects of Traditional Values and Fertility Practices)

Level two is the beginning of the descriptions of what women experienced resulting from the interactions of the four dominant factors from level one. The focus for women begins to shift at this level because of the experiences they encountered. From their descriptions, three immediate effects emerged which are: 1) unsuccessful traditional methods; 2) unintended pregnancies and 3) frequent childbearing (Female Experiential Perspective unfolds).

L3. Problems Associated with Frequent Child Bearing

At this level participants described problems resulting from frequent childbearing, unintended pregnancies, and unsuccessful use of traditional contraceptives. Some of these problems were also linked directly with factors from level one. The interaction of level one factors explained some differences in the magnitude within which women experienced the problems at the third level. For the third level the problems were: 1) low self-esteem and poor image of the wife; 2) lack of control in reproductive affairs; 3) health concerns for the mother and children; 4) lack of social and financial support from families, and spouse; 5) childbearing complications; and, 6) child-care burden.

L4. Driving Forces Prompting Women and Men to Seek Assistance

Driving forces which both men and women described, prompted them to act and reduce their burdens and any unpleasant situation they found themselves in because of the cumulative effects of the interaction among selected factors from the first three levels. The effects of the combination of factors from the first three levels which enabled individuals to consider changing their situations differed by families, individuals and by the perceived benefits of changing their existing situations. These drives were: 1) encouragement from

significant family members; 2) improving self esteem; 3) gaining control over their own fertility (mainly women); 4) emulating the ideal situation from successful users of FP services; and, 5) preventing a repetition of their personal unpleasant childhood experiences

L5. Determinants of Action and Perceived Consequences of not Acting

At this level, participants described how much suffering they had already endured by having the difficult situations they were in. Others described how much suffering they will undergo if they do not use modern contraceptives. In this category participants identified these: 1) pressure from managing large families; 2) the magnitude of suffering in the absence of support; 3) perceived vulnerability to ill health, poverty and death; and, 4) perceived advantages of contraceptive use versus non use.

L6. Seeking and Using Knowledge about Modern Contraceptives

Participants who already had the knowledge applied it by accessing family planning services in their areas. Participants reported their sources of contraceptive knowledge as health institutions, media, friends, family and community members and personal experiences. To access the services, individuals considered the distance they were from the health institution offering these services and the attitude of providers. Other people chose private clinics but the majority used government health institutions such as health centres and district hospitals.

Description of the Relationship of the Determinants of Contraceptive Decision-Making

Level One Factors

1. Male Dominance over Reproductive Issues.

In the discussions, many men affirmed their superiority in reproductive decisions and expressed discontent when women acted differently from traditional decision-making expectations. Men reported being responsible for making reproductive and other decisions for their families. In Karonga, some men wanted to be informed about modern contraceptives at the time family planning was introduced in Malawi. They expected the knowledge about modern contraceptives to supplement deficiencies in their reproductive decisions, thus enabling them to make better decisions over their wife's contraceptive use.

Some men were of the impression that since women are not expected to make reproductive decisions; and men are heads of their households; men should have accessed the knowledge on contraceptives before their wives did. In so doing, they would decide whether or not their wives can use modern contraceptives. Men expected the acquisition of contraceptive

knowledge to have expanded their role in reproductive decision-making and empowering them to take control of all reproductive decisions including contraceptive decisions. This thinking was mainly from men from Karonga and the Henga Valley of Rumphu.

Despite women having accessed information on modern contraceptives first, they reported having difficulties informing their husbands about their desire to use a method unless previously they used FP services and discontinued them. However, when men accessed the contraceptive information first and justified its suitability for their families, they informed their wives without hesitation to start using modern contraceptives. Wives accepted to use contraceptives without any problems or questions. Male dominance resulted in men having many children from several wives or many children from one wife. With many children, both men and women reported experiencing pressure. Between men and women, women reported to have had intense pressure on daily basis. Male dominance was portrayed differently in the different sites. The following behaviours suggest these differences.

a) Discouraging Women from Using Modern Contraceptives

Men reported discouraging their wives from using modern contraceptives for fear of encouraging them to be promiscuous. This was a big concern in men from Karonga, the Henga Valley of Rumphu, Mangochi and Nsanje. Discouraging women from using modern contraceptives was more of an issue in the four sites mentioned above than in Ntcheu and Mchinji. Some women reported accepting their husband's suggestions for a while but later used contraceptives. Others, whose husbands prohibited them from using FP services despite the burdens women experienced, did not wait at all but reported to have started using FP services immediately without their husband's knowledge (crossing traditional decision-making boundaries). However, when found, they reported to have been in serious trouble such as being threatened with divorce.

b) Encouraging Women to Use Modern Contraceptives Under Stipulated Conditions Set by the Husbands

In Mchinji, many men reported allowing their wives to use modern contraceptives. However, almost all of the responses showed that husbands informed their wives that they only allowed them to use contraceptives but had not granted them the opportunity to be promiscuous.

In Mchinji, there was one unique example of male dominance reported by one woman. She reported having forgotten her contraceptive pills when she left home temporarily to be a guardian to her sick sister at a district hospital. On her return, she informed the husband about the problem. She reported that her husband shouted at her using abusive

language and informed her that if she becomes pregnant he will not be held accountable yet he was having unprotected sexual relations with his wife; and, he could not use condoms knowing very well that his wife was not protected. Within a month, the woman was pregnant and the man refused being responsible. The wife was accused of infidelity; and her husband alleged that, while his wife was looking after her sick sister at the hospital, she was also having sexual relations with other men. The husband refused to listen to any explanation from his wife and she reported being evicted from the house. However, the wife reported that she refused to go anywhere and insisted on staying despite the eviction. She reported being verbally abused but she opted to stand the abuse than go any where else. After confronting her husband a number of times, her husband accepted her back and she was then three months pregnant.

c) Husbands' Desire for More Children or Specific Gender of a Child

Despite the knowledge and access to family planning services, some women reported accepting to fall pregnant in order to save their marriages. Women reported being threatened with a divorce if they were unable to bear more children. Also, when a woman was unable to give birth to children of the desired sex, her husband married another wife in the hopes that the other woman could bear him children of the desired sex. More than two women reported to have been divorced for this reason.

d) Power Imbalance over Reproductive Decisions

Women from Karonga, Nsanje and Rumphu expressed the concern that their husbands were prohibiting them from using modern contraceptives. Examples were cited where women reported having many children; were recovering from a life threatening childbirth experience; and, wanted to stop having children but their husbands wanted more children. Other women were motivated to use modern contraceptives because they were caring for many children from different marriages. Even with these reasons, some husbands insisted on having more children and did not want to hear that their wives were using modern contraceptives.

A woman from Nsanje said, I have seven children from my former husband and three from my current husband. He also has some children from his former wife. After three children from me he does not want me to use any contraceptives because he wants us to have more children. He says he has made it clear to me and he does not want to hear anything about contraceptives. He does not even show any interest in looking after the children. How does he expect me to do all that alone?

(Nsanje Southern Region Interview/FGD, July-Aug., 1997)

Some men reported deliberately prohibiting their wives from using modern contraceptives as a mechanism for monitoring their wives' sexual activities. The husbands also believe that by restricting the use of contraceptives, they are assured that their wives will preserve their chastity. Should the women have sexual relations elsewhere, and in the absence of contraceptive use, they will be pregnant and husbands will know the truth about their wife's sexual behaviour.

Women were concerned with this reasoning because they reported being aware of their husbands' indulgence in extramarital affairs or marrying other women but, had difficulties confronting their husbands. Rather than confronting their husbands, some women started using modern contraceptives secretly. This was reported frequently in Nsanje, Karonga and Rumphu and to a small degree in the other sites.

2. Women's Submissive Behaviour

Despite the knowledge about modern contraceptives women had known for a long time, some reported keeping this information before sharing it with their spouses for as long as five years. Their reasons for not sharing the information seem to be related to the sense of insecurity. Fear of being divorced or being accused of infidelity were the two reasons women feared. Women who were divorced before, those on separation and women whose husbands died but were beginning new relationships reported high levels of insecurity. Women acknowledged having difficulties in introducing family planning matters in a new relationship when men wanted more children.

a) Accepting Continuous Childbearing to Secure a Re-Marriage

Women who were married again, regardless of the number of children they had from the previous relationships, reported that their new husbands were expecting to have children too (Men's Influential Perspective). Women also reported submitting to their new husbands' wishes even when they wanted no more children for fear losing their second chance in marriage. The marriage would occur on condition that the woman will have children by the new husband. Women reported that the condition set for the marriage to occur made them feel powerless yet they wanted to be married.

Inevitably, they had unintended pregnancies; delivered frequently; experienced financial and other pressures; and risked their health. The extra children were reported to have been the responsibility of the women. Many women reported that their husbands were proving no or little assistance for the care of the children from different families resulting in child-care burden. Eventually, when women were pressured by the new husbands' negligence, they reported to have crossed the boundaries, go against the conditions set and started to

use modern contraceptives with or without the consent of their husbands (Women's Experiential Perspective).

b) **Submitting to Gratifying Early Sexual Demands from Husband after Childbirth**

Some women reported to have received pressure from their husbands to resume sexual intercourse after child birth before the period traditionally accepted which varies from four to eight months in the sites studied. Women in these situations reported feeling too embarrassed to consult family members concerning their husbands' nagging requests for the sake of protecting their husbands' reputation in the extended family. Women reported losing control over their own bodies; and powerless; because their husbands were familiar with the expected sexual practices after childbirth. Some women said that they felt that their husbands owned their wives. Although unwilling, but to please their husbands and prevent unintended pregnancies, women reported using modern contraceptives and keeping this secret from other family members.

c) **Young Women Accepting to be Married to Older Men**

For various reasons, in Nsanje, Rumphu and Karonga, young women accepted to be married to older men as third or fourth wives. Some of them reported not able to assert themselves and refuse this type of relationship. Some young women reported that they were advised by their relatives because older men were experienced in life and would therefore give them the security that young men cannot give. A 19 year woman was married to a 70 year old man. The young woman discontinued contraceptives because of pregnancy and she confided in one of the members that somebody else was responsible for the pregnancy. However she stated that she finds it difficult to leave.

3. Family Factors and Dynamics.

a) **Types of Families**

There were six versions of families reported among the participants and, some of them were characterized by a state of impermanence. The variations were: 1) husband, wife and their children; 2) husband wife with children from the man's previous marriage or woman's previous marriage and children born from the new relationship; 3) husband, with two to four wives and more than 15 children; 4) a woman with children born from different fathers; 5) a woman with children born from one husband; and, 6) husband, wife their children and orphans from deceased relatives.

In some female headed households, women reported that it was easy for a woman to decide and use modern contraceptives if she has: a large family; is sexually active but not committed to marriage or one partner; and, does not want any more children.

The impact of these family units on the use of contraceptives was both positive and negative. The positive effects were that if the family resources did not sustain large families, women reported that they suggested to their husbands for them to use of contraceptives. The negative aspect was that if a woman was previously using modern contraceptives, the new husband requested her to stop using contraceptives because he wanted children by her (Influential Perceptive). Further consequences from these were unintended pregnancies and frequent child bearing and child-care burden.

b) Polygamy and Extramarital Affairs.

Polygamy is traditionally accepted in three of the sites studied; Nsanje, Karonga and Rumphu. Women from these areas reported experiencing problems discussing contraceptive decisions with a spouse when he was moving from one wife's house to another. Men tended to have many children from their wives and each woman is responsible for looking after her own children unless the man is very wealthy. The constant absence of a husband from a household, created opportunities where women opted to use modern contraceptives without the husbands noticing. This was frequently reported in Karonga, Nsanje and Rumphu.

Only a few cases of polygamy were reported in Mangochi and Ntcheu but there were many reports of extramarital relationships. In Mangochi, some women also reported that they extramarital relationships. They justified their behaviour by a lack of sexual gratification from their husbands. Women described their husbands as being sexually inconsiderate, impatient and only concerned with their own sexual gratification and not the wife's. Some women therefore reported going out and seeking men to satisfy their unmet sexual needs. Women who reported having extramarital relations also reported using modern contraceptives to prevent unintended pregnancies.

c) Divorces, Separations and Death of Spouse

A number of divorces and separations were reported from Nsanje and Mangochi (see Tales 6 and 7, p.11) but a small number of men and women also reported being widowed. After death of a spouse, separation or divorce, the participants anticipated getting married for a second or third time. They also anticipated having children with each

new partner regardless of how many other children the man or woman had. This negatively impacted on women's use of modern contraceptives, and increased their probability of ill health from frequent childbearing, childcare burden and inadequate social support and support from the husband.

d) Reproductive History.

The actual fertility prompted women to use modern contraceptives. Some women who had miscarriages or whose children died, reported finding no good reason for them to use modern contraceptives. Nearly one third of the 165 women (32%) had one to three abortions; and, 17% delivered still born babies. More than half of the women (59%) reported deaths of children due to malaria, unknown causes, diarrhoea, anaemia, fever and witchcraft. Following these losses, many women reported conceiving pregnancies within three to six months. The women's responses to their losses seem suggest that their primary motivation for using modern contraceptive methods is to prevent untimely pregnancies. Other advantages of family planning such as promoting their own health and welfare or contributing to the socioeconomic development of the nation (MOHP & NFWC, 1996) are secondary if recognized or considered at all.

e) Discussion regarding Using Modern Contraceptives

Information from the participants seemed to suggest that there was no real substantial discussion concerning the use of modern contraceptives and family planning. Discussions tended to be limited to one person directing the partner in family planning issues and the responses were minimal. Apart from the discussions concerning family planning, in their daily undertakings, the style of communication reported was not through discussions and negotiations. Rather, both men and women reported having communicated by giving each other information while the other party listened.

Within this context of communication, women expressed feeling uneasy to discuss family planning matters because they perceive their role in decision-making to be a subordinate one. Only when women felt it was necessary to use modern contraceptives, did they inform their husbands of their intentions to use modern contraceptives.

As can be inferred from the information, women or families used modern contraceptives in a reactive way or as an intervention to solve pregnancy and childbirth problems they encountered.

4. Fertility Preferences (High Value for Children and Large Families)

A large majority of rural Malawians desire large families. However, with some education and socioeconomic developments, it was hypothesized that families, even those from the rural areas would desire smaller families. The results from this study do not support this hypothesis.

a) Value for Children

Participants reported marrying to have children who will provide future security and ongoing assistance to their parents. From their worldview, such a responsibility could not be achieved by a few children.

Generally, there was a tendency for males to prefer more sons than daughters and females to prefer both boys and girls in equal numbers. But, women from Nsanje, Karonga and Rumphu tended to prefer boys whom they valued highly because they were considered usefulness to their parents. In these three sites, parents reported valuing boy to girls because when boys marry, they remain at their parents' home. Also; because boys are decision makers in the family, that makes it easy for boys to assist their parents without seeking the approval of their wives.

Often when there are children of the same sex, parental needs are not met. Couples continue to bear children in the hopes of balancing the gender among their children. The implication however, is a delay in seeking modern contraceptives. Instead, they first seek traditional medicines to avert the problem. The woman's relatives in collaboration with the husband's relatives look for another woman who also has a similar problem but with children of the opposite sex. Once found, both women exchange traditional medicinal strings which they tied around their waists. The ritual signifies exchanging luck to the other woman so that she can bear children of the intended sex. The charm is reported to reverse the individual's misfortune of having children of similar sex. This is traditionally called "*Kutembenuza Mphapo*" (*Chichewa*).

Should this traditional method fail these desperate parents, they keep trying in hopes that they will have the type of children the family desires. Consequently resulting in frequent child bearing and child-care burden.

b) Value for a Large Family

Participants' definition of small families includes parents/parent with one to four children and large families comprise parents/ parent with seven or more children. Of the two family sizes, participants identified the family with four children as the ideal. Despite the stated ideal, more than half of the women (56%) had six to seven children. When asked to explain the discrepancy in what they believe in and what they practice, most respondents explained that four children are ideal

because that is what family planning providers advocate for and, it is easy to care for. In reality though many participants reported desiring large families but that they are constrained because of their limited resources.

Respondents were aware of the advantages of small families from the context of parental care and support. They easily described the advantages of small families such as: 1) adequacy of provisions from parents; 2) the ease for parents to maintain their children in a healthy state; 3) ease in educating a few children. The definition of a small family seemed to mean different things to different participants particularly women despite the known advantages. A small family means that: 1) the parents are still young and have not yet completed their families; 2) the family has childbearing problems; 3) parents started having their children late in their lives; and, 4) parents have less problems. Of these interpretations of a small family, only one was related to the advantages the participants mentioned earlier. These responses seem to suggest that a complete family ought to be large.

The meaning of a large family was almost consistent in many responses. To the majority of the participants it meant that the parents are having a hard time managing many children; others interpreted that the parents were rich to afford looking after many and specific examples were cited of large families where most of the children are educated and independent.

The conceptual definition of small and large families has great implications on whether or not women can use contraceptives early in their child bearing phase; and, sustain the use of modern contraceptives to have only a few children. In addition it also explains why some women start to use modern contraceptives later in their childbearing period.

Women in one FGD also described the disadvantage of starting modern contraceptives early in the child bearing age. They believe that modern contraceptives cause infertility. One young lady who was about 20 years old shared her experience using modern contraceptives before she had her ideal number of children. This young lady experiences represent what many women and men believe contraceptives do.

The young couple in Nsanje used Depo-Provera after the first child. The husband and wife decided to use contraceptives against the wishes of the woman's mother. After two years from birth of the first child, the woman has not conceived another pregnancy, she was being interviewed when her son was almost three years old. The husband is a working class man. The couple has been desperately trying to conceive another pregnancy without success. The husband has now

asked for a divorce, and he informed his wife that he will marry someone else to have children with. He also informed his mother in-law the same thing. His wife (the interviewee) reported feeling guilty and angry for using a contraceptive injection. Her mother was extremely angered by this event (daughter was unable to conceive a pregnancy). This triad of husband, wife and mother in-law) considered procreation as the primary purpose of a marriage. The wife reported to have felt cheated according to her interpretation of the husband and her mother's reaction, she considered herself not good enough for her mother and her husband.

The following quote conveys the reaction of the mother to the situation when she responded to her son in-law

My daughter was capable of bearing you children. You told her to start using contraceptives against my wish. After one child, she cannot bear children anymore and you want to send her back to me. Of what use will she be to me and other men if she cannot have children or when other men cannot marry her because they will know that she can not bear children?

(Nsanje, Southern Region Interview/FGD, July-Aug., 1997)

c) Family Dynamics: Communication about Fertility

Both men and women reported not discussing their fertility preferences. Discussing preferences before or soon after marrying was described as something one would not even consider thinking about. Participants perceive child bearing as an expectation for married people therefore, an inevitable expectation. Newly married couples want to prove their masculinity and femininity. Men from Nsanje mentioned special circumstances when they discuss numbers of children they desire, 1) after bearing several children and they are alive; 2) when couples are unable to have children; 3) if the family has children of the same sex; and, 4) if men are re-marrying. Men from Nsanje attributed these discussions to frustration and dissatisfaction with the children they have or do not have; or, when they are in a financial crisis. They however cautioned that discussions of the nature mentioned are very rare. Typically many participants do not discuss the number of children they desire and most of those who participated in this study did not discuss this issue. This quote illustrates how they justify their reason for not discussing the issue.

How can we discuss the numbers of children or their sexes as if we are with God or we can negotiate with God to give us the children we want? How do you plan for something you have no control over?
(Nsanje, Southern Region Interview/FGD, July-Aug., 1997)

d) Actual Fertility Beliefs and Practices.

Despite participants' knowledge of problems associated with managing large families, many families were large. Parents believe that children are important for the services they provide to them. Since in their perception, these needs could only be met by several children, it is difficult for them to imagine any advantages to having small numbers. The high infant and child mortality rates also motivate individuals to have large families.

Despite believing in the small numbers of four, participants reported having medium to large families. Women and men were still contemplating having more children if they were to have new relationships. More than half of the women reported having had five to twelve pregnancies. Some of the participants had between one to thirteen children. The average number of children born per family in these sites was five and the average number of children alive per family was four.

Husbands and wives from all sites asserted that they have the sole responsibility of deciding the numbers of children they want. This was also reported in the Namate & Kornfield study, (1997). Asked why there is this departure from the traditional practice where other members of the family participated in deciding the number of children a married couple had or where others dictated terms for the married couple, participants alluded the change in the trend to its social and economic impracticality.

Participants shared problems they experience in bringing up their children especially in feeding, clothing and educating them. They asserted that since other people did not assist them to bring up many children, individuals outside the house cannot dictate the terms for childbearing to them. From the participants' perspective, issues warranting the involvement of other family members such as ,in-laws; aunts; uncles; grandmothers; brothers; and sisters, are mostly related to infertility.

Men and women tended to talk with friends about their children's education; welfare; behaviour; and, other issues related to children except the numbers they desire to have. They feared witchcraft, that someone who does not wish them well can take advantage of that knowledge and cast evil spells on the family.

The Importance of Level One Factors

Level 1 factors are the core factors that could make a difference in contraceptive use and health promotion and health maintenance if many programmes were targeted at breaking the attitudes and practices at that level. All the four factors were consistently dominant in all sites. Although participants, talked of the advantages of small families, their fertility practices show otherwise. This may suggest that, 1) either individuals still do not understand at what point to implement the idea of family planning; 2) they understand it but the traditional values are so strong and disabling that individuals resist to change their attitudes; or 3) they understand but there might be inadequate tangible evidence to provide them the security that (a) if they have a small family, their children will survive despite the high incidence of infant mortality rate; (b) they are assured of alternate future social security so that they do not depend on meeting those needs by having many children, and (c) if there are short term, medium term and long term advantages of family planning strategically planned so that rural communities can work toward achieving.

All sites gave evidence of indicators showing a lack of planning for family sizes and lack of awareness about children's basic needs for love, security belonging, health, education and many more. Such needs cannot be met when children are too many to give affection to. If 56% of the women in this study had 5 to 10 children, and this is happening after they have been informed about family planning for a long time, this may suggest that families do not understand the risks they take in childbearing until they experience them. That is the reason why it is important for them to understand why they need reliable and sustainable family planning methods as young individuals, hence the importance of emphasizing the advantages of family planning to younger individuals in the rural areas.

Women seemed aware of the risks or complications arising from having many children but took them lightly. This was manifested greatly in those who re-married yet submitted to having other children despite the large number they already have. Women who seemed to have understood the negative implications of delivering many children have done so through experience. These women are not the ones who need the factual knowledge because they have experienced it. Practicing family planning after an individual has seven to ten children does not reflect the ideals of family planning. To these individuals, starting to use FP services after they have seven or more children seems like having a face lift or may suggest desperate attempts of preventing causes of death in women associated with excessive childbearing. These individuals are certainly not practising family planning and it is too late for three quarters of the participants in this study to enjoy and appreciate the full benefits of having small families.

Level Two Factors: Immediate Effects of Level 1 Dominant Factors

1. **Unsuccessful Use of Traditional Methods of Contraception**

A few women and men reported to have been frustrated because of failed traditional methods resulting in unplanned pregnancies. Such couples reported seeking information from their friends before attending FP services. With some word of encouragement from their friends they started to use modern contraceptives.

We discussed after six children and agreed to stop using traditional family planning medicines for modern contraceptives because my wife fell pregnant while using them. After the failures, we decided to try modern contraceptives.

(Mchinji, Central Region Interview/FGD, July-Aug., 1997)

2. **Unintended Pregnancies**

Many unintended pregnancies occurred due to male dominance over reproductive issues and female submission to the dominance. This occurred when a man insisted on having children with every wife they marry and wife accepting to be pregnant to secure her marriage even if she wanted no more children.

a) **Method Failure**

Less than ten men reported that their wives used modern contraceptives because of negative experiences from the past. Some women were breast feeding and had a late return of their menstrual periods after child birth. These women were reported to have been pregnant while breast feeding and before the return of their menstrual periods. To prevent this from happening again, the women use modern contraceptive methods.

We discussed the number of children I wanted but did not agree on numbers. My wife fell pregnant very often because she was not having her periods in between pregnancies. she had so many unexpected pregnancies. Because of this, we discussed and decided to use FP methods, both of us agreed.

(Mchinji, Central Region Interview/FGD, July-Aug., 1997)

3. **Frequent Child Bearing and Effects**

The ordeal of child bearing had an impact on all the women who used modern family planning methods. A high percentage of responses on the reasons for using modern contraceptives from almost every site were attributed to the effects of frequent births. Most women reported

multidimensional effects of frequent child bearing which could not be reduced to one. On average, women reported conceiving and delivering every year for three to four years. Thereafter, they spaced for a year and sometimes two years. Women described the effects of this frequent child birth in relation to how their general health, social life, productivity, sense of personal control, sexual life and self esteem were affected. These examples present the multidimensional effects of frequent childbirth:

The first year I had a baby, the following year I had another one. Before the second born was one year old, I got pregnant with the third born. During this third pregnancy, I started to reflect on the family planning methods I heard about at the clinics. I told my husband that I wanted to start using FP methods. He refused because he wanted me to have many children. I told him that I was the one experiencing the problems of caring for many dependent children. When I go to the hospital or market, how should I carry them? Should I put one on my shoulders and one on my belly? After all, you do not show any interest in assisting with the children. I went to the clinic and when FP provider asked me if my husband had consented to my using a modern contraceptive method I said "NO" I am the one needing of the services, not him. I told her that my husband does not take the children to all his chores and place of work, I do it On that basis I was given a method.
(Nsanje, Southern Region Interview/FGD, July-Aug., 1997)

Since I started child bearing, I have never rested at all. I deliver every year and I have delivered nine children. I am tired of child bearing and I want to rest
(Naumo nili kuyambira kubaba nindaimirepo nkhuti chaka mwana, chaka mwana, ndipo nababa chomene, nababa bana naini.
(Karonga, Northern Region Interview/FGD, July-Aug., 1997)

I had no real problem except that I started child bearing at a very young age. I have delivered many children now I want to rest
(Karonga, Northern Region Interview/FGD, July-Aug., 1997)

I had been giving birth almost every year. Many times I became pregnant before the other child was a year old. I delivered five children and started using FP methods after the fifth which was a twin delivery. Going through this experience made me realize that we could not manage to space our children using traditional methods as was the case with all my previous pregnancies. My other children became malnourished, we could not afford to provide for all their needs, we were even ashamed to go to the market.
(Mchinji, Central Region Interview/FGD, July-Aug., 1997)

Level Three Factors: Problems Associated with Frequent Child Bearing

1. Esteem factors

Some men reported that their wives started to use modern contraceptives because of poor self image. From the women's point of view, factors which affected their self esteem were: 1) having many children; 2) looking unkempt;

3) conceiving pregnancies at the same time when their daughters were also in active child bearing made them feel bad. Some women reported deciding to use modern contraceptives because they felt bad about the way they looked, or their husbands remarked about how old their wives appeared. Other women asked their best friends to verify whether their husbands were telling them the truth. Others reported comparing themselves with their friends and confirmed what their husbands told them (looking old). These remarks prompted the women to start using modern contraceptives.

Some men reported seeing their wives who once looked beautiful and strong were now looking older and less attractive because of frequent childbirth and having no time to rest and look after themselves.

2. Perceived Lack Control on Reproductive Matters

With problems and issues women presented, it was hypothesized that many women would feel the urge to control the changes they wanted to make in their lives. Contrary to the expectations, this hypothesis was only partially supported.

a) Internal Control

In some circumstances for example when women perceived that they :1) had suffered much through negative childbirth experiences; 2) lacked spousal support; 3) had child-care burden; 4) were providing for the children; 5) felt abused by their spouses; and, 6) felt the need to rest from child birth, reported believing that they are responsible to change the situation for themselves. These women showed a strong internal locus of control and started modern contraceptives despite counter forces outside of them. They sought modern contraceptive methods with or without the consent of their spouses. They said that they believe they have a problem and they have to do something about it regardless of what the husband said, did or felt. These empowered women who decided on their own to start using modern contraceptives were usually those who had suffered through many experiences or want to take control of their live.

b) Lack of Control

The second group comprised women who, despite the problems of child-care burden and ill health they experienced, tended to expect someone to validate their feelings. The power to persuade and the determination to use modern contraceptives was lacking in them. This group of women tended to dependent on their spouses to validate what they wanted to do. Seventy-five percent of the 21 women who participated in the in-depth interviews (N=15) felt they had no power to delay the next birth if they wanted to because of their husband's wishes. These women stated that they would act if their husbands told

them to start or stop using contraceptives. The feelings expressed by this second group clearly demonstrate the women's belief in male dominance and female powerlessness on reproductive decisions.

3. Physical Health Concerns of Mother and Child

Women reported that the frequent illnesses between pregnancies often make them feel tired. Even when women were sick they had to care for their families. They reported of pushing themselves to work; of being uninterested in what was happening and consequently the results were often non productive. This was also of concern to their families. Children's ill health, especially diarrhoeal diseases and malnutrition, and frequent child death all prompted parents to use modern contraceptives. Women wanted more time to recover and regain their strength before conceiving other pregnancies, and as parents they wanted ample time to care for their children before another pregnancy.

*When I was pregnant, I started to cough from the second to seventh month of pregnancy. I even advised my husband to marry a second wife because of my ill health. Later I heard about family planning at the under fives clinic. When I came back from the clinic, I told my husband about this information and he agreed. I further told my parents and they also agreed because they remembered how I suffered during the previous pregnancy. The whole discussion between me, my husband and parents took one week.
(Ntcheu, Central Region Interview/FGD, July-Aug., 1997)*

a) Maternal Ill Health

Women reported that they started modern contraceptives due to ill health during pregnancy and after delivery. Fifty percent of the women from Karonga (n=10) and 44% of women from Nsanje (n=14) reported this reason. The health problems women experienced were anaemia, high blood pressure, heart palpitations and general weakness.

Women from all sites reported having heart palpitations and anaemia. Some women also reported suffering from the effects of losing much blood at delivery and thereafter feeling excessively tired. Due to the suffering and general fatigue, other women reported being unable to cope with early and continuous sexual demands from their husbands. To prevent early and unintended pregnancy; gain time to recover fully from the ordeal of previous birth and child care; and meet the sexual demands from their husbands and women reported commencing family planning methods.

b) Poor Child Health and Frequent Childhood Deaths

Women reported being eager to see their children healthy. The most common child health problem was malnutrition. Child malnutrition was not a phenomenon reported for the northern region, but, only the

central and southern regions. IN order of their frequencies, malnutrition was reported in Mchinji, seconded by Nsanje; then, Ntcheu and lastly Mangochi. Although women expressed the desire for healthy children, this is a delayed concern because they were responding to already existing problems.

Women from Mchinji reported living in poverty and their husbands drinking beer excessively. Their men sell many agricultural products and earn adequate amounts of money. However, their money is usually spent on excessive beer drinking. Women complained of lacking financial support from their husbands, and lacking money for food. Mothers attributed their children's malnutrition to a combination of factors; their lacking money because of their husbands' money spending habits and living in poverty.

From Nsanje, a concerned father who has three wives reported this:

After birth of this baby, we abstained from sexual intercourse for six months until our parents came to perform traditional rites called "pyade" Sena word. Our children were frequently malnourished and my wife's health was going down. I told my wife to go and start using some contraceptives. I heard this at the hospital and also in health committee meetings because I am a chief. I wanted no more children and I informed my wife who refused in case I divorce her and she will have another husband and would like children by him
(Nsanje, Southern Region Interview/FGD, July-Aug., 1997)

4. Social Support

It was hypothesized that individuals living in the rural area receive social support from other family members because of collective reproductive decision-making. Data from this study partially supported that

a) Lack of Support from Relatives

Both husbands and wives acknowledged the lack of social and child support from their relatives. Those who reported being pressured to have many children justified using modern contraceptives because they know that they will be responsible financially and materially for their children. The following quote represents lack of social support.

I had no problems with the spacing of my first four children; it just happened naturally. However, after the fifth pregnancy which occurred in 1990 when my youngest child was only one year old, I had problems looking after two young children. I come from Zambia, and I am concerned that if I continue having more children and suppose my husband divorces me, there will be no one to assist me with the care of these children. My mother and father in-law do not regard my children as their real grandchildren. They say their

grandchildren are those from their daughters and not sons (ana anga ndi njere za zumba (therere), adzukulu anga ndi ana a ana anga a akazi, osakhala a amuna ai (Chichewa). While I was thinking of what to do, I heard about childspacing at the under fives clinic. I went home and told my husband about the available services and he agreed immediately. I also shared the information with my friend and sister in-law. My sister in-law discouraged me saying that I will have complications because pills accumulate in the abdomen. (Mchinji, Central Region Interview/FGD, July-Aug., 1997)

b) Positive Support from Husband

Two aspects of spousal support were reported which prompted women to use modern contraceptives. In the first type, men were reported to have been supportive of the woman's decision to use modern contraceptives. Secondly, some men took the initiative to decide that their wives start using modern contraceptives. This type of support was not available to many women.

c) Lack of Support from Husband

The other group reported having husbands who were not supportive and who neglected child care. Some women stated having received very little support from their husbands regarding child care. Because of this, women on their own, or, in consultation with their spouses, started to use modern contraceptives. If a woman's suggestion to use modern contraceptives was not approved by her spouse, she started on a method secretly.

In Mangochi, Nsanje and Karonga, women described how they suffered following a divorce or how they were neglected by their husbands. They decided to use contraceptive methods following these events. Women from Mangochi and Nsanje reported continuing being sexually active after divorce. To avoid undesired pregnancies, they used modern contraceptives. By using contraceptive methods they felt protected and were sure that their irresponsible sexual partners would not have the opportunity of having children without providing support for their upbringing.

In contrast, women from Ntcheu, Mchinji and Rumphu who did not experience divorce to such a great extent, reported lacking support from the husbands because of the husbands' indulgence in excessive beer drinking. A second type of abandonment and lack of support was reported from some women from Mangochi who had out-of wedlock pregnancies. These women reported being abandoned by the fathers of their babies. However, they reported still being sexually active to fulfill their unmet sexual desires but were using modern contraceptives to prevent pregnancy and consequences of lack of child support.

I am a divorcee. For some time I did not use any contraceptives so I became pregnant by a non committed man. He deserted me as soon as I was pregnant and since that time, I have no one to support me. I could not go for ante-natal care due to poverty. When I delivered my baby, I was very poor, I had no cloth for my self and the baby. From this experience, I pledged not to have another child by any other man, but because I was still sexually active, I went to the clinic for contraceptives

(Mangochi, Southern Region Interview/FGD, July-Aug., 1997)

d) Financial Problems

Men reported having financial problems which influenced their decisions to allow or suggest to their wives to start using modern contraceptives. They shared the difficulties they experienced in clothing, feeding and educating their children. Among the problems men from Mchinji and Ntcheu faced were finding adequate customary land to their grown up daughters for cultivation.

My wife and I discussed the number of children we should have after the fifth child in 1992. I advised her because I have eight daughters who need gardens and we do not have enough land to give each one of them. Because of this, we agreed to start using modern contraceptives.

(Ntcheu, Central Region Interview/FGD, July-Aug., 1997)

My wife was pregnant when our child was one and half years old, was still breast feeding, we had no helper; and, the child was weaned at one and a half years. My greatest problem was in care of our child and taking the child to the hospital when my wife was very pregnant. We had financial problems and I thought this would affect the mother and baby. I wanted only two children and wanted to plan for them too. However, I have discovered that preparations for a child are very expensive.

(Nsanje, Southern Region Interview/FGD, July-Aug., 1997)

I started thinking about childspacing in 1991 after I had three children having had financial constraints. The money we had was inadequate for our family needs and for buying fertilizer. At this time, there were no FP services at our nearest health centre until 1994. I heard about family planning from my aunt who motivated me to start. I then talked to my husband about it and he agreed with no problem but we had to wait until 1994 when childspacing services started at this clinic.

(Mchinji, Central Region Interview/FGD, July-Aug., 1997)

5. Childbirth Experiences and Pregnancy Complications

Many women reported having started using modern contraceptives following complications they experienced during pregnancy; labour and delivery; and, after child birth. Specifically, they mentioned suffering from anaemia, high blood pressure and lack of energy during pregnancy. During labour and

delivery women also suffered from; 1) anaemia, 2) high blood pressure; 3) difficult and long labours; 4) lack of energy in labour; 5), difficult deliveries; 6) delivery with the assistance of an operation; and, 6) heavy bleeding after giving birth.

Some women reported being advised by nurse-midwives to use modern contraceptives depending on the problems they had at delivery. Some men reported being afraid that their wives could die from childbirth if they continued bearing children and experiencing those problems. The problems women experienced affected some men to extent that some men assisted with activities in the home.. With evident problems such as the ones mentioned, women reported having no problems discussing with their husbands to use contraceptives methods and usually receive adequate support.

Men also reported similar reasons related to childbirth problems. In Ntcheu, Mchinji and Nsanje, men reported their wives started using modern contraceptives because of ill health and loss of vitality resulting from complications during pregnancy; frequent childbirth; and, excessive blood loss following delivery. Others reported that their wives had delivered by operation. Because of these problems, men saw it necessary to initiate or support their wives through FP methods. A few quotes were selected to illustrate what women experienced.

We discussed the issue of family planning after my wife experienced some problems, with the fifth and sixth pregnancy. When my wife was seven months pregnant with our fifth born child, she became unconscious. People informed the chief that my wife was dead. However, after some time, we noticed that the baby was alive, we rushed her to the hospital where she received treatment and was all right My wife became unconscious again with the sixth pregnancy. On this ground we discussed family planning and she started to use a modern contraceptive method
(Mchinji, Central Region Interview/FGD, July-Aug., 1997)

My wife lost a lot of blood during delivery. This was not a normal delivery as we know it but a miscarriage at eight months. She suffered a lot following the loss and she bled heavily such that she became very weak. After this experience we sought contraceptive services at the clinic to help her rest
(Ntcheu, Central Region Interview/FGD, July-Aug., 1997)

I had problems at my fist delivery because my baby was born dead. A few months later I conceived another pregnancy. Later I felt that I did not have to go to that labourward every year. I had no financial problems but I was constantly afraid that I might deliver another dead baby or lose the baby after birth. My husband suggested that I should start modern contraceptives. I accepted the suggestion immediately. No other relative was involved in the decision making
(Rumphi, Northern Region Interview/FGD, July-Aug., 1997)

There were variations in the number of problems participants reported from the sites. Three of the six sites reported more problems related to pregnancy and childbirth complications than the other three. Fifty-five percent of the women from Ntcheu (N=14), 78% of the women from Karonga (N=16) and 58% of the women from Rumphu (N=16) reported to have started using contraceptives because of pregnancy related problems. The proportions of women mentioning these problems was high in these three sites compared with that from Nsanje, Mangochi and Mchinji.

These variations could partially be explained by differences in the proximity to a district hospital or health centre some participants were and their health seeking behaviour. Women who reported experiencing more problems were living far from a large health care facility especially those from Ntcheu, Karonga and Rumphu and also were reluctant to use these facilities for care during pregnancy.

In Ntcheu, participants were drawn from Bilila area which is far from the district hospital. Women from this area reported being reluctant each time they were referred to a district hospital because it was expensive for them. In Rumphu, especially around the Henga valley (around Mhujju Health center) and Phwezi area women also reported problems getting to the district hospital. Women from Karonga particularly Kaporo and surrounding neighbourhood tended to prefer using traditional birth attendants (TBAs) for care during pregnancy and at child birth and some of them reported living far from the district hospital. In Mangochi and Nsanje, women participating included those who were living within reach of the main hospital. For Mchinji, participants were drawn from Tembwe area which has a good referral system to Mchinji district hospital.

Complications of child bearing resulted from frequent child bearing. These in turn affected the women's perception of the quality and amount of social support they receive from spouses and family members in relation to their health and child-care burden.

6. Child-Care Burden

Child-care burden, a frequently reported phenomenon by most women was described from a multidimensional perspective. Women described child-care burden within the context of; 1) frequent births; 2) large families; 3) divorce; 4) non committal family relationships; 5) inadequate social support for the children either due to (a) unsupportive social habits of the husband (b) poor financial management such as when husband spends money on beer drinking and neglecting to buy food for the children; 6) children born out-of wedlock; 7) a transient family unit; and 8) living in a state of poverty.

With frequent child bearing, women reported having no time to recover from the ordeal of pregnancy and; experiencing problems of caring for too many

dependent children; lacking free time; managing with few material and financial resources; lacking social support for the children. Some of the care-burden women experience arises from the lack of cohesive family unit; accommodating extra responsibility in caring for extra children who are from more than one family (orphans or children brought from previous marriages). Accordingly, most women reported having being overburdened, and feeling low about themselves (low self-esteem) and having a feeling of helplessness (lack of personal control). Women who were knowledgeable about modern contraceptives reported seeking family planning services.

The proportion of responses on child-care burden were similar for both men and women. However, men and women had different perspectives of child-care burden. Sixty-seven percent of the women (N=110) compared with 32% of the men (N=33) associated child-care burden with closely spaced children. Also the proportion of responses on diseases and number of children families had were different for men and women.

The context for the child-care burden differed among the sites studied. Besides the frequent births, women from Nsanje, Mangochi, and Karonga reported having experienced this care burden because of divorce and non committed husbands or men who fathered their children. Compared to the other sites, Mangochi reported more responses on divorce 28% (N=8) than Nsanje 21% (N=7) and Karonga 11% (N=2).

The information suggests that men and women from these districts may have normalized the impermanence of family units. It was not very unusual to hear men and women talking about replacing partners as if it is such a simple thing to do. Women as well as men described an end to one marriage relationship as the beginning of another. In Mchinji and Ntcheu sites, in addition to the frequent child births, women also described experiencing child-care burden because their husbands drink beer very much and spend the money on beers than on buying food for the family.

Several quotes illustrate the influence child-care burden has on men and women and their decision to use modern contraceptives.

We have seven children and there is no one to help me with caré. I have no time to do other things because of these children. They frequently get sick from diarrhoea and other diseases and we do not have enough money to look after them.

(Mchinji, Central Region Interview/FGD, July-Aug., 1997)

We have many children. My parents are all dead and there is no one to assist us with child-care. The responsibility of looking after these children is too much for me and as a result the children are suffering a lot

(Mchinji, Central Region Interview/FGD, July-Aug., 1997)

After I delivered my seventh born child I had no peace of mind. I had other young children, I had no time to rest but worked all the time. There was no one to help me with all the work including child care. My children frequently

fall ill. I abstained from having sexual intercourse with my husband for one year but I experienced great problems containing his sexual desires. When I went to the clinic with my seventh born, I heard about family planning. It sounded like this information was about me. I had experienced everything they talked about, such as problems looking after my children, having little food and no money to sustain such a large family.

(Nsanje, Southern Region Interview/FGD, July-Aug., 1997)

I fathered a child while I was at a primary school. Before I completed school, I had two children. I had financial problems. I heard about family planning while at school and I appreciated its importance. I wanted to have a few children so that I could take care of them. My wife had problems at delivery, our children were born close together and they also fell ill often.

(Mchinji, Central Region Interview/FGD, July-Aug., 1997)

My wife told me that she wanted to use modern contraceptives because we have many children and they are suffering. I only have one brother, my parents died a long time ago. My children have no grandparents so the responsibility is all mine therefore, I feel very helpless. My wife informed me about spacing, I agreed immediately. We talked in our house, we had no problems or differences of opinion. No one was consulted, they all know and no one would change our minds because we have decided this together. (Husbands' supportive role).

(Nsanje, Southern Region Interview/FGD, July-Aug., 1997)

I started because I wanted to have a few children, at least five because we have limited money and other things. We have problems feeding and meeting the needs of our children. My husband is a teacher. He had six children from his first wife and I have three by him, together we now have nine children in the home. I heard about childspacing at the hospital. I came back and informed my husband and he agreed immediately. My husband and I went back to the hospital together for assistance. No one else was involved and I started a method.

(Karonga, Northern Region Interview/FGD, July-Aug., 1997)

Level Four Factors: Driving Forces Prompting Women to Seek Assistance

1. Encouragement From Influential Family Members

A few members reported having started to use modern contraceptives after receiving encouragement from family members who lived far and they communicated by phone or in writing. The women verified every information they were told at the clinic with their relations mostly sisters. Three women in this study started because their sisters confirmed that it is important for them to use modern contraceptives. The sisters even suggested the types of methods for the participants to use.

2. Improve Self-esteem

Women who were younger and already feeling drained out; those whose husbands commented on their unkempt look wanted to improve their image. They reported having talked with their friends who encouraged them to space their children by using modern contraceptives.

3. Desire to Control Own Fertility

Some men learned the problem of fending for large families out of observing what other families go through. They wanted to avoid re-living their friends' experiences. These individuals believe that using modern family planning methods would help them avoid those problems. However, often their intentions were thwarted by their lack of proper timing for spacing their children. This is an example of a husband and wife who discussed the use of contraceptives based on other people's problems.

When we had children of our own, we became sensitive to other people's suffering. By this time we had our three children. We got scared by just seeing how other peoples' children were suffering, lacking food, clothing, good houses and women looking shabby. This instilled some fears in us. We did not know how to survive if we ended up like them. We now have seven children and want to stop at that number. Unfortunately we have not found a suitable contraceptive method yet.

(Ntcheu, Central Region Interview/FGD, July-Aug., 1997)

The wish to gain control of fertility was also reported from women who, are in polygamous marriages and receive little support from their husbands; and, in women who want to enterprise in different businesses.

4. Modeling from Previous Successful Users

Some women and their husbands reported to have started using modern contraceptives after observing what close friends were doing. This was very apparent in women who came from the same villages. If their friends had no complications and felt happy about the methods, the tendency was for the prospective users to ask for the same method.

5. Avoid Unpleasant Childhood Experiences

Some men reported coming from large families and remembered very well how their parents worked all day long to find food and clothing for the children. A number of men who identified with this problem came from families of eight or more children. They reported seeing their brothers and sisters who were unable to attend school because their parents could not afford to do so. Based on their own lived experiences, they sought ways of not re-living similar experiences and started using modern contraceptives

I come from a large family and my parents did not send us all to school. I could see the kinds of problems they were facing and I wanted to avoid that. After our third born child died, we started to have conflicts in the family. Relatives and other people accused me and implicated me in the death of this child. They said I was very promiscuous. I decided to stop at child number four because I could see this leading into problems like my parents faced because I knew that later, I will be accused of witchcraft.
(Ntcheu, Central Region Interview/FGD, July-Aug., 1997)

Level Five Factors: Determinants of Action (Perceived Consequences of not Acting)

1. Pressure from Managing Large Families

Women reported feeling pressured if they were divorced, had many children and were re-marrying someone who also had children. Some women reported being married to men already having from three to eight children while the women had three to four children of their own. Despite the already mentioned burden, the new husbands wanted at least four children from the new marriage. The women reported to have seen this as a very unrealistic expectation therefore suggested using modern contraception.

We discussed the number of children. I think it is important to have a few children. I have eight children in Balaka whose mother died. Here I had eight but two died and six are alive. So I have had 16 children in total and 14 are alive. My wife has one child from her previous marriage. Because my wife told me that the six children were all she could handle, we started family planning methods.

(Ntcheu, Central Region Interview/FGD, July-Aug., 1997)

2. Magnitude of Suffering

The context of suffering was described on the basis of women's physical health following childbirth, child-care support, childhood diseases and the number of children women had. Some women who were in polygamous relationships associated suffering with the absence of a constant husband in the home. Others associated it with both physical and emotional abuse. Women who reported negative experiences in most all these areas reported their desperation to use modern contraceptives even in the absence of their husbands' support.

3. Perceived Vulnerability to Maternal and Child Ill Health.

Women were motivated to seek FP services when they realized that they had just overcome a life threatening experience. Many women reported how close they were to death and realized how susceptible they are to dying from continued childbirth. Women whose childbearing experiences were not life threatening but very difficult recollected the amount of their suffering through

their childbearing and reported wanting to rest adequately before they were ready to go through the process once more.

Some women who reported child malnutrition and had the insight to its prevention, were convinced about using modern contraceptives. Women whose main issue was child-care burden and felt fatigued also reported to have been convinced to use modern contraceptives. Many participants reported that frequent childbearing and inadequate resources resulted in child malnutrition and frequent illness which could result in death of their children.

4. Perceived Advantages of Modern Contraceptives and Clinic Factors

In most of the discussions women reported that they actually decided to use modern contraceptives when they learned that their problems will be solved. In addition, they also considered the type of clinic and what other users said about the care providers. In most sites except two, women had heard encouraging news about the service provision. They also considered the frequency of using these services. In five sites (except Mchinji) were also encouraged when they learnt that there were contraceptive methods one receives three monthly.

L 6. Seeking and Using Knowledge about Modern Contraceptives.

Accessing Contraceptive Knowledge

At this level women sought knowledge on contraceptives or actively reflected on the knowledge they already had. There were three types of knowledge identified which women used in deciding to use modern contraceptives, 1) factual; 2) presumptive and, 3) experiential. This knowledge also facilitated women's discontinuation of contraceptives.

Types of Knowledge

1. Factual Knowledge about Contraceptives and Contraception.

From their reports, women gained factual knowledge about contraceptive methods, their effects and side effects from care providers in different settings or through the media. Almost all female participants from the six sites had knowledge of the types of contraceptives offered at their clinics. They reported their source of information as the ante-natal, under-fives and out-patient clinics; friends and female family members. In addition, they were encouraged by HSAs from the Community Based Distribution programmes to remember and utilize the existing family planning services.

After my seventh born child, I had no peace of mind. I had very young children, had no time to work, had no helper. My children got sick very often. I stayed for one year without having sex with my husband and it was difficult to

contain his sexual desires. I heard about child spacing when I went with my seventh born to the under fives clinic. It seemed like the talk was meant for me because we had problems looking after the children; there was little food; and, no money for all the children

(Ntcheu, Central Region Interview/FGD, July-Aug., 1997)

Men expressed their lack of knowledge in family planning methods and placed themselves at a disadvantage to offering support to their wives. In Karonga, men felt excluded and blamed the way family planning was introduced targeting women only in Malawi. This feeling of exclusion could probably explain why some of them in this site forbade their wives to use FP methods; did not support them when they experienced adverse side effects; and, did not encourage them to start using modern contraceptive methods as early as possible.

2. Presumptive knowledge

This type of knowledge is formed from the information which was almost fully unsubstantiated. Simply, this arose from rumours or myths about the adverse effects of modern contraceptives. A list of the presumed effects have been presented under "Women's experiences using contraceptives". The importance of this knowledge was its negative influence on women's and men's options they made. This information also aroused fear in clients about particular methods. The Knowledge provided women with preconceived ideas about types of contraceptive methods they would or would not select based on how they perceive the adverse effects to be. The data on presumptive knowledge shows that individuals have heard more about Depo-Provera and Oral Contraceptive Pills (OCPs) and condoms and not the other methods.

3. Experiential knowledge

Experiential knowledge is the knowledge women obtained from their lived experiences using modern contraceptives or information men and women learned after seeing or witnessing other individuals' contraceptive use experiences. In this study, experiential knowledge was established from women's lived experiences. Two mechanisms were reported through which this knowledge was acquired. The first was from the women's actual experiences of having used modern contraceptives before and the positive or adverse effects experienced. Husbands reported relating to this knowledge because of the positive or negative experiences they saw in their wives.

For example, husbands reported to have been happy when unplanned pregnancies did not occur. Secondly, when wives experienced extreme side effects from contraceptive methods, some husbands were greatly involved in household chores. Reports of men assisting with household chores were from central and southern regions. Experiential knowledge assisted women decide to use previously used methods or start different ones.

The second way of obtaining experiential knowledge is through what women observe or witness in other women who use modern contraceptives (for example whether or not they had positive effects). Women and men gave vivid narrations illustrating the positive and adverse side effects they observed in others. This has formed part of their knowledge base about modern contraceptives. This was a very powerful source of knowledge for those who lived these experiences.

Women reported their ability to delay or prevent pregnancies occurring as positive aspects of using modern contraceptives. They also reported that they had time to regain strength after childbirth and were able to enjoy sexual relations with their husbands for a long time and without the fear of pregnancy.

On a negative note, women described life threatening personal and other women's experiences resulting from using modern contraceptives. Some women reported that an acquaintance almost bled to death because of some contraceptive injections she had received. The women demonstrated the need to understand the cause of this phenomenon, and they seemed not to get satisfying explanations from their clinics. Some did not even attempt to seek explanations because they were forewarned by the care providers about the expected changes in their cycles.

From a focus group discussion in Nsanje, women described a woman who bled severely due to Depo-Provera. Her clothes were soaked in blood and she could hardly walk to the river to wash them. Every day she was carried to the river to wash. This quote illustrates how women interpreted this woman's experience.

This woman lives not far from here (the chief's house). We all know her and five people in this group have seen her. After receiving several injections, she started to bleed heavily every day. She became so weak that she could not walk without support. It became difficult for her relatives to clean her at home. They took her to the river every day to wash. When they lay her in the water, the whole area became red with her blood as if someone had slaughtered an animal. Women abandoned going to this area to wash or draw water.

(Nsanje, Southern Region Interview/FGD, July-Aug., 1997)

In Ntcheu, a woman described a heart breaking lived experience of how she thought she could have died from heavy bleeding after she received a contraceptive injection twice, and how she improved after she voluntarily discontinued using the method. In this interview, she told a story of how she noted that she was bleeding abnormally; how she went back and forth from the clinic as if she had no sense of integrity; how she believes that her health was compromised due to the bleeding; and, what strategies the family used to cope with the dilemma.

This woman reported having stopped doing anything at home; being in a dilemma explaining to her children what she was suffering from; how the husband took her sleeping mat and blankets to wash at night when no one could see what was happening; how her husband gave her a bath only at night to prevent the children from seeing what was happening; how she lost weight significantly; how she could not socialize with her friends neither could she go to church. Church people ministered to her at home. In his description, the woman's husband described how he perceives his wife to have suffered because of the injection, how miserable and pale she looked because of excessive bleeding. Fortunately this woman and her husband walked to the interview venue to tell their stories and were hopeful that something better will be done to make the experiences bearable.

Having considered the three types of knowledge women and men were exposed to and on the basis of why they wanted to use modern contraceptives, clients used different aspects of the knowledge base or ignored others and selected a method of their choice.

For the purpose of comparing responses between spouses, a sub-sample of the total, the in-depth interview sample of 43 individuals which had more paired couples was compared on the reasons why these families used modern contraceptives. Because this was a one to one interview, it was easy to identify patterns of communication in the family than in the focus group discussions

Table 8

Reasons for Using Modern Contraceptives: A Comparison of Responses from Women and Men Participating in In-depth Interviews (N = 43)

Reason	Females (N =21)	Males (N = 22)
Financial problems	48	59
Childcare burden	43	41
Frequent births	67	32
Maternal ill health	38	18
Had many children	24	32
Child diseases & death	19	36
Esteem problems	14	9
Childbirth problems	33	32
Overwhelming responsibility	0	18
Early sexual demands by husband	10	0
Failed traditional methods	0	9
Wanted healthy children	0	14

It is interesting to note the differences in reasons between husbands' and wife's responses. The responses were given by 20 couples and three individuals who did not bring their spouses to the interview. The responses suggest that men and women differed in the way they related to their use of modern contraceptives.

Comparisons of the responses given by men and women (see Table 8, p.45) seem to suggest that men were more focused on the economic and health advantages of family planning while women were focusing on the child-care burden, personal and health benefits of modern contraceptive methods. These differences give support to the observation made on contraceptive decision-making that men use an influential perspective while women use an experiential perspective during the process of making decisions for contraceptive use.

Husbands and wives had similar responses on child-care burden, pregnancy and child birth complications in relation to how these three factors influenced them to use modern contraceptives. Also, there were similarities as well as differences not in the areas but by the weight placed on the other reasons. Men were more likely to report that in their families they used modern contraceptives because of financial and childhood diseases or death of their children. By contrast, women were more likely than men to report using modern contraceptives because of closely spaced children, maternal ill health and esteem problems.

It was also interesting to note that only men reported that they supported their wives to use modern contraceptives because they (men) reported having overwhelming responsibilities, their wives experienced method failure from using traditional methods of contraception and they wanted to have healthy children. It is also worth noting that women reported one unique reason which men did not report. Some women stated that they used modern contraceptives because of pressured from their husbands who insisted on resuming sexual relations earlier that is expected when a woman has given birth.

Individuals Involved in Contraceptive Decision-Making

Since men control the reproductive decisions for women in Malawi, it was hypothesized that husbands or sexual partners would be fully involved and supportive in the contraceptive decision-making than any other individuals. Also, because modern contraceptives have not been used in Malawi for as long as traditional methods, it was hypothesized that women would consult other individuals before deciding whether or not to use the modern contraceptives.

The results of this study suggested that men especially from Mangochi, Karonga and a few sections of Rumphi were not fully involved in the decision making process. The second hypothesis was supported. Wives, a few husbands, nurse-midwives or care providers and immediate family members participated in the decision making-process, the differences observed were in the extent to which these individuals participated.

Although most women from Ntcheu, Nsanje and Mchinji decided to use modern contraceptives, they had either talked with their spouses, mothers, sisters, friends and other immediate family members before they started (Figure 3, p.43).

1. Spouses

Except for Mangochi, Karonga and Rumphi, more than half of the women in the other sites talked to their husbands about their intentions to start using modern contraceptives. Many women who talked to their husbands were: 1) 82% (n=21) from Ntcheu; 2) 68% (n= 17) from Mchinji; and 3) 62% (n= 20) from Nsanje. Women felt strongly that after talking and agreeing with their husbands to use modern contraceptives, there is no need to involve other persons. Most women believe that the wife and husband alone deal with the consequences of large numbers and not mothers or other relatives. This corresponds with the CDB data (Kornfield & Banda, 1996) and the condom study (Kornfield and Namate, 1997).

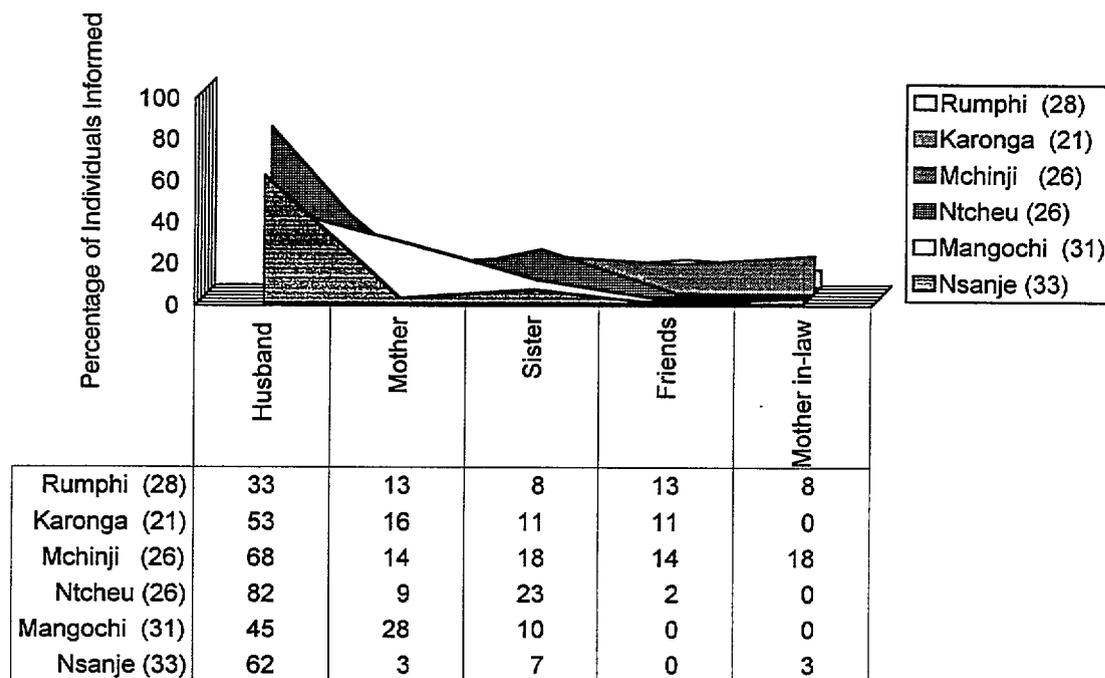
2. Mothers

Less than a third of all women talked to their mothers about their intentions to use modern contraceptive methods. The smallest number of women who confided in their mothers was 3% (n= 1) from Nsanje; and 9% (n= 2) from Ntcheu. Mangochi had the highest proportion of women who informed their mothers 28% (n=9) followed by Karonga with 15% (n= 3) then Mchinji with 14% (n= 3) and Rumphi with 13% (n= 3) (see Figure 3, p.38).

Women who informed their mothers reported to have done so for information in anticipation of any complications arising from the use of contraceptives. Women who did not inform their mothers reported either 1) being afraid that their mothers would discourage them from using the methods, 2) believing it was not necessary; or, 3) mothers live far away and could not be reached.

Figure 3

Communication about Contraceptive Use: Individuals Women Talked to about Modern Contraceptives



3. Sisters

Twenty women reported communicating with their sisters about their intention to use modern contraceptives. Some of the 20 women communicated with their sisters 1) for consultation and support for the decision already made; 2) to validate the family planning information with their sisters; and 3) for information just in case things went wrong. Women who informed their sisters also reported receiving little or no support from their husbands.

4. Friends

Eleven women talked to their friends who had or were using modern contraceptives to obtain experiential knowledge and learn what the current users were experiencing. Others reported being scared from rumours they heard. Consulting friends was a means of verifying the accuracy of the information they have heard.

5. Nurse-midwives

Women who reported talking to nurse-midwives were those who had problems related to child bearing. Nurse-midwives were consulted because of their professional expertise.

6. Others (in-laws)

Only five women from Mchinji, two from Rumphu and one woman from Nsanje reported to have informed their mother and sister in-laws. The communication with in-laws was for some women not voluntarily, but in response to the negative views these in-laws held against the women. Because some in-laws were against the idea, the women communicated to express their feelings and determination to use modern contraceptives.

Models of Contraceptive Decision Making

Four models of contraceptive decision making were identified from this data.

1. **Mother/Wife Driven Model**
2. **Husband/Sexual Partner Driven Model**
3. **Care Provider/Nurse-midwife Driven Model**
4. **Support/ Family Member Driven Model**

1. **Mother/Wife Driven Contraceptive Decision Model**

Women took the initiative to use and sustain the use of modern contraceptives based on their felt needs even though some of their efforts were challenged by their spouses. The data suggests that women went through some cognitive and reflective processes before they started using modern contraceptives. The data suggests that women went through the following cognitive processes.

- a) Collection of information about modern contraceptives.
- b) Analysis of events in their lives that would justify use of contraceptives.
- c) Reflection on the impact of taking such a move and timing for contraceptive use.
- d) Justification of taking action at the point of maximum threshold of personal burdens and use of that as a turning point for action.
- e) Information giving phase.
- f) Initiation of discussion phase.
- g) Consultation and verification of information with others.
- h) Action phase.
- i) Reaction and response phase.

a) ***Collection of Information about Modern Contraceptives.***

As women attended different clinics for pregnancy and child care, they received factual information about modern contraceptives. Some of them interacted with friends who had used these methods before and heard about the successes, failures and rumours related to modern contraceptives. Others referred to their past experiences using modern contraceptives. Some women reported to have heard and not used the contraceptive information for almost five years.

Although most women had access to factual knowledge about modern contraceptives and were empowered by this, they were still not ready to use the knowledge. Their spouses, who are heads of the families, lacked this factual knowledge such that even when the women received FP information early in the child bearing age, the information was of little or limited utility. Some women came home and shared FP information with their husbands; others reported to have kept it to themselves.

b) Analysis of Events in Their Lives that Would Justify Use of Contraceptives

Information about modern contraceptives obtained in different fora was not put to use immediately for many women. Women reported to have decided to act on the knowledge they stored on the basis of their childbearing problems, child-care burden, inadequate social support and economic factors.

I was having children almost every year. My children had frequent illnesses like measles and diarrhoea. I was unable to look after them well. My husband frequently married and he spent more time with other women. I cared for the children single handed. My daughters were also having their own children, so I felt ashamed to continue with childbearing. I had problems of clothing and feeding my children. I had tried traditional methods but they did not work. I remembered the family planning messages from the clinics. I decided to talk to my husband when he came home from his other wives. I explained my problems and he agreed with no problems. So I started.

(Mangochi, Southern Region Interview/FGD, July-Aug., 1997)

My 7th baby was born when my youngest child was one year and eight months old. When I came back from the clinic, I told my husband what I had heard from the clinic, including the FP methods and how this would assist us to rest. My husband agreed immediately because he appreciated how I was suffering with all the chores and the children. We discussed this in one day and no one else was involved

(Nsanje, Southern Region Interview/FGD, July-Aug., 1997)

c) Reflecting on the Impact of Using Modern Contraceptives and the Appropriateness of Timing for Its Use.

Reflection, accepting vulnerability and timing for contraceptive use were the characteristic features during this phase. The process started with women acknowledging the following: 1) their vulnerability to ill health; 2) the increased risks of continued child birth; 3) child-care burden; 4) lack of support they assumed they would receive; and, 5) the financial hardships they were experiencing. Some of them explained that at this point they started processing the family planning information they heard all along. These problems helped women to realize that they needed help.

According to the women's accounts, the phase of accepting that they needed assistance took months or years. Some of them reported to have realized the danger they were in after a near death experience resulting from child birth. Other women indicated they felt a gradual depletion of their physical energy resulting from continued childbirth and lack of time to rest. Others felt it because of neglect from their

husbands who were marrying other women. Only a few realized the positive benefits of modern contraceptives for the good health of the few children they had and their own health. Having realized their vulnerability, they planned to discuss contraceptive options with their husbands, and also indicated their wish to start using a method.

I had attended clinics for various services such as under-five clinics, Ante-natal clinics and even out-patient clinics. In all these clinics, they talked about the advantages of child spacing. I paid no attention about them but each time I came home, I informed my husband and none of us paid any attention.

(Nsanje, Southern Region Interview/FGD, July-Aug., 1997)

When I fell pregnant, my daughter was also pregnant at the same time and we delivered a week apart. Prior to that, the midwives said many unfriendly things about being pregnant at my age. Personally, I even felt that I was slowly losing my energy. All these things were said almost every time I went to the clinic. Only this time did I start to think what a difference it would have made if I had acted on the contraceptive information I heard about for all the past years.

(Ntcheu, Central Region Interview/FGD, July-Aug., 1997)

d) *Justifying Taking Action at the Point of Maximum Threshold of Personal Burdens and Using That as a Turning Point for Action*

Many women reported to have reached a turning point in their lives when they felt they had to do something about their situation. Women reported to have suffered a lot, felt unsupported and overburdened. They also reported to have reached a crisis where they felt it necessary to talk to their spouses about the contraceptive methods they heard about all along. At the point when women felt very low in their lives, they said that they felt compelled to act with or without the support of others. Some of them explained that at this point they started processing the family planning information they had heard about all along to identify how this would help them.

What triggered the crisis for some women was: 1) woman's ill health; 2) financial problems; 3) life threatening childbirth experiences such as excessive bleeding; 4) many children and physical help and 5) pregnancy, many children and sole provider for the family. When women could not handle any of these problems anymore, they perceived that as an opportune time to inform their husbands about modern contraceptives. Other women reported having a few for example three children yet they had other pressing problems such as child-care burden because the children were closely spaced with one year difference among them and were dependent on the mother and required close attention.

A woman whose crisis was triggered by multiple factors shared her experience

*When I carried my 13th pregnancy, I suffered from the fifth month. I felt running out of breath, I could not walk properly, my heart felt like it would leave my chest any time. I could not work at all. My children did all the work at home and run the grocery too. I could not sit in a crowded room. I stayed for nine months without working in my house. When I was about to have the baby, I could not walk. The car came and picked me from the house. I had problems with my labour and delivery. By God's grace, I delivered. Soon after that, I started to think of using family planning methods. I thought to myself, "What am I dying for? I have delivered thirteen times and three of the children are dead, if I continue like this, I might die." I told my husband about my intention to stop childbearing. My husband refused because he wanted me to have another baby. Since that time I decided to do it on my own. He does not know that I started a method
(Rumphi, Northern Region Interview/FGD, July-Aug., 1997)*

e) Information Giving Phase

Women reported sharing information obtained from clinics concerning family planning and modern contraceptives with their husbands but not in terms of its usefulness in their own relationships. It wasn't until families began to feel the pressures and problems associated with large families that this information was utilized and family planning suggested as an actual option for them.

f) Initiation of discussions

In all study sites, women initiated most of the discussions concerning modern contraceptives (see Table 9, p.54). Ntcheu had the greatest percentage of women initiating discussions to start using modern contraceptives. Women from Ntcheu also reported more problems with pregnancies and more problems with Depo-Provera.

A very interesting phenomenon was observed from this data. In Rumphi, fewer women initiated discussions. This could be interpreted as a shared concern for FP issues between husband and wife or that the high education status of participants from Rumphi accorded them the opportunity to equally discuss matters of mutual interest such as family planning.

The following examples illustrate discussions initiated by women.

I lied to my husband that the doctor advised me not to have another child in case I die. When I told him this he said I could go ahead. He was scared because I had mentioned death and he accepted without any further questions but it took him three days before he gave me an

answer. No one else was involved because we take care of the children on our own. No one else helps us.
(Mangochi, Southern Region Interview/FGD, July-Aug., 1997)

Table 9

Percentage of Individuals Initiating
 Contraceptive Discussions

Who Initiated	Nsanje (33)	Mangochi (31)	Ntcheu (26)	Mchinji (26)	Karonga (21)	Rumphu (28)
Wife Initiated	69	72	81	68	78	58
Husband Initiated	7	17	5	18	4	21
Nurse Initiated	21	7	14	9	12	21
Sister/mother	0	3	0	4	6	0
Others Initiated	3	1	0	1	0	0

Most women reported that the discussion did not take long. Once initiated, usually no one else would be involved. Later, relatives might only be informed of a decision that had already been made by the husband and wife.

g) Consultation and Verification of Information with Others

In all sites, some women reported to have used modern contraceptives without the knowledge of their spouses. Either earlier they had talked to their spouses about their intentions and husbands refused or they had not mentioned it at all. A large percentage reporting not to have informed their husbands were from the northern region 33% from Karonga (N=7) and 29% from Rumphu (N=9)

These women reported that they were almost certain that their husbands would insist that they stop using contraceptives. When asked to explain what that meant, they said their husbands wanted many children. With the exception of Mangochi, Karonga and Rumphu, almost all sites had approximately the same proportion of women who decided not to inform their husbands. In the absence of support from the spouse, women reported to have verified with others regarding their decision.

h) Action Phase and Locus of Control

Despite information about the negative consequences of modern contraceptives, women who had experienced problems with their pregnancies or child birth sought modern family planning services and felt strongly about continuing with the services. Women who had discussed with husbands and were supported, reported to have gone to the clinic within days or a week after the agreement.

Women whose husbands or relatives opposed the use of modern contraceptives reported to have made a unilateral decision and used FP services. Once they decided, women went ahead and started using a method which they perceive their husbands would never know about. The majority in this category were from Karonga. This class of women also exhibited an internal locus of control. They described their problems to be real to them and that they were determined to act and succeed.

Example of a Contraceptive Decision Process

An extract of a dialogue of a midwife (*M*), woman (*W*) and her husband (*H*)

- W:* I have been using the clinic in my area for ante-natal, under-five and out-patient clinic care for several years. In most of the talks, I heard about family planning and its advantages. For eight years I was using the same clinic. I started receiving ante-natal care with my third pregnancy and the nurses knew me very well. I had learnt that if a woman has a few children, she can take care of them, educate them and the mother and other children will all be healthy. At this clinic, before we received care, there was a talk about many things and including family planning. Each time I came back from the clinic I told my husband what they said. Usually I would tell him in the evening when we went to bed.
- H:* No wonder you take long before coming home. Who practices family planning? What is wrong with the traditional method you use? Don't just believe in everything they tell you.
- W:* I kept going to the clinics for other services and did not tell my husband anything anymore. When I went to the ante-natal clinic with my eighth pregnancy, the sisters (midwives) asked me whether I had met my daughter who had just left after receiving ante-natal care.
- M:* Your daughter is going to deliver at almost the same time you will be delivering your baby. Who is going to be whose guardian? Have you ever thought of that?
- W:* I kept quiet and forced a smile on my face.
- M:* Are you not ashamed of your self? You are going to have your eighth baby and your daughter is going to have her first baby. Who is going to teach your daughter how to be a parent? Look at you, you should have been waiting to have a grand child now. What do you need eight children for? You want to tell us that all we have been teaching about family planning is not important to you?
- W:* I was hurting inside but I could not say anything because I realized that the midwife was saying the truth except that she was cynical in her approach. I couldn't wait to leave the clinic. When I was done with the examination, the midwife said go well, I will see you next year when you come with a ninth pregnancy. I was burning inside and I

walked home faster than I usually did. I felt small and intimidated even though that I would never go back to the clinic any more. When I was on my way, I said to myself, what did I do with all the information I heard for all this time?.

W: When I got home I found my husband outside doing some repairs on our maize granary. I didn't go inside or wait for him to finish what he was doing. I went straight to him looking very furious.

H: What has happened?

W: I have been insulted by the midwives at the clinic. They made fun of my pregnancy. They also asked me how I am going to teach our daughter how to be a mother? I am really angry.

H: So what do you want to do?

W: How can you ask me as if you are also not a part of this?

H: How do I come in? I do not go to the clinic for ante-natal care.

W: Fine, this is my problem only. After this baby, I am going to the clinic and ask for the contraceptive methods.

H: Its up to you.

(Ntcheu, Central Region Interview/FGD, July-Aug., 1997)

Later the mother and her daughter delivered one week apart. Fortunately the woman reported that her daughter delivered first so she (mother) was able to wait on her daughter although she was very pregnant herself. She had no further discussions about modern contraceptives with her husband. At delivery, the midwife suggested to her to start using contraceptives but first to discuss the issue with her husband. She agreed, went home and said nothing to her husband. She stated that she had already mentioned this to him the day she was angered by the clinic staff and she found his response to be cold and discouraging.

A few days later, she asked a few friends about their experiences using contraceptives. Following these discussions with friends, she went back to the clinic and wanted an injection and not pills. She did not inform her husband that she had started using a method but she said she surprised her husband by accepting to resume sexual relations four months after the birth of their baby instead of their usual practice of waiting for six months after childbirth.

When my baby was four months old, my husband said isn't the baby smiling now? I said yes. He paused and said then what are we waiting for? (implying that the couple should resumed sexual relations). I said well I was waiting for you.

(Ntcheu, Central Region Interview/FGD, July-Aug., 1997)

It is interesting to note that although men ultimately make the reproductive decisions, it is the women who initiate the decision-making process, usually late in their childbearing years.

Women who used FP methods secretly reported that they were 1) not satisfied with their husbands' initial responses; 2) managing large families with little support; 3) had negative child bearing experiences; 4) had husbands who did not support them financially; or 5) their husbands had married second or third wives. Women who experienced problems related to the childbirth process, financial and other problems but felt that they could not start using modern contraceptives without their husbands' consent reported consulting friends, relatives or health care personnel to assist them make the decisions.

i) *Husband's Reaction and Response Phase*

Some women reported to have received immediate answers from their husbands while others waited for as long as a week to hear an answer. Both positive and negative responses were reported.

*I have many children and that's a lot of work for us. I have six boys and as you know, boy's clothes are very expensive so I needed to plan well. I wanted my children to eat well, and both mother and children to be healthy. I started feeling that we did not have adequate money when we had the fifth child. My wife also had problems at delivery. Our last born was born with a problem which I cannot describe, don't know what it is (CLEFT PALATE, Author's interpretation). My wife then brought up the idea of using contraceptives. When I heard this, I felt it was a good idea. I did not feel she had taken over my responsibility of deciding for the family. We talked about this in our house and it all went well. My wife started this as soon as she was ready. I informed no one else since this was only for us. Sometimes you can be led in trouble because parents may want you to have many children. After three days of discussion, I told my wife to start using family planning methods. We did not decide for how long we will use FP methods.
(Mangochi, Southern Region Interview/FGD, July-Aug., 1997)*

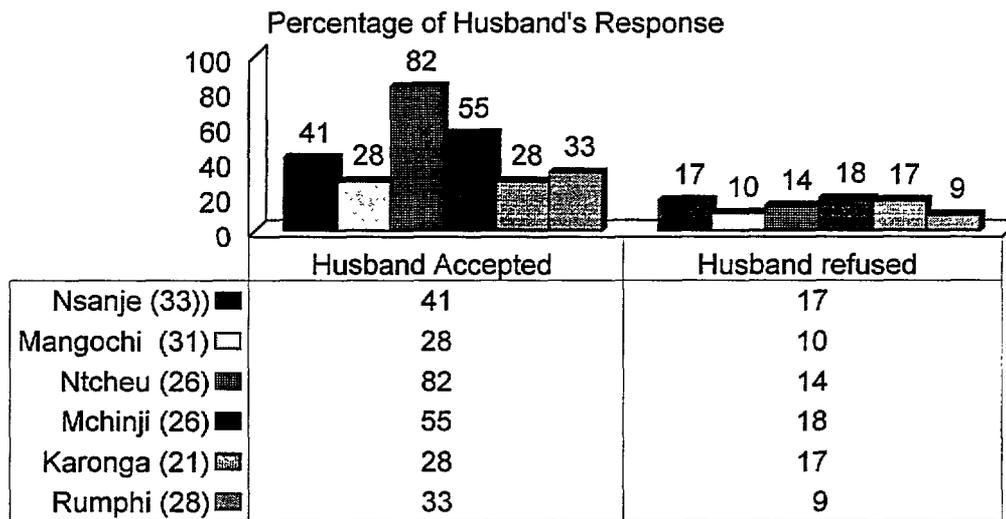
*My wife initiated the talk about childspacing and she told me the problems she was facing. I agreed the same time and even gave her transport money to go to the hospital. No one else was involved but she just informed her mother about our decision. Her mother advised her to check if it was really all right with me.
(Mangochi, Southern Region Interview/FGD, July-Aug., 1997)*

*My wife initiate the idea. I did not respond immediately. I stayed for one month before I gave her a response. She asked me again. I also did not answer. My wife asked me three times in three months before I gave her an answer. I was thinking that if I stop having children, God may not accept my decision. While I was still thinking about it, I came across my peers whose wives were using modern contraceptive methods. My friends and I talked about FP methods in general. After this discussion, I felt comfortable and allowed my wife to use a method. I did not involve any relatives because I did not want them discourage us.
(Mangochi, Southern Region Interview/FGD, July-Aug., 1997)*

Women whose husbands responded negatively reported to have consulted other individuals, mostly sisters to receive support. Some women who had negative responses from their husbands reported to have started using modern contraceptives anyway. Generally women from Karonga, Mangochi and Nsanje reported that some men were resistant to having them start using modern contraceptives. In other families, the resistance brought many problems including women's sexual dissatisfaction.

Figure 4

**Husbands' Responses to Contraceptive Communication:
Reports by Women**



2. Husband/Sexual Partner- Driven Model

Contrary to what was hypothesized, not many men initiated discussions concerning for their wife's use of contraceptive methods. However, although fewer men initiated the discussions, the data seems to suggest that women were more likely to start using contraceptives if their husbands told them to or if husbands introduced information on modern contraceptive use. Also, because fewer men initiated the discussions, the data fits the Mother/Wife Driven Model in that some men played a supportive role for women who initiated the discussions.

Karonga 4% (N=1), Ntcheu 5% (N=1) and Nsanje 7% (n=2) were really low on men initiating the discussion concerning use of modern contraceptives. Rumphhi 21% (N=6) and Mchinji 18% (N=5) respectively were the two sites where a larger percentage of women reported that their husbands took the initiative to advise their wives to start using modern contraceptives. Men reported to have initiated the discussions after hearing FP information

from health personnel and friends. Men initiated discussions because they had financial problems. When men initiated the discussions for family planning, they rarely involved other people in the decision except their wives. However, some men preferred that the parents or relations of their wives be informed of the decision once made. There was almost no discussion of the issue and the wives were expected to accept and use FP methods.

The data seems to suggest that men did not process the information for decision making in the same way their wives did. 1) They initially heard the information from many sources (funeral and social gatherings, beer drinking areas, friends and wives); 2) they weighed the importance of the information on the basis of their problems; 3) they informed their wives to start using modern contraceptive methods. The following extracts reflect initiation of discussion by husbands:

*I initiated the discussion to use modern contraceptives. I heard about this at school but by then I already had two children before I completed school. I talked to my wife. At first she refused because she had heard that those who use FP methods bear mentally retarded (imbecile) children (**mwana wozelezeka, Chichewa**) also women lose a lot of blood and can have sudden death. We discussed this issue for three months and finally reached a compromise. My wife's friend encouraged her, our family counselors were informed and they informed relatives from both our sides. They all agreed and we started using contraceptives.*

(Mchinji, Central Region Interview/FGD, July-Aug., 1997)

I wanted no more children and I told my wife to start contraceptive methods, but she refused for fear that I could divorce her. No one else was involved in the discussion. I am the head of the family, I ordered her to start, and she accepted.

(Nsanje, Southern Region Interview/FGD, July-Aug., 1997)

Initially, I discussed with my wife to start using condoms but she refused. She said she wanted flesh to flesh. Because of her desire, she snicked out and started receiving modern contraceptives. I thought the condoms would have helped us more than what she did. Besides, if she had told me that she wanted other methods, I would not have prevented her from doing so. While on the injection, she started having 2 to 3 periods per month. She stopped taking the injection but continued bleeding 2 or 3 times per month. When she stopped on her own, the CBDs followed her home and she started receiving the injection at home.

(Karonga, Northern Region Interview/FGD, July-Aug., 1997)

We had a child in 1984 and he died. Had another one in 1985 and died in 1986. After these problems we felt we should start child spacing to have time to care for the children. In 1988 we made the real decision because between 1986 and 1988 we had no child and I thought my wife was okay and able to care for the children therefore we started spacing in 1988. I initiated the talk.

(Nsanje, Southern Region Interview/FGD, July-Aug., 1997)

Most men from the southern and central regions responded favourably to the initial suggestion to use modern contraceptives by their wives. By contrast, fewer men from the northern region especially Karonga responded favourably. One of the contributory factors might have been the male dominance in reproductive decisions which led most women to use the modern contraceptive methods secretly. Men reported that allowing their wives to use modern contraceptives is like encouraging them to be promiscuous.

3. Care Provider- Driven Model

The care provider driven model was expected to be biased towards, 1) the provision of factual information to clients for them to make informed decisions, or 2) counselling so that their clients would make appropriate decisions. The data suggests that nurse-midwives initiated discussions in every site. In Nsanje and Rumphi, the percentage of nurse-midwives initiating these discussions was higher than in the other districts.

Of the women who discussed FP issues with nurse-midwives, 21% (n= 7) were from Nsanje; 21% (n= 6) were from Rumphi and 14% (n= 4) were from Ntcheu. These women stated that these discussions occurred after the women had delivered in various hospitals and most of the women were delivered by cesarean section. The midwives are said to have encouraged the women to seriously discuss the contraceptive options with their husbands. In the other three districts, there were fewer women who discussed contraceptive options with their midwives. For example 12% (n= 2) were from Karonga, 9% (n=2) from Mchinji and 9% (n= 3) from Mangochi.

As stated previously, women who discussed FP methods with nurse-midwives also reported to have had complications during child birth. They also had other risks apart from those associated with having many children. Nurse-midwives played a supportive role through counseling women who 1) had delivered by caesarean section; 2) had delivered many times; 3) had delivered a few times (one or more times); 4) women who had complications of pregnancy and labour and 5) women with medical complications especially high blood pressure and anaemia.

The women reported to have agreed with the explanations regarding contraception options they received from the nurse-midwives. Women themselves indicated that they identified with the reasoning, appreciated it and are committed to doing it. Because of the evidence of the women's difficult pregnancy and childbirth experiences, husbands to these women supported their wife's use of FP methods. The women also said that suggestions from the nurse-midwives to use modern contraceptives were taken more seriously by the husbands when husbands identified with their wife's suffering.

4. Support Members- Driven Model

The role of family members in initiating the discussion to use modern contraceptives was very minimal in the three study sites of Mangochi, Mchinji and Karonga. None were reported for Nsanje, Ntcheu and Rumphu (Table 9, p.54). This was very consistent with the participants' views that they did not need a person outside of their marriage to discuss matters concerning starting to use modern contraceptives. However, after the decision, other family members, especially the woman's parents were informed.

In one situation, a mother noticed that her daughter had problems because of frequent child bearing but did nothing to alleviate her suffering despite the obvious complications she had. The mother and a client's sister decided on behalf of this woman to initiate FP discussions. They instructed her to start using modern contraceptives or risk losing her life through the complications she was facing.

Another woman was instructed by her aunt because she also had numerous problems, financial, lack of support and problems at delivery.

I heard about family planning services from my aunt who motivated me to use this service based on the problems she knew I had. I went and told my husband about this information and he agreed immediately. However, we had to wait until 1994 when child spacing services were introduced at our nearby health centre.

(Mchinji, Central Region Interview/FGD, July-Aug., 1997)

TYPES OF CONTRACEPTIVE METHODS WOMEN EVER USED

Women were asked to mention the modern contraceptives they ever used and discontinued using. Men were asked to name any modern contraceptives their wives/sexual partners ever used and discontinued using. Both men's and women's responses showed that there were six methods used altogether. Of these, five were used by women and one type by men. The methods mentioned were:

- Oral Contraceptive Pills (OCPs)
- Depo-Provera Injections.
- Intrauterine Contraceptive Devices (IUCDs)
- Vaginal Foam
- Condoms
- Tubal Ligation

Women reported to have used primarily Depo-Provera and oral contraceptive pills (OCPs). The majority of women reported using Depo-Provera. Depending on the women's reported experiences with the method they used, some of them switched or discontinued after using a method for a period extending between one to eighteen months (short duration) or up to three to four years (long duration). Those who switched methods, switched from Depo-Provera to OCP or vice versa (see Table 10).

Table 10

Number of Women who Switched from one Modern Contraceptive Method to Another: Numbers by Study Site

Site	Number started on OCPs	Switched from OCP to Depo-Provera	Number started on Depo-Provera	Switched from Depo-Provera to OCP
Nsanje	10	3	18	5
Mangochi	12	1	16	4
Ntcheu	7	1	15	2
Mchinji	20	2	2	0
Karonga	5	4	13	1
Rumphi	10	3	14	1

Types of Contraceptives Used by Site

1. Oral Contraceptive Pills (OCPs)

Less than half of the women in each study site with the exception of Mchinji and Mangochi had used OCPs either as the initial method or the method they switched to (Table 10). The use of OCPs by site was as follows:

1) Mchinji 77% (n= 20); 2) Mangochi 52% (n= 16); 3) Nsanje 45% (n= 15); 4) Rumphu 39% (n= 11); 5) Ntcheu 35% (n=9) and 6) Karonga 28% (n= 6). From all sites, Mchinji registered the highest number of OCP users and Karonga was the lowest.

Women described taking OCPs daily and consistently at about the same time every day as demanding and sometimes not practical for these reasons: 1) women frequently travel to attend funerals and other activities and usually forgot the pills; 2) sometimes they got caught up in sudden events such as nursing a sick child or relative at the hospital and forget to carry the pills or their clinic cards; and, 3) some women reported having tendencies of forgetting so they were not able to take the pill consistently at the same time. Rather than risking a pregnancy, most of them reported opting to receive a contraceptive injection (Depo-Provera) once in three months.

2. Depo-Provera

More than half of the women from all sites except Mchinji initially used Depo-Provera. The ranking of Depo-Provera use by study site from the highest to lowest is as follows: 1) Karonga, 81% (n= 17); 2) Nsanje, 64% (n= 21); 3) Ntcheu, 62% (n= 16); 4) Rumphu, 61% (n=17); 5) Mangochi, 55% (n= 17); and 6) Mchinji, 15% (n= 4).

Many women reported that they were encouraged by the family planning providers or friends to use Depo-Provera. Other women especially from Karonga, Nsanje and Rumphu used Depo-Provera because they disagreed with their husbands who wanted more children when the women did not. The women therefore used Depo-Provera in disguise as an attempt to control their own fertility.

Women believe that if they use Depo-Provera secretly, their husbands would not suspect anything unless the women develop complications from using the injection. A smaller proportion used it because they had experienced problems (both method side effects and logistic) while using OCPs. Two women used Depo-Provera while waiting to have a Tubal Ligation (TL). Two others had Tubal Ligation after Depo-Provera.

Women reported to have preferred Depo-Provera because they claimed it was user friendly and less cumbersome. According to their responses, because they received one injection in three months, and did not have to drink any tablets thereafter, this was time saving and less involving.

Some women reported that they were told the effects of Depo-Provera such as the potential for bleeding more than usual, irregular, scanty or having no periods at all. Despite being told this information, women still opted to use Depo-Provera. With more probing to establish the reasons these women selected Depo-Provera despite being forewarned about the possible changes

in their menstrual bleeding, their responses suggested a lack of understanding of how Depo-Provera works. Qualities of bleeding variations FP providers mentioned seemed very abstract. The women reported interpreting the qualities in the context of ordinary menstruation variations. Other women reported approaching FP providers with predetermined decisions to use Depo-Provera regardless of its effects and what other methods were available. This practice was commonly reported by women who were determined to use contraceptive methods against their spouses' wishes. Three FP providers and four HSAs were asked at random to verify the information that many women insist on using Depo-Provera. The responses were affirmative from every FP provider and HSAs asked.

The providers whom we asked this question explained that some women go to the clinic with an already made decision to use Depo-Provera. Because of that, providers find it difficult in many instances to convince the women otherwise.

Among the women given Depo-Provera despite the method being unsuitable for them were: 1) women who had one or two children and anticipating pregnancy within the next two years; 2) women older than 50 years; and 3) women who suspected being pregnant. According to the guidelines stipulated in "Family Planning Policy and Contraceptive Guidelines (MOHP, 1996)", the three groups of women listed above are contraindicated from using Depo-Provera as a contraceptive option.

3. Intra-Uterine Contraceptive Devices (IUCDs)

Only two out of all the women in the study used an IUCD. One woman was from Nsanje and the other from Mangochi. Although some women had an idea of loops, their knowledge was scanty. From the women's responses, they did not hear much information about loops at the clinics compared with the information they heard about pills and Depo-Provera.

Whether or not IUCDs ought to be encouraged is a matter of clinical judgment.. For a sample such as the one in this study, the fragmentation of the family, the ease in which men and women had sexual intercourse and the high prevalence of sexually transmitted diseases (STDs) in Malawi would influence counseling a client's use of IUCDs. This however does not negate the fact that consumers of Family Planning need full and not partial knowledge on IUCDs for them to make informed decisions.

There is strong evidence from this data suggesting that many men and women had multiple sexual partners so that the use of IUCDs for that group would be risky because of the high prevalence of STDs in Malawi. According to the guidelines stipulated in Family planning Policy and Contraceptive Guidelines (MOHP, 1996), women with multiple sexual partners, those at risk for exposure to STDs, women with anaemia or heavy menstrual flow should not be using IUCDs. Most of the participants were experiencing bleeding

problems, others reported having anaemia. A majority of the women had multiple sexual partners or were married to men with multiple sexual partners therefore, have a high probability of acquiring STDs, hence the dilemma in counselling them for the use of IUCDs.

4. Vaginal Foam

Only one woman used spermicides for a short time (less than two weeks) and discontinued. She reported that the method was messy to use and she did not like it. Two women (9%) reported using two other methods, vaginal foam and condoms.

5. Condoms

Both men and women reported that condoms were not a popular method among them. When used, they were not used as a primary contraceptive method but as a backup method for beginning OCP users. Men also reported using condoms when they could no longer contain their sexual desire during the period when their wives had prolonged bleeding resulting from their contraceptive method of choice. Similar results were reported in the Namate & Kornfield (1997) condom study. Less than five families altogether used condoms, and they seldom used them in situations already reported.

EXPERIENCES WITH CONTRACEPTIVES USED

General Experiences and Concerns

A woman's decision to continue or discontinue of modern contraceptives depended on her experiences with contraceptive use, perceived family size and external persuasive factors. It was hypothesized that women who sustained the use of modern contraceptives were likely to report positive experiences and had complete families.

This study supported the hypothesis partially. Women reported some general and specific experiences contributing to both their sustained use or discontinuation of modern contraceptives. They also reported selecting methods based of the factual, presumptive and experiential knowledge. In addition, they also switched methods if they felt one was not working for them.

1. General Experiences

Of the women who started using OCPS, 80% (n= 4) from Karonga, 30% each (n= 3) from Nsanje and (n= 3) from Rumphi switched to Depo-Provera. The actual numbers of women who switched methods in all the sites are presented in (Table 10, p.62). Karonga had the smallest number of OCP users yet 80% of them switched to Depo-Provera. Women reported to have switched methods either because they experienced side effects or considered Depo-Provera to be more user friendly and economic for time management.

Of the women who initially started using Depo-Provera, 28% and 25% from Nsanje and Mangochi respectively each switched to OCPs because they experienced some side effects such as irregular or scanty bleeding while on Depo-Provera. Thirteen percent of the women from Ntcheu, 8% from Karonga and 7% from Rumphi also switched from Depo-Provera to Oral contraceptive pills for similar reasons as those given for women from Nsanje and Mangochi. Two women in Karonga switched from Depo-Provera to condoms while waiting to start what they considered a more reliable method.

In Mchinji, there were only four women out of the total sample who used Depo-Provera. Despite the problems they reported to have experienced (heavy bleeding) they did not switch to oral contraceptive pills.

Of the women who started using OCPS, 80% (n= 4) from Karonga, 30% each (n= 3) from Nsanje and (n= 3) from Rumphi switched to Depo-Provera

Women presented these general concerns:

- Some women complained that they were not examined fully
- Other women reported not having their blood pressures (B/P) checked at the initial visit, but sometimes B/P was checked if they had headaches.

- Some women reported receiving little information about the different contraceptive methods and were consequently unable to fully understand the effects of each method available.
- Once a woman selected a method, there was no follow up to ensure the suitability of the method chosen.
- Some women reported to have met very unfriendly providers who either talked to them rudely or made fun of their reproductive status.
- Some women stated that they experienced adverse side effects with the methods they selected. Examples were given of women who thought they were experiencing extreme side effects caused by the methods they selected. When they went back to the clinic to report, they were sent back home. Providers asked these women what else they expected since they had already been informed about those effects
- Women who went to report their negative effects with OCPs were told that they were using an excuse for discontinuing contraceptives to become pregnant.

2. Concerns Regarding the Safety of Contraceptives Used

Both men and women were greatly concerned about the rumours prevailing in their areas which prevented some women from using the methods or prompted users to discontinue using modern contraceptives. This information is what was designated as presumptive knowledge for this study. Knowledge in form of rumours (myths) surrounding modern contraceptives was more common among family planning users and their families than was the factual information from the health institutions. Male participants were more conversant with the rumours than the factual knowledge about modern contraceptive methods.

The following is a list of myths/rumours circulating in the six study sites and the surrounding villages. These rumours were of great concern to contraceptive users and their families.

- Modern contraceptives cause permanent sterility and should only be used when a couple has a complete family. Once the expected family is complete, and the woman becomes barren as a result of using these contraceptive methods, the effects will not disadvantage the couple in relation to family size.
- Oral contraceptive pills accumulate in the abdomen. Once taken, the pills solidify to the likeness of a stone. This mass like entity remains in the woman's abdomen until it is removed by an operation. If it is not removed

the woman could die from the accumulated pills.

- The loop causes one to deliver a weak child.
- When a condom gets stuck in the vagina, it gets to the heart, the individual eventually dies from that effect.
- When the tip of a condom sticks to the uterus, the woman will have no periods and consequently becomes barren. She may also require to undergo an operation to remove the condom which is stuck.
- When the condom gets stuck in the uterus, it causes obstructed labour and the baby cannot come out.
- Women's bodies change when they use modern contraceptives. They either lose or gain weight excessively.
- Modern contraceptives cause diseases such as AIDS
- Women bleed for one month when they receive modern contraceptives.
- Individuals can bleed continuously for many months if they receive a contraceptive injection (Depo-Provera).
- Modern contraceptives cause cancer of the uterus.
- Contraceptives cause stomach ulcers.
- The loop is a very bad device. It ligates the uterus and when the ligated area shrinks, the uterus just snaps and the woman will no longer have children.
- Pills cause headache and anemia.
- Depo-Provera causes swelling of legs and abdomen.
- It is sinful for anyone to use modern contraceptives. When they do, they go against God's command that people should multiply abundantly like the sand of the sea.
- God severely punishes a person who uses contraceptives by making her barren.
- Once a client receives an injection, she may not fall pregnant, loses weight and the medicine contained in the injection "sucks the woman's blood".
Munthu amamwedwa magazi ndi jakisoni (Chichewa).

The issues presented seem to suggest that participants had inadequate knowledge about how modern contraceptives work. It also suggests that clients are not proactive in seeking explanations for the adverse effects of the contraceptive methods they choose. As a result, they developed their own explanations and body of knowledge about modern contraceptives.

Participants' responses indicated that the rural areas studied were filled with confusing information about the effects of contraceptives which deterred women's sustained use of modern contraceptives. The network system in these rural areas appeared to be very strong judging from how rumours were consistently mentioned from all study sites. The sad part of this is that men and women believe in the rumours so much that an individual wishing to start using modern contraceptives or sustain the use of modern contraceptives does it against the odds of negative spouse, peer and family pressure. Participants expressed the concern that the rumours were spreading faster than factual information.

The list of what participants reported as the adverse effects of modern contraceptives clearly suggest that individuals have not fully accepted the use of modern contraceptives. The presumed effects of modern contraceptives discouraged some women from seeking the correct information about their experiences with modern contraceptives.

Despite the rumours, other individuals still use modern contraceptives. Some participants explained that many families seem to use the information regarding these the rumours seriously when they want to discontinue than when they decide to use modern contraceptives.

It was interesting to note that three women (two from Mchinji and one from Nsanje) dispelled the rumours that contraceptives cause secondary infertility based on their experiences. The woman from Mchinji who had used OCPs showed the group her full term baby whom she delivered after she was discouraged from using modern contraceptives. Unfortunately, there were only a few of such individuals in the groups who have a positive attitude toward modern contraceptives, but this could suggest the hope that people's attitudes could eventually change.

Specific Experiences with Contraceptive Methods Selected

1. Women's Experiences Using Condoms

The few women who received condoms from the clinics reported that they were advised to use them as backup, especially if they were using OCPs for the first time. These condoms were either thrown away for fear of angering husbands who were already suspicious of their wife's motives for using modern contraceptives. Other women brought condoms only to have the husband refuse to use them. One woman who brought home condoms as a

backup to OCPs fell pregnant the first month while on OCPs because her husband refused to use the condoms.

Women and men's accounts of condom use suggest that condoms are not considered as a method of contraception. They were more likely associated with a cheating spouse. None of the participants in this study used condoms as a primary contraceptive option.

The discussions also seemed to suggest that age was a factor that influence individuals to use condoms. Younger women tended to be a little bit positive on condom use but only for a short while.

In Karonga, a young woman who used condoms temporarily said she did not like the experience except the part of foreplay. She complained about diminished sensual pleasure, the burden of disposing the off after use, the limited number of times she had sex , the lack of freedom to have sex as she wished, the lack of spontaneity in the whole sexual encounter. In her own language she concluded her experience about condom use.

*Para ise taweni takhumbana, taweni tikujonkhonyolana waka pambula sugzo. Apo takhumbila taweni, tikusewela kanandi nadi, kwa nambala ili yose ise takhumba. Uheni wakondomu, kurya mukurya kamoza waka mbwenu mwamala, kunowa, vikunwaso chala, kweni na Makondomu aya, yayi vikusugza nadi, namunyinu natondeka... **Tumbuka, Karonga, Northern Region Interview/FGD, July-Aug., 1997***

Many women and men too from all study sites did not support the use of condoms in marriage. Women believe that if they are married to one man and the man starts to bring condoms home, that reflects that he has been unfaithful to his wife. Most married women asserted that they would not use condoms in their homes. If a husband suddenly brings home condoms the woman would be suspicious and insist on finding out from her spouse why they should use condoms this time. Similar views were reported by Namate & Kornfield study on condom use in marriage (Namate & Kornfield, 1995) .

2. Women's Experiences Using IUCDs

Only two women in the whole sample reported to have used an IUCD and both discontinued because of problems and discomforts. One woman from Nsanje had the loop removed because she reported that it was irritating her husband during coitus. The other woman from Malindi in Mangochi had attempted to have it inserted twice. On both occasions she felt the IUCD was improperly inserted and requested its removal immediately because she could not stand the associated severe abdominal cramps she felt.

3. Women's Experiences with OCPs

Most of the women interviewed reported that they took pills for one to 12 cycles. Some of them continued for as long as two years. After two years, most women discontinued to have a baby and restarted them for another period of 2 years. Women who reported taking pills for a short period stated that they had experienced problems on the pill. Women's problems of using OCPs with condom back up have already presented. Some women had as many as 12 cycles with no problems but started reacting with heart palpitations thereafter. Other women sought assistance at the clinic and were given Depo-Provera as an alternative method.

a) Side Effects

While taking the pills, women reported experiencing side effects including heart palpitations, nausea, vomiting and weight changes (both excessive weight gain and weight loss). Others encountered physical problems, especially abdominal pains, breathlessness and sweating. A few experienced heavy bleeding or an irregular bleeding pattern. Some reported to have become pregnant on the pill although they did not specify whether they were taking the pill regularly. A few reported using OCPs because they had problems with Depo-Provera. Women from each site who initially used OCPs changed to Depo-Provera because of the side effects they experienced. A small number changed to traditional methods because they had side effects with OCPs.

b) Providers' Attitudes

Many respondents from health centers, health posts and district hospitals alluded to provider's rudeness when providing services "*Kayankhulidwe ka chipongwe*" (*Chichewa*). A few women missed clinic appointments for various problems. When they went to the clinics for re-supply before resuming sexual relations with their husbands, they were ridiculed by the FP providers. Some of clients were told by the providers that they were not serious about using contraceptive methods. Other clients were told to go home and think of an alternative method. In the course of waiting for alternatives, they fell pregnant. The following examples illustrate what the women experienced.

My wife went to the clinic to receive her supply of pills. I don't know exactly what happened but she came back home with no supplies. I took the empties for refill on her behalf. At the clinic they refused but gave me condoms and asked me to send my wife back. When she did they shouted at her.
(*Ntcheu, Central Region Interview/FGD, July-Aug., 1997*)

*I did not plan to stop using contraceptive pills. The provider told me to stop because I had missed a scheduled appointment. I went to the district hospital to look after my sister who developed complications with her pregnancy. She was admitted at the district hospital for two weeks. For the entire two weeks, I did not take any contraceptive pills because I had just run out of supply a day before I left home for the hospital. I even forgot to carry my FP clinic card with me to the district hospital because this was an unexpected trip. When I came back from the district hospital, I immediately went to my clinic for a re-supply of the pills. The provider told me to discontinue because I had missed an appointment. I explained to her what had happened but the provider refused to listen. She said " **basi pitani, musakabwerenso kukatenga mapilisi**" (Chichewa) meaning "Go home and do not come back to ask for Pills" I pleaded with her to give me some pills. I even stayed at the clinic the whole morning and afternoon hoping the provider would reconsider my request but, to no avail. When this happened, I thought this was my bad luck, I even thought that I was going to die. I felt angry. When I informed my husband about the whole experience, he shouted at me and explained that if I became pregnant my sister who fell ill and I looked after at the district hospital, would provide all the baby's financial needs. Out of desperation, I went to the traditional birth attendant for assistance but she refused to do so. I fell pregnant the same month. When I informed my husband, he indicated that he was not responsible and accused me of infidelity while I was looking after my sister at the hospital. He also told me to go back to my home of origin. I did not go anywhere. After sometime, he accepted the responsibility for the pregnancy. Now when I look at my baby (pointing at her four month old baby), I consider her to be my gift.*

(Mchinji, Central Region Interview/FGD, July-Aug., 1997)

c) **Logistic problems**

A few fell pregnant while taking the OCPs because they had either gone to a funeral or had a sick child, and therefore missed a clinic appointment for re-supply or were too preoccupied with the child care and forgot to take the pills. A few forgot to take the pill with them when they temporarily relocated from their homes. They did not understand the consequences of missing a pill.

4. **Women's Experiences Using Depo-Provera**

Women who used Depo-Provera reported experiencing more problems than those who used OCPs even when the use of Depo-Provera was of a short duration. The majority reported a change in the pattern of their menstruation which they felt was different from what they were informed of at the clinics. These women's problems have been classified in two groups: 1) those related to menstrual flow; and, 2) other physical side effects.

a) **Problems Related to Menstrual Flow (Altered Bleeding Patterns)**

Of all the side effects of Depo-Provera, the ones that concerned women most were abnormal bleeding and severe abdominal pains. Women reported to have had scanty and irregular or heavy, continuous bleeding with clots. Despite being told the expected changes in the menstrual cycle, these changes disturbed the women very much. Several patterns of bleeding were characteristic of these women's experiences.

i. Heavy bleeding after the first injection

Women who experienced heavy bleeding after the initial injection did not continue with a second or third injection. They reported being scared by the amount of bleeding and decided on that basis to change or discontinue the method.

ii. Heavy bleeding after fifth to seventh injections

This group initially used Depo-Provera injections with no problems. After the fifth or seventh injection, women experienced heavy bleeding accompanied by passage of blood clots. They also reported changing sanitary pads at least five to ten times during the day and two or more times at night. They were not using the ordinary cotton pads but blanket material. Women described this type of bleeding as a very unusual phenomenon for them. According to their explanations, some women used old pieces of blanket which were thicker than the regular cotton material they normally use for sanitary pads. They believed that the blanket material would keep them dry for a longer period.

iii. Continuous bleeding with clots.

Women who experienced this type of bleeding described that they bled daily and continuously for three weeks. The nature of bleeding was heavy. In addition, they had backache and severe abdominal pains.

iv. Cessation of menses after one injection then scanty and prolonged bleeding

This group of women missed periods for four to five months soon after receiving the first injection. Thereafter they progressed to scanty periods for two weeks and continued bleeding minimally but daily up to three to five months.

v. ***Scanty bleeding from the first injection, normal and heavy for some time***

Another group reported having scanty bleeding from the first to the third injections. This was followed by normal to scanty bleeding for some time thereafter they had heavy bleeding for one month or more continuously. Women who participated in in-depth interviews gave graphic descriptions of how they bled heavily but did not go to the clinic because of the negative attitudes they anticipated from the providers. Because women who participated in in-depth interviews had ample time to describe their experiences, they also described how this bleeding curtailed their functioning in all areas of their lives including their sexual lives. For some, this bleeding cost their marriages. One woman, having reached a stage of helplessness due to the bleeding advised her husband to marry another woman.

vi. ***Bleeding after the first injection then cessation of menses.***

Some women reported to have had one menstrual period after one injection thereafter had no more bleeding. Some women reported to have stayed for almost one year without bleeding and were surprised that they bled after that period. Other women were bleeding irregularly after three or four months.

These bleeding experiences were manifested in both focus group discussions and in-depth interviews. Heavy bleeding, irregular, scanty and prolonged bleeding is expected in women who are on Depo-Provera. However, the women's perceptions of their bleeding was that they were suffering and some said that they were always living in suspense.

b) **Atypical Severe Abdominal Pain**

Women described the abdominal pain associated with the use of Depo-Provera as severe, excruciating sensation in the whole abdominal area and atypical of ordinary discomfort from menses. Some women described first feeling a wave of heat across the abdomen radiating down to the lower abdomen, then pubis and the back. Others equated it to labour pain. They reported feeling like someone was cutting inside their abdomens with sharp razor blades. In all their descriptions, the pain was intense prior to discharging clots and was relieved when they had passed clots. The intensity of the pain gradually increased as women were about to discharge some clots.

c) **Weight Changes and Other Physical Problems.**

Both weight gain and excessive weight loss were reported to have been associated with the use of Depo-Provera. Of the two, women were more worried about excessive weight loss. Some individuals even stated that Depo-Provera causes AIDS because of the extreme weight loss they saw in women using Depo-Provera.

It was beyond the terms of this study to establish whether these women were losing weight excessively due to the use of Depo-Provera. However, one factor was clear: some women were discouraged from using modern contraceptives when they saw their friends losing weight excessively. Men also alluded to the same issue of excessive weight loss. They did not encourage their wives to use Depo-Provera if they knew someone who had suffered excessive weight loss or their wives were losing weight while on the injection. Other women used excessive weight loss as a reason for discontinuing the use of the contraceptive method they were using.

d) **Service Provider Attitudes**

Some providers were reported to have had no time to listen to the women's problems to the extent that even when some women were experiencing abnormal bleeding, they went back to the clinics for more injections without mentioning their problems. One client tried to explain her concerns about her bleeding problems, but the providers did not care to establish the magnitude of this bleeding. In centres where women reported their problems, they were asked how they expected the providers to assist, since women were already told the side effects of Depo-Provera.

Did we not tell you that you could experience either heavy, scanty or no bleeding once you use Depo-Provera, what else do you want us to do for you?

(Ntcheu, Central Region Interview/FGD, July-Aug., 1997)

The women and men reported that the messages of ridicule and negative attitudes coming from providers were passed from one woman to the other using their social network. As a result, some women reported not informing the providers about their bleeding problem for fear of being ridiculed. Consequently, women received their subsequent injections from the same clinics but did not dare explain their bleeding problems.

DISCONTINUATION OF MODERN CONTRACEPTIVES

Women Discontinuing Modern Contraceptives

Participants were asked to explain their reasons for discontinuing the modern contraceptives they ever used including reasons for switching from one method to another. The switch of methods accounts for the discrepancies in the total numbers of women presented per study site. This implies that most women used and discontinued more than one method. The actual numbers of women discontinuing modern contraceptives in total and by study site are presented in this following section.

Although participants reported having used six contraceptive methods, only two methods, Oral contraceptive pills (OCPs) and Depo-Provera were discontinued by the majority therefore, this section focuses on why women discontinued OCPs and Depo-Provera in general and by study site. The reasons participants attributed to discontinuing the other four methods were included in the previous section on experiences with contraceptives used.

For comparisons of women who discontinued FP methods within a study site, the denominator used is the actual number of women registered in that site. Within study site comparisons give the numbers and percentages of women who discontinued OCPs and Depo-Provera in that particular site.

Number of Women Discontinuing OCPs and Depo-Provera in All Study Sites

Table 11

Number of Women who Discontinued
Modern Contraceptives: Numbers in all Study Sites

Site	Total Number of Female Respondents (N = 165)	Number who Discontinued Oral Contraceptives (N=77)	Number who Discontinued Depo-Provera (N=114)
Nsanje	33	8	31
Mangochi	31	17	19
Ntcheu	26	9	20
Mchinji	26	23	4
Karonga	21	9	20
Rumphi	28	11	20

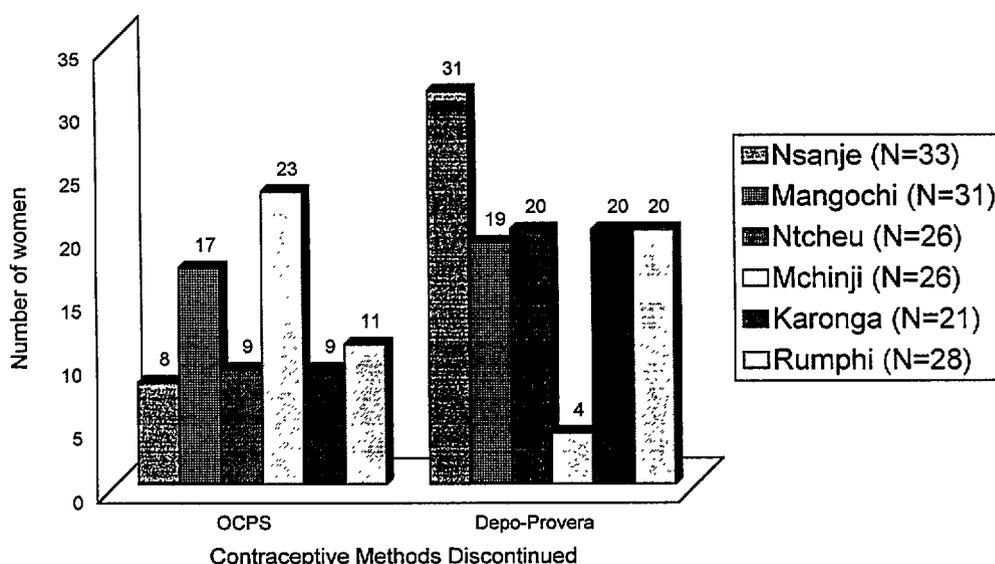
Out of the 165 women participants, 77 reported discontinuing OCPs and 114 reported discontinuing Depo-Provera in all study sites (Table 11). The number of

women discontinuing OCPs (n=77) was also used as the denominator to calculate the percentage of women discontinuing OCPs in all study sites. Similarly, the number of women discontinuing Depo-Provera (n= 114) was used as the denominator to calculate the percentage of women discontinuing Depo-Provera in all study sites (Table 12, p.78).

Comparison of Numbers of Women Discontinuing Modern Contraceptives Across all Sites.

Figure 5

Numbers of Women who Discontinued Contraceptive Methods



Across Study Site Numbers: OCPs (N=77) , Depo-Provera (N=114).

Figure 5 shows the actual comparisons by numbers of OCPs and Depo-Provera across study sites. Numbers for OCPs calculated out of 77 across sites show that there were more responses of women discontinuing from Mchinji and Mangochi. Similarly, numbers for Depo-Provera compared across sites calculated out of 114 show that Nsanje was the highest and Mchinji the lowest.

Percentages of Women Discontinuing Modern Contraceptives in all Sites.

Of the 165 women who discontinued modern contraceptives, 47% (n= 77) reported to have discontinued using OCPs and 69% (n=114) in all study sites. From the 77 who discontinued OCPs, 10% (n= 8) were from Nsanje; 22% (n= 17) from Mangochi; 12% (n=, 9) from Ntcheu; 30% (n= 23) from Mchinji, 12% (n= 9) from Karonga; and 14% (n= 11) from Rumphi (Table 12, p.78).

Of the 114 out of the 165 women reporting to have discontinued Depo-Provera: 27% (n=31) were from Nsanje; 17% (n= 9) from Mangochi; 17.5% (n= 20) from Ntcheu; 3.5% (n= 4) from Mchinji; 17.5% (n= 20) from Karonga and, 17.5%) (n= 20) from Rumphu (Table 12).

Table 12

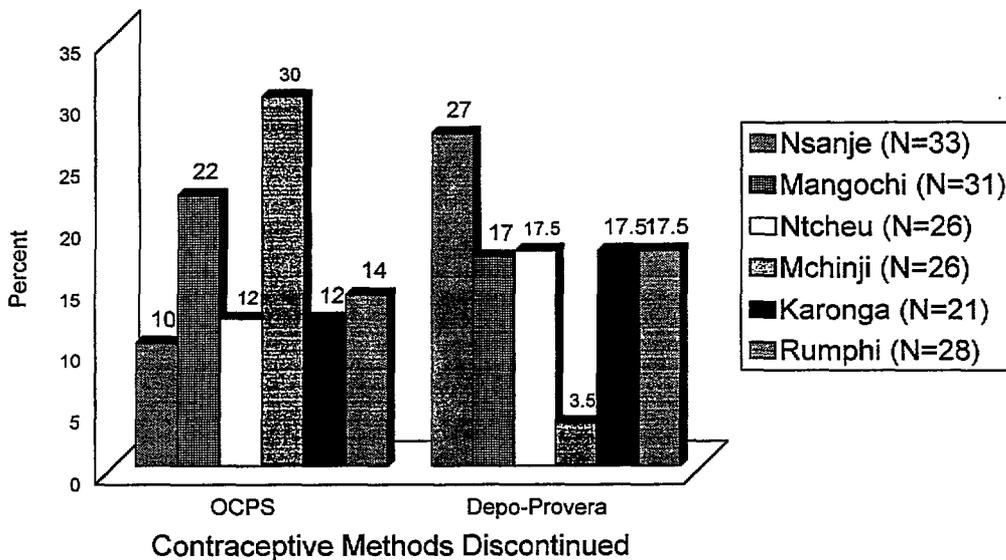
Number and Percentage of Women Discontinuing Modern Contraceptive Methods

Study Site	Number of Women who discontinued OCPs	Percentage of Women who discontinued OCPs	Number of Women who discontinued Depo-Provera	Percentage of Women who discontinued Depo-Provera
Nsanje	8	10	31	27
Mangochi	17	22	19	17
Ntcheu	9	12	20	17.5
Mchinji	23	30	4	3.5
Karonga	9	12	20	17.5
Rumphu	11	14	20	17.5

A Comparison of Percentages of Women Discontinuing Modern Contraceptives Across and Within Sites

Figure 6

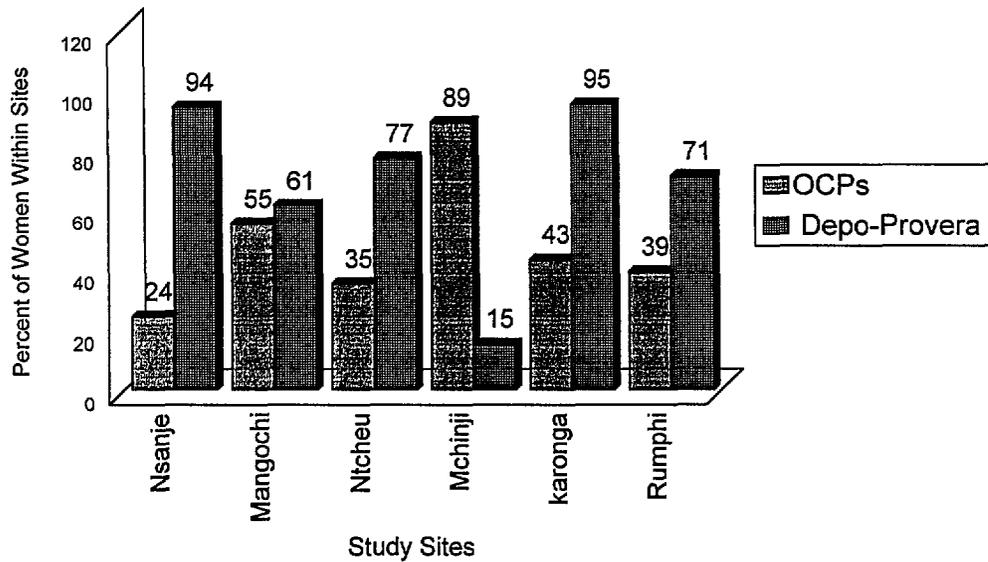
Percentage of Women who Discontinued Modern Contraceptives Across Study Sites



From figure 6 on page 78, out of the women who discontinued OCPs (n= 77), a larger proportion of them were from Mchinji and Mangochi 30% and 22% respectively; the smallest group was from Nsanje. The largest group of women who reported to have discontinued using Depo-Provera were from Nsanje (27%) and the smallest group was from Mchinji (3.5%).

Figure 7

Women Discontinuing Modern Contraceptives within Study Sites



Analysis of the modern contraceptives methods discontinued were made across and within study sites. Figures 6 and 7 show the differences. Figure 6 presents the comparisons of OCP and Depo-Provera across districts. From this figure the data shows that across districts, Mchinji and Mangochi were the two sites where more women reported to have discontinued OCPs. Also, more women from Nsanje reported to have discontinued Depo-Provera. In the other sites, the percentage of women discontinuing OCPs was almost the same. Also, with the exception of Nsanje and Mchinji, the percentage of women discontinuing Depo-Provera was almost similar across four study sites.

Discontinuation Of Contraceptives Within Sites

Within site analysis shows that more women discontinued Depo-Provera than OCPs (Figure7). As shown, when each district was compared separately, the percentages for OCP discontinuation were in this descending order: Mchinji, Mangochi, Karonga, Rumphhi, Ntcheu and Nsanje. The order for Depo-Provera was Karonga, Nsanje, Ntcheu, Rumphhi and Mchinji. Figure 7 shows a comparison of discontinuation of

OCPs and Depo-Provera for each study site. The general picture within a study site suggests that with the exception of Mchinji, a larger percentage of women reported to have discontinued Depo-Provera more frequently than they discontinued OCPs. This finding also supports the experiences women reported that they had more adverse effects from using Depo-Provera than they did from using OCPs.

1. Discontinuation Within Sites in the Southern Region

In Nsanje, 8/33 (24%) discontinued OCPs and 31/33 (94%) discontinued Depo-Provera. This shows that from Nsanje alone, more women had discontinued Depo-Provera than OCPs. From Mangochi, 17/31 (55%) women reported to have discontinued OCPs and 19/31 (61%) discontinued Depo-Provera. This shows that the proportion of women discontinuing OCPs was almost similar to that of women who discontinued Depo-Provera although slightly biased towards Depo-Provera.

2. Discontinuation Within Sites in the Central Region

In Ntcheu, 9/26 (35%) reported to have discontinued OCPs and 20/26 (77%) discontinued Depo-Provera. Therefore, a larger proportion had discontinued Depo-Provera compared with those who reported to have discontinued OCPs. Of the women participating from Mchinji, 23/26 (89%) reported to have discontinued OCPs compared with only 4/26 (15%) who reported to have discontinued Depo-Provera. Thus, more women had discontinued OCPs compared with those who discontinued Depo-provera.

3. Discontinuation Within Sites in the Northern Region

Of the 21 women participants from Karonga, 9/21(43%) reported to have discontinued using OCPs and 20/21(95%) Depo-Provera. This implies that a larger proportion of women from Karonga discontinued Depo-Provera compared with those who discontinued OCPs. From Rumphu, 11/28 (39%) reported to have discontinued OCPs and 20/28 (71%) Depo-Provera. According to these numbers, it shows that a smaller proportion discontinued OCPs compared with the larger proportion who had discontinued Depo-Provera.

REASONS FOR DISCONTINUING MODERN CONTRACEPTIVES

Reasons women attributed to discontinuing oral contraceptive pills and Depo-Provera are presented separately for the whole sample and separately per study site.

Reasons Attributed to Discontinuing Modern Contraceptives

It was hypothesized that women discontinue modern contraceptives because of multiple reasons. Findings from this study supported this hypothesis both for discontinuation of OCPs and Depo-Provera.

1. **General Reasons Women Attributed to Discontinuing OCPs**

The denominator used to calculate the proportions of reasons attributed to the discontinuation of each method was derived from adding the number of all reasons mentioned. For OCPs the denominator was 127.

Reasons women attributed to discontinuing OCPs are presented in their descending order according to the frequencies as presented irrespective of the study site. As indicated in Table 13, the reasons were: (1) method side effects manifested through physical health problems, (2) desired pregnancy, (3) inadequate knowledge about the effects of OCPs (misinformation through rumours), (4) social reasons, (5) bleeding problems, (6) method failure, (7) other reasons and (8), care provider factors especially provider attitudes.

Table 13

Reasons for Discontinuing OCPs in all Study Sites (N = 127)

Reasons	Number of Responses	Percentage
Method Side Effects	34	27
Desired Pregnancy	30	24
Rumours about Side Effects	27	21
Social Reasons	12	9
Bleeding Problems	11	9
Method Failure	5	4
Other Problems	5	4
Provider Factors	3	2

2. General Reasons Women Attributed to Discontinuing Depo-Provera

The denominator for calculating proportions for Depo-Provera discontinuance was 338. The reasons the 114 women who discontinued Depo-Provera attributed to the discontinuation were (1) bleeding problems, (2) method side effects, (3) severe abdominal pains, (4) social reasons, (5) rumours about adverse effects of Depo-Provera, (6) desired pregnancy, (7) provider attitudes, (8) service provision/clinic reasons, (9) esteem problems, (10) pregnancy, (11) death of child and (12) other reasons (Table 14).

Table 14

Reasons Women Attributed to Discontinuing Depo-Provera in All Study Sites (N = 338)

Reasons mentioned	Numbers	Percentage
Bleeding Problems	99	29
Method Side Effects	67	20
Severe Abdominal Pains & Backache	42	12.2
Social Reasons	42	12.2
Rumours About of Depo-Provera	37	11
Desired Pregnancy	11	3.3
Clinic Attitudes	10	3
Service Provision Reasons	8	2.3
Esteem Reasons	6	2
Pregnancy	6	2
Child Died	5	1.5
Others	5	1.5

3. Differences and Similarities in Reasons For Discontinuing OCPS and Depo-Provera

The general reasons for discontinuing OCPs and Depo-Provera presented in Tables 13 and 14 suggest that there were indeed differences and similarities in the reasons for the two methods women discontinued. These differences are noticeable in the type of reasons but mostly in the ranking of the reasons. the similarities are that there are method side effects mentioned in the two methods.

The first four reasons women discontinued OCPs for were method side effects, desired pregnancy, inadequate knowledge about the effects of OCPs and social reasons. The four reasons mentioned for Depo-Provera were bleeding problems, method side effects, severe abdominal pains and social reasons.

In this data, bleeding problems, severe abdominal pains and problems with service providers were more apparent in women who reported discontinuing Depo-Provera. Desire for another baby and method failure were mostly reported by women who reported discontinuing OCPs. Method side effects, lack of knowledge about the effects of contraceptive methods (rumours), social reasons, attitudes from providers were reported from women who used both methods although there were biases toward one method. However, women who reported discontinuing Depo-Provera had other problems which were not mentioned by women who discontinued OCPs. These include service provision, poor self-esteem, pregnancy, death of children and others (see Table 14, p.82).

4. Reasons Women Attributed to Discontinuing OCPs (by Study Site)

It was hypothesized that women' reasons by district would be different because of differences in sociocultural values influencing marriage and the value for children. For the discontinuation of OCPs this assumption was partially supported (Table 15). The most frequently mentioned reasons in all study sites were method side effects and rumours about the effects of OCPs.

Table 15

Reasons for Discontinuing OCPs by Study Site

Reason	Nsanje (15)	Mangochi (19)	Ntcheu (16)	Mchinji (34)	Karonga (18)	Rumphi (25)
Method Side Effects	20	26	38	15	39	32
Desired Pregnancy	20	0	12.5	50	17	20
Bleeding Problems	27	21	0	0	11	4
Social Problems	13	11	6.25	5.5	0	20
Method Failure	0	11	12.5	0	5	0
Provider Attitude	0	0	0	9	0	0
Rumours	20	26	25	15	28	20
Other Reasons	0	5	6.25	5.5	0	4

Percentage of women

a) Method Side Effects

The types of side effects women reported to have experienced varied. In many instances women reported a combination of side effects. The common ones were heart palpitations, dizziness, weight gain, weight loss, headaches, weakness and feeling sick. Specific examples are presented from some selected sites.

b) Desired Pregnancy

Some women discontinued OCPs because they or their husbands desired another baby. This desire was reported to have been initiated by men and women accepted that. Sometimes women reported to have had the desire for another child, but stated that they waited for their husbands to suggest it. There were variations among districts in the proportion of women who discontinued OCPs due to desired pregnancies. Mchinji ranked highest among women who discontinued because they were ready for another baby (65%). Mangochi and Karonga were the lowest in discontinuing on the basis of wanting a baby.

c) Misinformation about the effects of OCPs (rumours)

Some women discontinued OCPs due to rumours about the adverse effects of modern contraceptives. Women reported to have heard that OCPs accumulate in the abdomen, they form a hard mass as hard as a stone and this mass can only be removed by an operation. Also that if an operation was not performed the woman would die from the mass in her abdomen. All rumours about OCPs have been incorporated under the experiences of women.

d) Social problems

Frequently mentioned social problems were divorce, separation, death of a husband or men marrying other wives. The women using OCPs reported not to have found a good justification for continuing with OCPs following divorce or separation. Forty percent of the women from Rumphi and 14% of those from Ntcheu reported to have experienced more family problems than the rest and discontinued pills on that basis. No women from Nsanje or Karonga reported to have discontinued due to marital problems. Women from Nsanje and Karonga districts also had low usage of OCPs compared to the others.

e) Bleeding problems

A number of women reported to have experienced bleeding problems while on the pill to the extent of discontinuing contraceptives on that basis. The type of bleeding mostly reported was irregular or heavy bleeding. Other women also reported to have had heavy bleeding accompanied by clots.

f) Method failure

Women from different sites reported to have discontinued using OCPs because they fell pregnant while using the pill. Some of the women insisted that they took the pill regularly but fell pregnant. Some of them

could not recall whether or not they had missed taking a pill prior to falling pregnant.

g) Provider factors

Some women reported to have discontinued OCPs because they missed appointment dates for re-supply of their OCPs. Their reasons for missing a clinic appointment included attending funeral, supporting a sick relative at the hospital and attending to a very ill child.

None of the women reported to have just ignored the date. These women's pregnancies could have been avoided but the women expressed their frustrations after making futile attempts to receive assistance at their respective clinics.

According to their stories, they all realized that they were at risk of falling pregnant and they wanted to prevent that from happening. Unfortunately, they resumed sexual relationship with spouses with no backup method to prevent pregnancy. Some of them indicated that they were intimidated by family planning providers for example they were told that they were not serious about using OCPs and were asked to go home and think about another method.

h) Other Reasons

In this category, reasons reported were mostly child related. When the youngest children died and he/she was the reason why the mother was using contraceptives, after death occurred mothers indicated that there was no reason for continuing with contraceptive methods. Also examples were given where mothers were so preoccupied with the care of their very ill child that taking OCPs was not considered a priority.

4. Reasons Women Attributed to Discontinuing Depo-Provera (by Study Site)

a) Bleeding Problems

- i. Heavy and Pronged Bleeding*
- ii. Irregular and Scanty Menses*
- iii. Cessation of Menses*

Data presented in Table 16 shows that women attributed their discontinuation of Depo-Provera to bleeding problems. Women reported three characteristics of bleeding problems; heavy bleeding with or without clots, and with severe abdominal pains and backache, Irregular or scanty but continuous bleeding. Sometimes this was

accompanied by abdominal pains and cessation of menses. However, of the three types, women reported to have experienced heavy and continuous bleeding than irregular and scanty bleeding or cessation of menses.

Table 16

Reasons Women Attributed to Discontinuing Depo-Provera by Study Site: Percentage of Responses Given

Reason	Nsanje (N=31)	Mangochi (N= 19)	Ntcheu (N= 20)	Mchinji (N= 4)	Karonga (N= 20)	Rumphi (N= 20)
Bleeding Problems	29	14	19	4	18	15
Method Side Effects	6	8	26	6	13	8
Severe Abdominal Pains	8	8	8	3	11	4
Social Reasons	13	10	3	1	11	4
Depo-Provera Rumours	7	4	7	1	10	8
Desired Pregnancy	1	3	1	1	2	3
Clinic Attitudes	2	0	8	0	0	0
Service Provision Reasons	4	0	0	0	3	1
Esteem Reasons	3	0	0	0	0	3
Pregnancy	2	1	2	0	1	0
Child Died	4	0	1	0	0	0
Others	3	0	0	1	0	1

Table 17

Type of Bleeding Women Attributed to Discontinuing Depo-Provera by Site: Percentage of Responses

Type of Bleeding Problem	Nsanje (33)	Mangochi (31)	Ntcheu (26)	Mchinji (26)	Karonga (21)	Rumphi (28)
Heavy, Continuous with Clots	79	71	79	75	67	60
Irregular & Scanty	17	7	10.5	0	22	20
No Menses	4	21	10.5	25	11	20

i. Heavy and Prolonged Bleeding (with Clots or with no Clots).

Although some women reported to have been informed about the nature of bleeding to anticipate, the amount of bleeding they experienced was reported to have been heavy (Table 17). Some women reported to have bled continuously from three

weeks to three months and that this bleeding was accompanied by a discharge of clots. Women who had experienced heavy bleeding for a long time also reported feeling physically unwell, generally fatigued, limited their daily activities including doing chores in the house, gardening and socializing with friends. Some women reported having lighter complexions and pale hands. Due to these problems, some women sought assistance from their clinics. A few reported to have been assisted but many felt intimidated by providers' uncaring remarks.

In other centres, women who complained of heavy bleeding received some pills which they identified as a cycle of OCPs. Less than half of the women who received the pill indicated that the pill assisted them. Women whose bleeding problems were not alleviated either on their own or after the cycle of oral contraceptives went back to the clinic and were advised to change the method.

Women who felt not supported by their family planning providers reported going back to their villages. They also reported discouraging other women with similar problems from seeking help at their clinics because there was not help available. Consequently many women who were experiencing heavy bleeding discontinued Depo-Provera before seeking assistance from their providers. Examples of women who discontinued using Depo-Provera without seeking assistance from the clinics were given from Ntcheu, Nsanje, Karonga and Rumphu.

ii. *Irregular and Scanty Menses.*

Women who experienced irregular bleeding seemed to be bothered with this type of bleeding. Their concerns regarding irregular bleeding were that they were kept in suspense all the time. They could not tell when to expect their next period, how long it would last, how often they would bleed per month, or, how heavy the bleeding would be. Some of them reported having no bleeding the whole day and noticing some bleeding after sexual intercourse. A few women who assumed to have completed their periods for that month reported being surprised to notice that they were still bleeding after resuming sexual intercourse. This was reported to be a major source of concern for both husband and wife and that it affected their sexual lives and their sexual partner's chastity.

iii. *Cessation of Menses*

Women who had no menses reported that they were worried because they believed that a woman is complete when she has

her menstrual periods and the absence of menses not only made some women unhappy but their spouses too. Some women with no menses believed that the unclean & dirty discharges which come out monthly accumulate in the woman's body therefore making her body dirty.

By discontinuing Depo-Provera women believed that it would enhance the removal of the accumulated dirty discharge. Others believe that having no menses means that they will no longer have children. Therefore, they discontinued Depo-Provera believing they have no risk of falling pregnant but some women were surprised to see that they were pregnant afterwards. The other women whose menses had ceased while on Depo-Provera interpreted that as the end of their childbearing. This was their basis for discontinuing Depo-Provera, and they did not consult their FP providers.

b) Severe abdominal pains and backache associated with Bleeding

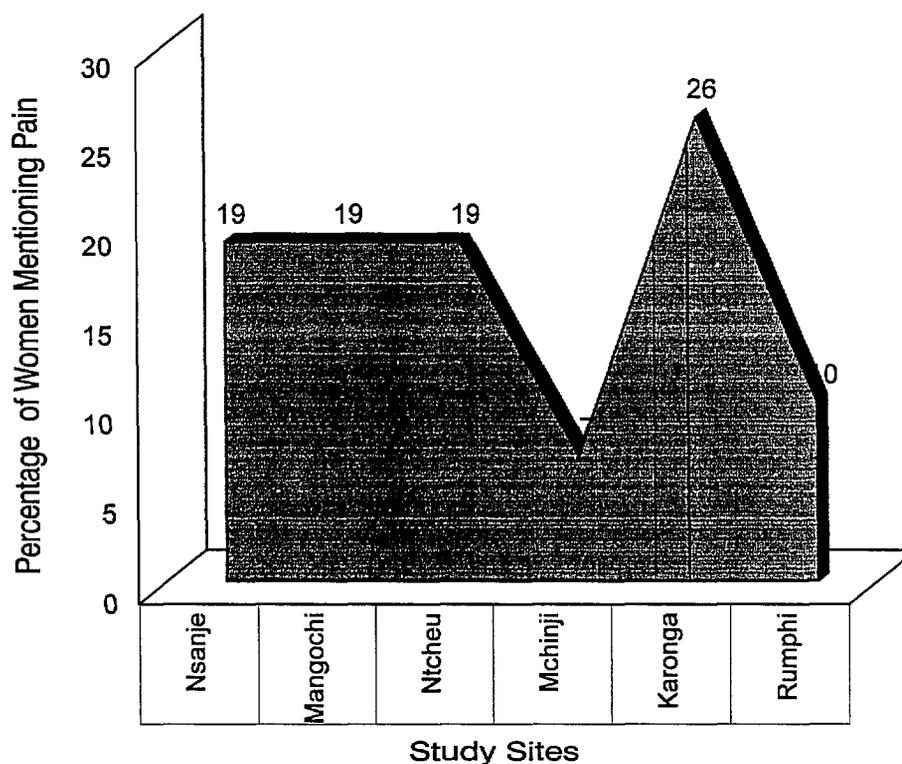
This problem was consistent in all sites even in a site where only four women received Depo-Provera (see Figure 8, p.89). According to the responses, 42 women interviewed reported having experienced this phenomenon.

Of the women who experienced severe abdominal pain, 8 were from Nsanje, 8 from Mangochi, 8 from Ntcheu, 3 from Mchinji, 11 from Karonga and 4 from Rumphu. Given these frequencies, a percentage of women experiencing this pain was calculated from each site as a proportion of the 42 total responses. Of the 42 women responding on pain, the largest percentage perceiving this excruciating pain were from Karonga and Nsanje and the least were from Mchinji. It was not established whether these women usually experienced dysmenorrhoea with their regular periods.

The pain characteristically was reported as sharp or colicky. Some stated that they felt like someone was cutting them in the abdomen with a razor blade. Typically women said they felt a wave of heat in the abdomen, followed by colic or cutting pain and with this the clots would come out. According to the responses, the pain radiated to the back and the supra pubic area.

Figure 8

Percentage of Women Discontinuing Depo-Provera due to Severe Abdominal Pain: Differences by Study Site (N = 42)



c) Method Side Effects

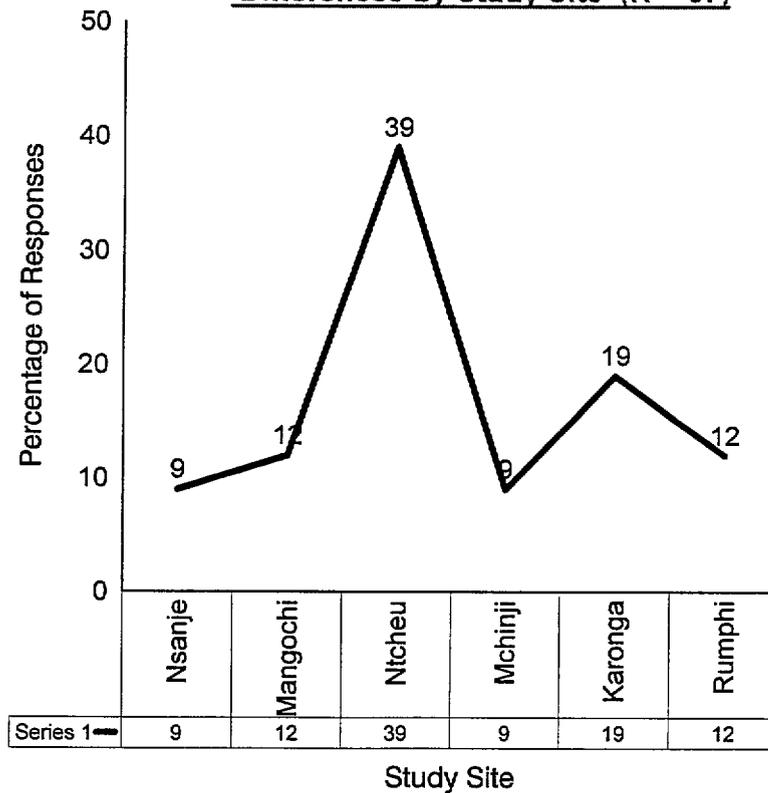
Sixty-seven of the responses were on method side effects. Women from all the six sites reported to have had physical side effects which led to their discontinuation of Depo-Provera. Among those most frequently reported were high blood pressure, feeling weak and fatigued, heart palpitations, dizziness, fainting, collapsing, loss of appetite, excessive weight loss and weight gain, general body pains, headaches swelling of legs, and difficulties in sleeping and breathing (Figure 9).

Of the women reporting side effects, 6 were from Nsanje, 8 from Mangochi, 26 from Ntcheu, 6 from Mchinji, 13 from Karonga and 8 from Rumphhi. According to their explanations, women experienced these effects in varying degrees ranging from mild to severe forms. In severe states of the physical effects women said they curtailed their activities and they believed this was due to Depo-Provera. Of all the side effects, women explained how they believe that excessive weight gain and loss is caused by Depo-Provera. Women who lost weight

excessively also reported having problems of bleeding heavily. Women who have a combination of bleeding heavily and excessive weight loss are considered to be from AIDS. Women who once had excessive weight gain reported having low self-esteem because they did not like their big bodies, but after discontinuing Depo-provera they felt better.

Figure 9

Percentage of Women Discontinuing Depo-Provera due to Method Side Effects: Differences by Study Site (N = 67)



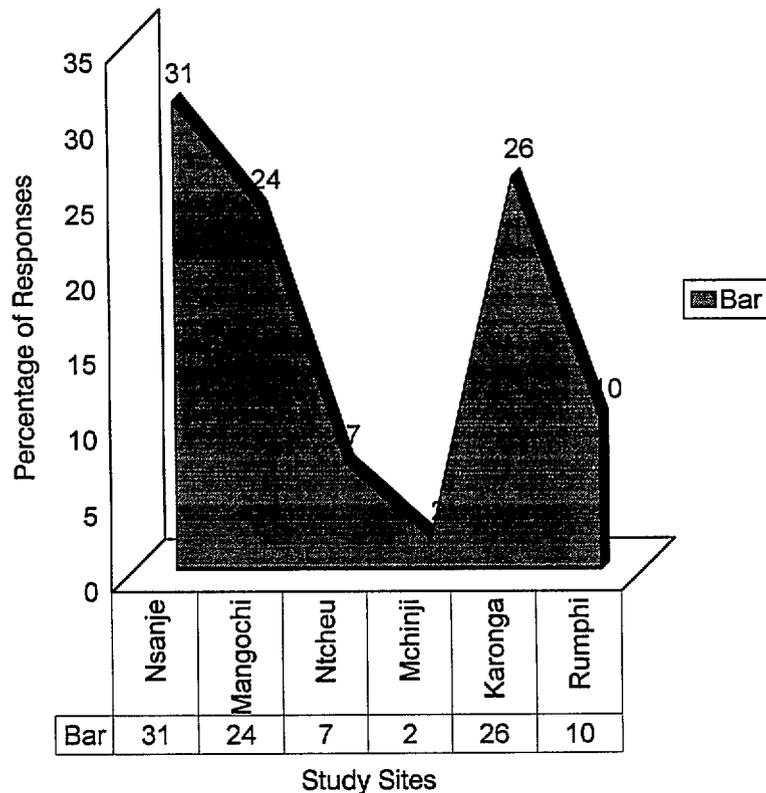
d) Social Reasons

Women gave 42 responses on social reasons that were attributed to their discontinuation of Depo-Provera. Among the reasons were: 1) husbands walking out on their wives if they were bleeding continuously; 2) divorce; and 3) husbands married second, third or fourth wives. In other sites, husbands had died. Some women reported to have experienced marital conflicts arising from not meeting the sexual demands of their husbands. All sites had reported social reasons. Of the responses given as social reasons, 13 were from

Nsanje; ten, from Mangochi; three from Ntcheu; one from Mchinji; 11 from Karonga; and, four from Rumphhi. The percentage responses are presented in Figure 10.

Figure 10

Percentage of Women Discontinuing Depo-Provera due to Social Reasons: Differences by Study Site (N = 42)

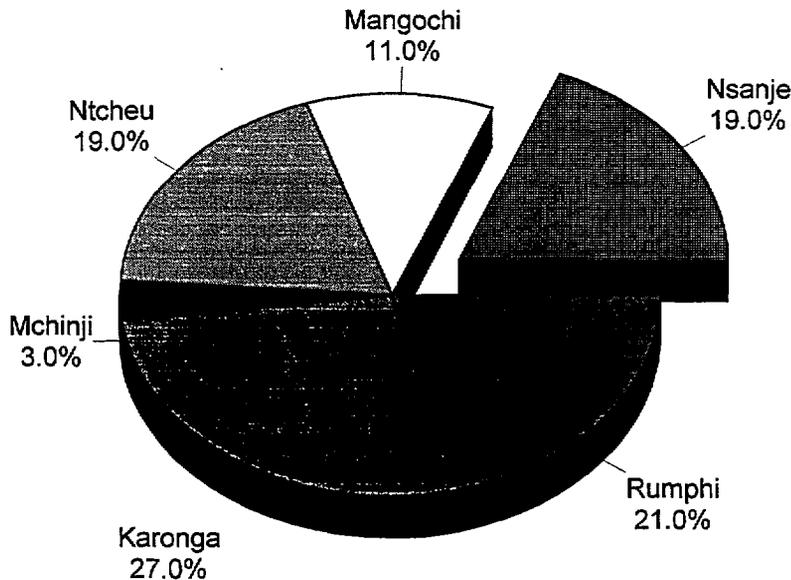


e) Rumours About the Effects of Depo-Provera

Thirty-seven women as well as men reported scary rumours about Depo-Provera. These varied from one site to the other. Most of them had heard that Depo-Provera causes infertility, cancer, AIDS, death and excessive weight loss and pain on sexual intercourse. Although there might have been no cause for alarm, participants indicated that they believe in these rumours very much and some of the participants based their discontinuation of Depo-Provera on these. There were seven women from Nsanje, four from Mangochi, seven from Ntcheu, one from Mchinji, ten from Karonga and eight from Rumphhi who reported to have discontinued Depo-Provera due to rumours of other reasons (Figure 11, p.92).

Figure 11

Percentage of Women Discontinuation of Depo-Provera due to Rumours: Differences by Study Site (N = 37)



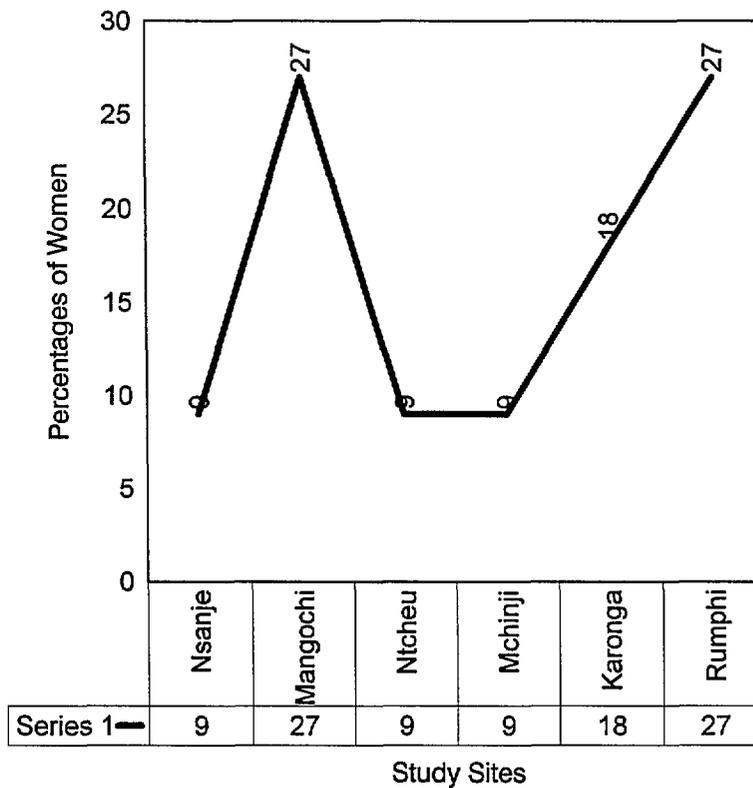
f) Desired Pregnancy

Besides side effects of Depo-Provera, women discontinued using it because they felt they were ready for another child. Compared to the other reasons, only a few women from the sites discontinued for this reason. Of the women reporting to have discontinued for another baby, one was from Nsanje; three from Mangochi; one from Ntcheu; one from Mchinji; two from Karonga; and, three from Rumphu. (Figure 12, p.93).

Considering that women started using Depo-Provera because they felt they had adequate numbers of children, had experienced child-care burden and wanted to rest from the ordeal of frequent childbirth, it seemed fitting that most women did not discontinue these methods for another child. Other women who started using Depo-Provera already had many children and they wanted to have TL but were scared to have an operation. Some of them chose Depo-Provera thinking that they would eventually develop permanent sterility. They got this information through the rumours circulating in their areas.

Figure 12

**Percentage of Women Discontinuing Depo-Provera
in Preparation for Another Baby:
Differences by Study Site (N = 11)**



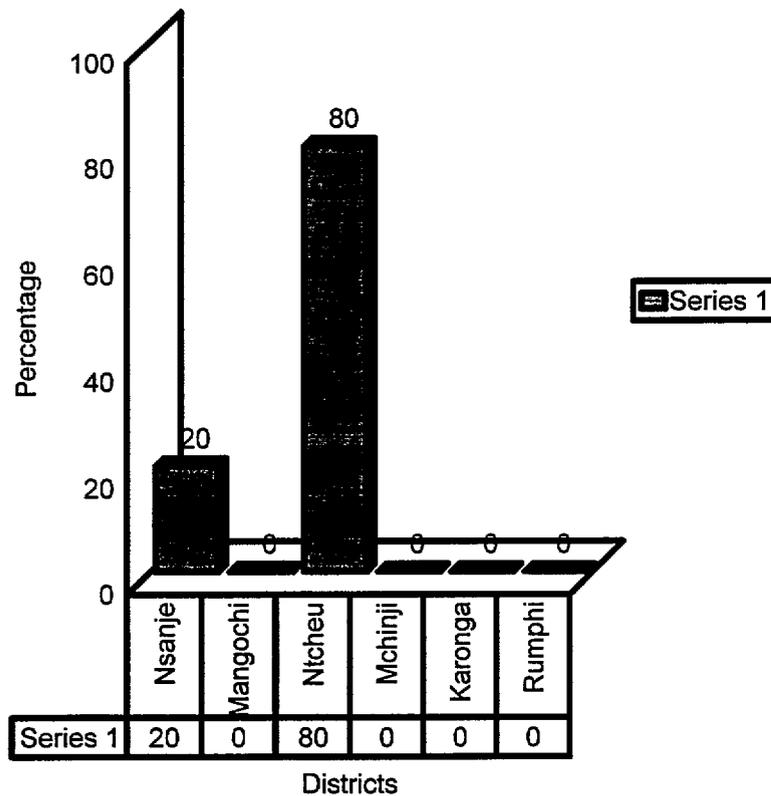
g) Provider Attitudes

Some women reported to have discontinued due to negative attitudes of family planning providers especially when they sought explanations about the bleeding phenomena they experienced. Negative responses from providers were communicated to other women who wanted to seek the assistance but declined because of the information they received from their friends. Although not all sites reported this problem, there were 10 women who discontinued due to negative attitudes.

Two of these women were from Nsanje, eight from Ntcheu and none from the other four sites (Figure 13, p.94). In Nsanje, some women reported that the care providers were not approachable. A woman reported that she was unable to express herself when she had a problem with excessive bleeding because the provider was unapproachable.

Figure 13

Percentage of Women Discontinuing Depo-Provera due to Provider Attitudes: Reasons by Study Site (N = 10)



It should be noted however that many women experienced negative attitudes from the clinics but they chose to continue with the methods because of the perceived valuable effects.

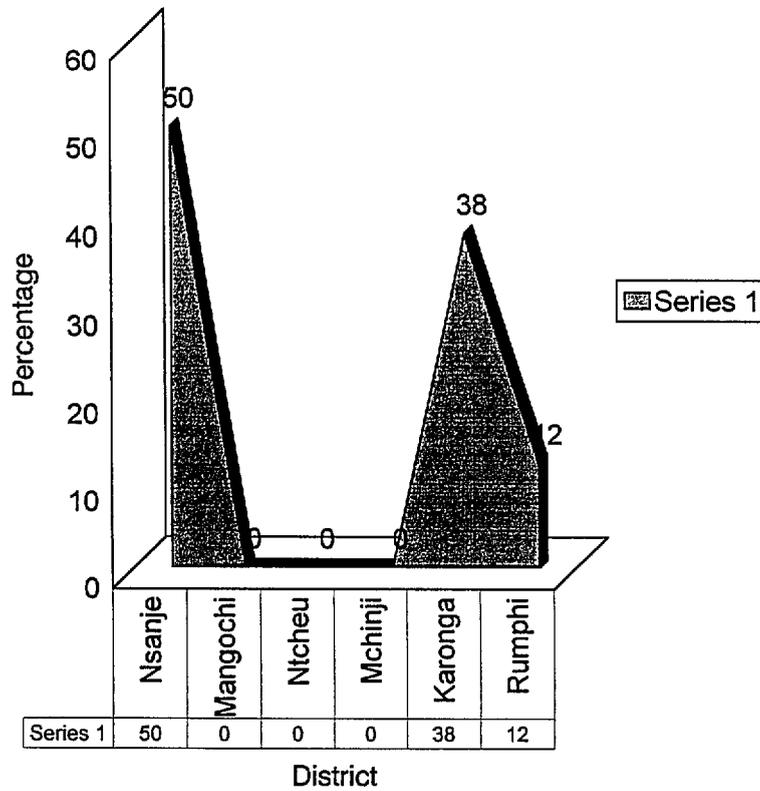
h) Service Provision/ Clinic Factors

Eight women reported to have discontinued Depo-Provera because of unavailability of services at the clinics on several consecutive days. The frequently reported reasons were industrial action by the civil servants, unavailability of Depo-Provera at one clinic, provider not available at the clinic on several consecutive occasions.

Of the eight women, four from Nsanje; three from Karonga; and, one from Rumphhi. In Nsanje, women reported that the care provider at one clinic was not available and sometimes not approachable. One woman went to the clinic three times in several weeks and found no provider. She complained about the time she had wasted by going to the clinic instead of doing something productive in the gardens (Figure 14).

Figure 14

Percentage of Women Discontinuing Depo-Provera due to Clinic Factors: Differences by Study Site (N = 8)

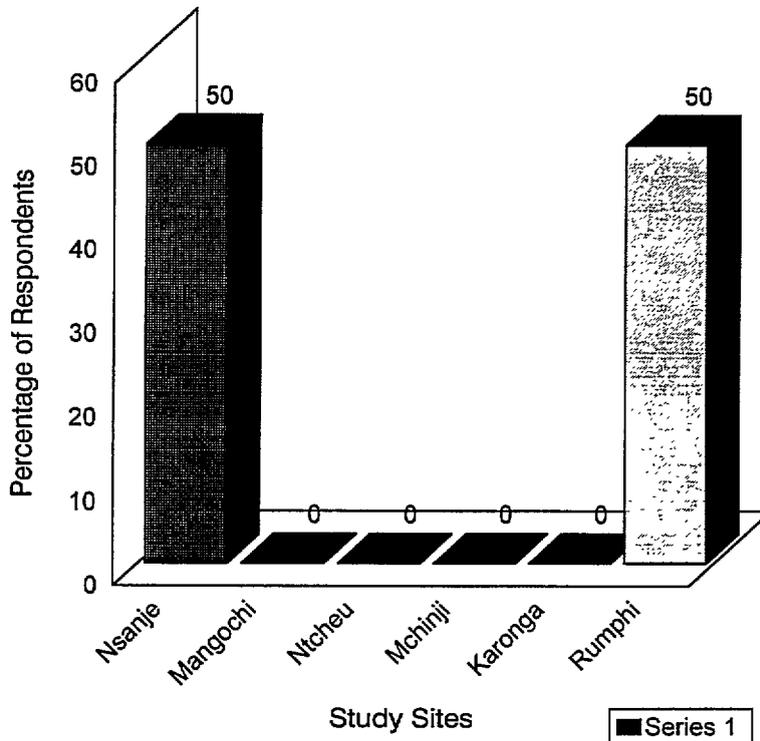


i) **Esteem Reasons**

Six women reported to have discontinued due to low esteem especially from the effects of heavy bleeding and weight loss. Others reported to have been affected due to cessation of their menses therefore it was hard for them to identify their femininity in the absence of their menstrual periods. Other women reported that their esteem was affected when their husbands walked out on them. Men expressed their disgust with the women's bleeding problems and that their sexual desires were not fulfilled. Of the six, three were from Nsanje and the other three from Rumphhi (Figure 15, p.96).

Figure 15

Percentage of Women Discontinuing
Depo-Provera due to Esteem Problems:
Differences by Study Site (N = 6)



j) Undiagnosed Pregnancy

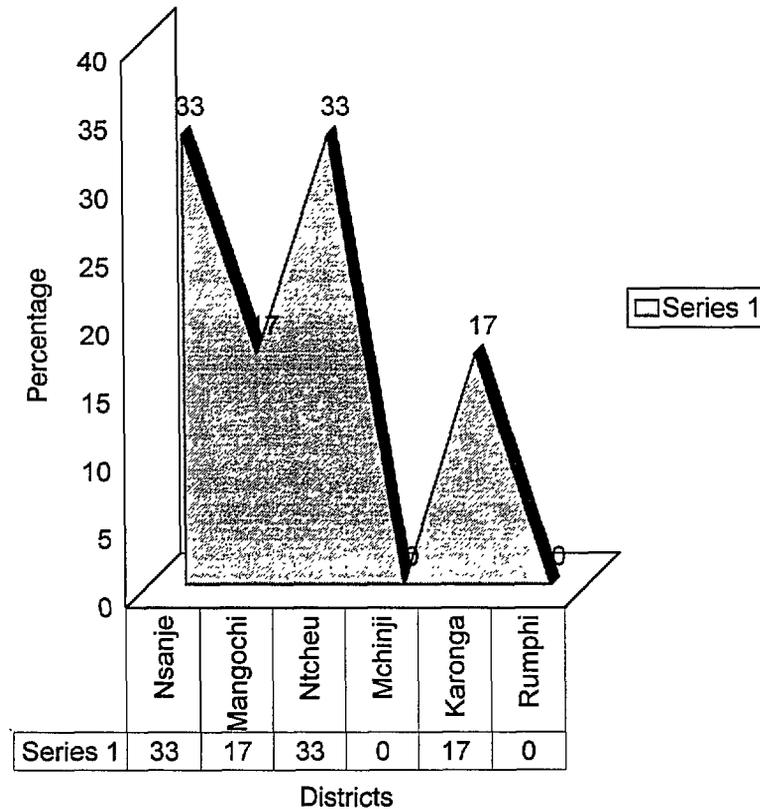
Six women were commenced on Depo-Provera while pregnant. There were two from Nsanje; one from Mangochi; two from Ntcheu; and, one from Karonga (Figure 16).

Five of the six women suspected that they were pregnant. They informed their FP providers of their suspicion. These women went to their clinics and explained that they had no periods for some time. However, they were started on Depo-Provera before further investigations were made.

A few reported to have received two injections of Depo-Provera by the time their pregnancies were confirmed. Some women reported to have persuaded the providers to examine them because the women suspected that they might have been pregnant. It was through this persuasion that a few of the women's pregnancies were confirmed.

Figure 16

**Percentage of Women Discontinuing
Depo-Provera due to Undiagnosed Pregnancy:
Differences by Study Site (N = 6)**



A participant who was a 2nd wife whose husband had only two children from his first wife stated that

I told my husband that I was tired of bearing children so I wanted to rest. He refused because he wanted more children. On my own I felt it was necessary to use a FP method despite my husband's disapproval. I consulted my sister who lives in Blantyre. My sister supported my ideas and said it was necessary to do that because life is very expensive so too is supporting a family. I further told her that I wanted to stop childbearing. I also consulted my mother and she supported my idea. Without my husband's knowledge I started to use the modern contraceptives. Because I didn't want him to know I took an injection. I was already pregnant when I received the first injection but I didn't know it.

(Mangochi, Southern Region Interview/FGD, July-Aug., 1997)

I had initially been instructed to go to the clinic once I had my periods. I had no periods for some time and I went to the clinic three times informing them that I had not menstruated. I was examined partially and was told not to

worry because I was not pregnant. I received the first injection and went home. When I was about due for my 2nd injection, I started feeling funny as if I was pregnant. I informed my sister and she advised me to go to the clinic to explain. Reluctantly, I went there. Upon examination, I was told that I was more than four months pregnant. I sought assistance from the clinic to abort the pregnancy because I was not ready for it but instead they advised me to have a Tubal Ligation after the birth of my baby. My husband was informed about T/L and he refused to sign a consent form. Thereafter I did not go back to the clinic or hospital, instead I had a home delivery. Up to now I am not using any method.

(Ntcheu, Central Region Interview/FGD, July-Aug., 1997)

k) **Child Related Factors**

Five women reported to have discontinued because their children had died. According to their explanations, they saw no reason for continuing with Depo-Provera when they had no small children to look after. There were 4 women from Nsanje and 1 from Ntcheu

12. Other Reasons

Five other reasons were given 3 from Nsanje, 1 from Mchinji and 1 from Rumphu. In some sites, women reported that their husbands were not happy with the women's health which was deteriorating and asked them to discontinue Depo-Provera. One woman wanted to change a method therefore discontinued Depo-Provera

Reasons Attributed to Discontinuing Modern Contraceptives Within Sites

1. Within Site Reasons for Nsanje

a) **OCPs**

Eight women from Nsanje gave 5 responses on the reasons they attributed to discontinuing OCPs. The problems, their frequencies and percentages, are presented a table below (Table 18, p. 99). From this data, the problems were, 1) bleeding problems ranked high; 2) desire for another baby; 3) rumours about the side effects of OCPs; 4) method side effects; and 5) social reasons.

b) **Depo-Provera**

From the main reasons women attributed to discontinuing Depo-Provera in Nsanje were: 1) Bleeding problems; 2) Social reasons; 3) Severe abdominal pains and backache; 4) rumours about the adverse effects of Depo-Provera; 5) method side effects; 6) service provision

and clinic factors; 7) death of a child; 8) esteem problems; 9) others (husbands' concerns); 10) provider's attitudes; 11) pregnancy; and, 12) desired pregnancy (Table 19, p.92).

Table 18

Reasons for Discontinuing OCPs in Nsanje (N = 15)

Reasons Mentioned	Number of responses	Percentage
Bleeding problems	4	27
Desired pregnancy	3	20
Rumours	3	20
Method side effects	3	20
Social	2	13

Table 19

Reasons for Discontinuing Depo-Provera in Nsanje (N = 82)

Reasons Mentioned	Number of Responses	Percentage
Bleeding Problems	29	35
Social reasons	13	16
Severe abdominal pain and backache	8	10
Rumours about Depo-Provera	7	9
Method side effects	6	7
Service provision/clinic factors	4	5
Child death	4	5
Esteem reasons	3	4
Other (husband's concern)	3	4
Provider attitudes	2	2
Pregnancy	2	2
Desired pregnancy	1	1
Total	82	100

In Nsanje, 29 women reported to have had bleeding problems. Of these, 23 reported heavy bleeding, five reported irregular and scanty bleeding and one reported having had no menses.

Women reported different social reasons for discontinuing Depo-Provera. Seven reported having sexual conflicts due to heavy and continuous bleeding; five reported that their husbands left and re-married other wives because their sexual desires were not satisfied by wives who were bleeding

heavily and continuously; one reported to have been divorced. As an attempt to win back their husbands, women discontinued Depo-Provera.

Eight women who reported heavy bleeding also reported having severe abdominal pains. Seven women reported to have been scared due to the rumours that Depo-Provera causes secondary infertility and excessive weight loss.

*My wife discontinued the injection without telling me. She said she was afraid of the rumours circulating in our area. There are some people who are bleeding daily and heavily and she says that scares her. I asked her why she discontinued, I noted that she discontinued earlier than the period I was informed and also last month she found that she was pregnant.
(Nsanje, Southern Region Interview/FGD, July-Aug., 1997)*

The method side effects these women reported were: 1) weakness of the body; 2), excessive weight gain; 3) and excessive weight loss.

Four women reported to have given up (discontinued) because of the non availability of services at the clinic. Women reported of having gone to the clinic many times and finding no one at the clinic.

*I gave up because the provider did not turn up. I went twice but did not receive anything. He was ill therefore I got lazy and just stopped. After 7 months I went again, the provider was not there so I gave up. My two days were wasted without going to the garden, this discouraged me and I just stopped completely.
(Nsanje, Southern Region Interview/FGD, July-Aug., 1997)*

Four women reported to have discontinued because of death of their children. Three women stated that they were worried about their excessive bleeding because even though their husbands did not react adversely, the women reported feeling low about themselves and helpless.

Three women reported that their husbands told them to discontinue Depo-Provera out of concern for their poor health resulting from the continuous bleeding. Two women reported to have discontinued due to poor attitudes of providers who were seen not to be helpful in assisting the women when they had excessive bleeding problems. Two other women reported that they were already pregnant before commencing Depo-Provera and the providers did not diagnose the pregnancy during the first visit. However, upon the confirmation of the pregnancies Depo-Provera was discontinued. Only one woman reported to have discontinued because she wanted another baby.

2. Within Site Reasons for Mangochi

Differences were noted in Mangochi in reasons attributed to discontinuing OCPs and Depo-Provera. Women reported multiple reasons.

a) **OCPs**

Seventeen women from Mangochi gave 6 reasons for discontinuing OCPs. These reasons were, 1) method side effects; 2) rumours; 3) bleeding problems; 4) social; 5) method failure; and others (see Table 20, p.101).

b) **Depo-Provera**

Reasons why women from Mangochi discontinuing Depo-Provera were: 1) bleeding problems; 2) social reasons; 3) severe abdominal pains and backache; 4) method side effects; 5) rumours about the adverse effects of Depo-Provera; 6) desired pregnancy; and, 7) pregnancy.

Table 20

**Reasons for Discontinuing OCPs
in Mangochi (N =19)**

Reasons Mentioned	Numbers of Responses	Percentage
Method side effects	5	26
Rumours	5	26
Bleeding problems	4	21
Social	2	11
Method failure	2	11
Others	1	5

Table 21

**Reasons for Discontinuing Depo-Provera
in Mangochi (N = 48)**

Reasons Reported	Number of Responses	Percentage
Bleeding Problems	14	29
Social reasons	10	21
Severe abdominal pain and backache	8	17
Method side effects	8	17
Rumours about Depo-Provera	4	8
Desired pregnancy	3	6
Pregnancy	1	2

Ten of the women with bleeding problems reported heavy and continuous bleeding, one reported irregular and scanty bleeding and three had no menses.

I receive the injection for one year. I bled continuously and heavily for 2 months, changing the heavy sanitary cloth I wore very frequently. Each time I changed, I was heavily soaked with blood. My heart started to beat very fast and I was not at peace. I went to the clinic, received white pills and took one tablet once a day till I finished a whole packet and this did not stop the bleeding. My husband just told me to stop the injection immediately
(Mangochi, Southern Region Interview/FGD ,July-Aug., 1997)

Of the women who discontinued Depo-Provera because of social reasons, four reported that their husbands left; one woman had just re-married, her new husband did not want her to use any modern contraceptives but she used contraceptives with her previous husband, Two were divorced, another two were on separation from their husbands because of family conflicts from sexual dissatisfaction; and one woman reported that her husband had gone out of the country.

Six women who had reported heavy bleeding also reported experiencing severe abdominal pains. Less than ten women discontinued due to method side effects unrelated to bleeding. These were: four women reported having general body pains; two experienced heart palpitations; one reported constant headaches; and the last woman reported having yellow colouration of her skin.

Four women reported to have been influenced by rumours about the effects of Depo-Provera. At this site the commonly reported rumours were that Depo-Provera causes AIDS and infertility. Three women reported that their husbands wanted another child.

My husband wanted me to discontinue because he wanted another baby. He talked about wanting a female baby. I was happy about the suggestion, the other children were already grown up. I also wanted a girl who would be like a sister to me. (Wife's version). I am not sure. May be she stopped. I have not seen her experience any problems enough to make her stop. I have failed to follow up on the methods. My wife goes home now and then so its difficult to trace what she is doing. If she gets pregnant that will be a problem but she insists that we should have enough children except I have not followed that up (Husband's version)
(Mangochi, Southern Region Interview/FGD ,July-Aug., 1997)

One woman was already pregnant when she was given the first dose of Depo-Provera but the method was discontinued once the woman's pregnancy was confirmed.

3. Within Site Reasons for Ntcheu

a) OCPs

Nine women from Ntcheu discontinued OCPs giving six reasons including, 1) method side effects; 2) rumours; 3) desire for another baby; 4) method failure; 5) social; and, 5) other reasons (Table 22).

b) Depo-Provera

Reasons women attributed to discontinuing Depo-Provera were: 1) method side effects; 2) bleeding problems; 3) severe abdominal pains and backache; 4) provider attitudes; 5) rumours about the adverse effects of Depo-Provera; 6) social reasons; 7) pregnancy; 8) death of a child; and, 9) desired pregnancy (Table 23).

Table 22

**Reasons for Discontinuing OCPs
in Ntcheu (N = 16)**

Reasons	Number of Responses	Percentage
Method side effects	6	38
Rumours	4	25
Desire for a baby	2	12.5
Method failure	2	12.5
Social	1	6.25
Others	1	6.25

Table 23

**Reasons for Discontinuing Depo-Provera
in Ntcheu (N = 75)**

Reasons	Number	Percentage
Method side effects	26	35
Bleeding Problems	19	25
Severe abdominal pain and backache	8	11
Provider attitudes	8	11
Rumours about Depo-Provera	7	9
Social reasons	3	4
Pregnancy	2	3
Child died	1	1
Desired pregnancy	1	1

The method side effects women from Ntcheu mentioned were: eight had heart palpitations; five reported having excessive weight loss; four had high blood pressure; four had dizziness; three reported having excessive weight gain; and, two reported feeling general weakness and numbness.

Of the 19 women with bleeding problems, 15 reported heavy bleeding, 2 irregular and scanty bleeding and 2 reported having no menses.

I used to have 3 months of continuous bleeding with clots. I felt like I was delivering a baby, I was changing my sanitary towels almost 10 times a day and I used to carry them to the river in a jumbo plastic bag like I was carrying baby's nappies to wash. I had severe abdominal pains. I talked to my friend and she told me that I will lose more blood and become anaemic. I got scared and stopped the injection. My husband was then working in Lilongwe and each time he came home he would find me bleeding and he was very disappointed in the method. I continued so I went and saw the nurse and she advised me to stop but I asked her to give me one more injection to see if I will continue bleeding. I continued for three more months up to September. I did not go back to the nurse but I asked my friend to help me. She brought me traditional medicine which I used for 4 days and the bleeding stopped. I stayed for 4 months without bleeding then started my periods. Soon after this I became pregnant. I tried to abort but it didn't work. I didn't want the baby but there was nothing I could do.

(Ntcheu, Central Region Interview/FGD ,July-Aug., 1997)

I asked my wife to stop the injection because of her experiences, bleeding and abdominal pain. I felt sorry for my wife. She was in agony and very pale. I just wanted her to stop because I thought she might die with the bleeding. I told her to stop using this method immediately because I was afraid that she might die.

Ndikuti anali womvetsa chisoni mwana wamkazi atatuwa mbuu chifukwa cha jekeseni. Ndipotu azimai akuzigwira ndi kudziona komwe. (Chichewa Make, basi siyani zikutengerani kumanda izi" (Chichewa).

(Ntcheu, Central Region Interview/FGD ,July-Aug., 1997)

Eight out of the women who reported having bleeding problems also reported that they had severe abdominal pain and backache.

Eight women reported to have discontinued Depo-Provera because they had problems which the provider was unable to assist them with. Three of these women had actual confrontation with the provider but the other five reported that they did not bother to seek help because they were advised by their friends not to go to the clinic because they will not receive any assistance.

Seven women reported to have discontinued for fear of secondary infertility, developing AIDS (because women who were using Depo-Provera were wasted). Two social reasons were reported from Ntcheu. Two women reported to have been divorced and one was on separation because husband just left her.

Two women reported to have been commenced on Depo-Provera while

pregnant. According to the women's responses, they did not receive thorough examination. As soon as pregnancy was confirmed, Depo-Provera was discontinued.

I had received the injection for three years. I got sick prior to my next scheduled injection. When I got better, I went for my next dose, I was not aware that I was pregnant. I assumed that this is what usually happens because I alternated heavy bleeding with six months of no bleeding. In July, I felt funny. I felt something moving in my tummy. I went to the clinic to report so they could examine me. When I reported this to the provider she asked me how I could think of pregnancy when I had been receiving a contraceptive injection?

The provider did not want to examine me. I pleaded with her and she did. She informed me that I was five months pregnant. With that I stopped the injection. The movements of my baby ceased in August. I went back to the clinic and was advised to wait, I waited for two months and they told me to go to the district hospital. The baby was born before I went to the hospital, was dead and very thin. The provider said I should still go to the hospital because it could have been a sexually transmitted disease which caused this. My husband refused because he said he never had any sexual intercourse with anyone. I think my baby died due to the injection and both of us are very upset about how we were treated.

(Ntcheu, Central Region Interview/FGD ,July-Aug., 1997)

One woman reported to have discontinued because her child died. Another woman reported to have been ready to have another child.

4. Within Site Reasons For Mchinji

a) OCPS

Twenty-three women from Mchinji reported 6 reasons for discontinuing OCPs. Two reasons were frequently mentioned and these were the desire for another baby and method side effects. It is important to note that Mchinji being a district where most women reported to have used OCPs, the number of side effects these women reported was relatively small (Table 24, p.106).

b) Depo-Provera

Although there were only 4 respondents who discontinued Depo-Provera they mentioned six reasons for this discontinuing the method. The reasons were, method side effects; bleeding problems; severe abdominal pains and backache; rumours about the adverse effects of Depo-Provera; social reasons; other reasons; and, desired pregnancy (Table 25, p. 106).

The desire for another baby influenced women's discontinuation of OCPs in Mchinji. Although many women reported the desire to have been from both husband and wife, the data seems to suggest that many women who discontinued OCPs in preparation for another baby responded to what their husbands suggestion. There were very few examples when women informed their husbands about their intentions to discontinue OCPs in preparation for a baby. Those few examples are noted in families where the youngest child had died.

Table 24

**Reasons for Discontinuing OCPs
in Mchinji (N = 34)**

Reasons	Number of Responses	Percentage
Desire for a baby	17	50
Method side effects	5	15
Rumours	5	15
Missed clinic appointment	3	9
Social	2	5.5
Others	2	5.5

*Although I bled heavily every month for one week, when I was using contraceptive pills, and was fat while taking them, I continued to use them for over one year. I stopped when my child was three years old. I had no problems with the clinic staff but I stopped last year because my husband wanted a child and my mother also said a lot of bad things about the contraceptives I was taking.
(Mchinji, Central Region Interview/FGD ,July-Aug., 1997)*

Table 25

**Reasons for Discontinuing Depo-Provera
in Mchinji (N= 15)**

Reasons	Number of Responses	Percentage
Method side effects	5	33.2
Bleeding Problems	3	20
Severe abdominal pain and backache	3	20
Rumours about Depo-Provera	1	6.7
Social reasons	1	6.7
Other reasons	1	6.7
Desired pregnancy	1	6.7

My wife was using pills. She was overdue for re-supply of the pills for four days. The provider chased her from the clinic indicating she was not serious. She was frustrated and just stayed at home

(Mchinji, Central Region Interview/FGD ,July-Aug., 1997)

We had two children and wanted to stop due to financial problems. Husband initiated that I discontinue and have my tubes tied. My parents agreed but his parents did not. My husband told me to listen to him only and not the rest of the people. We discussed this for one year and then I said I will start Depo-Provera and I was told not to. I had 9 cycles of OCPS between 1994 and 1995. I started having abnormal bleeding of 6 days and big clots instead of bleeding for 3 days. My husband could not wait for six days without sex so we used condoms. I could not go to the clinic to report for fear of being told that I lied about the bleeding because I wanted another child. I stopped because my husband told me to.

(Mchinji, Central Region Interview/FGD ,July-Aug., 1997)

The method side effects women from Mchinji mentioned were: heart palpitations; high blood pressure; and, shock or fainting due to excessive bleeding.

When my wife was going for her second injection at the clinic, she collapsed on the way. I was assisted to get her to the clinic. There she was told that I was very strong and that my pollen (sperms) was struggling with the injection. She was also told that her blood pressure was high so she needed to have another baby for her to be well. We had gone to a private clinic and we were told that if we went to the district hospital my wife will have an operation and could die from it.

"Amayi muli pa danger, chibelekero chanu chikufuna mwana pamene inu mukuchiletsa (Chichewa)"

(Mchinji, Central Region Interview/FGD ,July-Aug., 1997)

After delivering many children, friends told me that I could die from having my tubes tied. I went home and had a thirteenth child. After this I realized that I had too many children, had no money. I was once admitted at a district hospital with a grand child who was ill. Here I heard that there are other methods of contraception. Previously I only knew about the operation to tie tubes. I started Depo-Provera immediately in 1988 and took it for three years. I had slight bleeding. I used Depo-Provera up to 1991 when my husband died. I re-married in 1994 and re-started Depo-Provera until 1996, thus when I discontinued. I had heart problems, sometimes I could faint, and one day I collapsed and was taken to the hospital where I was found with a high blood pressure. I was advised to stop Depo-Provera and seriously consider having my tubes tied. I told my husband and he said it was not necessary because he said I had stopped bearing children anyway.

Mchinji, Central Region Interview/FGD ,July-Aug., 1997)

I think I have the high blood pressure because I changed husbands. The current one is very young and strong and my blood is trying to get used to his power (sperms). Mwamuna ndakwatiwa nayeyutu ndi wamphanvu zedi, moti mphavu yakeyo ikakomana ndi magari anga ndi amene akupangitsa kuti magari angawa adzithamanga chonchi (Chichewa).

Mchinji, Central Region Interview/FGD ,July-Aug., 1997)

All three women from Mchinji reported having heavy bleeding in addition to other problems they had with Depo-Provera. However, in responding to why they discontinued using this method, all mentioned multiple reasons. Heavy bleeding and abdominal pains were common experiences for all. They also had one or two of the problems indicated in the above table.

Because of heavy bleeding I stopped the contraceptives in April this year. Since I stopped, I am now feeling much better. I knew that it is the injection which made me feel like that and I still feel that I still have the effect of the medications in my body. My heart was pumping fast, I could feel it in my chest. I had colic pains in my abdomen like someone was cutting me with razor blades and my husband did not like what I was experiencing.

(Mchinji, Central Region Interview/FGD ,July-Aug., 1997)

My friend told me that her sister died from these medications and that I could also lose a lot of blood in my body because of the injection. Because of how I suffered with this injection, he told me not to receive it anymore.

Mchinji, Central Region Interview/FGD ,July-Aug., 1997)

All the three women from Mchinji who reported heavy bleeding also reported having severe abdominal pains and backache. Only one woman reported that she discontinued Depo-Provera after her friend convinced her to discontinue. She had one child and her friend informed her that she will have secondary infertility.

One woman discontinued because her first husband died but she was also bleeding heavily. Another woman discontinued Depo-Provera because her husband informed her to do so. The husband told her discontinue because of his concern about his wife's deteriorating health which resulted from heavy bleeding. The fourth woman who was on Depo-Provera discontinued because her husband wanted another baby.

5. Within Site Reasons For Karonga

a) OCPS

Nine women from Karonga gave 5 reasons for discontinuing OCPs including, 1) method side effects; 2) rumours; 3) desired pregnancy; 4) bleeding; and, 5) method failure (Table 26, p. 109).

b) Depo-Provera

In Karonga, women attributed the following reasons to discontinuing Depo-Provera: 1) bleeding problems; 2) method side effects; 3) rumours about the adverse effects of Depo-Provera causing cancer and death; 4) social reasons; 5) severe abdominal pains and backache; 6) desired pregnancy; 7) pregnancy; and, 8) service provision and clinic factors (Table 27, p.109).

Eighteen out of the 20 women (90%) reported to have discontinued Depo-Provera due to bleeding problems in addition to other reasons they gave. Of the 18 who experienced bleeding problems, 12 reported experiencing heavy and continuous bleeding; four reported having irregular bleeding; and, two reported stopping menstruating.

Table 26
**Reasons for Discontinuing OCPs
in Karonga (N = 18)**

Reasons	Number of Responses	Percentage
Method side effects	7	39
Rumours	5	28
Desired pregnancy	3	17
Bleeding	2	11
Method failure	1	5

Table 27
**Reasons for Discontinuing Depo-Provera
in Karonga (N= 69)**

Reasons	Number of Responses	Percentage
Bleeding	18	26
Method side effects	13	19
Severe abdominal pain and backache	11	16
Social reasons	11	16
Rumours about effects of Depo-Provera	10	15
Service provision & clinic factors	3	4
Desired pregnancy	2	3
Pregnancy	1	1

Women who discontinued Depo-Provera in Karonga reported the following experiences as the basis for some of their decision to discontinue the method.

I received the first injection in August 1996 and had no menses up to December. The second injection was in December thereafter I started to bleed irregularly. According to our tradition, by the seventh day after menstruation, we are expected to have sexual intercourse. So accordingly we did that and by the time I opened my legs ready to receive my husband I just saw blood coming and wondered where this was coming from because I had stayed for a whole day without bleeding. This was frustrating me. How could I just leave my husband in anticipation while we were sharing the same bed? This did not just happen once. We tried again on subsequent days and each time I flexed my legs I would feel wet and upon checking I noticed that I was bleeding. (Karonga, Northern Region Interview, August, 1997)

We decided to use condoms because this situation was perpetuating and my husband was becoming impatient. When we used them once or twice I felt that it was not the same sensation, there was less sensual feeling with condoms and I gave up. Then I just discontinued Depo-Provera.

Sono mwa dango lithu pa dazi la seveni nati niponye kalundi uku chee. Munthu wawene akudokera waka. Kuluta pabedi pako ndaleka waka ndiyegze mbwenu chee, mbwenu nadi yayi Kuyezga "Makondomu yayi vikuzizima, uku zii. Nkhalazga kuti waka nizizipizge kweni yayi namunyinu..... (Karonga, Northern Region Interview/FGD ,July-Aug., 1997)

Another frustrated woman said:

After a whole period, I would stay the whole day without bleeding. Sometimes I stayed for two days without bleeding. I would be convinced that I had stopped bleeding for that month. So when my husband finally said lets have sex, he was soiled with blood, this was very annoying and it happened almost every month Para badada wati waryeko mbewu wavisanza mwani mumu. (Karonga, Northern Region Interview/FGD ,July-Aug., 1997)

After receiving the first injection, I had no periods for three months. I spotted in the third month. After the second injection, I had irregular periods. I was bleeding for a day every three days for one month then I had no periods the following month. I started to bleed heavily after receiving the third injection. I bled heavily for one month and stopped. I was changing sanitary pads for more than ten times a day and they were completely soaked. Following the fourth injection, I bled for one and half months. This was very heavy and I was also passing big clots. For a whole month I was bleeding like this. Each time I passed clots, I felt like I was delivering a baby. Prior to discharging the clots, I felt very sharp pain in my stomach, it felt like someone was pulling a string through it. Also, my the whole private part area felt like someone was burning fire on it. Once the clots come out, I felt better. Three months after the third injection, I also bled continuously for one and a half months. While I was still bleeding, there was a funeral somewhere in our community and my

husband attended. There, he learnt that the deceased died from complications of the FP methods she was using (method was not specified). Because my condition was worrying my husband very much, when he returned from this funeral he immediately told me not to receive any more injections and I did as he told me to. From the time I stopped receiving the injections, I have observed a big change in my body. I am not bleeding much and now I can eat well.

(Karonga, Northern Region Interview/FGD ,July-Aug., 1997)

The method side effects women from Karonga attributed to their discontinuation of modern contraceptives were: 1) four women reported having lost weight excessively; 2) two women had lost their appetites; 3) four women felt very weak; 4), two reported difficulties in breathing; and 5) one woman had an increased appetite.

Women reported excruciating pain similar to labour pain. Most of these stated that this was associated with heavy bleeding and intensity increased prior to discharging large clots from the birth canal.

Women from Karonga reported two main social reasons contributing to their discontinuation of Depo-Provera. Four women reported to have discontinued because their husbands ignored them and left and seven reported that their husbands married other women. According to these women, they believe that their husbands left or married other women because they (participants in the study) were bleeding continuously. Their discontinuation was to stop bleeding and win back their husbands.

Both men and women reported that in the whole Karonga, people were scared about the effects of Depo-Provera because they heard that it causes cancer and that just prior to this study, a woman had just died because of Depo-Provera. While it was not easy to substantiate this information, both men and women, educated and not educated strongly believe in it and some women reported to have discontinued on that basis.

Service provision factors reported by women from Karonga were related to unavailability of contraceptive services because of industrial action which affected delivery of out patient care services including family planning.

Only one woman reported to have discontinued using modern contraceptives because her husband wanted her to have another baby. One woman reported to have discontinued because she was pregnant at the time she received the first injection thus, she could not receive the second dose.

6. **Within Site Reasons For Rumphi**

a) **OCPS**

Eleven women from Rumphi reported these reasons for discontinuing OCPs. They reported, 1) method side effects; 2) desired pregnancy; 3) rumours; 4) social problems; 5) bleeding; and, 6) other reasons (Table 28, p.112).

b) **Depo-Provera**

The reasons women attributed to discontinuing Depo-Provera in Rumphi were: 1) bleeding problems; 2) method side effects; 3) rumours about the adverse effects of Depo-Provera; 4) social reasons; 5) severe abdominal pains and backache; 6) desired pregnancy; 7) esteem problems; 8) service provision and clinic factors; and, 9) other reasons (see Table 29).

Table 28

Reasons for Discontinuing OCPs
in Rumphi (N =25)

Reasons	Number of Responses	Percentage
Method side effects	8	32
Desired pregnancy	5	20
Rumours	5	20
Social	5	20
Bleeding	1	4
Other	1	4

Table 29

Reasons for Discontinuing Depo-Provera
in Rumphi(N = 47)

Reasons Identified	Number of Responses	Percentage
Bleeding Problems	15	32
Method side effects	8	17
Rumours about effects of Depo-Provera	8	17
Social reasons	4	9
Severe abdominal pain and backache	4	9
Desired pregnancy	3	6
Esteem problems	3	6
Service provision & clinic factors	1	2
Other reasons (Wanted to change method)	1	2

Fifteen women reported to have discontinued Depo-Provera due to bleeding problems in addition to other problems they had. Of the 15, nine reported having heavy and continuous bleeding; three reported having had irregular bleeding and the other three reported having stopped their menses. Women who had heavy and scanty bleeding also experienced severe abdominal pains. Women reported that they were disturbed and felt bad that they were not menstruating because they associated bleeding with femininity.

The side effects were mainly physical such as: 1) excessive weight gain; 2) excessive weight loss; 3) headache; 4) dizziness; 5) weakness; 6) high blood pressure; 7) difficulty breathing; and 8) fainting.

In Rumphu, the rumours that concerned women were that Depo-Provera causes infertility and cancer. One woman was encouraged by her grandmother to discontinue this method to prevent having secondary infertility. Women reported two social reasons for discontinuing Depo-Provera. One woman was deserted by her husband because she had been bleeding excessively and the other one lost her husband.

Two women reported that they wanted another child while one said that her husband wanted a baby. There was only one woman who discontinued because there was no Depo-Provera at the clinic. One woman discontinued Depo-Provera because she wanted to change to a traditional method of contraception.

Reasons Men Attributed to their Wives' Discontinuation of Modern Contraceptive Methods

It was hypothesized that many men were aware of the reasons why their wives discontinued modern contraceptives. This hypothesis was partially supported.

The data seems to suggest that some men were insensitive to the reasons why their wives stopped using modern contraceptives even after men initially consented to contraceptive use. Part of the insensitivity is mainly because of the men's social habits such as excessive beer drinking; spending time elsewhere and not in the home particularly for fishermen and business men; giving divided attention if the man had more than one wife or spending time in extramarital relationships.

In addition, the data also seems to suggest that the insensitivity was demonstrated by some men through their reaction when their wives experienced problems with the methods they used. Examples of men's responses are: walking away from their wives; demonstrating impatience when their sexual desires were not met; marrying several wives seeking sexual gratification; and, a lack of drive to find out why their wives had those experiences. Men exhibited these reactions at the time women

needed them the most for example in times of prolonged bleeding and when they were unable to conceive a pregnancy.

The major problem it seems was the lack of follow up and lack of interest in family planning matters. The data also seems to suggest that some men assumed that their wives discontinued because of the daily complaints women raised because of the effects of contraceptive methods.

We discussed the number of children we would have after the sixth child. My wife started with an injection then changed to pills. She was advised by the nurse to change. I don't know which problem she had but I know she had switched to pills. Now she stopped taking the pills last month and I don't know why.

(Mangochi, Southern Region Interview/FGD, July-Aug., 1997)

On further probing, we discovered that the couple had separated when the woman was bleeding when she was using Depo-Provera and had reconciled a week before this study. At the time they were reconciling, the woman did not have any bleeding problems.

Some men were frank in their responses. They acknowledge that they were not sure why their wives discontinued the contraceptives and others stated that it was not up to the men to follow up what their wives experienced. Other men who also were unable to monitor and support their wives when they had unpleasant experiences made the following remarks:

My wife started with injection but stopped abruptly because she was scared by her friends who told her that she would be very sick and could even die from the injection.

(Mchinji, Central Region Interview/FGD, July-Aug., 1997)

My wife has already stayed for 5 months without receiving any injection. I don't know how many times she had taken the injection but I know she has received the injection several times.

(Nsanje, Southern Region Interview/FGD, July-Aug., 1997)

My wife was bleeding continuously but I did not think this was the reason why she stopped.

(Karonga, Northern Region Interview/FGD, July-Aug., 1997)

My wife uses some methods. Sometimes she says she receives an injection and I don't know what type it is, sometimes she does not receive it. My wife also goes home to see her mother many times and I do not know what she does there. You know I am the kind of person who never cares about what she does so I let her do her own things. Of late I have heard from her friends that she is using something else.

(Mangochi, Southern Region Interview/FGD, July-Aug., 1997)

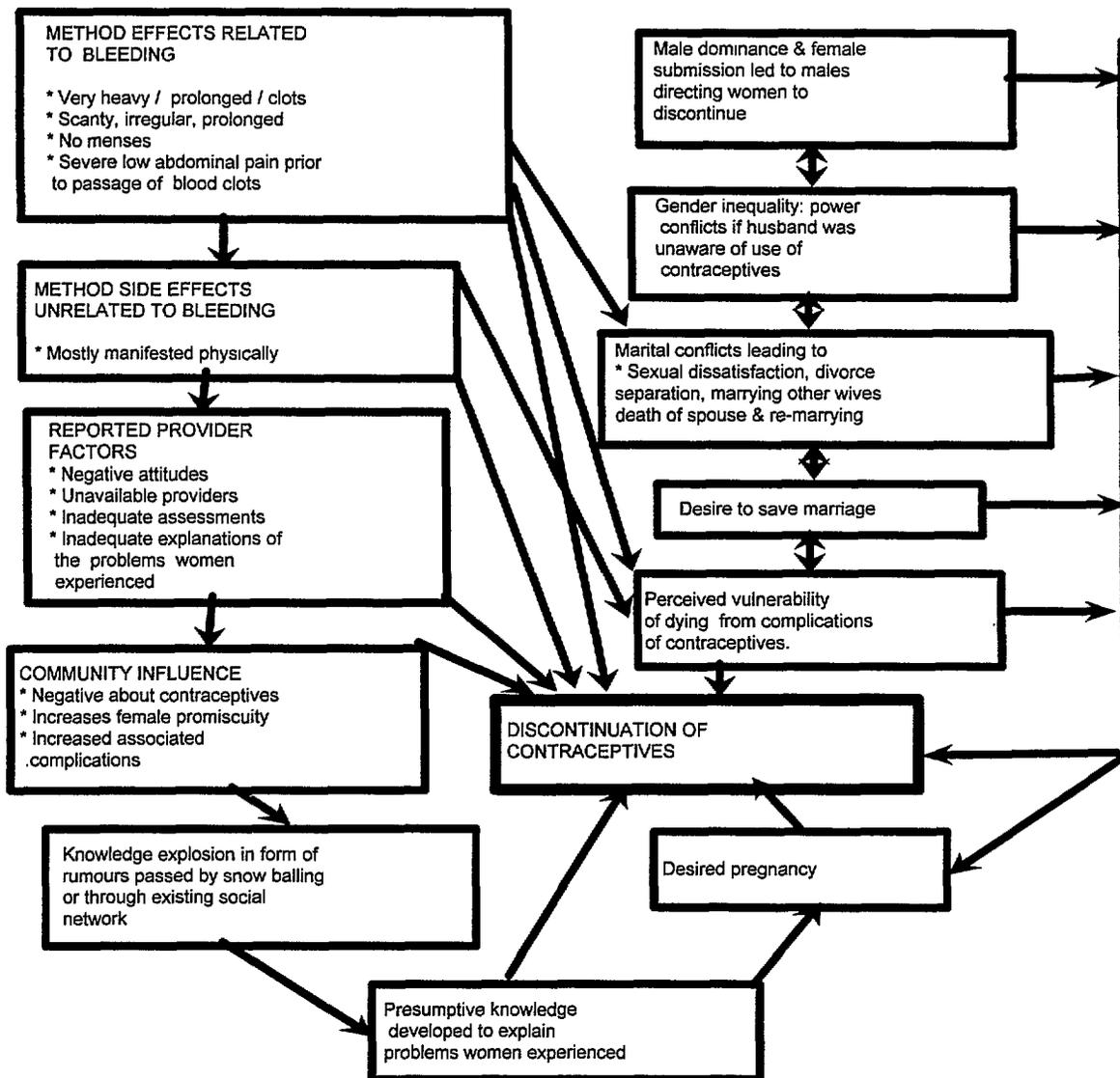
Other men paid attention to their wives' concerns when women were obviously suffering. The problems women experienced with the FP methods they opted for

seem to have made some men aware of the reasons women discontinued using modern contraceptives. These men cited the following reasons: 1) bleeding problems; 2) rumours about adverse effects of contraceptives; 3) method side effects such as high blood pressure, weight loss, ill health; 4) wives got pregnant while taking pills and did not go back to the clinic anymore; and 5) in preparation for another baby.

In some cases these men were correct but in many cases they made conclusions based on assumptions. Some women who had persistent bleeding problems and were deserted discontinued as an attempt to have their husbands back

Figure17

Reasons Most Women and Men Attributed to Discontinuing Modern Contraceptives



SUMMARY

This qualitative study was conducted in six districts (Nsanje, Mangochi, Ntcheu, Mchinji, Karonga and Rumphu) in Malawi representing a rural population. The study sought to identify factors influencing families or individuals to use and discontinue using modern contraceptives within the context of: contraceptive decision-making; the role that men play in contraceptive decision-making; individuals participating in the decision making process; experiences of women using contraceptives; and, the reasons participants living in these six sites attributed to their discontinuing modern contraceptives.

Data were collected from focus group discussions and in-depth interviews. Discussions and interviewed with female participants were held separately from discussions and interviews for male participants. Data were analyzed using Reduction, Display Conclusion Drawing and Verification process. Analysis of data on contraceptive use and discontinuation was done across study sites and within a study site.

Background of Study Participants

There were 268 participants comprising of 165 women who discontinued using modern contraceptives and 103 whose wives discontinued using modern contraceptives. Characteristically, these families and individuals were from low socioeconomic backgrounds. The majority were married, had primary school education and their sources of income were subsistence farming, fishing and small scale businesses. Their mean ages were 32 years for women and 38 years for men. Mean age differences were found among female participants only. Differences in levels of education and the number of times participants married or were married were found among female and male participants.

Results

Results of the study seem to suggest that multiple factors: (sociocultural; personal; gender inequality in the context of reproductive power relations; family structure and communication dynamics; consequences of frequent childbearing, perceived vulnerability to maternal and child ill health, poverty and maternal death; actual experiences of maternal and child ill health; child-care burden; and, poverty) influenced families and individuals to use modern contraceptives. These factors and their relationship to discontinuation of modern contraceptives are presented in figurative and narrative form (see Figure 2, p.15). The underlying theme that seems to have driven participants to use modern contraceptives was "**Suffering.**" Major differences were also observed in contraceptive decision-making among female and male participants.

Additionally, the results also seem to suggest an interplay of many factors influencing female participants to discontinue using modern contraceptives and or

influence men to advise their wives to discontinue using modern contraceptives (see Figure 17, p.115). Apart from discontinuing modern contraceptives in preparation for another pregnancy, most of the reasons cited also reflect the same theme of "**Suffering.**"

Conclusions

This study demonstrates that family planning was not an integral part of family formation in many families. Most of the participants used family planning as a means of treating an existing problem and not an option to deliberately plan families, promote health, prevent personal suffering, and enhance personal and economic development.

The major constraint to using contraceptives was the gender-inequality on contraceptive decision-making. Since men are the main decision-makers on many family issues, when women were empowered with contraceptive knowledge and their spouses were not, it became difficult for women to convince their husbands to allow their use of modern contraceptives. The only exceptions to this appeared to be the time the family was experiencing a major crisis such as financial problems, child-care burden, lack of social support and when the mother or the children frequently fell ill.

Most of the decisions were initiated by women and were supported or not supported by their husbands. Once the women were convinced of their need to start using modern contraceptives, they informed their husbands. However, many women feared to share with their husbands their knowledge about modern contraceptives. They reported waiting for an opportune time (in time of crisis) to share the knowledge. Very few women reported sharing their knowledge easily with their husbands when there was no crisis situation in the home.

Some women seemed to have made desperate attempts such as using the services secretly or lying to their husbands insinuating their own death if they did not use contraceptive methods. Women told their husbands that the health care providers advised them to use modern contraceptives to avoid the risk of dying. This shows that the gender inequality in family planning decision-making is a major deterrent to successful family planning activities in Malawi.

Another set back to the success of family planning is the family structure. With some of the families operating in a state of impermanence because of frequent divorces and re-marriages, frequent deaths of spouses, multiple wives, extra marital sexual relationships, it becomes such a big challenge to envisage the efforts needed to make family planning a success. Child bearing was considered a status symbol for the participants therefore, if women were divorced or their husbands died, and they were re-married, the new couples expected to have children in their new relationships. Some of them expected to have four children from the new relationships despite the number of children each one already had from their previous marriages.

Married couples did not discuss their fertility preferences before they had any children. Participants observed that it is not customary to discuss the family size they preferred to have before proving their femininity or masculinity. However, after five or more children, couples were ready to think about how many more children they wanted. This is a very crucial finding and extremely relevant to programmes we may develop. There is need to break this cultural element in order for programmes to be effective.

Due to the fertility preferences, value for children from the first or subsequent marriages, traditional values and practices that prohibit individuals from discussing the family sizes they desire before they have any children, contraceptive decisions were made late and the use of modern contraceptives for a majority of the participants in the Study appeared not to have benefited them much. Men seemed to encourage their wives to start using modern contraceptives when they (men) experienced financial problems and child care burden or when their wives had difficult or complicated child bearing experiences. The only times families made an early decision to use modern contraceptives were: 1) when individuals seemed to have understood the importance of family planning; 2) when a woman wanted to further her education; 3) when the woman wanted to participate in business activities; and, 4) when there was a crisis in the family.

Certainly there appeared to be no clear definition of complete family size for a majority of male and female participants. Their major concern was what would happen if they were divorced and had another relationship. It appeared that most men and women felt obliged to have children with subsequent partners should the first relationship fail. Participants seemed unable to foresee the risk of continued childbearing and not seeking assistance when they had adverse side effects from the modern contraceptives they used.

The passivity of men and their negative attitude toward modern contraceptives was of great concern especially considering that most of them still held keys for their wives' reproductive functioning. Some men talked as if they possessed their wives who seemed to have very little say about what to do with their bodies.

The attitudes of service providers had a big impact on the continuation of acceptors of modern contraceptives and women's willingness to come back for counselling when they had problems from the contraceptive methods they used. The data also seems to suggest that women were let down by providers' negative attitudes and some discontinued modern methods of contraceptives with their problems unnoticed and uncared for by service providers.

MAJOR FINDINGS FROM THE STUDY

Family Structure

Families studied were characterized by frequent changes of partners (were in a state of Impermanence) and this state appeared to have influenced contraceptive decision making both positively and negatively.

Types of Families Identified

Six types were identified comprising:

1. Father, mother and their children
 2. Parents each with children from a previous relationship and children from their new relationship.
 3. One husband with two to four wives and having 15 or more children
 4. Women with children fathered by different men
 5. Women with children from one father
 6. Father, mother, their children and orphans from deceased relatives
- Families in which the women experienced child-care burden, lack of support from the spouse and other family members were more likely to use modern contraceptives.
 - Men whose previous marriages failed for different reasons and married again with the desire of also having children in the new relationship were more likely to discourage their new wives from using modern contraceptives.
 - Families where both husband and wife had at least a full primary school education were more likely to have the participation of both in contraceptive decision-making.
 - Women who aspired to do other activities for income generating were more likely to use modern contraceptives

Fertility Preferences

Many families preferred large families and had large to medium families (56%) had five to ten children.

- Men tended to prefer boys to girls. Women from Ntcheu, Mchinji and Mangochi tended to prefer an equal number of boys and girls but women from Nsanje, Karonga and Rumphu tended to prefer more boys than girls.
- The tendency toward preferring large families and children of a specific sex seemed to have contributed to the women's delay in using modern

contraceptives but appeared to have enhanced their decisions to discontinue using contraceptives already commenced.

Communication about Fertility Preferences

Almost all participants did not communicate with their spouses the family size they wished to have before they had any children. They alluded the non communication to their traditional values and beliefs.

- The lack of communication seemed to be considered as a protective strategy to prevent ill wishers from taking advantage of the information and use it against the family.
- The consequences were continuous child bearing and a delay in the use of modern contraceptives.

Communication about Contraceptive Use

Women expressed problems communicating with their husbands about their intent to use contraceptives because they feared their husband's reactions to the women's motives for contraceptive use. The use of modern contraceptives is associated with promiscuity therefore families were very cautious about using the methods.

- Most women had knowledge about modern contraceptives but could not easily share it with their husbands because of women's lack of control in reproductive decision-making.
- Men appeared to have no problems instructing their wives to start using modern contraceptives when they had the requisite knowledge. Women appeared to have problems informing their husbands Women about

Contraceptive Decision Making

Many women in all sites initiated the decision to use modern contraceptives. Men either supported or did not support the decisions. Individuals involved in contraceptive decision making were spouses, care-providers and a few family members.

- Husbands seemed to play a low profile or offered minimal support for their wives use of modern contraceptive. Further, most men appeared not to be supportive when their wives experience problems with contraceptive methods they selected.
- Four model of contraceptive decision making were identified as Mother/Wife-Driven Model, Husband/Sexual Partner-Driven Model, Care Provider- Driven Model and Support Person/Family Member- Driven Model. Of these four models,

the one mostly used was the Mother/Wife-Driven model yet it was the least supported by the husbands

- There were two parallels to contraceptive decision-making. Men were involved in it from an influential perspective while women were involved in it from an experiential perspective.

Factors influencing Contraceptive Use

There were multiple factors social, cultural, economic, health, obstetric, childcare-burden, poverty, and threat to one's life are among the factors which influenced women to use modern contraceptives. These factors were classified in six groups by their level of influence. Many of them had direct and indirect impact on women's use of modern contraceptives (see Figure 2, p.15).

Contraceptive Methods Women Used

There were six methods that women used, such as OCPs, Depo-Provera, IUCDs, Condoms, Vaginal Foam, and Tubal Ligation.

- IUCDs and Vaginal Foam were only used once or for a month by one or two individuals and discontinued.
- Two women had Tubal Ligation having discontinued Depo-Provera. Families tended not to use Condoms as a primary method of contraception but as back up to the first cycle of OCP users.
- Condoms were also used as a protective barrier for the man from being contaminated with blood when the couple had sexual intercourse while the woman had prolonged bleeding. Only five families reported using condoms for the reasons stated.
- A majority of participants used OCPs and Depo-Provera.

Use of Modern Contraceptives

- Women (1) from polygamous relationships; (2) who had many children but received minimal or no physical and material support from their spouses; (3) who were prohibited from using modern contraceptives by their husbands yet felt the need to use a method; (4) believed had a problem and they had to change the situation themselves were more likely to use modern contraceptives (Depo-Provera) secretly.
- Women who seemed to have interpreted their experiences as *Suffering* were

more likely to use contraceptives with or without their husbands permission.

- Men (1) who seemed to understand the advantages of family planning; (2) experiencing financial pressure by managing large families; (3) experiencing pressure from assisting with household chores because their wives were experiencing childbearing related complications; and, (4) men who had at least completed full primary school were more likely to encourage their wives to use modern contraceptives.

Types of Contraceptive Knowledge Used in Contraceptive Decision Making

Participants appeared to have used three types of knowledge for contraceptive decision-making; factual, presumptive and experiential.

- Individuals used Factual knowledge which they acquired from family planning providers, the media family and friends. The facts participants recalled seemed to have been superficial.
- Presumptive knowledge was generated from rumours circulating in their areas about adverse effects modern contraceptives (see p.67-68). This information instilled fear in users as well as potential users of modern contraceptives and it seems to account for some discontinuations among OCP and Depo-Provera users. Men reported being familiar with presumptive knowledge than factual knowledge.
- Experiential knowledge developed from individuals' lived experiences having previously used the methods or through witnessing the experiences of a spouse, friend or other women. Most participants and men in particular identified with this knowledge. Experiential knowledge seemed to have been used for both the selection of a type of contraceptive method and for discontinuing a method.

Reasons for Discontinuing Modern Contraceptives

Generally women seemed to have discontinued using modern contraceptives depending on the experiences they encountered and the lack of support from husbands they experienced while using the methods. Secondly, women seemed to have discontinued for not understanding the meaning of their experiences. Women participating reported experiencing more side effects from Depo-Provera than from OCPs yet many were opting to use Depo-Provera.

- Multiple reasons were identified for the discontinuation of OCPs and Depo-Provera.
- Women who experienced adverse side effects regardless of the type of methods used were more likely to discontinue if they did not understand the

consequences of the side effects.

- Women discontinued OCPs mostly to method side effects, reproductive reasons, inadequate knowledge, social, provider and institutional reasons (Table 13, p.81).
- Women discontinued Depo-Provera mainly due to bleeding problems and consequences from these (family conflicts, unmet sexual desires of husbands arising because women were reported to have been bleeding for longer periods than usual); other method side effects; severe abdominal pains; social reasons; inadequate knowledge about the qualities of bleeding associated with Depo-Provera and how to manage them; reproductive reasons; service provider attitudes/ service provision reasons; and, personal/esteem problems (see Table 14, p.82).
- Women who felt neglected and abused because of continuous bleeding were more likely to discontinue using Depo-Provera to salvage their marriages.
- Women from all sites consistently reported a combinations of bleeding, atypical abdominal pain, heat wave across the abdomen and burning sensation on the vulva which occurred periodically prior to discharging large clots of blood. The symptoms were relieved once clots were passed. Women especially those from Karonga reported discontinuing Depo-Provera because of this problem in addition to the others already mentioned.

DISCUSSION AND RECOMMENDATIONS

Discussion

The recurrent theme emerging from the data is ***Suffering***. Issues from this study seem to suggest that participants perceive modern contraceptives as a means to an end of personal and family suffering, solving a crisis, treating or solving existing pregnancy related problems and their associated burdens. Participants' views seem to suggest their lack of insight that family planning is an integral part of family formation, deliberately planned in one's life to promote health, personal growth and development, socioeconomic development and prevent unnecessary suffering.

The major constraint to using contraceptives is the gender-inequality in reproductive decision-making. This seemed to have affected women's control of their fertility and limited their freedom and opportunity to use available family planning services on time. Since men are the main decision-makers on many family issues, when women were empowered with contraceptive knowledge and their spouses were not, this seems to have created a situation where men distance themselves from family planning matters involving the use of modern contraceptives.

Male participants believe that the limited factual knowledge men have might explain why a majority of men in this study showed a great deal of reluctance in holding discussions on contraceptive use; and a lack of interest and support for modern contraceptives. Men expressed their lack of support for modern contraceptives as a strategy to discourage their wives from promiscuity and also as a mechanism for controlling their wife's sexuality.

Use of contraceptives was delayed in many families until the time families perceived to have had enough children. Needless to say by that time, families were pressured financially and materially. Women were overburdened, and suffering from the effects of frequent childbearing despite possessing contraceptive knowledge. The results also suggest that women had the contraceptive knowledge for a period long enough for them to have prevented frequent childbearing had their husbands supported them to use modern contraceptives.

This data also seems to suggest that presently, in the rural areas, the support from husbands/male sexual partners is very crucial to the success of family planning services, and, may remain like that for a long time until men understand that women have rights to decide alongside their husbands and be allowed to differ in opinion without being abused for the differences. Access to accurate factual knowledge on contraceptives; adequate counselling and built in strategies for managing adverse method side effects are among the major determinants of successful use of modern contraceptives in rural areas of Malawi.

Some obstacles women encountered were a function of traditional practices which: (1) encourage male dominance over reproductive issues, (2) expect women to be submissive, (3) regard women as inferior and not intelligent, (4) prefer large families, (5) place high value on children for utility purposes (6) limit the form of communication between men and women and (7) legitimize men's possession of multiple wives and sexual partners formally and informally. Also, some family relations were characterized by a state of impermanence due to divorce, separation, polygamy and extramarital relationships. The magnitude of these problems were so much that they threatened women and inculcated a feeling of insecurity which consequently affected the women's capacity to make contraceptive decisions.

Although many participants seemed to have understood the benefits of small families, there were indications of value conflict among participants between what they identified as an ideal family size and their fertility practices and beliefs. They valued having large families, also, they value children highly mostly for utility purposes. This data seems to also suggest that although couples decided on the family size they wished without the influence of other people, their value for large families and children seemed to have outweighed the advantages of using modern contraceptives and ultimately having small families so that many couples delayed their decisions to use modern contraceptives.

It is interesting to note that although men openly said they are decision-makers, most of the discussions to use modern contraceptives were initiated by women and if the idea was acceptable, the wife and husband used family planning services without involving many people. In this study, men mostly played a very minimal supportive role when women were the initiators of the decision.

The decision-making process was difficult for many women because of fear. Women feared talking to their husbands about modern contraceptive methods and the consequences of initiating the decisions. Another setback was the lack of support from husbands. Women waited for an opportune time to produce evidence of suffering to justify the use of the services. Despite the suffering, other women still used the services secretly because of lacking spousal support. The repercussions of using FP methods secretly were reported to be serious when husbands realized what their wives were doing.

There was evidence of lack of knowledge in the area of effects of contraceptives. Participants in these sites had overwhelming amount of knowledge about the effects of modern contraceptives which were mostly misconceptions. These discouraged others from using or continuing to use the methods.

Women used Depo-Provera more than OCPs. Women tended to prefer Depo-Provera because it served them multiple purposes such as (1) reducing the number of times they took the medication, (2) can be used without the husband's knowledge and, (3) women who were close to menopause used it in hopes of terminating childbirth permanently because they feared having an operation (TL).

Women who chose OCPs seemed to have experienced less method side effects. Those who chose Depo-Provera experienced multiple problems including heavy or irregular bleeding. Women in all sites described consistently a combination of heavy bleeding, passage of clots severe abdominal pain of a distinct quality. This was of great concern to them. A majority of women who experienced bleeding problems had negative social consequences: were ill treated; deserted; divorced; denied support and many were neglected sexually. Those women who were in polygamous relationships suffered desertion the whole period they were bleeding. The husband spent his time with the other Co-wives. The reactions men showed when their wives bled abnormally seem to suggest that women are regarded favourably for their womanhood when they satisfy their husband's sexual desires.

Women discontinued OCPs and Depo-Provera for different reasons. Those who discontinued OCPs did so due to method side effects and their desire for another baby. Women who discontinued Depo-Provera did so because of bleeding complications, severe abdominal pains, other physical health and social problems. Rarely did women using Depo-Provera discontinue it in anticipation of a baby.

The overall findings seem to suggest that women are more likely to discontinue using modern contraceptives under the following conditions: 1) when they experience many problems with the method of their choice; 2) when they receive no support from the husband during the time they experience adverse method effects; 3) when they desire another child and, 4) when they do not understand their experiences. There is also evidence from this data suggesting that women were more likely to sustain the use of modern contraceptives if they experienced fewer problems with a method, have no immediate desire for a baby and receive support from their husbands.

Recommendations

Recommendations for Assuring safety in the Use of Contraceptive Methods

- Strategies need to be incorporated and protocols developed for managing women who complain of heavy bleeding and severe abdominal pain resulting from using Depo-Provera. These problems were expressed by many women and require urgent attention.
- Users of modern contraceptives also need to understand the specific duration within which to expect some physical side effects and the actions they need to take when experiencing the effects for a longer period. They also need to understand what they can do before coming to the clinic for assistance if they experience extreme method side effects.
- Providers need to strengthen their counselling skills to convince and direct women or families who make wrong choices and guide them to select safe methods based on the results of the physical assessment criteria. This will be in line with the MOHP policy on suitability or unsuitability of contraceptive methods for different women.
- Protocols are just guidelines. Providers should also use their discretion in directing families or women to select relatively safe methods based on the comprehensive information they obtain on the assessment. The importance therefore of performing thorough physical assessments can not be disputed.
- Each district hospital could develop a mechanism for follow up of clients who discontinue modern contraceptives. A community record keeping system could be developed by health workers in each village and submitted monthly to the health centres thereafter to the District family Planning coordinators. A Pilot project could be started using two districts in each region.

Recommendations for Service Provision

- With the overwhelming incorrect information on family planning, strategies are needed to address this issue. Civic education through mass media and the CBD programme; peer education groups could be used to disseminate the correct factual knowledge. Men at the community level need to be sensitized about the invaluable supportive role they can play for family planning programmes to be successful in Malawi. The same fora (Peer Education Groups) can address issues identified on level one of figure 2 page 15.
- The Ministry of Health might wish to establish the reasons why their clinics are offering only the hormonal contraceptives to women despite the skills and knowledge service providers have on other methods they learnt.

- Performance of physical assessments should be intensified. It is mandatory that clients receive this component of care before they select a method. This will prevent commencing contraceptive methods such as Depo-Provera on pregnant women or those with high blood pressure as was the case for some women in this study.
- The National Family Planning Council needs to development of strategies to empower women to use factual knowledge about contraceptives. These strategies will assist the rural communities to develop negotiating power and skills for them to be in control of their reproductive health.
- While we appreciate the importance of traditional values, individuals need to understand the concept of family planning that the ideals do not change. One man and one woman should have the number they both can afford to bring up within the confinement of their resources. This implies that the more women a man has, the smaller will be the numbers of children born to each wife. The total number of children born from four wives should be comparable to the number the man can afford to bring up had he married one wife. NFPCM and MOCWA can assume the responsibility of this since they already have community based programmes.
- The media could be used to intensify this concept in relation childcare burden, paternal responsibilities and the children's right to a bright future and prevention of child malnutrition. The childhood illnesses increase infant mortality, but some fathers appeared to have left the responsibility of child care to women only.
- Refresher courses for Family Planning providers need to be intensified and conducted regularly. In some sites women had already heard about Norplant but providers were unable to provide specific information about this. From the women's perspective, they believe that Norplant might be a better option than Depo-Provera.
- Strategies need to be developed or strengthened to break some of the traditions that override women's power to decide when and how they should use modern contraceptives. This is of extreme importance in situations where men are free to marry other wives or have extra marital relations yet they prohibit their wives from using modern contraceptives.

Recommendations for Improving Contraceptive Knowledge for Users

Content on contraceptives for users and their families should emphasize the advantages of family planning for the whole family. The main focus should include:

- Timing for contraceptive use. It is important for the rural communities to understand the difference between planning and correcting. Individuals need to be sensitized that family planning is an integral part of family formation, it is not a

strategy for solving problems which have already happened because of large families.

- Emphasis should also be placed on the relationship between child-care burden and infant mortality. Families in the rural areas need to understand that child-care burden and women's suffering can be prevented by early planning for sizable families and avoiding to use contraceptive methods when they have already attained the number of children they desire.
- Individuals should be encouraged to take risks of having small families and of starting contraceptive use early with an added focus that they will have time to prevent their children from dying from diarrhoeal diseases.
- The concept of family life education should be strengthened in rural area schools. As young men and women grow and understand how their bodies function, they will be able to appreciate and support each other in family planning issues. In comparison with their urban counterparts, the youth in rural areas are disadvantaged in obtaining information about growth and development to understand how their bodies work. The rural schools need this information.
- The study already indicated that those participants with more years of formal education understand and support each other in contraceptive use, school programmes in family life and sex education should be encouraged as a basis for enabling individuals make better choices in their future lives.

Recommendations to Demystify Misconceptions about Modern Contraceptives

- Women who have positive experiences using modern contraceptives could be used as resource persons at community level in activities or workshops for sensitizing potential users or encouraging defaulters to use the services.
- Providing factual knowledge to women and men to address the current confusion. It is recommended that various strategies be used such as

Mass campaign targeting the rural communities of different age set

Using the media for continuous air time and newspaper series presenting the factual information against the list of myths presented

Early counselling families on contraceptive decision-making

Development of small leaflets to provide to people in rural areas to read on their own, the content should incorporate some of the content on myths, and facts about contraceptive methods and families experiences using modern contraceptives.

Incorporating the use and experiences of using modern contraceptives as part of the content for adult literacy programmes.

- Women need to have explicit explanations of the type of feelings they may possibly experience with the different methods. It is necessary but not sufficient to tell clients that they may bleed heavily for a few days. Women should be informed about the quantities that classify different types of bleeding. Women should be able to distinguish the following: heavy, average, or small amounts of bleeding.
- Visual Aids need to be those women are familiar with for example women who claimed to have had heavy bleeding reported using blanket material as sanitary pads. It might be easy during the demonstrations of the different quantities of bleeding for FP providers to use the same material women use and saturate it with water to show women the difference between heavy, moderate and slight bleeding. This may help women to report accurately the nature of their bleeding.
- Women also need to be informed to report accurately how many times they change pads during day light and at night, and how saturated the pads are with blood.
- Continuous bleeding could be defined in terms of the number of days the woman bleeds consecutively.
- Prolonged bleeding can be described in terms of the number of days, weeks and months the woman bleeds continuously.
- Irregular bleeding can be described in terms of duration of the period that a woman bleeds interspersed with the number of days or weeks the woman did not bleed.
- Women also need to know the type, quality and amount of bleeding for which they need to seek help and what exactly they should observe in the bleeding that might assist their providers give supportive care.
- Intensify counselling to improve user's knowledge of other methods so that the use of modern contraceptives should not be strongly biased on hormonal contraceptives as was the case with these participants.
- Counselling of married couples together on the importance of using condoms in marriage with explicit reasons why this might be necessary may assist in the misconception that the use of condoms encourages promiscuity in married women. The emphasis in the counselling should be focused on importance of prevention of unintended pregnancy and care for each other.
- Contraceptive friendly campaigns could be conducted in the same way as Polio campaigns are conducted to give people correct information about modern

contraceptives to counteract the misconceptions currently existing in these rural communities.

Recommendations to Increase Men's Participation on Contraceptive Use.

There great need to develop strategies to involve men in contraceptive use.

- A series of workshops at local levels for the rural communities may assist men understand family planning concept and support its use and allow them to make informed contraceptive decisions.
- Advocating contraceptive decision-making partnership so that husbands accompany their wives to the clinics.

Recommendations to Improve Service Providers' Attitudes

- There is need to take some inventory of concerns regarding the service providers and institute disciplinary measures when necessary. When the rural families cannot approach their primary family planning providers, the mission of reducing the high fertility in Malawi will be difficult to accomplish. Negative attitudes of service providers were contributory to the women's discontinuation of contraceptive methods.
- Compulsory use of identity name tags should be enforced and will make it easy to trace providers who have negative attitudes. Simultaneously, the public needs to be informed on the importance of identifying their providers by name.
- Mechanisms should be put in place by the District Management team and the Family planning Coordinator in the rural communities and so that clients who are ill treated can report to, secondly, itemize the disciplinary actions to be taken when such a case is reported.

Recommendations for Supervision

With the mushrooming of private clinics, mechanisms need to be developed to ensure that family planning providers have been prepared for this service.

- Supervision of family planning providers be intensified for the private clinics in the rural areas. This is in response to a provider from a private clinic who informed a client who had more than ten children and was bleeding from Depo-Provera that she was bleeding because her uterus was ready for pregnancy.
- The scope of practice for HSAs in relation to contraceptive provision needs to be reviewed regularly. From this study, it appeared that the individuals who are in great contact with women experiencing adverse side effects in the under served

areas are HSAs. Although they are mandated to refer these clients to the nearest health centre, it seems that they are not conversant with the magnitude of bleeding they need to refer women to the health centre for. Protocols need to be developed for HSAs to assist them in assessing the types of women to refer to the clinics.

Recommendations for Enhancing Mutual Contraceptive Decision Making

Current education content for family planning should include or intensify mutual contraceptive decisions.

- The NFPCM in collaboration with the MOHP, MOWCA and the University of Malawi needs to develop a contraceptive decision making model which would be sustainable. This should be mutually driven. In this model, the husband and wife have equal say in the process and willing to face the consequences of their decision together. This model could be used for men and women before they get married and early in their marriage.

Recommendations for Further Areas of Research

- There is a serious and urgent need to establish the magnitude of the bleeding and severe abdominal pain effects of Depo-Provera in a cross section of women of different characteristics. Concurrent studies could be conducted comparing women in rural and urban areas to determine the extent to which women experience bleeding problems and they use to manage this.
- To compare bleeding reported by older pre-menopausal women who do not use hormonal contraceptives and the amount of bleeding manifested by older women using Depo-Provera. It was very difficult to determine whether there was an association of the bleeding reported by women in this study with menopausal changes or whether this bleeding they reported could all be attributed to Depo-Provera.
- There is also need to establish the appropriateness of the use of Depo-Provera in this country. When found appropriate, operation's research could be done to compare the demographic and other factors in women who experience extreme adverse effects and those with minor side effects.
- There is also need to conduct a comparative study of side effects of oral contraceptives and Depo-Provera on a larger scale. Encourage the use of contraceptives with relatively few risks based on Malawi data. Currently we do not know enough of whether the women experienced normal method effects or severe or adverse effects of modern contraceptives they used.
- With the disintegration of the cohesive family units, family studies from anthropological/ sociological perspectives may assist in providing a meaningful

context of families in Malawi and the development and implementation of relevant family planning programmes

- Clinical trials could be done on Norplant if the government can afford it to determine its efficacy and safety in comparison with Depo-Provera.

Recommendations for Policy on Contraceptive Service Delivery.

- A review of policy regarding the criteria for the administration of Depo-Provera in this country ought to be given priority. According to the Ministry of Health and population guidelines (1996), women over 50 years old and those expecting to conceive a pregnancy within a short period should not be given Depo-Provera. In this study contrary practices were observed. Of the women who reported adverse effects were 40 years and over. Those with delayed return of fertility (for two or more years) were young married women who both had one child.
- There is great need to make family planning services user friendly. Major re-organization of clinic management may be required to accommodate families for counselling on the use of contraceptive methods in partnership. This would empower both. Currently, clinics are not user friendly. This makes the involvement of men almost an impossibility. The same strategies used to re-organize STD clinics could be tried in a few centers and evaluate if this could be a feasible and viable national option.
- There is need to re-establish the reasons why Depo-Provera was not recommended at first, was banned from use, and establish what makes it safe to use on women now. That information plus what would be identified from studies in this country will form the basis for reviewing the policy on the future use of Depo-Provera in Malawian women.
- At the national level, the concept of Family Planning needs to be re-visited to consider who the family planning messages are intended for. The teaching of family planning as a developmental concept in all schools from primary school needs to be intensified to assist the future parents enter marriage relationships understanding not the importance of managing child-care burden, but the importance of proper timing, readiness for their children and appreciation for each other.
- The introduction of mandatory use of provider identity such as name tags could assist clients identify rude and insensitive providers. If there are complaints by users, corrective disciplinary measures should be instituted. Concurrently users of modern contraceptives should be encouraged to identify their providers by name.
- There is also need for the MOHP and NFPC to develop protocols for dealing with providers who discredit this important services.

- There might be need to do clinical trials on new hormonal contraceptives before they can be adopted and used nationally. Ultimately it becomes cost effective. There are many variables that may affect people's response to hormonal therapies in a developing country such as Malawi.

APPENDIX 1

Introduction.

We are conducting a study to find out people's views about modern contraceptives. We are particularly interested in talking with women and their husbands who have used these methods in the past and stopped using them. We want to find out what they experienced when using the methods. If you used more than one method, we would like you to talk about each of the methods you ever used.

We also are seeking your permission for us to write your responses and record them on the tape recorder so that what we can listen to the tapes to seek clarification of some discussion we were unable to write clearly.

This information will only be used for the study. We require no names for the report and no one will be mentioned by name in the report. The purpose of the information is that if we find many good things about the methods women use, we will recommend to the government that they make those contraceptives available to many women. However, if we find that some women have problems with some contraceptive methods, we will also recommend to the government for them to find out why there are problems and the responsible departments will look for solutions to the problems.

If the questions are not clear please feel free to ask us so that we can repeat them. Because we will be talking in a group, let us speak clearly so that everyone can hear us and don't be ashamed to share your experiences because we all experience things differently. Do you have any questions before we start?

If there are no questions then we will start our discussions. Thank you.

APPENDIX 2

Interview Schedule and Focus Group Guide (Female)

Circle or tick one which is applicable

1. Focus group / in-depth interview number _____
 2. Site: Region: 1___ (S) 2___ (C) 3 ___ (N).
 3. a___ Urban. b ___ Rural.
 4. Site Code _____
-

General Childbearing Issues, Views from Families and Individuals

1. **For what reasons do people want to have children? Are these reasons similar or different from your personal reasons?**

Nchifukwa chiani anthu amafuna kukhala ndi ana? Zifukwa zimenezi mukugwirizana nazo kapena ai?

2. **For what reasons do some people not want children? Are these reasons similar or different from yours?**

Chifukwa chiani anthu ena safuna kubeleka ana? Nanga inuyo mukugwirizana nazo kapena ai?

3. **Do men and women have similarities in what they expect their children to do for them in future?**

Kodi amai ndi abambo amafanana pa zomwe amayembekezera kuti ana awo angadzawachitire mtsogolo?

4. **What do women expect their sons to do for them in future?**

Kodi amayi amayembekezera zotani kuchokera kwa ana awo amuna?

5. **Do men and women differ in what they expect children to do for them in future? If so, in what way do they differ?**

Kodi amai ndi abambo amasiyana pa zimene amayembekezera kuti ana awo adzawachitire mtsogolo? Ngati ndi choncho, amasiyana bwanji?

6. How do you feel about families having a few or many children? In your opinion, how many children can be considered few?

Maganzizo anu ndi otani pa mabanja amene ali ndi chiwerengero cha ana chochepe? Kwa inuyo, ana ochepa ndi angati?
Nanga maganzizo anu ndi otani pa mabanja omwe chiwerengero cha ana awo nchochuluka? Kwa inuyo ana ochuluka ndi angati?

7. What happens in this community or area to women who have no children?

Mu dera lanu lino, chimachitika ndi chiani kwa amai amene sanabelekepo?

8. How affected would you be if you were unable to bear children?

Mukanakhala kuti inu simunabelekepo chikhalire chanu, zikanakukhudzani bwanji?

9. Do women talk to each other in relation to:

Kodi amayi mumakambirana pa nkhani izi?

- (a) **What to expect from their children.**
If they do, what do they expect from their children?
Why do they expect that from their children?
If women do not talk to each other about these what are the reasons for that?

Chiyembekezo chanu kuchokera kwa ana, ngati mumakambirana
Chiyembekezo cha amai kuchokera kwa anawo ndichotani?
Chifukwa chiani amai amakhala ndi chiyembekezo chotere kuchokera kwa ana?

- (b). **The size of a family: if they do,**
If they do, what do they discuss about family sizes?
What is the most preferred family size?
Why do women prefer that family size?

Chiwerengero cha ana mbanja.
Mumakambirana zotani za kuchuluka kwa ana mbanja ?
Mumakambirana kuti chiwerengero chabwino ndi chiti?
Nanga ndi chifukwa chiani amai ambiri amafuna chiwerengero chimenecho ?

- (c). **Use of modern contraceptives.**
Where do you often meet to discuss modern contraceptives? why do you have such discussions?
What aspects of contraceptives do you discuss?

Njira zolera zamakono:
Kawirikawiri mumakumanirana kuti pokambirana?
Mumakambirana zotani pa nkhanayi?
Chifukwa chiani mumakambirana za kulera?

- (d). **The preferred sexes of their children:
Why do you have preferences for sexes?
What is the most preferred combination of sexes?
How can the desired combination be achieved?**

Chilakolako chokhala ndi ana amuna kapena akazi amene
amai amafuna:
Chifukwa chiani amai amakhala ndi Chilakolako chotero?
Nanga anthu ambiri amafuna ana amuna angati ndipo akazi angati?
Kodi mukuganiza kuti mungachite chiani kuti mukhale ndi anawo
monga mmene mufunira inu?

- (e). **Education for children:
When you talk about children's education,
what do you talk about? Do you discuss boys' education or do
you discuss girls' education?**

Maphunziro a ana:
Mumakambirana zotani za maphunziro a ana anu?
Kodi mumakambirana za maphunziro a ana akazi kapena za
maphunziro a ana a amuna?

Fertility Preferences and Contraceptive Decisions-Making

1. **Do you discuss with your husband the preferences for the number of children? If you do, when in the marriage cycle does this discussion occur?**

Kodi mumakambirana ndi amuna anu za chiwerengero cha ana amene mukufuna kukhala nawo? Ngati mumakambirana, ndi nthawi iti imene zokambirana zimenezi zimachitika pa moyo wanu wa pa banja? (musanakwatiwe kapena mutakwatiwa kale koma musanabereke ana)
Kodi pali miyambo yina yomwe imakuletsani kuti musakambirane mutangokwatirana?

2. **Under what conditions do you discuss this?**

Chimayambitsa ndi chiani kuti muyambe kukambirana?

3. Before you had your first child, did you ever think of the number of children you would like to have?

; Musanabeleke mwana oyamba, kodi mudayamba mwaganizira za nambala ya
! ana amene mumafuna kuti mudzakhale nawo?

4. Have you talked with your husband at any time about the number of children you would want to have?

5. Kodi mudayamba mwakambiranapo ndi amuna anu za ana omwe mumafuna kudzabeleka?

6. At the time you talked, did he want more children than you, fewer than you, or same number as you wanted?

Panthawi imeneyo, kodi bambowo amafuna ana ambiri kuposa inu, ochepa kuposa inu, kapena nonse munagwirizana pa nambala imodzi?

7. How many children did you want at the time?

Ndi ana angati omwe munkafuna panthawiyo?

8. What were the differences in the preferences for the number of children?

Kodi panali kusiyana maganizo pakati pa inu ndi amuna anu pa za chiwerengero cha ana amane mumafuna kukhala nawo pa banja panu? Ngati ndi choncho munasiyana mnjira ziti?

9. How did you resolve your differences?

Munagwirizana bwanji?

10. How involved were your relatives in determining the number of children you should have?

Kodi abale anu anatengapo mbali poganizira za chiwerengero cha ana mbanja lanu?

11. How involved were your husbands' relatives in determining the number of children you should have?

Kodi akuchimuna anatengapo mbali yotani poganizira za chiwerengero cha ana mbanja lanu? Nanga anayamba nthawi iti?

12. How many children do you now want to have?

Kodi ndi ana angati omwe mumafuna kuti mudzabeleke?

13. How many of these would you like to be boys?

Mwa ana anu onse mwaberekapo, mukanakonda kuti anyamata akhalepo angati?

14. How many of these would you like to be girls?

Mwa ana anu onse mwaberekapo, mukanakonda kuti atsikana akhalepo angati?

15. How many would it matter if they were males?

Kodi mungadandaule mutakhala ndi ana a amuna angati?

16. How many would it matter if they were females?

Kodi mungadandaule mutakhala ndi ana a akazi angati?

17. What are the similarities in the preferences for the number of children you and your husband wish to have?

Kodi pali kufanana maganizo pa chiwerengero cha ana amene mukufuna kukhala nawo pa banja panu? Ngati ndi choncho mukufanana mu njira yanji?

18. How did you decide to use modern contraceptives? Explain all the reasons that lead you to start using modern contraceptives?

- **Probes: Social, economic, health & family pressures and any other relevant reasons.**

Longosolani zifukwa zonse zomwe zinakupangitsani kuti muganize zogwiritsa ntchito njira zolera? Nchifukwa chiani munaganizira zoyamba njira zolera zamakono?

- Funsani izi: zachikhalidwe, zachuma, za umoyo, ndi zipsyinjo zambanja.

19. When you decided to use contraceptives, did you decide on your own, with your husband or someone else suggested it?

- **Probe: Who was consulted? who gave the go ahead? who talked to whom?**

Mmene mudaganiza zoti muyambe kutsata njira zolera, mudaganiza nokha? ndi amuna anu? kapena wina wake adachita kukuuzani?

- Funsani izi: aliyense okhudzidwa popanga ganizo loyamba kulera: ndani munamufunsa? anapeleka chilolezo kuti muyambe ndani? ndi inu manayamba kuyankhula kapena winayo?

20. What was involved in making the decision to start using modern contraceptives?

- **Probes: Who started the issue and why? who was consulted? How long did it take to discuss the issue? who gave the permission and go ahead? under what conditions was modern contraceptives supposed to be used? What conditions were stipulated?**

Munakambirana zotani kuti muyambe kugwiritsa njira zolera zamakono?

- **Funsani izi: anayambitsa ndani ndipo chifukwa chiani? anafunsidwa ndani? Zokambirana zinatenga nthawi yaitali bwanji? ndani anapereka chilorezo kuti muyambe? ndi malamulo anji anaperekedwa potsatira njira zolerazi?**

21. Who was involved in the decision you made to start using modern contraceptives?

- **Probes: Who were these people? What part did they play? Who else was involved in the decision making process? Who was consulted first? Who agreed and who did not agree? Who reacted negatively? Who talked to whom? What happened as a result of this discussion? Who had the final say? Where were the discussions taking place? How often was the woman involved in the discussions?**

Anatengapo mbali ndani pamaganizo oti muyambe kugwiritsa ntchito njira zolera?

- **Funsani izi: anthuwo ndani? anachitapo chiani? aliponso ena anakhudzidwa? amene anafunsidwa koyamba ndani? amene anabvomereza ndani? ndipo anakana ndani? amene anaonetsa kusagwirizana nazo ndani? anakambirana ndani? nanga zotsatira zake zinali zotani? amene anagamula ndani? kodi zokambirana zimachitikira kuti? kodi pazokambiranapo amayi amnyumbamo anakhala nawo kangati?**

22. If those involved in the discussion disagreed, what reasons did they give for disagreeing with the decision to start using contraceptives?

Ngati pazokambiranapo ena sanagwirizane nazo, anapeleka zifukwa zANJI?

23. When you decided to start using modern contraceptives, how was the decision made?

- **Probes: who was consulted, who gave the permission and the go ahead, what conditions were stipulated?**

Mmene munkaganiza zoyamba njira zamakono zolera, kodi maganizo amenewa anapangidwa bwanji?

- Funsani izi: Munafunsa ndani? ndani anapeleka chilolezo choti mukhoza kuyamba kulera? ndizopingapinga zotani zomwe anakuuzani kuti mutsatire?

24. Did everyone involved in the decision at the time agree to contraceptives being used?

- **Probe: Who agreed? who did not agree? What happened as a result of this discussion?**

25. Kodi aliyense okhudzidwa popanga ganizo lakulera, adagwirizana nazo zoti inu muyambe kugwiritsa ntchito njira zamakono zolera?

- Fufuza izi: amene anavomera, amene anakana, chinachitika ndi chiyani pambuyo pa zokambirana zanu?

26. If those involved in the discussion disagreed, explain all the reasons they gave for disagreeing with the decision to start using contraceptives

- **Probe into responses given.**

Ngati onse omwe anakhudzidwa mu zokambirana anakana, fotokozani zifukwa zonse zomwe anapereka kuti inu musayambe njira yolera

- Mufunsitsitse bwino pa mayankho aperekedwa.

27. Explain all the reasons that led you to do something (to delay or avoid pregnancy).

- Fotokoza mwatsatanetsatane zifukwa zonse zomwe zinakupangitsani kuti muchitepo kanthu popewa kutenga kapena kupereka pa thupi?

28. If you and your husband ever discussed doing something about delaying or avoiding pregnancy, in what context did this happen?

- **Probes: What prompted the discussion? Who started the issue? How did the discussion go? How was the discussion resolved?**

Ngati munakambiranapo ndi amuna anu zolera chinachitika ndi chiani?

- Funsani izi: Chinayambitsa ndi chiani, zokambirana zinayenda bwanji, zokambirana zinatha bwanji?

29. Have you ever used a modern contraceptive?

Kodi munagwiritsapo njira ya makono ya kulera?

30. What type of contraceptive methods have you used? Mention all types

Ndi njira ziti zolerera zomwe munagwiritsapo? Tchulani zonse

31. Are you currently using a modern contraceptive?

Kodi pakanali pano mukugwiritsa ntchito njira iliyonse yolera?

32. For how long did you use each of the modern contraceptives you ever used?

- **Probes: months, years, number of times went back to the clinic for re-supply**

Ndi nthawi yaitali bwanji imene mwakhala mukugwiritsa ntchito njira yamakono iliyonse yomwe munagwiritsapo?

- Funsani izi: miyezi ingati, zaka zingati, ndikangati komwe munapita kukatenganso njira zolerera.

33. For the modern contraceptives you have mentioned, please explain your experiences using them?

- **Probes: What did you like about each of the contraceptives you used? What did you not like about each of the contraceptives you used?**

Fotokozani zomwe mwaonapo kapena kumva mutayamba kugwiritsa ntchito njira zolera (zamthupi, zakumva).

- Funsani izi: Pa njira zamakono zomwe mwatchulazo, fotokozani zomwe mwakhala mukukumana nazo pogwiritsa ntchito njirazo? Ndi chiani chinakusangalatsani mu njira zimene munagwiritsa ntchito. Nanga zimene sizinakusangalatseni panjira ili yonse yolera imene munagwiritsapo ntchito ndi chiani?

34. What problems did you experience as a result of using the particular modern contraceptives?

Ndi mabvuto anji amene munapezana nawo. Nanga ndimabvuto anji amene anapezana nawo akunyumba kwanu.

35. What did you do when you experienced those problems?

Munachitapo chiani mutakomana ndi mabvuto amenewo?

36. Did your husband or other family members know you were using modern contraceptives at the time you started using them?

Kodi amuna anu kapena anthu ena a banja lanu adadziwa kuti inuyo mwayamba kutsata njira yolera?

37. Did your husband and other family members agree to your using contraceptives at the time?

- **Probe: the significance of the husband or other family members to agreeing to her using contraceptives.**

Kodi amuna anu kapena anthu ena a banja lanulo adabvomera kuti inu muyambe njira zolera panthawiyo?

- Fotokozani kufunika koti amuna anu ndi anthu ena adziwe ndi kuvomereza zoti inu muyaambe kutsata njira zolera.

38. If your husband or other family members did not know that you were using contraceptives, and if they ever discovered you were using contraceptives, explain what happened after they discovered you were using a contraceptive method?

- **Probes: reactions of husband, other family members, sanction imposed in the marriage as a result of the discovery.**

Ngati amuna anu kapena anthu ena a banja lanu samadziwa, ndipo adadziwa pambuyo kuti inu mwayamba njira yolera, chinachitika ndi chiyani atazindikira?

- Funsani izi: amuna anu anachita chiyani? anthu ena okhudzidwa anatani? ndi mfundo zotani zomwe anazikhwimitsa mbanja lanu?

39. Explain what you think would happen if you discovered that your husband was taking contraceptives?

- **Probes: marital relationships, social, economic repercussion, sanction imposed sanctions on the marriage as a result of discovery.**

Fotokozani zomwe mukuganiza kuti zingachitike mutazindikira kuti amuna anu akugwiritsa ntchito njira zolera

- Funsani izi: Mgwirizano wa pa banja, chikhalidwe, zachuma, zoletsedwa kuchita mbanja.

40. Are you currently using a contraceptive method?

Kodi pakanali pano mukugwiritsa ntchito njira ya kulera?

41. Does your husband know you are using a contraceptive now?

Kodi amuna anu akudziwa kuti inu mukutsata njira ya kulera?

42. Explain what you think would happen if your husband discovered you were taking contraceptives?

- **Probe: marital, social, economic repercussion.**

Fotokozani zomwe mukuganiza kuti amuna anu angachite atazindikira kuti inu mukugwiritsa ntchito njira zolera

43. Explain what you think would happen if you discovered that your husband was taking contraceptives?

- **Probes: Marital relationships, Social, Economic repercussion, sanction imposed sanctions on the marriage as a result of discovery.**

Fotokozani zomwe mukuganiza kuti zingachitike mutazindikira kuti amuna anu akugwiritsa ntchito njira zolera

- Funsani izi: Mgwirizano wa pa banja, chikhalidwe, zachuma, zoletsedwa kuchita mbanja.

44. In the past six months, have you discussed the practice of family planning with your husband, friends, neighbours, or relatives?

- **Probe into whom she discussed with, what started the discussion, how the discussion ended**

Pa mwezi isanu ndi umodzi yapiyati, kodi inu pamodzi ndi amuna anu, kaya anzanu, ngakhale achibale mwakambiranapo za njira za maleredwe ziri zonse?

45. What is your opinion of most people's views in this community on family planning or modern contraceptive use?

- **Probes: Do people accept it, do they disagree, Why?, What reasons do they give for none acceptance, what reasons do they give for disagreeing, What are the reasons for their acceptance?**

46. What are the reasons for their agreement, Other opinions

Anthu a mdela lino maganizo ao ndi otani pa zolera?

- Funsani izi: Amabvomereza, chifukwa chiani, amakana, chifukwa chiani? ndi zifukwa ziti amapereka pakusabvomereza kwao, ndizifukwa ziti amapereka posagwirizana nazo, ndizifukwa ziti zimene amabvomerezera zolera, nchifukwa chiani , amagwirizana ndi zolera, pali zina zoonjezera?

47. Since you started taking modern contraceptives, have you stopped using the method for some time?

Pamene munayamba njira zamakono zolerera, kodi mudayamba mwasiyako njira yakulera kwa kanthawi?

48. Were you with your current husband the last time you stopped taking contraceptives?

Kodi pamene mumasiya kugwiritsa ntchito njira zolera, munali ndi mwamuna amene muli naye pano?

49. Explain all the reasons which lead you to stop using each of the modern contraceptives you ever used and stopped using.

- **Probes: medical problems, self-esteem reasons, social forces, cultural forces, religious forces, economic forces service provider reasons, personal reasons.**

Tsopano ndikufuna kuti mndiuzze zifukwa zonse zimene munasiyira kugwiritsa ntchito njira zolera, tiyambe ndi njira yoyamba imene munagwiritsapo nkusiya, keneka yachiwiri.

- Funsani izi: zaumoyo, kungofuna, miyambo, kukakamizidwa ndi chikhalidwe chanu, chipembedzo, mabvuto a za chuma, kotenga njirazo, zakuntima

50. Did your husband at that time know that you were using modern contraceptive methods?

Kodi panthawi imeneyo, amuna anu amadziwa kuti inu mukugwiritsa ntchito njira yolera?

51. Did you discuss your intention to stop using the method with him?

Mudakambirana zoti inu mukufuna kuleka njira yolerayo?

52. Explain his reaction when you informed him of your intention to stop using modern contraceptives.

- **Probe: Was the discussion useful, beneficial, demonstrated hostile attitude, (did not react at all).**

Fotokozani zomwe adachita mutawauza kuti inu mukufuna kuleka njira yolera.

- Funsani izi: Kodi kukambirana kwanu kunali kwa kofunika, kopindulitsa, kodi adaonetsa kusakondwa, adangokhala osachita kanthu.

53. What modern contraceptives do men use?

Ndi njira ziti zamakono zomwe azibambo amuna amagwiritsa ntchitoyo

54. What reasons lead men to stop using modern contraceptives?

- **Probes: Medical problems, self-esteem, social forces, cultural forces, religious, economic forces, service provider reasons, personal forces**

Chimawapangitsa azibambo kusiya kugwiritsa njirazi ndi chiani?

- Funsani izi: Zaumoyo, kungofuna, miyambo, chikhalidwe, chipembedzo za chuma, kotenga njirazo, zakuntima

55. If you were around when your husband stopped taking modern contraceptives, what would be your reaction?

Mukanatani mukanakhala kuti munalipo pamene amuna anu amasiya kugwiritsa ntchito njira yolera?

56. Why, from your opinion do women discontinue using these modern methods of contraception?

Nanga ndi chifukwa chiani amai amasiya kigwiritsa ntchito njira zolera zamakonozi?

- Funsitsitsani zomwe zimachitika pa ukwati wao, chikhalidwe, kayendetsedwe ka ndalama mbanja.

57. Explain your husband's opinion or feelings on your using contraceptives now?

Kodi amuna anu zikuwakhudza bwanji zoti mukugwiritsa maleredwe panopa?

58. Explain your husband's opinion or feelings on your using contraceptives in future?

Mukuganiza kuti amuna anu zidzawakhuza bwanji zoti mudzagwiritse ntchito maleredwe mtsogolo muno?

59. Have you and your husband ever discussed doing something about delaying or avoiding pregnancy?

- **Probe: How the discussion went, who started it, how the discussion ended**

Kodi pakati pa inu ndi amuna anu mwakambiranapo zoti mupumulirepo kubereka mwa kanthawi ndithu? Zinayenda bwanji mmene mumakamba zimenezi, anayambitsa ndani ndipo munagwirizana mfundo zotani?

60. Are there any other topics, issues or problems you have faced, witnessed or heard in relation to using and discontinuing modern contraceptives that we have not discussed that you want to share with us?

Pali zowonjezera zina za maleredwe zimene sitinakambe zofuna kuti muwonjezerepo? Muli ndi maganizo ena pa zogwiritsa ntchito njira zolera zomwe mukuona ngati sitinakhudzepo ndipo mukufuna tikambirane?

61. I wish to thank you for your time, the information you have shared and your patience.

Ndikuthokozani chifukwa chondipatsa nthawi ndiponso chifukwa chopilira nthawi yonse takhala tikucheza, Zikomo

APPENDIX 3

LOCUS OF CONTROL QUESTIONNAIRE

General, Family Planning and Fertility Locus of Control

Used for in-depth interviewees only.

Please indicate if you agree, disagree or have no opinion to the following statements:

1. I have often found that what is going to happen will happen, whether I want it or not.
 - (probe into whether they agree, disagree or have no opinion and reasons for taking the particular stand).
2. My life is chiefly controlled by people with more power than me.
 - (probe into who these people are, whether they agree, disagree or have no opinion and reasons for taking the particular stand).
3. In order to get what I want, I have to conform to the wishes of others.
 - (probe into who the others are, whether they agree, disagree or have no opinion and reasons for taking the particular stand).
4. What others want in the family should always come first before what I want.
 - (probe into who the others are, whether they agree, disagree or have no opinion and reasons for taking the particular stand).
 -
5. I can generally determine what will happen in my own life.
 - (probe into whether they agree, disagree or have no opinion and reasons for taking the particular stand).
6. When I get what I want, its usually because I have worked hard for it.
 - (probe into whether they agree, disagree or have no opinion and reasons for taking the particular stand).
7. If my husband doesn't want to practice family planning, there is nothing I can do to change his mind.
 - (probe into whether they agree, disagree or have no opinion and reasons for taking the particular stand).

8. A couple can choose the exact number of children they want and stop after that.

- (probe into whether they agree, disagree or have no opinion and reasons for taking the particular stand).

9. If I decide that I want no more children, I will be able to have my way.

- (probe into whether they agree, disagree or have no opinion and reasons for taking the particular stand).

10. If I decide that I want to delay the next birth, I will be able to have my way.

- (probe into whether they agree, disagree or have no opinion and reasons for taking the particular stand).

11. Even if he doesn't agree at first, I could convince my husband to use contraceptive methods if I feel we should use them.

- (probe into whether they agree, disagree or have no opinion and reasons for taking the particular stand).

12. I don't have much control over the number of children I will have with my husband, it is mostly up to the will of God or chance.

- (probe into whether they agree, disagree or have no opinion and reasons for taking the particular stand).

13. I don't have much control over how long I wait until I have the next child, it is mostly up to the will of God or chance.

- (probe into whether they agree, disagree or have no opinion and reasons for taking the particular stand).

14. The number of children I will have with my husband depends mostly on what my husband or others want, not what I want

- (probe into who the others are, whether they agree, disagree or have no opinion and reasons for taking the particular stand)

15. The time we wait before the next birth depends mostly on what my husband or others want, not what I want

- (probe into who the others are, whether they agree, disagree or have no opinion and reasons for taking the particular stand)

APPENDIX 4

Demographic Data and Reproductive History.

1. In which year were you born? _____
2. What is the highest level of education you attained?
 - a) _____ Junior primary school
 - b) _____ Senior primary school
 - c) _____ Junior certificate
 - d) _____ MSCE
 - e) _____ University
 - f) _____ other (specify) _____
3. What is your current occupation? _____
4. How long have you been married to your spouse _____
5. How many times have you been married? _____
6. What happened to your first husband?
 - a) _____ died
 - b) _____ divorced
 - c) _____ separated
 - d) _____ married another woman
 - e) _____ other reason, specify, _____
7. What is your tribal language? _____
8. What religious group do you belong to?
 - a) _____ Protestant denomination
 - b) _____ Roman Catholic
 - c) _____ Moslem
 - d) _____ Other, specify _____
9. How many times have you been pregnant? _____
10. How many times have you delivered altogether? _____
11. How many of the pregnancies were abortions or miscarriages? _____
12. How many children were born before nine months (preterm) ? _____
13. How many children were born dead? _____

14. What were causes of death in all your children who died? (Write the cause of death for each child mentioned in the space below).

15 How many children have been born to you? _____

16 How many of these are boys? _____

17 How many of these are girls? _____

18 How many of your sons are alive? _____

19 How many of your daughters are alive? _____

20 How many of your sons are dead? _____

21 How many of your daughters are dead? _____

Community Characteristics

22 How do you obtain information on contraceptives?

23 Where do you obtain contraceptive methods?

24 Would you consider this a highly religious community?

THANK YOU FOR THE INFORMATION AND YOUR TIME

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